

Advancing Population Health: Four Presentations from 2022 APHA Oral Health Student Awardees

CareQuest Institute Continuing Education Webinar

February 16, 2023

Housekeeping

- We will keep all lines muted to avoid background noise.
- We will send a copy of the slides and a link to the recording via email after the live program.
- We'll also make the slides and recording available on carequest.org.

To receive CE Credits:

- Look for the evaluation form, which we'll send via email within 24 hours.
- Complete the evaluation by **Friday, February 24**.
- Eligible participants will receive a certificate soon after via email.

We appreciate your feedback to help us improve future programs!



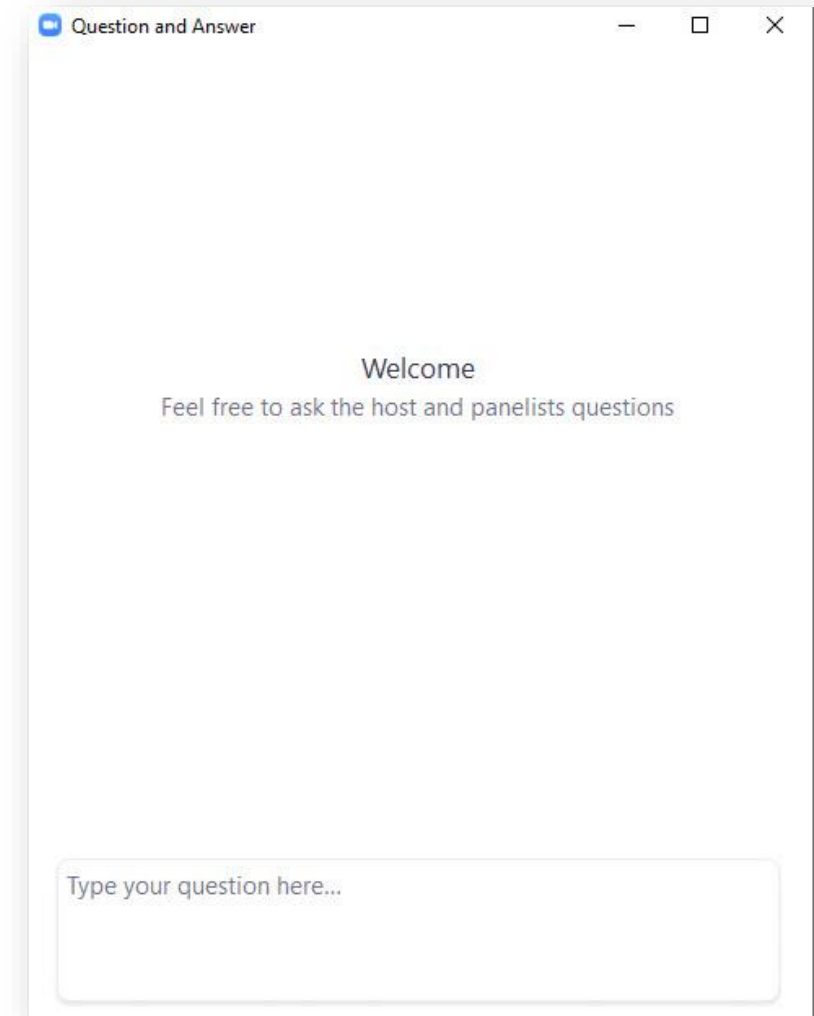
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*Full disclosures available upon request



Question & Answer Logistics

- Feel free to enter your questions into the **Question & Answer box** throughout the presentations.
- We will turn to your questions and comments toward the end of the hour.



Learning Objectives

At the end of this webinar, you'll be able to:

- Analyze successful oral health promotion strategies for college students.
- Explore current trends in knowledge and attitudes regarding alternative payment mechanisms in value-based care among dental providers.
- Evaluate the current scope of geriatric dental training in rural health care settings.
- Recognize the impact of paid sick leave on dental care utilization among working adults in the US.

Our Strategy

Vision

A future where every person can reach their full potential through optimal health

Mission

To improve the oral health of all

Purpose

To catalyze the future of health through oral health



Advancing Population Health: Four Presentations from 2022 APHA Oral Health Student Awardees

Dr. Navita Kaliar, BDS, MPH

Acknowledgements

The APHA Oral Health Section is grateful to the student award committee and reviewers for their hard work in making this award a success. The APHA Oral Health Section is also grateful for the generous support provided by CareQuest Institute for Oral Health for both the student awards.

APHA Oral Health Student Awards

- Anthony Westwater Jong Memorial Population Oral Health Pre-Professional Student Award
- Caswell A. Evans Population Oral Health Post-Professional Student Award

Students and early career professionals who win the awards receive mentorship opportunities, two years of APHA membership, APHA meeting registration, and travel support to the annual meeting.

