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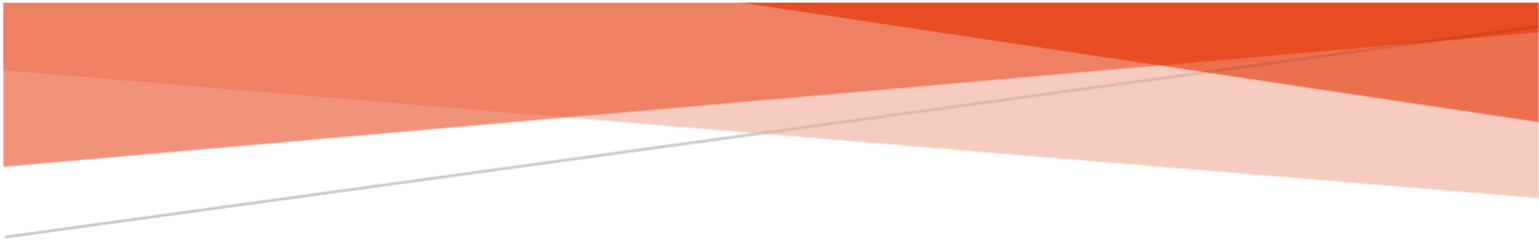
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Oral Care & Asian and Pacific Islander Communities in Oregon

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2013

Abstract

This report attempts to describe the current knowledge of oral health care access within Asian American, Native Hawaiian, and Pacific Islander communities in Oregon based on secondary data from the Oregon Health Authority's Smile Survey 2007, Smile Survey 2012; and the Coalition of Communities of Color's 2012 report, *The Asian and Pacific Islander Community in Multnomah County: An Unsettling Profile*. To be clear, the 2012 survey report draft is cited most, as the 2012 survey reported more data on children of color compared to the 2007 survey. This paper also attempts to highlight the multifaceted aspects of access to care for Asian Americans, Native Hawaiians, and Pacific Islanders, from public health scholars nationwide, as well as their recommendations for moving towards health equity for these communities. It is my hope that this work provides a call for action with health care policy makers, planners, and service providers to implement systematic data collection of Oregon's Asian American, Native Hawaiian, and Pacific Islander communities to strengthen and enhance cultural competence, improve access to care, and ultimately increase the health outcomes of a population that by 2050, will triple in growth and represent 8 percent of the U.S. population (Islam, Trinh-Shevrin, Rey, 2009).

The Importance of Breaking the Myth of a Model Minority without Health Problems

On June 2012, the Pew Research Center released the report, *The Rise of Asian Americans*, which portrayed Asian Americans as the “new immigrants” with the “highest-income, best educated and fastest growing racial group in the United States,” adding further to the model minority myth that Asians as a monolithic group dominate and succeed far beyond white Americans. However nothing can be further from the realities of an extremely heterogeneous group, with intersecting locations influenced by U.S. colonization, multiple waves of immigration periods (1609-present), white racism, as well as the intersections of gender and class within Asian American, Native Hawaiian and Pacific Islander populations. Lin-Fu challenged this notion of Asian Americans as a model minority without health problems, stating that “such stereotypes based on data collected from subgroups at one end of the spectrum have masked the misery of those at the other end who are truly in need, but poorly visible and barely audible in a society that views them as ‘all’ successful” (1988). While there are significant economic gains with some Asian American families compared to white families, the fact that significantly higher rates of Asian American, Native Hawaiian, and Pacific Islander families living below the poverty line is minimized perpetuates the model minority myth and erases the unique health risks of groups. In addition to highlighting the fact that Asian Americans have significant socioeconomic differences (Tseng, 2007), the most current national-level health data indicate that rates of disease morbidity & health behaviors among particular Asian American groups in some instances exceed that of the general population. This should be of concern, as socioeconomic status, while not the only factor, is linked to health outcomes.

Conversely, oral diseases are among the most common conditions children and adults in the United States experience, and by virtue of being in a readily accessible location, oral diseases are easily diagnosed and managed by a combination of personal and professional care. However, low socioeconomic status and minority populations have higher levels of total untreated disease, and are linked primarily with challenges in accessing and using dental preventive services. Furthermore, oral disease and their impact among Asian Americans have not been systematically examined and do not account for national and ethnic diversity (Ahluwalia, 2009). Ahluwalia further challenges the model minority myth by highlighting data from the National Survey of Children’s Health, pointing out that while Asian American children

are more likely to live in households that have higher family incomes, more parental education, and dental insurance than their white counterparts, it does not explain the fact that close to 12 percent have never seen a dentist, and only 33 percent reported their oral health to be excellent, suggesting that simply gaining access to care does not increase oral health outcomes (Ahluwalia, 2009). Oral health research and systematic data collection that account for national and ethnic diversity among Asian American, Native Hawaiian, and Pacific Islander communities can bring to light oral health disparities over time; which groups may be at higher risk for certain oral diseases; reasons for accessing (or not accessing) care; create a baseline that accurately reflects the oral health of Asian American, Native Hawaiian, and Pacific Islander communities, that health care policy makers, planners, and service providers can use to create oral health outcomes to improve upon.

