Compiled Responses from Data Walk
Northern Virginia Oral Health Forum
Thursday, January 26, 2017 | Tysons, VA

Where specific comments were made about a particular chart, the page and chart number from the accompanying handout are given.

Adult Oral Health Indicators	Children Oral Health Indicators
1. What most surprises you or challenges you about this data? Why?	
General: • Lack of information regarding American Indian and Asian/Pacific Islander populations • Degree of oral health problems despite having some of the richest communities in the state • Adults in NOVA are accessing the dentist • Chronic conditions may be impacting oral health • % that responded, know the criteria for the sample • Even when dental insurance is available, they don't take advantage of it (employable years) • Lack of details about the groups • No info on statistical validity – size of sample not known Specific data points: • Dental visit in the last year by race – surprised that Hispanic data is not included [pg 1, slide 2] • % of NOVA – where is the Hispanic – is that a huge gap? Very low (unreliable) #s of adults surveyed per CDC [pg 1, slide 2] • Broader representation of communities: How do you reach them? Social media? [pg 1, slide 2] • Is data inconclusive? Hispanic represented – how does region compare to state and country? [pg 1, slide 2] • Dental visit by age: 18-24 – need good cross-section of entire population in surveys. Too general data – subdata – age, disabilities, access to care. [pg 1, slide 3] • % with dental visit, 65+ was 85.4% [pg 1, slide 3]	General • Data not statistically significant? • Population size is not clear. • What is the sample made of? • Put state and national comparison on posters • Even when children have insurance (Medicaid) they do not access care • How limited data was for kids • Not surprised Medicaid utilization the same across region if looked at all kids suspect see differences • Surprised sealant rate is low across all races – opportunity: some dentists and pediatricians are fully bought in • Sample size and statistical validity not known • Not seeing a larger connection between lack of sealants and prevalence of tooth decay • Low sealants even in affluent area • High % of tooth decay Specific data points: • What happens between 7 to 8 years old to explain big jump in tooth decay rates? [pg 3, slide 11] • Tooth decay by age – anesthes. in office don't accept Medicaid – need collaboration between services – not true representation huge jump in decay between 7-8 years [pg 3, slide 11] • 7 yrs: 17%, 8 yrs: 38.3%, 10 yrs: 44.4% - what happens between 7 & 8 years? [pg 3, slide 11]

- % without dental coverage 18-24 – how to reach? Underrepresented – ½ >65 y/o without coverage but 85% seen by dentist within last year – emergent? [pg 1, slides 3 & 4]
- As adults age, more likely to go to the dentist, also 50% 65+ don't have coverage [pg 1, slides 3-4]
- 45-54 year-olds have lower percentage of dental coverage; not clear insured vs. uninsured [pg 1, slide 4]
- 48% without dental coverage 65+ [pg 1, slide 4]
- Data on decrease in coverage at 45-54 y/o [pg 1, slide 4]
- Unemployment impacted dental coverage by age (2013) [pg 1, slide 4]
- Percentage of 65+being highest for dental visit in last year [pg 1, slide 4]
- Out of pocket costs don't seem so bad [pg 2, slide 5]
- Patient info for NVDC should include demographics for Fairfax and Sterling [pg 2, slide 6]
- Huge disparity related to income and pain [pg 2, slide 7]
- Major impact of pain on activities of daily living (ADLs) for low income [pg 2, slide 7]
- Huge effect of low income on dental pain [pg 2, slide 7]
- Patterns of care/utilization by income – there isn't too much surprising about this [pg 2, slide 8]
- Percentage who put off dental treatment due to cost is lower than we thought it would be [pg 2, slide 8]
- 24% with incomes <$40k put off dental care vs. 11% with incomes >$40k [pg 2, slide 7]
- Dental visit – higher than thought, but disparities by race [pg 1, slide 2]
- ¼ adults missing teeth [pg 3, slide 9]
- 60% 65+ no surprise [pg 3, slide 9]

- Dental sealants by age [pg 3, slide 12]
- For 3rd grader data – Not enough information regarding private vs. Medicaid insurance. Assumptions made. [pg 3, slides 11-12; pg 4, slides 13-16]
- Reportable measures for primary care providers and oral health (tooth decay and sealant) [pg 3, slides 11-12; pg 4, slides 13-16]
- % decay and tooth: data doesn't indicate when sealants applied? [pg 3, slides 11-12; pg 4, slides 13-16]
- Little disparity in sealants, big in decay – not much correlation between sealants and decay (except for insurance status) [pg 3, slides 11-12; pg 4, slide 16]
- Dental sealants – data doesn't seem to correlate with previous slide – who is applying sealants? Dentist vs. peds [pg 3, slide 12; pg 4, slides 13-16]
- % decay by race/ethnicity: Decay vs. sealants seem to correlate. [pg 4, slides 13-14]
- Native Americans 3rd grade tooth decay is the lowest? [pg 4, slide 13]
- Assumed % of children with decay would be higher than 38% [pg 4, slide 13]
- 50% of 3rd graders don't have sealants [pg 4, slide 14]
- Sealants – white kids 62% - everyone else about 53% [pg 4, slide 14]
- Similar % outcome for sealant rate across income levels [pg 4, slide 15]
- % with health insurance: very broad definition of health insurance – reporting by parents or students [pg 4, slide 16]
- That the tooth decay rates on uninsured side aren't higher [pg 4, slide 16]
- 40% of 1-20 aren't accessing dental services even though enrolled in Medicaid/FAMIS [pg 5, slide 17]
- 60+% Medicaid kids go to dentist – pretty consistent but 71% Hispanic [pg 5, slide 17]

