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RESEARCH REPORT

Oral Health in the District of Columbia

Parental and Provider Perspectives

Janice C. Blanchard • Vivian L. Towe • Stephanie Donald
The research was completed by RAND Health, a division of the RAND Corporation, and by the District of Columbia Pediatric Oral Health Coalition.

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Preface

Research suggests that there are significant barriers to oral health care for many children in Washington, DC. This report assesses the perspectives of Washington, DC, stakeholders, including parents and providers, about the oral health of children receiving Medicaid benefits.

This report was commissioned by the District of Columbia Pediatric Oral Health Coalition, a community-driven alliance of multidisciplinary public and private stakeholders convened to address access to oral health for DC children. The work was completed by RAND and the District of Columbia Pediatric Oral Health Coalition through grants from the Consumer Health Foundation, the DentaQuest Foundation, and the Jessie Ball DuPont Fund.

The research was conducted in RAND Health, a division of the RAND Corporation. A profile of RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health.
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Summary

Oral Health has important implications for children’s overall health status and well-being. In the District, parents are more likely to report that their children have fair or poor oral health than parents of children nationwide. Wards 1, 7, and 8 have particularly high percentages of children with fair or poor oral health status. There is a shortage of oral health providers who serve persons insured by Medicaid, children, and populations east of the Anacostia River. Wards 7 and 8, as well as several clinics that serve high numbers of children insured by Medicaid, have been designated as dental health professional shortage areas.

The District of Columbia Pediatric Oral Health Coalition is a community-driven alliance of multidisciplinary public and private stakeholders, convened to address access to oral health for District of Columbia children. Motivated by a 2009 health and health care needs assessment of District youth that noted significant barriers to oral health care in the city (Chandra et al., 2009), the coalition commissioned this report on the oral health of District children receiving Medicaid benefits. This report assesses the perspectives of Washington, DC, stakeholders—parents, medical and oral health clinicians, and school health nurses—regarding the oral health of children in the city.

Data for this report were collected from three focus groups with parents (n=26) and three focus groups with providers, including dentists and school health nurses (n=25). In addition, data were collected at an oral health forum of various stakeholders (n=30) and from an oral health provider survey with pediatricians, dentists, and other oral health clinicians (n=37).

Key Findings from Focus Groups

Providers believe that there is a general lack of parental awareness of the importance of preventive oral health care.

While the parents in the focus groups felt that oral health for children is important, many providers stated that, in their experiences, parents do not always view oral health as a priority. In particular, providers felt that parents do not prioritize preventive oral health care, instead only bringing in children for the required completion of the DC Oral Health (Dental Provider) Assessment Forms or urgent complaints.¹

Access to care, particularly for specialty services, is a challenge for parents seeking oral health services for children who are Medicaid beneficiaries.

Specialty care (such as endodontics and orthodontics) is particularly challenging, as few specialty providers accept Medicaid. Low reimbursement and administrative hurdles are barriers to provider participation in Medicaid.

¹ The District of Columbia uses the school system to encourage oral health prevention by requiring parents to complete the DC Oral Health (Dental Provider) Assessment Form, which indicates that an oral health screening exam has been conducted within 150 days of starting the school year.
Some parents perceive quality to be lower at sites that treat patients insured by Medicaid.
Many parents expressed the perception that the care they get at clinics serving populations insured by Medicaid is of lower quality, often because of lack of continuity of care by the same provider at such clinics.

Providers report that parents often do not obtain follow-up for children who have urgent oral health needs identified at their bi-annual preventive oral health visits.
According to providers, while many parents are motivated to bring children to the dentist for an initial oral health appointment to have the DC Oral Health (Dental Provider) Assessment Form completed, if an oral health problem requiring urgent follow-up is identified, the recommended follow-up visits are often not completed. This may be due to a lack of parental understanding of the importance and urgency of such follow-up. In addition there is no mandate that requires follow-up care to be completed.

There is little coordination of care among school health nurses, pediatricians, and oral health providers.
Although school nurses do enter information from the DC Oral Health (Dental Provider) Assessment Forms into a database, there is little care coordination among the nurse, dentist, or pediatrician to ensure that parents get appropriate follow-up care for urgent oral health problems identified at their child’s preventive visit.

Oral health education in schools is limited, with great variation across schools.
Some school nurses do organize sessions on oral health education for students. In general, such sessions are limited and are not consistent across all schools. Parents expressed interest in having their children learn about proper oral health care in the school setting.

There are few oral health education initiatives that target parents in schools.
Although few oral health educational initiatives target parents in schools, both parents and providers agreed that this would greatly enhance parental education and follow-up for children’s oral health.