In an editorial in the American Journal of Public Health, Ro called for the public health field to address the health of Asian American and Pacific Islander women. While this editorial did not cover API children, the suggestions are easily applicable to API children and oral health. According to Ro, “Little is known about the health of Asian American and Pacific Islander (AAPI) women, a rapidly growing population marked by diverse socio-demographic characteristics, health needs, and access to and use of health services” (2002). Ro outlined 5 recommendations:

- Improve data collection, analysis, and dissemination
- Ensure access – especially linguistic access – and cultural competence
- Protect civil rights and equal opportunity
- Strengthen and sustain the community’s ability to address its health needs (community capacity)
- Recognize Native Hawaiians and Pacific Islanders in federal programs and services

Ro wrote another editorial for the American Journal of Public Health, writing a similar message from the previous editorial. Despite recent texts that further explore Asian American health disparities, “there is a scarcity of basic health research on Asian Americans, Native Hawaiians, and Pacific Islanders.” In addition, Ro states, “The data and research available for Native Hawaiians and Pacific Islanders is almost nonexistent. The aggregation of Asian

American, Native Hawaiian, and Pacific Islander data continues to make Pacific Islander disparities, making them a minority with an already 'invisible' minority" (2010).

Ahluwalia further illustrates Ro's points on the need to expand research in Asian American health in "Oral Health Among Asian Americans: Emerging Research" (Ahluwalia, 2009). According to Ahluwalia "most studies are not national in scope, use convenience samples, and do not account for national and ethnic diversity among Asian Americans, making it difficult to assess the effects of social norms, immigration status, and acculturation on disease, risk, and health-protective behaviors," and that "data on South Asians in the United States are sparse." In addition, Ahluwalia cites figures from two national studies that address access to and use of dental care that challenge the model minority myth. Data from the National Survey of Children's Health (NSCH) showed that even with Asian American children living in households that have higher incomes, more parental education, and dental insurance than whites, close to 12% have never seen a dentist and only 33% reported their oral health to be excellent. According to a report based on the 1997-2000 National Health Interview Survey data, 15.5% of Asian American children, and 20.8% of Asian Indian children have never seen a dentist. To add to Ro and Ahluwalia's points on disseminating disaggregate data, Javier, Huffman, and Mendoza in "Filipino Child Health in the United States: Do Health and Health Care Disparities Exist?" state that even though Filipinos are the second largest Asian subgroup in the United States, few studies have examined health and health care disparities in Filipino children, and cited cultural differences as possible barriers that create disparity between Filipino children and their white counterparts.

Furthermore, "Racial and Ethnic Disparities in Medical and Dental Health, Access to Care, and Use of Services in US Children," Flores and Tomany-Korman noted significant disparities in the 2003-2004 National Survey of Children's Health (NSCH), concluding that "minority children experience multiple disparities in medical and oral health, access to care and use of services." Of note to Asians/Pacific Islander communities is that while Asians/Pacific Islander children were the least likely to be uninsured, they also had unmet needs substantially more often because of transportation problems; parents not knowing where to go for treatment; dental health plan problems; no one accepting the child's insurance; with odds that range from 11 to 17 times greater than for their white counterparts (2008).

Flores and Tomany-Korman further illuminate disparities between children in non-English-primary-language (NEPL) and English-primary-language households. While API NEPL children actually had a lower disease burden than EPL children, NEPL children experienced fair/poor teeth conditions more often than EPL children. In addition, unmet medical needs were more likely due to cost and uninsurance for NEPL children, with 40% of NEPL children not being able to access specialty access as opposed to 22% of EPL children (2008).

In “Health and Medical Care among the Children of Immigrants,” Zioli-Guest and Kalil affirm what Flores and Tomany-Korman did not explicitly say: “children of immigrants are much less likely to have health insurance than native children, even after controlling for key demographic characteristics, and the barriers immigrant families face in accessing health care often extend beyond those created by insurance coverage issues.” Zioli-Guest and Kalil also point out that as health is increasingly being recognized as an important component of development, and outstanding task is to identify who among the immigrant child population is most at risk for poor health outcomes, and conclude that families with noncitizen member face barriers, real or perceived, to using relevant [health-related] programs (2012).

