



## Barriers and Solutions to Accessing Care

### **INTRODUCTION**

In 2000, the U.S. Surgeon General identified the state of oral health in the United States as an epidemic, noting that illnesses related to oral health resulted in 6.1 million days of bed disability, 12.7 million days of restricted activity, and 20.5 million days of lost workdays each year.<sup>1</sup>

Since then, numerous organizations, public and private, have dedicated countless hours and dollars to propose solutions to improve “access to care.” However, twelve years after the Surgeon General’s report, we have accomplished little to improve the oral health of the public.

The reasons for this are many, from federal and state budgetary constraints, to wasteful expenditures on unproven programs, to misidentification of the problem as a shortage or unwillingness of providers to provide care, to a continued failure to convince the public to embrace and act upon the importance of oral health to produce positive behavioral outcomes.

The focus of this paper is to identify the underlying barriers that have held us back from bettering the state of oral health for the last twelve years, with proven solutions that are within our immediate reach to improve oral health in the United States.

Future publications of the AGD shall further explore each barrier to identify what has worked in pockets and states across the nation, and how we may apply those lessons to overcome barriers in other areas.

### **BARRIERS AND SOLUTIONS**

“Access” is a shorthand term used for a broad set of concerns that center on the degree to which individuals and groups are able to obtain needed services from the health care system. Often, because of difficulties in defining and measuring the term, legislatures equate access with insurance coverage and with having enough doctors and hospitals *within* the areas in which populations live.

However, having insurance or having health care providers located within the immediate vicinity does not guarantee that people who need services will get them. Conversely, when other barriers

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<sup>1</sup> U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research, 2000. NIH publication 00-4713. Available from: URL: <http://www.surgeongeneral.gov/library/oralhealth/>

are addressed, both insured and uninsured residents of federally-sanctioned shortage areas do find and receive care. Therefore, while access has been used by some to refer to coverage and proximity, the extent to which a population “gains access” to health care depends upon financial, organizational, and social or cultural barriers that may limit utilization.

Specifically, addressing the following key barriers will move our nation toward gaining and utilizing available care:

1. Oral Health Literacy
2. Psychological Factors
  - a. Turning literacy into healthy behaviors (Patient activation)
  - b. Treatment mentality vs. prevention mentality
  - c. Social and cultural misperceptions
3. Financial Factors
  - a. Economics of sustainable care delivery
  - b. Provider distribution
4. Patients with Special Needs

## ORAL HEALTH LITERACY

Section 5002 of the Affordable Care Act of 2010 defines health literacy as “the degree to which individuals have the capacity to obtain, process, communicate, and understand basic health information and services needed to make appropriate health decisions.”<sup>2</sup>

“Health literacy in dentistry is ‘the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate oral health decisions.’”<sup>3</sup>

“In the U.S., limited literacy skills are a stronger predictor of an individual’s health status than age, income, employment status, education level, and racial or ethnic group. Limited health literacy is estimated to cost the U.S. between \$100 and \$200 billion each year.”<sup>4</sup>

Increased oral health literacy provides a first step toward enabling patients to see value and ask for services, and will allow communities to develop a culture of oral health as a priority that they should work to achieve.

Oral health literacy efforts have paid dividends in numerous states across the nation. The AGD calls for collaborative actions with all stakeholders to ensure the following actions:

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2 Tetine Sentell. Implications For Reform: Survey Of California Adults Suggests Low Health Literacy Predicts Likelihood Of Being Uninsured. *Health Affairs*, 31, no.5 (2012):1039

3 ADA Strategic Action Plan 2010-2015, p. 1. Also, “The American Dental Association (ADA) affirmed that limited health literacy is ‘a potential barrier to effective prevention, diagnosis and treatment of oral disease,’ and ‘clear, accurate and effective communication is an essential skill for effective dental practice.’”

