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Meeting People Where They Are: Lessons Learned from Dental Screening in Low Income Community Settings

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ABSTRACT:

Background: Oral health disparities disproportionately affect low-income populations, contributing to systemic health issues. Limited access to affordable dental care often results in untreated dental conditions, which can impair overall health and economic stability.

Objectives: This study explored the feasibility of conducting dental screenings in community settings and supporting individuals in establishing a dental home.

Methods: The study was implemented across two sites, a food pantry (*n*=64) and a free medical clinic (*n*=63), serving socioeconomically disadvantaged populations. Participants were randomized into intervention (n=59) and control groups (*n* = 67). Follow-up assessments were conducted one month post-intervention to evaluate dental appointment adherence and identify barriers to care.

Results: Screening in a food pantry or a free medical clinic is feasible. However, no significant difference was found in dental appointment follow-through at the one-month timeframe , $\chi^2(1) = 0.43$, $p = .512$, $1 - \beta = 0.07$, likely due to systemic delays in accessing Medicaid-accepting providers.

Conclusions: While community-based dental screenings are viable, systemic challenges hinder timely access to care. Future outreach efforts should account for the extended time required to establish a dental home and consider multi-month follow-ups. Innovative, community-engaged strategies—such as mobile dental units and streamlined referral systems—may enhance access and continuity of care for underserved populations.

KEYWORDS: Oral health disparities, dental, dental home, community-based public health

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Dental caries and tooth pain disproportionately affect lower resourced individuals due to lack of access to, and cost of, care. [1] Untreated dental problems result in pain. Tooth removal, especially in emergency settings, is often a substitute for complex and unaffordable treatment. [2,3] Multiple studies have shown a strong association between lower income and increased tooth loss. [1,4-6] By age 65, one in ten low-income adults have no remaining teeth. [7] Dental pain affects employment, and if severe enough, can impede upward economic mobility due to job absenteeism and potential job loss. [8,9] Despite insurmountable evidence to the contrary, dental pain is viewed as a negative behavioral trait rather than a symptom of systemic inequality and poverty. [10]

The barriers to accessing dental care include lack of transportation[11], financial cost[12], lack of dental insurance[13], and dental anxiety[14]. Lower resourced people often lack paid sick time or child care, making it challenging to find a dentist that accommodates their schedule.[15] By not receiving dental care, people are putting their systemic health at risk. Poor dental health contributes to many chronic diseases including cardiovascular disease[16], diabetes[17], obesity[18], depression[19], and other medical and behavioral health conditions that impact population health.

Lower-resourced individuals without a dental home strain the healthcare system by utilizing emergency rooms to manage dental issues that could be alleviated with less expensive preventative care.[20] A dental home is an ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.[21] Unfortunately, Medicaid enrollees often have difficulty finding Medicaid-contracted dental providers and establishing a dental home because only 20% of dentists nationwide accept Medicaid and some states have no dental Medicaid benefits for adult populations.[22]

Community Engagement on Dental Health

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In 2020, prior to the work on dental care, faculty and students at the university began to volunteer time at the local food pantry with the Seneca-Babcock Community Association (S-BCA), an organization that provides a variety of services to the community, including afterschool programming, daycare services, senior feeding programs, and meals on wheels. The (S-BCA) is located about 20 minutes' drive (7.7 miles) from the University at Buffalo dental school. This community is predominantly lower socioeconomic status (SES), and predominantly white. In this collaboration faculty and students began a weekly community food pantry. The Executive Director of the community association and members of the local Block Club expressed the need for dental care in the neighborhood. The Block Club is a resident-led neighborhood organization that works to improve safety, cohesion, and quality of life. It collaborates with the (S-BCA) to address community needs and often engages with academic partners through association initiatives, ensuring resident perspectives inform programs and research. This need was evident among the pantry clients, and many expressed the need for dental services. With the support and input from the community association and community Block Club, we completed a brief needs assessment that was drafted with and reviewed by the community partners and found that only 48% of people had been to a dentist in the past year, compared to the national average of 67%.[23]

