Institutional Barriers to Providing Oral Health Services for Underserved Populations in New York City

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Abstract

Objectives: *We sought to explore institutional barriers to the provision of oral health services for the underserved among inner-city health centers.* ***Methods:*** *Mail-based survey of Medicaid-approved health centers in New York City without oral health services. The importance of four barrier categories was rated: resource issues, dental provider difficulties, referral problems, and low priority of dental care.* ***Results:*** *36 health centers completed the survey. The most important barriers were resource issues (66.7% agreed), dental provider difficulties (29.4%), referral problems (24.2%), and low priority (15.2%). Top individual barriers were lack of start-up funds (88%), lack of physical space (74%), lack of available funding sources (71%), and low reimbursement rates for dental services (69%). Most centers (78%) identified a need for dental services for their patients.* ***Conclusions:*** *Access to oral health care remains a large problem for the underserved. Institutional barriers will need to be addressed to close the gap. [J Public Health Dent 2004;64(1):55-57]*

Key Words: oral health, health care accessibility, medically underserved areas, dental care, urban health services.

Oral health care is an essential part of primary care for all patients. However, inadequate access remains a large problem, especially for the poor. Over 33 percent of Americans lack dental insurance and only 35 percent of those below the poverty line saw a dentist in the previous year (1). Lower income, Mexican-American, and African-American children and adults have more untreated decayed teeth than do their higher-income or non-Hispanic white counterparts (2-4).

The Surgeon General's Report on Oral Health in 2000 recognized the importance of oral health and a number of national initiatives have aimed to improve access to dental care (5). Despite these efforts, reducing disparities requires approaches that target populations at highest risk (6). Reasons for underutilization of dental services include patient denial, cost, cultural, and geographic barriers (5,7).

Besides understanding barriers faced by individuals, it is also important to assess the reality that institutions face in making services available. Few studies have identified institutional barriers to providing dental services to vulnerable populations. In this paper we describe a survey of inner city community health centers in New York City that care for underserved populations. The study sought to identify institutional barriers to providing oral health care.

Methods

The target population was community-based institutions providing care to underserved populations in New York City. Eligible institutions were drawn from the New York State Department of Health list of Medicaid-approved centers. Of the 168 centers, 82 (49%) were listed as not providing oral health services and were invited to participate in this study. Surveys were sent to executive directors or other key administrators. Follow-up calls were made to all nonrespondents.

The questionnaire assessed characteristics of the institution, types of services provided, and perceived need for dental services. The major variable, reasons for not implementing dental services, was assessed with a list of 17 barriers derived from discussions with multiple dental clinicians and clinic directors, and personal experience in community clinics. The barriers were grouped in four categories: resources/funding issues, dental provider difficulties, referral problems, and low priority of dental care. Items assessed strength of agreement with possible reasons for not providing dental services on a four point scale (from 1=strongly agree to 4=strongly disagree). Subjects also were asked to identify the single most important barrier from the list.

We compared the most important reasons for not providing dental care by type of center, age of institution, and program director vs other administrator responding to the survey using Fisher's exact and ANOVA tests.

Results

Of 82 surveys mailed, 49 were returned (60% response). It was determined that 13 of the 49 institutions actually did provide dental services, and these centers were excluded. The final sample was therefore 36 institutions that did not provide dental services, effective response rate, 36/69 = 52 percent. Surveys were completed by Medical Directors (53%) or other administrators.

The 36 institutions included 16 general health care clinics, 7 hospitals, 7 HIV-specific community-based organizations (CBO), and 6 others (faith-based organizations and others). There was a mix of newer and older

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organizations with 42 percent in service for less than 5 years and 42 percent for more than 20 years. Most provided medical, mental health, preventive, substance abuse, and social services to adults and children. Funding sources were state (78%), federal (72%), and private grants (50%). Federal funds came from Medicaid (72%), Health Resources and Services Administration (HRSA) Bureau of Primary Care (53%), and Ryan White Title I (31%) and Title II (22%).

The four-point scale for agreement with potential barriers to providing dental services was dichotomized to reflect agreement or disagreement. Agreement meant that the subject felt the potential barrier was an important reason for not implementing dental services. Table 1 lists the barriers in order of descending importance within each of four categories.

The most important barrier category, to which two-thirds agreed, was resources. The lack of start-up funds and physical space for a dental practice was most commonly cited. Almost 30 percent felt that the challenge of recruiting and retaining motivated providers was an important barrier. About a quarter indicated that establishing and tracking dental referrals was a barrier, citing a particular problem establishing dental school affiliations. The least prevalent barrier category was a low priority for dental care at the institution.