Advancing Population Health: Four Presentations from 2022 APHA Oral Health Student Awardees



WEBINAR | Thursday, February 16, 2023 | 7–8 p.m. ET | ADA CERP Credits: 1

MODERATOR



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Dental Providers' Familiarity and Attitudes About Alternative Payment Mechanisms in Value- Based Care

Kevin Rodriguez-Lichtenberg, DDS, MPH, CPH

Introduction

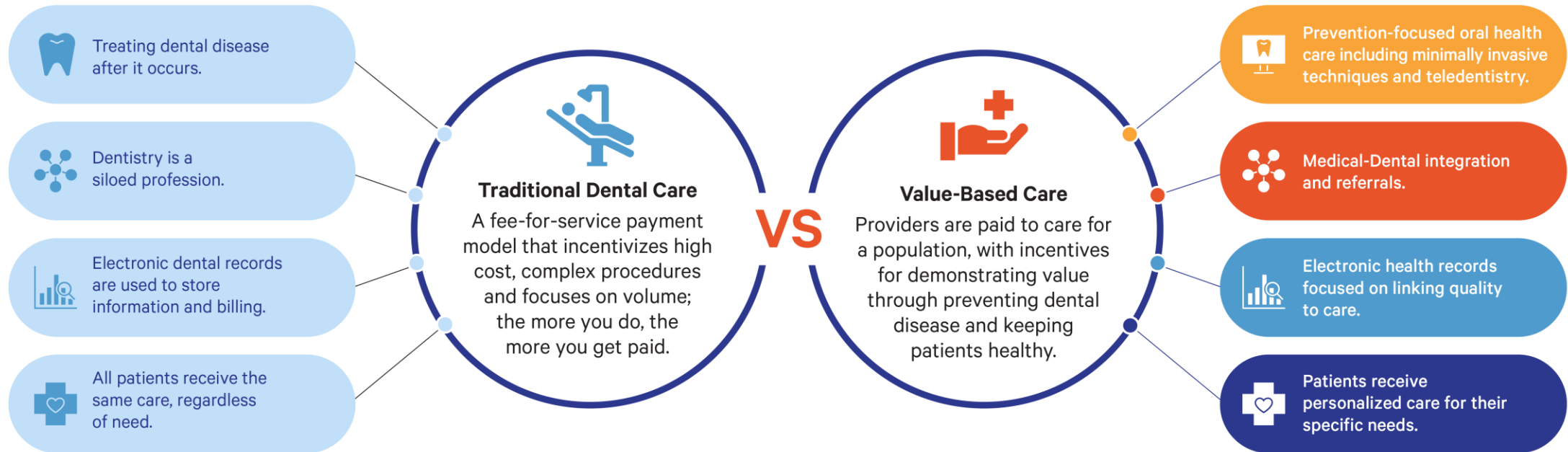
- The biggest payer of health care in the United States
- Massive amounts spent on dental care in the United States
- The value-based care (VBC) model versus fee-for-service (FFS)
- Alternative payment methods (APMs) versus fee-for-service (FFS)
- The goal of healthy outcomes over volume

FFS versus VBC

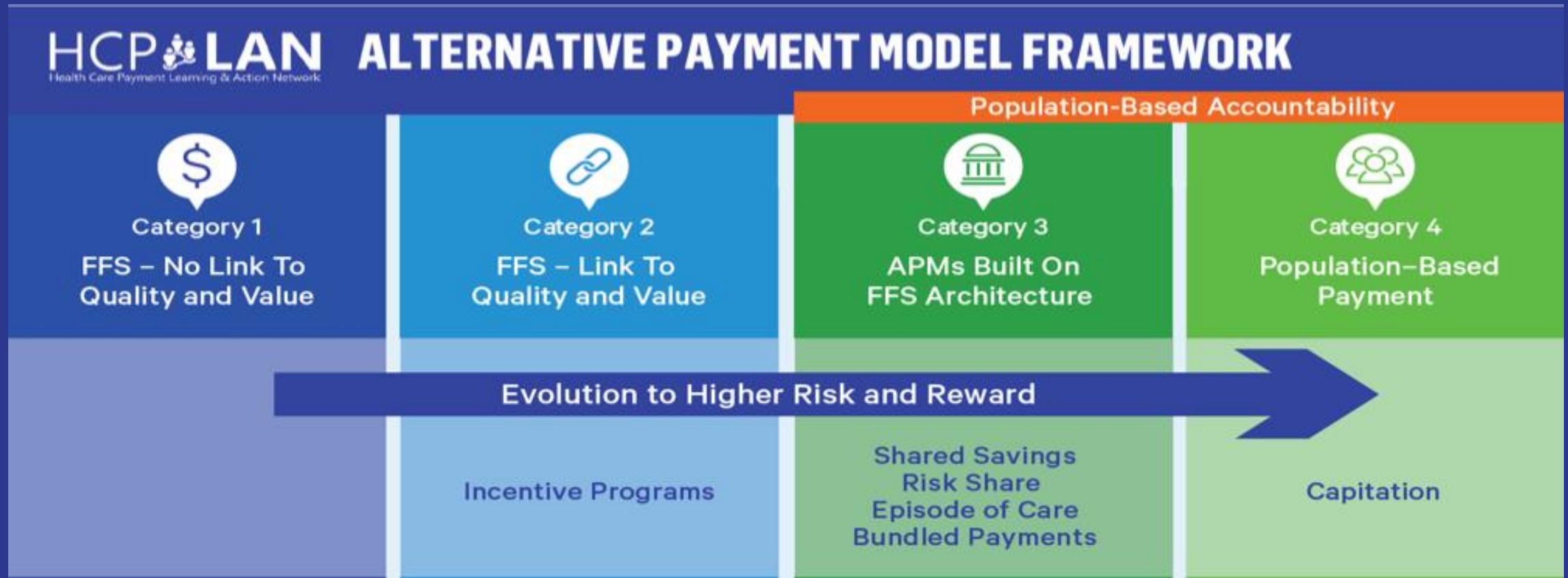
Improving the Patient Care Experience

For more than two centuries dentists have practiced in a fee-for-service (FFS) reimbursement environment. Workflow, care delivery, business plan, staffing, documentation, health information technology, scheduling billing, goals, productivity, policies and procedures, and communication have all been designed and implemented around a care and financing model that emphasizes volume over value.