To address the local need for dental care, we worked with the community organization, Block Club, and the university to apply for a Community Partnership Development Seed Grant from the university's Clinical and Translational Science Institute, with the Executive Director of the Association serving as a co-investigator on the $5,000 grant. The funding, outside of the gift cards to incentivize participation, went to purchase disposable supplies for the dental screenings and to provide care kits (toothbrush, toothpaste, and floss) to all participants. The community

partners at both sites were in agreement and supported how the funds were allocated for this project. After receiving funding, we focused on developing a novel process of on-site screening of community members that attend the local food pantry for dental health issues and supporting them to establish a dental home. The process used for the screening was created and supported by the community partners that were part of the project. The support provided is discussed later in the control and intervention description of this paper. This project tested the feasibility of screening people during their routine activities at a locally trusted food pantry and helping them to overcome barriers to access to care by consulting with a social worker.

The Lighthouse Free Medical Clinic (LHFMC) was chosen as a comparison site due to the similar socioeconomic conditions of the participants. The clinic is student-run and one of the faculty members on this project serves as a faculty preceptor at this location, which is approximently 8 minutes' drive (1.1 mile) from the University at Buffalo dental school. Students and faculty advisors at LHFMC were consulted on the potential benefits of patient participation in the study, and all agreed that it would support community health. Throughout the study, student managers partnered with patients to encourage and facilitate dental visits. The population served at the clinic is predominantly lower-income African American/Black people. A social and behavioral screening form administered to all patients at the clinic indicated that 27% of people seen had tooth pain and 53% had not seen a dentist within a year, demonstrating similar dental health profiles to clients at the food pantry.

Methods

Approach

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This study was approved by the institutional IRB prior to implementation (IRB #00007041). This project utilized an experimental design to test if screening patients in a community setting increases their likelihood of scheduling an appointment and going to that appointment, which is the first step to establishing a dental home. The evaluation design was longitudinal with both intervention and comparison phases in each of two community sites, each acting as its own control, with results compared across sites. During month-long intervention phases, community members completed the screening form, had an oral exam performed by a licensed dentist, and met with a dental social worker who were both part of the project team. The dentist would then provide an explanation of the results of the screening. The social worker completed a brief social work assessment and informed participants of the social work services available to established patients at the University at Buffalo dental school. The number of patients who established a dental home was tracked.

Recruitment

Participants were recruited approximately two days a month for 8 months at each location (the food pantry (n = 63) and the free medical clinic (n = 63)). Both locations are only open one day a week for four hours at a time. Participants were randomized into the intervention group and control group based on the day they came to the location. Eleven total intervention group events (4 food pantry and 7 free medical clinic) and nine total control group events (4 food pantry and 5 free medical clinic) were conducted. Cancellations due to inclement weather and academic holidays resulted in scheduling additional events at the free medical clinic to collect the target number of participants. People were eligible to participate if they had not seen a dentist within the last six months and were 18 years old or older. Participants were incentivized with a $20 bank gift card for partaking in the study.

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Intervention Group

The intervention group activity took 15-20 minutes to complete. Participants (n = 59) randomized into the intervention group read and signed an electronic informed consent form and then completed a brief dental survey administered on Qualtrics using an iPad. This survey asked them questions about their dental health and perceived susceptibility and severity related to dental health. They then had an oral health screening conducted by a dentist. For the screenings, the dentist would bring disposable dental equipment including oral mirrors and probes. Because the city's water lacked fluoride over the past several years in Buffalo, New York, the dentist also offered to apply a fluoride varnish to each participant's teeth. During the dental screening, the dentist looked into the individual's mouth to observe any cavities or previous dental work. This involved the dentist using a small mirror and a dental explorer to check the dentition and tooth enamel. Participants were supplied with a list of local dentists that accept payment by Medicaid insurance at the end of the oral screening.

