ORIGINAL ARTICLE

A mixed methods study reviewing consumer experiences for oral health treatment in Medicaid-eligible children in Florida

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Abstract

Objectives: Oral health is essential to a person's overall health, well-being, and dignity; unfortunately, dental caries, which can cause pain and difficulty eating, affect approximately 50 percent of children between 6 and 8 years old. This is in part because Medicaid-eligible children face numerous obstacles obtaining dental care. To date, there are 74 million Americans who do not have dental coverage or access to dental services, which is strongly associated with race, class, gender, and ethnicity. The objective of this research was to identify barriers to accessing and utilizing children's Medicaid oral health care and services, to evaluate care delivery and quality, and to assist in establishing a more consumer-driven approach.

Methods: A mixed methods study was conducted throughout the state of Florida, using qualitative and quantitative data collection to seek answers to these questions. There were 422 surveys and 39 interviews distributed to Medicaid-eligible families and individuals across the state; data collection focused on experiences with oral health care, gaps in current access to Medicaid dental care, and concerns when utilizing care.

Results: Our study shows the majority of barriers parents face when accessing Medicaid oral health care are due to logistical access issues, such as cost, appointment wait-times, and confusion surrounding which dental providers accept specific insurance plans. The findings also highlight how location, race, language, and ethnicity impact families who lack preventive dental health services access and how, in turn, families view their own access to dental services.

Conclusion: Ultimately, there exists an avenue to implement programs and policies that address existing disparities in oral health to improve health outcomes by increasing access to care and reducing cultural and socioeconomic barriers.

Introduction

Oral health is central to a person's overall health and well-being. To this end, the federal government created Healthy People 2020, a nationwide agenda promoting health in the United States, which highlights oral health in children and adolescents as one of its primary objectives.[1] Public health measures and goals surrounding children's oral health reflect the importance of this subject for state and federal programs and budgets. While programs in the United States have improved oral health outcomes through preventive care and services, 74 million Americans lack preventive dental coverage in 2016.[2] This is a problem because poor oral health due to lack of regular treatment can cause pain and tooth loss, impede productivity and potentially exacerbate a number of other chronic conditions. Additionally, dental caries (tooth decay) remains

one of the most common chronic health problems in the United States.[3] If untreated, dental caries contribute to pain and can cause difficulty eating and children with untreated caries are at greater risk for oral and craniofacial diseases.[4] In fact, outcomes related to poor oral health can persist through adulthood and contribute to a variety of issues that go beyond the mouth (e.g., diabetes, heart attack, etc.), which is a contributing factor to why the Office of Disease Prevention and Health Promotion has included Oral Health as one of its Healthy People 2020 objectives.[5] The National Association of Dental Plans (2017) notes that individuals without dental benefits are 67 percent more likely to have heart disease, 50 percent more likely to have osteoporosis, and 29 percent more likely to have diabetes.[6] While sizable progress has been made since the Surgeon General's Report on Oral Health, as we near the report's 20th anniversary, there are still populations who cannot readily access preventive oral health services.[5] Unfortunately, children of low socioeconomic status are at a higher risk for poor health indicators, like adverse dental or oral health care, which can continue from childhood to adulthood.[7]

Approximately 74 million Americans do not have dental coverage and many are less likely to use preventive dental services due to out-of-pocket costs.[2] This situation is exacerbated in some states in the United States, like Florida. Florida has not expanded Medicaid as part of the Affordable Care Act, one of only 14 states that have not done so, despite being the third most populated state in the nation.[8] Within this population, children are most at risk; according to the Centers for Medicare and Medicaid Services (2017), Florida remained low in national oral health rankings, with 47 percent of all US Medicaid-eligible children age 0–20 receiving any dental service (as supervised by a dentist) compared to only 40 percent in Florida.[8] Moreover, only 36 percent of Medicaid-eligible children received preventive dental services, compared to the national average of 45 percent.[8] Gaps in the ratios for children's dental care exist for many reasons and include but are not limited to the number of low-income children residing in the state, migrant worker status, inefficient use of healthcare system resources (e.g., no oral health care in hospital settings) and poor socioeconomic status.[9–11] Populations in Florida suffer from health inequality, as policy measures and underfunded programs continue to contribute to oral healthcare disparities.[9]

The objective of this research was to take a different perspective on the issue and instead, focus on the population's view on these programs. The goal was to review Medicaid-eligible parent's perspectives on children's oral health in Florida. The expectation was that by understanding the complexity and range of challenges that parents face when accessing dental care, alternate or supplemental programs or preventive services could be implemented to improve the rates of oral health care for children in Florida.

