2015 Adolescent Health Symposium

Christina A. Demopoulos, DDS, MPH
Diplomate-American Board of Dental Public Health

January 21, 2015

Adolescent Oral Health: Oral Health Status of Adolescents in Nevada

Learning Objectives

- Understand the oral health status of adolescents in Nevada
- Understand the pediatric dental provisions within the Affordable Care Act and how these provisions can increase access to dental care for adolescents
- Identify statewide oral health partners that can help address the oral health needs of adolescents
- Identify innovative public/private partnerships that can help promote oral health in this target population

Background

- University of Nevada, Las Vegas (UNLV) undergrad
- University of Southern California (USC), School of Dentistry
- UNLV (Master of Public Health)
- University of Texas, Health Science Center at San Antonio (UTHSCSA) School of Dentistry (Dental Public Health Residency)

UNLV School of Dental Medicine Community Outreach

UNLV School of Dental Medicine
Crackdown on Cancer

What is the Crackdown on Cancer Program?

- Funded by the Fund for a Healthy Nevada (MSA funds) ; additional funding from Trust Fund for Public Health (MSA funds for middle school program)
- Presentations/screenings in high schools
- Presentations in middle schools
- The program began in 2001. As of June 30, 2010:
  - Conducted over 78,000 screenings
  - Given almost 4,500 presentations with 170,000 students in attendance
  - Documented more than 2,000 tissue abnormalities

UNLV School of Dental Medicine
Crackdown on Cancer

- The program used two mobile dental clinics with qualified dental professionals to offer free comprehensive oral cancer screenings to students enrolled in the public high schools in Nevada.

- Program staff offered:
  - tobacco education
  - brief intervention counseling
  - environmental tobacco smoke (ETS), secondhand smoke education
  - referrals for tobacco cessation as well as follow-up services for evidence of a tobacco-related disease or dental disease

- By bringing the mobile dental clinic to participating schools, we were able to overcome many access issues which allowed for maximum participation.

UNLV School of Dental Medicine
Crackdown on Cancer

The Goals of Crackdown on Cancer:

- Create awareness about the damaging effects of tobacco use
- Reduce the initiation of tobacco use among teens
- Create awareness about the effects of environmental tobacco smoke
- Provide tobacco information for students' family and friends


CRACKDOWN ON CANCER
Where have we been?
NEVADA
OREGON
IDAHO
UTAH
ARIZONA
Lakeview
McDermitt
Alturas
Susanville
Winnemucca
Battle Mountain
Wells
Elko
Great Salt Lake
Lovelock
Pyramid Lake
Austin
Eureka
Ely
Lake Tahoe
Placerville
Walker Lake
Hawthorne
Tonopah
Caliente
Cedar City
St. George
YOSEMITE NATIONAL PARK
Mono Lake
Yosemite NP
Modesto
Merced
Bishop
KINGS CANYON NATIONAL PARK
Madera
Fresno
SEQUOIA NATIONAL PARK
Visalia
Tulare
Coalinga
Independence
Lone Pine
Beatty
Indian Springs
Overton
Lake Mead
Las Vegas
Henderson
DEATH VALLEY NATIONAL PARK
LAKE MEAD NATIONAL RECREATION AREA
Kingman
Needles
Barstow
Ridgecrest
Bakersfield
Delano
Paso Robles
Morro Bay
San Luis Obispo
©1997 MAGELLAN Geographix
(805) 685-3100 www.maps.com

Statistical Findings

Data collected: 7/1/01-3/31/10

2001-2010	Las Vegas Metro	Reno Metro	Rural
# Screenings	35,692	21,196	19,163
% of Database	47% of Total	28% of Total	25% of Total
Male	44%	29%	27%
Female	50%	26%	24%
% Use Cigarettes	32%	35%	33%
% Use Smokeless Tobacco	7%	24%	69%
Tissue Abnormalities	562	830	686

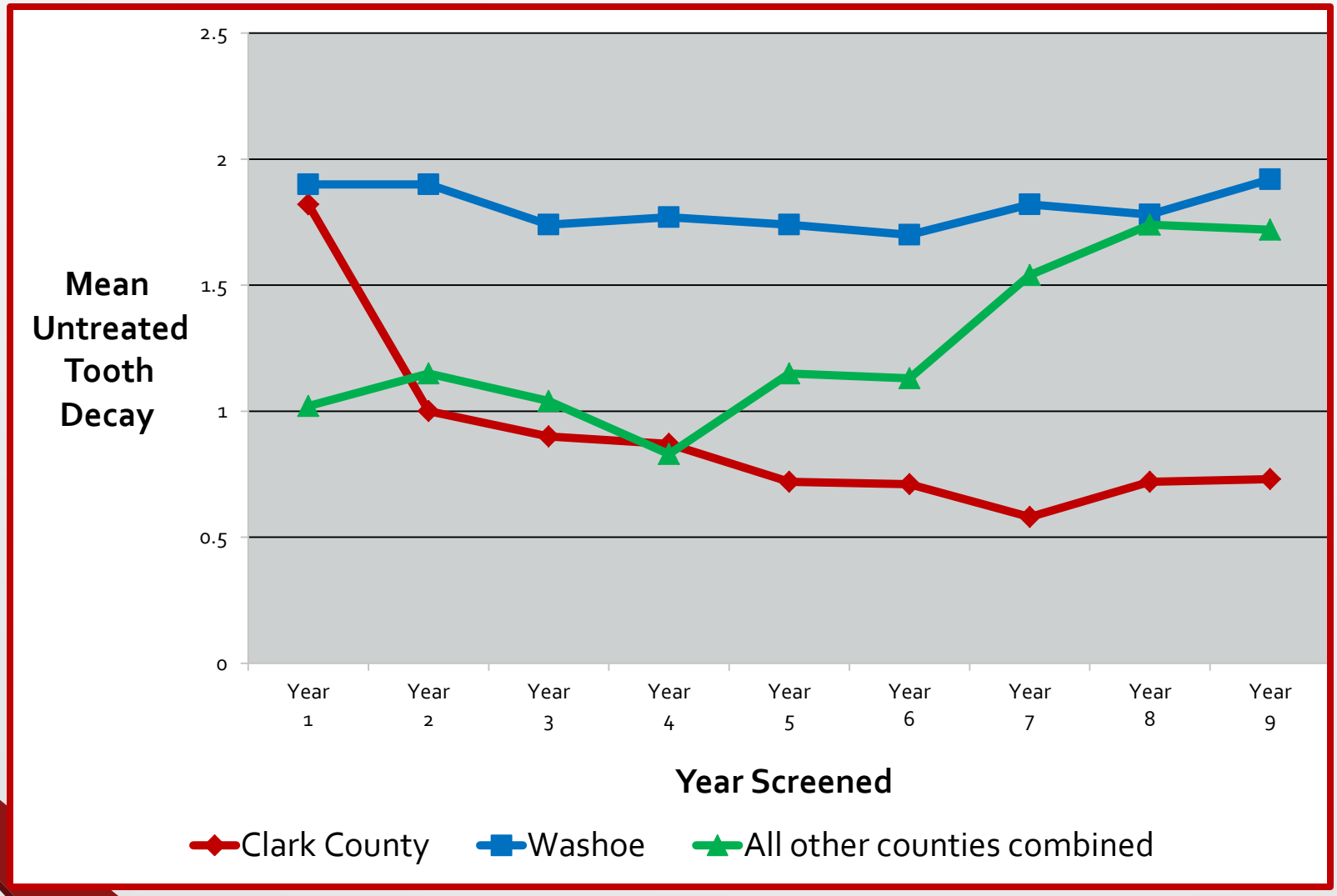
Table 1. Comparison of Nevada Oral Health Screening Initiative Data (2008) to NHANES (1999-2004)

Nevada Oral Health Screening Initiative				NHANES (1999-2004)			
Variable	Decay % (SE)	DMFT Mean (SE)	Sealants % (SE)	Variable	Decay** % (SE)	DMFT Mean (SE)	Sealants % (SE)
Age				**Age**			
13-15	28.4% (1.22)	2.46 (0.03)	49.6% (0.63)	12-15	16.91% (0.99)	1.78 (0.08)	41.04% (1.83)
16-18	38.0% (1.48)	3.60 (0.07)	50.0% (1.10)	16-19	22.24% (1.45)	3.31 (0.09)	34.28% (1.70)
Sex				**Sex**			
Males	29.2% (1.03)	2.67 (0.05)	51.1% (0.82)	Males	19.89% (1.22)	2.31 (0.09)	36.43% (1.65)
Females	31.0% (1.31)	2.91 (0.05)	48.3% (1.12)	Females	19.31% (1.30)	2.79 (0.08)	38.93% (1.51)
Race/Eth*				**Race/Eth**			
White, NH	26.4% (1.26)	2.64 (0.05)	58.4% (1.57)	White, NH	16.22% (1.45)	2.54 (0.10)	43.90% (1.81)
Black, NH	36.1% (1.74)	2.91 (0.12)	27.4% (1.22)	Black, NH	25.66% (1.39)	2.20 (0.10)	25.68% (2.01)
Hispanic	37.5% (1.42)	3.25 (0.06)	37.7% (1.85)	Hispanic	28.57% (1.54)	2.82 (0.13)	27.23% (2.34)

