COHI
Connecticut Oral Health Initiative

NOVEMBER 2024

ASSESSING BARRIERS TO ACHIEVING GOOD ORAL HEALTH FOR CONNECTICUT RESIDENTS

FUNDED BY

CareQuest Institute for Oral Health

ACKNOWLEDGMENTS

The Connecticut Oral Health Initiative (COHI) thanks the CareQuest Institute for Oral Health for funding this project, COHI's Board of Directors for their support, and the staff and volunteers who contributed. COHI also thanks the community partners who assisted in the research and this report.

About COHI

COHI is a 501(c)(3) organization founded in 2001, focused on strengthening and safeguarding access to quality, affordable oral health services for all Connecticut residents. COHI does this work by advocating for statewide policy changes, communicating the impact of structural and social factors on oral health, and promoting the necessity of good oral health for overall health and well-being. COHI envisions a Connecticut where residents achieve equal opportunity, regardless of race, ethnicity, or socioeconomic status, to the services needed to maintain good oral health.

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EXECUTIVE SUMMARY

Although one of the wealthiest states in the country, Connecticut is also one of the most inequitable in terms of income disparities. Income inequalities are associated with significant gaps in access to quality health care in general, and have resulted in unequal access to quality oral health services. These disparities in access greatly affect racial and ethnic diversity, as well as rural and urban communities with limited resources resulting in an inequitable oral health care system for a large percentage of Connecticut's residents.

The Connecticut Oral Health Initiative (COHI) is a statewide non-profit organization dedicated to strengthening and safeguarding access to quality, affordable oral health services for all Connecticut residents. In 2022 and 2023, COHI conducted two studies on Medicaid service delivery: (1) the Medicaid Gap Analysis[1] that examined gaps in adult Medicaid oral health care utilization, and (2), an examination of private providers' perspectives on the challenges and advantages of providing Medicaid oral health care services. To expand on the Medicaid Gap Analysis and to examine more closely barriers to dental treatment, in 2023, COHI carried out a statewide survey to explore patient perspectives on barriers to treatment, maintenance of good oral hygiene, and the impact of the type of insurance on the achievement of good oral health across ethnic/racial and income groups.

Survey data were collected from a widely representative sample (700+) of consumers of oral health care spread across 91 different communities throughout the State of Connecticut enrolled in Medicaid, private insurance, or with no insurance at the time of the survey. Respondents were equally distributed across the main racial-ethnic groups in the state (Black, White, Hispanic), with smaller numbers of mixed, Asian Pacific, and Indigenous people respondents. The sample sought and recruited more lower-income ($49,000 and below) than higher-income ($50,000 and above) households and included an approximately equal number of people who were enrolled in Medicaid public insurance or private insurance, or had no insurance.

The survey study sought to answer three main questions:

1. Does the type of insurance (Medicaid, private, or none at all) make a difference in oral health treatment access and oral hygiene behaviors and perception?
2. What are the most common barriers to dental treatment faced by CT residents and are they associated with the type of insurance they have?
3. How do ethnicity and income interact with type of insurance, oral health treatment access, and oral hygiene behaviors to illustrate inequities in treatment, barriers to care, and oral health?

Summary of Findings

- 22.5% of participants reported difficulty finding a dentist and 38.4% of participants said their last visit was longer than a year ago or didn't recall their last visit. Of those who had difficulty finding a dentist, a significantly higher percentage were enrolled in HUSKY Health (Medicaid) (53%) than those with private (38%) or no insurance (7.5%).

- Over 50% of the participants reported one or more barriers to accessing oral health care with the most frequently mentioned barriers being fear of the dentist (21.6%), inconvenience of dental office hours (21.6%), and excessively long wait times for an appointment (18%).

- Individuals enrolled in HUSKY Health (74%) or with no insurance (13%) reported more fear of seeing a dentist compared to those with private insurance (12%).

- Only 44% of the participants considered their oral health to be good and conversely, about 56% considered it to be fair or poor. Individuals enrolled in HUSKY Health and those with no insurance considered their oral health to be worse than those with private insurance.

- 33% of participants reported brushing less than the recommended twice a day, and 43% of participants reported flossing less than the recommended once a day. Individuals enrolled in HUSKY Health brushed less frequently than those with private or no insurance.

- There are inequities in the geographic, racial, and ethnic distribution of dental care that can partly be attributed to income levels, which are connected to the type of insurance. In this survey sample, those with higher incomes and those who were African American/Black had better oral health access and oral at-home hygiene behavior than lower-income Hispanics and Whites.

Summary of Policy Recommendations

Based the study's results, COHI recommends the following to policymakers, administrators, oral health providers, and other stakeholders to reduce the barriers and improve oral health for all of Connecticut residents in the following areas:

- **Reducing the fear of dental treatment will help more consumers receive needed preventative and restorative dental care. COHI recommends:**
  - Providing additional training to direct care oral health providers and front office staff on how to build trusting relationships, improve cultural competency, and enhance communication with patients who experience anxiety.
  - Improving provider standards for explanations for oral health exam and treatment plans.
  - Enhancing collaboration between oral and medical professionals to ensure approaches to treatment that reduce fear and anxiety.
  - Educating consumers on oral health literacy and empowering them to advocate for their own care.
- **Reducing the barriers to accessing a dental appointment or being able to afford services will help increase the utilization of services. COHI recommends:**
  - Offering more flexible appointment hours for all consumers.
  - Developing a better and real-time Medicaid provider availability search database.
  - Increasing Medicaid reimbursement rates to recruit and retain more providers in the HUSKY Dental network.
  - Expanding oral health mobile care units, especially in rural areas.
  - Implementing the dental therapy profession into public health to expand provider availability.
  - Evaluating gaps in Medicaid benefit coverages and exempting preventative services from the annual maximum benefits cap on adult services.
  - Enhancing non-emergency medical transportation system reliability.

- **Good oral health must start at home with good oral hygiene and a healthy lifestyle, as well as the knowledge to utilize annual preventative care visits and seek restorative care when needed. COHI recommends:**
  - Improving educational materials and training to teach individuals how to properly brush, floss, and maintain good oral health.
  - Improving the cultural competency of oral health providers through additional training, to ensure that they can obtain a sound understanding of patients' oral health cultural beliefs and practices, and communicate more effectively how patients should care for their teeth and gums.
  - Developing improved messaging and more effective strategies for tailoring oral health literacy and at-home hygiene to different age, gender, and ethnic groups.
  - Integrating oral health into primary medical care to expand the number of medical providers who can convey the importance of oral health and health care to overall health.
  - Create peer oral health champions, such as community health workers and peer educators, who can provide trusted information to adults on Medicaid about good oral health hygiene practices.

An appendix can be found at:
https://www.ctoralhealth.org/assessing-barriers-report/appendix-accessing-barriers-report

Oral Health Disparities in Connecticut

While Connecticut has one of the highest average incomes per resident, it also ranks as one of the most inequitable states in the country in terms of income disparities.[2] The unequal distribution of income across the state is directly associated with gaps in access to quality health care in general, as well as oral health care. In Connecticut, the lower the income, the greater the potential for poor quality health and oral health care, and greater health and oral health disparities.

Despite the high cost of dental treatment, Connecticut is regularly recognized as one of the states ranked highest for its residents' dental health including, access, utilization, and overall oral health.[3, 4] These data are based on averages and are biased by the state's large number of wealthier residents who have access to better quality dental insurance, and can afford the high out-of-pocket costs for dental care. They are less likely to be affected by the inequitable distribution of negative social determinants of health that result in oral health disparities in racial/ethnic and other economically and geographically marginalized groups across the state.

Examples from Recent Reporting on Oral Health Disparities in Connecticut:

- Over half of adults enrolled in Medicaid's HUSKY Health, did not seek any annual reimbursable treatment for which they were eligible, in each year from 2016 and 2020.
- Of the over 1,300 total active dentist offices in the state, only about ⅓ accept Medicaid and approximately 20% of those offices can easily be reached by public transit.[5]
- Among Connecticut's kindergarten and third graders, children from lower-income families have a higher prevalence of every major category of dental decay. There are also racial and ethnic disparities. Asian children had the worst dental decay, followed by multiracial, Hispanic, Black, and White.[6]
- Vulnerable lower-income older adults in Connecticut have significantly more untreated dental decay, substantial tooth loss, and are more likely to be edentulous (no natural teeth) compared to the general population of older adults in the United States. These rates vary by racial and ethnic group.[7]

Earlier COHI Studies & Policy Change

In 2022-23, COHI conducted a Medicaid Gap Analysis (MGA) of Oral Health Care for Adults in Connecticut focusing on adult (21+) enrollees in Medicaid and revealed that over 59% of enrolled individuals did not utilize their Medicaid benefits for dental services each year from 2016 to 2020[8]. The study highlighted significant gaps and barriers to obtaining quality and timely dental treatments, disproportionately affecting Black, Hispanic, and economically marginalized communities. Both state data sources and those individuals interviewed for the study reported consequences of barriers to treatment including insufficient or delayed general and periodontal treatment, tooth loss and replacement with dentures, and limitations on coverage for certain needed services. The medical consequences of delayed treatment or treatment gaps are long term exposure to pain, periodontal disease and dental caries that if not remedied lead to unnecessary tooth removals, and secondary infections with implications for cardiovascular and other serious health conditions.

