



Oral Health Opinions and Practices of Pediatricians: Updated Results From a National Survey

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ABSTRACT

BACKGROUND: Professional guidelines and state Medicaid policies encourage pediatricians to provide oral health screening, anticipatory guidance, and fluoride varnish application to young patients. Because oral health activities are becoming more common in medical offices, the objective of this study was to assess pediatricians' attitudes and practices related to oral health and examine changes since 2008.

METHODS: As part of the 2012 Periodic Survey of Fellows, a random sample of 1638 members of the American Academy of Pediatrics was surveyed on their participation in oral health promotion activities. Univariate statistics were used to examine pediatricians' attitudes, practices, and barriers related to screening, risk assessment, counseling, and topical fluoride application among patients from birth to 3 years of age. Bivariate statistics were used to examine changes since 2008.

RESULTS: Analyses were limited to 402 pediatricians who provided preventive care (51% of all respondents). Most respon-

dents supported providing oral health activities in medical offices, but fewer reported engaging in these activities with most patients. Significantly more respondents agreed they should apply fluoride varnish (2008, 19%; 2012, 41%), but only 7% report doing so with >75% of patients. Although significantly more respondents reported receiving oral health training, limited time, lack of training and billing remain barriers to delivering these services.

CONCLUSIONS: Pediatricians continue to have widespread support for, but less direct involvement with oral health activities in clinical practice. Existing methods of training should be examined to identify methods effective at increasing pediatricians' participation in oral health activities.

KEYWORDS: education; fluoride; oral health; pediatrician; practice; prevention

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WHAT'S NEW

National surveys have noted pediatricians' support for, but limited engagement in oral health. This study updates the progress made regarding pediatricians' oral health attitudes and practices since 2008, to help inform strategies to increase delivery of preventive oral health services.

DESPITE IMPROVEMENTS IN oral health throughout the United States, dental caries remains highly prevalent among preschool age children.¹ Since 2000, pediatricians have become more involved in early childhood oral health promotion due to: 1) a shortage of dentists who treat young children,² 2) recognition that young children are more likely to visit medical than dental offices,³ 3) payment to

pediatricians for fluoride varnish application from state Medicaid programs,⁴ and 4) recommendations supporting the pediatricians' role in oral health promotion.⁵⁻⁷ As detailed in *Bright Futures*, pediatricians should begin oral health screening by the 6-month well-child visit, conduct caries risk assessment, counsel caregivers on oral health, and apply fluoride varnish to high-risk children.⁸ Pediatricians are advised to refer children to a dentist by 1 year of age or, when faced with a limited dental workforce, continue providing preventive oral health services in the medical home until a referral is possible. With the inclusion of children's dental care within the essential benefits package outlined in the Patient Protection and Affordable Care Act, pediatricians will continue to play a critical role in oral health.⁹

In 1998, the first national oral health survey of pediatricians' assessed providers' knowledge, attitudes, and professional experiences.¹⁰ This survey found that pediatricians believed they have an important role in oral health, with 74% willing to apply fluoride varnish. At the time, only Medicaid programs in Washington and North Carolina paid for preventive oral health services in medical offices. In 2008, when 29 state Medicaid programs were reimbursing pediatricians for these services, the American Academy of Pediatrics (AAP) conducted a survey to examine similar constructs. Pediatricians continued to view oral health as within their purview, yet few performed these activities, and lack of training (41%) was reported as the most common barrier.¹¹

A number of initiatives aimed at increasing pediatricians' participation in oral health have been introduced since the last survey. The AAP, funded by the American Dental Association Foundation, launched Chapter Advocate Training on Oral Health in 2008 to provide oral health education to pediatricians who became Chapter Oral Health Advocates and subsequently trained others in their states.¹² Additionally, Web-based training such as the AAP Protecting All Children's Teeth and the Society of Teachers of Family Medicine's Smiles for Life have been developed to help educate physicians and others about oral health. Smiles for Life, now endorsed by 13 medical and dental organizations, has seen its utilization increase sevenfold since 2011, with >130,000 lifetime discrete site visitors (M.B. Clark, personal communication; Smiles for Life, 2013). Furthermore, 45 state Medicaid programs currently pay physicians to apply fluoride varnish.¹³ Recognizing the changing landscape of oral health promotion in medical offices, this survey sought to assess AAP fellows' attitudes and practices related to oral screening, risk assessment, counseling, topical fluoride application, and barriers to dental visits, and examine changes since 2008.

