Despite significant strides in children’s oral health through preventative measures, poor oral health remains the most prevalent unmet healthcare need, and tooth decay constitutes the most common chronic childhood disease in the United States. Children from low-income families are less likely to receive comprehensive dental care and are more likely to have acute dental disease than children from middle- and upper-income families. Children from some racial/ethnic minorities, large families, and caregivers who have low educational attainment are most at risk for suboptimal dental care. Access to care is limited by the number of dentists who accept Medicaid or provide charity care for the uninsured. In the few caregiver studies that have been conducted, factors affecting access include lack of knowledge among caregivers and physicians of the consequences of oral disease among children, children’s dental anxiety, and negative experiences with the dental care system (difficulty with locating providers, arranging appointments, and transportation; long waiting times; and discriminatory treatment).

We did not find a previous study of factors that differentiate caregivers of Medicaid-enrolled children who do not access professional preventive dental care from caregivers who do. The purpose of our qualitative study was to examine factors that uniquely affect caregivers of diverse racial/ethnic backgrounds who do not seek preventive dental care for their Medicaid-enrolled children. It was limited to Jefferson County, Kentucky, to allow exploration of potential psychosocial and cultural barriers among caregivers who experience similar structural factors, including reimbursement rates, availability of dentists who accept Medicaid, and public transportation. Utilization in Jefferson County is low: only 37% of Medicaid-eligible children obtained any dental care in 2002. The long-term aim of our research is to develop and evaluate a community-, family-, and practice-based intervention to improve access to care.

Objectives. We identified psychosocial, structural, and cultural barriers to seeking dental care among nonutilizing caregivers of Medicaid-enrolled children.

Methods. We used Medicaid utilization records to identify utilizing and nonutilizing African American and White caregivers of Medicaid-enrolled children in Jefferson County, Kentucky. We conducted 8 focus groups (N = 76) with a stratified random sample of responding caregivers; transcripts were qualitatively analyzed.

Results. Psychosocial factors associated with utilization included oral health beliefs, norms of caregiver responsibility, and positive caregiver dental experiences. Utilizing groups reported higher education; health beliefs included identifying oral health with overall health and professional preventive dental care with caregiver responsibility for children’s overall health. These beliefs may mediate shared structural barriers, including transportation, school absence policies, discriminatory treatment, and difficulty locating providers who accept Medicaid. Expectation of poor oral health among some low-income caregivers was an among factors identified with nonutilization.


Methods
We conducted focus groups with caregivers of Medicaid-enrolled children in Jefferson County, Kentucky, which comprises urban and suburban metropolitan Louisville. We selected focus group methodology to (1) explore in depth previously identified barriers, (2) compare experiences of caregivers who access care with those who do not, and (3) provide insight into perspectives on children’s oral health. Because the outcomes are informing the development of a community-based intervention, we elicited both community and individual experiences and knowledge.

Sample
Caregivers of Medicaid-enrolled children aged 4 to 12 years who had been continuously enrolled during the previous 2-year period, who were residents of Jefferson County, and who were identified as White or African American were eligible to participate in our study. Recruitment conformed with Medicaid administrator policy and Health Insurance Portability and Accountability Act regulations. The Medicaid administrator randomly selected a stratified sample of 1000 children who had utilized preventive dental services during the past 2 years and 1000 children who had not. Letters were mailed to caregivers informing them of the study and providing a contact telephone number. The Medicaid administrator’s vendor used bulk mailing postage rates, and undeliverable letters were not returned. As a result, it is not known if all 2000 letters were received by the intended sample. Respondents who contacted investigators were invited to participate in a focus group (2 African American/utilizing groups, 2 African American/nonutilizing groups, 2 White/utilizing groups, and 2 White/nonutilizing groups).

Data Collection and Analysis
Participants were screened for eligibility before each focus group was conducted.
informed consent was obtained at the begin-
ing of the session, and a $30 incentive was
offered to participants upon session comple-
tion. Focus groups were held from 6:30 PM to
8:00 PM in a centrally located facility in the
urban center of the county, where there is ac-
access to public transportation. Focus groups
were conducted by a moderator and an
investigator/notetaker; sessions were audio-
and videotaped, and tapes were transcribed.

The moderator’s guide (Figure 1) included
structural and personal barriers from the
Access to Personal Health Care Services
Model (Figure 2) and factors identified in
previous studies. This model was used by
Margolis et al.15 and colleagues in a communi-
tywide intervention to improve delivery of
preventive services to children. We selected it
as a framework for the long-term aims of our
study.