	• It seems that a lot of parents are behind with dental visits for 1-2 age group [pg 5, slide 18] • % with insurance Medicaid/FAMIS [pg 5, slide 18] • Disparity between >$40k and <$40k children not as big as expected [pg 5, slide 19] • Pregnant women <$40k not accessing care (are they in care or not?) [pg 5, slide 19] • Prenatal care really driven by income [pg 5, slide 19] • % of children who receive 2+ dental visits per year (82% with $40k+ income) [pg 5, slide 19]

2. What information is missing? Why is this missing information important?

General: • Missing correlation between data posters. Leaves a lot of room for deductions. • Access in terms of providers – how many dentists accept Medicaid • Data broken up by gender • Dental care utilization (are these adults covered?) • How data captured in surveillance system • Regional ethnic demographic baseline – how defined? • Race not provided, skewed data • Reasons – don't value dental/oral health? Why not accessing dental care? • What types of services were provided? • More granular data needed (income, # of people in household, race) • Income level of each group, racial composition, geographic info – disparity between age groups (working vs. elderly) important for identifying disparities. Info by county would be more helpful. Specific data points: • Hispanic data missing on race/ethnicity [pg 1, slide 2] • No Hispanic data [pg 1, slide 2] • 1st dental visit in the last year – 80% (are they are covered or not?) [pg 1, slides 2-3]	General: • Specifying time school year vs. calendar year • Private vs. Medicaid vs. uninsured • Were specific populations targeted? • Sample size • Data broken out by gender and sub-region • Parental consent rate? • Dental coverage of pregnant women • The data at face value paints a picture but unless you dive deeper it is not as meaningful • We'd have a better understanding if we knew more about the types and quality of treatment (e.g., when did someone go to the dentist and why?) – we know this is virtually impossible data-wise • Racial inequity • The big thing missing is why • % by race/ethnicity – is it just based on a representation of our community's #s or is it other communities aren't steered to care? Or communities don't value? • Overlay or combine ethnicity, income, etc. • How is data captured in surveillance system? • Absolute #s vs. percentage – are there enough providers? • What is the range of these numbers compared to previous years? Is there a trend we should be paying attention to? Is there a target

- Did those who had a dental visit go for follow-up treatment? [pg 1, slides 2-3]
- What was dental visit for? [pg 1, slides 3-4]
- No data for 18-24? [pg 1, slides 3-4]
- How is dental coverage defined? [pg 1, slide 4]
- It is not clear whether out of pocket dental care are for uninsured or insured [pg 2, slide 5]
- Out of pocket costs disaggregated [pg 2, slide 5]
- Amount paid out of pocket – needs specification of data – looks preventive care only if <$200 – extraction at 14% [pg 2, slide 5]
- Are payments made deductibles for insurance or just out of pocket for services? [pg 2, slide 5]
- Out of pocket in last year – insurance status not included [pg 2, slide 5]
- Dental pain effect: no surprise – people bearing disproportionate amount of problems [pg 2, slide 7]
- How pain data and income compare to other regions [pg 2, slide 7]
- Patterns of utilization and deferring treatment really interesting. It would be great to know the sample size (meta data) and have more recent. [pg 2, slide 8]
- Dental care utilization and deferring treatment – household income <$40k only 25% defer treatment? [pg 2, slide 8]
- Deferring treatment: surprise that >$40k deferring treatment not higher. Question vague – what is treatment? Stop-gap vs. true treatment, bandaid vs. cure. [pg 2, slide 8]
- The range is too wide for 18-64: meaningful to know who by 18 lost tooth [pg 3, slide 9]
- Ages 65+ expect to be higher % [pg 3, slide 9]

goal we are aiming for? Has there been any influence on these numbers from ACA?
- Large % of race data not provided can skew the data
- 14-18 data-specific/college, young adult data

Specific data points:
- 3rd graders with sealants by age – what happened between 9 years and 10 years? [pg 3, slide 12]
- Is the dental sealants by 3rd grade data cohort data? Hard to understand this chart – not very useful. [pg 3, slides 11-12; pg 4, slides 13-14]
- Is race/ethnicity data for kids with tooth decay controlled for education, income, other data? [pg 4, slides 13-14]
- Of uninsured third graders are they new-comers or are they eligible for insurance and don't value oral health? [pg 4, slide 16]
- Loudoun County left off chart for FAMIS/Medicaid [pg 5, slide 18]
- The data was too aggregated – age 1-20 should have been broken down (p 5, slide 17)
- What is the age of the children? [pg 5, slide 19]
- Did the increase in coverage for pregnant women improve visits (and then outcomes?) [pg 5, slide 20]