The transition to value-based care (VBC) has the potential to change each of those areas in a significant way.



Brief Overview of APMs



Aim of the Study

To provide a baseline of the current *familiarity* and *attitudes* among dental providers regarding VBC and APMs in dental care

Methods

- Questions related to VBC and APM from a survey of DentaQuest-enrolled dental providers
- Inclusion criteria
- Three types of APMs were considered
- Stratification and data analysis

Results



Demographics

N=378	n	%
Age categories	Total: 377	
18 to 34	33	9%
35 to 44	97	26%
45 to 54	115	31%
55 to 64	92	24%
65 and older	40	11%
Race categories	Total: 378	
White	205	54%
Black	30	8%
Hispanic	43	11%
Other	100	26%
Practice type	Total: 368	
Private Practice Setting	321	87%
Public Health Setting	47	13%
Practice location	Total: 359	
Rural	61	17%
Suburban	155	43%
Urban	143	40%
Specialty type	Total: 235	
General Dentist	170	72%
Pediatric Dentist	41	17%
Other	24	11%
Gender	Total: 371	
Female	211	57%
Male	148	40%
Would rather not say	12	3%

*Attrition due to incomplete responses

How familiar are you with alternative payment models (APMs) in dentistry, as alternatives to fee-for-service reimbursement models?				What factors do you believe would accelerate the adoption of alternative payment models to support value-based care?						
	Have never heard of APMs	Have only heard of APMs/Know a little-moderate amount	Know them well but may p-value or may not be reimbursed via an APM		Appropriate provider compensation and incentive	Increase in risk sharing models like accountable care organizations	Medical dental Integration	Policy and regulation changes	Other	p-value
Age categories										
18 to 34	51.9%	44.4%	3.7%	0.766	65.2%	0.0%	4.4%	13.0%	17.4%	0.736
35 to 44	44.1%	52.4%	3.6%		57.1%	6.5%	10.4%	10.4%	15.6%	
45 to 54	38.6%	54.5%	6.9%		60.8%	3.1%	12.4%	9.3%	14.4%	
55 to 64	32.9%	59.5%	7.6%		66.2%	2.7%	10.8%	8.1%	12.2%	
65 and older	43.2%	51.4%	5.4%		62.2%	0.0%	2.7%	18.9%	16.2%	
Race categories										
White	36.8%	57.1%	6.1%	0.647	65.3%	1.2%	9.3%	9.8%	14.5%	0.240
Black	48.0%	52.0%	0.0%		65.2%	0.0%	13.0%	4.4%	17.4%	
Hispanic	46.9%	50.0%	3.1%		56.7%	10.0%	13.3%	10.0%	10.0%	
Other	41.5%	50.0%	8.5%		55.3%	6.6%	7.9%	15.8%	14.5%	
Practice type										
Private Practice Setting	43.4%	50.9%	5.7%	0.003	62.8%	3.8%	8.3%	10.5%	14.7%	0.237
Public Health Setting	17.1%	75.6%	7.3%		52.6%	0.0%	18.4%	13.2%	15.8%	
Practice location										
Rural	39.3%	55.4%	5.4%	0.992	58.8%	2.0%	9.8%	11.8%	17.7%	0.193
Suburban	38.7%	55.5%	5.8%		61.1%	2.3%	6.1%	13.7%	16.8%	
Urban	40.5%	52.9%	6.6%		65.5%	5.2%	12.9%	6.9%	9.5%	
Specialty type										
General Dentist	41.2%	54.7%	4.1%	0.695	61.1%	4.2%	11.8%	11.8%	11.1%	0.673
Pediatric Dentist	44.7%	50.0%	5.3%		57.9%	2.6%	7.9%	7.9%	23.7%	
Other	38.0%	54.2%	7.8%		63.5%	2.4%	7.9%	10.3%	15.9%	

What alternative reimbursement models would you be interested in?

	Risk Share				Partial Capitation				Full Capitation			
	Extremely/ moderately interested	Slightly interested	Not interested at all	p-values	Extremely/ moderately interested	Slightly interested	Not interested at all	p-values	Extremely/ moderately interested	Slightly interested	Not interested at all	p-values
Age categories												
18 to 34	33.3%	40.0%	26.7%	0.049	40.0%	33.3%	26.7%	0.13	46.7%	40.0%	13.3%	0.16
35 to 44	30.4%	45.7%	23.9%		41.3%	30.4%	28.3%		43.5%	32.6%	23.9%	
45 to 54	25.9%	40.7%	33.3%		27.8%	44.4%	27.8%		31.5%	35.2%	33.3%	
55 to 64	30.4%	17.4%	52.2%		36.1%	19.2%	44.7%		45.8%	16.7%	37.5%	
65 and older	13.0%	43.5%	43.5%		20.8%	50.0%	29.2%		21.7%	43.5%	34.8%	
Race categories												
White	20.2%	42.4%	37.4%	0.199	28.7%	36.6%	34.7%	0.457	32.0%	34.0%	34.0%	0.171
Black	28.6%	21.4%	50.0%		35.7%	21.4%	42.9%		46.7%	13.3%	40.0%	
Hispanic	42.9%	23.8%	33.3%		47.6%	38.1%	14.3%		57.1%	33.3%	9.5%	
Other	34.8%	32.6%	32.6%		34.8%	32.6%	32.6%		39.1%	28.3%	32.6%	
Practice type												
Private Practice Setting	25.7%	34.2%	40.1%	0.063	31.2%	34.4%	34.4%	0.318	37.0%	30.5%	32.5%	0.674
Public Health Setting	34.5%	48.3%	17.2%		41.4%	37.9%	20.7%		41.4%	34.5%	24.1%	
Practice location												
Rural	23.1%	42.3%	34.6%	0.077	26.9%	30.8%	42.3%	0.001	34.6%	30.8%	34.6%	0.014
Suburban	17.6%	35.1%	47.3%		19.7%	35.5%	44.7%		27.6%	29.0%	43.4%	
Urban	35.1%	36.4%	28.6%		46.8%	36.4%	16.9%		48.1%	33.8%	18.2%	
Specialty type												
General Dentist	27.7%	34.0%	38.3%	0.196	29.8%	36.2%	34.0%	0.091	39.0%	31.0%	30.0%	0.149
Pediatric Dentist	6.3%	37.5%	56.3%		11.1%	50.0%	38.9%		12.0%	53.0%	35.0%	
Other	31.1%	39.2%	29.7%		43.2%	28.4%	28.4%		42.7%	26.7%	30.6%	