4 ADA Strategic Action Plan 2010-15, p.1

- Pursue development of a comprehensive oral health education component for public schools' health curriculum in addition to providing editorial and consultative services to primary and secondary school textbook publishers;
- Provide exams for one-year-old children as part of the recommendations for new mothers to facilitate early screening;
- Equip teachers at various levels with creative educational tools, including educational videos, puzzles, word searches and experiments that show children the value of their teeth and how to care for them;
- Train daycare providers and school nurses on the importance of oral health, including on proper nutrition;
- Provide dental information to pediatricians regarding use of bottled water, fluoride, fluoride varnishes, and appropriate diets;
- Provide multi-factorial interventions and educational programs to parents of young children, including through public media and information provided at hospitals and other healthcare points of care.<sup>5</sup>

## PSYCHOLOGICAL FACTORS

### *Turning literacy into healthy behaviors (Patient activation)*

When one truly understands the importance of oral health, he or she acts upon it, and action in turn becomes engrained as value. This - patient activation - is the unspoken solution to improving oral health and yet, it is free and readily available.<sup>6</sup>

Unfortunately, studies have shown that education alone does not translate to value that leads to patient activation and positive patient outcomes.<sup>7</sup> Education must be coupled with health promotion to ultimately result in patients' realizing and acting upon their need for preventive care, both through self-care at home and through regular visits to their dentist – a dental home.

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<sup>5</sup> U.K. Report. The oral health of young children should be promoted through multiple interventions and multisessional health promotion programmes for parents.

- Oral health promotion programmes to reduce the risk of early childhood caries should be available for parents during pregnancy and continued postnatally.
  - Oral health promotion programmes for young children should be initiated before the age of three years
- Oral health promotion programmes should address environmental, public and social policy changes in order to support behaviour change.

<sup>6</sup> "...that is, how confident, skillful, and knowledgeable they are about taking an active role in improving their health and health care..." Peter J. Cunningham, Judith Hibbard and Claire B. Gibbons. Raising Low 'Patient Activation' Rates Among Hispanic Immigrants May Equal Expanded Coverage In Reducing Access Disparities. *Health Affairs*, 30, no.10 (2011):1888

<sup>7</sup> "A review of public health education interventions found that studies aiming to increase knowledge were successful, but the effect of information acquisition on behaviour was uncertain. It concluded that health education interventions alone are insufficient to change behaviour but can be effective when combined with environmental or legislative changes" (U.K. Study). Also, "(...) **In the latest Research!America poll, 97 percent responded that oral health was somewhat or very important to overall health, yet oral health is a top unmet need for many.**" Susan A. Fisher-Owens, Judith C. Barker, Sally Adams, Lisa H. Chung, Stuart A. Gansky, Susan Hyde and Jane A. Weintraub. Giving Policy Some Teeth: Routes To Reducing Disparities In Oral Health. *Health Affairs*, 27, no.2 (2008):407

“Health promotion supports individuals in translating their health knowledge into positive behaviours and lifestyles. Health promotion activities should be directed at a wide variety of areas likely to impact on health, eg social, economic and structural environments as well as the policies of public and local institutions. The rationale is to increase the community’s day-to-day capacity and ability to follow a healthy lifestyle.”<sup>8</sup>

“[Health promotion] interventions have included the tailoring of information to meet the needs of specific groups, active involvement by participants, direct contact from services and active learning techniques in addition to dental health education.”<sup>9</sup> This often requires a multi-factorial approach.

### *Treatment mentality vs. prevention mentality*

“A study of decay-related ER visits in 2006 found that treating about 330,000 cases cost nearly \$110 million.<sup>3</sup> States are saddled with some of these expenses through Medicaid and other public programs.”<sup>10</sup>

“A study in Washington State revealed that a trip to the ER was the first ‘dental visit’ for one in four children overall, and for roughly half the children younger than 3 and a half years.<sup>11</sup>

The success of our efforts for oral health improvement should be measured by the outcome goal of no disease. The US, New Zealand and others have a fixation on treatment as the route to health. In contrast is Denmark, a nation whose dental health outcomes are much more positive than those of New Zealand and even the United States. Its success is due to its focus on prevention, starting at a very young age, rather than on fillings, extractions or root canals. By focusing on the preventable nature of dental disease, Denmark has greatly reduced the need for treatment interventions, whereas in New Zealand and elsewhere, the use of increased treatment mainly by therapists has not caused a decrease in the Caries experience.<sup>12</sup>

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8 U.K. Study...

