Barriers to Accessing Oral Health Care

A report for the Waterloo Region Oral Health Coalition

Prepared by: Katherine Horst, MPH Practicum

April, 2017
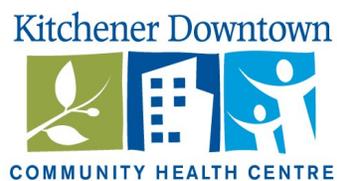
Kitchener Downtown

COMMUNITY HEALTH CENTRE

Table of Contents

Barriers to Accessing Oral Health Care

Background

Good oral health is important for overall health and well-being. Although oral health problems are mostly avoidable through healthy habits and preventive care, income is an even more important factor influencing oral health and access to oral health care. For vulnerable groups, cost can impact how likely they are to seek preventive care and how long they wait to get treatment when dental problems do occur. The result is a greater burden of oral disease. The current oral health care system creates inequitable access to care because it is largely privately financed through employer-provided dental benefits and out-of-pocket payments. This model of private dental practice and fee-for-service payments is inadequate for the low-income segment of the population since people who are most in need of oral health care can least afford to access it.

In Waterloo Region, the groups primarily affected by limited access to oral health care are those with low income (including children living in low-income families, the working poor, seniors on fixed incomes), refugees and immigrants, Low-German speaking Mennonites from Mexico, people who are homeless, and long-term care residents. People who receive social assistance are eligible for some dental care. Those who neither qualify for social assistance nor receive workplace benefits – yet cannot afford to pay out-of-pocket – have limited options.

Over the last few years, a number of reports exploring the issue of equitable access to oral health care have been published. They cite the complexity of the issue and the need for a multi-factorial approach. Recommendations have included:
• Integrating oral health into public health policy
• Developing minimum standards of preventive and restorative oral health care to which all Canadians would have access
• Mandating and funding public health units, Community Health Centres, and Aboriginal Health Access Centres to provide this standardized level of services
• Providing preventive oral health care for children in dental offices and non-dental settings (e.g. daycares, schools) and integrating oral health into early childhood development initiatives
• Partnering with housing and employment support programs to include dental services
• Educating professionals about the oral health care needs of vulnerable groups
• Training non-dental professionals (e.g. medicine, nursing) on oral health care
(Barnes, Abban & Weiss, 2015; CAHS, 2014; & CDA, 2010).

Led by the Association of Ontario Health Centres and Ontario Oral Health Alliance, groups across Ontario are advocating for the provincial government to expand publicly-funded dental programs in order to improve access to care for low-income adults and seniors. The Waterloo Region Oral Health Coalition has supported these efforts by collecting signatures for a petition, delivering them to local MPPs to present in the Ontario Legislature, and requesting that Regional Council endorse a dental access resolution. For those who qualify, publicly-funded and other low- or no-cost dental programs would obviously help to eliminate a significant barrier to accessing dental care. However such programs still do not guarantee access, nor completely eliminate disparities in use.

In its 2014 report on improving access to oral health care for vulnerable Canadians, the Canadian Academy of Health Sciences (CAHS) outlined five challenges to using oral health care services:

- Affordability – the client is able to pay what the provider is charging for services
- Availability – the provider has the resources necessary to meet the client's needs
- Accessibility – the client can get to the provider's location
- Accommodation – the provider operates in a way that meets the needs and limitations of the client
- Acceptability – the client is comfortable with the provider and vice versa

Region of Waterloo Public Health (2012) has also identified common barriers to getting care. In addition to living with low income, they include:

- Having difficulties accessing and scheduling dental services
- Lacking knowledge of the importance of oral health
- Not being able to communicate in English
- The low reimbursement levels for dentists treating clients on government benefits

The purpose of this report is to explore the challenges to accessing affordable oral health care, particularly for refugees/immigrants and the homeless. It is also to describe interventions that could possibly be implemented locally by the Kitchener Downtown Community Health Centre and the Oral Health Coalition.