Methods

A mixed methodology was used for this study. A triangulation protocol was implemented, wherein data are collected and analyzed separately for each component to produce two sets of findings to gain a more complete picture of the data. This approach is converging and complements data and while it does not necessarily require a unique collaboration between researchers, partnerships can be created to conduct this research.[12] The research focused on parents and their children who were enrolled in social services organizations serving Medicaid-eligible populations in both rural and urban sites in Florida in 2017. Through focus groups ($n = 4$) and surveys ($n = 422$) with Medicaid-eligible families, the current state of dental health in urban and rural Florida was assessed.

Quantitative data

Surveys were administered both in English and Spanish to capture a broad spectrum of consumer experiences. These surveys were distributed to the top 10 counties in Florida with the highest number of Medicaid-eligible children (up to 20 years old) as of June 30, 2016 and included the following counties: a) Miami-Dade; b) Broward; c) Hillsborough; d) Orange; e) Palm Beach; f) Duval; g) Polk; h) Pinellas; i) Lee; and j) Osceola (Agency for Healthcare Administration, 2016). Surveys were administered using both a paper format and mobile technology (e.g., iPad) depending on preference and convenience for participants. The survey included 40 questions that determined basic demographic information, oral health practices and attitudes, barriers to accessing dental care for one's child, child's first dental visit, satisfaction of dental care treatment, and source of oral health information. Survey data from the 386 surveys were exported via SurveyMonkey and analyzed with SPSS statistical analysis software. Using SPSS, the distribution of responses from the surveys was examined. Next, potential relationships between basic demographics (e.g., race, income, education, employment status) and other variables related to insurance status, overall health, dental health, treatment at the dentist office, type of insurance, and so on were analyzed by running cross-tabulations.

Qualitative data

Focus groups were targeted to the same 10 counties referenced above with the highest number of Medicaid-eligible children in Florida. Strategies to recruit

participants included disseminating a promotional flyer that described the focus group session and research; providing incentives to participants for contributing their time; and word of mouth by employees, families, and friends. Interviews with focus groups were conducted. Each session lasted between 45 and 90 minutes and included between 6 and 15 parent/caregiver participants, depending on location. A nonthreatening, safe, and comfortable environment was created to aid parents/caregivers in sharing their perspectives and experiences. Participants were required to sign a consent form prior to participating in the session. The interviews were all transcribed and triangulated for content confirmation. Categorical codes were created based on the conceptual framework of a phenomenological study (as described by Moustakas) into which researchers organized descriptive data provided by study participants.[13] Five main code categories included "oral health," "barriers," "gaps," "education," and "prevention." Themes were then generated from these codes, which represented information that appeared to provide authentication of the experiences of individuals and oral health care. Themes were then reanalyzed and verified.

Validity is often a primary concern in qualitative research. The researcher established validity through peer debriefing and confirmability.[14] Peer debriefing and triangulation occurred during the initial writing, reviewing, creating of interview questions, analyzing data, and developing themes. Confirmability seeks to confirm results, which was sought by the comparison of answers to the point of saturation, as well as by cross-comparing data.

Results

Both survey and focus group participants were asked to identify the most important dental health issues that need to be addressed in their community to deduce how to best address the oral health disparities that exist among Florida's Medicaid-eligible children. The results from both methods suggest common themes in how to provide better oral health care moving forward in 2019–2020. The major themes illustrated that the most common barriers toward accessing dental care were tied to cost and locating a provider.

Quantitative results

There were 362 surveys administered and completed in English and a total of 24 surveys administered and completed in Spanish, bringing the total number of surveys to be included in analysis to 386. Most respondents were between the age of 25–34 years old (40 percent) or 35–44 years old (30 percent). Approximately one-third of respondents identified as Black or African American (30 percent), while 25 percent identified as Hispanic or Latino (including but not limited to Afro-Latino, White Hispanic, etc.), 19 percent identified as White, and 13 percent identified as Haitian/Creole. English was the most common spoken language among respondents at 69 percent; 14 percent spoke Spanish and 10 percent spoke Creole as their primary language. Majority of respondents reported living in Miami-Dade County (40 percent); in total, respondents represented 24 of Florida's 67 counties. Respondents in 8 of the 10 counties in Florida with the highest reported number of Medicaid-eligible children in 2016 were surveyed – only Duval and Osceola County were unaccounted for.