9 U.K. Study

10 Pew’s ER Report, 2012, p. 3.

11 Pew’s ER Report, 2012

12 AAPD Policy 2011 Council on Clinical Affairs. New Zealand, known for utilizing dental therapists since the 1920’s and frequently referenced as a workforce model for consideration in the US, recently completed its first nationwide oral health status survey in over 20 years. Dental care is available at no cost for children up to 18, with most public primary schools having a dental clinic and many regions operating mobile clinics.<sup>22</sup> Overall, 1 in 2 children in New Zealand aged 2–17 years was caries-free. The caries rate for 5 year olds and 8 year olds in 2009 was 44.4% and 47.9% respectively.<sup>23</sup> These caries rates, which are higher than the US, United Kingdom, and Australia, help refute a presumption that utilization of non-dentist providers will overcome the disparities.

Gillies A. NZ children’s dental health still among worst. The New Zealand Herald. March 6, 2011. Available at: “[http://www.nzherald.co.nz/nz/news/article.cfm?c\\_id=1&objectid=10710408](http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10710408)”. Accessed March 14, 2011.

New Zealand Ministry of Health. Age 5 and year 8 oral health. In: Our Oral Health: Key findings of the 2009 New Zealand Oral Health Survey. New Zealand, 2010. Available at: “[http://www.moh.govt.nz/moh.nsf/Files/oralhealth-statistics/\\$file/age5-year8-oral-health-data-from-school-dental-services-2009-v2.xls](http://www.moh.govt.nz/moh.nsf/Files/oralhealth-statistics/$file/age5-year8-oral-health-data-from-school-dental-services-2009-v2.xls)”. Accessed March 14, 2011.

The issue of emergency room visits is a symptom of our treatment mentality when it comes to healthcare, and the solution is to prevent the need to resorting to oral health care in an emergency room in the first place.

We must work together to restore oral health care from the hospital emergency room back into the home and into the dental home.

Patients need to be connected to a dental home and have a sustainable relationship with a fully-trained dentist.

Solutions targeted to move dentistry away from expensive emergency room care and back to the dental home include:

- Develop and fund patient navigators to work within communities to ensure that patients keep preventive appointments and to minimize emergency room visit and return rates.

### *Social and cultural misperceptions*

“Oral health knowledge and practices differ by ethnicity and culture. Groups vary in beliefs about the usefulness of treating the primary teeth; caries etiologies; the meaning of oral pain, dental discolorations, or loss; home remedies; dental hygiene and preventive efficacy; and trusted dental information sources.

Our Native American populations reflect the stark contrasts in social and cultural realities. Native American children, ages 2-5, are more than three times more likely to have untreated decay than children of the same age group in the general population - 68% vs 19%, respectively.<sup>13</sup>

Some solutions to overcome social and cultural misperceptions include:

- Provide information to dentists and their staffs on cultural diversity issues, which will help them reduce or eliminate barriers to clear communication and enhance understanding of treatment and treatment options;
- Work with community leaders to breakdown the cultural barriers
- Provide oral health information in multiple languages through multiple community channels.<sup>14</sup>
- Work with Indian Health Services (HIS) and community organizations such as COPE.<sup>15</sup>

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<sup>13</sup> Retrieved from [http://www.sddental.org/ohc\\_native\\_american\\_oralhealth.htm](http://www.sddental.org/ohc_native_american_oralhealth.htm)

<sup>14</sup> “It is also worth noting the importance of having outreach and materials for both Medicaid and the insurance exchanges in multiple languages, given that 60.4 percent of the uninsured with low health literacy had limited English proficiency, as did 26.6 percent of the uninsured with adequate health literacy.” Tetine Sentell. Implications For Reform: Survey Of California Adults Suggests Low Health Literacy Predicts Likelihood Of Being Uninsured. *Health Affairs*, 31, no.5 (2012):1039-1044