From videotapes and transcriptions, 3 in-
vestigators independently coded responses
and noted frequent responses and intense
discussion. Codes were compared and re-
ined, and emerging themes were identified.
All team members reviewed the final analysis
for accuracy and consensus of interpretation.

RESULTS

We conducted 8 focus groups with 76
caregivers (N=46 African Americans, 30
Whites). Groups ranged in size from 4 (White/
utilizing) to 14 (African American/utilizing),
with a mean of 9.5 participants. Of the 2000
letters, 144 (7.2%) respondents called with
interest in participating, and all were asked to
join a focus group. The overall response rate
was 3.8% of the initial mailing and 52.8%
of those scheduled and confirmed for focus
group sessions. Attendance rates ranged
from 41.9% among White/utilizing care-
givers to 61.5% among African American/
utilizing caregivers.

Participant demographics are shown in
Table 1. The strongest demographic factor
associated with utilization was caregiver ed-
uation. Approximately three quarters of
nonutilizing caregivers reported no more

FIGURE 1—Questions from the focus group moderator’s guide.

FIGURE 2—Access to Personal Health Care Services Model.
than a high school education, and more than half of utilizing caregivers reported at least some college. Focus group data suggested oral health beliefs and norms of caregiver responsibility for professional preventive care may explain the effects of higher educational attainment on utilization. This interpretation supports findings in other health care settings that education may affect health behaviors through health beliefs and subjective norms. Findings are summarized in Table 2 and in the next section.

**Oral Health Beliefs**

Belief in the importance of oral health for overall health emerged as a major theme associated with accessing professional preventive dental care. By contrast, all caregiver groups discussed preventive care at home. Utilizing caregivers emphasized preventing dental problems (“lays the groundwork for good teeth when you’re an adult”), monitoring dental growth (“make corrections if they have teeth that grow in crooked”), and developing life-long preventive dental care habits (“if you start at a young age, they won’t be so scared of the dentist”). Discussion among nonutilizing groups included issues of “tooth problems” and “emergencies,” but these caregivers also emphasized appearance (“white teeth”), self-esteem (“being made fun of”), and hygiene (“fresh breath”) as being more important reasons than health concerns for accessing professional pediatric dental care. These findings are similar to those found in a recent study of adolescent oral health beliefs and use of free dental care, which identified distinctions between medical and aesthetic views of the importance of oral health.

Nonutilizing African American caregivers reported perceiving both dental and general health care in emergency rather than preventive terms (“It’s just not part of the routine. It sneaks up on you.” “If there’s no problem, it’s not important.”). They reported relying on home remedies for dental pain and believing dental care to be more important for older children than for younger children. In some cases, home remedy use was associated with the perception of difficulty in accessing dental care (“I’d never get into the dentist until a week later. I’d get children’s Tylenol and give it to her. Put some ice on it.”). Nonutilizing White caregivers reported that dental care was less important than other medical care, and they would engage in preventive health behaviors before preventive dental care. One caregiver stated, “I consider the things I do for my heart the most important. Other things come after that.” A dental visit would usually be for dental pain not treatable at home, with the emergency room the most likely source of care. “I never took my child to the dentist until last year, when she had a real bad toothache. She never had any problems so I never took her.” Nonutilizing White caregivers expressed high expectations of tooth loss with aging: “My mom was a single parent with 8 kids and no insurance, and she didn’t stress dental care . . . she got false teeth when she was my age.”

Utilizing caregivers more strongly expressed the belief that dental care is equally as important as medical care and that oral health is integral to overall health (e.g., heart disease). Nonetheless, some perceived dental care as something “the poor must often set aside” and that societal emphasis on medical over dental insurance reinforces beliefs that dental care is less important to health. “Our society has said so many organizations must provide medical coverage but that does not include dental. That’s saying that dental coverage is not as important as medical coverage. I think our society has just accepted that.”

African American caregivers who accessed dental care were knowledgeable about infant gum and tooth care and about long-term consequences of dental disease in baby teeth. By contrast, nonutilizing caregivers were less knowledgeable and were more likely to report practices harmful to baby teeth.