In a second study, "Expanding The Oral Health Private Provider HUSKY Network: An Assessment of Results of Increased Reimbursement Rates and Provider Participation in Connecticut", over 200 private provider dentists shared their perspectives via an online survey on the challenges they faced in providing adequate treatment for Medicaid enrollees[9]. The systemic or structural problems that were discovered included inadequate reimbursement rates, burdensome paperwork, and lost revenue as a result of unreimbursed missed appointments. Providers also mentioned frustration at the inability to provide needed non-reimbursable treatments such as dental implants, replacement of dentures as needed, and timely replacement of crowns on an as-needed basis. This report which focused purely on the oral health provider perspective echoed many of the difficulties reported by enrollees in Medicaid when trying to access quality oral health care.

Role of COHI in Advocating For Oral Health Equity

For over twenty years, COHI has been a leader in the State of Connecticut in advocating for better oral health of all of Connecticut's residents, most especially individuals from medically underserved communities that face racial, ethnic, and socioeconomic inequities. Recent advocacy includes expanding services covered under Medicaid, increasing private provider adult Medicaid reimbursement rates, and expanding eligibility to public insurance programs.

COHI's vision is for all of Connecticut residents to have equal opportunity to obtain the services needed to maintain good oral health. To better understand, create awareness, and develop policy recommendations to overcome current barriers that are creating inequities and disparities to oral health services for Connecticut residents, COHI has conducted a series of quantitative and qualitative studies over the last few years. This report is the most recent of these studies and focuses specifically on consumers of oral health.

In this third study, we report on the results of a survey administered in Connecticut in 2023 to explore patient perspectives on barriers to treatment, maintenance of good oral hygiene, and the impact of different types of insurance on achieving good oral health. The goals of the survey were to increase awareness of existing problems and disparities that exist from the perspective of patients including Medicaid enrollees, and to inform policy and strategies for reducing resident as well as provider barriers to achieving oral health for all in Connecticut.

Despite best efforts made by the State of CT to enroll those eligible, and to notify them about their benefits in the Medicaid/HUSKY Health dental program, the MGA report showed that each year from 2016 to 2020 there were no claims for reimbursement from 59-70% of enrollees and on average 30% or less of the claims were under $500, which is 50% of the state's $1,000 annual maximum adult benefit cap. The MGA did not answer specifically why utilization of annual benefits was so low, but it did partly unveil some of the reasons based on the barriers adult Medicaid enrollees face, including the unequal distribution of providers in some parts of the state where the need is great. The study also pointed to the critical need to understand more about the barriers all residents, and especially Medicaid enrollees, face in accessing dental treatment and quality care.

This new report focuses on the challenges in accessing treatment in a large sample of consumers of oral health care who live in the State of Connecticut including those enrolled in Medicaid and other forms of insurance. It explores differences reported by those across Medicaid, private insurance, and uninsured people in areas such as oral health treatment access, barriers to care, and oral hygiene practices.

The study asks several main questions:

- **Does the type of insurance (Medicaid, private, or none at all) make a difference in oral health treatment access and oral hygiene behaviors and perception?** This study included consumers and patients with different types of insurance, making it possible to compare the relative benefits of Medicaid and private insurance, and to examine the implications of having no insurance at all.
- **What are the most common barriers to dental treatment faced by CT residents and are they associated with the type of insurance they have?** This study asks about exposure to 13 different barriers to quality dental care that emerged from reports in prior studies and compares them across Medicaid, private, and uninsured consumers.
- **How do ethnicity and income interact with type of insurance, oral health treatment access, and oral hygiene behaviors?** There is considerable evidence to suggest inequities in the distribution of treatment and barriers to treatment across ethnic groups. These inequities may be attributed to differences in household income within ethnic groups. In this study we examine inequities across three major ethnic groups, and the interaction of ethnicity with household income to understand how class (income) differences intersect with ethnicity in relation to dental treatment access.

The responses provide valuable information on policy and practice approaches to reducing barriers to improve access to regular annual dental visits, especially in Medicaid-eligible populations, and show the need for more effective strategies tailoring different types of messaging to different groups, to improve oral hygiene.

OVERVIEW OF SURVEY DEVELOPMENT

As part of a statewide Oral Health Access and Equity Campaign, COHI developed an anonymous survey to be implemented with attendees at local events organized by COHI or by organizational partners. The survey was created in English, translated into Spanish by a native Spanish speaker and back-translated. It was administered in the language of preference of the respondent. The survey was designed to be completed in less than 15 minutes. It was administered in multiple locations where large numbers of people were gathered for other purposes, such as oral health education events, health fairs, job fairs, back-to-school events, and in other public health education settings that included a wide diversity of populations.

COHI staff assisted individuals with the completion of the survey when requested because of difficulty with reading or understanding the questions. Almost all surveys were completed on paper, entered by hand into Survey Monkey, and double checked by COHI staff with data entry experience. The small number of online surveys were collected through Survey Monkey to complete the database. All 719 participants were included in the analysis of the data.[10]

Distribution of Survey Responses

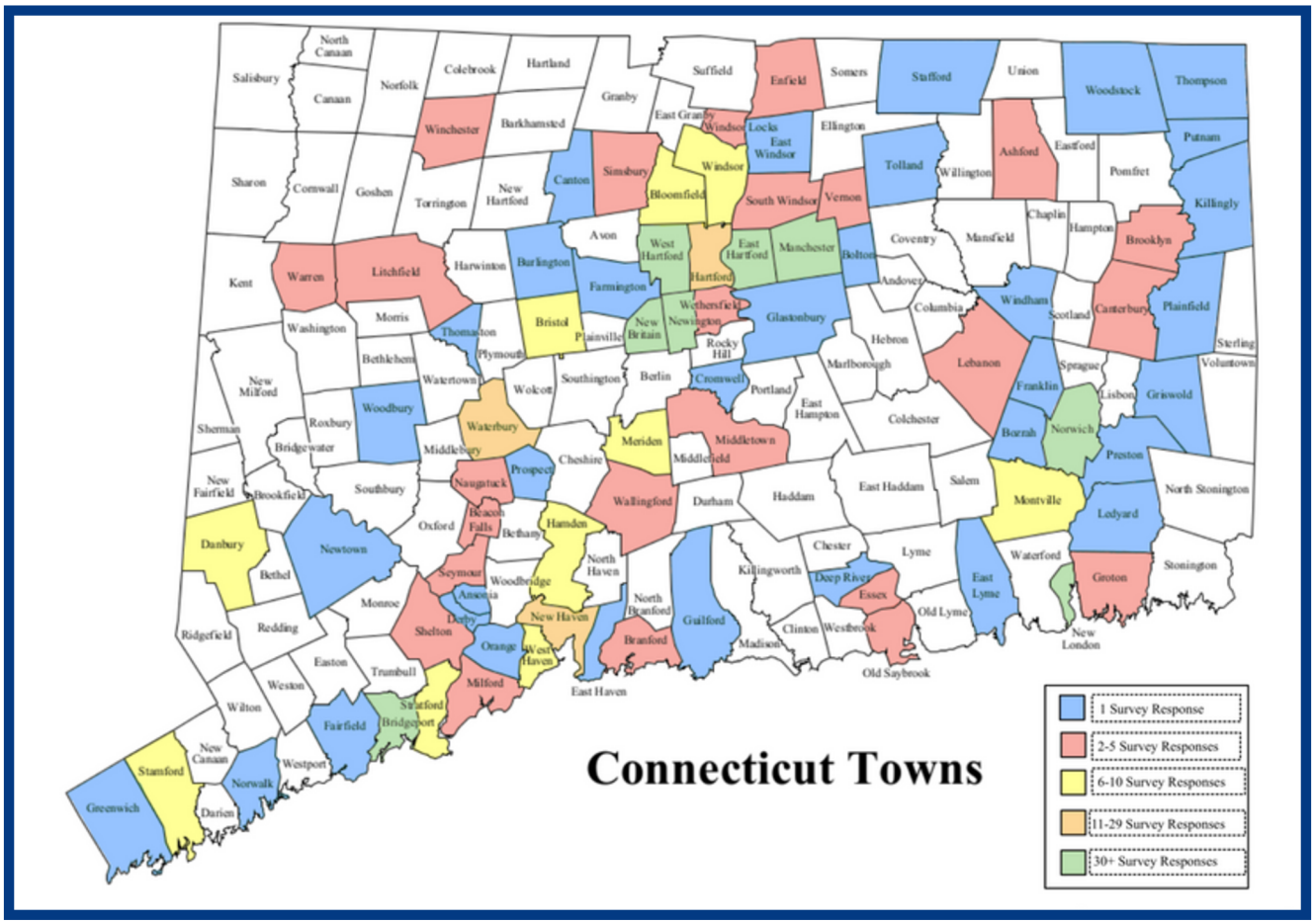
We anticipated that in Connecticut, people faced more barriers to dental care in locations with more limited economic resources. For this reason, respondent recruitment was designed to reach a broad diversity of people by age, gender, ethnic/racial group, income, and from urban areas and small rural towns. While we thought it was likely that people with no insurance would face oral health challenges, we also thought that those enrolled in HUSKY Health or private insurance could face similar barriers. So recruitment included people with any kind of dental insurance as well as those without any insurance coverage.