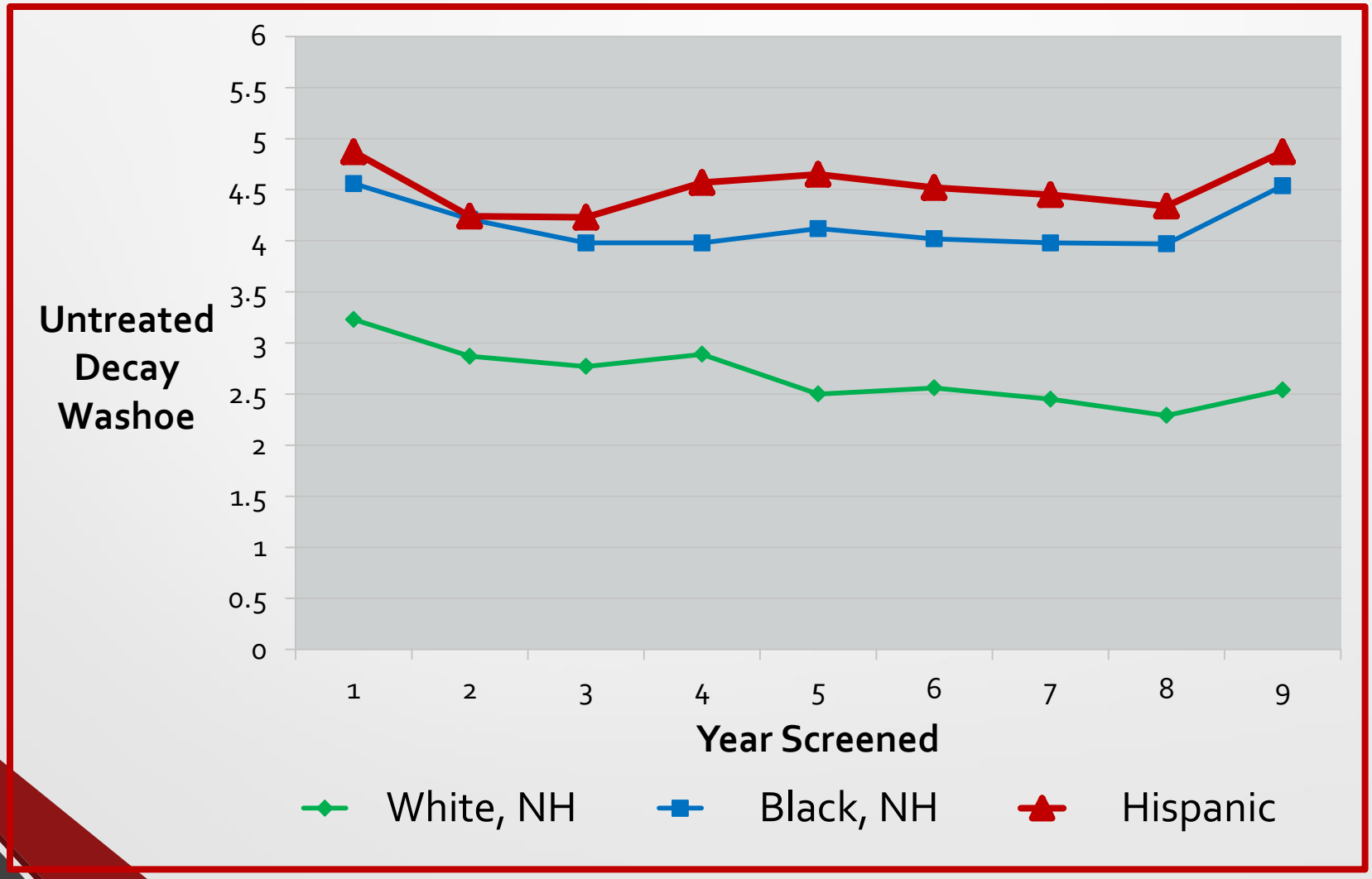
Note. Nevada Data: N=9202; *N=8participants0 due to missing data; **Untreated Caries
NHANES (1999-2004) estimates are adjusted to the US 2000 standard population (3); SE= Standard Error.

Healthy People 2020 target for 13 to 15 yo: 15.3%; baseline was 17% from NHANES

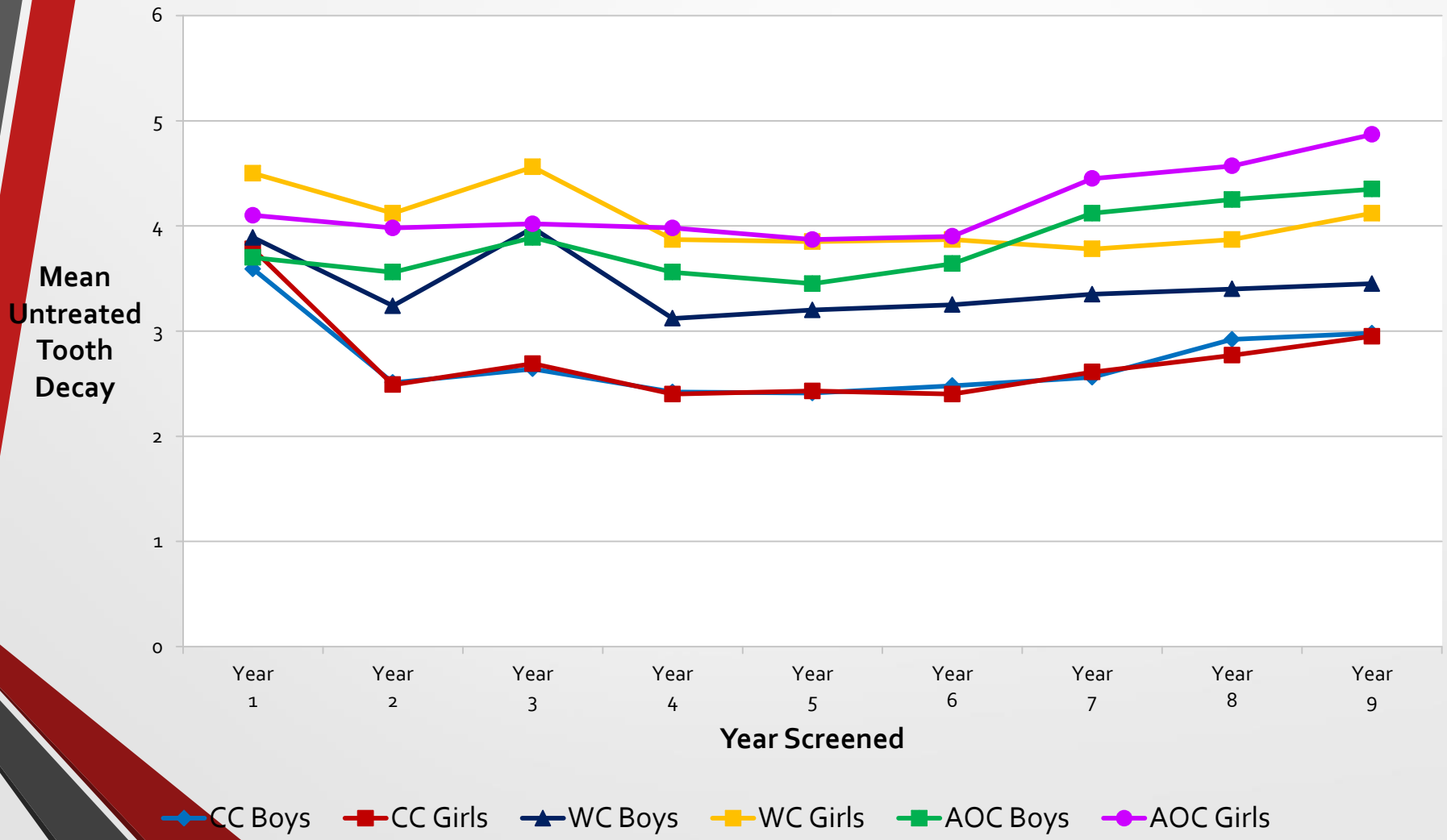
Overall Trends
Untreated Tooth Decay
(2001-2010)



Mean Untreated Decay, By Race/Washoe County



Untreated Tooth Decay, 3 counties by gender

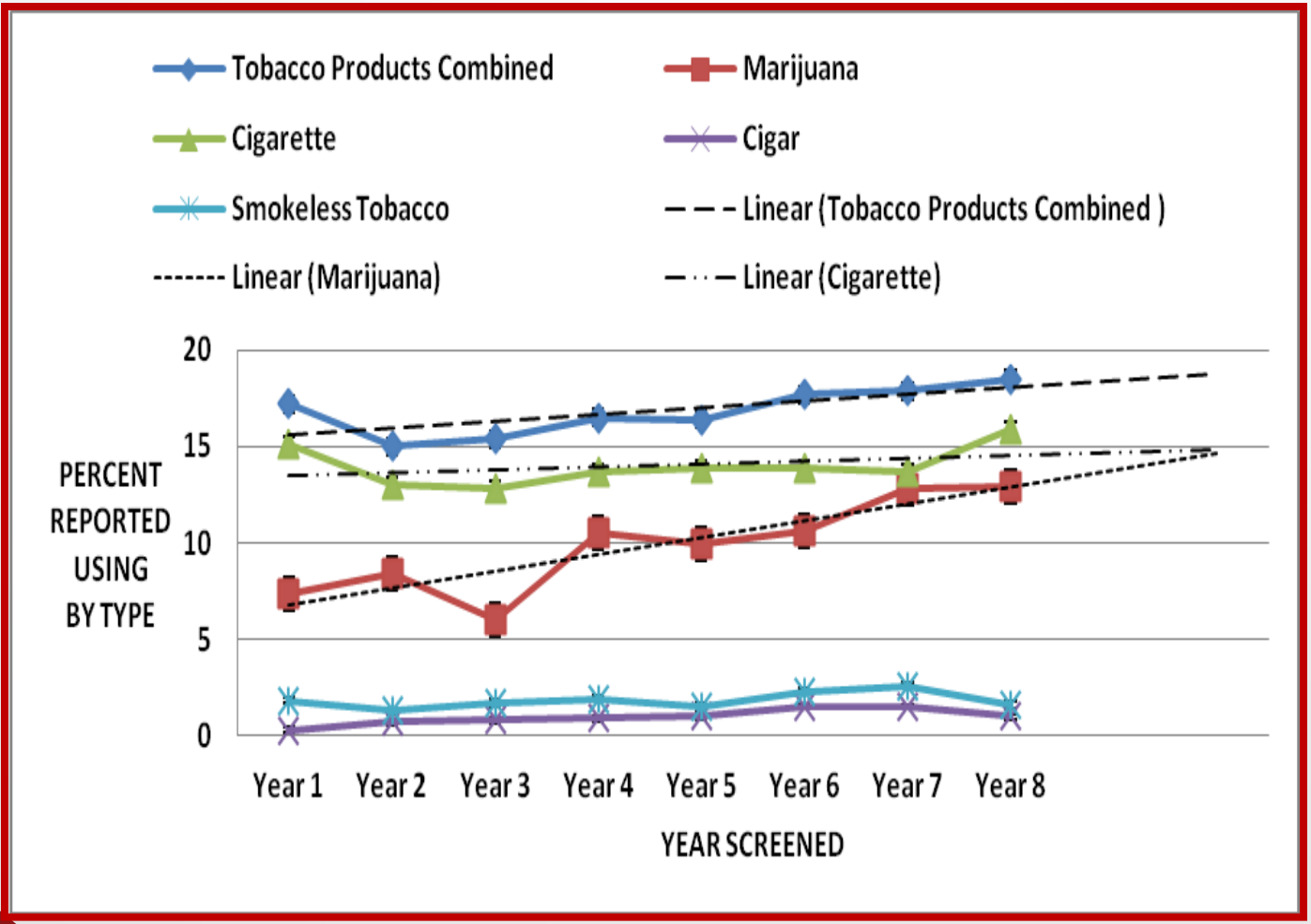


Untreated Tooth Decay - Percent Difference between Those Who Use and Those Who Do Not Use Tobacco/Marijuana (2002-2010)