**Responsibility for Children’s Preventive Dental Care and Oral Health**

Belief about responsibility for children’s professional preventive dental care was a major factor that differentiated utilizing from nonutilizing caregivers. Utilizing caregivers said accessing professional preventive dental
TABLE 2—Perceived Barriers Experienced by Utilizing and Nonutilizing Caregivers of Medicaid Insured Children

<table>
<thead>
<tr>
<th>Factor/Barrier</th>
<th>Utilizing Caregivers</th>
<th>Nonutilizing Caregivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver responsibility</td>
<td>Normative belief that caregiver responsibility for health includes professional preventive dental care</td>
<td>Weak norm that caregiver responsibility for health includes professional preventive dental care</td>
</tr>
<tr>
<td>Oral health beliefs</td>
<td>Professional dental care important for prevention of dental problems, monitoring dental growth, and development of life-long dental habits</td>
<td>Lack of knowledge</td>
</tr>
<tr>
<td>Knowledge of Medicaid</td>
<td>Knowledgeable about Medicaid services and system</td>
<td>Lack of control of child’s oral health behavior</td>
</tr>
<tr>
<td>Quality of care and trust</td>
<td>Parents are responsible for ensuring quality and access</td>
<td>Oral health important for appearance, self esteem, and hygiene</td>
</tr>
<tr>
<td>Medicaid provider experiences</td>
<td>No difficulty in locating Medicaid providers (African American)</td>
<td>Dental care less important than medical care</td>
</tr>
<tr>
<td>Caregiver’s dental experiences</td>
<td>Neglect of own dental health due to lack of insurance and low priority</td>
<td>Tooth loss inevitable</td>
</tr>
<tr>
<td>School policies</td>
<td>School attendance policies a factor to be worked around</td>
<td>Dissatisfied with dental care they had received</td>
</tr>
<tr>
<td>Structural barriers</td>
<td>Structural barriers overcome by scheduling dental appointments during summer and school breaks</td>
<td>High levels of personal dental fear (African American)</td>
</tr>
</tbody>
</table>

Physical and psychosocial factors included feeling in control of their child’s dental experiences, setting a positive example for home preventive dental care (brushing and flossing), and transmitting positive attitudes to children about professional preventive dental care. Other factors included feeling knowledgeable about services and products available to support children’s oral health and being proactive in accessing children’s dental care. “I’m going to do whatever I have to do to prevent any type of health or medical issues for my child.”

Nonutilizing caregivers did not strongly identify professional preventive dental care as a normative caregiver responsibility and did not strongly associate dental care with a child’s overall health. These caregivers reported their children were not aware of the consequences of poor oral health, they were not transmitting positive attitudes about dental health, and they were having difficulty overcoming children’s resistance to regular brushing and flossing. Nonutilizing White caregivers in particular reported setting a poor example, lacking sufficient knowledge about oral health, relying on schools and dentists to transmit oral health information to children, and not being in control of their children’s oral health behaviors. Nonutilizing African American caregivers reported a lack of knowledge about child dental care and oral health.

Knowledge of Medicaid Coverage and Children’s Dental Services

In Kentucky, Medicaid provides reimbursement to providers for 1 prophylaxis per year and the restorative, surgical, endodontic, and prosthetic treatment needs of eligible children. Participants in all caregiver groups were unclear about Medicaid coverage for pediatric dental services, and fear of additional costs was a barrier for some. Although all groups reported that children should have 2 preventive dental visits per year, most reported 1 pediatric visit annually. Utilizing caregivers were more knowledgeable than nonutilizing caregivers about the range of services, Medicaid-provided transportation, and how to locate Medicaid dentists.

Perceptions of Medicaid Providers

African American and White caregivers reported strikingly different perceptions of the availability and the ease of locating dentists who accept Medicaid in Jefferson County. African American caregivers reported that they had little difficulty locating Medicaid providers and that most dentists accept Medicaid. Discussion showed shared community knowledge of available dentists. Utilizing African American caregivers generally reported positive experiences with Medicaid providers. Some reported seeking child-friendly, high-quality dental care outside their neighborhoods and being willing to pay out-of-pocket rather than receive inferior care closer to home. One caregiver commented on the “cultural Whiteness” of a suburban dental office (e.g., music and
Lack of familiarity was suggested as a potential barrier to accessing care. “All she sees is children. . . . She’s got the TV/VCR set up with different kids’ movies or she’s got music and posters on the ceiling. It’s fun.”

This provider was contrasted with dentists who were “in it to get Medicaid money” and who “don’t respect their patients.” Utilizing caregivers reported difficulties using public transportation to reach quality providers during convenient hours. Utilizing African American caregivers reported some experiences with discrimination attributed to racism and ability to pay from both African American and White providers.

Nonutilizing African American caregivers reported discriminatory treatment as Medicaid recipients; however, some reported better treatment when paying through Medicaid than out-of-pocket. “We lived in the projects. We didn’t get treated differently. Dentists knew we were on Medicaid and they were getting paid.”