Of the total surveys administered ($n = 386$), 61 percent of respondents ($n = 235$) reported having a dentist that their child visited regularly, while 24 percent ($n = 95$) reported they did not and 3 percent ($n = 12$) declined to answer; respondents who declined to answer this question were skipped to the end of the survey and only answered demographic information.

There were 235 respondents who reported having a regular dentist for their child, and of those respondents, 88 percent ($n = 206$) reported that their child had health insurance, 3 percent ($n = 8$) reported that their child did not have health insurance, and 9 percent ($n = 21$) declined to answer. Medicaid was the most common type of health insurance among those who reported having a regular dentist (69 percent; $n = 140$), followed by private insurance (19 percent; $n = 38$), Kidcare/CHIP (6 percent; $n = 13$), and Medicare (5 percent; $n = 10$); 0.5 percent ($n = 1$) responded "Other" and 0.5 percent ($n = 1$) declined to answer.

Of the 95 respondents who reported not having a regular dentist for their child, 79 percent ($n = 75$) reported that their child had health insurance, 17 percent ($n = 16$) reported that their child did not have any form of health insurance, and 4 percent ($n = 4$) declined to answer. Medicaid was also the most common type of insurance among those who reported not having a regular dentist for their child (71 percent; $n = 53$), followed by private insurance (16 percent; $n = 12$), Medicare (7 percent; $n = 5$), and Kidcare/CHIP (4 percent; $n = 3$); 1 percent responded "Other" ($n = 1$) and 1% ($n = 1$) declined to answer.

However, there was a difference seen depending on whether the respondents reported having a dental home for themselves. There were 76 percent of parents/caregivers who had a regular dentist for their child also reported having a regular dental home for themselves, while only 22 percent of parents/caregivers who did not have a regular dentist for their child, reported having a regular dental home for themselves. Odds-ratio analyses confirmed that participants who had a regular provider were 2.69 times as likely to have health insurance for their children than those who did not have a dentist they visited regularly.

Among respondents who reported their child visited a dentist regularly, 30 percent reported their child had "excellent" overall health; of these, 20 percent reported having Medicaid, 8 percent reported having private insurance, and 2 percent reported having Kidcare/CHIP. There were 38 percent of respondents that reported having a child in "very good" overall health; of these, 26 percent reported having Medicaid, 8 percent reported having private insurance, 3 percent reported having Kidcare/CHIP and 1 percent reported having Medicare.

Among the 235 respondents who reported their child had a dentist they saw regularly, 69 percent ($n = 162$) of respondents reported ever having to cancel an appointment. The most common response when asked what reasons they had for canceling an appointment was that "the time was not convenient for me" (30 percent), followed by "I couldn't find transportation" (12 percent), "it was too expensive" (9 percent), "the wait at the office was too long" (5 percent), and "no one in the office spoke my language (3 percent)." Most respondents reported that they felt they were treated "very well" (41 percent) or "well" (43 percent) during their child's last dental visit.

To identify areas of concern while visiting a dentist, papoose boards were highlighted as a negative aspect that may hinder dental care. Roughly one-fifth of respondents (19 percent) who reported their child had a dentist they saw regularly ($n = 235$), reported that their dentist had used a papoose (a restraint to keep the child from moving during dental work or a dental exam) for their child during their dental visit.

Among respondents who reported their child did not have a dentist they visited regularly ($n = 95$), approximately one-third of respondents (30 percent) reported that they found dental health information from their child's doctor, 16 percent of respondents reported finding dental health information for their child online, 11 percent reported finding information from their family/friends, and 7 percent reported finding it from their child's school; approximately 8 percent of respondents reported not knowing where to find this information.

When asked how much they agreed with the statement that dental health was an important part of their child's overall health, majority of respondents replied that they either "strongly agree" (55 percent) or "agree" (22 percent) with the statement; 20 percent declined to answer. When asked what some of the reasons were why the child did not visit the dentist, the most common answers were "it is too expensive" (15.5 percent), "my child does not have dental insurance" (15.5 percent), and 'I cannot find a dentist for my child" (14.4 percent).