Oregon Smile Surveys

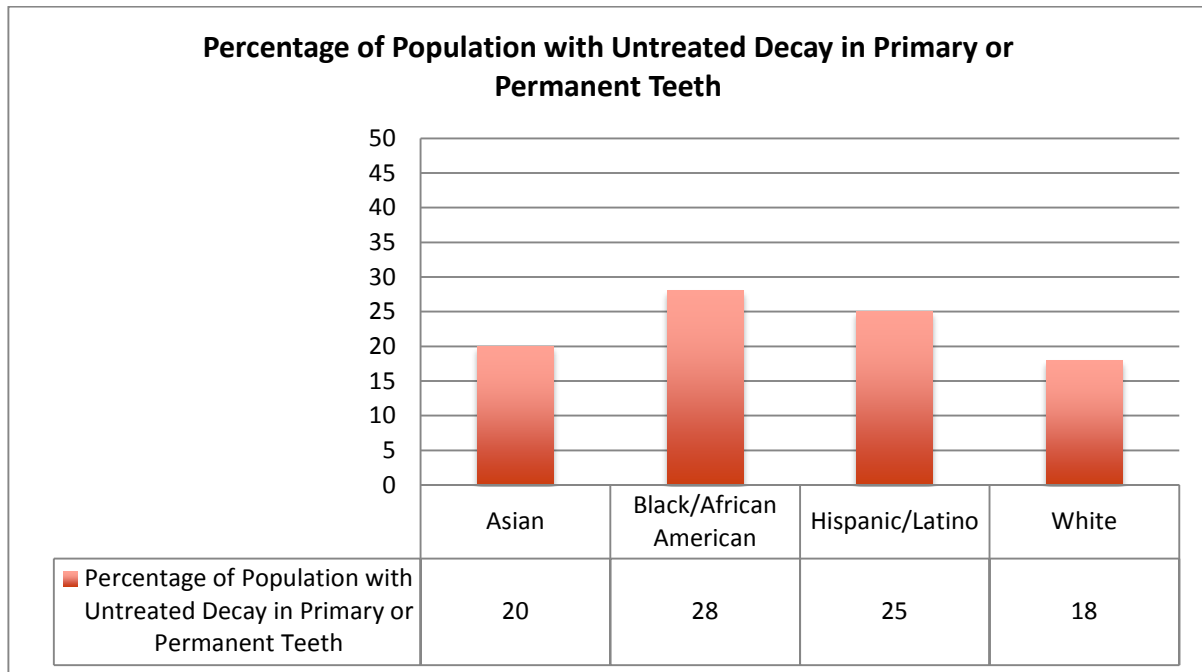
According to the 2012 Smile Survey, Oregon began using national Basic Screening Survey (BSS) criteria recommended by the Centers for Disease Control and Prevention and the Association of State and Territorial Dental Directors in 2002, and since then have been conducting Smile Surveys every five years. In 2007, Oregon scored worse in every major measure of oral health for children compared to the first Smile Survey conducted in 2002. The 2012 Smile Survey showed signs of improvement. For example, the rate of children 6-9 years old that have already had a cavity decreased from nearly two-thirds (2007) to a little over half of children that participated in the survey (2012). However, the 2012 survey revealed that many children do not receive the oral health they need. More than 24,000 children need access to professional care, while 3% of children had pain or infection that needed urgent treatment the day they were examined by the survey dental hygienist. In addition, the 2012 results indicate that oral disease disparities in Oregon still exist for children based on geographic residence, race and ethnicity, socioeconomic status, and primary language spoken at home.

Compared to the published 2007 survey, the 2012 survey made considerable improvements in data reporting based on racial categories. The 2007 survey reported racial disparities between categories of Hispanic and White Non-Hispanic children, but did not report rates of Black, African American, Asian American, Native Hawaiian, and Pacific Islander children. The 2012 reported data for Asian, Black/African, Hispanic/Latino, and White children. However, again there was no data reported for Native American, Native Hawaiian, and Pacific Islander children, as well as immigrant refugee children, nor were racial categories disaggregated into subgroups.

Reported Data on Racial/Ethnic categories

Native American
Black/African American
Hispanic/Latino
Asian
White/Non-Hispanic

	Smile Survey 2007	Smile Survey 2012
Native American	No	No
Black/African American	No	Yes
Hispanic/Latino	Yes	Yes
Asian	No	Yes
White/Non-Hispanic	Yes	Yes



