Does Where We Live Matter To Oral Health? Tensions Between Rural Older Adults' Concept of Community and Health Individualism

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Abstract: *Oral health is essential to overall health; however, structural obstacles influence older rural residents' oral health outcomes, especially those from disadvantaged backgrounds in the South. Poor oral health is typically attributed to individual choices, shifting the focus from the inconspicuous community influences, making it more difficult for older rural people to obtain oral healthcare. This qualitative study explores how older adults in rural Georgia understand the community's role in shaping their oral health. Twenty-two older adults were interviewed from five rural communities in southeast Georgia. Participants defined their community in geographic terms. Community barriers and self-reliance emerged as themes of how living in a rural community affects oral health. The concepts of community and one's oral health were perceived as distinct. Participants did not see how where they lived could matter to their oral health, even when they identified critical community barriers to oral health. In collaboration with rural healthcare systems, social workers can support healthy self-reliance, moving beyond a health individualism lens, by helping bolster older adults' social supports, an essential function of social relationships that positively influences a sense of community. Additionally, social workers can advocate for equitable policies to create opportunities for rural communities to support and maintain oral health.*

Keywords*: Rural, older adults, oral health, community, self-reliance, qualitative, health individualism*

The rapidly growing older population in the United States is disproportionately concentrated in rural areas compared to the younger population (Glasgow & Brown, 2012), with more than one in five older Americans living in rural areas (Smith & Trevelyan, 2019). According to the American Community Survey (ACS) data from 2012-2016, there were 46.2 million older people in the United States, with 10.6 million living in areas designated as rural by the U.S. Census Bureau (Smith & Trevelyan, 2019). Cromartie (2018) explains, "rural counties make up nearly 85 percent of the 1,104 "older-age counties"—those with more than 20 percent of their population age 65 or older" (para. 1).

Adults aged 65 and above make up about 14% of Georgia's total population of 10,799, 566 residents (U.S. Census Bureau, 2021). Georgia is projected to have the 11th fastest

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growing 60 and older population and the 10th fastest growing 85 and older population in the United States between 2010 and 2030 (Polaceck, 2019). During the 20th century, the number of Georgians aged 60 and over increased ninefold, compared to a fourfold growth in the population overall (GA-DHS, 2017). Akin to the national trends, the older population in Georgia is growing more rapidly in the rural counties compared to the nonrural counties (Tanner, 2021). Adults aged 65 years and above make up about 18% of the rural population in Georgia compared with about 13% of the nonrural population in Georgia (Office of Health Indicators for Planning, Georgia Department of Public Health, 2020).

Rural older residents face structural barriers which may prevent them from reaching their full health potential including oral health. Historically, U.S. medical and dental health services have been separated, which created lasting public health consequences still seen today (Otto, 2017), especially for marginalized, rural aging populations. O'Neil and colleagues (2017) point out that poor modern-day communication and different healthcare insurance plans between dental and medical services generate "missed opportunities to further the knowledge base for prevention and treatment efforts that address oral health issues in the context of overall health" (p. 3). They also suggest that keeping these two systems separate relegates dental services to be considered nonessential, further distancing oral healthcare from comprehensive healthcare.

Understanding older adults' accounts of living in rural communities is necessary as a robust sense of community has been found to preserve aging adults' oral health, a pivotal component of overall health (Mao et al., 2021). However, research is needed to examine the connection between community and oral health among rural older adults in the United States. This study investigated how older adults living in rural communities of southeast Georgia perceive whether and how their community impacts their oral health.

The Connection Between Oral Health and General Health

Most chronic systemic conditions and oral disease share common lifestyle modifiable risk factors mediated by genetic, environmental, behavioral, and socioeconomic factors. Oral health is one domain of health that can affect general and cognitive health including emotional, cultural, psychosocial, and functional well-being. The U.S. Department of Health and Human Services (2000) Report of the Surgeon General highlighted the link between oral and general health. The oral cavity is a well-balanced ecosystem that harbors diverse bacterial species in high-density biofilm. Lifestyle habits, environmental disparities, as well as host/individual response to bacterial accumulation on the hard and soft oral tissues will shift the balance to initiate an inflammatory response with entry points to the respiratory system, digestive tract, the bloodstream, and with the possibility to penetrate the blood brain barrier. In addition, numerous systemic conditions first present as changes in the oral cavity. For example, autoimmune diseases such as lupus erythematosus, systemic sclerosis, Sjogren syndrome, and amyloidosis are manifested as oral ulcerations, changes in the salivary and parotid glands, as well as changes in the tongue (Napeñas et al., 2020). While hematologic disease is often observed as gingival bleeding as well as tongue changes, endocrine disorders also are manifested in various oral markers (Napeñas et al., 2020).