Survey data were collected in person from 21 geographic locations across the state of Connecticut with a few people responding online. Many of the sites were at health fairs, where COHI staffed a booth; several were at events attended by COHI that were sponsored by specific organizations such as an American Legion or Federally Qualified Health Center.[11]

Though half of the surveys were collected from just a few sites where community events attracted a large attendance, the respondents who completed the surveys came from 91 of 169 separate municipalities across the state. The approach to data collection through solicitation at large community events was successful in attracting a fairly geographically representative sample of people. The map below shows where specific numbers of people were recruited. The largest number of people were recruited from Hartford, 284, or 39.4%; This is not surprising since many of the recruitment sites were in Hartford. The next largest number came from New Haven, 63 (8.4%). Other cities included Groton/New London with 21 people (3%), followed by Waterbury (34 people, 4.7%) and East Hartford (21 people or 3%), Bridgeport (16, or 2%), and New Britain (19 or 2.6%). 70% of all respondents were from larger urban or larger town locations. Only 10 of the 91 towns mentioned had more than 2% of the total sample. The 81 remaining towns each were represented by less than 2% of the total sample.

Chart 1.0: Connecticut Towns Included in The Study

The map below shows the reach and spread of the recruitment effort. The locations with the largest number of respondents also have some of the highest rates of poverty in the state, two to three times higher than the average poverty rate in CT in 2022, of 9.8%. For example, Hartford's poverty rate was 28.1%, New Haven's 26.6%, Waterbury's 23.4%, New Britain's, 21.7% and New London's 24.5%.



Demographics

Chart 1.1: Age

The age range of the population in the study was 12 – 82. We grouped people into five age groups (0-20 21-40, 41-50, 51-64 and 65 and over. Most people were adults and between the ages of 21 and 64 and potentially eligible for enrollment in Medicaid.

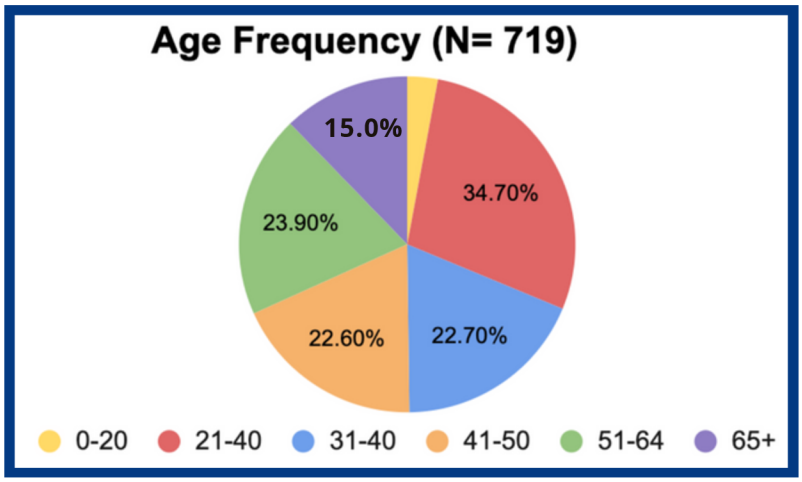
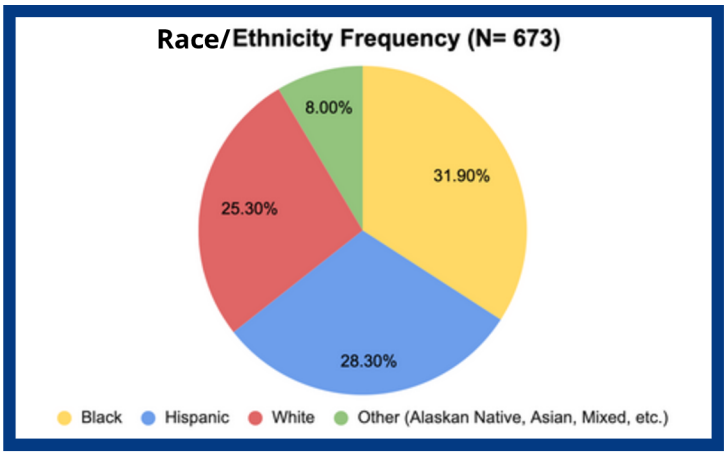


Chart 1.2: Race/Ethnicity



The race/ethnicity of the study population based on self-reported data was mainly Black (31.90%), Hispanic (28.30%), and White (25.30%). Only a small number identified as Asian, Alaskan Native, or mixed.

Chart 1.3: Household Income

Income was divided into four groups: 50% of the sample earned $0 to $29,000, 30% earned $30,000 to $70,000, and 11.7% earned over $70,000.

Most households reported multiple members. The Medicaid income cutoff is $34,341 for three-person households and $41,496 for four-person households, indicating that at least 68% of the sample (earning $0 to $49,000) may qualify for Medicaid/HUSKY Health.

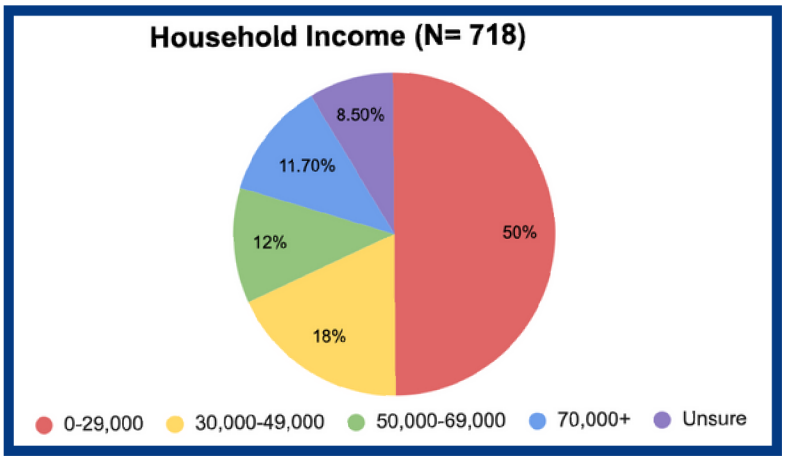
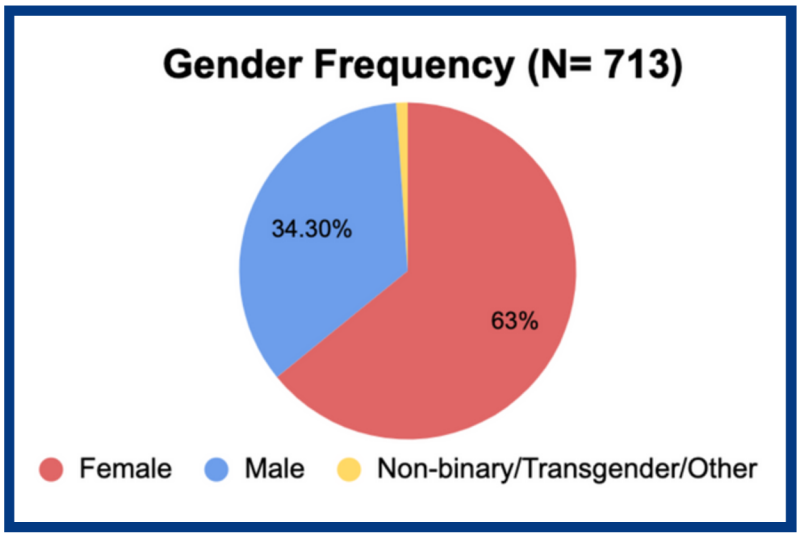


Chart 1.4: Gender

Women made up about two-thirds of all the respondents (64%). Approximately one-third of the sample consisted of men, (34.6%), and the rest (2%) were nonbinary or transgender. This may mean that the approach used did not attract as many men to public events, or to fill out surveys, and may not have attracted those who identify as transgender or nonbinary.[12]



Dental Treatment Access

Chart 1.5: Dental Insurance

Access to dental treatment can depend on the quality of insurance coverage held by an individual. Private and public insurance sources function differently and offer different coverage with different reimbursement rates. Insurance reimbursement options and rates, and provider ease of access as a result of those rates can have a great deal to do with how difficult it is to find a dentist, and follow American Dental Association guidelines for obtaining a dental checkup and cleaning at least once or twice year. Barriers to treatment may apply at any stage from finding a dentist to obtaining service that meets patient needs.

