Bringing School-Based Comprehensive Oral Health Care to Immigrants and Refugees Attending Edison High School

Sarah Wovcha, J.D., M.P.H.
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School-Based Comprehensive Oral Health Care Services Grant Program

- Funded by MCHB and HRSA
- Integrate comprehensive oral health services into an existing school-based health center (SBHC); within Schools, Head Start Centers and Community Centers
  - Increase access to oral health care
  - Assure delivery of quality education and preventive and restorative care
  - Targeted to children and adolescents from underserved populations, immigrant and refugee community, and at-risk for oral disease.
Mission:
Children’s Dental Services is dedicated to improving the oral health of children from families with low incomes by providing accessible treatment and education to our diverse community.

CDS History
- Began in 1919 as a women’s charity that supported the provision of oral health care services to orphans living in Minneapolis
- Became the first provider of Head Start-based oral health care in the United States in the 1960s
- Quadrupled in size since 2000 due to lack of access to affordable dental care for low-income children and families
- Is currently the single largest provider of on-site oral health care in Minnesota schools and Head Start programs
CDS Target Population

- Children from birth to age 21
- Pregnant women with low incomes
- Individuals with low incomes, the uninsured, and the under-insured
- Individuals with special health care needs
- Individuals who are chemical and alcohol dependent
- Homeless individuals and families
- Members of the gay/lesbian/bisexual/transgender community
- Racial and ethnic individuals including those from East Africa, Central and South America, Southeast Asia, and Native American communities

Oral Health Care Services

- Outreach
- Oral health education
- Preventive oral health care (prophylaxis, fluoride, sealants)
- Restorative care (restorations, extractions, pulpotomies, stainless steel crowns, and root canals)
- Hospital care, if needed
Population Served by Race and Ethnicity, 2013

- Somali/East Africa: 25%
- Latino: 24%
- African America: 22%
- Caucasian: 14%
- Hmong: 10%
- American Indian: 5%

Map of CDS Service Area
Focus on Culturally and Linguistically Competent Care

- **Language fluency**: CDS staff speak over 16 different languages and hail from 20 countries
- **Representing cultures served**: Understanding the cultural norms, religious needs and diets of target communities staff create culturally targeted and translated curriculum for care in school-based settings

Unmet Needs Faced by the Community

- Shortage of Providers
- Language Barriers
- Insurance Status

Children and pregnant women go without needed services
School-Based Oral Health Care

- Providing portable oral health care services at SBHCs, Schools, Community Centers and Head Start Centers
- Decreasing multiple barriers affecting families’ with low incomes access to oral health care
- Serving as a model for delivery of school-based oral health care services for other Minnesota cities

Demographics: Why Care is Needed

- Minneapolis:
  - 65.8% of residents are of a race or ethnicity other than European American
  - 69% of students are enrolled in free and reduced lunch program
  - Family income is <185% of federal poverty guidelines
- Edison High School (where CDS provides Care)
  - 89.1% of students are of a race or ethnicity other than European American
    - 61.1%: African American
    - 16.7%: Hispanic American
    - 8.5%: Asian American
    - 2.8%: American Indian
  - 92.4% are enrolled in free and reduced lunch program
Representative Staff

“One important means to promote oral health in diverse populations is to develop a workforce that is both culturally and linguistically competent, as well as one that is as culturally diverse as the American population.”

Patients feel comfort and trust in staff who:
- Understand from where they come
- Understand their cultural norms and language

Multiple Languages Offered

- CDS acknowledges the need to speak the same language as their patients.
- Staff offer verbal and written communication in:
  - Somali
  - Spanish
  - Hmong
  - Karen
  - Oromo

Provide Care in a Location of Established Trust

- Clinical settings can be intimidating.
- Families know and trust in the education system.
- No additional transportation required.

CDS provides on-site care in elementary schools.
African Immigration to Minnesota

- Number of African-born residents in MN increased by 580% between 1990 and 2000.
- By 2002, ~9,000 immigrants arrived in MN directly from various African nations.
- 13% of MN’s foreign-born residents are from Africa.
- Most came as refugees from Liberia, Somalia, and the Sudan.
- Recent immigrants arriving from Nigeria, Ethiopia, and Eritrea.

Minnesota’s Somali Community

- MN has the largest population of Somali residents in the U.S.
- Most Somalis live in the Minneapolis metro area. Fewer numbers live in Rochester, Owantonna, and other suburban and greater MN communities.
- Nearly 1/3 of student who speak Somali at home attend Minneapolis public schools.
- Somalis immigrants are diverse; coming from urban, coastal, agricultural and/or nomadic regions.
Provide Financial Assistance

“Children in non-English-primary-language households are significantly more likely than children in English-primary-language households to be poor (42% vs 13%)”.

- CDS Offers:
  - Coordinated assistance for families applying for Medical Assistance
  - Certified MNCAA agents can assist families and submit insurance application on behalf of eligible families


Oral Health Care for East African Community

- 60% of students served by CDS are African, including those who self-identify as East African.
- East African immigrants do not place high importance on oral health and preventive health.*
  - Dental checkups are not the cultural norm
  - Caries is not considered a health issue

Special Considerations for African Immigrants

- Impact of refugee camps
  - Poor diet
  - Limited or no access to oral health care
- History of torture
- Effective oral health practices that are not the norm in the U.S. (e.g., brushing with the miswak)

Considerations After Immigration

- Lack access to preventive and restorative oral health care
- Inadequate or no interpretative services in dental care settings
- Unfamiliar with the dangers of western diet on oral health (e.g., high sugar in food and drink)
- Potentially unfamiliar with tooth brushing and flossing
References


Questions?

Sarah Wovcha, J.D., M.P.H.
Executive Director
In-House Counsel
Children’s Dental Services
(612) 636-1577
swovcha@childrensdentalservices.org