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Guest Editorial

Oral Health Literacy: Be part of the change!

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Oral health is acknowledged worldwide as a key component of overall health and impacts quality of life. The burden of oral diseases is found among individuals least able to access care: the elderly, individuals with low socioeconomic status, have poor English proficiency, are ethnic and racial minorities, or are enrolled in public assistance programs. These individuals often have inadequate oral health literacy (OHL), the "degree to which individuals have the capacity to obtain, process and understand basic oral health information and services needed to make appropriate health decisions."[1] Measuring OHL has been suggested as a more accurate single indicator than any of the previously mentioned demographic factors. While no national statistic reports adult oral health literacy, it may roughly equate with the 36% of adults in the United States (US) estimated to have low health literacy.[2]

Several difficulties make OHL measurement on a broad level challenging, one of which is deciding on which instrument or survey to use. There are currently at least 20 validated OHL instruments; the earliest developed and most frequently used measure uses word recognition and reading skills. Newer instruments seek to measure "functional oral health literacy," a concept that encompasses several domains included in prior instruments plus numeracy and dental knowledge. The length of many of the instruments makes them difficult to use in clinical settings as they often consist of approximately 20 questions or more.[3]

How best to measure OHL is a continuing debate between researchers, clinicians, and policymakers. While consensus exists that the path to improved dental access hinges on optimizing oral health literacy, it is important to be clear about what this actually means. The people most likely to have inadequate OHL often have compromised social determinants of health. These may include co-morbidities, job-related constraints, lack of social support, and inadequate health insurance. Expecting these individuals to increase their ability to learn more about preventive oral health and navigate the health care system without assistance is burdensome. Drawing on the 'minimally disruptive care' approach described by Allwood et al. in 2021, moving to a *careful* and more *kind* approach of care may be a more successful strategy.[4] "Careful" care is described as evidence-based and tailored specifically for each patient. "Kind care" involves seeing each patient as a unique and whole individual, taking into consideration their unique situation. This approach is being pioneered in chronic disease settings, and initial studies have shown decreased costs and improved outcomes.

A parallel approach was proposed by the Institute of Medicine in 2004 where healthcare systems and academic institutions were tasked with implementing strategies to address OHL.[5] Suggested strategies included expanding traditional healthcare boundaries by communicating with religious, social work, home health, and other social organizations. The benefit of this collaboration has the potential to not only establish referral networks through interprofessional collaboration but could result in marked improvements in the health of the whole person. Academic institutions can impact and facilitate OHL by educating future dental professionals on communication techniques that can easily be integrated into current daily practice. Strategies such as limiting the amount of information to no more than three key points, teach-back, and motivational interviewing are effective strategies for improving communication with all patients regardless of their OHL level.

On a national level, the US Oral Health Literacy Awareness Campaign bill (H.R. 4555) was passed by the House of Representatives in December 2021. The purpose of the legislation was to identify oral health literacy and awareness strategies that are "evidence-based and focused on oral health care education, including education on prevention of oral disease such as early childhood and other caries, periodontal disease, and oral cancer." The companion Senate bill has been rolled into the larger Health Equity & Accountability Act of

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2022 (S4486) and was referred to the Committee on Finance in June 2022. One critical aspect in the House bill refers to including a process for measuring outcomes and effectiveness, although specific metrics have not been identified. The impending over-arching legislation provides fuel to speed up the decision on how best to measure OHL and oral health outcomes. On a broader scale, the Senate bill incorporates the recently updated Quintuple Aim of Healthcare. In addition to striving toward improving outcomes, lower costs, better health, and clinician well-being included in the Quadruple Aim, increasing health equity is part of the vision to optimize US healthcare. As oral health literacy is encompassed within the realm of health equity as a determinant of health, systems engaged in improving health equity must coordinate general health and oral health care to meet this goal.[6]

While this may seem a daunting task, there are steps that dental hygienists can take in our daily practice as we interact with individual patients. As is often the case, change often begins at the grassroots level. Implementing strategies to increase the ability of patients to navigate and access care need not be difficult nor expensive. We can assist patients by using plain language in our clinical conversations. We can work within our practices to assure that adequate signage and parking at the point-of-care facilitates patients who may struggle with finding our offices. When possible, provide sliding fee scales for patients who are under- or uninsured to reduce the financial burden for potential patients. Having a "real person" answer the phone, an interpreter service available for patients requiring language assistance, written materials written at a 6th grade reading level and available in the predominate languages spoken in your geographic area can make a difference.

When you are ready for a larger commitment, establish a monthly screening program at community sites to reach the most vulnerable and least likely to self-initiate care. Private practices initiating a relationship with a collaborative dental hygienist can facilitate preventive care in community settings and create both the trust and resources needed to refer patients for restorative treatment. For more details, toolkits are readily available online that provide oral health literacy best-practices.[7]

In conclusion, the frameworks that integrate general and oral health care are promising. Yet much work is left to be done at the grassroots and systems levels that begins with agreeing on process and outcome measures. The many moving parts that comprise healthcare in the US make change slow and cumbersome. Yet, change only occurs when those with similar goals put forth the coordinated efforts required to move the dial. Be the change you want to see!

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Erratum

Correction to Bosma, ML, et al. (2022)

In the article "Efficacy of Flossing and Mouthrinsing Regimens on Plaque and Gingivitis: A randomized clinical trial, by Bosma, ML, McGuire, JA, Sunkara, A, et al. J Dent Hyg. 2022 Jun: 96(3);8-20. PMID: 35654568 https://jdh.adha.org/content/96/3/8, there was an error in Table V, page 17, sample sizes for "Week 12." The correct sample size (n) for the 4EO mouthrinse group should read 40, the correct sample size for the Professional flossing (FBH) group should read 35, and the correct sample size for the Supervised flossing (FUS) should read 38.