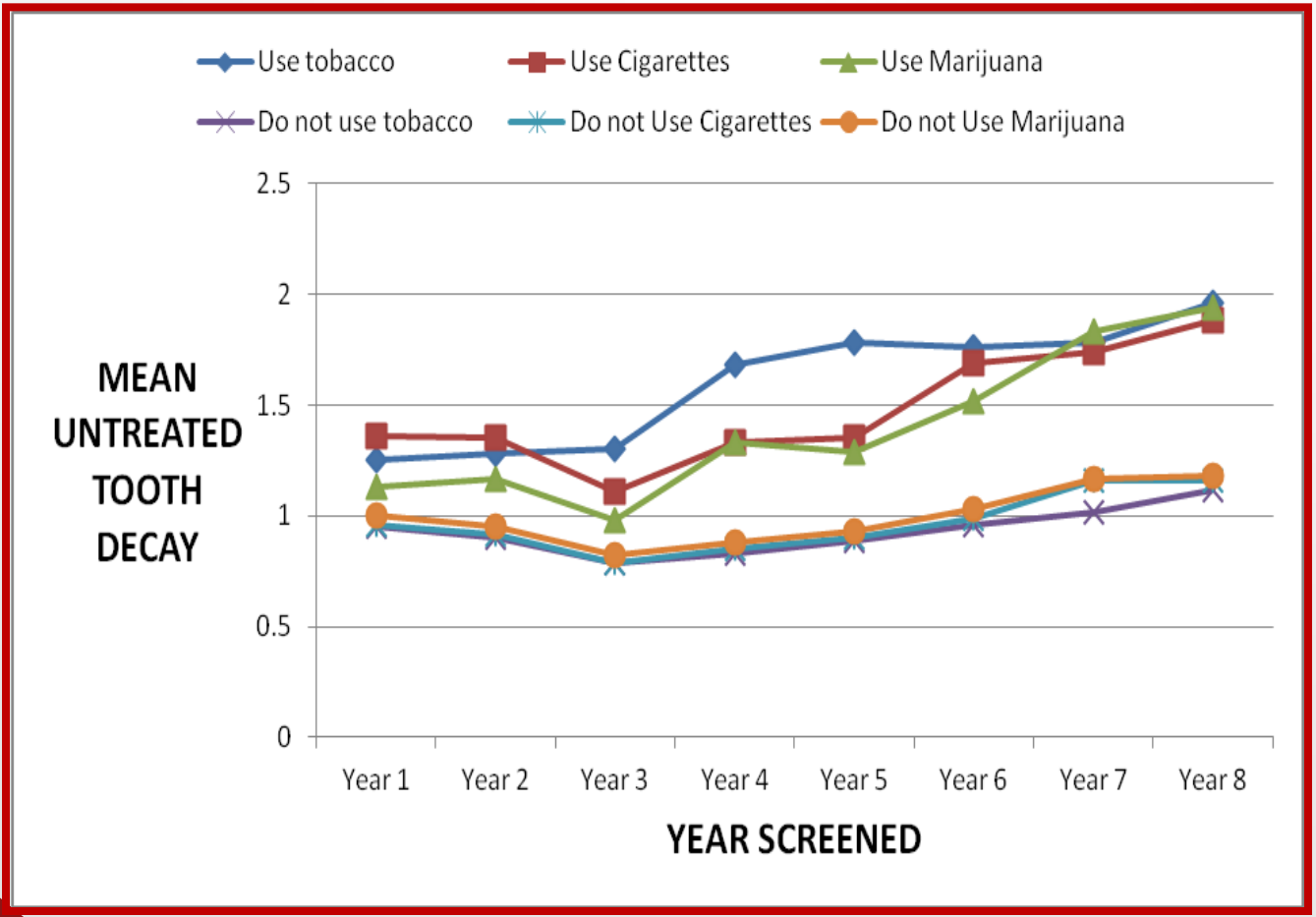
	Year 1	Year 3	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
	2002/2003 n=8236	2003/2004 n=11959	2004/2005 n=8697	2005/2006 n=9154	2006/2007 n=7290	2007/2008 n=7378	2008/2009 n=7064	2009/2010 N=7163
	M (SE)	M (SE)	M (SE)	M (SE)	M (SE)	M (SE)	M (SE)	M (SE)
Total Mean Untreated Tooth Decay	1.04 (0.02)	1.00 (0.02)	0.85 (0.02)	0.95 (0.02)	0.98 (0.02)	1.10 (0.03)	1.26 (0.03)	1.25 (0.03)
Tobacco Use*								
Use tobacco	1.25(0.06)	1.28(0.05)	1.30(0.05)	1.68(0.06)	1.78(0.06)	1.76(0.06)	1.78(0.07)	1.96(0.07)
Do not use tobacco	0.95(0.03)	0.90(0.02)	0.79(0.02)	0.83(0.02)	0.89(0.03)	0.96(0.03)	1.02(0.03)	1.12(0.02)
% Mean Difference	31.58%	42.22%	64.56%	102.41%	100.00%	83.33%	74.51%	75.00%
		†	†	†		†	†	
Cigarette Use								
Use Cigarettes	1.36(0.05)	1.35(0.05)	1.11(0.04)	1.33(0.06)	1.35(0.06)	1.69(0.07)	1.74(0.07)	1.88(0.07)
Do not Use Cigarettes	0.96(0.03)	0.92(0.03)	0.79(0.03)	0.85(0.04)	0.90(0.04)	0.99(0.04)	1.16(0.05)	1.16(0.05)
% Mean Difference	41.12%	47.43%	40.95%	55.31%	50.01%	71.29%	46.53%	61.97%
		†	†	†	†	†	†	†
Marijuana Use								
Use Marijuana	1.13(0.05)‡	1.17(0.05)	0.98(0.03)	1.33(0.04)	1.29(0.05)	1.52(0.04)	1.83(0.06)	1.94(0.06)‡
Do not Marijuana	1.00(0.04)	0.95(0.04)	0.82(0.03)	0.88(0.03)	0.93(0.04)	1.03(0.04)	1.17(0.04)	1.18(0.05)
% Mean Difference	12.97%	22.12%	20.35%	50.38%	38.71%	46.78%	56.25%	65.00%
		†		†	†	†	†	†

Note. * Percentages were computed using the combined tobacco and marijuana use numbers as denominator
† $p<0.01$; ‡ Significant difference between year 1 and year 8 ($p<0.05$)

Percent USERS with Linear Forecast line 2002 to 2010



Reported Use of Tobacco and/or Marijuana, 2002-2010 Untreated tooth decay



ETS Study Results

Table 1. Demographic Breakdown (CDOC, 13-18 yo participants, 2002-2010)

	Total N(%)	ETS Exposure N(%)
Gender		
Male	22161 (49.1)	7531 (38.2)
Female	22979 (50.9)	8027(39.3)
Age		
13	427 (.8)	114(.7)
14	16723 (32.6)	5142(33.2)
15	14532 (28.4)	4940(31.9)
16	7346 (14.3)	2869(18.5)
17	4486 (8.8)	1813(11.7)
18	1267 (2.5)	536(3.5)
Race/Ethnicity		
White/Non-Hispanic	26876 (52.5)	10367 (38.7)
Black/Non-Hispanic	3147 (6.1)	1061 (33.8)
Hispanic	11761 (23.0)	3087 (26.3)
SES		
High SES	30091(67.6)	9906(64.1)
Low SES	14455(32.4)	5547(35.9)

Note: N=45,200; some categories do not equal 100% due to missing data
ETS = 15573 (30.4%); Non-ETS = 29450 (57.5%)

ETS Study Results

- Total of 45,200 screening records with slightly more than half female (50.9%) with a mean age of 15.1 years
- Of the 30.4% (15,573) student population that self-reported exposure to ETS in the home, a slightly higher rate of exposure among females was reported (39.3%) compared to males (38.2%)
- Untreated decay in the target population was 30.7% compared to 38.8% in the population exposed to ETS (HP2020: 15.3% 13-15 yo)
- Mean DMFT score for the target population was 2.84 with a mean DMFT of 3.32 for students exposed to ETS compared to a mean of 2.58 for those not exposed

ETS Study Results

Table 2: Untreated Decay/DMFT among ETS Exposure Group/Non-ETS Exposure Group (CDOC, 13-18 yo participants, 2002-2010)

Group Evaluated	Untreated Decay (%)	Mean DMFT Indices
Target Population Total	30.7	2.84
ETS Exposure Group	38.8	3.32
Non-ETS Exposure Group	26.5	2.58
ETS Exposure Group		
Male	38.2	2.24
Female	39.3	2.51
Non-ETS Exposure Group		
Male	25.0	1.95
Female	28.0	2.17

Note: p=0.244 (95% CI, 0.898-1.028); Gender is statistically not significant

Table 3: Logistic Regression (CDOC, 13-18 yo participants, 2002-2010)

Variable	Wald Statistic	Beta Weights	Untreated Caries	
			OR	95% CI
Primary Smoker	741.59*	1.391		
Not Currently Using			1.00	Referent
Currently Using			4.02	3.64 – 4.44
Fluoride in Municipal Water	544.73*	-0.937		
Those living outside Clark County	p<0.001		1.00	Referent
Those living inside Clark County¶			0.39	1.36 - 1.42
Socioeconomic Status	47.04*	0.264		
High SES			1.00	Referent
Low SES			1.30	1.21 – 1.40

Note. N= * Significantly different from referent; $p \leq 0.001$

Nagelkerke R Square variance accounted for by these variable – 14.8% of the variance in untreated tooth decay is accounted for by these 3 variables.