Key Parental and Provider Recommendations from Focus Groups

Incentives to encourage dentists to accept Medicaid and to serve in underserved communities are needed.
Providers who participated in the focus groups expressed concern about administrative rates and hurdles associated with Medicaid. Many stated that Medicaid reimbursement rates for oral health should be increased. They also felt that loan repayment programs and other incentives to encourage providers to practice in underserved communities should be expanded.
Provider insurance information should be made readily available to parents. Often, parents may not be aware of what oral health benefits are covered by their insurance. Improved and up-to-date resource lists are needed to help inform parents of their coverage benefits and provider availability by insurance type.

Expanded hours for oral health care are needed. Oral health appointments set during weekday hours may be prohibitive for parents who work, or for children enrolled in school. Parents and providers felt that expanded hours during afterschool time periods would make appointments more readily accessible.

Interventions to improve follow-up are needed. Both parents and providers felt that reminders for appointments are helpful. Suggested potential interventions include automated reminders via calls (robocalls), text messaging, email reminders, and phone calls.

Providers viewed the revised oral health forms as favorable. The revised DC Oral Health (Dental Provider) Assessment Forms were viewed as favorable by providers, specifically, the removal of the tooth map, shortening the length to one page, and the box that allowed identification of problems requiring follow-up as urgent.

Better communication between local oral health providers and schools is needed to improve collaboration. A mechanism in which school nurses can notify pediatricians of the need for further care, as well as report back to dentists about the receipt of follow-up care, is also needed to help reinforce the need for follow-up by parents.

Oral health stakeholders should work across disciplines to improve care. Providers felt that, to promote good oral health, it is important for multiple stakeholders to come to the table to work together. Such stakeholders should include the Department of Health and the DC Public School system, as well as parents, providers, insurers, nutritionists, medical societies, and community organizations.

Schools should incorporate oral health as part of the standard health curriculum. Although many school nurses offer limited school educational sessions that focus on oral health, most participants felt that this education should be expanded. Education should incorporate practical aspects of oral health care and principles of good nutrition.

Education should focus on the entire family. Both parents and providers agreed that, while it is important to educate children about the importance of oral health, education should be targeted to the entire family. Events such as parent-teacher conferences and health fairs can serve as outlets in which parents can be educated. Educating parents to take a greater role in their children’s oral health would lead to improvement in follow-up of children’s oral health issues.
Medical education should stress the incorporation of oral health care education as part of general pediatric practice. Focus group participants felt that medical school education should be expanded to teach medical students and residents how to provide basic oral health education. In addition, providers should be educated to encourage patients to engage in oral health prevention at all stages of the life continuum.

Improved community-based and culturally appropriate outreach is needed. Community-based outreach focusing on oral health should include media campaigns that reach a broad audience. Participants noted that it would be important for such outreach to be culturally and linguistically appropriate to appeal to the diverse communities who use the DC Public School System.

The concept of an oral health home should be considered. The concept of an oral health home, similar to a medical home, would promote continuity of care, with parents and children linked to a consistent provider, and could potentially improve perceptions of quality as well as increase rates of follow-up care.

The District government should enforce completion of the DC Oral Health (Dental Provider) Assessment Form. Participants felt that the DC Oral Health (Dental Provider) Assessment Form should have more consistent enforcement by the District of Columbia Public Schools system and the Department of Health.

More data are needed about oral health trends in the District. There are few data available about oral health care and access in the District. Such data can guide promotion efforts and target priority geographic areas.
Acknowledgments

We would like to thank members of the DC Pediatric Oral Health Coalition and the Children’s National Medical Center Child Health Advocacy Institute, specifically Ruth Fisher Pollard, Executive Director of Advocacy and Community Affairs; Anupama Tate, DMD, Director, Oral Health Advocacy; Tesa White, Manager of Advocacy and Community Benefit; and Yolette Gray, Project Coordinator. We would also like to acknowledge the Rivera Group Inc., which was responsible for the execution and data collection of five of the six focus groups, the survey, and the oral health forum. We would also like to thank Anita Chandra and Carole Gresenz for providing review of and feedback for our report. In addition, we would like to thank the Consumer Health Foundation, the DentaQuest Foundation, and the Jessie Ball DuPont Fund for their support of the work of the DC Pediatric Oral Health Coalition that led to this report.
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARF</td>
<td>Area Resource File</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>DOH</td>
<td>District of Columbia Department of Health</td>
</tr>
<tr>
<td>EPSDT</td>
<td>Early Periodic Screening, Diagnosis and Treatment</td>
</tr>
<tr>
<td>GAO</td>
<td>U.S. Government Accountability Office</td>
</tr>
<tr>
<td>HHS</td>
<td>U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td>HPSA</td>
<td>health provider shortage area</td>
</tr>
<tr>
<td>HRSA</td>
<td>Health Resources and Service Administration</td>
</tr>
</tbody>
</table>
CHAPTER 1

Introduction

The District of Columbia Pediatric Oral Health Coalition is a community-driven alliance of multidisciplinary public and private stakeholders convened to address access to oral health for District of Columbia children. The coalition’s overall mission is to improve oral health access and care for all children in the District of Columbia. Coalition priorities include supporting prevention and public health infrastructure, fostering medical and oral health collaboration, and promoting oral health literacy and education.

