

# Dental Public Health Activity Descriptive Summary

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## Maryland Pilot for Older Adult Basic Screening Survey

The Maryland Office of Oral Health (OOH), in collaboration with the Maryland Department of Aging, conducted the Basic Screening Survey (BSS) of Older Adults in 2013/2014. The objective of this survey was to provide baseline data for surveillance of the oral health of the older adult population and to identify areas throughout the state where dental programs and treatment policies are needed. This activity addresses the Healthy People (HP) 2020 objectives of increasing oral health care access and improving frameworks to measure progress for health issues in specific populations by assessing the oral health status of older adults in Maryland, which will better enable the OOH to address the specific oral health needs of older adults and develop related programmatic and policy priorities.

Overall, a total of 994 older adults participated in the survey. While a representative sample was selected from long-term care facilities around the state, lack of participation from several sites made it difficult to provide statistically valid population estimates and variances. The breakdown of participants based on the type of long-term facilities is highlighted below.

Type of Facility	Number of Sites Visited	Number of Participants Surveyed
Senior Centers	24	302
Nutrition Sites	15	204
Assisted Living Sites	18	183
Nursing Homes	22	305
<i>TOTAL</i>	<i>79</i>	<i>994</i>

### Methods

Four public health dental hygienists were hired and calibrated in September 2013 and the data collection process began in October 2013. A representative sample of older adults 50 years and older were selected from approximately 160 long-term care facilities (congregate meal sites, senior centers, nursing homes and assisted living facilities) around the state. A [dental screening](#) and [health questionnaire](#) was administered to adults in congregate meal sites and senior centers. Only the dental screening was administered to adults in nursing homes and assisted living facilities because of the lack of cognitive ability within that population. An information packet was sent to each facility with introductory information, [older adults' pamphlet](#), and a [frequently asked questions flyer](#). Participants were given a summary of findings form and if necessary, information for additional treatment from public health dental clinics in the area.

In this project, early care is defined as an individual who needs to seek treatment within the next several weeks; and urgent care is when an individual has pain or infection and needs to seek treatment within the next week.

### **Lessons Learned:**

#### Staffing Issues

Three registered dental hygienists (RDHs) were initially contracted to perform the screening duties at the selected sites. A calibration was held prior to the initiation of the project to standardize treatment

urgency indicators and screening procedure. The ASTDD Older Adults BSS video and PowerPoint presentation was used as part of the calibration process. Due to a variety of unforeseen circumstances both personal and professional, there was a high rate of RDH turnover (a total of 8 RDHs participated in the screening process over the course of the project), and the process of hiring and calibrating new RDHs in the midst of the project caused the timeline to be delayed. Two strategies can be implemented to avoid these staffing issues in the future: first, to assemble a larger team at the start of the project; and second, to hire RDHs with expressed interest in and experience working with the target population, to ensure a clear understanding of the unique challenges and requirements of working with older adults.

#### Site Non-Participation

While a representative sample was selected from long-term care facilities around the state, lack of participation from several sites made it difficult to provide statistically valid population estimates and variances. Therefore, the results presented provide information on the oral health status of the survey participants rather than a statewide estimate. Some non-participant sites were unresponsive to attempts to make contact, but the majority of non-participant sites were contacted but declined to participate. This issue may have been partially due to a gap in timing between initial contact (a letter sent out to all selected sites informing them of the project and indicating that a representative would be contacting them) and follow-up contact by the individual screeners to confirm participation and schedule a screening. Ensuring a shorter interval between initial and follow-up contact with potential participants could potentially increase the number of participant sites.

An additional issue involved the organization of the site sample. An initial sample, designed to be representative of the state overall, was selected, and individual sites were assigned to the RDH screeners based on regional divisions. The documentation of site assignments for each RDH was done using Microsoft Excel files, which each RDH would update with their progress in contacting sites and scheduling screenings. The use of these Excel spreadsheets became a concern due to the high potential for error in manual entering of site information, and the need for constant updates between RDHs and OOH staff, which resulted in some disorganization of records. Future survey implementation should use a more efficient organizational tool, such as a Microsoft Access+ database, to track site sample information and progress.

#### Treatment Referrals

A third issue that arose over the course of this project was how to handle referrals for subjects who need early or urgent dental care. The terms of the survey prohibit the RDH screeners from administering any treatment to survey subjects due to Maryland's scope of practice definition. Following each individual screening, subjects were informed of their treatment urgency, and when appropriate (as in the case of a cognitively impaired subject) an administrator at the site facility was informed as well. Subjects and site administrators were provided with the Maryland Oral Health Resource Guide, which lists public health dental service providers across the state. However, there was no system in place for direct referrals to care or for follow-up contact with those subjects with early or urgent treatment needs. This raised an ethical dilemma for the dental professionals involved with the project, who feel a professional obligation to ensure that care is received by subjects who require it. A standard procedure for giving direct referrals and making follow-up contact with sites and subjects would be a valuable addition to the survey.

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