Hosmer and Lemeshow Test – Good fit

Ran a **Pearson chi-square** correlation matrix and found none to weak correlations between the variables. No multicolinearity was found.

ETS Study Results

- After controlling for socioeconomic status (SES), primary smokers, and optimal levels of community water fluoridation, students were still more likely to have untreated decay than the students that were not exposed to ETS
- Strongest predictor for untreated decay was being a primary smoker (OR=4.02, $p<0.001$; 95% CI, 3.64-4.44)

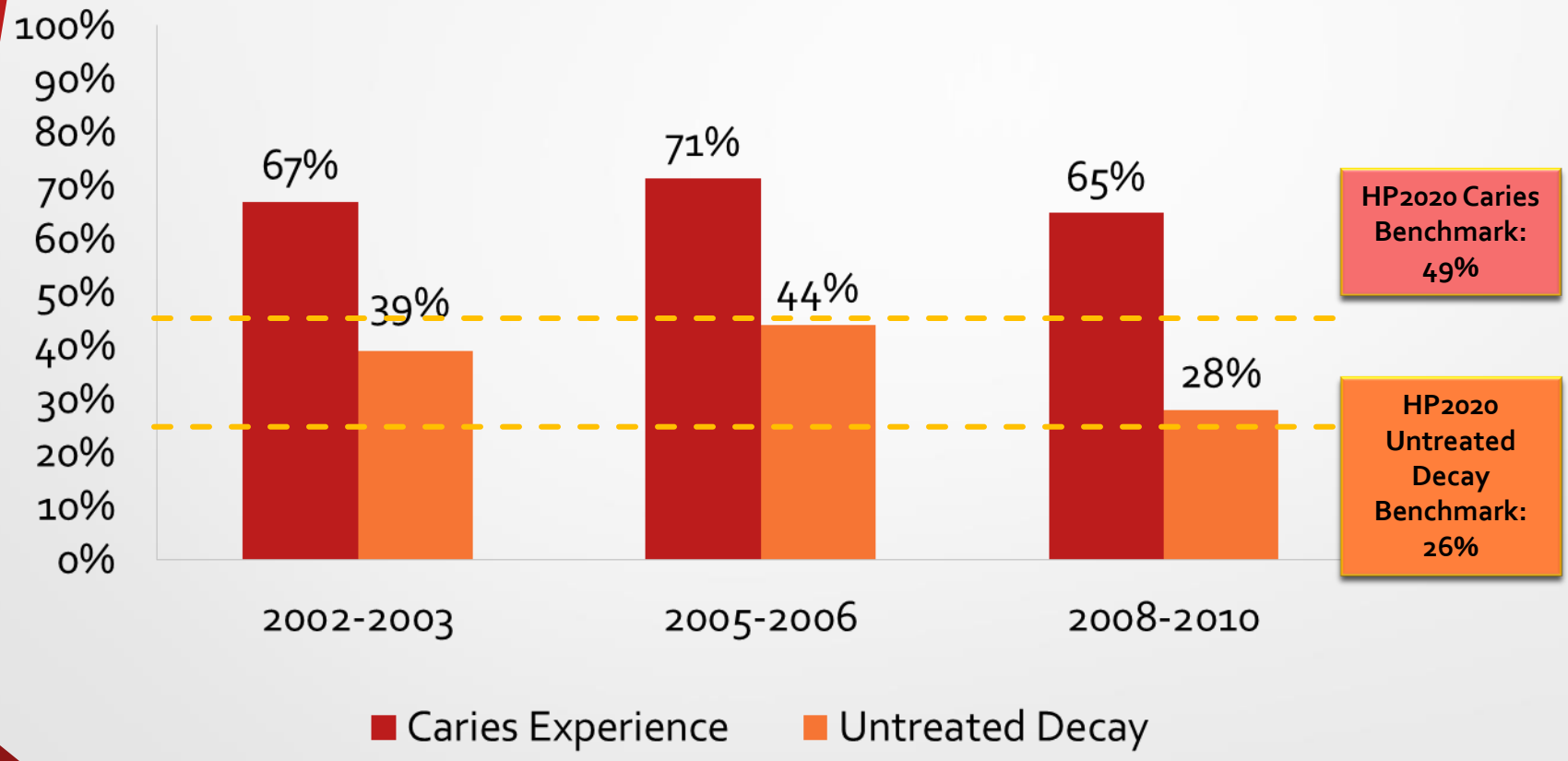
Surveillance Data

Public Health Surveillance

- ***Basic Screening Survey (BSS)***
- Third Grade Survey (2008-2009)
- Head Start (2011-2012)
- Special Needs Population (2008)
- Senior Oral Health Survey (2005)

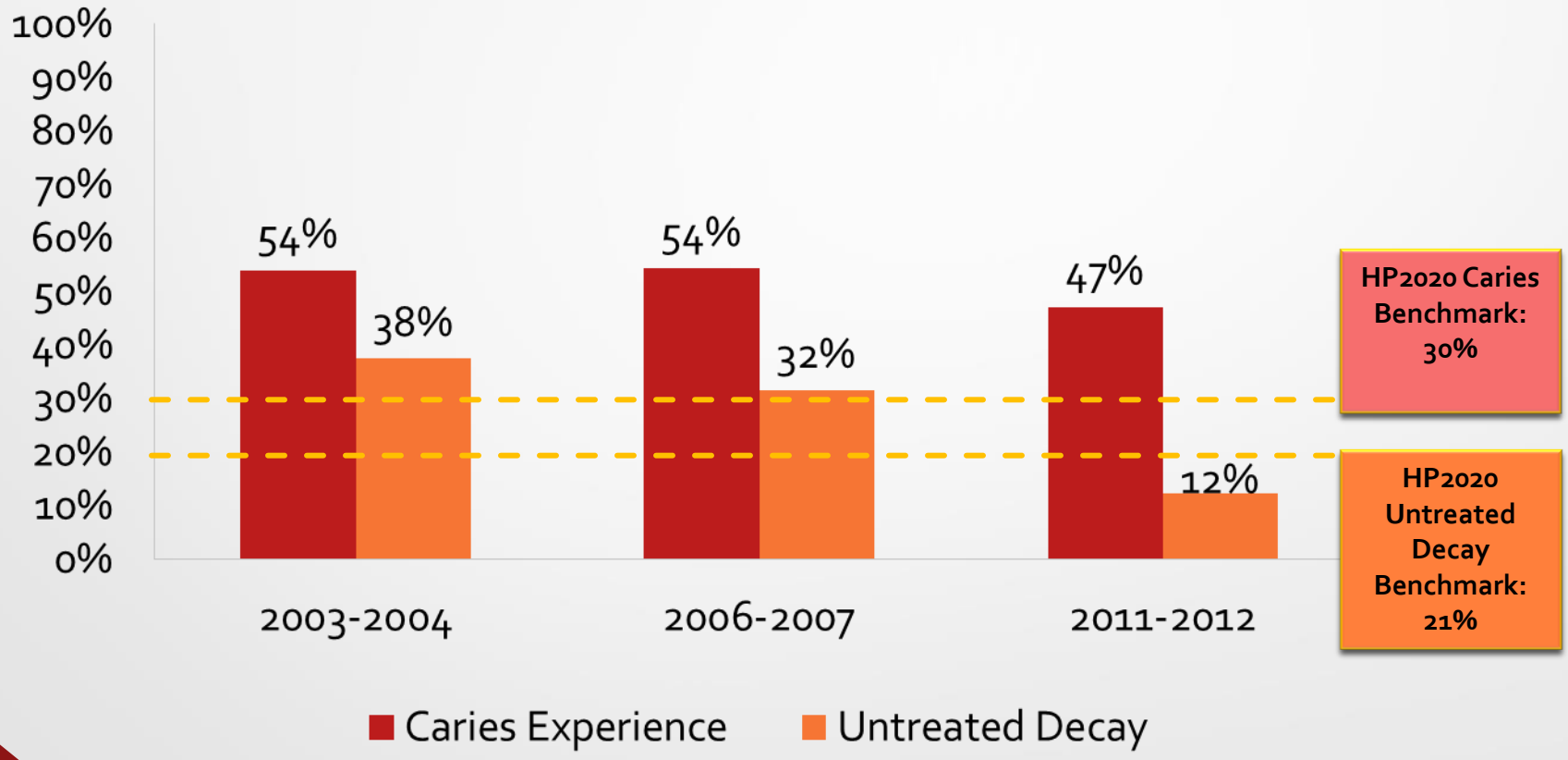
- **National Oral Health Surveillance System (NOHSS)**

Oral Health in Nevada



Source: *Healthy Smile Happy Child Oral Health Survey of Third-Grade Children* – Nevada 2006, 2008, 2010.
http://health.nv.gov/CC_OralHealth.htm

