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**Coming Clear –
Patients, Poverty,
and Perspective**



There are many models, proposed or in practice, to address the issue of patients in poverty, but understanding comes from the thoughtful, attentive chairside presence that is prepared and willing to cross this significant barrier to care. There is much to find out, and much to know; another layer, if you will, in our lifetime of learning.

Outreach, Prevention, and the “Urgent Chair”

Cindy Shirtcliff, M.S.W.* and
Terie Dreussi-Smith, M.A.Ed.**

Each member of *Northwest Dentistry’s* Editorial Advisory Board brings his or her individual experience and interest to the journal, and our brainstorming is a pretty lively and heartfelt process. When one of our members told us about the topic “Understanding Poverty”, the discussion ignited, and it was decided to invite representatives† from the “Bridges Out of Poverty” movement to share their insights and constructs with *NWD’s* readers. If “understanding poverty” feels like a rather elevated, even arrogant, viewpoint to adopt, well, we shared that discomfort. Then we got over it, put our hearts in the right place, picked a place to start, and presto (and hopefully change-o), we went ahead on that splendid “need-to-know” basis. So here is something scratch-practical we all need to know: One way or another, we are all in this together, and if we don’t find a way to make that work, life, as the saying goes, will.

The Editors

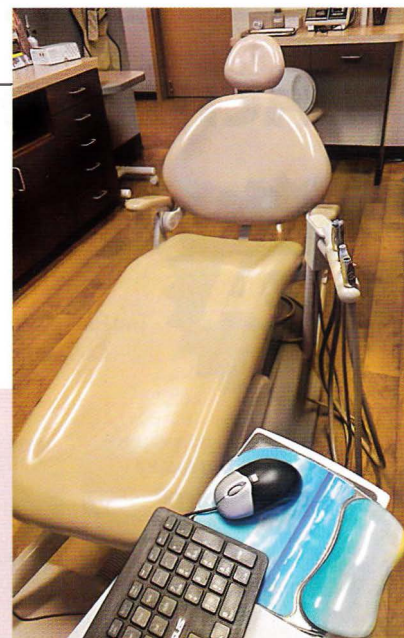
Meet Our Source: The “Bridges” Perspective

The Bridges Out of Poverty movement has grown considerably beyond the content of the 1999 book from which it draws its name.¹ This growth has stemmed in large part from the people championing and applying its tools and strategies. Bridges is not a program *per se*, but rather a continuous learning process featuring a set of constructs, tools, and strategies that has spread across 40 U.S. states and six other countries to date. It is an active, evolving, grassroots response to poverty that uses the “Triple Lens” of change through individuals, institutions, and

About Advantage Dental

Advantage Dental (AD), headquartered in Redmond, Oregon, has developed innovative dentistry practices to build dental health equity throughout the state. Two of the models it used to define and design its practices are *Bridges Out of Poverty: Strategies for Professionals and Communities* (1999, 2009) and the later book *Bridges to Health and Healthcare* (2014).

Founded in 1994 by a group of Oregon dentists concerned with the lack of access to dental care in rural Oregon, the model AD created addressed this concern, as well as the need for affordable and effective dental insurance to groups of all sizes throughout Oregon. AD’s clinics are located strategically throughout Oregon to serve the uninsured and underinsured populations. It is geographically the largest and numerically the second largest dental care organization in the state of Oregon. Advantage Dental has always been an advocate for local communities. Recently there has been a campaign to promote the medical management of caries, helping to change the traditional paradigm from “drill and fill” to one of caries prevention. ■



Expecting the unexpected.

the community. It has led to follow-up programs which engage people living in poverty, bringing all economic classes to the problem-solving and decision-making tables. In short, Bridges involves innovations that have resulted in new thinking, creative programming, and an increasingly comprehensive approach to addressing issues surrounding poverty.

The Ten “Bridges” Constructs

Basic to the Bridges philosophy are its “Primary Constructs of the Bridges Out of Poverty Lens”.

1. Use the lens of economic class to understand and take responsibility for one’s own societal experience while being open to the experiences of others.
2. Address inequalities in access to resources at the intersections of poverty with other social

disparities (race, gender, physical ability, age, etc.).

3. Define poverty as the extent to which a person, institution, or community does without resources.

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†Please see sidebar this page.

