FIRST 5 SACRAMENTO

# What Parents Are Saying About....

## Fear, Misconceptions and Other Barriers to Children's Use of Dental Services

Research Conducted by

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# Executive Summary

This report presents the results of interviews with 157 Sacramento County parents and other caregivers,[1] 123 (78%) of whom met the main study criteria: they had never taken or had delayed taking their child aged 1-6, covered by Medi-Cal, to the dentist. The purpose was to explore through one-on-one interviewing what kept them from utilizing or fully utilizing their child's dental benefits. The 123 parents comprise the main study sample and all references are to them unless otherwise noted. When we discuss the entire group of interviewed parents, we describe the study sample parents and their children as the "non-utilizer" families and those whose children *did* see a dentist in the last 6 months as the "utilizer" families. While the 34 "utilizer" families represent a small sample, their experience and helps to inform the analysis.

## Positive Findings

- Nearly all parents expressed positive attitudes and beliefs about oral health regardless of whether their child had made a recent dental visit. (A few, however, thought *they* were the best ones to assess their child's oral health status during the early years.)
- 1 in 2 parents knew children should see a dentist once they had developed teeth or by their first birthday (47%, however, were not aware of this).
- Knowing that First Tooth/First Birthday was the time for a child's first dental visit was positively associated with the use of dental services for children and parents alike; 28.8% of children with parents having that knowledge had visited the dentist within the last 6 months, compared to 14.7% of children with parents who were unaware.
- Contrary to expectations, transportation difficulties did not emerge as an important reason for no/delayed dental visits.
- While parents had negative things to say about non child-friendly *dental offices*, there were almost no negative comments about the dental managed care plans they were enrolled in.

## Findings that Present Challenges

- While it was usually the parent who thought their child was too young to see a dentist, 35% who delayed taking their child for that reason were told to do so by a dental or medical office.
- Dental fear and anxieties expressed by the child or the parent's fear from their own experience emerged as one of the most important barriers that influenced the use of dental services.

[1] The term "parent/caregiver" includes anyone with the primary responsibility of raising the children.

- Parents were really concerned about taking their child to a child-friendly dentist. They sometimes waited until they learned about one through friends' experience before deciding to take their own child to that dentist for the first time.

- Non-utilizing families reported to a greater degree than utilizing families that their lives were too busy and complicated to overcome the personal or structural barriers they faced, (e.g., "*Going to the dentist is not a number one priority at this time*").

- The frequency of children's visits for dental services was lower than for medical appointments. This is important because well-child and other preventive medical visits are strong predictors of visits to the dentist.

- Some parents think that if their child does not eat a lot of sugar there is no need to take them to the dentist because "*Then they shouldn't have cavities*."

- Many parents reported neglecting their own dental health. Only 1 in 5 had made a dental visit in the last year. The main reasons were lack of any type of dental insurance (or money to self-pay) and fear of the dentist. Parent non-use is important because of its relationship to children's non-use.

- The more time that passed since parents visited a dentist was associated with a greater likelihood that their children would not have seen a dentist recently or at all. Among parents without a history of a recent dental visit, 85% of their children had also not had a recent or any dentist visit—a statistically significant proportion.

## Recommendations

The following recommendations, which are more fully described beginning on page 28, are a reminder of some of the essential ways to improve access and utilization of dental services for low-income populations.

**A.** Support a broad-based oral health education campaign that uses the stature of the California Department of Health Care Services to encourage families to "Call your dental office today."

**B.** Ensure and modify if needed, oral health educational materials that contain information linking the importance of good oral health to good general health.

**C.** Broaden the First Tooth/First Birthday campaign to include non-traditional organizations and businesses that interact with families of young children; continue to support current organizations that are engaged in this effort.

**D.** Require the child-friendliness of enrolled dental offices and help parents navigate the dental network to enroll in practices that serve young children especially well, communicating to

parents that dentists' offices have become much more kid-friendly and new techniques and procedures make visits more child-friendly.

**E.** Fund the inclusion of oral health education in programs, community resources and classes that reach parents in places where this information is not traditionally included.

**F.** Ensure every baby born in a Sacramento maternity hospital receives a Sacramento County customized *Kit for New Parents*; continue to include the oral health products currently offered.

**G.** Ensure all home visiting programs and family resource centers find ways to include key messages about oral health and encourage clients to make (and keep) dental appointments for their children and themselves.

**H.** Make families with Medi-Cal Dental Managed Care benefits aware of transportation assistance opportunities through their dental plan.

**I.** Support basic adult dental services for more low-income adults.

# Introduction

Although dental disease is preventable, it remains the most common chronic disease of childhood, disproportionately affecting low-income children.[2] This is particularly disturbing because dental disease can affect all aspects of children's lives: from their nutrition and sleep habits to their educational performance and self-esteem. For example, children with poor oral health status are nearly 3 times more likely than their counterparts to miss school as a result of dental pain.[3] Importantly, the foundation of adult oral health is "laid during the formative preschool years when a child's dental health pattern and caries (cavities) risk are established."[4] According to research, early prevention of caries is the key to a receptive, cooperative child regarding oral health in later years.

The main predictors for routine dental visits are higher economic status, mothers with more schooling, and caregivers who receive guidance about prevention.[5] Data from one study of 423 low-income African American kindergarteners and their families, for example, showed children of parents/caregivers with high school diplomas were nearly 6 times more likely to visit the dentist routinely.[6]

Children with the highest prevalence of oral disease, including children with Medi-Cal, face the greatest barriers to accessing dental services and are the ones least likely to visit the dentist.[7] Barriers to receiving dental services include personal family issues as well as "structural" or dental delivery system issues.

The lack of enough Denti-Cal providers—due largely to low reimbursement rates and cumbersome administrative processes—and the inability to manage young children in the dental office are known to account for the main barriers on the delivery system side.[8,9,10] On the patient side, factors such as a lack of perceived need and knowledge about the importance of oral health, dental fear and logistical challenges like transportation have been shown to

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[2] Benjamin RM. Oral Health: The Silent Epidemic. *Pub Health Rep.* 2010; 125(2): 158–159.
[3] Jackson SL, et al. Impact of poor oral health on children's school attendance and performance. *Am J Public Health.* 2011 October;101(10): 1900–1906.
[4] Johnsen DC. The preschool "passage." An overview of dental health. *Dent Clin North Am* 1995;39:695-707. In Mattila M-L et al. Caries in five-year-old children and associations with family-related factors *J Dent Res* 2000;79:875-881.
[5] Camargo MB et al. Predictors of dental visits for routine check-ups and for the resolution of problems among preschool children. *Rev Saude Publica* 2012;46(1):87-97.
[6] Heima M et al. Caregiver's education level and child's dental caries in African Americans: a path analytic study. Caries Res 2015;49:177-183.
[7] Mouradian WE, Wehr E, Crall JJ.. Disparities in children's oral health and access to dental care. *JAMA.* 2000;284(20):2625–2631.
[8] *California Department of Health Services. Weaknesses in its Medi-Cal Dental Program Limit Children's Access to Dental Care*. Report 2013-125. Sacramento: California State Auditor, December 2014.
[9] *Without Change it's the Same Old Drill: Improving Access to Denti-Cal Services for California Children through Dentist Participation.* Sacramento, CA: Barbara Aved Associates, October 2012. http://www.barbaraavedassociates.com/samples/denti-cal-final-report-nov-2-2012.pdf.
[10] *Provider Experience with Denti-Cal: Findings from a Market Study of California Dentists and Clinics.* Sacramento, CA: Barbara Aved Associates, January 2015.

contribute to delayed visits and high rates of appointment no-shows.[11] The Geographic Managed Care (GMC) Dental Plans that serve most Sacramento County children have consistently cited these factors as contributing to the challenge of providing services to their Medi-Cal members.

This report presents the results of interviews we conducted with parents whose children had Medi-Cal coverage but were not fully using or not using their dental benefits at all. The purpose was to learn what prevented them from doing so.

## Background

In 2010, and again in 2016, we studied the GMC dental program and learned that Sacramento County children with Medi-Cal visited the dentist less often than their statewide peers did.[12,13] About one-third (35.4%) of Sacramento children compared to one-half (50.9%) of California children made a routine dental visit in 2015. Utilization was even lower for the 0-3-year olds: 18.8% locally and 31.9% statewide.[14] Utilization levels actually slipped a little in both the state and Sacramento County, which in fact had plateaued since 2013. Why, one wonders, when children have good dental benefits with no cost to families, and theoretically do not have to hunt for a Medi-Cal dental provider because they are enrolled in a dental managed care plan, would the greatest majority not have regular dental care?

In 2015, we learned some of the reasons why Sacramento parents did not take their children with Medi-Cal to the dentist by conducting a Member Survey for the GMC Dental Plans.[15] Based on written surveys returned by 341 families (181 in Sacramento County, 160 in Los Angeles County), a few reasons stood out markedly:

- having to wait too long during a dental visit (ranked significantly higher by Spanish-language respondents)
- fear of the dentist
- absence of any tooth pain so "no need to go"
- not knowing where to go (significantly higher among English than Spanish-language)

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[11] Freeman R. The psychology of dental patient care: Barriers to accessing dental care: patient factor. *British Dent J 1999(***187)**: 141–144. http://www.nature.com/bdj/journal/v187/n3/full/4800224a.html

[12] *Sacramento Children Deserve Better*. *A Study of the Sacramento Dental Geographic Managed Care Dental Program.* Sacramento, CA: Barbara Aved Associates, June 2010. http://www.barbaraavedassociates.com/samples/denti-cal-final-report-nov-2-2012.pdf.

[13] *Sacramento Children and Dental Care: Any Better Served Than 5 Years Ago? An Updated Study of Sacramento Dental GMC..* Sacramento, CA: Barbara Aved Associates, January 2016. http://www.barbaraavedassociates.com/samples/denti-cal-final-report-nov-2-2012.pdf.

[14] California Department of Health Care Services, Medi-Cal Dental Division, special data run for author, July 7, 2016.