Oral Health in Nevada

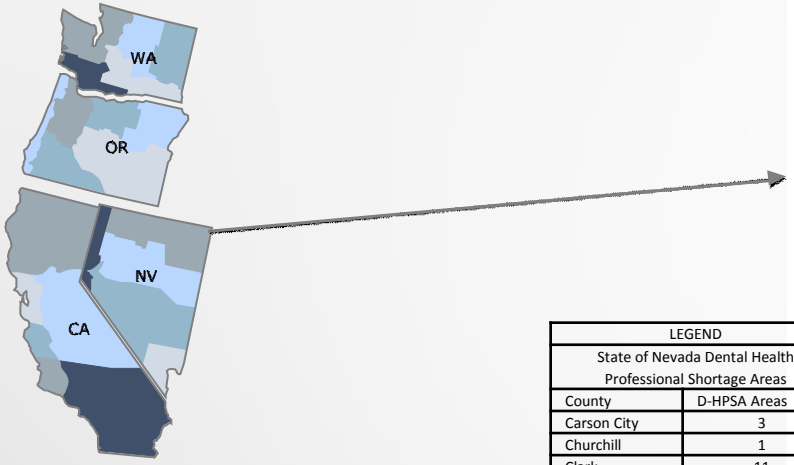


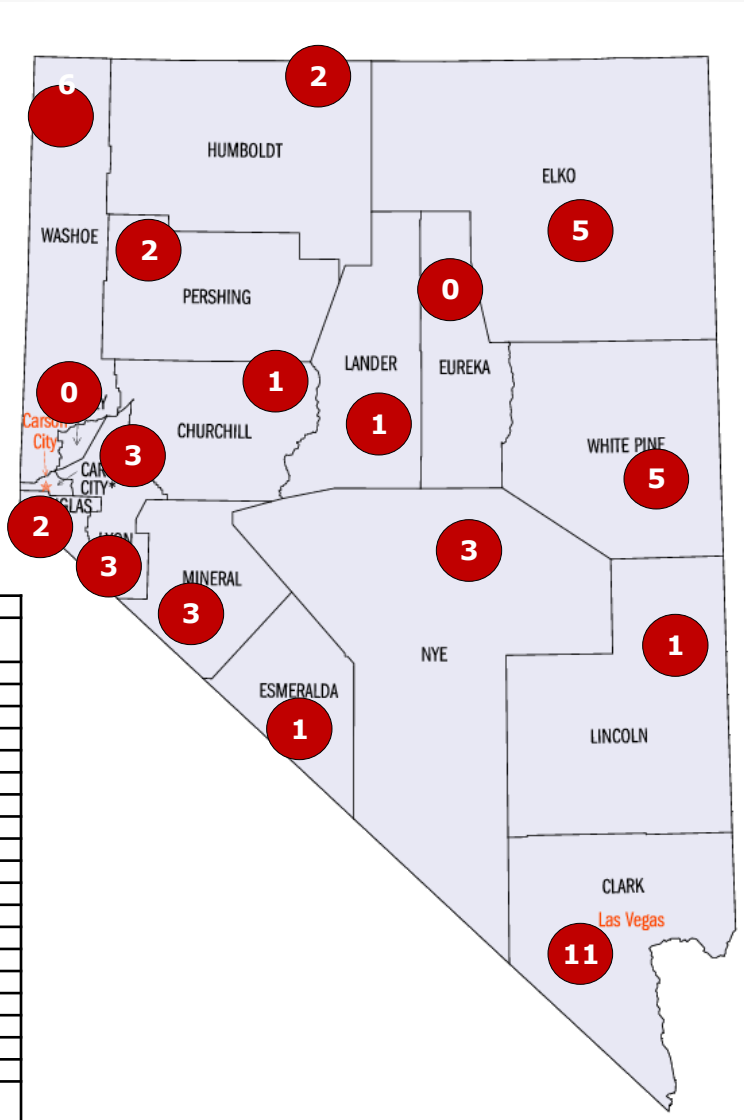
Source: ***Healthy Smile Happy Child Oral Health Survey of Head Start Students*** **– Nevada 2004, 2007, 2012. http://health.nv.gov/CC_OralHealth.htm**

Nevada Dental Health Profile

- National ratio is one dentist for every 1,700 people
- Nevada: one dentist for every 2,407 people leaving 15 of 17 counties as DHPSAs
- As of January 2014, Nevada needs an additional 69 dentists to meet the needs of its citizens
- As of June 2014, Nevada has 1,147 licensed general/pediatric dentists

NEVADA
N- DHPSAs

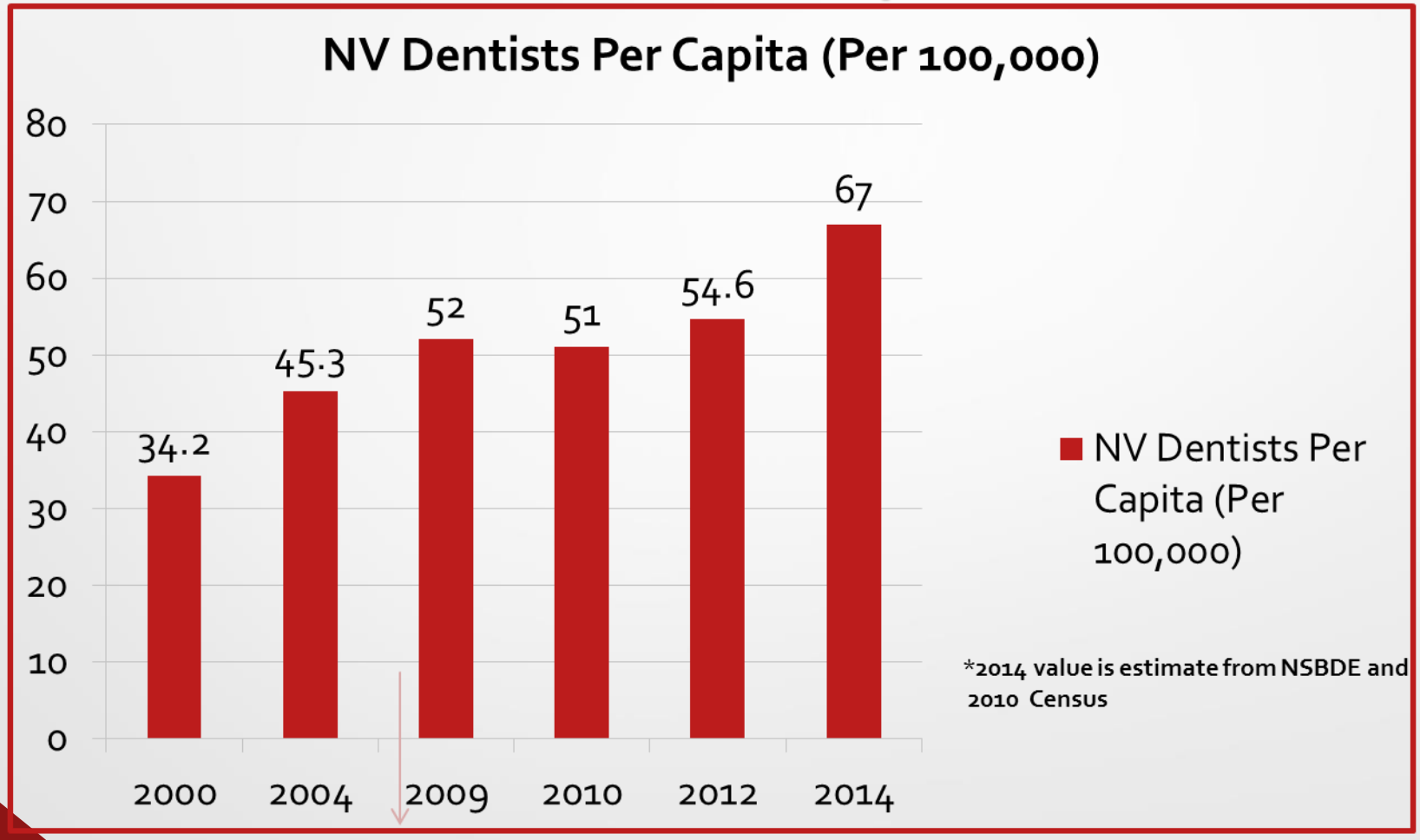




LEGEND	
State of Nevada Dental Health Professional Shortage Areas	
County	D-HPSA Areas
Carson City	3
Churchill	1
Clark	11
Douglas	2
Elko	5
Esmeralda	1
Eureka	0
Humboldt	2
Lander	1
Lincoln	1
Lyon	3
Mineral	3
Nye	3
Pershing	2
Storey	0
Washoe	6
White Pine	5
Total	49
Data: US Department of Health and Human Services, Health Resources and Services Administration Accessed December 22, 2014	

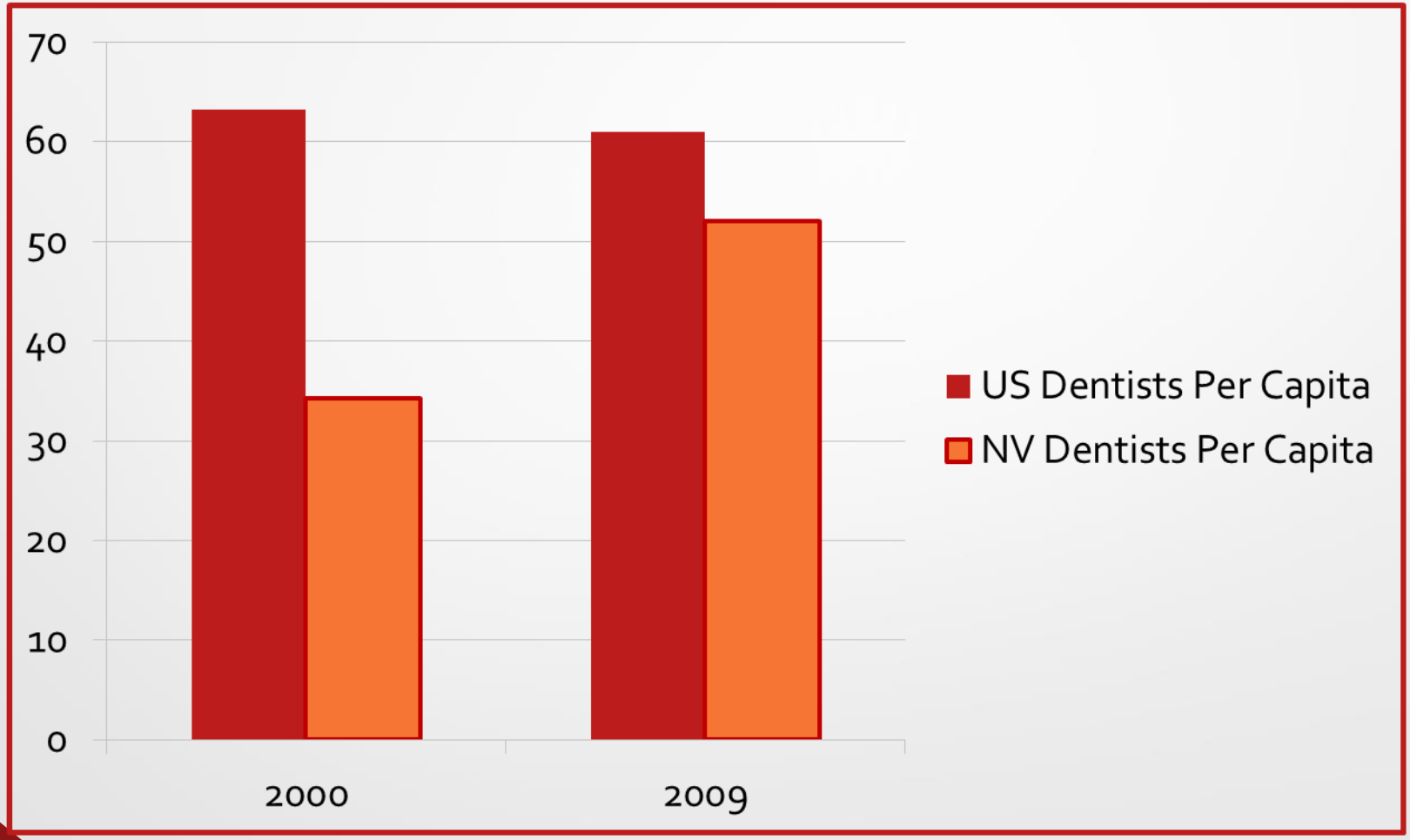
Census tracks not included

Nevada
2000-2014



2006: SDM First Graduating Class

Nevada
2000-2009



Nevada
2004-2012 (By County)