In support of its mission, the coalition commissioned this report on the oral health of District children receiving Medicaid benefits, which was motivated by a 2009 health and health care needs assessment of District youth that noted significant barriers to oral health care in the city (Chandra et al., 2009). From this work, it was determined that further study of these barriers was needed to improve pediatric oral health in the District of Columbia. The objectives of this assessment were to examine the following:

- stakeholder perspectives about the oral health of District children
- feedback on the utility of the current as well as revised versions of the DC Oral Health (Dental Provider) Assessment Form
- recommendations on how to improve oral health education and access to pediatric oral health care for parents.

This report assesses the perspectives of Washington, DC, stakeholders, including parents and providers, about the oral health of children. Although the report addresses many issues pertinent to oral health regardless of insurance, most of the parent and provider perspectives apply specifically to children insured by Medicaid in Washington, DC. This report is intended to provide aggregated points of view on systematic issues for connecting and retaining children insured by Medicaid in oral health care in the city. The scope of this work is limited to information obtained from focus groups and should not be considered a full-scale needs assessment of children’s oral health in the city. Nonetheless, the opinions captured here provide a snapshot of the complexities experienced by providers, patients, and their parents in the improvement of oral health care for children insured by Medicaid in the District.

In the chapters that follow, we first present (in Chapter Two) a brief background on oral health in the District from the 2009 RAND report and other available published data sources. In Chapter Three, we present qualitative data from focus groups with parents and providers, from an oral health forum with primary care medical and oral health clinicians and representatives from the DC government, and from a provider survey. In Chapter Four, we discuss stakeholder feedback collected from focus groups about the revised DC Oral Health (Dental Provider) Assessment Forms developed and proposed by the DC Pediatric Oral Health Coalition. In Chapter Five, we present recommendations generated from our parental and provider focus groups, the oral health forum, and the provider survey. In Chapter Six, we present conclusions and limitations.
CHAPTER 2

Background

2.1 Oral Health Importance and Impact
Oral health is essential to the general health and well-being of adults and children. Dental caries is a chronic disease that broadly affects children and adolescents, but treatment for dental caries varies greatly by race and income group. A report on oral health released by the U.S. General Accounting Office (GAO) in 2000 noted that nearly one-third of children aged 2–5 years living in families with incomes of less than $10,000 had untreated dental caries compared with approximately 10% of children living in families with incomes of $35,000 or more (GAO, 2000). Since then, improving the oral health of children living in poverty in the United States has become a health concern at all government levels. Continued monitoring of children’s oral health has shown that disparities persist in treatment for dental caries by race and socioeconomic status.

Analysis of data from the National Health and Nutrition Examination Survey, 2009–2010, showed that approximately 25% of children in the age categories of 3–5 and 6–9 years living in poverty have untreated dental caries (Dye, Li, and Thorton-Evans, 2012). Dental sealants were more prevalent among non-Hispanic white adolescents (56%), relative to with non-Hispanic black adolescents (32%), aged 13–15 years. Analysis of data from the 2007 National Survey of Children’s Health (showed that, compared with non-Hispanic white children, Hispanic and non-Hispanic black children were much more likely to be reported by parents to have fair/poor oral health, lack preventive dental care, and experience delayed dental care/unmet needs. However, these differences were largely attributable to having low socioeconomic status and a lack of insurance and could be mitigated by better access to treatment (Fisher-Owens et al., 2012).

2.2 Oral Health Status Among District Children
In 2007, according to data from the National Survey of Child Health, 8.8% of District children age 17 and under had poor or fair oral health, slightly higher than the U.S. average of 8.4%. Over 30% of District parents reported that their child had at least one dental problem (cavity, toothache, broken tooth, or bleeding gum) as compared with just fewer than 27% nationwide (see Table 2.1) (Chandra et al., 2009).

| Table 2.1 Oral Health Status for Children Ages 0–17 years, District Columbia and the United States, 2007 (%) |
|---------------------------------|-----------------|-----------------|
| Poor/fair oral health           | District: 8.8   | United States: 8.4 |
| Dental problems*                | District: 30.6** | United States: 26.8 |

Source: National Survey of Children’s Health data analysis in Chandra et al., 2009.

* Dental problems include decayed teeth or cavities, toothache, broken tooth, bleeding gums as reported by parents.