Table 2 compares the proportion of respondents agreeing that the four barrier categories were important by type of center. Although none of the comparisons were statistically significant, there were a few trends. General health clinics reported funding issues as less important than did hospitals and HIV-CBO centers. In contrast, the HIV-CBO centers indicated that provider difficulties were greater than for the other two types of centers. Hospitals appeared to perceive referral problems and the low priority of dental care as a more important barrier than did the others. With one exception, there were no differences in responses whether the center was new or old, or whether a medical director or another administrator completed the questionnaire. Only 42 percent of medical directors agreed that funding issues was an important barrier in contrast to 94 percent of other administrators (P=.001).

TABLE 1
Potential Barriers to Providing Dental Care Services

	% Agree (N=36)*	Mean†
Resources/funding issues		66.7
—Lack of start-up funds for dental office setup	88	
—Lack of physical space	74	
—Not aware of all funding sources available	71	
—Not many funding options for dental services	69	
—Reimbursement rates do not cover overhead	69	
—Institution has applied for funding unsuccessfully	7	
Dental provider difficulties		29.4
—Difficult to recruit providers to treat medically ill patients	44	
—Providers unwilling to care for underserved population	41	
—Hard to retain providers at institution	37	
—No success in negotiating partnerships with providers	21	
Referral problems		24.2
—Affiliations with dental schools are difficult to establish	49	
—No effective way to follow up dental referrals	25	
—Unsure how to establish connections for dental referrals	23	
Low priority		15.2
—Dental care is not a priority within institution	33	
—Dental care is a low priority for patients within institution	19	
—Not enough patients in institutions to support services	19	
—Dental care is not part of primary care	10	

*Agree=strongly or moderately agree on 4-point scale.
†Mean agreement for all barriers within category.

TABLE 2
Mean Proportion of Centers that Agreed Barrier Was Important Within Each Category, by Type of Institution

	Type of Institution*		
Barrier Category	General Health Clinic (n=16) (%)	Hospital (n=7) (%)	HIV-CBO† (n=7) (%)
Resources/funding issues	57.1‡	71.4	75.0
Provider difficulties	31.3	16.7	66.7
Referral problems	20.0	50.0	33.3
Low priority	14.3	42.9	0.0

*Six centers self-categorized as "other" were excluded from this analysis.
†HIV-CBO=community-based organization with services for HIV-infected patients.
‡None of the differences were statistically significant (Fisher's exact test).

When asked to indicate the most important barrier from the list of 17, 25 percent chose lack of physical space or lack of start-up funds for setup of a dental office. The low priority of dental care within the institution was selected by 17 percent. The most important reason, selected by 38 percent of general health care clinics, was lack of funding for initial office setup. The most important reason for hospitals was the low priority of dental care (43%). For HIV-CBO centers the most important barrier was lack of office space (43%).

Most (78%) health care centers strongly agreed that there is a need for dental services among the population they served. If dental services could be provided, 58 percent of centers would be strongly interested in offering them. However, only 20 percent had applied for external funding for dental services.

Discussion

This survey of Medicaid-approved health care centers in New York City identified barriers to implementing dental services. The most important reasons these inner-city centers cited were related to resources and funding. Health centers also indicated problems with recruiting and retaining dental providers and coordinating referrals. While other studies have identified barriers for patients to access oral health care, this is among the first studies to explore institutional barriers that may prevent organizations from integrating and providing such care (5,7-9).

Not surprisingly, the most commonly cited problems were related to resources—start-up funds, space, funding sources, and low reimbursement rates. Capital investment is needed to implement dental services. A combination of private and public funds may be required to obtain capital. Partnerships among community health centers, dental schools, and hospitals could expand sources of funding. Most centers were not aware of available funding sources (e.g., State Department of Health, HRSA) and only a few had applied for funding. Most felt that Medicaid reimbursement is inadequate to defray the high costs of providing dental care. The Center for Medicare and Medicaid Services plans to offer incentives by linking its payment rate to the volume of dental services provided for the year (10).

Strategies to improve recruitment and retention of dental providers may include exposing more dental residents to inner-city health centers, expanding loan repayment programs for those working in medically underserved communities, greater focus on public dental health in dental school, and strengthening ties between these inner-city practices and academic health centers.

Referral partnerships with dental schools and outside dentists were identified as a barrier. Cooperative arrangements between dental schools and community health centers are worth pursuing, as they may create new funding alternatives for oral health services as well as expanding the patient base.

Although respondents personally disagreed with the statement that dental care is not a priority, they nevertheless considered it a barrier at the institutional level. There appears to be a need for patient education and institutional advocacy to improve understanding of the importance of oral health care.

The generalizability of this study is limited by its small, local sample. However, problems faced by inner-city centers in New York, where Medicaid reimbursement is relatively generous, may resonate with similar institutions across the country. This survey suggests that institutions caring for vulnerable populations will need to overcome multiple hurdles to provide oral health services.

Understanding institutional barriers to provide oral health services for vulnerable populations is essential because these community health care centers may be the only access to care for such patients. These institutions are on the front lines, caring for populations with the poorest access to care. The concerns of these centers will need to be addressed to integrate oral health services with primary health care. With attention to these problems we may bring needed dental care to underserved populations.

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