County	Number		Change 2004-2012		Number per 100,000 Population	
	2004	2012	Number	Percent	2004	2012
Churchill	4	11	7	175.0	15.3	43.1
Douglas	24	25	1	4.2	50.2	52.9
Elko	17	23	6	35.3	36.6	43.6
Esmeralda	0	0	0	0	0	0
Eureka	0	1	1	0	0	49.6
Humboldt	7	6	-1	-14.3	41.9	34.0
Lander	1	1	0	0	18.7	15.9
Lincoln	1	1	0	0	26.2	18.4
Lyon	11	8	-3	-27.3	24.6	15.0

Source: Nevada State Board of Dental Examiners (2004), (2012). Nevada State Demographer's Office (2012)

County	Number		Change 2004-2012		Number per 100,000 Population	
	2004	2012	Number	Percent	2004	2012
Mineral	1	2	1	100.00	21.4	42.8
Nye	6	14	8	133.3	15.7	30.6
Pershing	2	2	0	0	30.2	28.7
Storey	0	0	0	0	0	0
White Pine	5	5	0	0	55.8	47.5
Carson City	25	39	14	56.0	44.5	70.3
Clark	763	1102	339	44.4	44.5	55.4
Washoe	224	260	36	16.1	58.4	61.5
Nevada-Total	1091	1500	409	37.5	45.3	54.6

Affordable Care Act (ACA) Pediatric Provisions- Public Health Perspective

Oral Health and the ACA

- Integrated, comprehensive plan to improve the nation's oral health
- 23 provisions focusing on:
- 1. Prevention & health promotion
- 2. Coverage & financing
- 3. Delivery system/safety net
- 4. Infrastructure & surveillance
- 5. Workforce & training

Children's Dental Project, 2013 (www.cdhp.org)

Intent of the ACA

- Expand dental coverage to nearly all children
- Make dental coverage an integral part of kids' coverage
- Improve quality and affordability of dental care
- Make prevention-focused, science-based practice a priority
- Bridge the gaps between medical and dental care & providers
- Improve the oral health care system

Dental Coverage

- Qualified Health Plan (QHP) (integrated with vision, medical and dental)
- Stand-Alone Dental (purchased in conjunction with QHP for medical)
- QHP (contracted/bundled dental)

Limitations

- No requirement to purchase separate dental plan inside exchanges (unless state requires it)
- QHPs require the purchase of dental if it is outside the exchange
- Cost-sharing reductions don't apply to stand-alone dental plans
- IRS's interpretation of the tax credit may prevent some from paying for a dental plan (ie goes towards medical first)

Nevada Plans

- Nevada is one of 3 states that mandate that dental coverage be purchased for children inside the exchange (WA, KY other states)
- Eligible for Medicaid (HMOs: Amerigroup/Scion or HPN)
- May pick from commercial plans that receive approval from the State (ie Liberty, Premier, and Nevada Dental Benefits)
- May choose commercial plan outside of the exchange
- In Nevada, children may also be eligible for CHIP (Children's Health Insurance Program)
- Plans have different co-payments and premiums

Medicaid/CHIP

- Participation rates for Medicaid/CHIP: 70.6%*
- Medicaid: age 21
- CHIP: age 19

- *http://www.insurekidsnow.gov/professionals/reports/index.html

ACA Oral Health Trends

- It is estimated that an additional 8.7 million children and 17.7 million adults will have dental benefits
- Estimated 55% decline in the number of children without dental benefits
- Estimated 5% decline in the number of adults without dental benefits (depends on adult coverage)

Implications of ACA

- 17.7 million additional adults gain dental benefit through ACA
- 4.5 million adults gain extensive dental benefits
- 0.8 million adults purchase private insurance with extensive dental benefit coverage
- 5.3 million gain extensive dental benefits (of the 17.7 million)
- Remaining is limited or emergency care

Implications of ACA
Number of adults/children (millions) with dental benefits

	2010				2010-2018			
	Medicaid	**Individual**	**Employer**	**Total**	**Medicaid**	**Individual**	**Employer**	**Total**
Children	32.3	2.1	24.9	**59.3**	3.2	3.0	2.5	**8.7**
Adults	17.5	4.1	92.2	**113.8**	16.9	0.8	-	**17.7**

ACA Implications and Opportunities for Dentistry

Utilization of Dental Care:

- Percentage of children seeing a dentist increased from 2000 to 2003 and remained steady through 2011; increase in 2012 to 47.6%
- Percentage of adults seeing a dentist has decreased since 2003 (profound effect on earnings and busyness)
- Greatest change in decreased adult utilization can be seen in working adults (19-64 yo) with the most dramatic decrease based on percentage is the 19-34 yo ("younger adults")

ACA Implications and Opportunities for Dentistry

Why is utilization declining in adults?

- Inability to access routine dental care
- Most dramatic increase is in emergency room visits for dental conditions (21-34 yo)
- According to the American Dental Association (ADA), the number of emergency room visits doubled from 2000 to 2010, 1 million vs 2 million, respectively
- The 21-34 yo population accounted for most of the increase in emergency room visits followed by the 35-49 yo population

ACA Implications and Opportunities for Dentistry

Source of dental benefits:

- Children:
- 1. No insurance: 19.6% (2001); 15.7% (2010)
- 2. CHIP/Medicaid: 23.9% (2001); 35.5% (2010)
- 3. Private/commercial: 57.3% (2001); 48.8% (2010)
- Adults:
- 1. No insurance: 31.8% (2001); 34.3% (2010)
- 2. Public/Medicaid: 6.5% (2001); 9.3% (2010)
- 3. Private/commercial: 61.7% (2001); 56.4% (2010)

Tools to Help with Enrollment

- Nevada Health Link
- Community advocates/navigators/assistants
- Educational material through public/private organizations and HMOs
- Word of mouth and education is the key to helping increase enrollment
- Nevada has a high rate of undocumented people so limited on insurance options

Addressing the Need Through Public/Private Partnerships

- Community engagement
- Integrated workforce
- Sustainability (diverse funding streams)
- Leveraging of resources


Community Engagement
Shared Vision
Improve Oral Health of Target Population
Shared Mission


Integrated Workforce
Dental
Medical
Allied Health Professionals
Staff Support


Sustainability
Federal Support
Foundation Support
Non-profit
Coalition Support
Academic Support
State Support
Private Support


Leveraging of Resources
Direct Delivery of Care
Product Donation
MOUs
Workforce Development
Staff Support
Subject Matter Experts

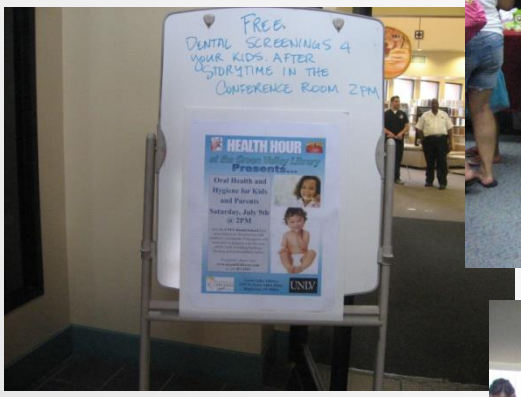
Innovative Partnerships

- State/Government
- Academic/Higher Education
- Private Institutions
- Faith-Based Organizations
- School Districts/Board of Trustees
- PTAs/Boys and Girls Clubs/Teacher Associations
- Managed Care Organizations
- Federally Qualified Health Centers
- Commercial Insurance Plans
- National Organizations
- Organized Dentistry/Dental Hygiene
- Allied Health Professionals Workforce
- Foundations
- Non-profit
- Professional Organizations
- Dental Supply Companies
- Oral Health Product Organizations
- Coalitions
- Advisory Councils

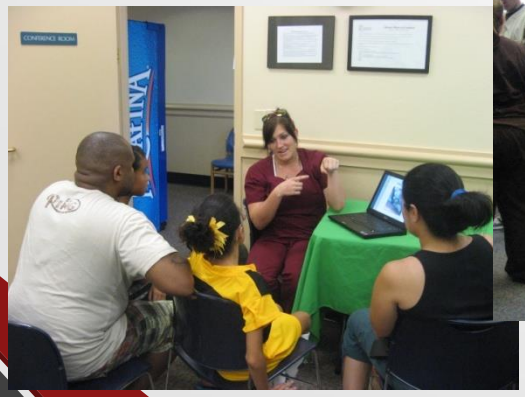
Innovation in Practice

- Managed Care Organization events
- Immunization clinics/health fairs
- Back to school health fairs (vision, immunization, dental clinics)
- Tobacco, oral health, diabetes, immunizations
- Faith-based organizations
- Volunteer faculty (Continuing Education credit)
- Volunteer pre-dental students