Do you think shifting dental practice toward value-based care will generate more equitable outcomes among patients?

	No	Yes	p-value
Age categories			
18 to 34	58.3%	41.7%	0.102
35 to 44	65.9%	34.2%	
45 to 54	75.0%	25.0%	
55 to 64	72.2%	27.8%	
65 and older	86.1%	13.9%	
Race categories			
White	74.6%	25.4%	0.025
Black	73.9%	26.1%	
Hispanic	48.4%	51.6%	
Other	74.4%	25.6%	
Practice type			
Private Practice Setting	74.2%	25.8%	0.015
Public Health Setting	55.3%	44.7%	
Practice location			
Rural	75.0%	25.0%	0.77
Suburban	73.9%	26.2%	
Urban	70.4%	29.6%	
Specialty type			
General Dentist	75.5%	24.5%	0.186
Pediatric Dentist	77.8%	22.2%	
Other	66.7%	33.3%	

Discussion

- A VBC delivery system utilizing APMs could be financially advantageous.
- Hispanic dentists were more likely to think VBC will increase equitable outcomes.
- Public health practitioners and SDOHs (social determinants of health)
- Interest in APMs, and factors that could accelerate the adoption of APMs to support VBC
- There is a lack of education among provider responses regarding APMs and VBC.

Discussion, Cont.

- Behavioral public health interventions might be advantageous toward moving to VBC.
- The change toward VBC in dentistry will involve incremental approaches.
- VBC and APMs in dentistry will completely change the way dental care is delivered and how practice finances are managed.
- Our findings support the need for further research and educational opportunities for dental providers to learn about our health care system.

Conclusion

- Providers in public health settings and in urban areas are more familiar and currently utilize APMs.
- Most of the dental workforce has a lack of familiarity regarding both VBC and APMs.
- It is imperative to create educational interventions to increase familiarity, knowledge, and positive attitudes and perceptions toward VBC.

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Impact of Paid Sick Leave on Dental Services Utilization Among Working Adults in the United States

Rashmi Lamsal, PhD

Introduction

- **\$142 .4** billion for dental expenses
- **\$45** billion productivity loss
- Poor oral health leads to severe health problems
- The American Dental Association's recommendation
- Dental visits increased from **65.1%** in 2000 to **65.5%** in 2019, then decreased to **63%** in 2020

Research Gap

- The United States is one of the three OECD countries with no statutory PSL for their worker.
- **22%** of workers in private industry and **59%** in service occupations do not have access to PSL benefits.
- Few studies have explored the benefits of PSL.

Purpose and Objective

To examine the impact of the availability of PSL on different types of dental services utilization among working adults aged 18-64 using nationally representative data

- **Hypothesis 1:** Employed adults aged 18-64 with access to PSL are more likely to have at least one dental visit.
- **Hypothesis 2:** Employed adults aged 18-64 with access to PSL are more likely to have preventive dental visits.
- **Hypothesis 3:** Employed adults aged 18-64 with access to PSL are more likely to have diagnostic dental visits.
- **Hypothesis 4:** Employed adults aged 18-64 with access to PSL are more likely to have dental treatment visits.

Data Source

Medical Expenditure Panel Survey

Applicable population:

- Adults aged 18-64 who were employed throughout the survey year, not self-employed at some point during the survey year and did not change their job

Total sample

- 7,645 adults were employed throughout the period 2019.

Variables

Dependent variables

- At least one dental visit in the year 2019
- Preventive dental visits
- Diagnostic dental visits
- Treatment dental visits

Independent variables

- Paid sick leave

Covariates

- Age, gender, race/ethnicity, marital status, education, health insurance, dental insurance, poverty, general health status, and region