** Statistically significant difference from 2007 U.S. mean at .05 level.
Significant disparities in oral health status exist by ward, with 13.8% of children in Ward 1 with fair or poor oral health, significantly higher than the District average. Wards 7 and 8 also have high rates of fair or poor oral health (see Table 2.2) (Chandra et al., 2009).

Table 2.2 Oral Health Status Among District Children Ages 0–17 Years, by Ward in the District of Columbia, 2007 (%)

<table>
<thead>
<tr>
<th>Ward</th>
<th>Poor oral health</th>
</tr>
</thead>
<tbody>
<tr>
<td>DC</td>
<td>8.8</td>
</tr>
<tr>
<td>Ward 1</td>
<td>13.8*</td>
</tr>
<tr>
<td>Ward 2</td>
<td>6.0</td>
</tr>
<tr>
<td>Ward 3</td>
<td>2.6*</td>
</tr>
<tr>
<td>Ward 4</td>
<td>8.0</td>
</tr>
<tr>
<td>Ward 5</td>
<td>6.4*</td>
</tr>
<tr>
<td>Ward 6</td>
<td>6.4*</td>
</tr>
<tr>
<td>Ward 7</td>
<td>11.0</td>
</tr>
<tr>
<td>Ward 8</td>
<td>10.8</td>
</tr>
</tbody>
</table>

Source: National Survey of Children’s Health data analysis in Chandra et al., 2009.
* Statistically significant difference from 2007 DC mean at .05 level.

2.3 Oral Health Access

2.3.1 Preventive Care Visits

Only one in four children in the District reported having a preventive oral health visit in the last 12 months, but this rate is not significantly different than that of the U.S. population. According to data from the National Survey of Children’s Health, in 2007 about 75% of District children had a preventive oral health visit in the prior year as compared to 74% of children nationwide. Visits were lowest for children aged 0–5 years, and highest for children aged 6–12 years, which is similar to national patterns (see Table 2.3) (Chandra et al., 2009).

Table 2.3 Preventive Dental Care in the District and the United States, by Age, 2007 (%)

<table>
<thead>
<tr>
<th>Age</th>
<th>District</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ages</td>
<td>74.6</td>
<td>74.0</td>
</tr>
<tr>
<td>Age 0–5</td>
<td>44.5</td>
<td>44.7</td>
</tr>
<tr>
<td>Age 6–12</td>
<td>94.4*</td>
<td>89.7</td>
</tr>
<tr>
<td>Age 13–17</td>
<td>90.8</td>
<td>87.2</td>
</tr>
</tbody>
</table>

Source: National Survey of Children’s Health data analysis, in Chandra et al., 2009.
* Statistically significant difference from 2007 DC mean at .05 level.

Both nationally and locally, access to care is more challenging for children insured by Medicaid, which covers medical and oral health care for approximately half of District children aged 18 and under (Kaiser Family Foundation, 2012). Oral health services for children are a mandatory Medicaid benefit under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program (Maternal and Child Health Resources and Services Administration, 2012). An analysis of data on EPSDT-eligible children in the District indicated that only 43% had received a dental service of any kind in FY 2010.
Among those who received services, about 82% received preventive services, but only 46% received treatment (CMS, 2010). Although the time frames differ, the percentage of EPSDT-eligible children receiving oral health care in the District appears to be substantially lower than for all District children.

2.3.2 Oral Health Provider Supply
According to the 2009 RAND report, many parents cited challenges to getting oral health care due to a shortage of dentists who accept Medicaid (Chandra et al., 2009). Only 20% of the 179,000 practicing dentists in the United States accept patients insured by Medicaid (HRSA, 2012). Poor reimbursement and administrative barriers have been previously cited as major disincentives to providers serving Medicaid populations (GAO, 2000).

Although there are less data available about Washington, DC, prior reports have indicated significant shortages of dentists who serve certain populations in the District. According to the 2011 Area Resource File (ARF), there are 765 dentists in the District. The District has a higher number of dentists (130 per 100,000 resident population) than the national median (33 per 100,000 resident population) (HRSA, 2012), but access to providers accepting Medicaid is problematic. Although the exact number of dentists that treat children or bill Medicaid is not reported in the ARF, according to data reported by the District Department of Health (DOH) to the Centers for Disease Control and Prevention (CDC), in 2009 only 150 dentists billed more than $10,000 to Medicaid, and in that same year only 15 dentists saw over 100 children annually (unknown breakdown by Medicaid for children) (CDC, 2012). Oral health provider locations are mainly concentrated west of the Anacostia River, with fewer providers available in Wards 7 and 8 (Lurie et al., 2008).