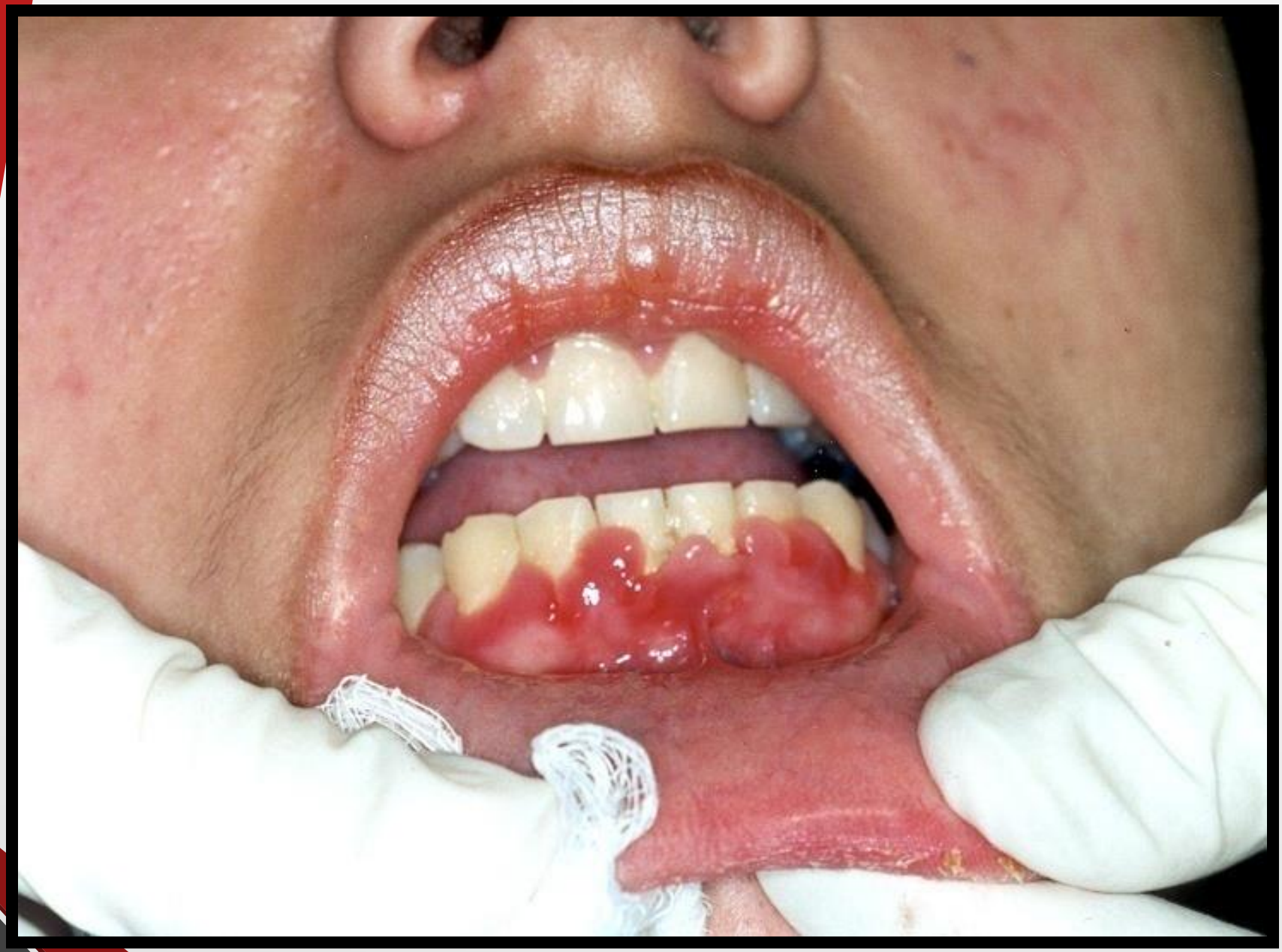

PANDA CARES

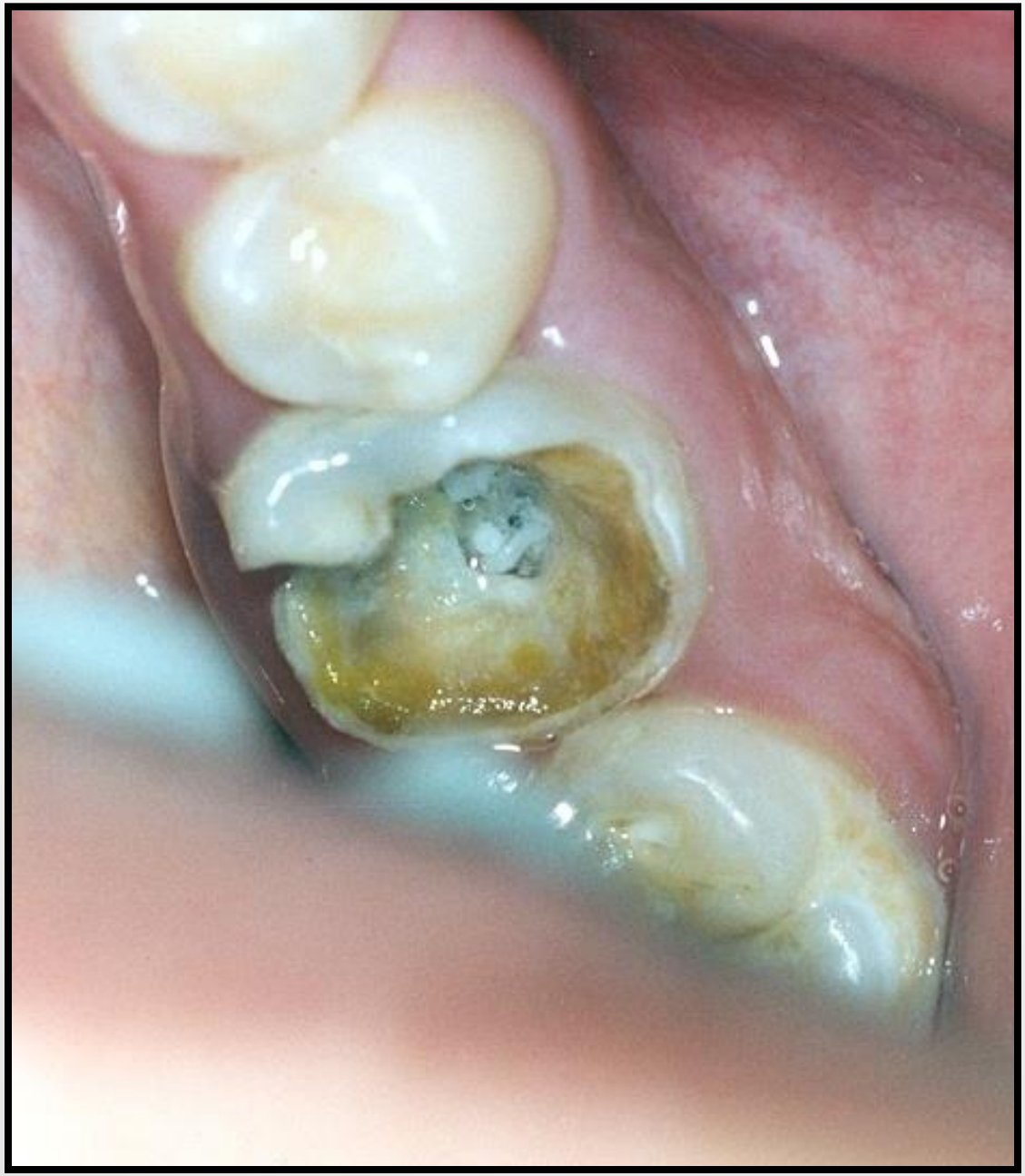

FREE
DENTAL SCREENINGS 4
YOUR KIDS AFTER
STORYTIME IN THE
CONFERENCE ROOM 2PM
HEALTH HOUR
Presents...
Oral Health and
Hygiene for Kids
and Parents
Saturday, July 9th
@ 2PM
UNLV