Analysis

Bivariate analysis: Pearson χ^2

Multivariable logistic regressions controlling for all covariates

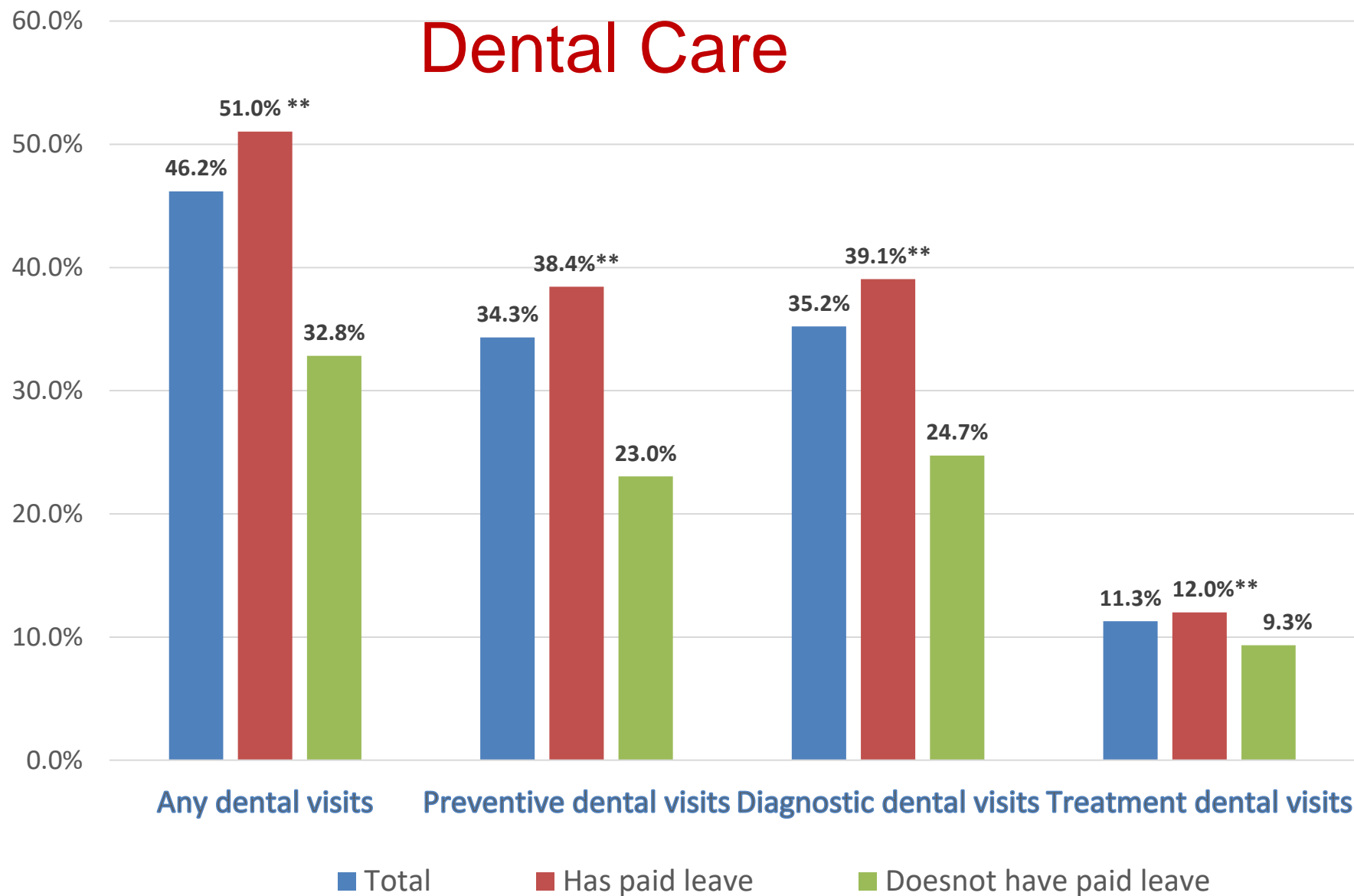
Sensitivity analysis: full-year dental insurance and people who changed their jobs

Stata MP v.17 adjusted for complex survey design

Results

	Total Study Population N=7645	Paid leave		p-value
		Yes (N=5450)	No (N=2195)	
Age				<0.01
18-24	522 (7.81)	208 (4.55)	314 (16.75)	
25-34	1698 (24.52)	1191 (24.37)	507 (24.92)	
35-44	1921 (24.41)	1416 (25.59)	505 (21.18)	
45-54	1850 (23.34)	1396 (24.60)	454 (19.88)	
55-64	1654 (19.92)	1239 (20.88)	415 (17.27)	
Female	3780 (48.01)	2746 (49.03)	1034 (45.20)	<0.01
Race/Ethnicity				<0.01
Non-Hispanic White Only	4301 (61.97)	3235 (64.28)	1066 (55.66)	
Hispanic	1720 (17.82)	1045 (15.39)	675 (24.46)	
Non-Hispanic Black Only	947 (10.72)	693 (10.95)	254 (10.09)	
Non-Hispanic Asian Only	454 (6.59)	321 (6.62)	133 (6.51)	
Others	223 (2.90)	156 (2.77)	67 (3.28)	
Marital Status				<0.01
Never married	2160 (29.69)	1341 (26.08)	819 (39.60)	
Married	4352 (56.80)	3300 (60.21)	1052 (47.43)	
Divorced/separated/Widowed	1133 (13.51)	809 (13.71)	324 (12.97)	
Education				<0.01
Less than high school	633 (6.60)	234 (3.26)	399 (15.76)	
High school graduate/GED	3264 (39.95)	2114 (36.07)	1150 (50.59)	
Bachelors and above	3748 (53.45)	3102 (60.67)	646 (33.66)	
Region				<0.01
Northeast	1147 (17.24)	848 (17.59)	299 (16.28)	
Midwest	1720 (22.65)	1188 (22.38)	532 (23.40)	
South	2773 (36.62)	1892 (35.08)	881 (40.85)	
West	2005 (23.49)	1522 (24.95)	483 (19.48)	
Poverty	555 (5.15)	181 (2.35)	374 (12.82)	<0.01
Dental Insurance	4767 (65.62)	3857 (72.85)	910 (45.80)	<0.01
Health Insurance	7004 (93.10)	5251 (97.02)	1753 (82.35)	<0.01
Self reported health	6546 (87.04)	4725 (87.92)	1821 (84.62)	<0.01

