ACADEMY of GENERAL DENTISTRY

BARRIERS AND SOLUTIONS TO ACCESSING CARE

"to serve and protect the oral health of the public"

Barriers and Solutions to Accessing Care

INTRODUCTION

In 2000, the Office of the Surgeon General (OSG) identified the condition of oral health in the United States as an epidemic, noting that illnesses related to oral health resulted in approximately 6.1 million days of bed disability, 12.7 million days of restricted activity, and 20.5 million lost workdays each year.[1]

Since then, numerous organizations, public and private, have dedicated countless hours and dollars to propose solutions to improve "access to care." However, more than a decade following the OSG's warning, very little has been accomplished to improve the oral health of the public.

The reasons for this lack of progress are many, including federal and state budgetary constraints, wasteful expenditures on unproven programs, misidentification of the problem as a shortage or unwillingness of providers to provide care, and failure to convince the public to adopt positive oral health habits.

The focus of this paper is to identify the underlying barriers that have held us back from bettering the state of oral health over the last 12 years, and also provide us with proven solutions for improving the public's overall oral health in the United States.

Future publications of the Academy of General Dentistry (AGD) shall further explore each oral health barrier, identifying what has and has not worked in areas across the nation, and how we may apply those lessons to overcome barriers in other areas.

BARRIERS AND SOLUTIONS

"Access" is a 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 a given area.

However, having insurance or having health care providers located within the immediate vicinity does not guarantee individuals will receive the treatment and services they require. Conversely, when other barriers are addressed, both insured and uninsured residents of federally-sanctioned shortage areas can 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, instead, upon financial, organizational, and social or cultural barriers that may limit utilization.

The AGD believes that addressing the following key barriers will allow the U.S. public to properly gain and utilize available oral health 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

According to Title V, Subtitle A, of the Patient Protection and Affordable Care Act (2010), "The term 'health literacy' means the degree to which an individual has the capacity to obtain, communicate, process, and understand health information and services in order to make appropriate health decisions."[2]

The American Dental Association Health Literacy in Dentistry Action Plan, 2010–2015 further indicates that, "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."[3]

Increased oral health literacy provides a first step toward enabling patients to see value and ask for services, and will inspire communities to consider positive oral health a priority they should work toward achieving.

Oral health literacy efforts have paid dividends in numerous states across the nation. The AGD calls for collaboration from all oral health stakeholders to help in:

- Developing a comprehensive oral health education component for public schools' health curriculums, in addition to providing editorial and consultative services to primary and secondary school textbook publishers;
- Providing oral health exams for 1-year-olds to help facilitate early screenings and implement oral health recommendations for children and their mothers;

1. 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: *www.surgeongeneral.gov/library/oralhealth*
2. Patient Protection and Affordable Care Act, PL 111-148, March 23, 2010, 124 Stat 119. *See also* 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. American Dental Association (ADA) Council on Access, Prevention and Interprofessional Relations. American Dental Association Health Literacy in Dentistry Action Plan, 2010–2015. 2009: 1. (The ADA further states that limited health literacy is "a potential barrier to effective prevention, diagnosis and treatment of oral disease," and that "clear, accurate and effective communication is an essential skill for effective dental practice.")

- Equipping 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;
- Training daycare providers and school nurses on the importance of oral health, including nutrition's role in maintaining healthy teeth;
- Providing dental information on the use of bottled water, fluoride, fluoride varnishes, and appropriate diets to pediatricians;
- Offering multi-factorial interventions and educational programs to parents of young children, including through public media and information provided at hospitals and other health care points of care.[4]

PSYCHOLOGICAL FACTORS

Patient activation, turning literacy into healthy behaviors

When one truly understands the importance of oral health, he or she acts upon it, and action in turn becomes engrained as value. Patient activation encapsulates, "how confident, skillful, and knowledgeable they are about taking an active role in improving their health and health care."[5] Patient activation is the unspoken solution to improving oral health, a solution that is readily available.

Unfortunately, studies have shown that educating patients about the importance of proper oral health care isn't enough to lead to patient activation and positive patient outcomes.[6] 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.

"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, e.g. 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… [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."[7] This often requires a multi-factorial approach.