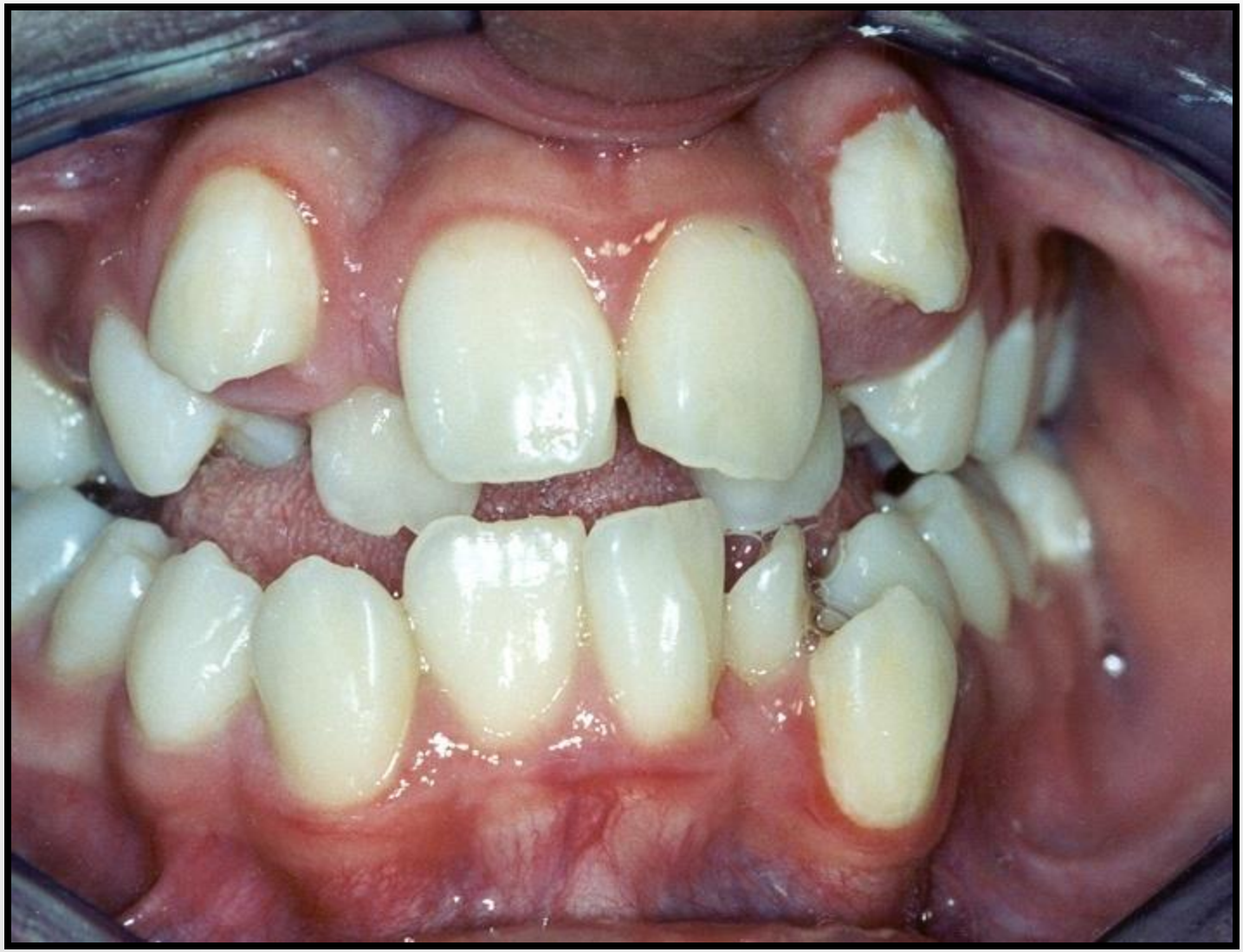

shots
4 tots
Southern Nevada Health District




Dental Screening
Here Today







Oral Health Partners

UNLV SCHOOL OF DENTAL MEDICINE

SATURDAY CHILDREN'S CLINIC

New patients are currently being accepted at the UNLV School of Dental Medicine Saturday Children's Clinic. The following treatments are available:

- ◇ Cleanings
- ◇ Fluoride treatments
- ◇ Filings
- ◇ Extractions
- ◇ Sealants
- ◇ SS Crown / Pulpotomy

Treatment at the Saturday Children's Clinic is complimentary for children between 5-12 years of age without dental insurance. We are a participating provider with Medicaid and several insurance programs. Cost for care at the UNLV School of Dental Medicine is often less than half of private practice care.

The first step to becoming a patient in our Saturday Children's Clinic is to call the UNLV School of Dental Medicine Monday–Friday to schedule an appointment. The next clinic will be on DATE with appointments available at 8:00AM.

Please Call
Gil Manzano at
702-774 -2461
for more information or to schedule an appointment

UNLV School of Dental Medicine
1700 W. Charleston Blvd.
Building A
Las Vegas, NV 89106

Miles for Better Smiles

UNLV School of DENTAL MEDICINE

New patients are currently being accepted at the UNLV School of Dental Medicine Comprehensive Care Clinic. This clinic includes:

- ◇ Cleanings
- ◇ Implants
- ◇ Filings
- ◇ Dentures
- ◇ Orthodontics (available)
- ◇ Partials
- ◇ Root canal therapy
- ◇ Gum disease care
- ◇ Aesthetic dentistry
- ◇ Bridges
- ◇ Crowns
- ◇ Oral surgery
- ◇ Children's dentistry

Cost for care at the UNLV School of Dental Medicine is often less than half of private practice care. We are a participating provider with Medicaid and several insurance programs.

The first step to becoming a comprehensive care patient is to call the UNLV School of Dental Medicine to arrange a screening appointment between 8:30AM—4:00PM Monday through Thursday and 8:30AM—11AM Friday.

The initial screening appointment costs $20. If you are accepted as a patient, the next appointment typically costs $100 to start to treat your dental needs.

If you are having any pain, swelling or infection, please mention this when calling as you may be seen as an Urgent Care patient. Urgent Care appointments start at $125.

Please Call

702 - 774 - 2400

for more information or to schedule a screening appointment

UNLV School of Dental Medicine
1700 W. Charleston Blvd.
Building A
Las Vegas, NV 89106

UNLV School of Dental Medicine (SDM) Main

UNLV Dental School

No time to go to the Dentist?

UNLV School of Dental Medicine is proud to announce the opening of a brand new state of the art dental clinic in the Wellness center across from the pharmacy. Appointments available, walk-ins welcome for all your dental needs from cleanings to crowns. Senior dental students perform all services under the supervision of experienced licensed faculty.

Monday through Friday 8am—5pm. 702-774-7108

UNLV School of Dental Medicine
SDM on Main

4505 S. Maryland Pkwy
Room 1395
Las Vegas, NV 89154

Office Hours: Mon – Fri
8:00 am - 5:00 pm

Phone: 702-774-7108

UNLV SDM Partnership-Supported Clinics

- Sgt Ferrin Clinic (Veterans under $25,000)
- Women's Clinic (Shade Tree, other shelters)
- Partnership with Huntridge (Teens, Adults, Homeless)
- School-Based Sealant Program (Seal Nevada South)
- Give Kids a Smile

Additional Partners

- Future Smiles (ES, MS, HS): Preventive services
- Nevada Health Centers: Comprehensive services
- Dental Care International: Comprehensive services
- Huntridge Dental Clinic: Preventive/Comprehensive
- Community Health Alliance: Comprehensive services
- RAM (Remote Area Medical): Comprehensive services
- Team Smile: Comprehensive services
- Community-based events (dentists, hygienists, community nurses) [Assessments, referrals, preventive]

Nevada Wellness

- http://nevadawellness.org/

Incentives to Maintain Engagement

- Evidence-based, effective prevention programs tend to be less costly than comprehensive or urgent care treatment
- Cost savings in emergency room visits can translate to implementation of additional prevention programs or new programs in underserved populations
- Partnerships/collaborations in underserved communities focused on an integrated healthcare model approach can improve the health of the individual (overall health)

Incentives to Maintain Engagement

- Increased capacity/infrastructure
- Message is delivered by a diverse workforce passionate about promoting healthy lifestyles (no more silos)
- Standardized message across all partners (consistency with education to community; increased health literacy)
- Potential for future funding with data driven, evidence-based practices (Best Practices)

Lessons Learned

- Standardized data to demonstrate the need
- Key stakeholders representative of a diverse group of community members that share the same vision/mission and passion for oral health initiatives in target population
- Clear evaluation plan (person with skill set to conduct outcomes assessment and implement changes)
- Increased capacity/infrastructure to provide the care that is needed in underserved communities
- Sustainability plan with realistic objectives

What Can Coalition Members do to Improve Oral Health in Nevada?

Partnership Development

- Shared Mission: improve the oral health status of children/adolescents (less untreated decay)

Partnership Development Partners

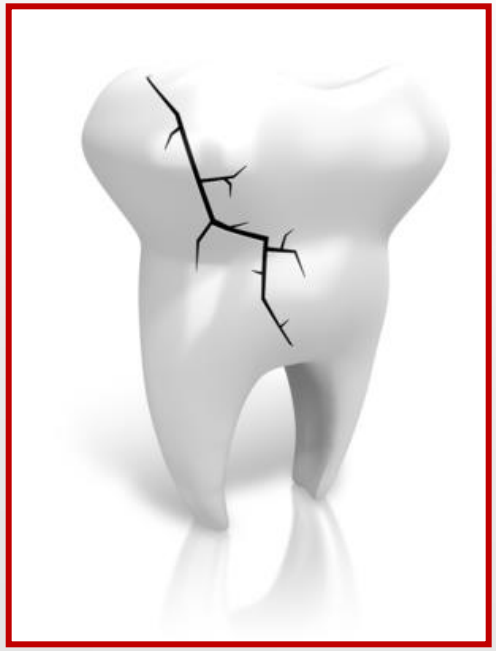
- Oral health professionals
- Medical professionals
- Day care staff
- Early Head Start
- Head Start
- Women, Infant, Children (WIC) Centers
- Maternal and Child Health (local, state coalitions)
- State/government (Oral Health Program)
- Home Visiting Programs
- Community Health Nurses
- Community Health Workers

Partnership Development Sustainability

- Diverse workforce for education/preventive services
- Train the staff to provide the education at family meetings
- Train the allied health professionals to conduct assessments (caries risk, nutrition)
- Case management for continuity of care
- Partnership with local providers or with academic institutions (volunteer support)
- Consistent messaging in newsletters or fact sheets that can be distributed at family meetings

Partnership Development Outcomes Assessment

- Less untreated decay after education and/or preventive services are offered
- Use Basic Screening Survey protocol to assess the oral health status at 6 month and 12 month intervals (compare to Head Start Basic Screening Survey)



Partnership Development Incentives

Articles Published on This Topic

- Ditmyer M, Demopoulos C, Mobley C. Under the Influence: an in-depth look at the association between tobacco and marijuana use and dental caries. Dimensions 2013, July; 40-44; Retrieved http://www.dimensionsofdentalhygiene.com/print.aspx?id=17050
- Ditmyer M, Demopoulos C, McClain M, Dounis G, Mobley C. The effect of tobacco and marijuana use on dental health status in Nevada adolescents: a trend analysis. *Journal of Adolescent Health, 52*(5), 641-648; doi: 10.1016/j.jadohealth.2012.11.002. Epub 2013 Jan 23.

References

- Nasseh K, Aravamudhan K, Vujicic M, Grau B. Dental care use among children varies widely across states and between Medicaid and commercial plans within a state. Health Policy Resources Center Research Brief. American Dental Association. October 2013. Available from: http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief_1013_5.pdf
- Nasseh K, Vujicic M. Dental benefits continue to expand for children, remain stable for working-age adults. Health Policy Resources Center Research Brief. American Dental Association. October 2013. Available from: http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief_1013_3.pdf
- Nasseh K, Vujicic M. Dental care utilization continues to decline among working-age adults, increases among the elderly, stable among children. Health Policy Resources Center Research Brief. American Dental Association. October 2013. Available from: http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief_1013_2.pdf
- Nasseh K, Vujicic M. Dental care utilization rate highest ever among children, continues to decline among working-age adults. Health Policy Institute Research Brief. American Dental Association. October 2014. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_4.ashx.
- Vujicic M, Munson B, Nasseh K. Despite economic recovery, dentist earnings remain flat. Health Policy Resources Center Research Brief. American Dental Association. October 2013. Available from: http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief_1013_4.pdf

Christina A. Demopoulos, DDS, MPH
UNLV School of Dental Medicine

Christina.Demopoulos@unlv.edu

Any Questions?