Then participants talked with a dental social worker who completed a brief social work assessment with them, discussed any barriers to care they encountered in finding a dentist, and provided a printed leaflet detailing the services of the dental school's social work patient support program. The program offered advocacy for financing dental treatments, transportation, housing, employment, access to health care and mental health support. The social worker also called to collect follow-up data from all participants. Participants who were followed up with by phone one month after the screening were asked two questions to determine if they had seen a dentist, and if not, what barriers they have to doing so. Each person was called 3 times at different times of day during the follow-up prior to being marked as no-response.

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Control Group

The control group activity took five minutes to complete. Participants (n = 67) randomized to the control group also read and signed an electronic informed consent form and then completed the dental survey administered on Qualtrics using an iPad. Following that, they were supplied with a list of dentists in the area that accept payment by Medicaid insurance. Individuals were followed up with one month after the screening by phone to determine if they had a dentist, and if not, what barriers they have with securing one. The same follow-up procedures were used as with the intervention group.

Statistical Analyses

We conducted descriptive statistics separately for participants at the Seneca Babcock Food Pantry and the Lighthouse Free Medical Clinic (Table 1). These included frequencies for gender, current oral health, time in pain, having concerns about teeth other than pain, barriers to dental care, and having a regular dentist at follow-up. Means, standard deviations, and ranges were reported for responses on current oral health, the dental pain scale, and number of barriers to dental care. We calculated frequencies of participants' dental behaviors separately by site (Table 2). We conducted 2 (Site: Seneca Babcock Food Pantry or Lighthouse Free Medical Clinic) x 2 (Condition: Intervention or Control) Analyses of Variance (ANOVAs) comparing sites and participant conditions (intervention vs. control group) on dental behaviors at time of screening and calculated effect sizes (Table 3).We calculated post-hoc statistical power for comparisons. These ANOVAs examine the equivalence of sites and conditions at baseline (screening time), significant effects would indicate biases. We conducted Chi-Square analyses for non-parametric comparisons of differences by site in having dental insurance at screening

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time, having concerns about dental issues other than pain, and having a dentist at follow-up. We conducted Chi-Square analyses for non-parametric comparisons of differences by study condition in having dental insurance at screening time, having concerns about dental issues other than pain, and having a dentist at follow-up. A post-hoc non-parametric comparison examined whether those who had a dentist at follow-up were more likely to have dental insurance at screening time.

Results

Overall, this project found that it was feasible to screen people for dental health issues in a food pantry and a free medical clinic. There were no differences by site or condition for level of dental pain, time in dental pain, time since last dental checkup, frequency of eating sweets or candies, or frequency of drinking sugary drinks or soda at the time of screening. Only 13% of participants overall had a dentist they see regularly at the one-month follow-up.

Differences by Site

Patients at the Lighthouse Free Medical Clinic had more barriers to care on average than clients at the Seneca-Babcock food pantry, but also brushed their teeth more often than clients at Seneca-Babcock (See Tables 2 and 3). Clients at the Seneca-Babcock food pantry were more likely to have dental insurance at screening time than patients at the Lighthouse Free Medical Clinic ($\chi^2(1) = 18.15$, $p < .001$, $1 - \beta = 0.59$). There were no differences by site in the likelihood of having concerns about dental issues other than pain ($\chi^2(1) = 2.05$, $p = .211$, $1 - \beta = 0.32$) or having a dentist at follow-up ($\chi^2(1) = 2.35$, $p = .126$, $1 - \beta = 0.34$).

Differences by Condition

Participants in the control condition rated their oral health slightly better than participants in the intervention condition (See Tables 2 and 3). Participants in the intervention condition were more likely to have concerns about dental issues other than pain at screening time ($n = 38$, 63.3%) than participants in the control condition ($n = 20$, 29.9%, $\chi^2(1) = 13.80$, $p < .001$, $1 - \beta = 0.97$). There were no differences in having dental insurance at screening time ($\chi^2(1) = 0.49$, $p = .482$, $1 - \beta = 0.11$) or having a dentist at follow-up, $\chi^2(1) = 0.43$, $p = .512$, $1 - \beta = 0.07$, based on study condition (10%, 6 of 39 reporting for intervention; 7.5%, 5 of 47 reporting for control). Those who had a dentist at follow-up ($n = 13$) may have been more likely to have dental insurance prior to the study ($n = 8$, 72.7%) compared to those who did not have a dentist at follow-up (59.5%, n = 76, 2 missing data), although this difference did not reach significance ($\chi^2(1) = 0.71$, $p = .399$) possibly due to an underpowered comparison ($1 - \beta = 0.13$).