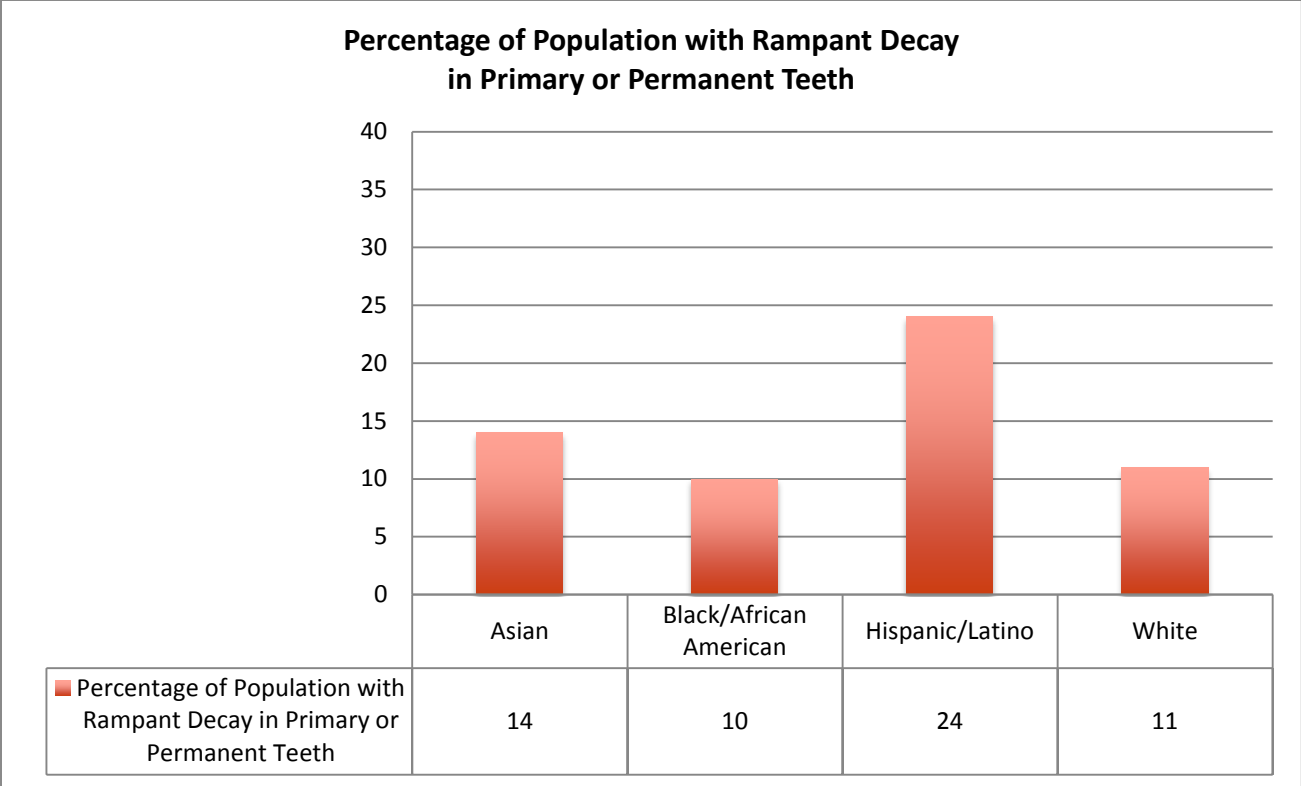
Source: Oregon Smiles & Healthy Growth Survey 2012

Untreated decay describes dental cavities or tooth decay in the primary or permanent teeth that has not received appropriate treatment.¹ If left untreated, tooth decay may:

- Cause damage to the permanent (adult) tooth that is growing underneath
- Cause premature loss of primary (baby) tooth
- Lead to infection of teeth & gums
- Can become severe enough to require emergency department treatment

Asian children's untreated decay rates as being comparable to their white counterparts should not be the focal point of this chart. This chart suggests that there are barriers that play major roles in impaired access to dental care for all children of color in Oregon. This chart also suggests that two out of every ten Asian children had untreated decay when Smile Surveys were conducted in 2012. The challenge in this data is that we do not know which groups among Asian American, Native Hawaiian, and Pacific Islanders' children experience the most untreated decay rates, which could guide the different methods of implementing purposeful and effective dental care education & outreach to AAPI communities in Oregon.

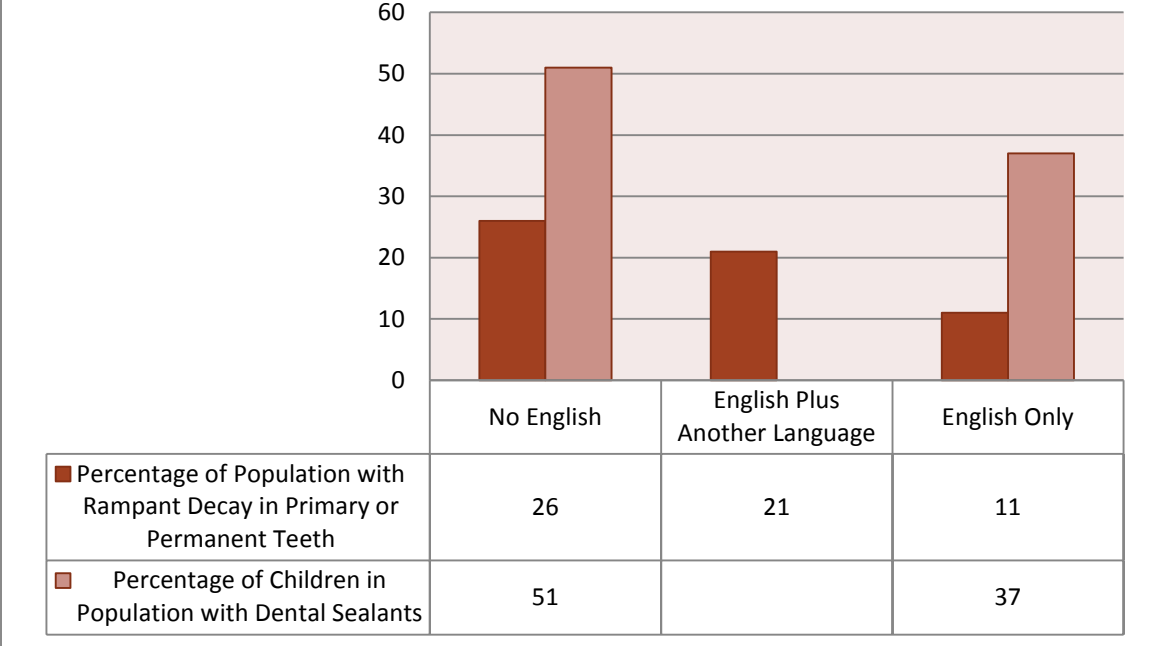
¹ 2012 Oregon Smiles & Healthy Growth Survey