Oral Health Disparities in Rural Aging Populations

Aging is a cumulative process that occurs at different rates in different tissues impacted by factors such as socioeconomic stressors, lifestyle habits, genetics, physiologic reserves, and biological resilience that influence health, severity of cellular, and molecular damage, resulting in disease over the life course (Kirkwood, 2017). According to the Centers for Medicare & Medicaid Services (2021), most Medicare (federal health coverage for adults 65 years and over) recipients are diagnosed with one or more noncommunicable lifestyle-related chronic systemic conditions that affect their quality of life, loss of autonomy/function, and result in increased health care costs. Modern technological advancements and poly-pharmaceutical interventions have transformed once fatal diseases into chronic conditions expressed later in life that exacerbate oral manifestations. Oral health status during the early years of life lays the foundation for good oral health in the later years of life (Schroth et al. 2014). Employer-based dental insurance has enabled older adults to retain their natural dentition, yet they are still in need of complex dental services post-retirement (Simpson et al., 2021).

Post-retirement/vulnerable populations also encounter environmental barriers that limit access to oral health care services with the emergency room as the only viable option to access dental services (Centers for Disease Control and Prevention [CDC], 2021; Dye et al., 2015). Older adults are at higher risk of poor oral health due to lack of dental insurance, underlying chronic systemic conditions, and compromised immune systems. Lack of access to oral health care providers is especially prevalent in underserved urban, rural communities, and those with limited financial resources as dental care becomes an out-of-pocket expense post-retirement (National Institute of Health [NIH], 2021).

Since oral health is an important component of overall health and well-being, structural obstacles also influence the oral health of older rural residents. Rural areas are typically geographically and socially isolated and lack transportation, healthcare, retail, and other needed services (Rural Health Information Hub [RHIhub], 2022a). Many rural areas are designated Dental Health Professional Shortage Areas (DHPSAs). According to the Health Resources Services Administration (HRSA), 68% (4,297/6,319) of the nation's DHPSAs were in rural or partially rural areas (Health Resources Services & Administration [HRSA], 2020; RHIhub, 2022b). The majority of counties, 122 out of a total of 159 counties in Georgia are considered Dental Health Professional Shortage Areas (DHPSAs) including those areas where only specified populations (e.g., low-income populations) face a shortage of dental care providers (HRSA, 2020; RHIhub, 2022b). Most of these counties are considered non-metro or rural counties. Approximately 1.4 million Georgians live in nonmetro counties designated as DHPSAs (RHIhub, 2022b). Many rural residents do not have dental insurance because of higher rates of poverty and unemployment in rural areas compared to urban areas, and hence rely on public health insurance programs such as Medicaid (Foutz & Artiga, 2018). Few rural dentists accept Medicaid patients because of low reimbursement rates (RHIhub, 2022b).

Medicare, the main health coverage for adults 65 years and over, does not cover dental services. Some Medicare Advantage (MA) Plans cover dental care; however, a recent study reported that more rural MA enrollees (10.5%) switched to traditional Medicare compared

to urban MA enrollees (5%) because of challenges to gaining access to care (Sungchul et al., 2021). More recently, federally qualified health centers (FQHCs) have helped close gaps in access to timely and appropriate dental services, thus reducing disparities in oral health (Crall et al. 2016; Jones et al., 2013). However, an analysis of trends between 2011 and 2014 showed an overall decline in the capacity to serve dental patients, resulting in lower levels of utilization of oral health services among FQHCs in the South compared to the Northeast, the Midwest, and the West regions of the US (Surdu & Langelier, 2018).

Based on data from 2018, older adults living in rural communities were less likely to have visited a dentist in the past year (60.6%) compared to their suburban (69.5%) or urban counterparts (69.3%). They were also more likely to have all their teeth removed (19.9%) compared to suburban (13.7%) and urban older adults (13.6%; Foutz & Artiga, 2018). These trends were consistent over the four-year period examined (United Health Foundation, 2018). Previous research also shows high levels of dental anxiety among rural older adults (Bell et al., 2012; Eitner et al., 2006). High dental anxiety has been linked to poor oral health outcomes including periodontitis or gum disease (Bell et al., 2012). Additionally, the American Dental Association (ADA) reported that there is a bi-directional relationship between oral health and nutrition as poor nutritional intake affects oral health, and loss of teeth and dental infections can prevent individuals from consuming a healthy diet (Swift, 2021). Poor oral health in rural older adults can further exacerbate their nutrition problems, as they already experience challenges related to food insecurity, access to healthy foods, and the ability to shop for groceries and cook for oneself easily (Valliant et al., 2021).