Client barriers

Disadvantaged groups experience a high burden of oral disease such as caries and gum disease and are at greater risk of losing their teeth. Although these problems are largely avoidable, individuals may not seek preventive care. Routine check-ups and cleanings are not usually covered by government programs so preventive services become a luxury rather than a necessity (Wallace, 2012). Dental treatment may be seen as a low priority and oral diseases as not serious or deferrable (Holtzman et al, 2014). As a result, individuals may wait longer to attend to dental problems, sometimes until they become unbearable, or leave dental needs untreated altogether (Loignon et al, 2012; & Wallace, 2012). Patients who are least likely to access dental care are the ones who need it the most.

Cost is a huge barrier to accessing oral health care, but it is not the only one. Oral health literacy influences the importance one places on their oral health. Fear and anxiety may prevent someone from visiting a dentist. Another common reason for not going is lack of transportation (Wallace, 2012). Disadvantaged clients who seek dental care feel misunderstood and stigmatized by dentists and dental office personnel. They are sometimes rejected because of their social status (Loignon et al, 2012). Cognitive and physical disabilities, sometimes made worse by substance use and homelessness, also pose difficulties for accessing treatment in a private dental setting (Wallace, 2012).

Dentist barriers

Dentists who attribute poverty and being on social assistance to individual factors (e.g. perceived lack of willingness to work) rather than social-structural or external factors, are more likely to hold negative stereotypes about poverty and be less compassionate toward people on

social assistance (Loignon et al, 2012). Dentists in a case study on access to oral health care expressed resentment about the expectation that they provide services at lower cost to certain people (Wallace, 2012). Publicly-funded dental programs pay significantly lower fees compared to rates in the fee guide (often 50% or less) and may not cover the practitioner's expenses. Dentists are often frustrated by the limited treatments covered by these programs, which can make it difficult for patients to get all of the treatment they need. In addition, dentists find it challenging to deal with government bureaucracies when they are trying to run their businesses (Wallace, 2012). For these reasons, some dentists will not take patients with public benefits at all; others may limit the number they serve. It is unclear how many dentists in Waterloo Region are willing to accept patients on publicly-funded programs.

For dentists who will accept patients from public dental programs, failing to show for appointments is a significant frustration. Some dentists think missing appointments is disrespectful and indicates that those patients don't value their oral health (Wallace, 2012). In fact, there are a number of factors that play a role in appointment-keeping behaviour and they will be described later in this report.

Barriers for immigrants and refugees

Newcomers to Canada experience a range of barriers to quality health care, such as:
• Complex health insurance eligibility and entitlement rules
• Limited pre-arrival health care
• Limited language and literacy skills
• Lack of familiarity with the Canadian health care system
• Precarious finances, and
• Factors related to gender and culture

These same issues arise when it comes to oral health care. Oral health and dental care are unmet needs of immigrants and refugees, especially children who may never have received oral health care or been exposed to preventive measures (e.g., a toothbrush, fluoridated toothpaste or water). This can lead to a number of complications such as pain, difficulty speaking, infections, sleep loss, and damage to the teeth (Canadian Paediatric Society, 2017).

Local service providers who support refugees and immigrants provided their thoughts on the oral health care barriers they see. Their comments reflect the challenges listed above and align with those identified by the CAHS.

Accommodation (interpretation/translation)
• Need for interpretation or translation of medical procedures/supports in a language they can understand (similar to hospital interpretation issues)

Access
• Finding a dentist – Refugee claimants and newcomers in general don't likely have connections to find a dentist accepting patients.
• Proximity and transportation – especially getting to dentists taking IFH or OW coverage

Knowledge
• Some confusion of what programs cover what services, and with service providers (and obviously clients) knowing where they should go for what

- Understanding a different system - when they go to the dentist, dentists often won't explain each step and each treatment –it may be very new for the recent immigrant/refugee
- Depending on where they may have come from, some newcomers may need education about benefits or practices of good oral health, or even just building the habits of preventive care. They may not have practiced any oral hygiene or may have had limited or no exposure to preventive or restorative dental care before coming to Canada.

Affordability
- Many people don't have sufficient coverage – similar to broader population, seniors, etc. Particularly, there is a lack of financial support for preventive dental care – it will be less costly in the long run.
- Refugees have Interim Federal Health Program (IFH) coverage – but
  - IFH only covers adults' emergency care, not preventive care
  - There may be a gap in time until IFH kicks in
  - Many dentists don't work with IFH because of the paperwork and not a lot of services are covered.