Qualitative results

From November 2016 to October 2018, four focus group sessions were conducted in the qualitative portion of this study. Participants were parents in counties with the highest number of Medicaid-eligible children in Florida. There were 39 participants total (36 females, 3 males) ranging in age from 18 to –70 years old. Participants identified as "Black or African American" ($n = 25$), "Haitian/Creole" ($n = 8$), "Hispanic or Latino(a)" ($n = 3$) and "Other" ($n = 2$). The primary language spoken at home was English ($n = 34$), though a few participants reported Creole ($n = 3$) as their primary language, as well as Spanish ($n = 2$). Most participants' children were insured through Medicaid ($n = 37$), though one child was reported as uninsured. Themes identified included: a) knowledge and care; b) barriers to accessing services; and c) consumer access to information.

Knowledge and care

In general, participants experiences focused on the importance of preventive dental care. They noted the importance for personal, cosmetic, and general health reasons. "It's very important. It affects everybody's self-esteem, you know, you see your kids walking around with their heads down, not smiling, it's because of their teeth…" P3.1. There was an overall knowledge about dental health that was described by participants., "You could have a toothache but then symptoms take over your body, and you get a fever, or chills, or an abscess in your mouth." P2.4 However, participants believed that preventive dental health was not as important as other health issues, "if nothing is wrong visually, then why go to the dentist?" P1.5 These data suggest a range of behaviors and attitudes exist in parents in regard to their children's dental health.

Participants highlighted the need to be guided through processes that may be new to them and their children.

> My son was in pain… and the dentist didn't do anything to calm him down, or talk to him, or walk him through it, and so I had to be the monster and scare him into sitting there, and the dentist walked out of the office and said he wouldn't do it. The dentist shrugged his shoulders and walked away. P3.1.

Finally, participants described their perceptions of dental care for themselves and their children. "The chair looks like a torture setting, the tools are scary." P1.2 Other participants described how they were scared of "needles" P1.1, "metal in your mouth" P1.3, and "[the] drill sound" P1.1. That said, participants also noted how the importance of education with dental care could change the perception of the experience.

> I'm excited to be here. In my experience, a lot of people [experience] fear because [they] don't know the issues they're having, but once they learn about it, they pursue oral health care and issues resolve themselves. P2.2.

Barriers to accessing services

According to participant experiences, there were several barriers that prevented Medicaid-eligible families from accessing dental health services. Participants revealed issues primarily related to cost, limited Medicaid-eligible dental offices, inconsistency of dental offices offering services to Medicaid eligible families, outdated information, limited hours, appointment wait times, transportation and distance, and general poor treatment from providers. The financial costs associated with going to the dentist were a major theme described by participants as well. "It's really expensive to go to the dentist." P2.2 Even when participants' children were able to go, Medicaid did not cover the treatments. "There are services that Medicaid won't cover and it's too expensive without coverage." P2.3 Participants further described another difficulty with Medicaid, which was when physicians or offices do not accept it. "Even if you have Medicaid not all doctors accept it. I have Coventry as a provider, and it hasn't been stable. It has taken a long time to find a dentist. I don't have a dental home because it takes so long to find a doctor." P2.1.

> Participants explained the difficulty in finding providers and updated information.
> The provider list is never updated – you'll call, and they say, 'Oh, we stopped accepting Medicaid patients altogether', so the provider list pretty much is never useful. P4.3.

When participants were able to find and make appointments, there were limited time slots available for them to visit. "Maybe they could make it more convenient for working parents, like longer hours." P1.1 Transportation to and from the appointment was discussed by participants as well. "Right now I don't have car and the dental office is far, the wait is horrible, and I work, I'm inconvenienced." Participants highlighted the long wait times while at their appointment and in the office. "After I call for an appointment, I have to wait for 2 months, and then when I go to the appointment, I have to wait for hours [to be seen by the doctor]." P1.4 Once the children were in their appointment, participants described the poor service. "The treatment in general for Medicaid patients, is kind of like whatever service I give you will be what you get. It's not a great situation." P1.7.

Consumer access to information

Parents experiences described their reliance on referrals and word of mouth to find dentists and other information for dentists in their communities. "My primary care doctor has been really helpful with that [making referrals]." P1.2 Technology (radio, TV, and the Internet) and those who have access to these sources of media were also useful for people looking for oral health services. One participant described, "Supermarkets, Walmart, Presidente, churches and adult schools [where GED programs are located] [were good areas to find health information.]" P2.2 Suggestions were also made where people could access information, "Health fairs are usually really helpful and I feel like if resources were given to children's schools, that could be helpful [too]." P1.1.