4. Build relationships of mutual respect.
5. Base plans on the premise that people in all classes, sectors, and political persuasions are problem solvers and need to be at the decision-making table.
6. Base plans on accurate mental models of poverty, middle class, and wealth.
7. Stabilize the environment, remove barriers to transition, and build resources at the individual, institutional, and community/policy levels.
8. Address all causes of poverty. Four areas of current research are at-risk children and youth populations; vulnerable adults; standard patients; and integrated health practice.
9. Build long-term support for individual, institutional, and community/policy transition.
10. Build economically sustainable communities in which everyone can live well.

The Tools: Motivational Interviewing

Developed by William R. Miller and Stephen Rollnick, Motivational Interviewing (MI) is an approach to counseling relationships.² The strategy uses non-judgmental, non-confrontational dialogue to increase patient awareness of potential problems caused, consequences experienced, and risks faced as a result of a behavior. The process helps patients envision a healthier future story, develop their own argument for change, and access increased motivation to achieve the change. The interaction is warm, neutral, and respectful of the patient's perspective.

Because MI focuses on the present and entails working with clients to access their *own motivation to change*, it can be particularly useful for individuals who live in environments of poverty centered on the "tyranny of the moment". It is a fresh approach for

patients in at-risk populations because it allows the voice and thinking of the patient to be the primary change agent. In contrast, the tendency of many professional organizations is to directly educate people regarding what they need to change, why they need to change, and how they need to change, virtually regardless of patients' perceptions or contexts.

Once relationships are established, individuals tend to weigh the pros and cons of their behavior throughout the dialogue. Originally used for addictions counseling, MI is now used in smoking cessation and other health and wellness sectors to address lifestyle-related health issues.

The First Big Idea

The Bridges initiative was not the first foray into innovative practices by Advantage Dental (AD). In 2004, Klamath County Public Health launched the Klamath County Early Childhood Cavities Prevention program, based on the community's desire to more effectively address oral health. The common goal was two-year-olds with no decay. The target populations were low-income expectant mothers, and the thinking was that treating the mother-and-child dyad would have better oral health outcomes than treating one or the other separately. A dental hygienist was the case manager for the project, and she collaborated with public health officials, WIC (federal Women, Infants and Children program), dental care organizations, and local dentists.

The result after five years was that 85% of the two-year-olds were cavity-free, compared with 58.9% in other Oregon counties. The study showed a strong correlation between poor oral health and a lack of resources available to those low-income mothers living in poverty. A cluster of poverty-related risk factors, including relationship issues, mental health and emotional well-being, lack of dependable

transportation, little money for gas, child care difficulties, time constraints, and other stressors, interfered with the expectant mothers' ability to get oral health care.

The lack of external resources impacting access and availability of care was a great part of the problem. The "nowness" or immediacy of poverty over a period of time when groups and families remain in deep poverty affects how many individuals view their future story, how they are motivated, and how they look at preventive health and dental care. The phrase "Dentists are for rich people" is heard in lower income neighborhoods, a powerful illustration of how marginalized, at-risk groups often feel about dental resources.

Bridges defines poverty as "the extent to which an individual does without resources". The day-to-day lives of individuals living in poverty make engagement with dental care difficult. Individuals living in poverty environments tend to be busy doing "agency time", seeking resources, and trying to meet basic needs. This makes life difficult and chaotic. The "tyranny of the moment" keeps them focused on the crisis of the now, with little time or energy to focus on tomorrow, next week, or next month. Survival needs of food, housing, utilities, and transportation often take priority over dental appointments.

AD's involvement with the Klamath study resulted in a change in thinking about how dental services are delivered to those in poverty. AD serves the Oregon Health Plan population (Medicaid), those who qualify by their low income. The Klamath Project³ taught the team that to be the most effective they would need to learn more about the day-to-day lives of those in poverty.

One quote in particular resonated with one of our authors: "The

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healthier you are psychologically, or the less you may seem to need to change, the more you can change”⁴. She realized that dentistry asks patients with the lowest and fewest resources to make significant changes in order to fit dental health into their already chaotic lives. We want them to call ahead, schedule appointments, show up on time, fill out pages of medical history, value their teeth, brush, floss, change their diet, and care for their children’s teeth, without ever considering the lack of resources in their environments. What could be done to meet these patients “where they were”? One of the Bridges constructs emphasizes the importance of stabilizing the environment and removing barriers. How would we do that in dentistry?

Knowing the value in community collaborations and non-traditional dental outreach via the Klamath Project, AD began by looking at vulnerable populations: pregnant women, young children, school-age children, mental health patients, adults with disabilities, and geriatric patients. We looked at the intersection of poverty with other social disparities in order to address inequalities in relation to accessing resources. We developed collaborations with community partners to help deliver the messages of oral health and dental health equity.

