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Oral Health and Barriers to Care in Burlington Housing Authority Residents

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Background

Oral health affects everyone and serves as a model for the long term benefits of establishing preventative health practices early in life[2,3,5]. However, children with significant socioeconomic stress or cultural and language barriers to access may have difficulty obtaining oral hygiene information, or developing and maintaining oral health regimens[1,4,6].

The Burlington Housing Authority (BHA) provides housing subsidization to low-income families and services many resettled refugee families in Burlington, VT. We recognize some intervention initiatives are already and place, and will evaluate program efficacy and utilization. Ultimately, we seek to understand barriers to the existing programs and recommend strategies to increase utilization, compliance, and education in our target population.

Methods

Nine respondents from two BHA housing developments were interviewed in individual and group settings about the dental health of children living in their homes. A convenience sample was employed, and respondents answered a standardized set of questions by the same interviewer with the help of a translator if necessary. All interviews were audio recorded for later review and use of direct quotations where applicable. Respondents and attendees were provided food, and a set of oral care implements regardless of participation.

Results

Among respondents, the majority made two visits to a dental provider per year (78%). Families averaged 3.44 children, with 33% of families reporting that children of different ages saw different dentists. For routine oral care, the majority brushed twice per day and flossed (67%), with most receiving dental care at Timberlane Dental (a private practice) and Burlington Community Health Center (56% and 44%, respectively). Almost all respondents were aware of School-Based Dental Center (SBDC), with five respondents (56%) choosing other dental care resources, and four (44%) utilizing the program.

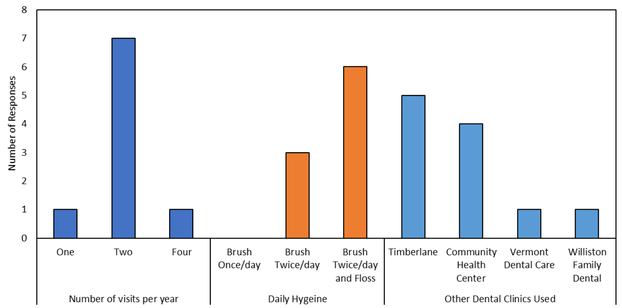


Figure 1: BHA residents have routine dental visits, and report daily oral care routines in accordance with expert recommendations. BHA residents utilize a variety of oral health services.

Table 1: Demographic characteristics of interview respondents

Resident Characteristic	Percent
Language Other than English	78% (7)
Medicaid	100% (9)
Sex, Female	100% (9)
Ethnicity	
White	11% (1)
African American	89% (8)

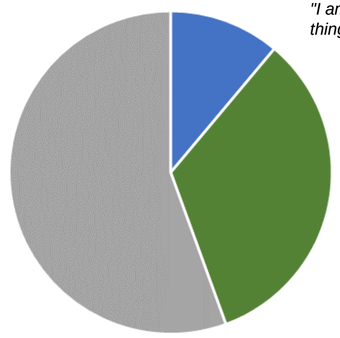
"It would be useful for someone who doesn't have a car."

"I wanted to have contact with the dentists myself."

"I'm happy with Dr. Dynasaur."

"I will use it when my children are old enough."

[Used to use it] "A long time ago, I was confused and mad. One of my sons had a cavity, and I think they did something wrong. He had pain afterwards."



"I am comfortable going myself and want to be there to discuss things with the dentist."

"They call me when they take my child from school, and I like that."

"They clean, check for cavities"

"It's very easy and important and [they] give them a ride from school. It wouldn't be possible for me to do myself."

Figure 2: Representative quotations corresponding to prevailing attitudes toward, and awareness of, the School-Based Dental Center among respondents (N=9).

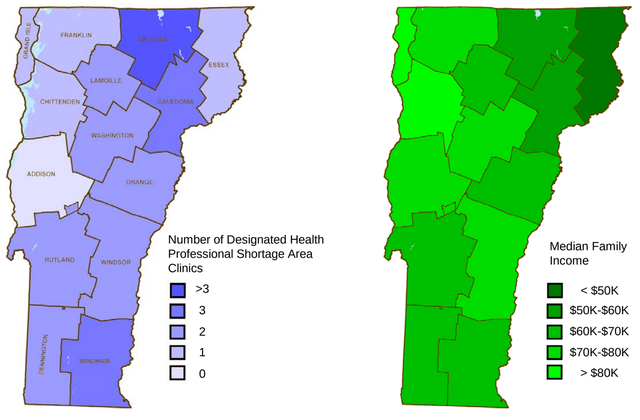


Figure 3: (left) A Vermont county map of designated Health Professional Shortage Area dental clinics, expressed as number per county (Health Resources and Services Admin., 2018). These are dental clinics which serve populations that the National Health Service Corps has identified as underserved. (right) Median family income for Vermont counties (U.S. Census Bureau, 2018).

Discussion

Families of BHA reported overall adequate access to dental care. All residents interviewed received government issued insurance plans, making them eligible for the SBDC and other dental coverage. Nearly all individuals had heard of the SBDC, and all who chose not to use it indicated their children were already patients of local dentists. Reasons that BHA parents gave for not utilizing the SBDC include a desire to be present at their child's visit and interact with the dentist which does not always happen at SBDC appointments. Additionally, one parent reported a negative experience with the SBDC where a failure of communication led to unauthorized and incorrect dental work.

This pilot study demonstrates high levels of oral hygiene knowledge and excellent dental habits for the BHA communities. Our data show low-income community members are utilizing public resources to access dental care for their children. This study also demonstrates that multiple BHA community members receive benefit from services of the SDBC, with another 33% considering utilizing the SDBC, pending improvements. This project has demonstrated a need being met in the Burlington community, and suggests that the SBDC model could be implemented outside of Chittenden county, where oral health professionals may be difficult to access. The SBDC can serve as a model for programs elsewhere in Vermont, such as Essex County where median family income is <$50,000 and currently only has one clinic for underserved families.

Limitations of this study include selection bias, response bias, and low population size.

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