Areas east of the Anacostia River have been designated dental health provider shortage areas (HPSAs) by the Health Services Resources Administration, as have several clinics that serve a significant population of Medicaid enrollees (Mary’s Center, Unity, Community of Hope, La Clinica del Pueblo, Spanish Catholic, Whitman Walker, Elaine Ellis Center of Health, and Family Medical and Counseling Service) (see Figure 2.1). In order to be a dental HPSA, an area must have a population-to-full-time-equivalent-dentist ratio of at least 5,000:1. Alternatively, the area can have a ratio of 4,000:1, but with unusually high dental needs. In addition, dental professionals in proximal areas must be inaccessible or difficult to reach (HRSA, 2012).
The DC State Medicaid Plan, approved in March 2012, allows primary care providers and dentists to bill fluoride varnish application using the Code on Dental Procedures and Nomenclature (CDT code) for reimbursement. For primary care providers, billing is reimbursed for children ages 0–3 up to four times per year. For dentists, there is no age or frequency specification associated with billing. The DC Pediatric Oral Health Coalition is working with DOH to add fluoride varnish applications to the DC immunization registry for tracking the applications by primary care provider. The expected rollout time is fiscal year 2014 (CNMC DentaQuest Foundation grant application, 2012).

2.4 Oral Health and Schools
Poor oral health has been shown to impact children’s education. Nearly 51 million school hours are lost due to oral health-related illness (HHS, 2000). Disadvantaged students with oral pain have been found to be almost four times more likely to have a low grade point average (Seirawan, Faust, and Mulligan, 2012). Students who cannot access needed oral health care are more likely to miss school, compared with students who have access; lower-income children are significantly more likely to miss school days due to oral health problems, compared with higher-income children (Pourat and Nicholson, 2009). However, schools may also be a key setting in which to deliver oral health education and dental services to children with unmet need. Programs that have been tested at schools and have garnered positive results among low-income students include
mandatory school entrance health examinations, mobile oral health programs (successful at serving Medicaid recipients), school-based dental sealant programs, and classroom oral health curriculums (American Academy of Pediatric Dentistry, 2008; Carr, Isong, and Weintraub, 2008; Bailit, Beazoglou, and Drozdowski, 2009; Griffin et al., 2007; Association for State and Territorial Dental Directors, 2007).

Although District of Columbia schools do offer some preventive oral health education and basic prevention through partnerships with outside organizations, currently there are no oral health clinics based within schools in the city. The District does, however, use the school system to encourage oral health prevention through the DC Oral Health (Dental Provider) Assessment Form. The District has made completion of this form a requirement for parents for school matriculation at the beginning of each academic year. According to DC Code 38-602, children at both public and non-public schools must have the form completed, indicating that an oral health screening exam has been conducted within 150 days of starting school for pre-kindergarten, kindergarten, 1st grade, and then every other year thereafter through 11th grade (the code does not specify whether the screening has to be specifically for preventive health). Individual schools are responsible for maintaining the data, with DOH as the regulatory agency to enforce completion (Children's Dental Health Project, 2008). However, the potential negative consequences associated with enforcement of completion of the form (delay of entry into school) may be in conflict with another District law that mandates compulsory education at age 5 for all school children (Code 38-202) (DC Municipal Regulations and DC Register). Oral health providers complete the examination section of the form, and the parent/child takes the form to the school health nurse, who enters information from it into a DOH database. The school health nurse also has other responsibilities related to general health in schools, including health education promotion, treatment of medical conditions and medication administration, preventive health screening and referrals, and liaison services between community providers, parents, and the school. These activities, however, are not specifically directed toward oral health (Chandra et al., 2008).

2.5 Summary

- Oral health has been shown to have important implications for children’s overall health status and well-being. In the District, children are more likely to report fair or poor oral health than the national average. Wards 1, 7, and 8 have particularly high percentages of children with fair or poor oral health status. There is evidence of a disparity in oral health care usage between children insured by Medicaid and all children in the District.
- Oral health providers in the District are clustered such that populations east of the Anacostia River may have trouble accessing them. It is unclear how many oral health providers serve Medicaid beneficiaries, but available evidence suggests that the number is low. Wards 7 and 8 have been designated as dental health professional shortage areas.
- District law requires children to have a completed DC Oral Health (Dental Provider) Assessment Form prior to commencing school, but it is unclear how this law is enforced given compulsory education requirements.
CHAPTER 3
Qualitative Data Findings

3.1 Overview of the Qualitative Data Collection Approach and Objectives
Data were collected from focus groups, from qualitative comments from an online survey, and from an oral health forum conducted with District of Columbia parents, school nurses, primary care pediatricians, oral health clinicians, and representatives from District of Columbia government agencies. The goal of data collection was to better understand challenges faced by District stakeholders in achieving good oral health for children receiving Medicaid benefits, as well as to identify specific recommendations for improving the oral health services and education environment for District children. The focus group, forum, and survey had three objectives:

1. To gather information about experiences with pediatric oral health services and to identify barriers and facilitators to obtaining or delivering health services to children who are Medicaid enrollees.
2. To assess the utility of the DC Oral Health (Dental Provider) Assessment Form and to develop and obtain feedback on revised versions of this form.
3. To identify recommendations for improving the oral health services and education environment for District children.