Lessons Learned

This study found that it is feasible to complete dental screenings with a dentist onsite in a food pantry setting and within a free medical clinic. Furthermore, providing information on where people can get affordable and accessible dental care is key to help improve the dental health of the population. Yet, we found that it often takes people more than a month to secure a dental appointment and even longer to access dental care. Although participants with emergent dental issues were able to be seen within a month, those who needed a cleaning often waited longer than a month to become a patient at dental practices that accept Medicaid. Recruiting larger samples for longer timeframes would provide a more sensitive analysis that may demonstrate the effectiveness of the intervention.

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Due to these limitations, we found that many people in the study had an appointment scheduled beyond the one-month follow-up timeframe. Future interventions should provide multiple follow-ups beginning two to three months post-intervention, to account for the time it takes them to become established with a dental provider and complete the first appointment. Other limitations included small sample sizes and relatively homogenous samples. Although we recruited populations from similar socioeconomic backgrounds, they may not be matched on all relevant characteristics.

Next Steps

Although our project did not demonstrate differences between intervention and control groups in the likelihood of establishing dental care, it is important to conduct community outreach dentistry to promote oral health literacy, offer free dental healthcare services, and provide resources to connect community people in need with dental professionals. The control group rated their oral health slightly better, perhaps the act of self-assessment during the study influenced participants' perception of their oral health. Future studies should explore if self-assessment impacts participants' perceptions of their oral health. This study demonstrates how even without having a dentist in the community, public health or other community health workers can raise awareness about the need for dental care in community settings. Healthcare professionals engaging with the community can identify the barriers to care within the communities they are working with and implement necessary interventions to encourage people to seek dental care.

The results were discussed with the community partners on the project, these partners suggested including expanding mobile health services to reduce the barrier of transportation for people living in the area. With this information we have sought additional grant funding to bring

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a mobile dental unit to both locations to reduce the burden of transportation. Furthermore, the dental school is working on changing their procedures to reduce the time burden on patients and is discussing how to modify the policy to dismiss patients after three no-show visits. We are continuing to work with the dental school to create a streamlined referral system from this community partnership to increase access to expanded dental services for underserved community members.

Conclusion

This study is the first to explore the impact of screening people at a food pantry and a free medical clinic for dental health and establishing a dental home. Bridging the gap of dental health inequity will not be achieved with a one-size-fits-all solution. Utilizing existing stakeholders and community partners that work on dental initiatives is key to increasing access to care. Researchers, policymakers, and clinicians have proposed different courses of action to tackle this problem, from expanding Medicaid benefits to community outreach training for dental students and dental hygienists. Furthermore, federally qualified health care centers, hospitals, and local public health deparments should respond to the community needs and expand dental services provided and reduce barriers to access. This complex problem calls for innovative solutions. The best course of action would incorporate different interventions to address the need for policy changes, community outreach, and targeted dental education. More research must be done on this topic to aid in finding the most ideal solutions to this complex problem.

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Table 1. Participant demographics and descriptives by site