[15] *Barriers to Utilization of Dental Benefits: Medi-Cal Dental Managed Care Member Survey.* Sacramento, CA: Barbara Aved Associates, January 2016. http://www.barbaraavedassociates.com/samples/Member%20%20Survery%20Final%20Report%20(Aggregate).pdf

These findings corroborated others' findings,[16] and included parent problems getting to the appointment, not feeling welcomed in the dental office, not thinking the child's problem was serious enough and feeling the child was too young to need to see a dentist.

Written surveys, however, can only tell so much. They cannot provide meaningful clarifications or follow-up answers. To get to the root of why parents delay taking their child to the dentist by their first tooth or first birthday, and what the barriers were and *really* meant to taking their young children for regular visits, First 5 Sacramento commissioned the present study.

## Acknowledgements

We wish to thank the many parents who took the time and interest to participate in our interviews and small-group discussions, sharing their experiences about their children's oral health and use of dental services. We are also very appreciative of the various organizations that hosted us and facilitated our access to these families. This study would not have been possible without their participation.

We extend warm thanks to Lupe Fussell, Prisila Isaias, Katarina Yaipen and Tatyana Antakova who assisted in providing interpreter services for some of our interviews.

We also wish to recognize the assistance of Julie Beyers, Program Planner, Oral Health and Medi-Cal Dental Advisory Committee staff at First 5 Sacramento Commission, for sending a letter of introduction to potential host organizations and for helpful suggestions about connecting with them. First 5 Sacramento has been a long-time leader in community oral health investments from parent and provider education to support of children's dental clinics. We particularly appreciated the children's gift bags that Sacramento County Smile Keepers Program and First 5 Sacramento made available as a thank-you for the participating parents; the toothbrushes and toothpaste the Sacramento District Dental Society provided for the bags were also a big hit with the families.

Barbara Aved, RN, PhD, MBA designed and conducted the study; Larry Meyers, PhD, and Elita Burmas, MS, of Barbara Aved Associates contributed to the statistical analysis.

[16] For example, see Kelly SE et al. Barriers to care-seeking for children's oral health among low-income caregivers. *Am J Public Health*. 2005 August;95(8):1345–1351.

# Study Method

The primary data for this study came from face-to-face interviews with low-income Sacramento County parents and other caregivers of young children that occurred between July 13, 2016 and October 7, 2016. The participant criteria established by First 5 Sacramento were:

- Being the primary caregiver of a child(ren) aged 1-6
- Having Medi-Cal coverage or no other form of dental insurance for the child(ren)
- Not having taken the child(ren) for a dental visit within the last 6 months[17]

It was inevitable that in a group setting there would be parents who did not meet all of the study criteria but participated in the discussion, for example, children with Medi-Cal who had a recent dental visit attending one of the library Toddler Story Times. Some of these "utilizing" parents, while representing a small sample, still had important experience to contribute, and their information was captured but not included in the data analysis except where noted. A few families with private insurance who were part of a group discussion were excluded from all the analyses.

Access to the study families was through local non-profit organizations. To reach a representative sample of Sacramento families, we contacted a variety of health and social service organizations, libraries and schools geographically distributed throughout the county. We explained in an email the purpose of the study and included a letter of introduction that First 5 Sacramento prepared. Non-responsive organizations were re-contacted at least twice with a request to participate. Attachment 1 contains a list of the organizations that agreed and were able to host. One additional organization hoped to participate but could never find the time to schedule us. Another organization declined, saying it "was not a fit" for their parent program.

Depending on the type of organization, we requested time on the agenda of an existing program or event (e.g., parent education class, storytelling time) to speak to participants either one-to-one or in a small group. For organizations that served parents with varying needs, we requested being scheduled with the types of families we described as those who "might be struggling with issues" and "experiencing greater barriers or having fewer resources for dealing with them" versus more stable families. Where there was a client flow situation (e.g., WIC clinics, food banks), we asked to be able to sit at a table in the waiting area and approach parents on a one-to-one basis and invite them for a personal interview. In the latter scenario, we set up a large sandwich board sign attractively decorated with a dental message that drew attention to the opportunity for an interview.

[17] We were a little flexible in counting last dental visit in that if the interview occurred in, for example, August and the parent said, "It was sometime earlier this year," we counted it as within the last 6 months. This was also the case if they added something like, "And her next appointment is next month."

We developed a participant consent form and made it available to any of the agencies that wished to use it (only one did); otherwise, all consents were obtained verbally from families. Only two families declined to be interviewed.

Close to three-quarters of the interviews were carried out on a one-to-one basis and the remainder as small-group discussions with parents answering a series of semi-structured and open-ended questions (Attachment 2). The small groups generally included about 6-10 parents and the discussions lasted an average of 25-30 minutes. The one-to-one interviews ranged from 10 to 15 minutes or longer when parents had many questions about oral health. For consistency, the study author conducted all of the interviews. Interpreters were available for Spanish and Russian-speaking families.

Because this was a convenience sample—participants were selected because of their accessibility—basic demographics such as race/ethnicity and geographic location/type of host organization were noted to ensure the study sample would be representative. However, the sample size was not large enough to analyze the data by these variables.

Each parent interviewed received an attractive gift bag—containing two children's books, a hand puppet, information about local dental resources, and toothbrushes, floss and toothpaste—as a thank-you for participating.

After the data were analyzed, the key findings were summarized and a final focus group, conducted at one of the School Readiness sites, was convened to validate and expand on them. The group was asked questions such as, "*Some parents don't take their young children to the dentist because they have fears. Can you tell me more about this? What do you think would help?"* Their feedback helped to shape our conclusions and recommendations.

It was our original intention that in addition to speaking with parents who were asked to recall their child's last dental visit, we would also interview another sample of families of children with Medi-Cal with no *documented* recent (or ever) dental visit. Since GMC Dental Plans' records of non-utilizing young children would be generally accurate—and accuracy of parental reports can be affected by recall timeframe—we thought there also would be value to accessing families in this way. We developed a protocol that conformed with Health Insurance Portability and Accountability Act regulations to conduct telephone interviews using randomly selected phone numbers of GMC Dental Plan members whose children aged 1-6 met the study criteria, and made a formal request to the Department of Health Care Services Medi-Cal Dental Division for a list of phone numbers with names withheld. After reviewing the request DHCS determined the information "could not be released."[18] Thus, all interviews for this study were based on in-person discussions and parent/caregiver recall of children's last dental visit.

[18] Letter from DHCS July 13, 2016. Similarly, the GMC Dental Plans were not allowed by DHCS to participate in this study by providing Medi-Cal member telephone numbers of children with no recent dental visit.

# Findings

This report presents the results of interviews with 157 Sacramento County parents/caregivers, 123 (78%) of whom had not taken their young child(ren) to the dentist within the past 6 months. This latter group, 123 parents/caregivers, constitutes the study sample in the analysis unless otherwise noted.

## The Study Sample

The greatest majority (91.9%) of the interviewees were parents (Figure 1); 11.6% of them were fathers. On balance, the interviews took place in similar proportion at various host organizations, with the largest portion occurring at community non-profit organizations such as the Robert's Family Development Center and Loaves and Fishes' Maryhouse (Figure 2).

**Figure 1. Type of Interviewee (n=123)**

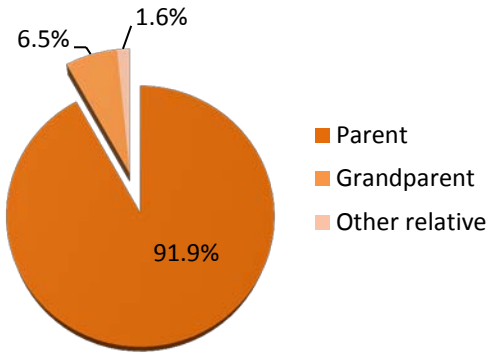
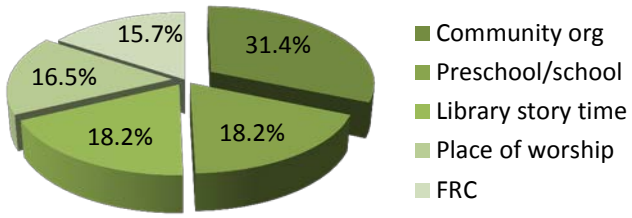



**Figure 2. Location of Interviews by Type of Organization**

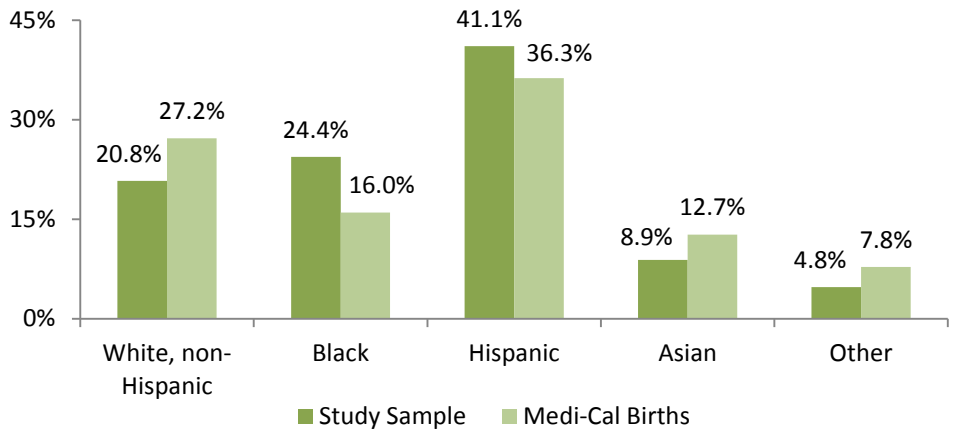



Although we did not collect dental enrollment data, the impression from the conversations was that the children were enrolled nearly equally across the 3 Medi-Cal Dental Managed Care Plans.