Acceptability (attitudinal/psychological barriers)
- Refugee claimants don't have the permanent residency so don't have any status and thus no access/support at all – sometimes they experience a lack of welcome and support, or an attitude of refugees being "illegal" leading them to being in limbo.
- Sometimes find a simple lack of understanding toward refugees who may have come from terrible situations – GARs and privately sponsored have at least someone or an organization caring for them but claimants may not have had anyone caring for them
- Refugees may also have a very limited time to put their claim together and are unable to tell their story on their own terms. They sometimes experience a lack of empathy ("you should be fine now because you are here in Canada!") which can all be very traumatizing.

Availability/need
- There were more dental issues with Syrian refugees because many had been in precarious situations for years and not able to get care, or preventative dental care was not a priority when fleeing violence.
- The influx of refugees from Syria resulted in a large bulge of people on the IFH Program, but many of them will likely go on OW after the initial 12-month immigrant/refugee financial support period is finished. While the children would qualify for oral health care through the Healthy Smiles Ontario (HSO) program, adults on OW would have very limited dental coverage.

(D. Vandebelt, personal communication, February, 2017)

Barriers for Low-German speaking Mennonites from Mexico

Region of Waterloo Public Health identified Low-German speaking Mennonites from Mexico as a priority group who are at risk of poor oral health outcomes. Often they arrive in Canada with poor oral health because they may not have practiced any oral hygiene behaviours (brushing, flossing) or been exposed to preventive or restorative dental care.   While some villages have lay people who do extractions and make dentures, there are few licensed dentists on the colonies. People may go to a community dentist if they can afford it and do not have to travel too far. Another factor is that diets typically change once in Canada. In particular, there is

increased consumption of processed and packaged foods, and sugar-sweetened beverages, which increases the risk for decay. The mindset in the population is to have teeth extracted and then to get dentures as soon as possible. Service providers who work with the population are trying to change this way of thinking by educating people that they can keep their natural teeth with good oral hygiene practices and dental care. Staff of local agencies described the challenges these Mennonites face with accessing oral health care in Waterloo Region. They echo those of other newcomers.

Acceptability
- Once in Canada, individuals would not think to visit a dentist unless they were in severe pain.
- They are accustomed to obtaining services through relationships and word-of-mouth. For people to feel comfortable accessing a service, providers need to build trust and be non-authoritative.
- HSO is becoming more acceptable. The program and its benefits must be clearly explained.

Availability
- Many children attend public schools and therefore have the opportunity to be screened by public health dental staff. If treatment needs are identified, children can be referred to the HSO program, and if eligible, receive dental care at no cost.
- Like other vulnerable groups, Low-German Mennonites from Mexico have difficulty finding a dentist who will take them. An oral health worker with the Woolwich CHC can assist adults with finding a dentist who will charge reduced fees so they can have their own dental needs taken care of.
- This group sometimes travels back and forth to Mexico which can interrupt treatment plans.

Affordability
- Some Mennonites from Mexico have employer-paid benefits but may not be aware of this, or may not understand what is covered. The men, who are more likely to be employed, are less likely to speak English.
- Having to pay a deductible may prevent them from using their benefits because they don't have the cash flow to cover this cost.
- If recommended treatment is unaffordable, they may return to Mexico to have their teeth extracted and get dentures. Even with the cost of the trip, this is a less expensive alternative than receiving treatment in Canada.

Accommodation
- May have difficulty making and cancelling appointments because our system is based on middle class values and they may never have interacted with a healthcare system before.
- Language is a big barrier and literacy levels are very low; parents may have children interpret for them.
- The oral health worker helps with HSO paperwork, finding a dentist, scheduling dental appointments, and interpretation/translation at consultations and some treatment appointments.
- The oral health worker has built relationships and done education with dentists to increase their cultural competence with the population.