Poor oral health among older Americans is also more likely when they report low income (Griffin et al., 2012; Northridge et al., 2020), lower educational attainment (Assari & Bazargan, 2019; Northridge et al., 2020), lack of insurance, and/or they belong to racial/ethnic minoritized groups (Assari & Bazargan, 2019; Fleming et al., 2022). For those living in rural areas, the impact of these social factors is compounded by barriers inherent to rural areas such as lack of transportation and limited access to healthcare services (RHIhub, 2022a).

Health Individualism

Despite growing evidence of systemic challenges contributing to poor oral health (Northridge et al., 2020), the public dialogue surrounding oral health in America is highly individualistic (O'Neil et al., 2017). "Americans focus narrowly on brushing, flossing, and eating habits as the primary causes of oral health or the lack thereof. Problems are assumed to be the result of poor personal hygiene" (O'Neil et al., 2017, p. 7). Aubrun et al. (2006) define health individualism as "an individual's personal responsibility to make healthy or unhealthy choices, and the impacts affect the individual…both the external causes of health and the broader implications of people's health disappear from the picture" (p. 3). Drawing from "health individualism," O'Neil and colleagues (2017) explain that poor oral health is typically attributed to individual choices and lack of control, ultimately shifting the focus from the inconspicuous community or political causes, making it more difficult for older rural people to obtain oral healthcare.

Views of health individualism may be more prevalent for people living in rural communities with few resources and may involve a level of perceived self-reliance. For example, O'Neil et al. (2017) theorize that,

> People don't connect the absence of water fluoridation or a shortage of oral health care providers in rural areas with their perception that a region has "bad teeth." They simply assume that such areas have a preponderance of people with poor personal hygiene and that these failures of personal responsibility aren't a matter of public concern. (p. 8)

Research on how older adults in rural areas manage their understanding of health provides insights into rural aging older adults' struggles in maintaining oral health. Ultimately, individuals normalize self-reliance and assume personal responsibility for poor health outcomes without realizing that "resources create choices" and community healthcare systems are not apolitical (Page-Carruth et al., 2014, p. 8). Research with U.S. rural older adults is needed to examine whether health individualism is also prevalent regarding oral health.

Community

The concept of community refers to a group of people situated in the same geographically-bound area (neighborhood, town, or city) or to a group that shares common interests, characteristics, or skills. Previous research shows strong feelings of community belonging among rural (Ramos et al., 2017; Walker & Raval, 2017) and/or older residents (Michalski et al., 2020) in countries such as the United States and Canada. The psychological sense of community, a widely used construct in community psychology, was defined by McMillan and Chavis (1986) as "a feeling that members have of belonging, a feeling that members matter to one another and to the group, and a shared faith that members' needs will be met through their commitment to be together" (p. 9). A strong sense of community has been associated with increased community engagement and participation (Talò et al., 2014) and with positive oral health (Mao et al., 2021) and general health behaviors (Michalski et al., 2020). Social support is one of the important functions of social relationships and positively influences the sense of community (Hombrados-Mendieta et al., 2019). House (1981 cited in Heaney & Israel, 2008) conceptualized social support as "Aid and assistance exchanged through social relationships and interpersonal transactions" that's meant to be beneficial (p. 191). Social support can be divided into categories of supportive behaviors and includes emotional (expressions of empathy, love, trust, and caring), instrumental (tangible aid and service), and informational (advice, suggestions, and information) support (Glanz et al., 2015). Although types of social support are distinct, they can be challenging to research as "relationships that provide one type often also provide other types" (Heaney & Israel, 2008, p. 190).

Another related concept is that of social capital. While sense of community is a psychological construct, social capital is embedded within communities, and entails informal or organized social networks and social structures which have the potential to tie people and communities together socially (Kitchen et al., 2015). Mapping and mobilizing social capital in communities has been one way of collective action to promote health

(Eriksson, 2011). Growing evidence supports the association of oral health with social capital, social support, and a sense of community in older adults (Mao et al., 2021; Rouxel et al., 2015a, 2015b) and other age groups (Batra et al., 2014). Examining older adults' experience in rural communities is essential as a strong sense of community is protective to older adults' oral health (Mao et al., 2021). Yet, no studies have explored the concept of community concerning oral health in U.S. rural older populations. This study aimed to fill a gap in the literature by examining how older adults living in rural communities of southeast Georgia understand their community's role in shaping their oral health. Types of social support were also assessed as it is vital to understand the nuances of social support that can influence a sense of community needed to promote oral health in rural communities.