Source: Oregon Smiles & Healthy Growth Survey 2012. Rampant decay occurs when there are 7 or more teeth with treated or untreated cavities or tooth decay in the primary or permanent teeth. This represents more than 17,000 children who have had 7 or more teeth with treated or untreated decay in the 2012 Smiles Survey.

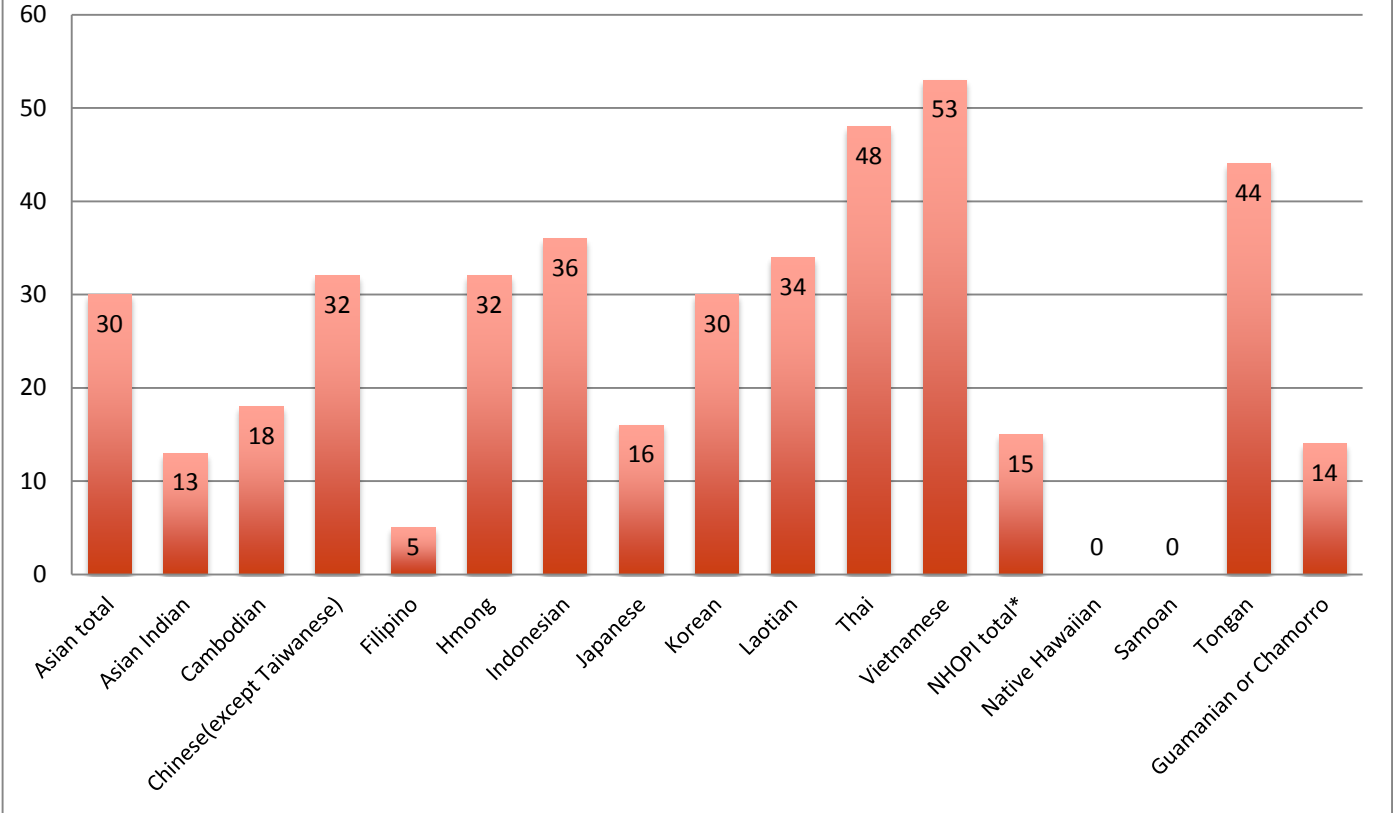
While this chart clearly illuminates the significantly higher rates of Hispanic/Latino children who had rampant decay in 2012, it also shows that Asian children are second to Hispanic/Latino children when it comes to the category of rampant tooth decay. For Asian and Hispanic/Latino children in Oregon, systemic collection of disaggregate data can begin the process of answering the challenges of addressing ethnic and national identity, cultural beliefs, and how it influences nonfinancial barriers to oral health status and use of dental services. Readily available and accessible disaggregate data on communities of color could decrease the rate of rampant decay not just among Asian American, Native Hawaiian, Pacific Islander children but all children in Oregon by creating a more culturally competent dental care delivery system.