Using the most recent Medi-Cal birth data,[19] the study sample appears to be generally reflective of the Sacramento County Medi-Cal population by race/ethnicity. There are some differences, however. Our sample is somewhat overrepresented by Black families, generally proportional with Hispanic families and slightly underrepresented by White and Asian families (Figure 3 on the next page). About one-third (31%) of the White families, or about 7% of the total study sample, were Russian.

[19] 2011 Medi-Cal Birth Statistics. California Department of Health Care Services. http://www.dhcs.ca.gov/dataandstats/statistics/Documents/22_Birth_Report_2011.pdf

**Figure 3. Study Sample Families with Medi-Cal Compared to Sacramento County Medi-Cal Births by Race/Ethnicity**




Source: Medi-Cal Births by Beneficiary County and Maternal Race/Ethnicity, 2011

## Type of Insurance and Awareness of Benefits

Nearly all (95.9%) of the children of the families interviewed were covered by Medi-Cal; the remainder, 4.1%, had no dental insurance (Figure 4). A slightly higher proportion (5.9%) of the *non*-study interviewed families—those who met the insurance criterion but *had* taken their child to the dentist in the last 6 months—did not have dental insurance.

Almost all (95.6%) of the parents with Medi-Cal were aware that this program included dental benefits (Figure 5), although a handful asked whether certain services were covered.

**Figure 4. Type of Insurance Coverage**

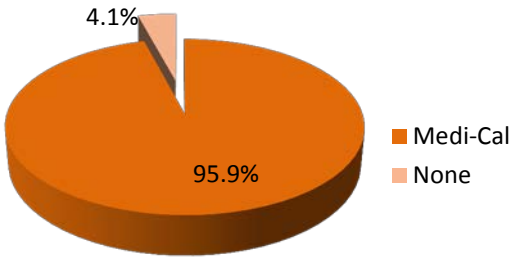
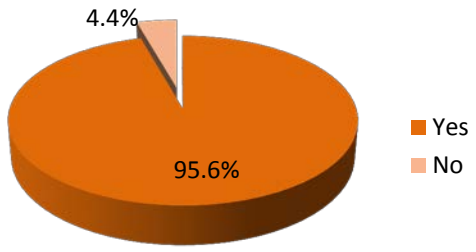



**Figure 5. Parents' Awareness of Medi-Cal Dental Benefits**




## Attitudes about Oral Health

While parents made positive statements about the *importance* of their child's oral health, about 10% expressed opinions that could have interfered with making a first appointment. These caregivers said that dental care experiences from their own childhood influenced their beliefs and affected their dental care behaviors. These beliefs were very similar to what focus

groups with other Medicaid families of non-utilizers have found that influences dental care-seeking behavior (Table 1).[20]

**Table 1. Parent Attitudes that Influence Dental Care Use**

| Supportive Attitudes | Non-Supportive Attitudes |
|---|---|
| ▪ It's as important as other medical care for your child.<br>▪ It's important to not neglect your teeth (especially if parent has bad teeth).<br>▪ It's just something you need to do, even if you're kind of scared. | ▪ Do not see the relationship of oral health to overall health.<br>▪ Dental visits are more important for permanent teeth.<br>▪ No need to see a dentist until child is older if parent feels she/he is taking good care of child's teeth.<br>▪ No need to see a dentist if parent can't see any problems in the child's mouth. |

Informative and interesting comments that offer a glimpse of the types of families who present special challenges included the following:

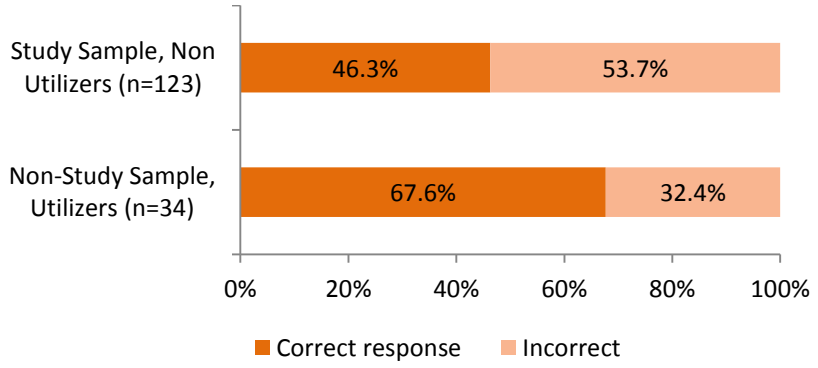
- *"All you have to do is take good care of them [teeth], brush them, make sure they don't eat much sugar and they'll be fine."*
- *"I'm confident she's OK because we've been brushing and flossing since she was little."*
- *"All dentists are putting microchips in people's mouths now so I'm making sure people know this. They put 4 in mine and I heard voices ….I prayed and it stopped. That's why I had them put in my daughter's dental chart 'no devices are to be put in her mouth.' "*
- *"Our schedules are just so busy we don't have time to see that they brush their teeth."*

## Awareness of Timing for First Visit

Just under half (46.3%) of the study parents reported knowing about "First Tooth/First Birthday" (FT/FB), and about half of them cited the actual campaign slogan as their response to the question. By contrast, two-thirds (67.6%) of the parents who *had taken* their child to the dentist within the last 6 months were able to give the correct response to the question (Figure 6).

[20] Kelly SE. Barriers to care-seeking for children's oral health among low-income caregivers. *Am J Pub Health* 2005;95(8):1345-1351.

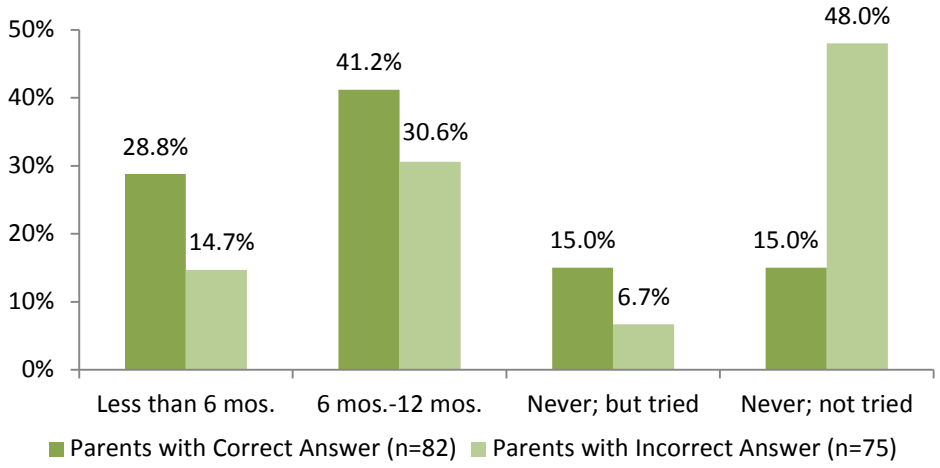
**Figure 6. Knowledge of Timing for First Dental Visit**




Note: "Non utilizers" = child's last dental visit more than 6 months ago;
"Utilizers" = child's last dental visit within last 6 months.

Parents' knowledge of the recommended time for a first dental visit was associated with children's recent dental visits.[21] As Figure 7 shows, 28.8% of children with all parents having that knowledge had visited the dentist within the last 6 months, compared to 14.7% of children with parents who were unaware. More striking, of the parents who had never tried to make a dental appointment, nearly half (48%) were unaware of FT/FB, compared to 15% of parents with that awareness.

**Figure 7. Parent Awareness of FT/FB* and Child Dental Visits, Total Parents (n=157)**




*FT/FB=First Tooth/First Birthday

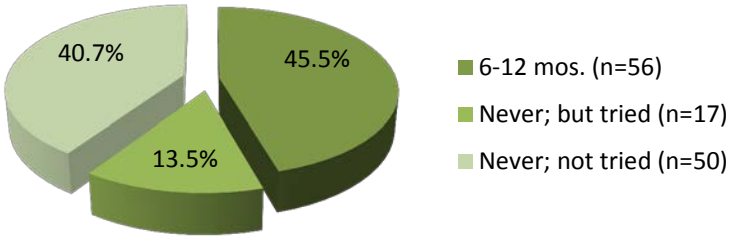
Knowing the correct answer to when a first dental visit should be is not the same as agreeing with it, however. The few parents who verbalized their disagreement were dentally fearful individuals who wanted to "save my child from starting out afraid of the dentist" and wanted to wait until the child was older (see discussion of fear as a barrier starting on page 18).

[21] We did not ask those who knew the correct timing whether they *had* taken their child to the dentist at first tooth or first birthday.

## Child's Last Dental Visit

As Figure 8 shows, 45.5% of the study parents reported a last dental visit for their child though it was more than 6 months ago. Of the remainder, with no visit, 13.5% stated they had tried without success to make (or keep) a dental appointment and 40.7% had never tried.

**Figure 8. Children's Last Dental Visits (n=123)**

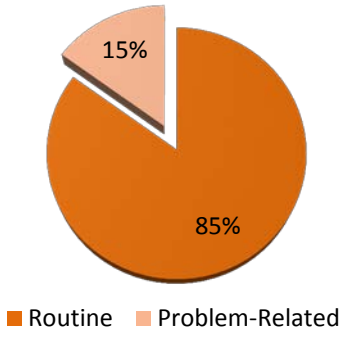



All of the dental visits reported were described as having been made to either a private dentist's office or a dental clinic (e.g., WellSpace, Western Dental). Parents seemed clear that dental screenings such as those conducted by Smile Keepers in preschools were not a substitute for going to the dentist.

## Reason for Last Dental Visit

The children's dental visits parents reported were mostly for routine exams, cleanings and x-rays and were self-directed (i.e., not in response to someone telling them to make an appointment). Only 15% of the last dental visits were problem related (a slightly higher proportion, 18.8%, of the "utilizing" parents said their child's recent dental visit was for a problem).

**Figure 9. Type of Visit by Children Who Made a Visit (n=56)**




When the last visit was problem-related, cavities and pain/abscess were the most common reason for the visit (Table 2).