Accessibility

- Transportation is also a challenge for many families. The Woolwich CHC can give gas cards and taxi chits; outreach workers from other organizations may drive families.
 (L. Hiebert-Rempel, personal communication, February, 2017; A. Wall, personal communication, March, 2017)

Barriers for homeless/homeless-at-risk

Individuals who are homeless/homeless-at-risk are a priority population of the Kitchener Downtown Community Health Centre and another group who face challenges accessing oral health care. The Working Centre, a social enterprise, began operating Community Dental in 2016. The clinic provides free dental care with a focus on individuals who are street-involved, and haven't seen a dental professional for a long time. In a meeting with clinic staff, they discussed the challenges their clients face.
- Sometimes not connected to any support services at all
- Experience substance use and/or mental health issues that make it difficult for them to go to a private dental office
- Even a public clinic, such as at a Community Health Centre, would not be a good fit for some members of this group
- There is a cultural incompatibility between traditional dental practice settings and the needs of this group
- Oral health literacy is a big factor – clients need to understand their state of oral health, how it's affecting their overall health, treatment options, why those options are recommended, and be given the choice on how to proceed
- Often need an outreach worker with them – this person can help the client complete intake/health history forms, communicate with the dental professional about their substance and mental health issues, and help the client understand their treatment options
- Treatment plans can change depending on the amount of time between initial assessment and the start of treatment because oral health can worsen during that period
- It can be difficult to contact clients for follow-up after treatment
- Dentists need to be flexible and not have the same expectations of clients as they do of those in their private practice
(J. Mains, S. Escobar, L. Uhrig, personal communication, April, 2017)

Reducing barriers for vulnerable groups

In addition to government-funded dental programs, there are a number of initiatives that reduce or eliminate the barrier of cost. These include: low- or no-cost clinics; dental assistance funds, which are typically financed by donations and cover the cost of emergency dental treatment; and loan programs. However these do not guarantee access to dental treatment because there are barriers to access besides cost. With the exception of strategies to improve dental appointment adherence, there is not a lot of research on successful approaches for reducing other barriers. Training dental students and providing education to existing dental professionals could: enhance their appreciation and understanding of the roots of poverty, the environment in which people live, and the factors that adversely affect their lives; develop their social competence and consciousness; and improve their sensitivity towards low-income patients (Loignon et al, 2012 & Wallace, 2012).

Alternative models of dental care for low income and vulnerable people, such as community-based clinics, could address the poor fit between private practice dentistry, publicly-funded benefits and the oral health needs of disadvantaged groups (Wallace, 2012). A number of Community Health Centres (CHC) and Public Health Units operate dental clinics (including mobile clinics). Some also offer outreach services to adults with special needs and the elderly. These programs usually have eligibility requirements and limitations on the services offered.

The Health Care for the Homeless Clinicians' Network (2010) offers recommendations for caring for homeless patients, which can be applied to the provision of oral health care. These recommendations include:
- Transportation – bus tickets, taxi chits
- Collaboration with outreach workers and case managers
- Client advocate to accompany person to an appointment
- Coordinated/integrated services easily accessible at the same location
- Provision of care where people congregate, e.g. drop-in centre, shelter, outreach sites
- Flexible service system, e.g. walk-in appointment slots
- Involvement of all members of the clinical team in care planning and coordination
- Non-judgemental and supportive patient interactions which build and maintain a trusting relationship
- Incentives, e.g. food, beverages, meal vouchers, hygiene products

A dental school integrated a Health and Wellness Screen into their admissions paperwork. Prospective dental patients completed the screen before being seen by a dental student. The screen included nine questions about the following: activities of daily living skills, ability to get around in the community, community social service assistance, living situation, financial situation, perception of health status, family relationships, caregiving situation, and desire to speak to a social worker for assistance (Zittel-Palamara, 2005). A social worker could provide links to community resources to assist with financial, transportation, health, mental health, living, family, caregiving, and legal situations that made it difficult for patients to access the dental care they needed (Zittel-Palamara, 2005). Some CHCs with a dental clinic have a worker who does intake for the clinic. This person can help clients navigate the oral health care system, assist with treatment coordination, and connect them to other programs and services, either within or outside of the CHC.