Children 6-9 years old, Oregon, Smile Survey 2012



Adapted from: Oregon Smiles & Healthy Growth Survey 2012

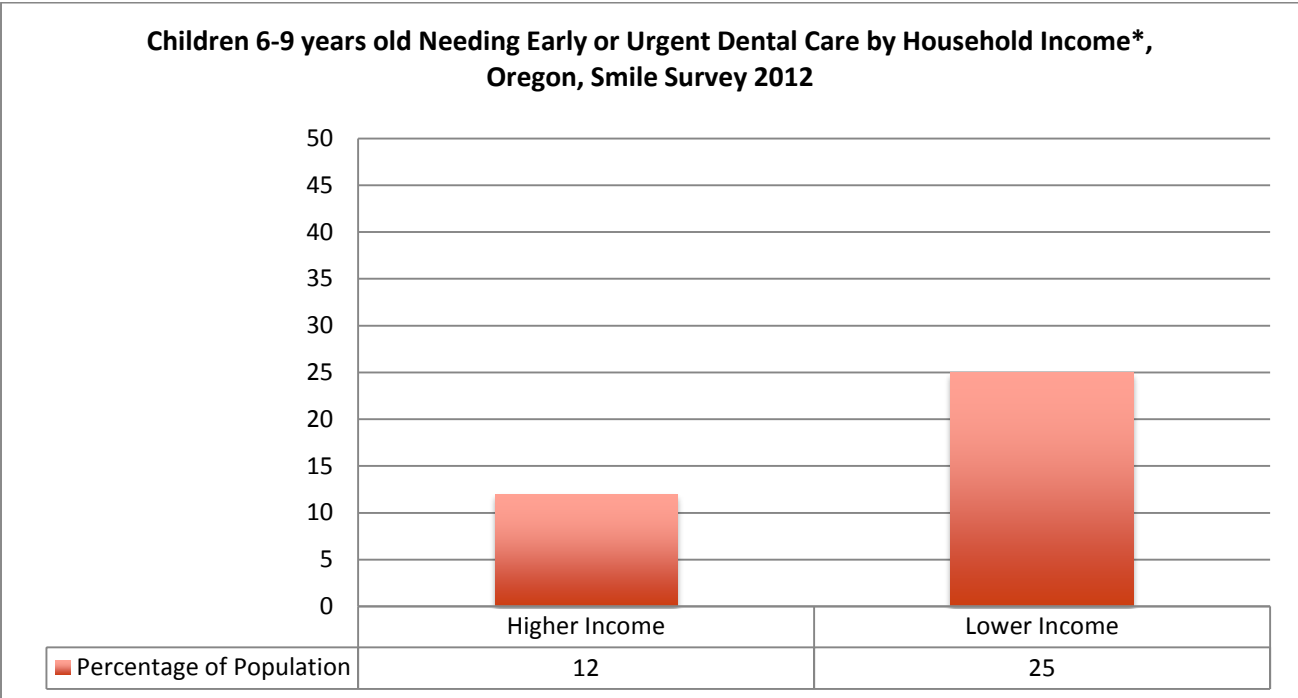
Percentage of Linguistically Isolated Households in Multnomah County, 2000



Source: The Asian & Pacific Islander Community: An Unsettling Profile, 2012

According to the 2012 survey, children who don't speak English at home are at a significantly higher risk of having rampant decay and significantly but more likely to have dental sealants. In addition, the 2012 report on API communities in Multnomah County reflects the National Survey of Childhood Health, which have shown that children in non-English Primary Language (NEPL) households were more likely than English-primary-language (EPL) households to be poor and Asian/Pacific Islander or Latino. For children in NEPL households, it is not just language, but other nonfinancial barriers also play a significant role in impaired early access to dental care. Even with NEPL children more likely to have dental sealants, they are also more likely to have rampant decay. Lack of dental insurance or ability to pay, isolated or difficult location, lack of providers, lack of cultural competency among providers, are just some of the barriers that NEPL households face when accessing the dental care delivery system (Hilton, Stephen, Barker, Weintraub 2005). With disaggregate data on which communities NEPL children identify with, it will be possible to address nonfinancial access barriers linked to NEPL households with measures such as improved access to medical interpreters, enhanced cultural competency, and health care systems that are more family centered and convenient (Flores, Tomany-Korman, 2008). For Multnomah County, a multifactorial approach that integrates cultural beliefs and values in addressing optimal access to dental care for Asian American, Native Hawaiian, and Pacific Islander communities could greatly decrease the amount of rampant decay and greatly improve early access to dental care.