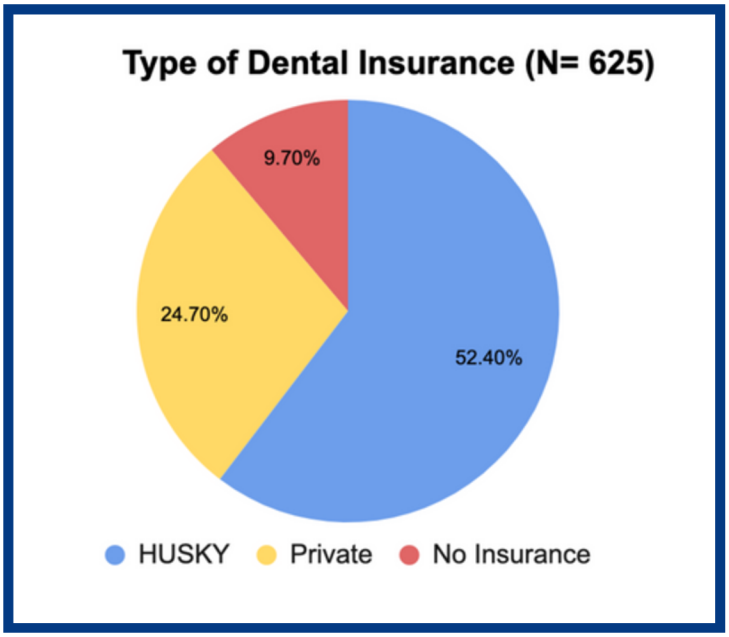


Chart 1.6: Finding a Dentist

In response to a specific question regarding whether or not a respondent had difficulty finding a dentist, 22% reported difficulty finding a dentist while 77% of the total population reported having no difficulty finding a dentist. Difficulty finding a dentist was reported as a problem in the 2022 Medicaid Gap Analysis. Some of the main reasons for difficulty cited in that report included distance to a dentist's office, lack of dentist office willingness to accept Medicaid, and long waits for an appointment.[13]

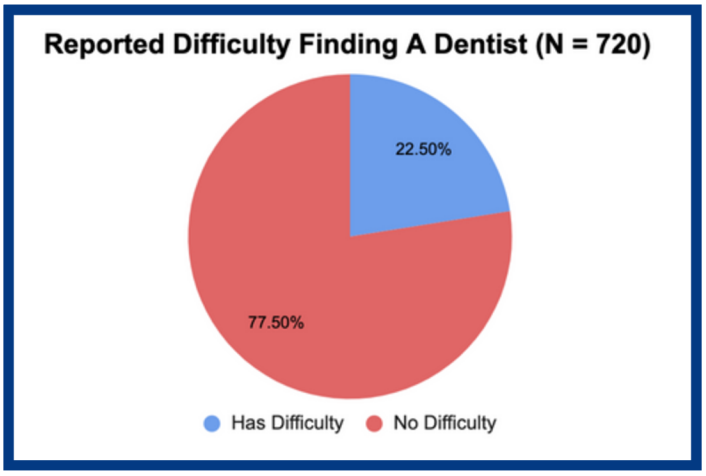
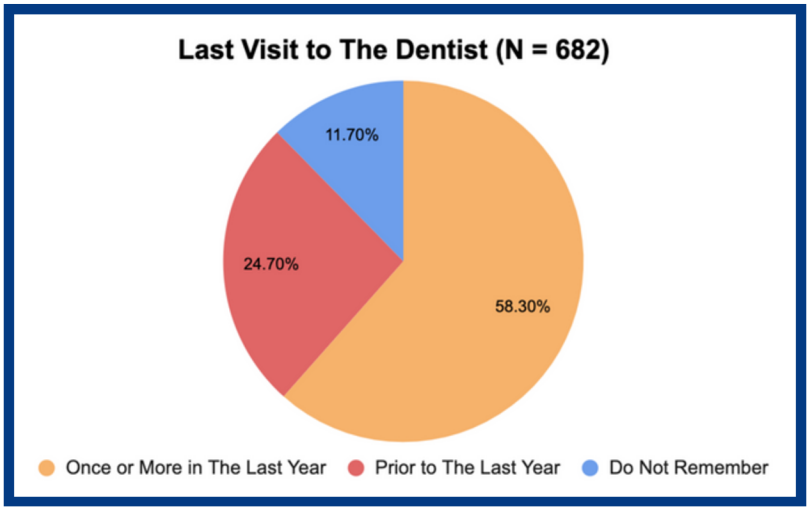


Chart 1.7: Dental Visit

The American Dental Association (ADA) and most other sources of oral health support and advocacy recommend at least one visit to the dentist each year, for a checkup, screening of teeth, gums and palate, and cleaning. 61% of respondents reported that their last visit to the dentist was within the past year, meaning that they had gotten at least one annual checkup. 38.8% said their last visit was longer than a year or didn't recall when their last visit was. If they could not recall their last visit, we assumed that the last visit was not in the past year. This rate of 61% reported visits may seem significantly higher than that reflected in the adult HUSKY enrollment Medicaid database from 2016 to 2020.[14] However, the data reported here are based on consumer recall, and include people on private insurance, whereas data used in the Medicaid Gap Analysis report are based on the CT Department of Social Services's Medicaid reimbursement reports over a five year period.



Barriers To Care

COHI's previous Medicaid Gap Analysis (MGA) Study emphasized the need to better understand and address barriers to treatment in order to increase the number of Medicaid enrollees taking advantage of their right to accessing oral health care per year. Using data from in-depth interviews conducted during the MGA study with Medicaid enrollees, we identified the most frequently mentioned barriers to care, ranging from structural problems such as transportation, difficulty getting appointments, coverage issues, and fears of going to the dentist.[15]

Chart 1.8: Total Reported Barriers

49% of the sample (n=351) reported that they did not experience any barriers to treatment. Half the sample (50.1%) said they did experience at least one barrier to care. Most people who reported any barriers chose only one of the possible barriers, but 13% of the total sample reported more than one barrier. This enabled us to consider the association of barriers to care with other factors, later on in the report.

