Oral Health Disparities and Inequities in Asian Americans and Pacific Islanders

See also Borrell, p. S6.

Oral health does not just affect the mouth, but can also have a significant impact on one's overall health. Poor oral health can affect chronic diseases, and be affected by these health conditions. Toothaches, caries, missing teeth, and periodontal diseases can cause considerable pain and low self-esteem, which can affect quality of life. Poor oral health has a disproportionate impact on racial/ethnic minority populations, limited-English-proficient populations, and low-income populations.[1] Risk factors for poor oral health include lack of dental insurance and access to dental care.[2]

Asian Americans and Pacific Islanders are the fastest-growing population in the nation,[3] yet remain the most understudied. Much of the data on this ethnically diverse population are aggregated, leading to hidden health disparities within some of the ethnic groups. Despite the limited disaggregated data, some evidence of oral health disparities among Asian Americans and Pacific Islanders exists. In California, 44% of low-income Asian Americans and Pacific Islander (AAPI) preschoolers had developed early childhood caries, one of the highest rates among all ethnic/racial groups.[4] AAPI children were also significantly more likely than White children to have teeth in suboptimal condition.[5] Absent of such data, dental providers serving the AAPI population are a valuable resource for identifying and addressing oral health disparities.

Drawing upon the experiences of a federally qualified health center (FQHC) serving Asian Americans and Pacific Islanders, this editorial highlights oral health disparities faced by Asian Americans and Pacific Islanders, and how FQHCs can play a major role in addressing them.

ACCESS TO DENTAL CARE AT FQHCS

For medically underserved populations, including Medicaid enrollees, FQHCs have become the mainstay of US safety nets. A vast majority of the 24 million FQHC patients are disproportionately low-income, limited-English-proficient, racial/ethnic minorities and tend to suffer from poorer health compared with the general population.[6] The presence of dental programs in FQHCs addresses a number of barriers to access and quality dental care, including affordability, and cultural and linguistic competency, as well as enhances the opportunity to provide whole-person care.

Founded in 1974, Asian Health Services (AHS) is an FQHC in Oakland, California, serving 27 000 patients. Asian Health Services provides comprehensive primary care, behavioral health services, and dental care in English and 12 Asian languages. Nearly 70% of AHS patients are limited-English-proficient. Asian Health Services opened its first dental clinic in 2003, and now has two dental clinics and three school-based sites, serving nearly 6000 patients, of its 27 000 primary care patients.

Having had little to no dental care in their native country, many AAPI immigrants and refugees come to the United States with poor oral health and in need of critical dental care. Figure 1 shows some of the dental outcomes among AHS dental patients, taken from its dental electronic health records. In the fiscal year 2015–2016, 51.7% of AHS's patients had untreated tooth decay compared with the national average of 18.9%.[8] Similarly, 61.1% of AHS's dental patients aged between 20 and 64 years had a missing tooth compared with the national average of 51.8%. These results highlight some of the oral health disparities among Asian Americans and Pacific Islanders that often go unidentified because of the limited data.

Affordable and Patient-Centered Dental Care

Access to oral health care for low-income populations is a major challenge because many private dental providers do not accept Medicaid coverage, which is the primary payer source of low-income populations. Federally qualified health centers rely on Medicaid as a primary funding source for providing dental services to its low-income patients. Because the provision of adult dental services is optional in the Medicare/Medicaid Act, a state is not obligated to offer adult dental services in its Medicaid scope. This can leave Medicaid patients vulnerable as dental services can be cut in a budget deficit year. Thus, it is important that dental services become part of the mandatory benefits in Medicaid.

Rooted in the patient-centered care concept, the idea of colocation and coordination of medical and dental care

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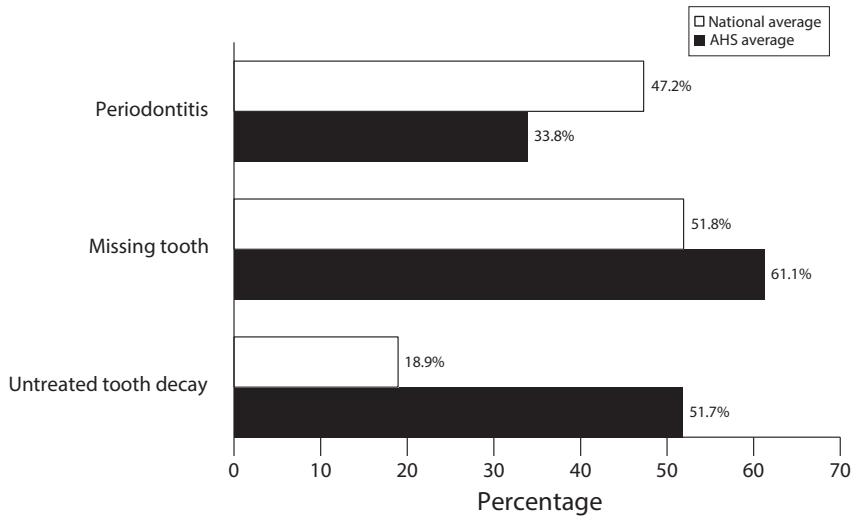

Note. Periodontitis is among those who are aged 30 years and older; national average from Eke et al.[7] Missing tooth is among those who are aged 20–64 years who have lost their permanent teeth; national average from Dye et al.[8] National average for untreated tooth decay from Dye et al.[8]

FIGURE 1—Dental Outcomes of Asian Health Services (AHS) Patients (n = 5620): United States, Fiscal Year 2015–2016

on-site is to increase access to and utilization of dental care for low-income and underserved patients. Integration of care, for primary care, dental, and behavioral health, enhances the opportunity to provide whole-person care. One of AHS's school-based clinic sites provides primary care, mental health care, and dental care.

Building a Workforce Pipeline

A shortage of culturally and linguistically competent dental providers contributes to major problems with access to care. Recognizing the need for workforce development, AHS has participated since 2003 in a national dental pipeline effort, in which it has developed sustainable partnerships with dental schools to invest in future dental providers. Through it, AHS has attracted a number of dental students and residents interested in working in the AAPI community. Under the mentorship of bilingual and bicultural providers and staff, these individuals are given opportunities to obtain on-the-job cultural competency training, ultimately building a pipeline for a culturally competent workforce. The financial benefit of this pipeline has been evidenced by the significant contribution it has made to clinic productivity and finances.[9]

Social Determinants of Health

Social factors can affect oral health, which can have a reciprocal effect on such factors. For example, an adult with no dental care to fix his or her missing teeth may suffer discrimination in employment, thus impacting the family's income.[1] As such, FQHCs provide an array of enabling services (i.e., nonclinical services that increase access to health care and improve health outcomes) to address these social determinants of health, including interpretation services, health education, and health coverage assistance. In addition, AHS takes an active role in promoting public policies (e.g., promoting tobacco and soda taxation) aimed at addressing social inequities that can have an impact on oral and overall health.

RECOMMENDATIONS

Dental care is integral to overall heath and should be integrated with primary care. Federally qualified health centers can play a major role as they provide culturally and linguistically competent care, advocate the right to such services, and provide critical data that illuminate hidden oral health disparities, particularly for the understudied AAPI population. There should be more dedicated resources invested in starting up dental clinics within FQHCs serving Asian Americans and Pacific Islanders, as well as recruiting, training, and placing culturally competent dental care providers at FQHCs to serve underserved Asian Americans and Pacific Islanders. AJPH

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