

Delivering Equitable Care to Underserved Communities

Follow up on: Sema CA, Arevalo O, Tomar SL. Dental-related use of hospital emergency departments by Hispanics and non-Hispanics in Florida. Am J Public Health. 2017;107(S1):S88–S93.

Sema et al. paid limited attention to certain public health failures that we elaborate on here toward promoting oral health and health care for all. First, at least in an aspirational sense, most dental conditions are preventable through attention to the social determinants of health, including oral health.¹ Consider the mission of public health to fulfill society's interest in ensuring conditions in which people can be healthy; in a more just era, most of the dental-related visits to emergency departments by Hispanics and non-Hispanics in Florida might have been avoided through lifelong provision of sound nutrition, educational opportunities, safe neighborhoods, and high-quality primary and oral health care. Evidence-based preventive strategies, including provision of fluoridated water and enforcement of legislation supporting the wearing of seatbelts, helmets, and mouth guards, might have also been used to avoid such visits.

Second, hospital emergency departments are ill equipped to handle dental problems, so many patients receive only antibiotics or pain medication, leaving their fundamental oral conditions untreated and thus likely to become exacerbated over time. Finally, although Sema et al. found that Medicaid is the primary payer for both Hispanics and non-Hispanics who use hospital emergency departments for dental problems, the harsh reality is that Medicaid

coverage alone is not sufficient to reduce barriers to high-quality dental services for enrollees.²

EQUITABLE CARE FOR FAMILIES AND COMMUNITIES

Among the set of guiding principles for developing oral health strategies is that interventions should be holistic; that is, they should involve a broad approach that focuses on the common risks and conditions that determine oral and general health.¹ Unfortunately, when families are forced to live under unrelenting stress with respect to their immigration status, they often forgo needed medical and dental care because they fear interactions with public and private agencies. Moreover, the threat of detention and deportation owing to lack of documentation (e.g., Social Security numbers and valid driver's licenses) has untoward effects on use of social services and government programs such as food assistance, which are often essential for survival.

Federal immigration enforcement policies have been increasingly delegated to state and local jurisdictions, leading to increased enforcement activities by local police.³ Rhodes et al. conducted focus groups and individual interviews with immigrant Hispanics/Latinos in North Carolina to understand how local immigration enforcement policies affect use of health services. Participants reported profound mistrust of health care providers and staff, often avoiding medical and dental

care and thus sacrificing their own health and that of their family members. Moreover, they expressed concern that immigration enforcement policies were exacerbating anti-immigrant sentiments and promoting racial profiling and discrimination, including within health care settings.³

Another change is that striking new settlement patterns have emerged that have brought about unprecedented geographic dispersion among the approximately 45 million Hispanics residing in the United States.⁴ One recent metropolitan area analysis showed that US-born Mexican Americans living in new versus traditional destinations have less favorable health care outcomes, including a greater probability of having an unmet need for or delay in receiving care and reduced satisfaction with care.⁴ By contrast, no differences were found between Mexican immigrants residing in new and traditional destinations in terms of the probability of having a usual source of care, reporting unmet need, and being satisfied with the care received. Still, immigrants who resided in new destinations were more likely than their peers in traditional destinations to have an emergency room visit, to be admitted to the hospital, and to have medical care expenditures.⁴

One possible interpretation is that Mexican immigrants enjoy better oral health (the Latino paradox) or access to care in new destinations than in traditional destinations. An alternate explanation, however, is that higher rates of hospital admissions and emergency room visits reflect worse access to ambulatory care among immigrants in new destinations.⁴

IMPLEMENTING EVIDENCE-BASED INTERVENTIONS

In care that is evidence based, existing knowledge of effectiveness and good practices is used as the basis for developing future oral health improvement interventions.¹ Local agents, empowered by resources, are best equipped for implementing evidence-based interventions.⁵ As one example, quantitative systematic reviews indicate that the ibuprofen-acetaminophen combination may be a more effective analgesic, with fewer untoward effects, than many of the currently available opioid-containing formulations.⁶ Hence, combining ibuprofen with acetaminophen provides dentists with an evidence-based therapeutic strategy for managing acute postoperative dental pain that mitigates the serious sequelae of prescribing opioids.⁶ Given that many patients reporting to hospital emergency rooms for dental conditions do so because they are experiencing pain, more

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evidence-based strategies are needed to effectively deal with pain before it becomes acute.

Implementing current guidelines into practice, however, requires more than publishing an article in a peer-reviewed platform. Indeed, scientific journals, with some improvements, are considered as agents for the initial stage known as diffusion.⁶ Collaboration between academics and medical and dental organizations is best suited to the next stage, known as dissemination (i.e., predisposing physicians and dentists to change their practices).⁶ Finally, implementing evidence-based interventions in practice requires the application of scientific methods that promote uptake of research findings into routine health care in clinical, organizational, and policy contexts.

SUSTAINING IMPROVEMENTS IN ORAL HEALTH

Sustainable interventions are capable of producing improvements in oral health that can be maintained by families and communities for the long term.¹ Even innovative models of integrated medical and dental services in community sites are insufficient to combat the economic, structural, geographic, and cultural factors that prevent access to regular high-quality care among vulnerable and underserved US populations, including immigrants.

Among the recommendations of the US Institute of Medicine and the National Research Council toward achieving oral health equity is to support the creation of a diverse workforce that is competent, compensated, and authorized to serve vulnerable and underserved populations

across the life course.² For example, community-based dental residency programs exist that are accredited by the Commission on Dental Accreditation of the American Dental Association. Residents build confidence and competence in diagnosing, treating, and managing the oral health needs of patients in diverse practice settings, including community health centers, private or group practices, Indian Health Service sites, and dental schools. They practice in supportive environments that promote interdisciplinary, interprofessional patient care and work collaboratively with primary health care and social service providers in strong partnerships.

Long-term data indicate that many graduates of these programs plan to practice at sites caring for underserved and vulnerable populations. If sufficiently scaled up, community-based dental residency programs may meaningfully increase access to and ensure equity in oral health care among families and communities.

TRANSFORMING MEDICAL AND DENTAL EDUCATION

In a provocative article, Sharma and colleagues argued that justice and inequity can be used to deepen collective understandings of power, privilege, and the inequities embedded in social relationships as a means of fostering active commitment to social justice among medical and dental trainees.⁷ Medical and dental education institutions and health care organizations are no longer able to meet their social accountability mandates without delving into the

complex and controversial issues of racism, income inequality, food insecurity, and inequities in education, taxation, and housing.⁷

Health equity and social change have thus become inextricably bound, and achieving the former is understood to be impossible without accomplishing the latter. The educational mandate of training institutions has also been shifting, from developing competent and socially accountable physicians and dentists to training providers who are engaged in the struggle toward social justice. Only through transformational change can we better ensure that no one needs to present to a hospital emergency department for a dental-related condition. **AJPH**

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