3.2 Methods
Using a semistructured protocol, three parental focus groups were conducted: two with English-speaking parents and one with Spanish-speaking Latino parents (n=26) at various sites throughout the city in May and June. The majority of parents participating in the focus groups had children who qualified for oral health care coverage under Medicaid (n=24). Although parents had children ranging in age from 1 year to 18 years, focus groups were not stratified by age or grade in school. In addition, three provider focus groups were also conducted (n=25). Two of the provider focus groups occurred in June and July, 2012 to assess input to revise the old version of the DC Oral Health (Dental Provider) Assessment Form (The Rivera Group Inc., 2012). The third provider group occurred in October 2012 to assess feedback about the revised DC Oral Health (Dental Provider) Assessment Form (see Chapter Four). In addition, data were collected at an oral health forum (n=30) as well as from qualitative comments provided in an oral health provider survey with pediatricians and oral health clinicians (n=37) (The Rivera Group Inc., 2012). We do not have detailed information about the type of insurance accepted by providers who participated in the focus groups or forum except for the October 2012 focus group; all providers in that group were either Medicaid safety net dentists (at Unity Health Care clinic sites) or school health nurses.

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1 Unity Health Care is a federally qualified health center and the largest provider of primary care services in the District. Unity clinics serve 93,000 patients at 29 sites in the District, including 13 community-based health centers. Seven of Unity’s community-based health centers provide dental care. The majority of Unity clinic patients are at or below the poverty level and are either uninsured or are insured by Medicaid or DC Alliance (Unity Health Care, 2012, no date).
Table 3.1 shows a description of data sources. All focus groups except for the October 2012 provider group were facilitated by the Rivera Group Inc. The RAND team integrated data from these focus groups with the October 2012 group, which was conducted directly by RAND.

Table 3.1 Data Sources for Qualitative Findings

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Date</th>
<th>Number of Participants</th>
</tr>
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<tbody>
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<td>Focus Groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents (English-speaking)</td>
<td>May 24, 2012</td>
<td>8</td>
</tr>
<tr>
<td>Parents (English-speaking)</td>
<td>May 31, 2012</td>
<td>8</td>
</tr>
<tr>
<td>Parents (Spanish-speaking)</td>
<td>June 12, 2012</td>
<td>10</td>
</tr>
<tr>
<td>Providers: school nurses, Head Start health manager, and District of Columbia Public Schools officials</td>
<td>June 27, 2012</td>
<td>7</td>
</tr>
<tr>
<td>Providers: oral health clinicians</td>
<td>July 31, 2012</td>
<td>11</td>
</tr>
<tr>
<td>Providers: oral health clinicians and school nurses (feedback on revised form)</td>
<td>October 25, 2012</td>
<td>7</td>
</tr>
<tr>
<td>Oral Health Forum—providers (oral health clinicians, school nurses) and oral health stakeholders in the city</td>
<td>July 7, 2012</td>
<td>30</td>
</tr>
<tr>
<td>Online Survey—providers (pediatric and oral health clinicians)</td>
<td>June 19–June 25, 2012</td>
<td>37</td>
</tr>
</tbody>
</table>

Data from the focus groups and surveys were reviewed and analyzed for themes. The next sections present the major themes identified in the focus groups, survey, and oral health forum, with summary points and, in some cases, illustrative quotes from participants that support these themes (The Rivera Group Inc., 2012). We present feedback regarding the DC Oral Health (Dental Provider) Assessment Form in Chapter Four and recommendations generated from the focus group, oral health forum, and survey in Chapter Five.

3.3 Access to Care

3.3.1 Medicaid Coverage

Insurance was discussed as a barrier to accessing oral health care. Many parents in the focus groups stated that Medicaid’s options for oral health care for children were limited. Although Medicaid covers oral health visits, not all dentists will take Medicaid. Some parents expressed challenges with understanding which oral health services do take Medicaid and when they will be covered (e.g., six-month intervals between visits). They specifically did not know where dentists who would accept Medicaid are located.

Providers in our focus groups thought that in most cases, the insurance covers basic pediatric oral health care, yet parents may not be aware of such coverage. Specialty care, however, such as orthodontics, oral surgery, and endodontics, may not be covered in its entirety. As one provider stated,
Lack of knowledge about insurance coverage and services that are provided at early ages are two important barriers.