Methods

Study Design and Participant Recruitment

This study is part of a larger mixed-methods study. Participants were recruited through senior centers and other community-based services, including meal delivery services. The surveys in the first phase of quantitative data collection in the study were conducted at senior centers and at participants' homes from September until December 2018. At that time, the participants filled out a form expressing their willingness to participate in a follow-up interview during the study's second phase of qualitative data collection. The follow-up interviews were conducted between March and April 2019. Only findings from these interviews are presented in this paper.

The study sites were located in five rural counties in southeast Georgia using convenience and snowball sampling. Several definitions of "rural" are available (Cromartie & Bucholtz, 2008). We followed the Office of Management and Budget's (OMB, 2018) guidance for selecting the counties that would participate in the study. OMB's guidance is used by many federal programs and policies when determining funding, financial incentives, and targeting (Pipa & Geismar, 2021). OMB designates the counties with 50,000 or more people as "metropolitan" (metro) areas; and those between 10,000 - 49,999 people as "micropolitan" (micro) or nonmetropolitan areas (Cromartie & Bucholtz, 2008; OMB, 2018). Often micropolitan or nonmetro is used as a proxy for rural (Pipa & Geismar, 2021). Based on this guidance, all the study sites were in micropolitan, nonmetropolitan, or rural counties.

Participants

Twenty-two participants were interviewed. The study participants were adults aged 50 years and over who lived in their own homes. The choice of a cutoff at 50 was deliberate to encompass a broader range of older adults, allowing us to explore the early stages of aging-related dynamics. While census statistics focus on adults 65 and older, including those aged 50 and above provides a more comprehensive understanding of aging experiences. This approach aligns with recent research trends aiming to capture a diverse aging population and its evolving needs. This study did not include those living in assisted

living communities and skilled nursing facilities. Both edentulous and dentate individuals were included. The Katz Index of Independence in Activities of Daily Living (Katz ADL) was used to screen the participants (Katz, 1983; Katz et al., 1970). The eligible participants scored between three (moderate impairment or partially dependent) and six (full function). Individuals who scored two or less (severe functional impairment) were excluded from the study. All interview participants received a $15 Walmart gift card for their participation.

Table 1. *Descriptive Statistics of Interview Participants (Older Adults)*

Characteristic	**Category**	***n (%)***
Age in years	50-54	1 (4.5%)
	55-59	3 (13.6%)
	60-64	3 (13.6%)
	65-69	5 (22.7%)
	70-74	6 (27.3%)
	75-79	1 (4.5%)
	80-84	2 (9.1%)
	85 and older	1 (4.5%)
Gender	Male	8 (36.4%)
	Female	14 (63.6%)
County of residence	Bulloch *(urban)*	15 (72.7%)
	Evans (*rural*)	4 (18.2%)
	Screven *(rural)*	1 (4.5%)
	Tattnall (*rural*)	1 (4.5%)
	Toombs (*rural*)	1 (4.5%)
Race/Ethnicity	Black/AA	14 (63.1%)
	White	7 (31.8%)
	Biracial	1 (4.5%)
Annual income	≤ 20,000	11 (50%)
	20,001 to 42,000	4 (18.2%)
	Above 42,000	2 (9.1%)
	Refuse to Answer	5 (22.7%)
Education	High school degree or less	11 (50%)
	Some college, no degree/associate degree	7 (31.8%)
	Bachelor's degree or higher	4 (18.2%)
Marital status	Married	7 (31.8%)
	Widowed	6 (27.3%)
	Divorced	6 (27.3%)
	Separated	1 (4.5%)
	Never married	2 (9.1%)
Lives alone	Yes	10 (45.5%)
	No	12 (54.5%)
Total		22 (100%)

Most of the participants were female (n = 14). The ages of the participants ranged from 50 - 85 years, with most participants ranging in ages from 70 - 74 years. A majority of the participants were African American (n = 14) and had annual incomes below $20,000 ($n$ = 11). Half of the participants reported having a high school degree or less (n =11), followed by some college (n = 7), and bachelor's degree or higher (n = 4). The largest group of

participants reported being married (*n* = 7), followed by those who were widowed (n =6), divorced (*n*=6), never married (*n* =2), and separated (*n* =1). Please see Table 1 for respondents' demographic profile.