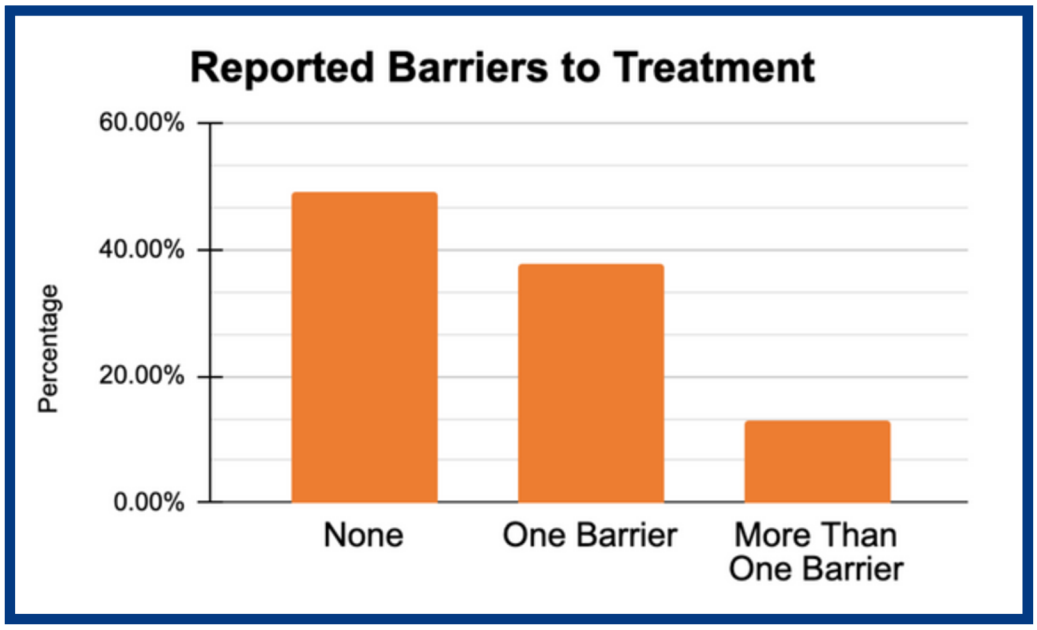
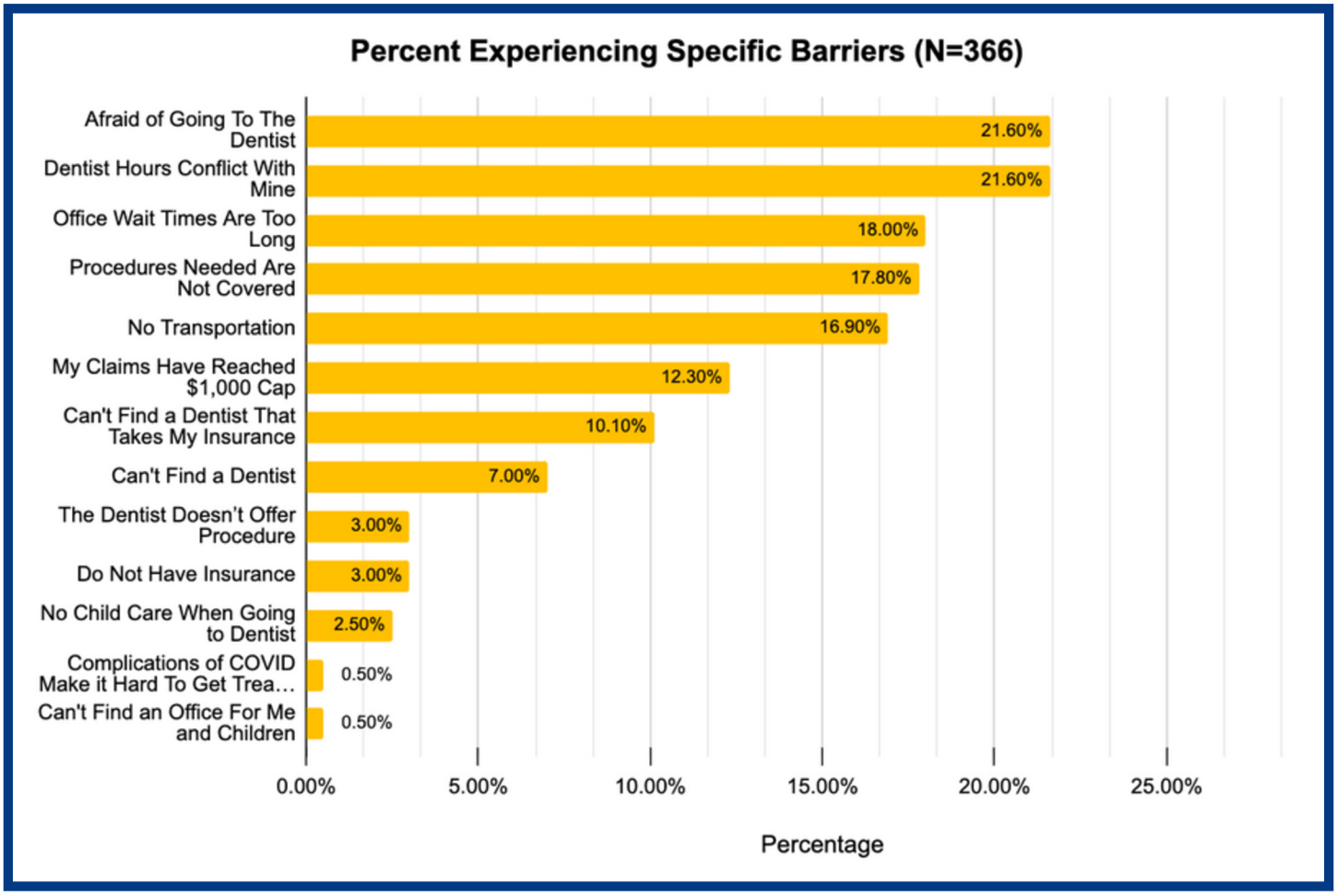


Chart 1.9: Barriers To Treatment

For those that reported at least one barrier to treatment, the types of barriers and percentages reported are shown in the below chart. The most frequently mentioned barriers were fear of going to the dentist, conflicts with hours of service, wait times, and insurance or procedure coverage issues.



Oral Health and Hygiene

The way a person rates or describes their own oral health provides useful information about their perception of their general health, their teeth and mouth, the way they present themselves to others, and how often they go to the dentist for regular checkups and cleaning.

Chart 2.0: Oral Health Rating

We asked participants to rate their own oral health as good, fair, or poor. Only 44% of this sample considered their oral health to be good and conversely, about 56% considered it to be fair or poor[16]. This is consistent with other limited-resource settings in the U.S. and globally where there are challenges to treatment access as well as nutritional and general health challenges.

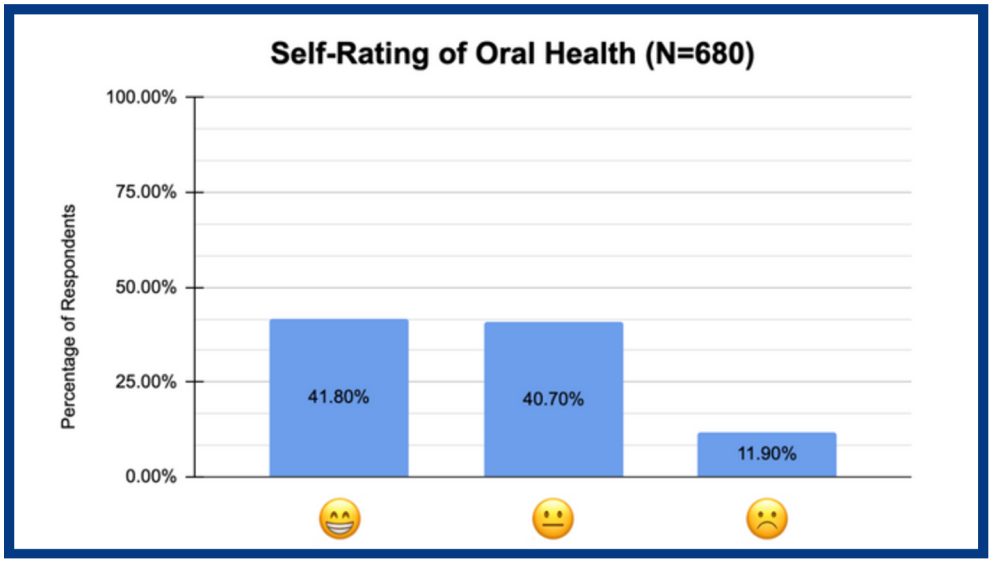


Chart 2.1: Brushing

To preserve good oral health, daily oral hygiene care is highly recommended by the American Dental Association, and dentists' offices. Dentists and dental professionals and educators recommend brushing your teeth at least twice a day and flossing at least once a day.[17] Oral hygiene is critical to reduce risk of dental cavities, periodontal disease and gum and tooth infection.

In our sample, 66.4% reported brushing their teeth at least twice a day, 29.9% reported brushing less than that, and less than 3% reported not brushing at all. Thus 33% were not brushing at the optimal level, recommended by the American Dental Association.