<sup>15</sup> “The Community Outreach and Patient Empowerment (COPE) Program is a formal collaboration between the Navajo Nation Community Health Representative Program, the Gallup, Shiprock, Fort Defiance and Chinle Service

## FINANCIAL FACTORS

### *Economics of sustainable care delivery*

“When we talk about raising the [Medicaid] reimbursement, we really are looking at being able to reimburse small businesses and dentists to make the care that they provide, sustainable.”<sup>16</sup>

State efforts to make care for all persons economically feasible have been proven to be effective.<sup>17</sup>

Solutions to make care for vulnerable populations economically feasible include:

- Extend the period over which student loans are forgiven to 10 years without tax liabilities for the amount forgiven in any year;
- Provide tax credits for establishing and operating a dental practice that serves vulnerable populations<sup>18</sup>;
- Offer scholarships to dental students in exchange for committing to serve vulnerable populations;
- Provide senior dental students education through the provision of care in outreach community dental facilities supervised by faculty and interacting with other health care providers<sup>19</sup>;
- Increase funding of and statutory support for expanded loan repayment programs (LRPs);

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Units of the Indian Health Service, and BWH’s Division of Global Health Equity.” *Health Workers Help Navajo Patients COPE*. Retrieved from <http://www.knowledgeofmedicine.com/brigham-womens-hospital-boston/health-workers-help-navajo-patients-cope/>

16 Dr. Oh’s testimony with Maine Watch, March 2012 (Retrieved from

<http://www.mpbn.net/Television/LocalTelevisionPrograms/MaineWatch/tabid/477/ctl/ViewItem/mid/3470/ItemId/20955/Default.aspx>).

Dr. Oh stated, “On average the overhead for providing dental care is quite high; it’s about 65% that’s on a normal fee but [Medicaid] reimburses dentists at approximately 25% [or similar % in your state] of the usual and customary fees. So if it costs 65% percent to just cover your overhead, that fraction of a reimbursement you get is often a loss. There are many offices that would take [Medicaid] if the reimbursement is brought up to a sustainable level and that would be more fair to the patients and to the providers.”

17 “[In Connecticut, in 2007,] there were only 150 dentists who took their Medicaid program to provide dental benefits. The Connecticut legislature realized this and said we have to find a way to make this care sustainable. So, in 2008, they passed legislation to increase the reimbursement for their Medicaid dental procedures. Within a couple of years they went from 150 providers who were accepting Medicaid children to over 1,000. This wasn’t dentists who were worried about making money; this wasn’t about making the largest possible profit. This was just making sure that the care was reimbursed so that the dentist’s office would stay open and they could keep taking the patients.” (Dr. Oh, Maine Watch, March, 2012)

18 “**The Maine Dental Association's own bill, called ‘An Act to Increase Access to Dental Care,’ has become law.** Starting 2009, dentists became eligible to receive up to \$15,000 in income tax credit annually-for up to five years as long as they practice in underserved areas. American Dental Association (ADA) *Update*, June 10, 2008 (Retrievable from [www.ada.org](http://www.ada.org)).

19 “The new Commission on Dental Accreditation Standard 1-9, which requires that ‘the dental school must show evidence of interaction with other components of the higher education, health care education and/or health care delivery systems,’ will help guide more of our schools in this direction.” American Dental Education Association (ADEA). *Charting Progress*. May 2012.