Data Collection

Interviews were conducted over the telephone allowing for privacy and to engage participants dispersed across different communities, especially those who were homebound. The recruitment and interviews were done simultaneously, and participant recruitment continued until no new information emerged from the interviews. The principal investigator conducted all the interviews. The average length of the interviews was between 30 and 45 minutes. Participants were asked to describe what it means to live in a rural community, how living in a rural community affects the health of their teeth, gums, and mouth, and how important oral health is for their community and how their community can help with their oral health. All interviews were audio-recorded and supplemental notes were taken. Interviews were transcribed verbatim by a professional transcription service. Pseudonyms were used to protect participants' identities. Any personal information identifying the participant was removed from the transcripts. The proposed study was approved by the Georgia Southern University Institutional Review Board. Verbal consent was obtained from all the interviewees prior to beginning the interviews.

Data Analysis

Data analysis was guided by the following question: How do older adults living in rural communities of southeast Georgia understand their community's role in shaping their oral health? Two analysts, including the principal investigator, reviewed the data independently using Braun and Clarke's (2006) framework for thematic analysis. The first five transcripts were used to inform the development of the codebook. Inductive codes were developed and modified throughout the coding process, and the first five transcripts were revisited after all the codes had been finalized. NVivo11 (QSR International, 2018), a qualitative data analysis software, was used. Steps were taken to ensure that the data were trustworthy. The two analysts met intermittently to discuss their analysis, including any disagreements. The analysts also maintained memos or notes while understanding and interpreting the data to ensure that the meaning of codes did not drift or shift during the process of coding.

Finally, because social support positively impacts a sense of community, deductive coding using a social support framework (Heaney & Israel, 2008, p. 190) was applied to the data, using instrumental (tangible aid and service), emotional (expressions of empathy, love, trust, and caring), and informational (advice, suggestions, and information) support.

Findings

First, participants defined their understanding of community, and subsequently, two themes were identified: community barriers and self-reliance. Findings centered on the tensions between rural older adults' concept of community and independence related to

oral health. Types of social support, including instrumental, emotional, and informational, were also applied.

Defining Community

Overall, participants tended to define community as geographic, as a group of people getting together or living together in proximity to one another. Community included the town or neighborhood they lived in and the people in their immediate surroundings, such as their friends, family, and congregants at their faith community. Community also meant the people who shared common interests and values, such as social clubs.

Most participants enjoyed living in what they described as a quiet and serene rural community rather than living in a more urban area. Participants tended to speak positively about their community. For example, Ross (male, 50-54 years, African American) explained how meaningful the relationships in their community are and how helpful people can be,

> *Community means a lot, you know. They can do a welfare check, come, and see how if I'm okay, and sometimes you have cold, real cold night and stuff, and they come and make sure I'm okay, you know? Make sure you're taking your medication and everything alright with you. And, you know, in my case sometimes I may need help opening a can, can of food, to get something to eat, you know. And they can help me out, you know? So, community means a lot. To have good neighbors and family, you know?*

Eleanor (female, 80-84 years, African American) also found community members to be supportive. She lived by herself and had only one neighbor she did not interact with much. Regardless, she posited that her neighbor would likely lend a helping hand, "If there's something going on with you and you have to go to them, and I feel like they would help you with whatever you needed."

On the other hand, some participants, like Deena (female, 65-69 years, White) were less optimistic. "Well, my neighbors and friends don't help me. I have to do that myself. They don't help me, yeah."

Community Barriers

Despite noted strengths from many participants, they were well aware of the downside of living in a rural community, including the impact on their oral health. First, isolation was discussed by the participants and reflected difficulties with all three types of social support (instrumental, informational, and emotional). The geographic seclusion made it difficult for them to access instrumental and informational social supports such as oral health care and education resources. When asked about the experience of living in a rural community, Sheila (female, 55-59 years, White) described a sense of geographic and social isolation.

> *It's got nothing but a Post Office and a gas station. But I really don't know nobody in this town…It's real quiet. I don't ever see nobody. I just see the cars and trucks that go by the road and that's it.*

Vera (female, 60-64 years, African American) shared a similar sense of seclusion and said:

> *It's not really a community to me…And the rural area don't get as much togetherness as you would have a community…You don't get much, you don't get no education, you don't get no help. And stuff like that. It don't help you. Cause you be left out, when you in a rural area. And you isolated—you can't get the things like you should and could.*

Donald (male, 65-69 years, African American) was concerned about the lack of informational support in his community and articulated the consequences for peoples' oral health:

> *Your teeth get rotten faster, what to do when your gums are bleeding, you have lack of information of how often you should brush your teeth and the information you need about how often you should go to the dentist, how often you should get your teeth cleaned because you brush them and that's it. You learn to brush them, but you don't know how to take care of them. You learn brushing them is all you need to do.*

Steve (male, 50-54 years, African American) shared ideas for improving oral education. He suggested a type of informational support and proposed that dental providers could hold an exhibition with specific resources for low-income people.