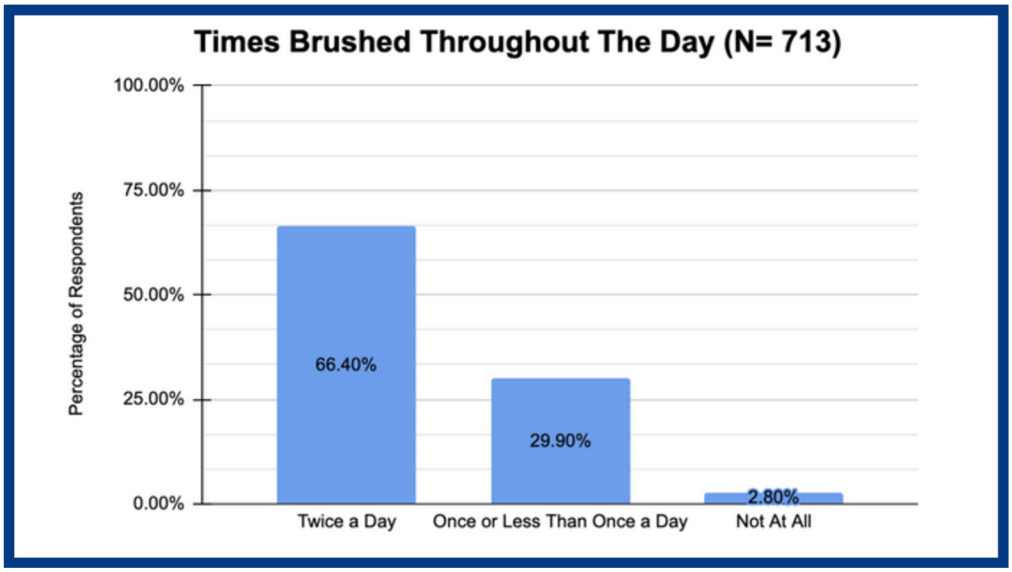
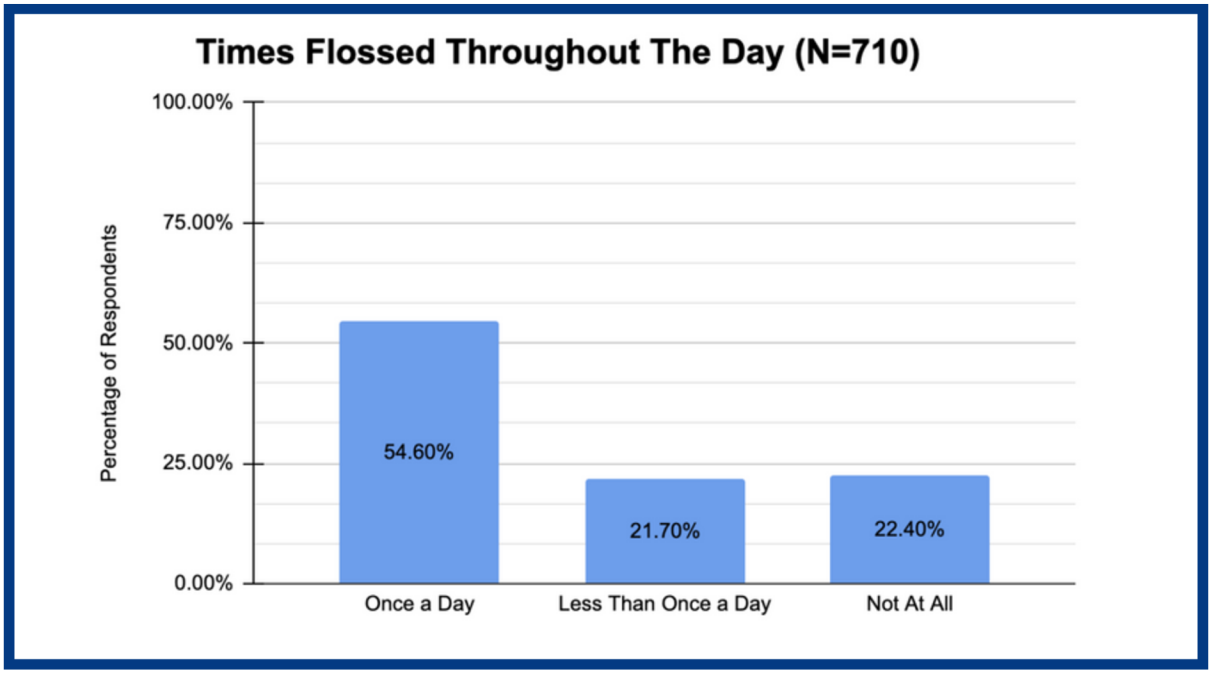


Chart 2.2: Flossing

While brushing is very important for removing plaque from the front and back of the teeth, it does not remove plaque from between the teeth and under the gums as well. This accumulated plaque transforms into a hard substance called tartar, and both plaque and tartar irritate the gums, resulting in gum (gingival) irritation, gum erosion, and potential infections, with periodontal disease and tooth loss as the outcomes.

Proper flossing is essential to avoid these oral health problems that often require treatments that Medicaid may not cover, or require a high patient out-of-pocket costs for consumers.[18]

Flossing is less frequent than brushing among participants in this study. More than half of respondents (55.4%) reported that they flossed once or more a day, 22% less than once a day, and 21% not at all. Thus 43% were not flossing at the optimum level and half of them did not floss at all. This strongly suggests the need for more oral health and hygiene education and demonstrations of flossing and related behaviors for cleaning between the teeth.



Demographic Differences across Types of Insurance

In this section, we ask what demographics are associated with the type of insurance that people in this study have access to, and whether the insurance they have makes a difference in their access to dental treatment, the quality of their oral health, and the degree to which they carry out oral hygiene practices considered best for health. We categorized reported insurance types into three groups: HUSKY Health (Medicaid), private insurance, and no insurance at all. Private insurance included all forms of insurance apart from Medicaid (e.g. VA, different insurance companies including Aetna, BlueCross Blue Shield, United, Delta Dental and other private insurance purchased independently or obtained through work).

Some people did not respond to the survey question about insurance. Others in the pilot stage of the study were not asked the question. In this analysis, those who did not or could not answer the question on the type of insurance were excluded where differences are reported. All analyses are conducted with the chi-square statistic, which assesses the probability of an association between variables.

Gender:

- More women than men reported enrollment in private insurance.
- Gender did not make a difference for those without any insurance.
- For LGTBQ+ and nonbinary people, the responses were too few to be included in the analysis.

Ethnicity:

- The percentage of enrollment in HUSKY Health was high across all ethnic groups, from 30% to 35% in each group.
- Blacks were more likely to be enrolled in private insurance plans in this study.
- Hispanics were more likely than others to have no insurance. Of the 64 people who reported having no insurance, 53% were Hispanics.
- A large number of white respondents were enrolled in HUSKY Health.

Age:

- The age of respondents was evenly distributed across the three insurance groupings, indicating that there was no significant variation in age among those within each insurance category.

Household Income:

- People with incomes of $0-$29,000 were more likely to be enrolled in HUSKY Health or to have no insurance.
- Older adults were more likely to have private insurance (complementing Medicare Insurance).

Type of Insurance and Utilization of Oral Health

The type of insurance may impact whether or not a respondent goes to the dentist as recommended, at least once a year, and how they rate their oral health. According to the survey data:

- 60% of people enrolled in HUSKY Health insurance had seen a dentist in the past year as compared to 75% who were enrolled in private insurance and only 40% for those with no insurance.
- 40% of those enrolled in HUSKY Health and those with no insurance rated their oral health as good. However, more enrolled in HUSKY Health (15%) rated their oral health as poor compared to those with no insurance (11%). More private insurance enrollees rated their oral health as good (53%) and fewer rated it as poor (8%).
- The majority of people (89%) reported being unafraid of going to the dentist. Of those that were afraid, a higher percentage (14%) of those enrolled in HUSKY Health said they were afraid of going to the dentist in contrast to 6% of those with private insurance and 13% of those with no insurance.
- Most people regardless of insurance, did not report difficulty finding a dentist (from 70-85% of respondents). Among those who did report difficulty, a total of 134, a higher percentage was enrolled in HUSKY Health (53%), fewer - only 38% - had private insurance, and 7.5% had no insurance, perhaps because this group was not looking for a dentist or were receiving free dental care.
- Although the differences are not significant across insurance groups, a higher proportion of people on HUSKY Health (53%) and those with no insurance (60%) reported experiencing one or more barriers to treatment than those with private insurance (37%).
- There is no significant association between flossing once a day as recommended and the type of insurance. People who flossed once a day or more were just as likely to be enrolled in HUSKY Health, to have private insurance, or to have no insurance.
- Those enrolled in HUSKY Health brushed less frequently than ideal. Those with private insurance and those with no insurance brushed twice or more a day more often. Those with no insurance may be brushing more often because they are concerned about the need for dental work, and brushing helps to prevent oral health problems.

Ethnic/Racial Comparisons

The study considered whether there were demographic differences by ethnicity, comparing African American, Hispanic, Mixed, White, or other and whether these same ethnic differences were associated with better or worse oral health access and self-management behavior. Unless noted as non-significant, the differences across ethnic groups are significant. This analysis has removed the much smaller numbers of people reporting mixed backgrounds, Asian Pacific Islanders, Native Americans, or no ethnic/racial identity.

Access and Other Oral Health Considerations

- African Americans were more likely to go to the dentist more often, Hispanics were more likely to be unable to remember, and Whites were more likely to go to the dentist less often.
- More Hispanics said they had no difficulty finding a dentist, while Whites had the most difficulty, likely due to a large percentage of Whites who completed the survey living in rural areas.
- More African Americans were likely to rate their oral health as good, and more Whites were likely to rate their oral health as poor.
- Fewer African Americans feared the dentist, and more Whites but this association was not significant.
- More African Americans were likely to brush as recommended, and fewer Whites. Hispanics were in between.
- More African Americans and Hispanics were likely to floss the ideal amount, more Whites were less likely to do so.