It is also important to keep in mind *who* is eligible for federal programs within Asian American, Native Hawaiian and Pacific Islander communities. Immigrant status plays a major role in what federal programs an individual, whether the individual is an adult or a child, is eligible for. For example, in all states, access to TANF (Temporary Aid For Needy Families) are barred from documented immigrants for the first five years (Pereira, Crosnoe, Fortuny, et al 2012). For undocumented immigrant mothers, their children may be eligible for benefits, but this does not mean the mothers themselves are. Exclusionary policies greatly influence how much (or how little) children in NEPL households receive early childhood access to dental care.



Source: Oregon Smiles & Healthy Growth Survey 2012

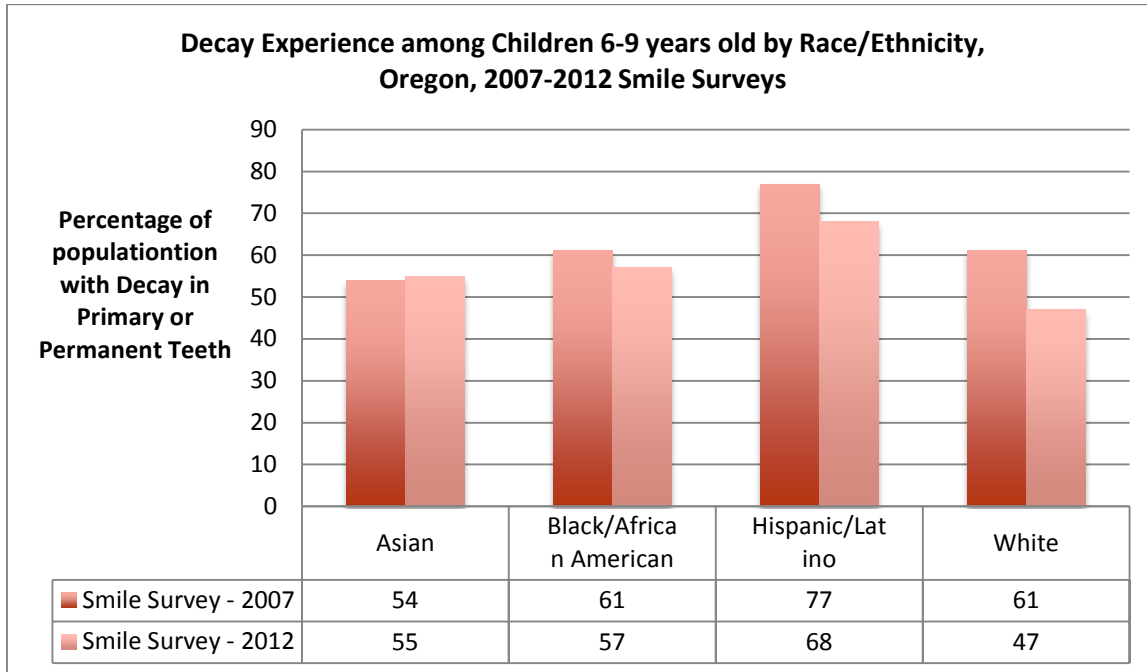
*Information on household income was not collected in this survey. A proxy for income was used instead – if the the child participates in the federal free or reduced lunch program (FRL) program.²

Children who were characterized as living in a low income household were more than twice as likely to need treatment according to the chart above. For Asian American, Native Hawaiian, and Pacific Islander families in Multnomah County, roughly 2 out of 10 single mother households are living in poverty, and 1 in 10 families are living in poverty. However, because the 2012 Smile Survey used the FRL (federal free or reduced lunch program) as an identifier of which child is characterized as a child living in a lower income household, we can only suggest that some of the children in this category could be from Asian American, Native Hawaiian, and Pacific Islander, low-income households.

