COMMUNITY ACTION REPORT

The Community Dental Facilitator Project: Reducing Barriers to Dental Care

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Abstract

Objectives: *This report describes an initiative developed and implemented by a low-income, urban, Canadian community to respond to their children's dental problems.* ***Methods:*** *The first strategy pursued by the community was the development of the Community Dental Facilitator Project. This project facilitated children's access to existing government funding for dental treatment, and subsequently facilitated access to treatment at local dental offices. Children in need of treatment were identified by a school dental screening. The facilitation work was done by three lay workers hired from within the community who represented the community's predominant ethnic groups.* ***Results:*** *Parents revealed that barriers to dental care in local dental offices were lack of information about funding programs, language, inflexible work situation, and mistrust of bureaucracy. By the project's end, with the assistance of the facilitators, a significantly increased number of children had been enrolled for government dental benefits (P<.001). In addition to the 123 children identified at the screening as needing treatment, another 30 children "self-referred" to the program. At the end of the project's original funding period, dental appointments had been made for 68 children: 60 (48.8%) of the "screened" group, 8 (26.7%) of the "self-referred" group. One-year telephone follow-up to parents of the screened children revealed that 42 of 59 (71.1%) had completed treatment.* ***Conclusions:*** *Barriers to dental care for low-income children go beyond economics. A community facilitation model can improve low-income children's access to existing dental services and may reduce the barriers to care for some children requiring treatment. [J Public Health Dent 2003;63(3):126-28]*

Key Words: health services accessibility, dental health services, dental care for children, medically underserved area, consumer participation, ethnology.

This report describes one community's path to managing the dental problems of their children. The project was undertaken by members of a low-income neighborhood in Vancouver, British Columbia, Canada. The neighborhood, called Strathcona-Seymour, is located in Vancouver's Downtown Eastside (DTES). In recent years the DTES has struggled with many of the complex challenges facing inner-city neighborhoods such as drug addiction and dealing, HIV infection, crime, lack of adequate housing, high unemployment, and the loss of many legitimate businesses (1). Strathcona-Seymour is a diverse neighborhood with some light industry, shops, manufacturing, and wholesale storage. Nearly 61 percent of residents speak Chinese as a first language. The neighborhood contains heritage homes, apartments, public housing, converted houses, and rooming houses. About 68 percent of families are considered to be low-income, with an average annual family income of about (Canadian) $11,000.

Medical care for all children in British Columbia is funded by the provincial Medical Services Plan, but dental care is funded differently. Low-income children, such as those children living in the Strathcona-Seymour neighborhood, usually qualify for one of the provincially funded dental benefit programs, or they are able to access low-cost dental services at a local Health Board dental clinic. Despite such programs' existence, school and local public health staff were painfully aware that many schoolchildren were not receiving necessary dental treatment.

The Strathcona-Seymour Children's Dental Committee was established by the local community in response to the neighborhood children's poor oral health. The committee consisted of parents, school principals, community health committee members, community dental staff, and local dentists. The committee's primary goal was to facilitate access to dental services. Children in grade two and below were eligible for dental care for a nominal fee at the local Health Board clinic; children in grade three and above had to seek treatment in private clinics. Up to $700 per year of basic dental treatment was provided by the provincial government's "Healthy Kids" benefits program to these older children. It was these children who seemed to be the least likely to receive needed dental care, as the younger children were looked after by the local Health Board clinic.

The committee chose to pursue two main strategies. The first strategy was to develop what came to be known as the Community Dental Facilitator Project, a project to facilitate the older children's access to available funding for dental treatment, and, subsequently, to facilitate access to the treatment itself. The other strategy was to develop a business plan for a dental clinic to be located in the Strathcona Elementary

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School. This report will describe the first strategy, the Community Dental Facilitator Project.

Methods

The first stage of this project was to assess the need for dental treatment among children in grades three to seven at the two elementary schools in the community—Lord Strathcona and Admiral Seymour. This needs assessment was done in partnership with community dental staff of the Vancouver/Richmond Health Board, who agreed to extend their regular dental screenings to include children in these grades. This dental screening performed by a calibrated certified dental assistant was a flashlight-and-tongue-depressor assessment for visible decay. Because of the cursory nature of the screening examination, the data provided by the screening likely underestimated existing untreated dental caries. Of the 453 children screened in grades three to seven at both schools, 123 (27.1%) had visible decay and were in obvious need of restorative treatment or extractions.

About 60 percent of families in Strathcona-Seymour speak Chinese (Cantonese or Mandarin) at home, followed by Vietnamese (13%) and English (12%). Therefore, the three "facilitators" hired from the community represented these different ethnic backgrounds. Two of the facilitators were mothers of children who attended the schools. The facilitators were trained in the procedures to help families apply for the Healthy Kids government funding.

The day-to-day duties of the facilitators were many and varied. They promoted their role in the community by sending letters in the appropriate language to parents and attending community events. They facilitated individual families' access to funding by assessing their eligibility, by working with financial assistance workers, by assisting parents to complete the necessary application forms, and by working with the ministry to expedite the process. Once parents had finally obtained the Healthy Kids funding, the facilitators recommended several dentists to each family with due consideration to language, transportation issues, and office hours, and advised parents on booking a dental appointment. In some cases, the facilitators actually escorted the child to the dental office after a parent had signed a release form. Facilitators also managed specific special cases where a child had special treatment needs, for example, orthodontic treatment. Finally, the facilitators surveyed parents with a short questionnaire that asked them to identify the barriers or problems they faced getting dental treatment for their children.