Where oral health literacy is a concern, written and verbal communications could be improved to enhance patients' understanding of the benefits of timely and preventive dental care and the risks of deferring care. Clear communication is particularly helpful for patients who have difficulty understanding risks and benefits of health decisions (Holtzman, 2014)

An oral health report from the Davenport Perth Neighbourhood CHC recommended that the organization become an "Oral Health-Friendly CHC". The Kitchener Downtown CHC could endeavour to do the same, which might include:
- Creating internal campaigns and materials to show that the CHC is "oral health-friendly"
- Including oral health assessments in patient visits
- Increasing staff knowledge and dialogue on the scope and extent of oral health issues among the population
- Building staff capacity to orient and assist their clients/participants to access oral health care, especially those who don't speak English, those who have disabilities, and those with low literacy and/or very low oral health self-ratings

- Integrating oral health content into existing programs (e.g. Healthy Living in Canada)
- Coordinating with Region of Waterloo Public Health to disseminate oral health materials and hold free education sessions
- Creating a database of dentists and independent hygienists who will take patients with publicly-funded dental benefits and pro-bono cases, and developing a mechanism for referring clients who can't access services to these dental professionals (DPNCHC, 2013).

Dental appointment adherence

Patient failure to show for appointments is a major frustration of dental providers. There are a number of potential impacts on both patients and dental offices when appointments are missed. For dental practices, missed appointments: reduce clinic efficiency by disrupting clinic flow and wasting provider resources; decrease population-wide access to care by artificially reducing the number of available appointments; and lower revenue. (Holtzman, 2014 & Lapidos, 2016).

For individuals, broken appointments may contribute to adverse oral health outcomes. Worsening of oral health often occurs gradually though, so unlike other health issues, the effects of postponing dental care may not be immediate and may go unnoticed. Missing appointments can jeopardize patients' health and well-being, interrupt the treatment plan, and lead to more severe decay or infection. An additional potential impact is the use of more expensive forms of medical care, such as emergency rooms and urgent care clinics (Lapidos, 2016 & Schmalzried, 2012).

The reasons for broken appointments are complex. They can be grouped by demographic characteristics, psychosocial characteristics and other factors:

Demographic characteristics:
- Cost - paying out of pocket/no insurance
- Rural residence
- Couch surfing, inadequately housed or homeless
- Adolescent age
- Use of public assistance
- Distance to clinic
- Lower education
- Race (non-white)
(Lapidos, 2016)

Psychosocial characteristics:
- Debt
- Student as dental provider (rather than fully trained dentist)
- No working phone
- Previous history of broken appointments
- Lower health literacy – belief that oral health care is low priority, undervaluing oral health, not understanding the need for dental visit, not understanding instructions or value of follow-up
- Dental fear, anxiety
- Common fears

- Depression, moodiness
- Limitations in working memory or executive functioning
- Emotional exhaustion leading to a decreased ability to problem solve

(Lapidos, 2016)

Other reasons:
- Lack of knowledge of how health care systems work, how to schedule/reschedule appointments
- Scheduling problems
- Weather
- Conflict with other activities
- Illness
- Transportation
- Work conflict – may not be able to get time off
- Family emergency
- Travel
- Disrespect – demeaning and discriminatory attitude and behaviour of front office personnel
- Dissatisfaction with services

(Lapidos, 2016)

The literature describes various strategies for dealing with patients who fail to show for appointments. It is important to be respectful of patients and to help them understand the effects of missing appointments, both on them and other patients. Agencies often follow a series of steps that depend on the number of occurrences of missed appointments. This may include sending letters to the patient, requiring them to attend an education session, and ultimately terminating them as a patient. Occasionally, double and triple booking of appointments is used but this can cause unpredictable patient flow and often increases wait time for patients (Schmalzried, 2012). Wait-lists are sometimes kept of people who can be contacted on short notice to fill an appointment slot.

Additional interventions that may decrease failure to show include:
- Reminders
- Case management – phone-based disease management support
- Transportation support
- Extended operating hours
- Advanced access scheduling
- Outreach to anxious patients using behavioural health strategies
- Clinical management of anxiety – suggesting coping skills
- Building reflective listening, problem-solving, and cultural competence skills of administrative and clinical staff
- Improved readability and usability of forms and health information (use plain language, minimize medical jargon)
- Teach back method – asking patient to explain or demonstrate information/instructions given to them by dental care provider to ensure they understand
- Ask me 3 technique – patient encouraged to ask three basic questions: what is my main problem; what do I need to do about the problem; why is it important for me to do this
- Providing information that increases the importance and relevance of oral health

(Lapidos, 2016)

Conclusion

According to the Canadian Academy of Health Sciences there are five main challenges to using oral health care services: affordability, availability, accessibility, accommodation, and acceptability. More specifically, access to dental care is influenced by language and literacy level, transportation, fear and anxiety, oral health literacy, lack of knowledge of the oral health care system and how to navigate it, mental health and/or substance misuse issues, and the attitudes of dental office staff towards disadvantaged groups. These factors were confirmed in communications with local agencies who provide services to groups at greater risk for poor oral health outcomes including newcomers, Low-German speaking Mennonites from Mexico, and the homeless/homeless-at-risk.