METHODS

Data on oral health promotion practices of pediatricians were collected as part of the AAP Periodic Survey of Fellows. The AAP conducts these surveys on topics of importance to pediatricians 3 to 4 times per year. Surveys are 8-page self-administered questionnaires sent to a unique random sample of nonretired US AAP members. Periodic Survey 82 was sent to 1638 AAP members between July and December 2012. Oral health assessment was 1 of 3 topics included in this survey, with questions replicated or adapted from Periodic Survey 70 which was sent to 1618 AAP members between October 2007 and March 2008.¹¹ For both surveys, 7 mailed contacts were made to nonrespondents; each contact included a cover letter, questionnaire, and a business reply envelope. The initial mailing included a \$2 bill. For the 2012 survey, e-mails were sent to nonrespondents after the second and fourth mailing, offering the option to respond electronically.

Both surveys addressed pediatricians' attitudes, practices, and barriers related to oral health screening, risk assessment, counseling, and fluoride among patients from

birth to age 3 years. Subjects were asked if they believed pediatricians should perform 11 activities related to these topics (yes vs no). Likert-type scales were used to assess the proportion of patients they provided each oral health activity (collapsed to "0% to 75% vs 76% to 100% of patients"), ability to perform each activity (collapsed to "excellent/very good" vs "good/fair/poor"), and barriers to dentist visits (collapsed to "moderate/significant barrier" vs "somewhat/not a barrier"). Subjects were asked to provide demographic information, such as: age, gender, practice location (inner city vs urban not inner city vs suburban vs rural), practice setting (solo/2-physician practice vs group/health maintenance organization vs hospital/clinic), hours per week providing patient care, and receipt of oral health training (medical school/residency/postresidency vs none). Subjects provided an estimate of the percentage of patients with public health insurance (Medicaid, State Children's Health Insurance Program, or other) within their practice that were examined as a continuous measure and then dichotomized based on the sample mean value to indicate subjects who had $\geq 41\%$ of patients with public health insurance.

Analyses were performed using SPSS Statistical software, version 18.0 (SPSS Inc, Chicago, Ill).¹⁴ Chi-squared test statistics were calculated to examine the association of respondents' oral health activities with receipt of training (vs no training) and to compare means between results from the 2008 and 2012 survey when appropriate, with statistical significance examined at the levels of $P < .05$, $P < .01$, and $P < .001$. Because Medicaid is the only insurer in most states to reimburse fluoride varnish in medical offices, we calculated chi-squared test statistics to examine differences in oral health-related activities between respondents with $>41\%$ of patients with public health insurance and respondents with $<41\%$ of patients with public health insurance. The AAP Institutional Review Board approved this study as exempt from human subject review.

RESULTS

SAMPLE CHARACTERISTICS

In 2012, 790 completed questionnaires were received for a response rate of 48%. To assess possible nonresponse bias, respondents and nonrespondents were compared on variables available from the AAP membership file. No significant differences were found for gender (57.0% female). Respondents were slightly older than nonrespondents on average (47 years vs 43 years; $P < .001$). Practice location varied significantly among respondents and nonrespondents, respectively (Northeast respondents, 22.5% vs 25.0%; Midwest, 25.2% vs 19.1%; South, 31.9% vs 36.9%; West, 20.4% vs 19.0%; $P < .05$). To ensure comparability with the 2008 Periodic Survey,¹¹ analyses were limited to 402 postresident pediatricians who provide preventive care (51% of all respondents; 25% [402 of 1638] adjusted response rate). On average, providers were 49 years of age and worked full time in direct patient care in group practices located in suburban communities (Table 1). On average, 41.2% of respondents' patients were publicly

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