Discussion

The results of this study highlighted several important factors that affected Medicaid-eligible children receiving dental healthcare in Florida. Quantitative data illustrated that the most common barriers accessing Medicaid dental care were tied to cost and locating a provider, while qualitative data found difficulties in provider service. Interesting barriers identified for children accessing care evidenced in this research included cultural aspects involved with dental care (e.g., use of a papoose), difficulty finding providers, novel places to locate dental information (e.g., culturally based centers), and a high number of canceling appointments despite finding a provider. Delving deeper into these areas through future research could help to better understand their magnitude and effect.

Inability to afford care was a primary aspect encountered through these data. This was not surprising, as the number of Americans who do not have access to dental insurance is four times greater than people without medical insurance.[2] Interviews also suggested the difficulty in making dental appointments for their children and then being treated poorly when seen by the dentist, which could be offset by being a long-standing patient. This type of discrimination has been visited in literature before, reported based primarily because of Medicaid status.[15–18] Moreover, some parents indicated that they had dental insurance, but still could not afford services for their children, as Medicaid currently only covers certain procedures for children age 0–20 in Florida. Misinformation and outdated resources about which dental providers accept which insurance was also a common reason parents had issues accessing dental care. In fact, more than two-thirds of the dentists are not participating in Medicaid; Medicaid participation is affected by dentists' perception of social stigma from other dentists who participate in Medicaid and the lack of specialists to whom Medicaid patients can be referred.[19, 20] This last point is an area that could be explored through further research studies (e.g., internal and external stigmatization of providing care for Medicaid participants.)

More unique challenges experienced by participants included inflexible work schedules, cost, wait times, and

lack of dental offices serving Medicaid-eligible families near immediate communities. Novel ideas include increasing office hours on specific weekdays or opening on weekends to better accommodate working parents who may otherwise not have the time to attend would improve access; this idea is a different approach to research that suggested distance traveled does not necessarily contribute to appointment-keeping behavior.[21] Many participants said Medicaid should improve communication with their members to update them on when their plans change (one participant noted her plan changed but she was never notified by Medicaid), and provide them with an updated provider list when changes occur. It may be more feasible for the Agency for Healthcare Administration to consider offering a resource that shows where to access free oral health services in each county or zip code for those who do not have a specific health insurance plan, like Aunt Bertha (https://www.auntbertha.com).

Other solutions and future directions or guidelines could be used to improve access to dental care for children, specifically. One means of improving access to care would be to use a dental care coordinator, which has been proven to increase dental utilization for children who receive Medicaid services.[22] Increasing awareness may help decrease the burden of future disease outcomes in Florida.[23] Another idea would be to amend Florida's current Scope of Practice rules for dental hygienists (DHs), which are currently very limited when compared to those in other states; the scope of practice for DHs is defined by each state's laws and regulations that describe the educational and certification qualifications for licensing, the settings in which services may be provided, the range of allowable services, and the required levels of professional supervision.[24]

Limitations

Selection bias in the sampling process and the use of self-reported data were cited as a major limitation in numerous consumer studies and is a limitation in the quantitative portion of this study. Daly and colleagues (2013) noted that recall and social desirability bias may impact the reliability of self-reported information.[25] Barrett and colleagues pointed out that mothers' responses about their child's oral health may be based on her knowledge of the "right answers."[26] Similar studies will face the same challenges without a complementing verification of parents' responses with medical record reviews or oral health exams of their children. Moreover, social desirability and translation errors may have also occurred in the qualitative portion of this study; thus, information gathered from the participants may not be generalizable or transferable to all people in the United States. Finally, nonresponse bias could occur.

Conclusion

This research determined that parents and caregivers in Florida have had poor experiences with Medicaid dental providers and office staff, and the majority of issues parents face when attempting to access and utilize oral health care arise from logistical access issues, such as cost, appointment wait-times, and confusion surrounding what dental providers accept specific insurance plans. These outcomes can have effects on children's dental care as well, which was the overall view of this research and subsequent data. Parent perspectives suggest there are constraints that exist at state, municipal, Medicaid, and inter-personal levels with Medicaid-eligible families and children's access to oral health. These findings can be used to further design programs that can improve access to dental care for children. The above recommendations would likely contribute to a reduction in early childhood caries in the state of Florida and promote the notion that oral health is inextricably linked to overall health.

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