Dental Care



	Any Dental Visits OR (95% CI)	Preventive dental visits OR (95% CI)	Diagnostic dental visits OR (95% CI)	Treatment dental visits OR (95% CI)
Paid Leave	1.38 (1.17 , 1.63)	1.33 (1.12 , 1.57)	1.31 (1.11 , 1.55)	1.21 (0.98 , 1.49)
Age				
18-24	Ref	Ref	Ref	Ref
25-34	0.67 (0.50 , 0.89)	0.77 (0.57 , 1.03)	0.71 (0.53 , 0.94)	0.70 (0.49 , 1.02)
35-44	0.89 (0.66 , 1.21)	0.92 (0.66 , 1.28)	0.95 (0.70 , 1.30)	0.78 (0.53 , 1.13)
45-54	0.91 (0.68 , 1.24)	0.97 (0.70 , 1.35)	0.91 (0.67 , 1.25)	0.83 (0.57 , 1.19)
55-64	1.43 (1.06 , 1.93)	1.21 (0.87 , 1.70)	1.16 (0.86 , 1.56)	1.24 (0.86 , 1.79)
female	1.47 (1.32 , 1.64)	1.33 (1.18 , 1.50)	1.40 (1.25 , 1.56)	1.18 (0.99 , 1.41)
Race/Ethnicity				
Non-Hispanic White Only	Ref	Ref	Ref	Ref
Hispanic	0.62 (0.51 , 0.74)	0.61 (0.52 , 0.73)	0.55 (0.45 , 0.67)	1.02 (0.79 , 1.31)
Non-Hispani Black Only	0.58 (0.47 , 0.72)	0.54 (0.42 , 0.71)	0.55 (0.44 , 0.69)	1.00 (0.75 , 1.33)
Non-Hispanic Asian Only	0.58 (0.44 , 0.75)	0.54 (0.39 , 0.75)	0.59 (0.43 , 0.83)	0.94 (0.65 , 1.37)
Others	0.63 (0.43 , 0.94)	0.64 (0.42 , 0.97)	0.64 (0.42 , 0.98)	1.00 (0.61 , 1.64)
Marital status				
Never married	Ref	Ref	Ref	Ref
Married	1.08 (0.93 , 1.26)	1.15 (0.97 , 1.36)	1.07 (0.90 , 1.25)	0.90 (0.73 , 1.11)
Divorced/separated/Widowed	0.92 (0.75 , 1.14)	0.94 (0.74 , 1.18)	0.96 (0.78 , 1.19)	1.00 (0.76 , 1.33)
Education status				
Less than high school	Ref	Ref	Ref	Ref
High school graduate/GED	1.23 (0.96 , 1.57)	1.38 (0.98 , 1.93)	1.17 (0.87 , 1.57)	0.96 (0.68 , 1.36)
Bachelors and above	2.35 (1.78 , 3.10)	2.71 (1.92 , 3.82)	2.13 (1.57 , 2.89)	0.93 (0.64 , 1.35)
Region				
Northeast	Ref	Ref	Ref	Ref
Midwest	1.17 (0.97 , 1.41)	1.07 (0.87 , 1.31)	1.23 (1.00 , 1.52)	1.17 (0.84 , 1.65)
South	0.91 (0.76 , 1.09)	0.76 (0.61 , 0.94)	0.91 (0.75 , 1.12)	1.12 (0.83 , 1.50)
West	1.22 (1.02 , 1.46)	1.01 (0.83 , 1.24)	1.12 (0.94 , 1.34)	1.41 (1.05 , 1.89)
Poverty	0.73 (0.56 , 0.96)	0.67 (0.48 , 0.92)	0.84 (0.62 , 1.14)	0.82 (0.55 , 1.21)
Health Insurance	2.05 (1.46 , 2.88)	2.15 (1.43 , 3.22)	2.13 (1.43 , 3.16)	1.60 (0.97 , 2.63)
Dental Insurance	1.59 (1.39 , 1.82)	1.55 (1.34 , 1.79)	1.51 (1.31 , 1.74)	1.25 (1.01 , 1.56)
Self-reported Health	1.15 (0.97 , 1.38)	1.50 (1.23 , 1.84)	1.30 (1.07 , 1.59)	0.72 (0.57 , 0.92)

Discussion

More than **50%** of working adults did not utilize regular dental services.

More than **25%** of the working adults still don't have access to paid sick leave.

Our study is the first to use a national estimate to show the association.

The study showed differences in the use of dental care based on race and ethnicity.

Access to PSL allows workers to take time off from work and care for their dental needs.

Limitations



Causal deduction
could not be
established



Lack of data on the
number of PSL among
employees



Focuses only on full-
time workers

Future Direction



Nationally representative data as statistical evidence to mandate paid sick leave



A need to increase access to primary dental care services

Routine wellness days
Increase the scope of practice
Teledentistry



Explore other barriers that lead to lower dental service utilization

Conclusion



Insurance is a significant predictor but not sufficient for dental services



Paid sick leave is also one of the effective ways



Valuable insights to medical professionals and health policymakers

Disclosure

Authors:

- Rashmi Lamsal
- Dr David Palm
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- Dr Melissa Tibbits
- Dr Li-Wu Chen,
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Training and Educational Programs that Support Geriatric Dental Care in Rural Settings: A Scoping Review

Tejasvita Chandel BDS, MMSc

Background

- Older adults are living longer than before.
- They are at higher risk of having poor oral health and lacking insurance.
- They often have underlying complex health conditions, especially those who are frail, homebound, and living in long-term care facilities.