Constructs changed how we planned, how we viewed our patients, and how we came to understand how we use our own “economic class lens” to communicate with patients who have a very different experience and focus.

As we looked at the mental models Bridges uses to illustrate the concrete experience of economic class, we realized that at all levels organizations tend to design and plan from a middle-class perspective. We had always collaborated with our “community”: The international Bridges community involves brilliant people from all

socioeconomic classes across the U.S. and beyond to come together to forge systemic change at the institutional and community levels, giving us the opportunity to talk with people who use Bridges in health and healthcare, as well as in building sustainable communities. What we needed to add was a lens of understanding of the population we were serving; those living in poverty.

At-Risk Children and Youth Populations

In the WIC program, parents (primarily mothers) bring their young children to get recertified for benefits. AD works with WIC to place expanded-practice dental hygienists at the WIC office to perform free oral health screenings and fluoride varnish treatments on the young children from birth to age five. These screenings allow us to provide preventive services and detect problems early. We can then triage the children to their primary care dentist. Data from the assessment are entered into an electronic system, which generates an e-mail to the dentist of record and AD’s case management system. This allows the case managers to help those with the highest urgency get appointments in a timely manner. When indicated, we will help the parent call from the WIC site to set up the appointment with the dentist.

We find less than one percent of these patients have urgencies of infection, pain, or rampant decay, and hope the preventive services will decrease that even more. Mothers are receptive to the screenings in this environment, where they already have trusted relationships. They almost

universally express that “I don’t want my child to have bad teeth like me” or to suffer from tooth pain.

Our hygienists are trained to use MI skills to promote relationship building for patient engagement. In the prenatal and/or preschool outreach setting, solicitation of what a mother does or does not know about taking care of her child’s teeth begins a reciprocal conversation and avoids the paternalistic approach of “talking to” as opposed to “talking with”. Here a parent may be asked, “Would you like your daughter to keep her teeth for her lifetime?” And asking a parent “When is the best time of the day to brush your child’s teeth?” sets the expectation that it can happen in the future. It gives the message a future focus and

helps the parent plan for the upcoming event of cleaning the child’s teeth. Once a relationship is established, “change talk” can be elicited by asking someone waiting for an emergency dental procedure, “Would you like to hear some ideas about how to avoid being in the pain you’re in today?” or “How does constant tooth pain interfere with things you would like to do?”

Different environments in which we live will provide us with different insights and motivations.

The Bridges context can teach us to be aware that different environments in which we live will provide us with different insights and motivations. Not everyone is motivated by choice and future story; some are motivated by survival, entertainment, connections, and relationships. The dialogue begins with AD staff “seeking first to understand”⁵. Additionally, we have trained home-visiting nurses to apply fluoride varnish on young children’s teeth while in the home

setting, reducing the barrier of scheduling a dental office visit. The hygienist also teaches oral hygiene and nutrition to pregnant mothers, offering a free dental assessment, giving out kits with toothbrush, floss, and toothpaste while triaging to care in the Prenatal Nutrition class of WIC. We promote our dental offices being able to get a pregnant woman in for an appointment within 10 to 14 days of her initial call.

Hygienists perform dental screenings on children kindergarten through sixth grade in the school setting. The school-based programs offer education to students about oral health care as well as assessments, fluoride varnish, dental sealants on permanent molars, along with kits that include toothbrush, toothpaste with fluoride, and floss. A “report card” goes home with the child telling the parent the level of urgency. We also reach out to screen Head Start children and relief nurseries.

One Head Start hosts a health fair at the beginning of the school year that includes a physical, vision screening, and oral health screening. If a child is reluctant to participate, we have him or her watch peers receive assessment and fluoride. Of the approximately one percent of these children who have urgencies of pain or infection, with the electronic data system, some can get triaged to care the same day.

Language and Relationship Building

We know there is little significant learning without significant relationships, and we continually assess the language registers, non-verbals, and communication styles that we use, while appreciating that not everyone will use and understand formal language registers. The Bridges language and communication concepts help us improve patient engagement while improving outcomes. This may seem like more time and funding

are being used, but in the long term money is saved, or it is a budget-neutral strategy.

We need to be aware that in poverty and related environments, information may be mainly communicated within an 800-word vocabulary called “casual register”. This is accompanied by a circular story structure that may not have information sequenced in terms of beginning, middle, and end. Casual register and story structure allow for good relationship building, but if one of our staff should glance at her watch, we know the relationship with that patient probably is broken. It may take longer to communicate with patients who don’t use the middle-class formal register and sequenced two-minute “get to the point” discourse pattern. Therefore, it is vital to structure services with time flexibility to ensure that all patients know they are both “seen” and heard.