Treatment mentality vs. prevention mentality

"A study of decay-related ER [emergency room] visits in 2006 found that treating about 330,000 cases cost nearly $110 million. States are saddled with some of these expenses through Medicaid and other public programs."[8]

Additionally, "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.[9]

The success of our efforts for oral health improvement should be measured by the outcome goal of no disease. The U.S., like many other countries, including New Zealand, has a fixation on treatment as the route to quality oral health. However, in contrast, some countries like Denmark—a nation whose dental health outcomes are much more positive than those of New Zealand and even the United States—succeed due to their focus on prevention at a very early age, rather than the notion that fillings, extractions, and root canals are the answer. 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 dental caries.[10]

The issue of emergency room visits is a symptom of our treatment mentality when it comes to health care, and prevention is the solution. We must stop resorting to emergency rooms as a place for oral health care, and promote preventive oral health care at home and in the dental home.

In order to do this, 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:

- Developing and funding patient navigators to work within communities and ensure that patients keep preventive appointments;
- Minimizing emergency room visits 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;

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4. NHS Quality Improvement Scotland. Prevention and management of dental decay in the pre-school child: A National Clinical Guideline. *Scottish Intercollegiate Guidelines Network (SIGN)*. 2005: 20. (This guideline further states:
   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.)
5. 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
6. NHS Quality Improvement Scotland, op.cit., p. 19. ("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"). See also, 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. ("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")
7. NHS Quality Improvement Scotland, op.cit., p. 19
8. The Pew Center on the States. A Costly Dental Destination: Hospital Care Means States Pay Dearly. 2012: 1. Available at: *www.pewstates.org/projects/childrens-dental-campaign-328060* (Referring to the findings of R. Nalliah, V. Allareddy, S. Elangovan, N. Karimbux, and V. Allareddy, "Hospital Based Emergency Department Visits Attributed to Dental Caries in the United States in 2006," *Journal of Evidence Based Dental Practice* (2010), Vol. 10, 212-222, *www.jebdp.com/article/S1532-3382(10)00183-1/abstract*.)
9. ibid., p. 3.
10. American Academy of Pediatric Dentistry (AAPD) Council on Clinical Affairs. Policy on Workforce Issues and Delivery of Oral Health Care Services in a Dental Home. *AAPD Oral Health Policies, Reference Manual.* Vol. 33. No. 6. 2011: 28 ("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. 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. 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.").
    See also, Gillies A. NZ children's dental health still among worst. *The New Zealand Herald.* March 6, 2011. Available at: *www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10710408.* Accessed March 14, 2011.
    See also, Ministry of Health. Our Oral Health: Key findings of the 2009 New Zealand Oral Health Survey. Wellington: Ministry of Health. 2010. Available at: *www.moh.govt.nz.* Accessed March 14, 2011.

caries etiologies; the meaning of oral pain, dental discolorations, or loss; home remedies; dental hygiene and preventive efficacy; and trusted dental information sources."[11]

The U.S. Native American population reflects this stark contrast in social and cultural realities. According to the South Dakota Dental Association, Native American children, between 2 and 5 years old, are three times more likely to have untreated decay than children of the same age group in the general U.S. population, 68 percent and 19 percent, respectively.[12]

However, these social and cultural misperceptions may be overcome by:

- Providing information to dentists and their dental teams on cultural diversity concerns, which will help dental professionals reduce or eliminate communication barriers and help enhance patients' understanding of treatment and treatment options;
- Working with community leaders to break down cultural barriers;
- Providing oral health information in multiple languages through multiple community channels;[13]
- Working with Indian Health Services (IHS) and community organizations such as COPE.[14]

FINANCIAL FACTORS

Economics of sustainable care delivery

According to Timothy Oh, DMD, "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."[15] State efforts to make care for all persons economically feasible have been proven to be effective.[16]

Solutions for making care economically feasible for vulnerable populations include:

- Extending the period over which student loans are forgiven for dental school students, to 10 years without tax liabilities for the amount forgiven in any year;
- Providing tax credits to dentists who establish and operate dental practices that serves vulnerable populations;
- Offering scholarships to dental students in exchange for commitments to serve vulnerable populations;
- Providing senior dental students education through the provision of care in outreach community dental facilities supervised by dental faculty;[17]
- Increasing funding of and statutory support for expanded loan repayment programs (LRPs) for dental school graduates;
- Providing federal loan guarantees and/or grants for the establishment and equipping of dental clinics in underserved or financially challenged areas;
- Increasing appropriations funding for the U.S. Department of Health and Human Services (HHS) loan repayment programs for dental school graduates and for the National Health Service Corps, Indian Health Services, and other federal programs, which would allow the creation of more dentist positions for programs that serve disadvantaged populations;
- Developing dental clinics within hospitals to treat dental emergencies that are too complicated or systemically compromised to treat in community clinics;
- Funding for dentists who provide oral health care within hospital dental clinics;
- Taking the following steps to facilitate effective compliance with government-funded dental care programs, helping achieve optimum oral health outcomes for indigent populations:
    - Raising Medicaid fees to at least the 75th percentile of dentists' actual fees
    - Eliminating extraneous paperwork
    - Facilitating e-filing
    - Simplifying Medicaid rules
    - Mandating prompt reimbursement
    - Educating Medicaid officials on the unique nature of dentistry
    - Providing block federal grants to states for innovative oral health programs
    - Requiring mandatory annual dental examinations for children entering school (analogous to immunizations) to determine their oral health status
    - Educating patients in a culturally sensitive manner about the importance of proper oral hygiene and routine oral health appointments

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11. 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
12. Albino, J. E. N. and Orlando, V. A. (2010), Promising directions for caries prevention with American Indian and Alaska Native children. *International Dental Journal*, 60: 216–222. doi: 10.1922/IDJ_2566Albino07
13. 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 ("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.")
14. Brigham and Women's Hospital (BWH) Bulletin. Health Workers Help Navajo Patients Cope. 2012. Available at: *www.brighamandwomens.org/About_BWH/publicaffairs/news/publications/DisplayBulletin.aspx?articleid=5533&issueDate=3/30/2012%2012:00:00%20AM.* Accessed May 25, 2012. ("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 Units of the Indian Health Service, and BWH's Division of Global Health Equity.")
15. Dental Therapists / Maine's Maple Sugar Industry [transcript]. The Maine Public Broadcasting Network. March 22, 2012. (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.")
16. ibid. (Dr. Oh further stated, "[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.")
17. Commission on Dental Accreditation. Accreditation Standards for Dental Education Programs. 2012: 19. Available at: *www.ada.org/sections/educationAndCareers/pdfs/predoc_2013.pdf.* Accessed June 6, 2012. (Standard 1-9 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.")

- Utilizing case management to ensure that patients are brought to the dental office
- Increasing the general dentist's understanding of the benefits of treating indigent populations;

- Encouraging funding from organizations that serve the public, including 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 dentists to number of persons in their localities, without regards to practice capacity, volunteer programs, and other important 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 who have attained the education and expertise—particularly general practice residency (GPR) or advanced education in general dentistry (AEGD) training—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 above as solutions. However, numerous economically conservative solutions are also readily available to help connect the undeserved patient with a dentist.

Solutions that bridge the location gap include:

- Actively recruiting dental school applicants who are from underserved areas;
- Establishing alternative oral health care delivery service units, including arranging for transportation to and from care centers and soliciting volunteer participation from the private sector;
- Encouraging private organizations, such as Donated Dental Services (DDS), fraternal organizations, and religious groups to establish and provide services;
- Providing mobile and portable dental units to serve varying age groups in underserved areas or places with indigent populations.

PATIENTS WITH SPECIAL NEEDS

Patients with special needs include patients with disabilities, elderly patients, and those 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 for these deserving populations include:

- Assuring funding for Title VII general practice residency (GPR), advanced education in general dentistry (AEGD), and pediatric dentistry residencies;
- Identifying 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, which will ultimately lead to optimal dental 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 the OSG noted more than a decade ago in "Oral Health in America: A Report of the Surgeon General," "Oral diseases are progressive and cumulative and become more complex over time." But as we all know, many of these common oral diseases are easily prevented.

ACKNOWLEDGMENTS

The Academy of General Dentistry (AGD) Barriers and Solutions to Accessing Care was developed by the AGD Board appointed White Paper Task Force in collaboration with the Dental Practice (DP) and Legislative & Governmental Affairs (LGA) Councils, the Division Coordinator to the DP and LGA Councils, the Executive Committee, and AGD Staff. The paper could not have been completed successfully without the dedication, persistence, expertise, and tireless efforts of these individuals, and therefore, they are recognized by name as follows:

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Academy of General Dentistry, July 2012