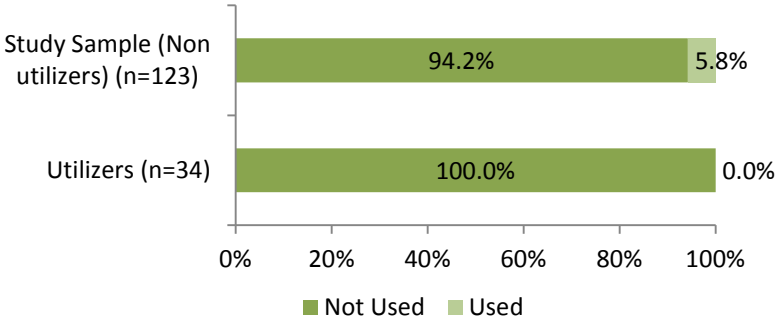
**Table 2. Specific Reasons when Last Dental Visit was Problem-Related (n=15)**

| Type | N | Percent |
|---|---|---|
| Pain/abscess | 6 | 40.0% |
| Cavities | 5 | 33.3% |
| Hypercalcification (discoloration/"spots") | 2 | 13.3% |
| Broken piece of tooth embedded | 1 | 6.7% |
| Excessive gingivitis | 1 | 6.7% |

## Use of the Emergency Department for Dental Care

The use of the emergency department (ED) for non-urgent dental problems serves as a marker for inadequate access to preventive dental services. In Sacramento County, 522 ED visits in 2014 by children aged 0-5 (representing about 1% of all ED visits) were for a dental condition, most paid for by Medi-Cal,[22] underlining the importance of access to regular dental care. Close to 6% of our study sample reported taking their child to the ED for a dental condition; the utilizing parents, though a smaller sample, reported none (Figure 10). In nearly every case of an ED visit, parents reported the child received an antibiotic and a recommendation that they see a dentist for follow-up care. The parents who used the ED said they did so because they were not sure where to go, were worried about something and did not want to wait, or thought the problem required an ED. In one extreme case, a parent who used the ED reported being too fearful to go to the dentist because she was slapped by a dentist for crying when she was young and stated, "*I try not to let my own fear of the dentist lay on my kids but it's hard not to*."

**Figure 10. Use of the ED for a Non Urgent Dental Condition**




Note: "non utilizers" = child's last dental visit more than 6 months ago; "utilizers" = child's last dental visit within last 6 months.

[22] *Sacramento Children and Dental Care: Any Better Served Than 5 Years Ago? An Updated Study of Sacramento Dental GMC..* Sacramento, CA: Barbara Aved Associates, January 2016. http://www.barbaraavedassociates.com/samples/denti-cal-final-report-nov-2-2012.pdf.

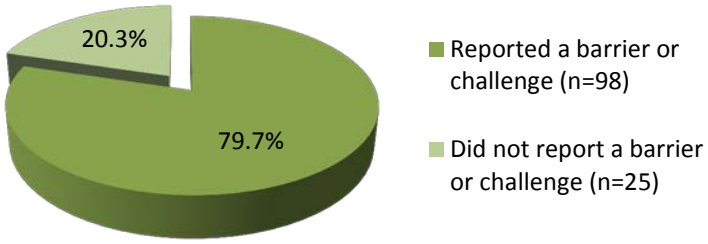
## Child's Last Medical Visit

Well-child and other preventive medical visits are strong predictors of visits to the dentist (along with a high value on dental care).[23] For example, a study of 6,322 Medicaid-enrolled children showed that children ages 1-2 years and ages 2-3 years with more well-baby/well-child visits were 2.96 and 1.25 times as likely, respectively, to have earlier first dental examinations as children with fewer visits.[24] While the study parents were less conscientious about dental visits, 94.2% of them reported taking their child for a doctor visit within the last 12 months (56% within the last 6 months; 38.2% within 6-12 months). The "utilizing" parents reported not only a more recent children's dental visit but a medical visits as well; 100% of the "utilizing" parents said they had taken their child to the doctor within the last 12 months (76.5% within the last 6 months; 23.5% within 6-12 months).

## Barriers to Dental Care

Of the 123 study parents, 98 (79.7%) reported some type of barrier or reason for delaying or never taking their child to the dentist (Figure 11); 25 indicated that "nothing, really" interfered with the child getting care or was a problem for them. We prompted this second group of parents a little to ask about certain issues that *might* be a barrier (e.g., "What about transportation to get to the dentist or doctor? Is that ever a problem for you?"). However, all of those parents maintained their original statements of not experiencing any difficulties. When the "barrier" group was asked, "Are there any *additional* issues?" 24.5% of them cited a second barrier. (The second-mentioned barriers are discussed on page 21.)

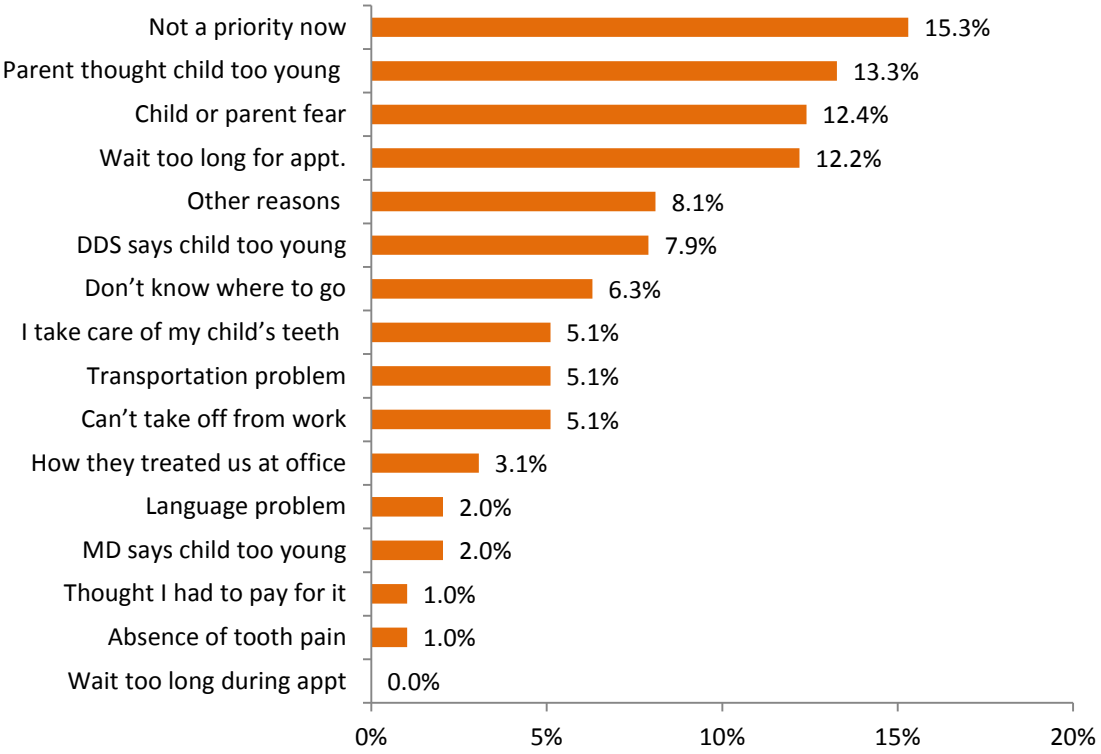
**Figure 11. Percentage of Parents Who Reported a Barrier for Child Dental Visits**




As Figure 12 on the next page shows, of the 98 of 123 parents who described a barrier, no single barrier stood out markedly as the reason for a delayed or no dental visit. Although the differences among the top reasons were not significant, the most commonly reported barrier was low parent priority.

[23] Milgrom P et al. An explanatory model of the dental care utilization of low-income children. *Medical Care* 1988;36(4):554-566.
[24] Chi DL at al. Relationship between medical well baby visits and first dental examinations for young children in Medicaid. *Amer J Pub Health* February 2013;103(2):347-354.

**Figure 12. Most Frequently Mentioned Barriers That Interfered with Child Having a Dental Visit (n=98)**




[1]The first barrier mentioned by those who expressed any type of barrier
Note: Data about barriers for each type of parent study group are shown in Table 3 on page 22.

## Low Priority

Just over fifteen percent of the 98 non-utilizing caregivers indicated a dental appointment was not a priority now. About half of these parents reported, "*I just haven't gotten around to it*," "*I've been procrastinating*," or "*I keep forgetting to do it*" as the most frequent responses for delayed/no dental visit. Probing or asking follow-on questions about parent neglect without appearing to pass judgement was challenging and some parents volunteered more information than others did. Four parents actually said, "*Oh, I've just been lazy about it.*"
The other half of "low-priority" parents who described specific challenges said their lives were too busy and complicated at present to make taking their child to the dentist a priority. They described needing to find permanent housing, dealing with custody issues, and other personal life challenges as the reasons for non-utilization. For example, a couple of parents said it was "*hard to keep track/manage family oral health needs when custody between parents/family members switches back and forth*."

It is important to reiterate that despite parent neglect, the non-utilizing parents conveyed the sense of placing a high value on children's oral health.

## Long Wait for Dental Appointment

The majority of parents reported that except for urgent care, frequently children's routine dental appointments were nearly always 1 to 2 months out, typically a 2-month wait regardless of which Medi-Cal network dentist or clinic the child was enrolled in. While this waiting period was not a problem for some of the parents ("*I just mark it on my calendar*"), the majority indicated 2 months was "*just too long to wait for an appointment*." When asked *why* this was a problem, most said they simply did not like the idea of having to wait that long. Mentioning that most privately insured patients also faced similar waits for routine visits did not alter their view. As a group, the more newly-arrived Russian parents did not seem bothered by waits for appointments, some indicating they considered it a small price to pay to have dental insurance (Medi-Cal) when coming to this country.

More of the "at-risk" families (such as those interviewed at meal programs and homeless shelters) explained that their concern about long waits for appointments were because of the challenge of managing future commitments when life circumstances changed frequently.