The Hidden Rules of Poverty

Many living in poverty have their own “hidden rules” about oral health. Examples include:

- “I only go to the dentist if I have a toothache.”
- “I expect to lose my teeth someday.”
- “It’s just their baby teeth.”
- “Going to the dentist costs too much.”
- “Dentists are for rich people.”

Most of the women in the Klamath Project appeared to believe they must be lucky or rich to have good teeth.

One aspect of Bridges that helped us here was the understanding that even though doing “agency time” – going to various organizations for help – assists under-resourced individuals in gaining access to services, there

tends to be considerable distrust of organizations and “authority”. We understood the environment and the “hidden rules” of poverty enough to respect the story and experience of each person we encountered.

Reasons parents were not accessing care ranged from transportation issues to substance abuse treatment to doing agency time to domestic violence. The most common reason for not taking

the child to the dentist was the parent’s own fear of the dentist. One mother stated, “Well, she isn’t complaining that it hurts”, offering an opportunity to help her understand our main message, that her child could keep her teeth for the rest of her life. The pain and embarrassment of

missing teeth and gum disease have been experienced from generation to generation for many in poverty.

Our goal is to keep interventions from being punitive. Our concern is that if it becomes punitive, some parents would stop consenting to the school preventive services. That said, as mandatory reporters, we will report to Child Welfare when appropriate and as necessary.

Integrated Health

Oregon launched coordinated care organizations across the state in 2012 to integrate physical health, oral health, and mental health. The goal of this integration was to meet the triple aim of improving patient experience of care, improving population health, and reducing costs of care. The rural poverty population in Oregon is not very diverse ethnically in most areas, but there is a high rate of poverty.

Vulnerable Adults. Our Coordinated Care Organization (CCO) team developed an expanded

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We know there is little significant learning without significant relationships.

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care clinic for individuals with comorbid conditions of diabetes and severe and persistent mental illness. We integrated a hygienist to work alongside the physician to do oral health screenings and education.

At an Integrative Administrative Workgroup of the CCO meeting, the Executive Director of Mental Health and one of the authors brainstormed the idea of doing oral health screenings in the mental health setting. On the first day of screenings in this setting, they discovered two patients with abscessed teeth. Now, if we find patients whose mental health diagnosis interferes with their ability to access care, the mental health organization will assign a case manager to help them get into their dental home.

A local brokerage case-manages 250 adults with disabilities. We ask that caregivers of the patient come to the screenings so we can help educate them about oral health care for the patient, and we distribute toothbrush kits and triage to care as needed. Many of these patients are more comfortable with the screening outside of the traditional dental office.

The Urgent Chair

Understanding that many in poverty have difficulty doing future planning, knowing that most have had limited dental care/coverage, and being aware

of their hidden rules about their teeth, we realize that every day there will be a certain number of patients who will have unexpected emergencies. In each of our 35 clinics, we plan for such urgencies by having a third chair and emergency time set aside for patients in pain. During one week this past spring, in 18 clinics we handled 327 emergencies. We also have a special fee and financing for anyone with an urgent situation who is uninsured. Our policy of turning away no one in pain due to inability to pay allows us to treat patients in the appropriate setting instead of having them end up in the hospital emergency room.

A tool we use every day is the Bridges resources model that reminds us that each patient has strengths and is a problem solver. This includes assessing financial resources, of course, but goes beyond this to looking for strengths in cognition, coping skills, spiritual and cultural strengths, physical health, and the extent to which the patient has bonding social capital (our inner circle of friends and family) and bridging capital (those beyond our circle who support our health, wellness, and other areas of sustainability). As individuals, institutions, and communities, we seek to build more than dental health; we are building critical resources together with our patients.

Conclusion

Author Robert Sapolsky⁶ tells us “human relationship is a sledgehammer that obliterates every societal difference”. The Bridges Out of Poverty concepts are helping us to not just remove barriers, but cut them down at their roots. Rapport-building with organizations and engaging them to help spread the message that decay has a bacterial cause that is generally transferred from the primary caregiver (usually the mother) to the child through saliva is paramount to the outreach model being successful. We want to help spread the word about oral health across the lifespan from prenatal to end of life.

Finally, we have found that taking oral health science to the people in their own particular locations allows us to touch more lives outside of the traditional oral health care setting. ■

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“Of all the preposterous assumptions of humanity over humanity,
nothing exceeds most of the criticisms made on the habits of the poor
by the well-housed, well-warmed, and well-fed.”

Herman Melville