> *Have a doctor, dentist, or something you know to come out and talk to everybody, and everybody would learn certain things, you know, show us any stuff we need to know we might not know about our mouth, teeth and gums and stuff. And the ones that can't afford to go to a dentist and get advice, they could have one come out and talk with us or someone of that nature, you know?*

Participants explained that isolated rural areas lacked other instrumental social supports like public transportation, making it difficult to get to their doctor's appointments. They relied on either special transportation services provided by their health insurance program or on family or friends to drive them to health appointments.

Dwayne (male, 70-74 years, African American) stated, "I find it to be peaceful [to live in a rural community], but when you do need medical services, you got be able to go where you going, get where you going because there is no public transportation or anything." Earl (male, 66 years, African American) compared resources in the city to his rural community and is fortunate to have access to transportation through his health insurance. He reported, "Chicago has the street buses if you don't have a car. Down here, you need transportation. I have United Healthcare and they have a system where I can get special transportation to my doctor's appointments and things like that."

When asked directly about oral health in their community, participants believed that it was essential, and it often centered on emotional support and concern about disconnection from others. According to Vera (female, 60-64 years, African American), "All oral health

is important to the community." Most people thought it was socially undesirable to have poor teeth. Earl (male, 65-69 years, African American) stated, "It's very important because when you meet people you don't want an odor from your mouth or anything like that." Likewise, Marvin (male, 80-84 years, White) explained:

> *It's kind of embarrassing to be around people that doesn't have good teeth, good healthy mouth and teeth and gums. Especially when you're speaking with them, you're near them. Probably they have an odor, even though they might brush their teeth, if their teeth is bad, it's still gonna be kind of embarrassing and have a bad look.*

Another reason participants may believe community is important to their oral health is that their oral health tends to worsen with age. Steve (male, 50-54 years, African American) suggested, "The older I get. I know the worst state my mouth gets in." Vera, (female, 60-64 years, African American) has the same challenge. "As I got older my teeth have gotten weaker in my mouth and they also have gotten tooth decay as I get older." Deteriorating oral health may lead to further isolation, social disintegration, and potentially less emotional support.

Instrumental support is needed to cover the high cost of dental services, blocking some participants from the oral health care they would like to have. Linda (female, 70-74 years, White) is unable to afford dentures, "Well, I wish I could get some dentures. I haven't got much money. With my Medicaid and Medicare, I thought I might could get dentures without costing me anything." In some cases, the absence of teeth or dentures can be distressing and may reduce social interaction and emotional support. Thus, the lack of instrumental support may lead to less emotional support.

Kim (female, White, 55-59 years) described the connection between the shame of tooth loss and low self-esteem—another instance where instrumental support and emotional support are paired.

> *In the apartment complex that I live in, the majority of the people that live in this apartment complex are in the same boat that I'm in. A lot of them have had all their teeth removed, but they can't afford dentures. A lot of them have teeth that are broken, missing, and it just looks bad. And like I said, it destroys your self-esteem and your self-confidence. It just does.*

Participants, however, indicated that few people have direct conversations about oral health because it is a private matter, likely shameful for some people. Bob (male, 70-74 years, African American) stated, "We don't sit around and discuss oral health, we really don't." Michelle (female, 75 -79 years, Biracial) explained, "It's very important to people around me [oral health], but that's something we don't ask other people about is their oral health. That's a personal thing with them." She continued, "That's something private that I don't talk about it, my mouth to other people." Dwayne (male, 70-74 years, African American) explained that oral health is only brought up in passing conversation. "We discuss little things if we have a colonoscopy done, if we have a tooth pulled, you know we'll talk about that…But kind of briefly."

Self-Reliance

Interestingly, participants expressed a disconnect between the concepts of "community" and "oral health." Despite rural community barriers and lack of emotional, informational, and instrumental support that participants could easily list, they believed they were solely responsible for maintaining their health. From their perspective, their community neither supported nor hindered them in maintaining their oral health. They did not think that geography or social support impacted their oral health in a major way. The only instance of social support suggested by the participants was that of getting a ride from a family member or a friend to dental appointments. The participants believed their oral health was solely dependent on how regularly they performed oral hygiene habits such as brushing, flossing, and visiting the dentist. Although they knew that regularly visiting dentists was important for preventing oral diseases, they felt that dental work was expensive and they could avoid it if they maintained regular oral hygiene habits.