3. Does this data help you to understand oral health inequities in Northern Virginia? Why or why not?	
General: • Yes, paints a better picture of who lives in the region • The data mainly showcased race, income, health insurance coverage • The barriers to care weren't highlighted: transportation, time, employment, language, education • Yes, but still gaps in data	General: • No, need sample size • Overall data is too broad • Not providing details • Yes, paints a better picture of who lives in the region

- Maybe the working poor barriers are a place/target for intervention
- Not very helpful by race, depending on what your goal is with this slide. Is it because of a targeted intervention where communication is key? Then knowing race vs. 1st language could be helpful. Otherwise, whether or not you see a dentist in the last year seems to be moderated more by SES and not race.
- Disparity in access
- Cultural perspectives re: prevention
- Income snapshots were helpful – yes
- Why do parents sacrifice for children but don't see need for themselves?
- No, more info is needed to understand the data
- Yes, but would be helpful to have more of a breakdown in income

Specific data points:
- Uninsured folks with lower SES have less access to treatment for pain [pg 2, slide 7]
- Dental pain is pretty subjective. Those in low SES status may live with more pain for other reasons in life and not report as high interference with life activity. [pg 2, slide 7]
- % Adult lost tooth to decay – high % of 18-64 [pg 3, slide 9]
- Big age difference in number of elderly who lost teeth [pg 3, slide 9]
- Lost a tooth to decay by age – shows prevalence of periodontal disease [pg 3, slide 9]
- Losing teeth >65 years – wear and tear, pre-fluoridation [pg 3, slide 9]

- The data mainly showcased race, income, health insurance coverage
- The barriers to care weren't highlighted: transportation, time, employment, language, education
- Yes, but would be helpful to know in conjunction with other socioeconomic factors
- It appears that even among the insured, there is work to do.
- There appears to be no start difference between localities in NOVA. Would be great to see this against other regions in the state.
- Does WIC refer to dentist?
- Questions: data – seemed vague
- Little disparity between ethnicities except whites
- Other factors that impact decay = cultural
- Native American vs. American Indian
- No, the data was insufficient
- Somewhat – we felt that more info was needed (mostly specificity and re: sample size and geographic focus)
- Yes, helps show where the greatest need is – pregnant women do not seek care

Specific data points:
- Surprised that children having dental coverage is roughly the same regardless of household income – is this a reflection of Medicaid? [pg 5, slide 19]

4. What questions do you have about this data?

General:
- Why were different years of data collected?
- Inconsistencies in data across the board
- Need criteria details
- Subjective interpretations
- Is there out of pocket paid data for pediatrics? I.e., are people more willing to pay for kids?
- What kind of care – preventive? Urgent? Emergent?

General:
- How the not provided ethnicity affects the data
- Statistical significance?
- At what age are sealants applied?
- Information on migrant population (especially Hispanics)
- Language barriers
- Transportation
- How does VDH get data? (population they're pulling from)

- How do we compare to the national average?
- Missing school, ER, and cost data
- How data captured in surveillance system
- Regional ethnic demographic baseline – how defined?

Specific data points:
- Are visits prevention or treatment for having had dental visit? [pg 1, slides 2-3]
- Coverage by age: what % of lower ages forego dental insurance vs. getting above? [pg 1, slide 3]
- Is it only <$200 because that's all the work they required or is it because that's all they were willing to afford despite the need for more extensive work? [pg 2, slide 5]
- Out of pocket costs: by household [pg 2, slide 5]
- NVDC access – does this data represent that these populations have the greatest need or is it that other communities don't know to access or how to access? [pg 2, slide 6]
- Dental pain: household size, access to insurance [pg 2, slide 7]
- Can dental pain effects be broken down into smaller groups according to income? i.e. $20k vs $40k [pg 2, slides 7-8; pg 5, slide 19]

- Do parents not know? How does this data compare to parental rates?
- More with pediatricians – can apply varnish
- Is the data statistically significant?
- Can it be broken down further by geographic area?

Specific data points:
- Does the causal relationship of the sealants really lower tooth decay rates? [pg 3, slides 11-12; pg 4, slides 13-16]
- Where is the sealant intervention going already? Is higher SES population getting sealant earlier in identification of tooth decay? [pg 3, slides 11-12; pg 4, slides 13-16]
- How much of the sealants are placed on child/baby teeth vs. 2nd/adult teeth? [pg 3, slides 11-12; pg 4, slides 13-16]
- No specifications of who is getting care? Need subset (population?) E.g., children with decay are not the same as those with sealants. Shows importance of sealants. [pg 3, slides 11-12; pg 4, slides 13-16]
- Why the age difference? Are they primary or adult or insurance status? [pg 3, slide 11]
- Sealants – 3rd graders by age? [pg 3, slide 12]
- 3rd graders with dental sealants (ages 7-10 seems wide) – does this explain large variance? [pg 3, slide 12]
- Really need a sample size for age-related data to determine if differences are significant/meaningful [pg 3, slide 12]