- *"A month out to get an appointment? I can't plan that far ahead. What if things change?"*
- *"I don't even know where I'll be then."*
- *"I am likely to forget about it that far away and sometimes they don't call me."*
- *"I get it, I understand. It's free [*Medi-Cal*], so that's why it takes so long and you have to push so hard to get the care you need for your child."*
- *"If they give me an appointment 2 months away I have to be OK with it, don't I? What else can I do if I want an appointment for my child?"*

While we did not specifically inquire about appointment no-shows, one parent explained, "*Parents break appointments when things just come up and they have to deal with it; they don't always think to call to cancel."*

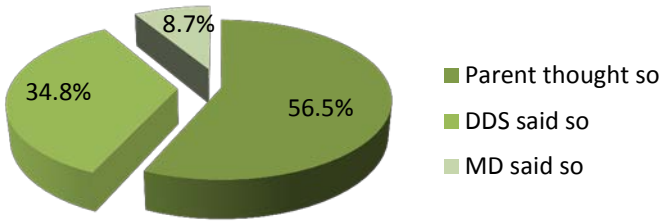
We did hear from 4 parents that appointments for a problem (one that the parent noted or one the dentist was monitoring for follow-up) were also "too long to wait." In one case, the parent gave up and went to the emergency department for care. Note from Figure 11 above that these comments referred to appointment wait times; excessive *in-office* waiting time as a barrier was reported by only 1 parent; she had 3 children and stated, "*It's a hardship when they won't see multiple kids on same day*." (Another parent had left her child's former provider for that reason and was now satisfactorily re-enrolled elsewhere.)

## Child Age

Twenty-two percent of the reason for delay/non-utilization was attributed to the parent or someone else thinking or saying the child was "too young to see a dentist." In the majority of

cases (56.5%), it was the parent who did not know a child should have a dental visit by age 1 or disagreed with that recommendation (Figure 13). About one-third (34.8%) of these parents reported they had tried to make an appointment but the dental office told them their child needed to be older, even when referred by the pediatrician *("Bring him back when he's able to sit still;" "Bring her back when she's 2 years old").* The remaining 8.7% of parents said they were told by their child's physician or health plan they should wait until the child was older.

**Figure 13. Sources that Thought Child was too Young to see the Dentist (n=23)**




Parent attitudes and experiences that reflected these concerns are apparent from the following comments:

- *"In my country [*Vietnam*], we just let the baby teeth with cavities fall out; they don't have pain in them because baby teeth aren't deep."* [Note: this father said he would not allow the dentist to put silver caps on his 4-year old with multiple cavities because *"they should just let them be."]*
- *"I think it's about dentists wanting money; what're they going to do anyway with a child that young?"*
- *"I think the dentist gives up too easily. He said 2 seconds later, 'That's it, take him home, he won't open his mouth.' "*
- *"I didn't see anything wrong when I checked his teeth so I don't think he needs to go yet."*

## Dental Fear and Anxieties

It has been estimated that 19.5% of children have a high level of fear of the dentist.[25] Previous negative dental experiences learned by children or from others (typically the influence of dental fear in the mother) accounts in large part for children's dental fear. Dental fear also matters because children with dental fear have greater odds of having negative behavior at the dental office.[26] It was not surprising then that fear emerged as one of the most important barriers among the study parents. While 12.4% of the parents specifically named fear as the reason their child had not seen or delayed seeing a dentist, the proportion was actually higher when

[25] Milgrom P, Mancl L, King B, Weinstein P. Origins of childhood dental fear. *Behav Res Ther* 1995;(33):313-319.
[26] Baier et al. Children's fear and behavior in private practice. *Ped Dent* 2004;26(4):316-322.

we consider the ways in which dental fear and anxiety were related in various ways to other barriers.

For example, it was clear from these parent conversations that fear played part of the role for delaying a first visit until the child was older and in waiting until they could find a dental provider "known to be child-friendly." Parents said they were "not willing to take the chance" that taking their child to the dentist when young could result in life-long fear of the dentist. They also did not like the idea of subjecting their child to a situation where they were "just going to cry anyway" (though they seemed to get past this by taking them for medical visits on time.) Fear was also the basis of some parents' thinking that they could take care of the child's teeth themselves while the child was young. (*"I just lay them [the children] on my lap and make them open their mouths and check all around their teeth. That way they're not scared. I swear, I'm an unlicensed dentist [jokingly]."*

As the following comments show, compared to children's physicians, dentists seemed to get a bad rap from many of the parents, generally because of their own childhood dental treatment experiences:

- *"I plan to take my child to the dentist when she's 5 so they won't strap her down by then [neither she nor her daughter had been "strapped down" by a dentist]; her doctor knows how to make her feel comfortable; I don't think dentists know how to do that."*
- *"Dentists are scarier than doctors. Dentists have all these tools. The doctor is chill and plays with my son."*
- *"Dentists just look at you that way, you know? They need to think 'What if it was their own teeth they was [sic] hurting?' "*
- *"There's no way he's going to open his mouth for the dentist. As it is, he cries when he goes to the doctor and* he *gives him a balloon. I'm going to wait until he's at least 3 to take him."*

Parents were extremely concerned about finding a child-friendly dentist. They sometimes waited until they learned about one through friends' experience before deciding to take their own child to the dentist the first time.

- *"I don't want to make an appointment anywhere until I know for sure my kid will be confident and not scared."*
- *"There's toys in the front office; we knew right away this [dental clinic] would be a good place to take our son."*
- *"He was scared when we tried to take him the first time, and they couldn't do anything, so my wife played dentist with him at home and now we think he'll be OK if we go."*

About a dozen parents mentioned that not being able to go into the dental exam room with their child made them feel too anxious ("*Would you let a stranger take away your child?");* as a result, some of those parents had chosen to go to another dental provider.

## Transportation

Contrary to what was expected from anecdotal information, transportation difficulties did not emerge as an important reason for no/delayed dental visits. Five of the 98 study parents and 1 of the non-study utilizing parents (thus, 3.8% of the total interviewed) cited transportation as a sometimes barrier ("*I ask a friend to drive me if I need to*") or an always barrier ("*We are a 1-car family and need to go where we can walk*" [their dental office was 2 blocks away]). When prompted a little to address it, very few people claimed they had a transportation problem, many saying, "*Oh, I/we have a car*," including families at food programs and the homeless shelter. Informal conversations with Dental Managed Care Plan representatives confirmed that they receive very few requests from Medi-Cal families for transportation assistance (and those who request it do not abuse it), though it is not clear all GMC members are aware or remember they can ask for it.[27]

## Other Issues and Barriers

Each of the following "Other" barriers was mentioned by 2 or 3 parents. Although few in number, the issues bear paying attention to because they can determine whether and how soon a child sees a dentist.

"Bureaucratic" Policy Related. A couple of parents described the "run around" by Medi-Cal (they specifically said it was not their dental plan but the State helpline) waiting to be called and given an appointment time but "never getting called." One parent described trying unsuccessfully (so far) to switch from managed care to fee-for-service because of foster care-related issues and said she felt "caught in the crosshairs" as a result.

Dental Office Policy/Practice-Related.[28] The restrictive policies and practices described included not allowing multiple children on the same day, limiting the number of services per visit so that multiple visits were necessary (which presented a hardship), and use of a papoose board to restrict a child's movements. In one case the parent said she was *"offended at how my son at age 4 was treated with 5 teeth pulled and no general anesthesia; he's 7 now and won't go back to the dentist."*

[27] As Medi-Cal managed care beneficiaries these families *can* request transportation assistance. While their *medical* plans are responsible for non-medical transportation for *medical* covered services, their dental plans are responsible for dental covered services. The Dental Plans are required to let members know how to access this service, i.e., website information and in the Member Handbooks. For example, the Access Dental Plan webpage https://www.premierlife.com/camedicaid dedicated to Sacramento Geographic Managed Care (GMC) tells members, "If you do not have transportation to a dental appointment, please contact Member Services to determine if you qualify for plan-sponsored assistance." Before automatically providing a taxi or reimbursement for the bus, Member Services works with the dental office to secure an appointment (or re-appointment them) at a time the member says they have transportation and/or they help families switch providers for better geographic access.

[28] While parents had negative things to say about *dental office* practices and non-child-friendly *dental offices*, there were almost no negative comments about the dental managed care plans they were enrolled in.

Special Needs-Related. Two parents were waiting to find providers who they felt could accommodate their child's special medical or behavioral needs. Another parent whose 3-year old child was autistic stated that the dentist "*was willing to try, but I can't deal with it right now*."

Lack of Oral Health Knowledge. Parents understand the relationship between eating sugary foods and cavities, so have a hard time believing that avoiding sugar doesn't mean no dental decay ("*My children don't eat a lot of sugar so they won't have cavities*.") They also do not understand how one child in the family can have cavities when other children have not had them ("*My older son didn't have anything wrong with his teeth so I don't get how this one could be having these cavities*"). Diet and infant feeding practices are heavily influenced by cultural factors, including social and family norms, that can create sociocultural barriers or resistance to change. One frustrated parent shared *"I can't keep my son's grandmother [the caregiver] from putting Nestles chocolate in the bottle no matter what I say. The doctor even printed out something about this in Spanish for her but she doesn't care and won't listen to us."*

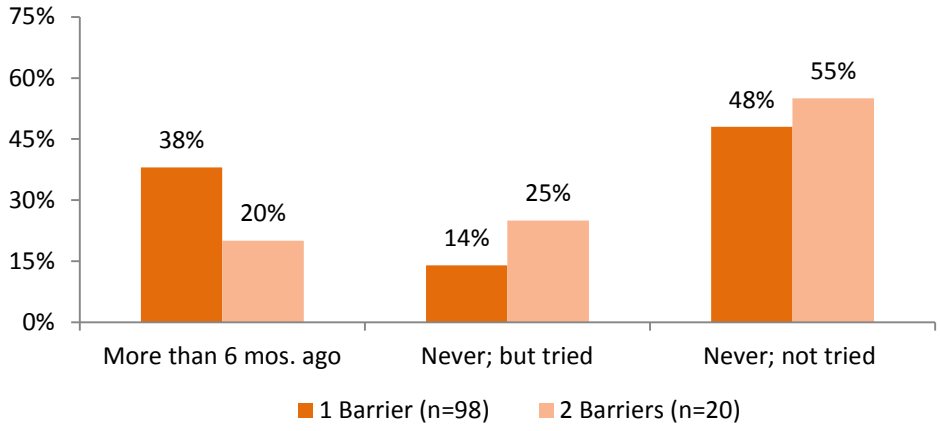
## Second-Mentioned Barriers or Issues

Twenty of the 98 parents (20.4%) mentioned a second barrier that interfered with their child's dental care; the second reasons were generally distributed proportionately to the same first-mentioned barriers, i.e., "just not a priority at this time," "child too young," "waiting to find a child-friendly dentist," "I can take care of their teeth myself."