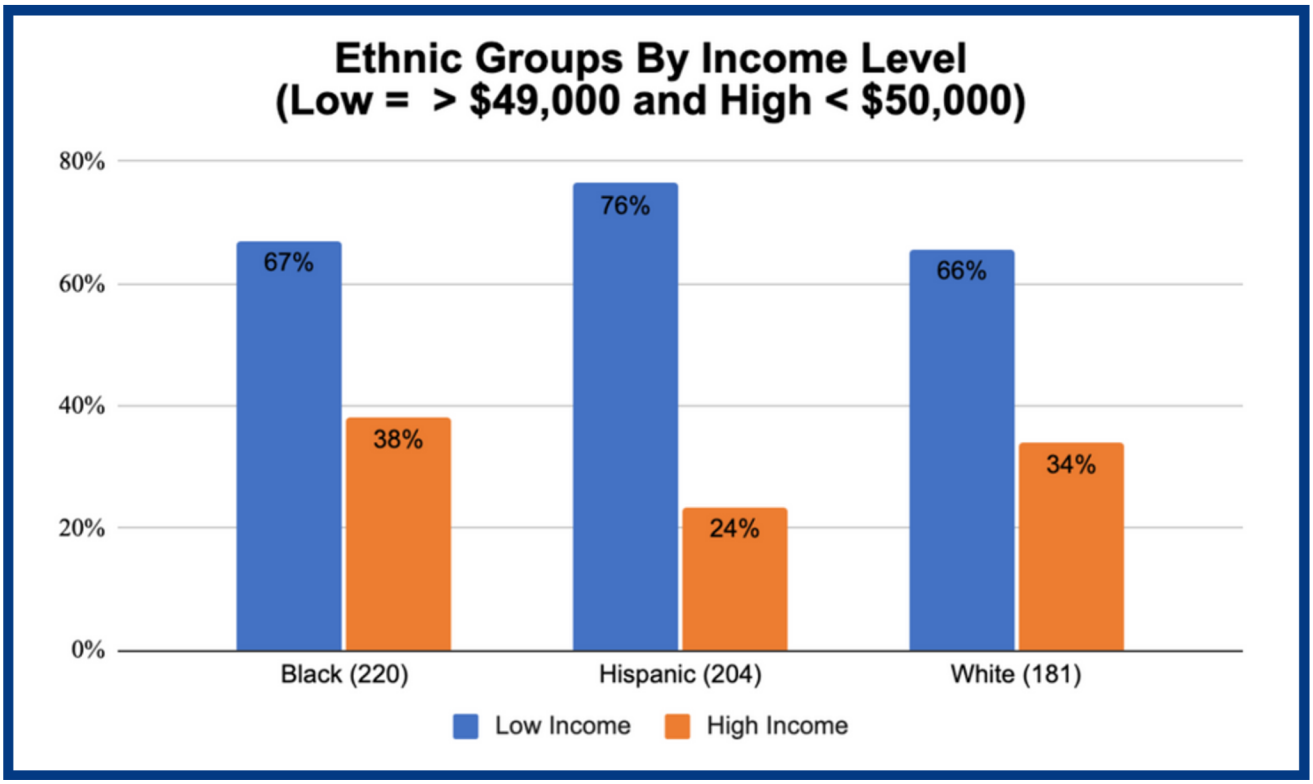
Income Differences by Race/Ethnicity

Chart 2.3: Ethnic/Racial Group Comparison by Income

The study showed earlier that income levels make a difference in terms of insurance and other factors. In this final part of the report, we look more closely at the interaction of ethnicity and income levels. We divided the sample into six groups, Black, Hispanic, and White respondents with lower incomes (3 groups) and with higher incomes (3 groups). Lower income was defined as those with household incomes reported from 0 to $49,999. We questioned whether people in the lower income category in each of the ethnic groups would fare less well than those with higher incomes in terms of oral health access and behaviors.

Sixty-nine percent of the total sample (422/615) was in the lower income category, 0 - $49,000 per household: 64% of Blacks, 76.5% of Hispanics, and 67.7% of Whites. The highest percentage of lower-income Households was among Hispanics.

The table below shows the frequencies of the six groups by ethnicity combined with income level: low and higher income Blacks, Hispanics and Whites.



Enrolled in HUSKY Health:

- Among Blacks, 65% of low-income, and 44% of higher-income Blacks were enrolled in HUSKY Health.
- Among Hispanics, 57.5% of lower-income and 68% of higher-income Hispanics were enrolled in HUSKY Health.
- Among Whites, 74% of lower-income and 43% of higher-income Whites were enrolled in HUSKY Health.

Though more lower-income people in all ethnic/racial categories were enrolled in HUSKY Health, the highest proportions were among lower-income Whites and higher-income Hispanics.

Enrolled in Private Insurance:

- Among Blacks, 25% of low-income, and 51% of higher-income Blacks were on private insurance.
- Among Hispanics, 16.4% of lower-income, and 24% of higher-income Hispanics were on private insurance.
- Among Whites, 15% of lower-income, and 46.4% of higher-income Whites were on private insurance.

Blacks were more likely to be enrolled in private insurance along with higher-income Whites. Hispanics and lower-income Whites were more likely to not be enrolled in private insurance.

No Insurance:

- Among Blacks, 10% of low-income, and 3% of high-income Blacks had no insurance.
- Among Hispanics, 26% of low-income, and 8% of high-income Hispanics had no insurance.
- Among Whites, 11% of low-income and 10% of high-income Whites had no insurance.

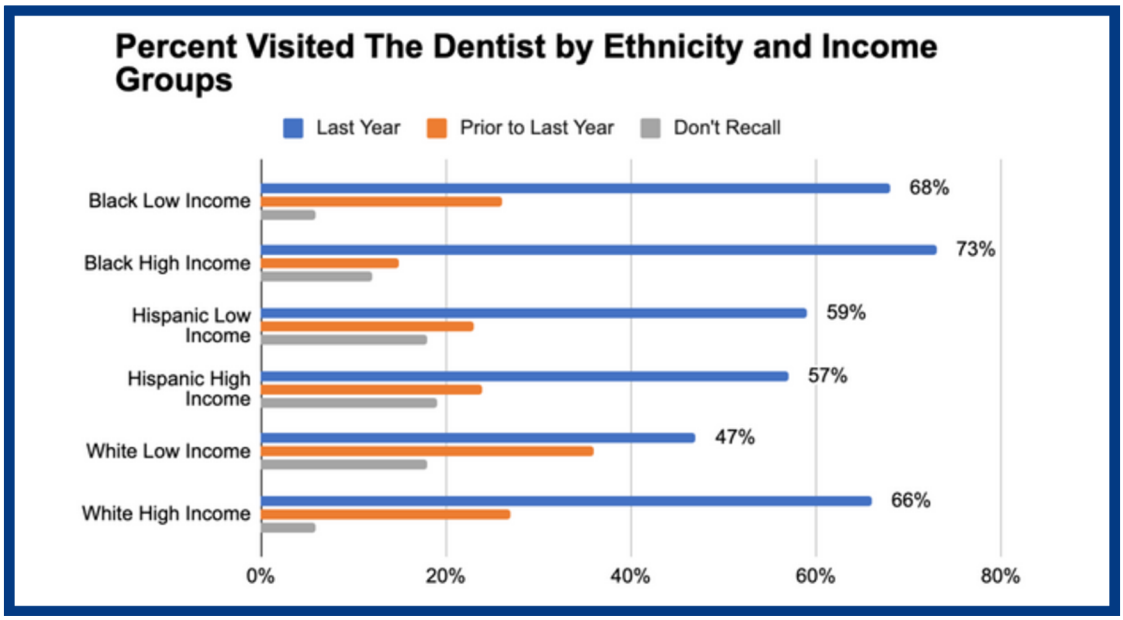
Hispanics were more likely to have no insurance, especially if they have the lowest levels of income.

We asked what was the association of these six groups with demographic characteristics in regard to oral health treatment access and oral health behavior.

- The study found no differences across income or ethnic groupings in finding a dentist.
- There was no difference across income/ethnic groupings in the probability of fearing going to the dentist.
- More than expected high-income Blacks and Whites, and fewer than expected lower income Whites rate their oral health as good. For Hispanics, there is no difference across income groups. Those who rate their oral health as fair are more likely to be Blacks and Whites from low-income households. For Hispanics, there is no difference across income groups. Those who rate their oral health as poor are more likely to be Blacks and Whites from lower-income households. Again, for Hispanics, income did not make a difference.
- Flossing teeth once a day is recommended. More Blacks, both low and high-income, and more low-income Hispanics than expected are flossing as recommended. A higher number of low-income Whites than expected are not flossing at all. The other differences are minor.
- Brushing teeth twice a day or more is recommended practice. Fewer low-income Whites than expected are brushing as recommended and more low-income Whites than expected are brushing less than expected. The other differences are minor, but in general more low-income Blacks, and Hispanics in both groups than expected are brushing as recommended.

Chart 2.4: Income/Ethnic Comparison by Dental Visits

More Blacks in both lower and upper-income groups reported at least going to the dentist at least once annually. Fewer lower-income Whites reported going once a year or more, and there were no differences across income groups for Hispanics. All three higher-income groups have higher rates of past-year visits than those with lower incomes.