White caregivers reported difficulty locating dentists who accept Medicaid and/or new Medicaid patients, delays with appointments, and being dissatisfied with the treatment they received as Medicaid recipients. A utilizing caregiver said, “You call and you say, ‘Are you taking new patients?’ Yes, we are. ’When you say, ‘I have Medicaid,’ ‘No, we’re not.’ That’s wrong.” Dissatisfaction with dentists who accept Medicaid was particularly strong among White nonutilizing caregivers. “The offices aren’t as nice. The services they give your kids may be what they consider necessary, and it isn’t as much as what another dentist considers necessary.”

Utilizing caregivers also expressed frustration with Medicaid providers who rescheduled appointments, which disrupted care and required renegotiation of factors such as time off from work and transportation. White caregivers generally reported not using Medicaid-provided transportation and expressed dissatisfaction with the convenience of the service.

African American utilizing caregivers emphasized the importance of developing trust, building a good dental provider relationship for their child, and avoiding negative experiences. “My children have had 2 dentists in their entire life. They got to know everybody in that office.” Lack of familiarity was suggested as a potential barrier to accessing dental care: “There ought to be some way that parents can have some contact with dentists before they need to take children. I feel crazy taking my child to a dentist I know nothing about, that none of my friends know anything about.” Another said, “I wanted to take my daughter, but I wanted to go somewhere that I knew and was acquainted with.”

Caregiver’s Dental Experiences

Nearly all caregivers reported neglecting their own dental health. Nonutilizing caregivers expressed dissatisfaction with dental care they had received. They complained of pain, poor quality, cost and uncertainty of cost, and discriminatory experiences on the basis of income and ability to pay. High levels of dental fear among nonutilizing caregivers, which was most pronounced among African American caregivers, may affect seeking care. Fear included needles, needles or fingers in the mouth, pain, sedation (fear of unwanted touching), and receiving bad news (e.g., cancer).

Both utilizing and nonutilizing caregivers reported dental care experiences among their family of origin influenced their oral health beliefs and dental care behaviors. White caregivers frequently described having little or no childhood exposure to preventive dental care, with dental care either out of reach or not of importance in their families: “I have a very large family. Nobody got dental treatment until we went into foster care. No dental, that’s just the way I thought it was in the country. Poverty stricken.” Some nonutilizing African American caregivers expressed similar experiences: “My parents didn’t care if we brushed our teeth or not.” “I don’t think my parents didn’t care. It wasn’t possible.” Utilizing caregivers reported being motivated by these experiences to access dental care for their children, and nonutilizing caregivers reported unfamiliarity and discomfort with dental providers and less confidence in their ability to locate and access dentists.

School Policies and Programs

All nonutilizing groups reported school absence policies as a barrier to accessing care, a problem compounded by provider schedules, multiple children, transportation difficulties, inconvenience, repeat visits, and missed work. A White caregiver said, “I have to bring a note back from the dentist, even though I went and signed my child out, stating that I was there before they will make that an excused absence. And she’s like, ‘Can’t you make these appointments after school or on the weekends?’ No, you can’t.” School policies were perceived to not treat medical and dental appointments equally: “The school does not consider that important. It’s not a doctor visit. That’s absent. They should consider that the same as a doctor’s appointment.”

However, utilizing African American caregivers reported little difficulty with school policies and with scheduling dental visits during weekends and school breaks. White utilizing caregivers were similarly better able to negotiate school policy and transportation factors than nonutilizing caregivers, but they reported more difficulty than African American caregivers.

Most caregivers were aware of school-based dental programs. Acceptability of free school-provided dental screening and/or treatment was related to 2 factors: preference for care giver-controlled care and beliefs about caregiver responsibility. Nonutilizing caregivers were generally accepting of school-based programs but would limit care to cleaning and checkups unless the caregiver was present; White nonutilizing caregivers were most accepting of having someone else take their child to the dentist.

Utilizing African American caregivers were the least accepting of school-based programs. They emphasized caregiver responsibility and that caregivers should be present for any dental care for several reasons, including safety, discrimination by staff, and preventing a bad dental experience. “I think the parent or a family member needs to be involved when children are going through any kind of procedure. The parent really needs to be confident of what’s happening to their child.” Utilizing White caregivers would limit school-based programs to screening only; all caregivers wanted more detailed information about participating dentists before accepting care.

Overcoming Structural Barriers

Nonutilizing caregivers reported their lives were too busy and complicated to overcome the many structural barriers they faced. “We ride a bus. We don’t have a car. We don’t have daycare. We work around each other’s schedule. The dentist is not the number one priority.” Nonutilizing African American caregivers...
pointed to structural barriers, including the length of time required for appointments, difficulty coordinating with employment, and negotiating care for several children. “When you have 4 or 5 kids, it’s hard to get on the bus, get them out of school, get them back home.”