TABLE 1
Barriers to Dental Care Reported by Families Who Interacted with Community Dental Facilitator Project

Barrier	Number (%) of 109 Parents Reporting
Lack of information about funding programs	77 (71%)
Language	73 (67%)
No family dentist	30 (28%)
Financial barriers	20 (20%)
Work situation; need to work for income	13 (12%)
Mistrust of bureaucracy	10 (9%)

TABLE 2
Dental Benefits Coverage Before and After Community Dental Facilitator Project

	Children Followed Up from Screening (n=98)	Children Self-screened (n=30)	Total Number of Children (N=128)
Families who had received some Healthy Kids benefits *before* the project	16 (16.3%)	7 (23.3%)	23 (17.2%)
Additional families who received Health Kids benefits as a direct result of the project	30 (30.6%)	18 (60.0%)	48 (32.8%)
Total number of families with Healthy Kids coverage at project completion	46 (46.9%)	25 (83.3%)	71 (55.5%)

Chi-square analysis demonstrated that total number of families with access to Healthy Kids dental benefits was significantly greater at the end of the project; $P \leq .001$.

Results

Of the 123 children in grades three to seven who were originally identified in the screening as needing treatment, 98 (79.7%) participated in the project. Sex was not associated with need for treatment; children in need of treatment were evenly distributed among the school grades. Of the 25 children (20.3%) who did not participate in the project, 10 could not be contacted following the screening because the family had moved or had not provided reliable contact information to the school; families of an additional 15 children, though contacted repeatedly by facilitators, chose not to respond. However, parents of another 30 children who, because of their young age or for other reasons were not in the original screening, "self-referred" to the facilitators. Of these self-referred children, 13 (43.3%) were in grade two or below; the remainder were in grades three to seven. Families concerned that their children should have a dental visit contacted the facilitators in person at community events, through school-based outreach, and, in some cases, by telephone.

The 30 self-referred children had not had a screening appointment. Sex distribution was not different between the self-referred and the screened children. Therefore, after excluding the 25 non-participant children and adding the self-referred children, a total of 128

children eventually interacted with facilitators in the first phase of the project. One hundred nine parents were willing to respond to the questions about barriers to dental care (Table 1).

Barriers reported for the screened children were not significantly different from those reported by parents of the self-referred children. Healthy Kids dental benefits coverage before and after the first phase of the facilitator project for the total group of 128 children is shown in Table 2.

Within a year of this phase of the project, funding was received to follow up with the 60 screened children who were known to have made an appointment with a dentist as a result of working with a facilitator. These 60 children included 39 children with Healthy Kids coverage, and another 21 children who had other dental insurance coverage, for example, through parents' employer or refugee emergency coverage. Facilitators wanted to hear from parents as to whether their child's treatment had been completed, and, if treatment had not been completed, why it had not been completed, the type of treatment that was done, and whether the child had since returned to a dentist for regular preventive care.

In some cases the parent who spoke to the facilitator was unsure of the situation regarding their child's dental treatment, so their response was recorded as "does not know." Of parents who responded with certainty, 42/59 (71.1%) indicated that their child's treatment had been completed. Parents were less certain of the number of appointments, but 20 of 51 (39.2%) of parents who responded to this question reported that their child needed three or more visits to complete the required treatment. Three children were reported to have required at least one permanent tooth extraction. For the 17 children whose treatment was not completed, the most common reasons cited were difficulty getting to the office because of a parent's inability to afford an absence from work, transportation problems, or concern about the child missing school. Although the follow-up telephone calls were made just a year after the end of the original facilitator project, only 27 of the 42 (64.2%) of the children whose treatment had been reported to be completed had since returned to their dentist for a recall visit and preventive care.

Only 42 of the original group of 123 children (34.1%) identified at screening as needing dental treatment actually completed their treatment and 27 of 123 (22%) had a recall appointment within a year.

Discussion

The outcomes of this project reflect some of the problems that low-income children often face in their quest for health care. Initially, 10 of 123 (8.1%) of children needing treatment were lost to the project as their families had moved with no forwarding address or the contact information was incorrect. Lack of a permanent fixed address makes it difficult for families to establish a relationship with a health care provider. Caregivers of another 15 children had no interest in participating in the project. Low-income families have often had unsatisfactory experiences with aid workers and the "system" and reacted to offers of assistance with some suspicion, or did not want to appear as in need of government "handouts."

The facilitators were successful in acquiring dental benefits for a significantly greater number of children than had benefits prior to initiation of the project ($P<.001$) (Table 2). This increase demonstrates that, while benefit programs often exist "on the books" for families in need, language barriers, excessive bureaucracy, and lack of program information in appropriate languages are significant barriers for families to access these programs. The fact that parents of another 30 children sought out the facilitator program seeking assistance to access dental services is, therefore, not surprising. A sizable proportion (43.4%) of these self-referred children was young enough to be eligible for the local Health Board dental clinic. The facilitators helped make appointments for these children.

The work of the facilitators to increase access to dental treatment went far beyond removing financial barriers. Many families needed help scheduling the required appointments with a dental office. Two working parents frequently meant that no family member was available to take a child to the dentist for a daytime appointment. While some offices offered evening hours, parents did not like to rely on public transport for evening appointments and felt unsafe taking their children out of the neighborhood in the evening. Facilitators played a key role in escorting children to dental appointments.

Socioeconomic status is a reliable predictor of poor dental health in children (2). However, this project demonstrated that barriers to dental care go beyond economics. It is noteworthy that of 21 of the 60 screened children who made a dental appointment actually had some form of dental insurance in place and did not need to access the government Healthy Kids coverage, but it was the work of the facilitator that encouraged the family to seek dental treatment. A community working together to facilitate access to existing services can reduce the barriers, for some, but unfortunately not for all, children requiring treatment. Despite the successes of the Facilitator project, the committee has subsequently established a nonprofit society that is working to establish a permanent dental clinic for neighborhood children in Strathcona school.

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