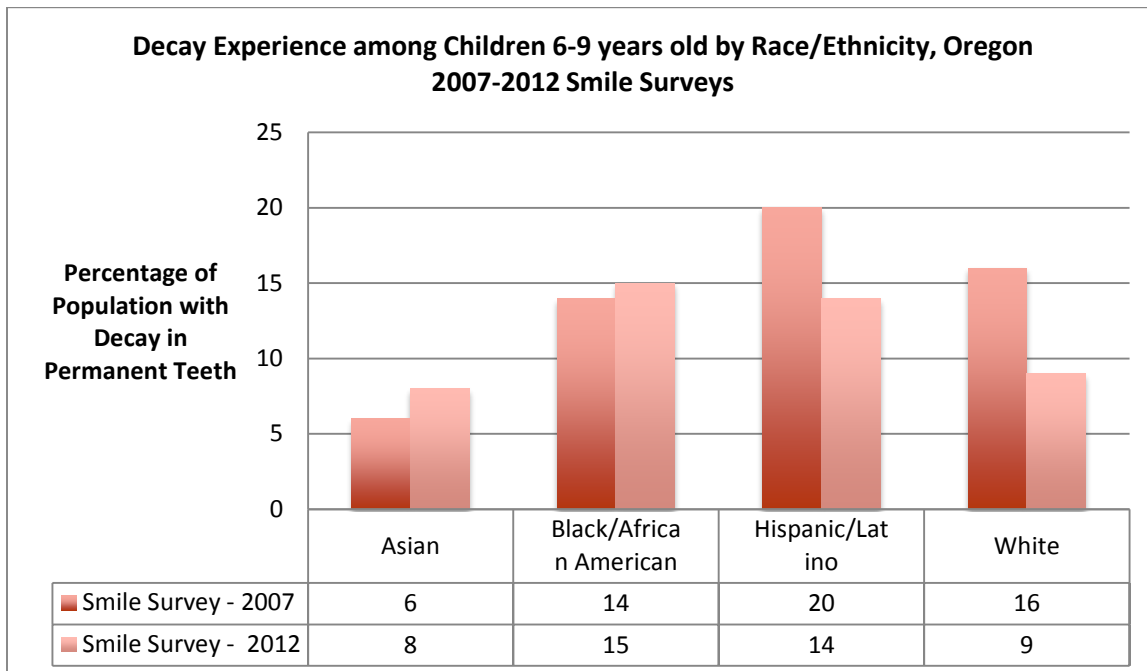
Conversely, Grembowski, Spiekerman, & Milgrom linked mothers’ access to dental care and child oral health, stating that another approach to preventative care may exist through the connection between mother and child oral health and mothers’ access to dental care. In their study, across racial/ethnic groups, low-income mothers who have a regular source of dental

² Eligibility for the Free & Reduced Lunch (FRL) program is a household income at or below 130% (Free) and between 130% - 185% (Reduced) of the poverty level.

care rated the dental health of their children higher than mothers without a regular source of dental care. Through regular dental care, mothers build positive dental knowledge, attitudes, and self-care practices, which could increase a child's dental utilization and oral health (2009).



Source: Oregon Smiles & Healthy Growth Survey 2012



Source: Oregon Smiles & Healthy Growth Survey 2012

For children 6-9 years old in Asian & Black/African American communities, rates of decay experience showed little improvement, and for Asian children 6-9 years old in Oregon, increased from 54 percent to 55 percent. For both Asian & Black/African American communities, there's significant heterogeneity. Asian American, Native Hawaiian, and Pacific Islanders greatly differ in cultural beliefs, practices and values related to accessing and utilizing dental care, in particular, caring for primary (baby) teeth. The same could be said of Black/African communities & Hispanic/Latino communities--- for example, just as there are differences in AAPI communities, there are differences between Black American, West Indian, and African immigrants who reside in Oregon. Oral health education, dental care delivery, and outreach to these communities will inherently look different from the way dental care delivery looks like for White identified communities. Dental cavities prevention and access to quality care are influenced by larger systems that systematically categorize populations as statistically insignificant simply by focusing on comparing communities of color to white counterparts. Because we do not know which specific groups experience the highest disparities, because we do not have readily available and accessible disaggregate data on groups within Asian American, Native Hawaiian, and Pacific Islander communities, it is not possible to even have a baseline to improve upon cultural competency of evidence-based programs that already exist.

Challenges to Interpreting Existing Data

In many ways I saw this report as a failure. The title of this report is "Oral Care & AAPI in Oregon," but throughout this project the main challenges I faced with existing data was that disaggregate data for the Smile Surveys concerning Asian American, Native Hawaiian, and Pacific Islanders were not readily available nor were they accessible on print or via the internet, or did not exist at all. Producing disaggregate data would have meant that I would request for permission from the Oregon Health Authority's Oral Health Program to access raw data from previously conducted surveys. This simply is beyond my current skill sets and therefore my report is limited to already existing secondary data. While the width of content between the 2007 and 2012 Smile Surveys had considerable differences and major improvements, the

surveys still did not address the differences of oral health measures within Asian American, Native Hawaiian, and Pacific Islander children 6-9 years old. Questions for further research on factors that impair access to dental care become erased when these groups are aggregated into one category for statistical significance. The statement above is also true for Black/African American & Latino communities and their children. For an accurate and more robust research project on all communities of color in Oregon, improved collection and dissemination of data is essential, which would require more time, funding, and working with both social work and public health perspectives.

I also attempted to find out how much untreated decay is costing the state of Oregon by the amount of dental related emergency department visits by contacting the Oregon Association of Hospitals and Health Systems (OAHHS). However, currently this data does not exist. OAHHS has collected data for emergency visits in past, however OAHHS as an organization has not analyzed data regarding emergency department visits. From an advocacy standpoint, understanding the costs of dental caries and untreated decay are important aspects in moving policy that addresses the multiple factors that influence impaired access to dental care for all residents of Oregon.

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