3.3.2 Provider Capacity
In our focus groups, there were differing perceptions about capacity for basic oral health care for children in the District. Some providers in our focus groups felt that because Unity has an extensive oral health program, most children with Medicaid have adequate options for routine care. Parents, however, felt that many community-based providers are less likely to accept Medicaid patients, or they do not care for children under age 5. In addition, providers perceived the capacity of oral health specialists as being more limited under Medicaid. This was thought to be particularly problematic and a major barrier to follow-up care. One provider noted:

The greatest challenge is finding other specialists, such as endodontists, oral surgeons, and orthodontists, to [whom to refer] Medicaid patients.

Low reimbursement rates and Medicaid administrative barriers may affect provider capacity. Some providers felt that there may be limited numbers of oral health providers that accept Medicaid due to the many administrative burdens associated with participating in the program. As one provider noted:

The application process for dentists to become credentialed with DC Medicaid is time-consuming, overly complex, and ultimately frustrating. With that in mind, the reimbursement rate for Medicaid services is very low.

3.3.3 Transportation
Because providers, especially those who treat children with Medicaid, may not be conveniently located in local neighborhoods, often parents have to take prolonged routes to reach their oral health appointments. Both parents and providers cited transportation as a common barrier in accessing oral health care. As one provider noted:

Transportation is a key issue. I have seen parents waiting for three hours to be picked up.

One parent noted:

It's hard to go to the dentist if you don’t have a car….The dentist is like 30 minutes away from where I live.

3.3.4 Appointment Availability
Many parents expressed concerns about the difficulty they faced trying to schedule appointments, especially for patients with immediate needs. Being able to schedule
appointments right away is a frequent need for parents, since children may be in pain. At some of the Unity clinics, it may be very difficult to get an appointment due to restrictions on ability to make appointments more than 30 days in advance. This policy was implemented by Unity to minimize the rate of no-shows. As providers noted:

> Parents are very frustrated because they have to wait so long for appointments.

> Our no-show rate is pretty low. The one month policy has helped this….The downside is that we see 16–17 patients per day….That discourages us from allowing people to walk-in.

Another issue is that appointments for providers seeing pediatric Medicaid patients may not be offered at convenient times. Many oral health offices are not open for appointments during weekend and evening hours. Because of parental work schedules and child school schedules, this poses a major barrier to care. One provider noted:

> Appointments are not after school when children are off.

### 3.4 Coordination of Care

#### 3.4.1 Provider Perceptions About Parental Follow-Up

Oral health providers expressed the concern that parents often do not obtain follow-up for children who have urgent oral health needs identified at preventive oral health visits. Their experiences were that many parents are motivated to bring their children in for an initial appointment in order to have the DC Oral Health (Dental Provider) Assessment Form completed. However, if a dentist identifies a problem needing urgent follow-up, parents may not perceive the importance of a follow-up visit. Often this is due to a lack of parental understanding of the importance and urgency of such follow-up. In addition, beyond the requirement for submission of the DC Oral Health (Dental Provider) Assessment Form, there is no administrative requirement that mandates follow-up. In some cases, with very urgent matters, dentists will schedule the appointment at the time of the initial visit to increase rates of follow-up. Parents indicated that appointment reminders help them keep appointments, but that there is variability in the ability of parents to receive those reminders. For example, many participants in parental focus groups stated that they prefer text messages, phone calls, or email reminders; others felt that some people could not operate voicemail or did not have ready access to computers and needed postcards.

#### 3.4.2 Provider Coordination

Currently, there is no system that coordinates pediatric oral health among the school nurse, dentist, and pediatrician to ensure that parents get appropriate follow-up care for urgent oral health problems identified at their preventive visit.
One of the issues that was raised in both parental and provider focus groups was the role of the school nurse in oral health care for children. School nurses are responsible for entering the results of the DC Oral Health (Dental Provider) Assessment Form into their school’s database, but there is no formal requirement for them to insure that follow-up for problems identified on the form has been completed. However, the requirement of submission of the DC Oral Health (Dental Provider) Assessment Form has led some parents to think that schools could play a role in improving their children’s oral health. As one parent stated:

*What I want to know [is,] if the school just wants the form and that’s it? What is the follow-up care? What is the school doing to ensure proper oral health care or do they just need the form?*

Some nurses in the forum, however, did at times take further responsibility to follow up with children whose oral health needs have not been met. As one school nurse noted:

*When you find a concerned parent, that parent will make sure that their kids are seen, and then you have some parents that don’t care because nobody holds them accountable.*

Routine follow-up and preventive services may be better when communication among the dentists, schools, and parents is improved. Oral health providers that work in community health centers stated that the integrated provider network, combined with their electronic health records, make it very convenient and reliable to get children’s oral health visits scheduled, because along with reminders to the parents, they can also remind the child’s pediatrician that a follow-up visit is due. As one dentist noted:

*We have electronic health records. The patient’s name pops up and I leave a note that states when they need another dental appointment.*