## Child Dental Visit History for Parents Who Cited Barriers

Despite relating various challenges to getting dental care, some children *did* go to the dentist, though not recently, while others did not. As Figure 14 on the next page shows, a greater proportion of the children of parents citing more than one barrier never made a visit or attempted to make an appointment compared to those reporting only one barrier (55% vs. 48%, respectively).

**Figure 14. Children's Dental Visit Experience of Parents Who Reported Barriers**




## Barriers by Type of Parent Study Group

We examined the data separately by the 3 types of study sample parents—those with children who had not yet had a dental visit (parents who had tried and those who had never tried) and parents of children with delayed visits (more than 6 months ago)—to look for anything unique about the barriers they encountered (Table 3). Generally, the findings for the 3 separate parent groups followed the same pattern as for the study parents overall with the following differences:

**Table 3. Reported Barriers by Type of Parent Study Group**

| | Parents who Tried, No Visit[1] (n=17) | Parents who Never Tried (n=50) | Parents with Delayed Child Visits (n=56) | All Study Parents[2] (n=123) |
|---|---|---|---|---|
| Other reasons | 29.4% | 18.4% | 5.2% | 20.3% |
| None | 17.6% | 22.4% | 34.3% | 20.3% |
| Child too young to see a dentist | 11.8% | 18.4% | 12.1% | 18.7% |
| Can't take off from work | 11.8% | 2.0% | 3.4% | 4.1% |
| I take care of child's teeth | 11.8% | 2.0% | 0.0% | 4.1% |
| Wait too long for appointment | 5.9% | 8.2% | 21.4% | 9.6% |
| Don't know where to go | 5.9% | 8.2% | 3.4% | 5.7% |
| How treated us at office | 5.9% | 4.0% | 1.7% | 2.4% |
| Fear | 0.0% | 10.2% | 5.2% | 8.5% |
| Transportation problem | 0.0% | 4.0% | 8.6% | 4.1% |
| Language problem | 0.0% | 0.0% | 3.4% | 1.6% |
| No tooth pain | 0.0% | 0.0% | 1.7% | 0.8% |
| Thought I had to pay for it | 0.0% | 2.0% | 0.0% | 0.8% |
| Wait too long during appointment | 0.0% | 0.0% | 0.0% | 0.0% |

[1]Figures in the table are in rank order by "Parents Who Tried" column.
[2]Note that figures in this column will not match the figures in the Figure 11 graph on page 16. The data in that graph include only the study parents who cited at least one barrier (n=98) and excluded those who said "no barriers" (n=25).

- The fewest barriers were reported by parents of children with delayed dental visits.
- The "Other" reasons, highest among the parents who had tried unsuccessfully to make a dental appointment, were "low priority for follow through" (the greatest majority), "waiting for approval for general anesthesia for treatment," "waiting to find a child-friendly dental office," and "hardship because dental office won't see multiple kids on the same day."
- The parents expressing dissatisfaction with the dental office described a quality of care issue: one parent saying she was "offended" at the pain her 4-year old suffered "because he had 5 teeth pulled without general anesthesia."

- Parents likeliest to think or be told by a health professional their child was too young to see a dentist were those who had never tried to make an appointment.
- Expressed fear was a more important factor among the parents who had never tried to make an appointment.
- Taking care of the child's teeth themselves (in place of a dental visit) and problems getting off work were barriers more common for parents who had tried to make an appointment.
- Transportation was more of a problem among parents of children with delayed dental visits.

## Barriers for the "Utilizing" Parents

We also looked at what difficulties parents who reported they *had* taken their young child to the dentist in the last 6 months might have encountered since these were also children with Medi-Cal dental benefits. Not surprisingly, the majority (59%) of parents had not experienced any barriers to accessing services (Table 4 on the next page). However, for the 41% who did, the factors were similar to the "non-utilizing" parents: being told their child was too young to need to see a dentist and confusion about where to go, followed by fear of the dentist and problems in getting time off from work.

**Table 4. Barriers Reported by Non-Study Sample Parents*(n=34)**

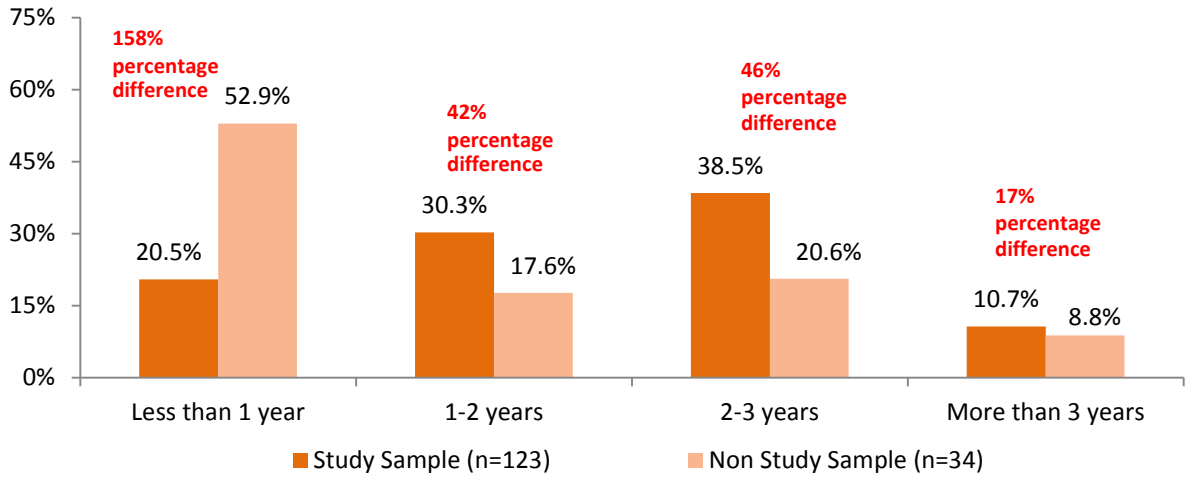
| | N | Percent |
|---|---|---|
| None | 20 | 59% |
| Child too young to see a dentist | 4 | 12% |
| Don't know where to go | 4 | 12% |
| Parent/child fear | 2 | 6% |
| Can't take off from work | 2 | 6% |
| Transportation problem | 1 | 3% |
| Wait too long for appt. | 1 | 3% |
| Wait too long during appointment | 0 | 0% |
| How treated us at office | 0 | 0% |
| Language problem | 0 | 0% |
| No tooth pain | 0 | 0% |
| Thought I had to pay for it | 0 | 0% |
| I take care of child's teeth | 0 | 0% |
| Other reasons | 0 | 0% |

*Parents whose children had made a dental visit within the last 6 months.

## Parents' Last Dental Visit

Parents were asked how long it had been since they visited the dentist. Many of the study parents/caregivers reported neglecting their own dental health; about 1 in 5 (20.5%) had made a dental visit in the last year. By contrast, about 1 in 2 (52.9%) of the non-study parents made a recent visit—a difference of 158% (Figure 15).

**Figure 15. Parents' Last Dental Visit**




The main reasons parents gave for delayed or no dental visits for themselves were cost-related (lack of dental insurance; inability to pay) and fear of the dentist, in equal part. The most typical response to the question, "Oh, gee, for *myself*? It's been years," was usually expressed with embarrassment about being fearful and avoiding the dentist or frustration at not having financial resources. In a few cases parents exhibited nonchalance (indifference about "getting around to it") and in one case acknowledged the reminder about the importance of dental care.[29] Representative parent comments included the following:

- *"I'm more worried about my kids than myself to go to the dentist."*
- *"I've just been procrastinating; I know I should go."*
- *"I know that was a long time ago, but I still think about it [dental fear] and don't want to go."*
- *"Actually, I made an appointment for myself once but I just didn't show up. I guess I should go."*
- *"I won some money on the Lottery and I'm planning to have all my teeth pulled and buy dentures with it."*

[29] One of the fathers apparently was so stimulated by the interview that he pulled out his cell phone on the spot and made his next dental appointment. He also got a couple of the other parents to say they would do the same when they got home.

Parents' use of oral health services is also very important because of its relationship to children's use.[30] A bivariate correlation analysis indicated that there was a significant positive relationship between parent and child use of dental services ($r$ = .234, $p$ < .001). Generally, the more time that passed since parents visited a dentist was associated with a greater likelihood that their children would not have had a recent or any dental visit. Among the 113 parents without a history of a recent dental visit, 97 (85.8%) of their children, a statistically significant proportion (chi square, 1 df = 56.64, p < .001), also had no recent or any dental visit.

We wondered whether parents would be more likely to have made a recent dental visit if they were among the parents who were aware that a child's first dental visit should be by First Tooth/First Birthday. This appeared to be the case. While 44% of the "aware" parents had gone to the dentist within the last year, none of the "unaware" parents had done so (Figure 16).