Kim (female, 55-59 years, White) stated, "I don't think it [community] has any effect on it [oral health]. That's something an individual has to do." Vera (female, 60-64 years, African American) explains the contradiction between community and self-reliance. "But, you know, the community is supposed to be a unity, but it's not really like that but that's why I tell you, have to take care of yourself."

Although Dwayne (male, 70-74 years, African American) identified a lack of transportation in rural areas as problematic, he did not see place mattering to his oral health.

> *I don't think living in rural community would make me pay less attention or more attention to my dental care, my dental savvy, because I would still go to the dentists and get cleanings, checkups, I would do that no matter where I lived.*

Trevor (male, 55-59 years, White) stated, "I don't see anything about being in this community that limits someone's ability to get proper oral care." Regardless of community belonging, participants tended to use an individualistic rather than collectivist interpretation of oral health. Michelle (female, 75-79 years, Biracial) explained:

> *You have to do it all the time, because if you stop [caring for] your mouth...your teeth will start deteriorating, but if you don't keep it up, that's how you get a bad mouth. That's how you get gingivitis and bad teeth. If you dental floss and brush every day, you still have to see a dentist, but it won't be as bad as it is .... If you don't do these things, of course they're gonna deteriorate and rot, and you're gonna have to go to the dentist, and that's a lot of money going to the dentist. Some people can't even afford to pay for them, because I've been around people that have their teeth, but they are soft and they're dingy, and that's because of the build-up that over the years has caused. There's nothing much you can do except try to do the best you can to keep them clean and keep the upkeep of them.*

Discussion

This qualitative study explored a gap in the literature regarding how older adults living in rural Georgia perceive the role that community plays in shaping their oral health. It is

essential to explore the lived experiences of older rural Georgians to best meet their unique regional health needs. Participants defined their understanding of community and similar to previous research (Walker & Raval, 2017), most described a sense of at least some community belonging. Community barriers and self-reliance were identified as the key tensions between the concept of community and independence of oral health among rural older adults.

Participants recognized the inherent barriers and absence of social support in a rural community, such as isolation, lack of transportation, educational resources, and cost, that prevented them from getting the care they needed. However, they expressed notions of health individualism (Aubrun et al., 2006; O'Neil et al., 2017) and felt they were fully responsible for their oral health. In their estimation, poor oral health resulted from them not keeping up with dental care habits such as brushing and flossing; thus, in their view where they lived did not matter to their oral health despite the barriers they identified. Most participants desired going to a dentist and getting dentures, but they recognized that dental services were expensive, and hence they had to do the best they could to avoid these out-of- pocket expenses or live with the consequences. They also may have relied on hygiene habits more because issues like lack of affordable dental coverage were beyond their control.

Like in other qualitative studies (Bacsu et al., 2014; Lawrence et al., 2018; Neville et al., 2018), the participants in this study described "community" in terms of where they lived, and the groups of people who they shared a connection with. Family, friends, neighbors, and those who they shared common interests and values with and obtained support from when needed were considered as part of their community. However, these aspects of a community were not viewed as enablers to optimal oral health. In general, living in a rural community was described as an isolating experience for many participants, which is similar to the experience of rural residents participating in previous studies conducted in the United States as well as in other countries (Buys et al., 2015; Walker & Raval, 2017). Social isolation and loneliness have been linked to poor health outcomes among rural older people (Rouxel et al., 2016). A strong sense of community belonging and social capital have been associated with positive oral health outcomes (Mao et al., 2021; Rouxel et al., 2015a, 2015b) and general well-being (Carver et al., 2018) among older adults in both rural and non-rural areas (Au et al., 2020).

Altogether, the participants in this study recognized factors that influenced their oral health, yet ultimately "oral health" and "community" were disparate concepts for them. They viewed oral health as a product of sustained and regular dental care habits such as brushing and flossing. This is not surprising, as previous research has shown that the public perception of oral health and health in general is highly individualized; they are viewed as isolated concepts, without awareness of the social and structural factors shaping them (O'Neil et al., 2017).

Limitations

Study findings must be considered in light of its limitations. For example, the research consisted of a small convenience sample conducted in five rural counties in the southeast

region of Georgia approximately four to five years ago, which limits the generalization of the results to older adults in other rural regions, especially those in other countries. The study consisted of people served by specific community-based programs that consented to become study sites. The demographic composition of this study sample emulated the demographic characteristics of the program clients. Hence, some biases may have been introduced during the participants' selection, which may have influenced the findings. Nevertheless, this study gave voice to older rural Georgians' understanding of how community impacts oral health, a neglected topic in the literature.