Nonutilizing caregivers reported little or no assistance from family or friends, a potential resource for overcoming barriers to accessing care. Reasons included support not being available or desire to avoid reciprocity. Utilizing caregivers more often described ongoing involvement of a family member (e.g., grandmother, spouse) in childcare responsibilities, involving a family member (e.g., grandparent) in ongoing caregiving more often described ongoing involvement of a family member (e.g., grandparent) in ongoing caregiving.

Our study confirmed many previously identified structural barriers, including difficulty locating Medicaid providers, scheduling convenient appointments, transportation, and discrimination. Our findings suggest that caregivers may experience and respond to these barriers differentially in ways that affect care-seeking behaviors. Importantly, educational attainment was higher among caregivers who utilized professional preventive dental care for their Medicaid-enrolled children than among caregivers who did not. Perceiving oral health to be associated with overall health, identifying professional preventive dental care as one of activities that fall within normative caregiver responsibilities, and greater knowledge of preventive dental care are mediating beliefs associated with education.

We found support for a relationship between medical and aesthetic motivations for preventive dental care and utilization. During focus group discussions, nonutilizing caregivers emphasized appearance, self-esteem, and pain as being more important reasons than preventsive concerns for accessing care, and they viewed dental care in emergency rather than preventive terms.

Our findings show heterogeneity in experiences of poverty and public programs within 1 service area that may have implications for seeking care. African American caregivers reported greater availability of Medicaid providers and greater satisfaction with dental experiences than White caregivers did, which perhaps reflected residential location and distribution of dentists who accepted Medicaid. However, African American utilizing caregivers reported proactive steps (paying out-of-pocket, traveling outside their neighborhoods) to access high-quality care. These options may reflect the somewhat higher income levels reported by utilizing African American caregivers than nonutilizing African American caregivers. (The majority reported incomes close to or below 2004 federal poverty guidelines.20) All groups reported poor dental care during childhood; unfamiliarity with pediatric dental care and expectations of poor oral health and tooth loss were most common among White nonutilizing caregivers.

We sought caregiver responses to school-based dental screening and treatment programs, such as a recent demonstration project that provided free dental care and transportation, which was conducted by the University of Louisville School of Dentistry and the Colgate-Palmolive Company. Preferences for caregiver-controlled dental care, concerns about negative experiences, and concerns about unnecessary treatment were identified as potential explanations. School absence policies discouraged seeking care, although schools were identified as sites of dental education.

Study Limitations

Limitations to our study include potential selection bias. Recruitment was particularly difficult among utilizing White caregivers, which may have been the result of more suburban residential locations and employment commitments. Jefferson County may not represent experiences in other locations. Our study also was limited in racial/ethnic diversity; the current population of the county is 76.4% non-Hispanic White and 18.9% African American.21 Finally, our study was exploratory in nature; further research into the identified psychosocial and cultural factors is necessary to support effective community-based interventions.

Conclusions

Our results suggest that interventions to improve utilization of professional preventive dental care among Medicaid-enrolled children should include efforts to educate caregivers about the importance of oral health for overall health and include professional preventive dental care as part of caregiver responsibilities for a child’s overall health. Community-based initiatives, including school-based programs, should emphasize developing trust with providers and encouraging and supporting caregiver-controlled care. Providers, with Medicaid program initiatives, should encourage Medicaid clients’ identification with a “dental home.”

About the Authors

Susan E. Kelly, Catherine J. Binkley, and Bruce S. Gale are with the University of Louisville, Louisville, Kentucky. William P. Neace was with the Pacific Institute for Research and Evaluation Louisville Center, Louisville, at the time of the study.

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Contributors

C.J. Binkley originated the study and supervised all aspects of its implementation. S.E. Kelly and B.S. Gale developed focus group materials, conducted the focus groups, and completed the analyses. S.E. Kelly supervised data analysis, synthesized analyses, and led the writing. W.P. Neace participated in the study design, sample preparation, and project data management. All authors developed analytic concepts, interpreted findings, and reviewed the text.

Human Participant Protection

The institutional review boards of the University of Louisville and the Kentucky Cabinet for Health Services reviewed and approved the study.

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References

Caring For Our Children: National Health and Safety Performance Standards for Out-of-Home Child Care

Caring for Our Children is the most comprehensive source of information available on the development and evaluation of health and safety aspects of day care and child care centers. The guidelines address the health and safety needs of children ranging from infants to 12-year-olds. This field-reviewed book provides performance requirements for child care providers and parents, as well as for regulatory agencies seeking national guidelines to upgrade state and local child care licensing.

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