**Figure 16. Parent Awareness of Recommended Child's First Dental Visit and Their Use of Dental Services**

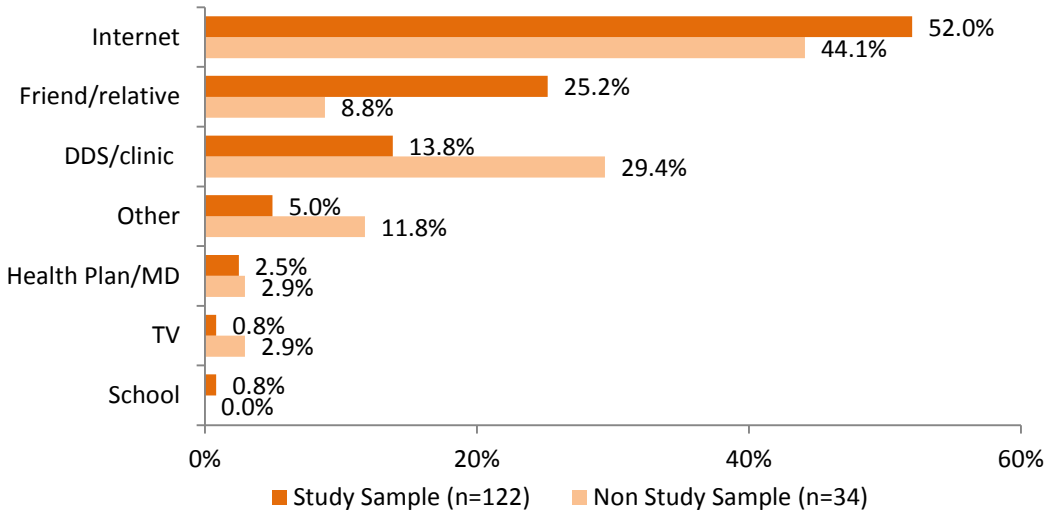
| | |
|---|---|
| Parents *aware* of FT/FB, with a recent visit | n = 25 |
| Parents *unaware* of FT/FB, with a recent visit | n = 0 |

FT/FB = First Tooth/First Birthday.

## Source of Oral Health Information

The majority of the parents were typical of most adults in the U.S.—81% who report using the Internet and, of those, 72% saying they have looked online for health information in the past year[31]—as 44.1% said they looked to "Dr. Google" for their oral health information (Figure 17).

**Figure 17. Parents' Primary Source of Oral Health Information**




[30] Isong I.A. et al. Association Between Parents' and Children's Use of Oral Health Services *Pediatrics* 2010;125(502):2009-1417.
[31] Health Online 2013 (January 15, 2013): Pew Survey of Americans' Online Health Habits. http://www.chcf.org/publications/2013/01/pew-survey-online-health

The non-utilizing families depended more on family members and friends when they had questions about teeth or oral health in general than the utilizing families did (25.2% vs. 8.8%). A common response to the question was, *"I ask my mom. She knows everything because she's had a lot of kids."* A higher proportion of families whose children had made timely dental visits reported the dentist or dental clinic as their primary information source as would be expected because of their greater contact with dental offices.

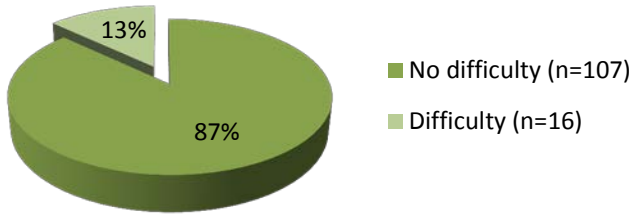
The "Other" sources cited for oral health information, in order of frequency, included:

- Call 211 for information or assistance (n=5)
- Call the Advice Nurse (source not specified) (n=4)
- Get information from the Family Resource Home Visitor who helps with appointments (n=2)
- Get information from the Advice Nurse at Kaiser (n=1)
- Get information from the Advice Nurse [sic] on the back of the Medi-Cal Card (n=1)

## Understanding Oral Health Information

The greatest majority (87%) of parents reported they had no trouble understanding oral health education or instructions given by the dentist or other professionals; however, 13% were unsure they understood everything (Figure 18). There was no difference in understanding capability between the non-utilizing and utilizing families.

**Figure 18. Ease of Understanding Oral Health Information at the Dental Office (n=123)**




Language barriers were the main reason for the lack of understanding oral health information, though not by a very large margin (Table 5). A slightly higher proportion of those with language barriers were Russian-speaking, followed by Spanish and Chinese-speaking parents.

**Table 5. Type of Difficulty in Understanding Oral Health Information (n=16)**

| | N | Percent |
|---|---|---|
| Language barrier | 9 | 56.3% |
| Educational level | 6 | 37.5% |
| Other | 1 | 6.3% |

Many monolingual Hispanic as well as Russian mothers said they depended on older children or their husbands to interrupt.[32] They said they tried to make appointments when their husband had a day off work because there was only 1 car in the family or the husband "*speaks better English than I do*." Representative comments included the following:

- *"My husband talks to the dentist but then he doesn't explain everything to me the dentist says."*
- *"They [at the dental office] don't explain well enough."*
- *"Some [at the dental office] won't talk to you or tell you what you ask and I don't understand."*

An ability to comprehend adequately was also problematic for some parents, perhaps due to low education level. This is important because in dentistry, lower caregiver education levels have been shown to be associated with fewer children's dental visits, less tooth brushing and more dental caries.[33,34] For example, in a population of kindergarteners with Medicaid whose characteristics were similar to our sample, those whose parents/caregivers had high school diplomas were nearly 6 times more likely to visit the dentist routinely.[35]

[32] Note in Figure 11 above only 2% of parents reported that a language barrier was related to a delayed or no dental visit for their child.

[33] Edelstein BL. Disparities in oral health and access to care: findings of national surveys. *Ambulatory Pediatr.* 2000;1(Suppl):141–147.

[34] Kelly SE. Barriers to care-seeking for children's oral health among low-income caregivers. *Am J Pub Health* 2005;95(8):1345-1351.

[35] Heima M et al. Caregiver's education level and child's dental caries in African Americans: a path analytic study. *Caries Res* 2015;49:177-183.

# Discussion

Our study revealed some of the important reasons Sacramento County parents of young children with Medi-Cal do not more fully utilize their children's dental benefits, and indicated areas of policy and practice where improvements can be made.

Limitations to the study include potential selection bias. Some parents whose children visited a dentist may have been more likely to participate in the interviews. Accuracy of parental report can also be affected by recall timeframe; because of social desirability, parents may overestimate children's preventive dental visits.[36] Some studies have found that parents are optimistic reporters of unmet need for dental care.[37] At the same time, although their recall and self-report of selected dental treatments have been found to be valid, studies have also found parents sometime *underestimate* the frequency of their children's routine dental visits.[38] Similarly, we cannot be sure that the high frequency of well-baby/well-child visits parents reported is reliable as utilization of those visits by children with Medi-Cal in Sacramento County (data are available only for 3-6 year-olds), is not reported to be as high.[39]

Our findings of utilization patterns and barriers are consistent with other studies where low-income and ethnically and culturally diverse families with similar characteristics have participated in surveys and focus groups.[40] Our parents represented the more suburban and urban residential locations in the county and so may not represent experiences of Sacramento parents in other locations. While our sample overall was reflective of the race/ethnicity characteristics of Sacramento Medi-Cal births, the overrepresentation of Black families and slight underrepresentation of White and Asian families may have had an unknown influence on the study findings. Additionally, parents who "had it together" enough to go to places such as the type of host organizations where interviewees were recruited, may also be likelier parents to have taken their child to the dentist routinely or at some point.

One of the main findings this study revealed is the importance of dental fear and the extent to which it appears to influence parents' attitudes and behaviors. Dental fear is important because it results in avoidance of dental visits and in schoolchildren is associated with a greater

[36] Gilbert GH, Rose JS, Shelton BJ. A prospective study of the validity of self-reported use of specific types of dental services. *Public Health Rep* 2003;118(1):18–26

[37] Edelstein B. Children's Oral Health and Use of Dental Services. http://mchb.hrsa.gov/researchdata/MCHESP/dataspeak/pastevent/april2008/files/bedelstein.pdf

[38] Huebner CE, Bell JF, Reed SC. Receipt of preventive oral health care by U.S. children: a population-based study of the 2005–2008 Medical Expenditure Panel Surveys. *Matern Child Health J* 2013;17 (9):1582–90.

[39] *2015 HEDIS® Aggregate Report for Medi-Cal Managed Care.* California Department of Health Care Services. January 2016 (rev. March 2016).

[40] For example, see Heima M et al. Caregiver's education level and child's dental caries in African Americans: a path analytic study. *Caries Res* 2015;49:177-183, and Kelly SE. Barriers to care-seeking for children's oral health among low-income caregivers. *Am J Pub Health* 2005;95(8):1345-1351.

number of caries.[41] It is also important because children with dental fear, younger children, and children exposed to treatment involving local anesthesia also have higher odds of displaying negative behavior[42]—reinforcing some providers' reluctance to see very young children or children more apt to need anesthesia such as these children with Medi-Cal.

Some barriers are educational. While nearly half of the parents have gotten the message about when to first take their child to a dentist (regardless of whether they followed through), the others, as evidenced by this study, have not and need to be informed through outreach. However, what is also clear from the feedback of some parents who tried to make a dental appointment but were unsuccessful was that being told by a health professional that the child was too young to see a dentist accounted for their reason for the lack of a dental visit, even for those who knew about first tooth/first birthday.

The parents who "just haven't gotten around to it" need help to make dental care a higher priority. Addressing factors that affect the establishment of a child's dental home, such as these caregivers' dental neglect, is essential as their engagement is key for increasing use of preventive dental services. Caregivers have "a pivotal role" in children's oral health care. Ideally, as we suggest in the recommendations, interventions aimed at improving children's oral health should involve community outreach to engage caregivers in a culturally appropriate manner when their children are infants or toddlers.[43]

As 31.3% of Sacramento County residents age 5 years and older are reported to speak a language other than English home,[44] it was surprising that most parents with limited English proficiency expressed satisfaction with their interpreter arrangements. While there was clearly a preference for bilingual providers, nearly all of these parents (regardless of whether they cited language as a barrier to a child's dental visit), said they "got by" with using a family member or someone else to make dental appointments, and in some cases to interpret during the visit. Section 1557, the civil rights provision of the Affordable Care Act,[45] lays out provider requirements related to "meaningful language access." According to the GMC Dental Plans, dental offices are still trying to deal with the challenges of complying with this law including interpreter services for patients with language barriers.