Possible solutions or strategies to reducing barriers to accessing oral health care, besides cost, include: education of dental professionals and office staff to increase awareness and sensitivity; case management; client advocacy/system navigation; and alternative models of dental care (e.g. The Working Centre's Community Dental). The Waterloo Region Oral Health Coalition has been supporting province-wide advocacy initiatives to improve access to oral health care for individuals with low-income; in particular they are calling for the expansion of government-funded dental programs. While the cost of oral health care is a significant barrier for many people, research has shown that even publicly-funded or other low/no-cost programs do not guarantee access. It is recommended that the Coalition continue with its education and advocacy efforts, but also that members consider how they may play a role in addressing additional obstacles to accessing care.

References

Barnes, S., Abban, V., & Weiss, A. (2015). Low wages, no benefits: Expanding access to health benefits for low income Ontarians. Retrieved from Wellesley Institute website http://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Low-Wages-No-Benefits-Wellesley-Institute-Feb-2015.pdf

Canadian Academy of Health Sciences. (2014). Improving access to oral health care for vulnerable people living in Canada. Retrieved from http://cahs-acss.ca/wp-content/uploads/2015/07/Access_to_Oral_Care_FINAL_REPORT_EN.pdf

Canadian Dental Association. (2010). Position paper on access to oral health care for Canadians. Retrieved from http://www.cda-adc.ca/en/about/position_statements/accesstocarePaper/

Canadian Paediatric Society. (2017). Caring for kids new to Canada: oral health screening. Retrieved from http://www.kidsnewtocanada.ca/screening/oral-health

Davenport Perth Neighbourhood Community Health Centre. (2013). DPNCHC oral health research project: final report. Retrieved from http://dpnchc.com/wp-content/uploads/2011/03/DPNCHC-Oral-Health-Research-Report.pdf

Health Care for the Homeless Clinicians' Network. (2010). Adapting your practice: General recommendations for the care of homeless patients. Retrieved from, http://www.nhchc.org/wp-content/uploads/2011/09/GenRecsHomeless2010.pdf

Holtzman, J. S., Atchison, K. A., Gironda, M. W., Radbod, R., Gornbein, J. (2014). The association between oral health literacy and failed appointments in adults attending a university-based general dental clinic. *Community Dent Oral Epidemiol, 42(3), 263-70*. doi: 10.1111

Lapidos, A., Shaefer, H.L., & Gwozdek, A. (2016). Toward a better understanding of dental appointment-keeping behavior. *Community Dent Oral Epidemiol 44, 85–91*. doi:10.1111

Loignon, C., Landry, A., Allison, P., Richard, L., Bedos, C. (2012). How do dentists perceive poverty and people on social assistance? A qualitative study conducted in Montreal, Canada. *J Dent Educ 76,545-552*. Retrieved from http://www.jdentaled.org/content/76/5/545.long

Region of Waterloo Public Health. (2012). A Review of Priority Populations for Dental Health in Waterloo Region. Unpublished.

Schmalzried, H. D., Liszak, J. (2012). A Model Program to Reduce Patient Failure to Keep Scheduled Medical Appointments. *J Community Health 37,715–718.* doi: 10.1007/s10900-011-9505-0

Wallace, B. B., MacEntee, M. I. (2012). Access to dental care for low-income adults: Perceptions of affordability, availability and acceptability. *J Community Health 37,32-39*. doi: 10.1007/s10900-011-9412-4

Zittel-Palamara, K., Fabiano, J. A., Davis, E. L., Waldrop, D. P., Wysocki, J. A., Goldberg, L. J. (2005). Improving patient retention and access to oral health care: The CARES program. *J Dent Educ, 69(8), 912-918.* Retrieved from http://www.jdentaled.org/content/69/8/912.long