	Seneca Babcock Food Pantry	Lighthouse Free Medical Clinic
N	64	63
Gender		
Female	51.6%	60.3%
Male	48.4%	38.1%
(missing)	0	1.6%
Current oral health (M, SD, range)	3.3, 1.0, 1-5	3.1, 0.9, 1-5
Excellent	7.8%	4.8%
Good	35.9%	30.2%
Average	37.5%	36.5%
Poor	12.5%	25.4%
Very poor	4.7%	3.2%
(missing)	1.6%	0
Pain scale (M, SD, range)	2.3, 2.8, 0-10	2.4, 2.5, 0-8
Time in pain		
A day or two	4.7%	1.6%
A week	3.1%	1.6%
A month	3.1%	3.2%
More than a month	17.2%	17.5%
(N/A)	71.9%	76.2%
Other concerns about teeth	39.1%	52.4%
Dental Insurance	76.6%	40.3%
Barriers to care (M, SD, range)	0.9, 0.8, 0-3	1.4, 1.0, 0-4
Barriers		
Financial problems	26.6%	38.1%
Geographic location	4.7%	11.1%
Childcare	3.1%	7.9%
Lack of insurance	10.9%	34.9%
Transportation	23.4%	22.2%
Other	23.4%	23.8%
Established dental home at one month follow-up		
Yes	12.5%	4.8%
No	56.3%	61.9%
(missing)	31.3%	33.3%

Table 2. Participants' dental behaviors by site

	Seneca Babcock Food Pantry	Lighthouse Free Medical Clinic
N	64	63
Brushing teeth		
Twice or more per day	39.1%	57.1%
Once per day	48.4%	38.1%
Less than once per day	4.7%	1.6%
Rarely	7.8%	3.2%
Eating sweets or candies		
6 or more times per week	28.1%	11.1%
3-5 times a week	17.2%	38.1%
1-2 times a week	28.1%	22.2%
Less than once a week	17.2%	19.0%
Rarely or never	7.8%	6.3%
(missing)	1.6%	3.2%
Drinking sugary drinks or soda		
6 or more times per week	28.1%	14.3%
3-5 times a week	15.6%	17.5%
1-2 times a week	12.5%	30.2%
Less than once a week	18.8%	17.5%
Rarely or never	23.4%	19.0%
(missing)	0	1.6%
Time since dental checkup		
6 months	12.5%	6.3%
1 year	26.6%	31.7%
>1 year, < 2 years	15.6%	23.8%
>2 years, < 5 years	20.3%	27.0%
> 5 years	21.9%	11.1%
Never had one	1.6%	0
(missing)	1.6%	0

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Table 3. ANOVA results comparing sites and participant conditions at time of screening

Effect	*F*	*d.f.*	*p*	Partial-η^2	1 - β
Current oral health					
Site	1.60	1, 122	.209	.013	.241
Condition	3.96	1, 122	.049	.031	.506
Site * Condition	2.14	1, 122	.146	.017	.306
Dental pain					
Site	0.08	1,62	.78	.001	.059
Condition	0.15	1,62	.696	.002	.067
Site * Condition	2.65	1,62	.109	.041	.360
Time in dental pain					
Site	0.37	1,29	.548	.013	.090
Condition	2.79	1,29	.106	.088	.365
Site * Condition	0.01	1,29	.947	0	.050
Barriers to dental care					
Site	7.85	1, 123	.006	.060	.794
Condition	0.00	1, 123	.981	0	.050
Site * Condition	0.88	1, 123	.350	.007	.153
Time since last dental check up					
Site	0.39	1, 122	.534	.003	.095
Condition	2.14	1, 122	.146	.017	.305
Site * Condition	0.56	1, 122	.456	.005	.115
Brushing teeth					
Site	4.85	1, 123	.029	.038	.589
Condition	2.14	1, 123	.146	.017	.306
Site * Condition	0.07	1, 123	.787	.001	.058
Eating sweets or candies					
Site	0.37	1,120	.544	.003	.093
Condition	0.25	1,120	.616	.002	.079
Site * Condition	0.94	1,120	.333	.008	.161
Drinking sugary drinks or soda					
Site	0.39	1,121	.531	.003	.095
Condition	0.37	1,121	.544	.003	.093
Site * Condition	0.03	1,121	.872	0	.053

Note: Partial-η2 = .010 indicates a small effect, partial-η2 = .060 indicates a medium effect, partial-η2 = .140 indicates a large effect. 1 - β indicates observed statistical power, the probability of correctly rejecting a false null hypothesis given the observed effect size.

Figure 1: Process of Intervention and Control Group