- Provide federal loan guarantees and/or grants for the establishment and equipping of dental clinics for underserved or financially challenged patients;
- Increase appropriations funding to increase the number of dentists serving in the National Health Service Corps and other federal programs, such as Indian Health Services, programs serving other disadvantaged populations and U.S. Department of Health and Human Services (HHS)-wide loan repayment authorities;
- Develop dental clinics within hospitals to treat patient who are too complicated or systemically compromised to treat in community clinics; the hospital dental clinics should have the capacity to accept after-hours emergencies that would otherwise go to higher-cost emergency rooms;
- Fund dentists to provide oral health care within hospital dental clinics;
- Take steps to facilitate effective compliance with government-funded dental care programs to achieve optimum oral health outcomes for indigent populations:
  - Raise Medicaid fees to at least the 75<sup>th</sup> percentile of dentists' actual fees
  - Eliminate extraneous paperwork
  - Facilitate e-filing
  - Simplify Medicaid rules
  - Mandate prompt reimbursement
  - Educate Medicaid officials regarding the unique nature of dentistry
  - Provide block federal grants to states for innovative programs
  - Require mandatory annual dental examinations for children entering school (analogous to immunizations) to determine their oral health status
  - Encourage culturally competent education of patients in proper oral hygiene and in the importance of keeping scheduled appointments
  - Utilize case management to ensure that the patients are brought to the dental office
  - Increase general dentists' understanding of the benefits of treating indigent populations;
- Encourage funding from organizations that serve the public, such as the W.K. Kellogg Foundation, Pew Charitable Trusts, DentaQuest and the Robert Wood Johnson Foundation, to support the above solutions.

#### *Provider distribution*

The AGD recognizes that the distribution of dentists is a consideration to access to care in certain geographic locations. However, the AGD disagrees with Americans being labeled as “underserved” strictly by the ratio of number of dentists to number of persons in their localities, with disregard as to practice capacity, volunteer programs, and other factors.

Further, as evidenced by the vast number of patients who routinely travel to receive care at volunteer clinic events such as those held by the Missions of Mercy (MOM), it is clear that other financial barriers present a far greater challenge than provider location.

Nonetheless, where distribution of dentists can be addressed with a limited expenditure of resource, it should be addressed. To successfully produce equitable distribution of care in areas

now deemed underserved, incentives must be established to encourage dentists, especially those with GPR or AED training, who have attained the education and expertise to competently and comprehensively address the oral health needs of potentially compromised populations and to practice in underserved areas in conjunction with their dental teams. Many of these incentives have been presented as solutions above. However, numerous economically conservative solutions are also readily available to connect the patient to the dentist. Solutions that bridge the location gap include:

- Actively recruit applicants for dental schools from underserved areas;
- Establish alternative oral health care delivery service units:
  - Arrange for transportation to and from care centers
  - Solicit volunteer participation from the private sector to staff the centers;
- Encourage private organizations, such as Donated Dental Services (DDS), fraternal organizations and religious groups to establish and provide service;
- Provide mobile and portable dental units to service the underserved and indigent of all age groups;

#### PATIENTS WITH SPECIAL NEEDS

Patients with special needs include patients with disabilities, elderly patients, and patients with medical conditions or co-morbidities that require additional care. Vulnerable populations often include a high proportion of patients with special needs, reminding us of the importance of ensuring that these patients receive high-quality care by educated and licensed dentists. Solutions to ensure the provision of high-quality care to these deserving patients include:

- Assure funding for Title VII general practice residency (GPR), advanced education in general dentistry (AEGD), and pediatric dentistry residencies ;
- Identify educational resources for dentists on how to provide care to pediatric and special needs patients;

#### **CONCLUSION**

The AGD believes that the role of the general dentist, in conjunction with the dental team, is of paramount importance to improving both access to and utilization of oral health care services. Equally important is the need for every member of the public to understand the importance of his or her own oral health and to transfer that understanding into action.

The AGD is willing and capable of working with other communities of interest to address and solve disparities in access to and utilization of care across the nation. We should work together to make sure that all Americans receive the very best comprehensive dental care that will give them optimal dental health and overall health.

During this process, we must maintain our focus on the patient and maintain awareness that dentistry works best as a preventive system. As noted in *Oral Health in America: A Report of the Surgeon General*, “Oral diseases are progressive and cumulative and become more complex over time.” Fortunately, “Most common oral diseases can be prevented.”