SUMMARY OF RESULTS

This study focused on barriers to treatment and potential consequences for oral health practices in a large self-selected sample of people recruited from health fairs and other public events held at multiple locations around the state during 2023 and invited to complete a hard copy or online survey. The sample included an approximately equal number of people enrolled in HUSKY Medicaid insurance, private insurance, or without insurance, enabling comparisons of HUSKY Health enrollees with others. The people recruited into the study were more likely to be women, and of working age. Approximately half the respondents lived in households with relatively lower incomes.

In terms of access to treatment, nearly 90% were enrolled in some form of public and private insurance, of which 60% of the sample were enrolled in HUSKY Health. 60% of the HUSKY Health enrolled group reported that they had gone to the dentist at least once in the past year. This rate is significantly higher than the rates in our previous Medicaid Gap Analysis report. However, the Medicaid Gap Analysis data was based on claims each year over a five-year period, rather than self-report, which is subject to inaccuracy of recall. Or it is possible that those people the survey was able to reach were more likely to seek out oral health care. It is too early to know whether recent Medicaid private provider rate reimbursement increases for HUSKY Health adult dental treatments have made it easier for HUSKY Health enrollees to find and utilize a dentist.

Most people in this sample, over 75%, said they had no difficulty finding a dentist. At the same time, over 50% of the sample experienced at least one barrier in obtaining treatment from a dentist's office, and 13% experienced two or more. One of the barriers was difficulty finding a dentist, but only 3% mentioned this as a specific barrier to dental care. **Thus it seems that people know where to find a dentist, but they are reporting difficulty in accessing dentists that provide them with the care they need at the level they can afford or have available appointment times**

The most frequently cited barrier to care was fear of going to the dentist. In our past Medicaid Gap Analysis study, some people also reported dental anxiety and attributed it to past bad experiences at the dentist, with pain, mistreatment, delays in treatment, and unpleasant interactions with office personnel.

The second most often mentioned barrier to care was the conflict between consumer availability and dentist office hours. Thus even if an office was identified, the hours of service may not be convenient in accommodating personal or work schedules, making it difficult for patients to actually get to the dentist without sometimes having to take a half or full day away from work to do so.

Other main complaints were wait times (both to obtain an appointment and to see the dentist when in the office and the inability to find a dentist that took their insurance.

In terms of oral health hygiene habits, two-thirds of the people in this sample reported brushing their teeth the recommended number of times, but one-third did not, and a handful of people did not brush their teeth at all. Fewer people reported flossing. Nonetheless, half of the people who reported flossing the ideal amount also brushed the ideal amount. Almost all of those who didn't brush their teeth at all did not floss. Those "in the middle" (either brushing or flossing at inadequate levels or both) are the targets for intervention.

Private insurance seemed to confer some benefits over HUSKY Health. For example, a higher proportion of people with private insurance had seen a dentist in the past year and rated their oral health as good. Most of those with private insurance said they had no fear of the dentist and were more likely to report no barriers to care. In contrast, those with HUSKY Health, and often those without insurance, experienced a higher rate of fearing the dentist and having one or more barriers. However, individuals with private insurance were more likely to report difficulty finding a dentist. Overall, people across all types of insurance faced barriers to dental care.

Income coupled with ethnicity does make a difference in terms of accessing health care and better hygiene. Whites were at a greater disadvantage in this sample since proportionately more had no insurance. In general income level made a difference across Black and White respondents. Groups, with those in the higher income level, reported going to the dentist more often, rating their oral health better, and taking care of their teeth and gums more effectively. But this pattern is not always repeated since more low-income Blacks and Hispanics than expected are flossing as recommended. Thus it is difficult to disentangle income level from ethnic racial grouping at least according to the way we are measuring it in this study.

In general, however, people with limited resources have less access to care, and fare less well than those with higher incomes. This problem can be addressed either by reducing income inequalities, or improving access to quality dental treatment and education, or both.

STUDY LIMITATIONS

- The study sample was not random, but it included people from a wide range of geographic locations, racial/ethnic designations, income levels, and insurance types.
- The sample included more women than men.
- The sample included more lower-income than higher-income households. However, the numbers were sufficient to support comparisons by income and by income and ethnicity.
- The study may not have included all of the relevant barriers to treatment experienced by people on any form of insurance.
- The mode of data collection limited the number of questions to be asked, requiring the elimination of questions such as employment status, reasons for going to the dentist, and dentist satisfaction which might have deepened our understanding of factors leading to barriers to care.

POLICY RECOMMENDATIONS

This study revealed numerous areas where consumers are facing difficulty in oral health care access and utilization. COHI recommends the following policy or practice improvements to policymakers, administrators, oral health providers, and other stakeholders to reduce the barriers and improve oral health for all of Connecticut residents.

- **Reducing the Barrier of Fear and Anxiety to Utilizing Oral Health Care:** With anxiety and fear of the dentist being large barriers to utilization, the following recommendations should be considered to help more consumers receive preventative and restorative dental care.
    - Provide additional training to direct care oral health providers and front office staff on how to build trusting relationships and enhance communication with patients, especially those who may be traumatized, discriminated against, and/or have increased dental anxiety due to poor past experiences or fear of dental treatments.
    - Improve the provider standards for oral health exams and treatment plan explanation from providers, so consumers especially those with anxiety have more understanding and increased comfort level with respect to their oral health treatment needs and are fully informed about reasons for and possible alternatives to extractions.
    - Enhance collaboration between oral and medical professionals to subscribe to treatments to reduce fear and anxiety, such as cognitive behavior or other forms of therapy and medications.
    - Educate consumers on oral health and empower them to advocate for their own care.
- **Recommendations to Reduce Barriers to Accessing Care:** Reducing barriers to accessing a dental appointment or affording the services will help increase the utilization of services. The following recommendations are targeted at reducing issues consumers are facing with office availability, appointment wait times, transportation, and affordability issues.
    - Modify oral health provider practices and clinics to have more flexible hours and availability for appointments outside of traditional business operating times.
    - Develop a more accessible, easily searchable, real-time online database system for enrollees of Medicaid on what providers are currently accepting Medicaid, appointment wait times, services provided, and languages spoken.
    - Expanding oral health mobile care units, especially in rural areas.
    - Increase Medicaid reimbursement rates for private providers and public health facilities like Community Health Centers and the University of Connecticut in order to expand their patient availability, provide more affordable care, and recruit and retain more providers.

- Address barriers related to lack of accessibility to needed treatments by improving Medicaid coverage of certain uncovered benefits causing access barriers such as universal periodontal debridement and second annual prophylaxis cleanings, improved prosthetics replacement timelines, and dental implants.
- Adjust the annual $1,000 Medicaid maximum benefits cap on adult benefits to exempt preventative and diagnostic services in order to encourage greater utilization.
- Examine overall efforts to reduce social determinants of health, especially in relation to income disparities, since consumers with higher incomes who have more access to private insurance report fewer barriers to care, better at-home oral health hygiene habits, and overall rate their oral health better.
- Create targeted campaigns and public health programs for the needs of the Hispanic community, especially those who do not speak English well or at all and are struggling with difficulties with access and may not be eligible for Medicaid or private insurance due to undocumented status.
- Implement the dental therapy profession into public health to expand provider availability.

- **Recommendations for Improving Oral Health Literacy and Personal Oral Health Hygiene Habits:** Good oral health needs to start at home with good oral hygiene and a healthy lifestyle, as well as the knowledge to utilize annual preventative care visits and seek restorative care when needed. The following recommendations are focused on improvements to enhance consumers' oral health literacy and personal hygiene habits.
  - Improve the cultural and linguistic competency through additional training of oral health providers and front office staff to assist in providing higher quality care to a more diverse patient base to better understand their cultural beliefs and practices, while emphasizing the importance of dental care as a priority in their health.
  - Developing improved messaging and more effective strategies for tailoring oral health literacy and at-home hygiene to different age, gender, and ethnic groups.
  - Expand the messengers of oral health care literacy by better integrating oral health into community health workers and medical care, such as primary care providers (PCPs) to conduct oral screenings, and provide education, and referrals to seek dental care.

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10. See survey in the appendix for both English and Spanish versions.

11. Locations listed in the Appendix.

12. Access Health CT. (n.d.). Covered Connecticut program. More details, appendices, and references can be found at: https://www.ctoralhealth.org/consumer-barriers-report/methodology-of-barriers-report

13. Those who did not respond (95) were excluded.

14. The HUSKY adult database does not include children and there is a relatively small number of children who responded to the survey.

15. SurveyMonkey. (2024). COHI survey. More details, appendices, and references can be found at: https://www.ctoralhealth.org/consumer-barriers-report/methodology-of-barriers-report

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20. Significance is set at 0.5 and below

An appendix can be found at:
https://www.ctoralhealth.org/assessing-barriers-report/appendix-accessing-barriers-report