An Aging Nation

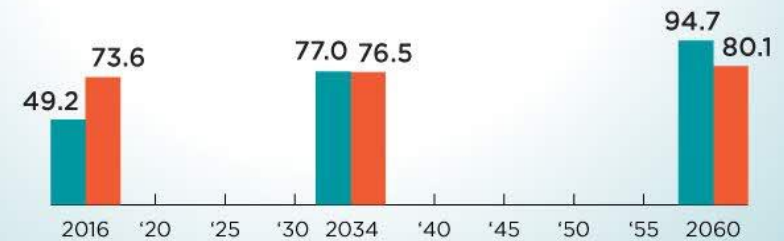
Projected Number of Children and Older Adults

For the First Time in U.S. History Older Adults Are Projected to Outnumber Children by 2034

Projected percentage of population



Projected number (millions)



Note: 2016 data are estimates not projections.

United States[®]
Census
Bureau

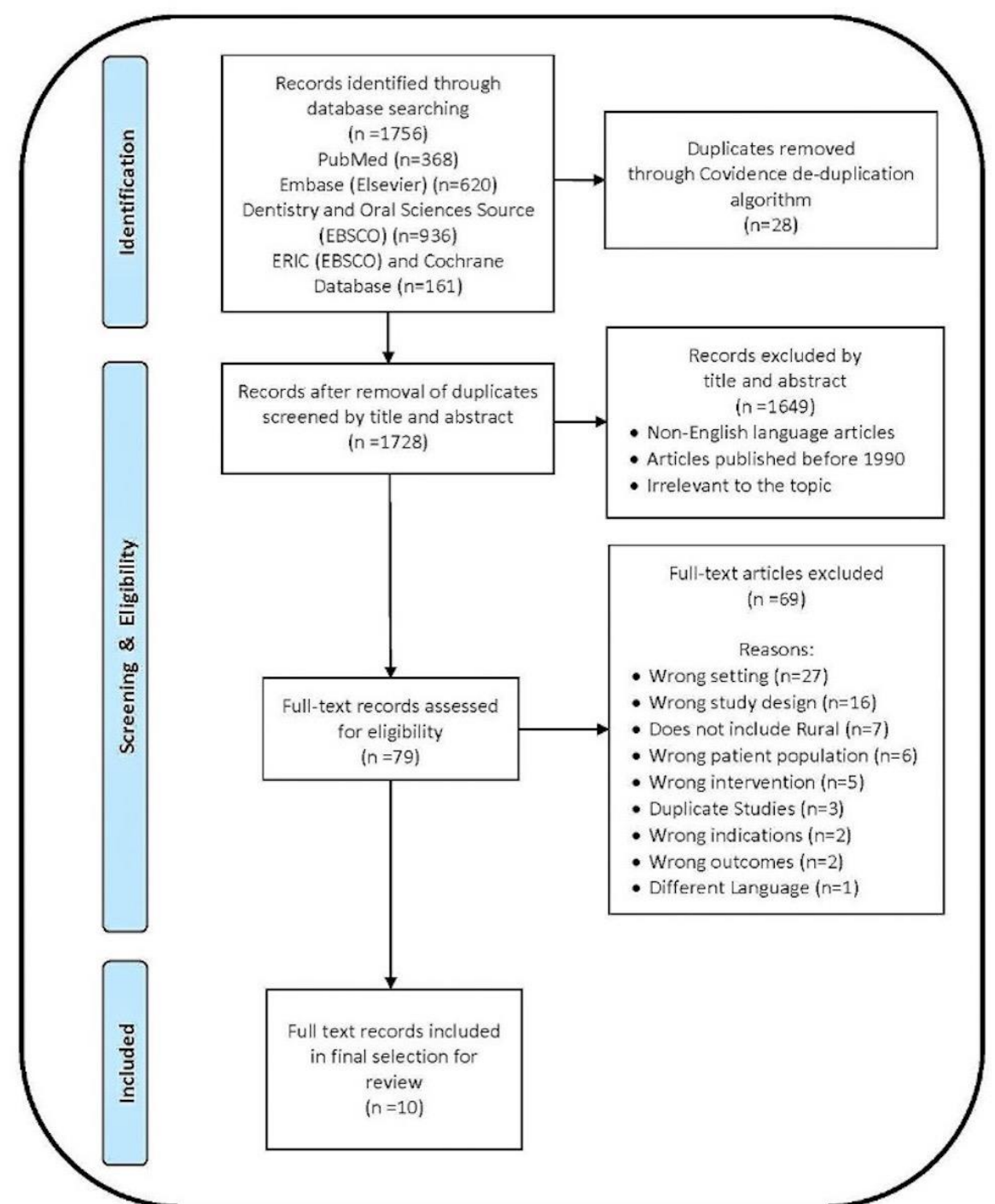
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census.gov

Source: National Population Projections, 2017
www.census.gov/programs-surveys/popproj.html

The aim of this study was to conduct a scoping review to identify the current landscape of geriatric dental training in rural health care settings.