In the current sample, African American participants took part in this study at higher rates than their white counterparts. Most African Americans live in the southern United States, and Georgia currently ranks as the second largest state for the Black population (U.S. Department of Health and Human Services, Office of Minority Health, 2021). Racial equity and oral health are critical so this area deserves intentional inquiry. As one of the social work grand challenges is closing the health gap and eliminating racism (Barth et al., 2022), future research should explicitly highlight oral health disparities among aging African Americans living in rural areas.

Please note that the data used in this study is limited to the timeframe of four to five years ago, serving as a contextual snapshot for our analysis.

Implications for Social Work Practice

To move U.S. discourse beyond health individualism frames, social workers can follow the oral health framing reform recommendations by O'Neil et al. (2017, p. 12). O'Neil and colleagues advocate using images and discussion of oral health that intentionally link oral health with overall health and avoid using conceptions only of teeth. They recommend using health equity frames rather than a one-size-fits-all health approach. They found health equity boosts "the public's agreement that society has a collective responsibility to address oral health inequities" (p. 15). O'Neil and colleagues (2017) promote using effective economic frames that include a discussion of avoidable costs, "highlighting how current approaches create incentives for people to defer treatment, leading to more serious problems that are ultimately more expensive to treat" (p. 16). They also call for the public to reimagine oral healthcare delivery systems beyond the dentist office to interdisciplinary teams (O'Neil et al., 2017). Social workers must be included in these teams as they work across numerous community locations and have specialized training in biopsychosocial models (Pope et al., 2014; Slovak et al., 2011; Warren et al., 2017).

As recommended by Lyons et al. (2021), licensed social workers can be integrated into dental teams to improve access to care which would help promote better oral health outcomes. Social workers are uniquely positioned to reduce barriers to care in rural communities as they are already working closely with underserved populations (Azhari, 2021). Social workers can also help interdisciplinary teams apply strengths-based, person-in-environment approaches and policies that help move the public discourse away from a health individualism perspective and reduce health disparities. In line with O'Neil et al., (2017), social workers can

> Direct public attention away from deficit thinking about populations that experience poor oral health and toward systems thinking about how disparities arise and how they can be redressed and to explain how structural factors—income, race and ethnicity, language, geographic location— influence oral health outcomes and show how shifts in the system can address disparities. (p. 8)

Within a strengths-based perspective, it is essential to identify and build on existing assets or supports and services that already exist within rural communities to help prevent oral diseases among older people in rural areas (RHIhub, 2021). Individuals, associations, and institutions can be mobilized to come together to build on their assets rather than focus on just their needs. For instance, oral health education programs and risk assessment and examination can be integrated with community-based supports and services such as mobile dental vehicles (Gao et al., 2019), home-delivered meals ("Meals on Wheels"), chronic disease management classes at senior centers, and mental health services (Siegler et al., 2015). Social workers need to include oral health as a part of biopsychosocial assessments and provide community resources. Azhari (2021) points out,

> Since many social workers, dentists, and health care professionals have mutual clients, it is crucial to understand the connection between oral health, mental health, and general health. Social workers can partner with dentists to provide clients with the tools (knowledge, access, and resources) to take responsibility for their oral health (p. 92).

To further enhance holistic healthcare and bridge the gap between oral and general health, it is recommended to incorporate basic dental screenings into routine general health check-ups. This integrated approach aligns with the comprehensive perspective advocated by O'Neil et al. (2017), emphasizing the interconnectedness of oral and overall health. By including basic dental screenings in general health appointments, social workers can play a pivotal role in early identification of oral health issues, promoting preventive measures, and fostering a more inclusive healthcare delivery system. This step aligns with the strengths-based, person-in-environment approaches, and policies recommended by O'Neil et al. (2017), Lyons et al. (2021), and Azhari (2021), empowering social workers to address disparities and contribute to the overall well-being of rural older adults.

Upstream interventions can help target and improve structural factors identified by the participants in this study, such as lack of transportation, lack of dental coverage, and changing the built environment of rural communities. Equitable policies focused on decreasing economic inequality (Moeller et al., 2017) can help create opportunities within rural communities to support and maintain oral health along with overall health and well-being (Daniel et al., 2018).

Social workers can be a bridge/link to other types of health/oral health needs and community support. Social workers already integrate physical and behavioral health in their healthcare delivery systems, thus including them in oral, physical, and behavioral health care settings, including FQHCs, is a practical solution to improving oral healthcare for rural and underserved groups. Adding oral health to social work education will benefit the participants in this study as well as other excluded groups. Incorporating social workers

may be the key to empowering rural older adults to pursue and advocate for their oral health.

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