Some parents rely on toothaches as the motivation for taking their child to the dentist, and it was encouraging to learn that this was essentially not a factor for this population (though pain *was* the driver for about 10% of the families responding to the GMC Member Survey described above).

[41] Yi-Ling L, et al. Child dental fear in low-income and non-low-income families: A school-based survey study. *J Dent Sciences* May 2014;9(2):165-171.
[42] Baier et al. Children's fear and behavior in private practice. *Ped Dent* 2004;26(4):316-322.
[43] Divaris K et al. Influence of caregivers and children's entry into the dental care system. *Pediatrics* 2014;133(5): e1268–e1276.
[44] http://www.census.gov/quickfacts/table/POP815214/06067
[45] https://www.hhs.gov/civil-rights/for-individuals/section-1557/fs-limited-English-proficiency/index.html

There are many factors at play when setting appointments and accommodating patient requests is not always possible. However, dental office staff may not always understand all of the patient issues, and parents do not necessarily "push" or feel comfortable revealing certain personal factors (e.g., custody issues) that necessitate more accommodation than for commercially insured children. Because the Medi-Cal population does not always have a set schedule with a general routine, more adjustment and closer appointment times would be helpful, as parent feedback indicated.

In addition to soliciting information *from* parents, this study had the additional benefit of providing education and referral information *to* parents about oral health and access to services. Although unplanned, some of the discussions developed into motivational interviewing and engaged parents in thinking about their attitudes and values about oral health, motivating them in some cases to consider dealing with their dental anxiety, and to change certain behaviors.

# Recommendations

**A.** The Department of Health Care Services should work with the GMC Dental Plans to design and fund a broad-based Member Education Campaign. The reality, according to the Plans,[46] is that many families are ignoring the Plans' telephone calls and written materials intended to help stimulate appointments. At a minimum, DHCS should use the stature of its government logo (possibly co-branding with the Plans) to get the attention of GMC members and send an attractive letter to parents of children aged 0-6 asking them to "Call your dental office today to make an appointment for your child," providing each Plan's Member Services phone number for those who need help.

**B.** The First Tooth/First Birthday campaign many Sacramento groups are engaged in should be broadened to reach more types of organizations and businesses that interact with families of young children (e.g., faith communities, social clubs, children's clothing stores, parks & recreation departments), especially those reaching culturally diverse groups. In addition, the traditional organizations need continuing support to provide and reinforce information to parents and promote optimal oral health for young children, including those whose staff "should" be aware of this information (e.g., preschool teachers, WIC counselors) but may not.

**C.** Given the importance of dental fear and anxiety and its influence on other barriers, and the need to establish a positive outlook about the dentist from the start, the GMC Dental Plans should encourage their network dentists to evaluate the dental fear of children (and parents) before exams and treatment. Screening for dental fear can allow pediatric and general dentists to prepare children more adequately for positive experiences.[47] The Plans can also play an important role by helping to increase the "child friendliness" of their network dental offices and staff (consulting professionals are available who can offer creative suggestions). The Plans should facilitate appropriate referrals to child-friendly dental homes and offer incentives for training in behavior management strategies important for managing children's dental fear. Plans' parent outreach and education materials should stress that dentists' offices have become much more kid-friendly, and new techniques and procedures make visits more child-friendly.

**D.** Parents/caregivers should be informed during oral health education efforts of its relationship to overall good health; it was clear this was new information for many of the parents. Almost all parents understood the relationship of eating sugary foods to cavities, but many did not understand the *consequences* of oral disease among children.

**E.** More support should be committed to including oral health information in parenting and other classes provided by community programs and resources where dental education would

[46] Informal conversations with GMC Dental Plan representatives, September – October 2016.
[47] Baier K et al. Children's fear and behavior in private pediatric dentistry practices *Ped Dent* 2004;26(4):316-321.

not typically be included such as those offered to new immigrants, food bank recipients, sheltered families and students enrolled in vocational education classes. Key messages can be incorporated in ways that fit with the "programming" of these resources. Oral disease is highly correlated with educational attainment,[48] and our experience suggests this population who is at higher risk, is receptive to the information; many have already seen their children suffer the damage of early childhood caries.

**F.** Every baby born in a Sacramento maternity hospital should receive a Sacramento County customized *Kit for New Parents*. The volume suggested by the most recent birth data for Sacramento County showed 20,837 live births in 2012.[49] Some but not all of the hospitals and some OB/GYN offices order the *Kit*. The oral health items it contains currently are the 1st Tooth 1st Birthday magnet, an infant toothbrush and a dental information flyer[50] and, at a minimum, these products should continue to be included.

**G.** Home visiting programs and family resource centers can strengthen their oral health focus to improve the oral health status of young children. Providing this information, including referral information to child-friendly offices, should be included in the scopes of work of these funded projects.

**H.** Although about only 4% of all parents interviewed indicated that transportation was the main access barrier, the Dental Managed Care Plans should make families with no record of recent or any dental visits more explicitly aware of the opportunity for transportation assistance than what is "passively" provided in the Member Services Guide. According to the Department of Health Care Services, the Dental Plans are required by contract to provide all new members, and potential enrollees on request only, with a written Member Services Guide that contains procedures for obtaining any transportation services to locations that are offered by the contractor or available through the Medi-Cal program, and how to obtain such services.[51]

**I.** It was beyond the scope of this study to address adult dental services directly; however, our study makes clear the critical need for such services. Greater access to *affordable* dental care through Medi-Cal and other programs for low-income adults should be on the agenda of all human service advocates and policymakers. As role models for their children, parents' own dental attitudes and habits are very meaningful. As other studies have also suggested, comprehensive strategies to eliminate barriers that target parents and not just children may help to address children's underuse of oral health services.[52]

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[48] Paulander J, Axelsson P, Lindhe J. Association between level of education and oral health status in 35-, 50-, 65- and 75-year-olds. *J Clin Periodont* 2003;30:697–704.

[49] This number has ranged between about 19,200 and 21,900 over the last decade. https://www.cdph.ca.gov/data/statistics/Documents/VSC-2011-0218.pdf

[50] Email communication with Erin Maurie, First 5 Sacramento, September 30, 2016.

[51] Email communication with Alani Jackson, Chief, DHCS Medi-Cal Dental Services Division, October 11, 2016. Additional information is available in the July 2015 Denti-Cal bulletin for more information on non-emergency transportation Provider Bulletin V31N8.

[52] Isong I.A. et al. Association Between Parents' and Children's Use of Oral Health Services *Pediatrics* 2010;125(502):2009-1417.

# Attachments

**Attachment 1**

## Participating Organizations/Partners
## And the areas from which they draw clients

*(In alphabetical order)*

The following organizations facilitated our access to their families and graciously allowed us to interview parents who agreed to participate in this study:

- Carmichael Seventh-day Adventist Church, Community Services (Orangevale, Carmichael)
- Center for Community Health and Well-Being (Elk Grove, South Sacramento)
- County of Sacramento Libraries (North Highlands, Del Paso Heights, Colonial Heights, Valley Hi)
- Community Resource Project WIC (South Sacramento, Elk Grove)
- First 5 School Readiness Program School Sites (Rancho Cordova, Rio Linda, Elk Grove, Galt)
- Head Start Policy Council (Del Paso Heights)
- La Familia Counseling Center (Lemon Hill)
- Loaves and Fishes' Maryhouse (North of Downtown)
- Robert's Family Development Center (North Sacramento)
- Sacramento Children's Home, North Sacramento Family Resource Center (Del Paso Heights)
- Sacramento County WIC (Meadowview)
- VOA Family Shelter (North of Downtown)
- WellSpace Health's Multi-Service Center (North Highlands)

**Attachment 2**

**Parent Oral Health Interview/Discussion Questions**[1]

| Question | Purpose (What we were looking for) |
|---|---|
| 1. What do you think is important about seeing a dentist? | Explore general oral health attitudes and beliefs, especially concerning prevention. |
| 2. When do you think a child should first see a dentist? | Understanding importance of baby teeth; importance of visiting the dentist at first tooth/first birthday |
| 3. Does your child have dental insurance? Did you know that free dental coverage is a part of your child's Medi-Cal insurance? | Awareness of dental benefits by parent/caregiver |
| 4. When was the last time your youngest child between age 1 and 6 was able to see the dentist? | Recency of last dental visit (or any?)<br>If none, identify reasons/barriers |
| 5. Where did she/he go for this visit? | Checking for a dental home; interested to see how parent defines dental visit/care |
| 6. What was the main reason for this child's last dental visit? | Problem oriented (e.g., was pain the motivator for the visit?), called by someone to go in, or self-directed for prevention |
| 7. Did you experience any problems making an appointment or when you went to the dentist? | Determining the extent to which common/uncommon barriers exist for this family (what do these really mean?) and if so, how they dealt with them. Note especially if transportation is a problem. |
| 8. Have you ever taken one of your children to the ER for a tooth problem? | Evidence of a dental home, access barriers |
| 9. When was the last time your youngest child between age 1 and 6 was able to see the *doctor* or clinic for a check-up? | Relative importance/perceived value of medical vs dental services |
| 10. When was the last time *you* were able to see the dentist? | Values and importance of OH for parent/caregiver; correlation with children's dental visits |
| 11. Where do you get your OH information from? What is your preferred way to learn about it? | Identifying sources for children's OH information, satisfaction level with it or if not the most preferred way to get this information |
| 12. When you go to the dentist, how well do you generally understand what they say to you about your child's teeth? | Identifying any health literacy issues and/or language/ cultural issues |
| 13. Is there anything about your child's teeth that you would like to change? | Identifying whether parent needs/wants OH information, help accessing services or making any changes at home, have any fears that can act as barriers |

[1]All interviews began with appropriate introductions, gaining consent, gaining trust, etc. The questions were worded to fit each situation; some required amplification and additional follow-on questions to better understand responses; questions were not always asked in the same order.

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