Methods

Preferred Reporting Items for Systematic Reviews and Meta-Analyses – scoping extension (PRISMA-ScR)



Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> ● Study population aged >65 years <p>The article must discuss the following concepts:</p> <ul style="list-style-type: none"> ● Concept 1: Dental Workforce provision of dental care, dental treatment, other medical care ● Concept 2: Education/trainings/curricula beyond the routine process of providing dental training/education to care for patients in clinical practice. Training material/ course/ educational material/ curriculum/ teaching instructions/ best practices/ guideline/ oral health assessment/ training for oral health care providers regarding geriatric care ● Concept 3: Rural ● Concept 4: Geriatric Care 	<ul style="list-style-type: none"> ● Studies not written in English. ● Studies not including geriatric care. ● Studies not including rural/remote settings. ● Non-peer-reviewed journals, government reports; theses. ● Articles published before 1990

Results

To date, the US does not have either the established and consistent educational geriatric dental training, nor the policies to provide optimal oral health care to older adults.

Recommendations

- Dental curriculum reform
- Reform of graduate dental accreditation of rural and underserved facilities
- “Mini residency” in rural/underserved areas

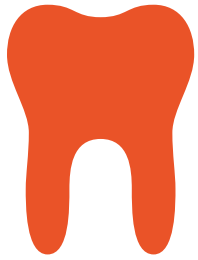


Recommendations

- Oral health care workforce model/scope of practice reform
- Interprofessional models – “smiles for life” and “tooth wisdom”
- Oral health education among family caregivers



Conclusion



Scant number of
trained geriatric
dentists



Gap within the
dental curricula



Need for innovative
strategies

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Why We (Still) Need to Add Dental to Medicare	Adult Dental Benefit, Expanding Access, Health Equity	Report
A Cross-Sectional Analysis of Oral Health Care Spending over the Life Span in Commercial- and Medicaid-Insured Populations	Expanding Access, Health Equity	Article
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Missed Connections

Providers and Consumers Want More Medical-Dental Integration

Oral health and overall health are inextricably linked. There is mounting evidence to suggest that poor oral health is related to a variety of chronic health conditions, such as high blood pressure, dementia, diabetes, and obesity. Despite this known connection, dental care is still largely siloed from medical care. The Centers for Disease Control and Prevention (CDC) estimates that integrating basic health screenings into a dental setting could save the health care system up to \$100 million every year.¹

CareQuest Institute for Oral Health conducted a nationally representative survey in January and February 2021 to assess consumers' perspectives on oral and overall health (n=5,320). CareQuest Institute also conducted a nationwide survey of oral health providers to assess perspectives and current behaviors related to interprofessional practice (n=377). Consumers and oral health providers described a lack of integration between medical and oral health care, and a desire for increased interprofessional collaboration.

Key Findings:
Medical-dental collaboration is currently uncommon.

- 63% of consumers report that their primary medical doctor "rarely" or "never" asks about their oral health.
- 33% of consumers report that their oral health provider "rarely" or "never" asks about their overall health.
- 45% of responding oral health providers report "rarely" integrating their care with clinicians outside of dentistry, with only 14% reporting it is part of their "daily" practice.
- Less than a third of consumers report receiving general health screenings from their oral health provider.
- A majority (89%) of adults report never receiving a referral from their oral health provider to a non-oral health professional.
- Almost a fourth (24%) of participating oral health providers report currently implementing interprofessional practice.

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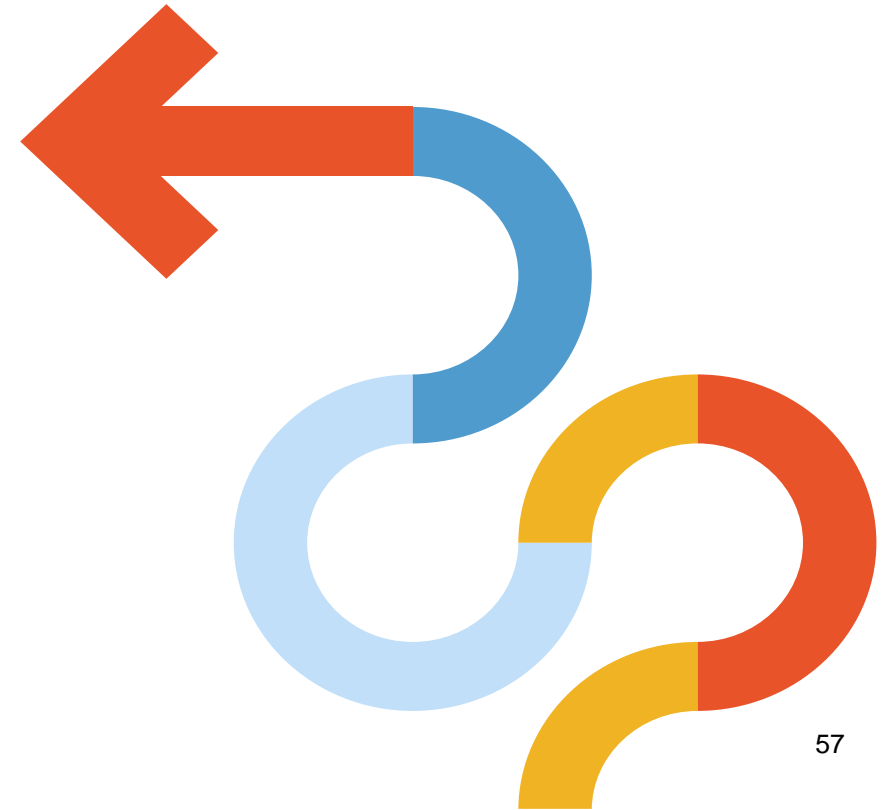
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