### 3.5 Oral Health Promotion

#### 3.5.1 Oral Health Promotion in Schools

Oral health education in schools is limited and has great variation across school sites. Some school nurses stated that they do organize sessions on oral health education for students. In general, such sessions are limited and not consistent across all schools. According to parents, there was great variability in oral health promotion at their children’s schools, ranging from no activities to oral health fairs and training in oral hygiene. However, many parents wanted their children trained in school on how to properly take care of their teeth. As one parent noted:

*In my son’s school they have prevention [screening] of various things—vision screenings, hearing screenings—but they haven’t done anything about dental care.*
Much of the education that occurs in schools is done through collaboration with outside providers who offer oral health education in schools as a public service. Although some school nurses have successful collaborations with case managers and local oral health groups to provide prevention screening and education in the schools, this is not a uniform service offered by all schools. Instead, it is dependent on an individual school nurse’s establishment of such relationships. As one school nurse commented:

*I have Kid Smiles in my school. They examine and clean, and give X-rays. [The provider] is excellent, but he has to be invited. If he is not invited to the school, the school will not get the services.*

The nurses in the focus groups stated that they do not have any oral health education specifically for parents in the schools. Most participants agreed that this would greatly enhance parental education and follow-up. Parents also thought that oral health community education would be valuable and many said they would attend.

### 3.5.2 Knowledge of the Importance of Oral Health by Parents

Parents thought that, overall, the oral health of their communities needed improvement, but that much of this was due to lack of or limited insurance. While the parents in the focus groups felt that oral health for children is important, many providers felt that, in their experience, parents did not always view oral health as a priority. Often parents will only bring children to the dentist for completion of the DC Oral Health (Dental Provider) Assessment Form or for acute care when an oral health problem is in an advanced stage. Most will not get preventive checkups every six months. Often, this lack of attention to preventive oral health is because parents also do not take care of their own oral health, as reflected by provider comments:

*Most parents don’t see the importance of oral health for their kids because most don’t see the importance for themselves.*

*For some parents, it is a challenge to just keep an appointment for a well-child check and keep up on vaccinations. So dental care is even seen as less important than regular medical checkups and therefore will not be accessed.*

Some parents expressed challenges with understanding preventive care recommended intervals (e.g., six-month intervals between visits). Many providers also felt that many parents focused on oral health merely in terms of cosmetic concerns or when urgent complaints became apparent, rather than being related to preventive health care. As providers stated:
Parents tend to see oral health [as] cosmetic; they don’t try prevention.

[Oral health] becomes more valuable when the child is in pain... when the school sends the child home from school and when schools require dental evaluation forms to be completed.

Some parents viewed the need for preventive care differently from the providers in our focus group. As one parent commented:

If you take your child to the dentist and they do a cleaning, the dentist is going to automatically tell you “we’ll see you in six months.” The only time you [should] go to the dentist is when there are problems with the child’s teeth or gums.

3.5.3 Community-Based Outreach and Education Programs

There are few public campaigns focusing on preventive oral health care. Most parents believed that there was nothing being currently done to improve pediatric health care for children in the District and that there was a need for more dialogue with parents about the state of pediatric oral health in DC. It was difficult for some parents to discuss improvements to the system of pediatric oral health care because they simply did not have enough information on how it works. Parents indicated that their sources for oral health care information were mainly the dentist, and less so media, such as magazines and websites. As one parent noted:

If you don’t know about the system, how can you know what’s wrong with the system?

3.6 Perceived Quality of Oral Health Care

Some parents perceive quality to be lower at sites that treat Medicaid patients. Parents discussed their dislike of having appointments with different dentists at a given site and viewed this lack of continuity as a mark of such lower quality. Parents expressed a general desire for their children to be able to see the same dentist at all visits, similar to many of their experiences with their primary care physicians. One parent commented:

Sometimes it feels like I’m going to a factory. You don’t get to see the same doctor. The form of the preschool [my son] goes to has a part in the application for dentist and I couldn’t put the dentist’s name because every time he goes there, he sees somebody different….Yeah [it affects quality] because it is not consistent. They won’t have an institutional memory of the child.

Many parents expressed concerns about how dentists treat patients insured by Medicaid compared with those with private insurance. Some focus group participants stated that they were treated poorly by dentists due to a lack of income, education, and insurance.
One parent stated:

*When I was a kid, I went to the dentist and she treated me like I was a queen or something because it was my mom’s insurance—it was private. And when I moved back here for school, I went to Medicaid clinics,…They made me scared.*

Another parent expressed the concern that they often receive different care based on Medicaid coverage, with dentists opting to be less aggressive for certain cases based on insurance:

*People need to be treated with dignity and respect…. A molar should not be pulled only because of the type of insurance we have.*

### 3.7 Summary

- Access to oral health care for their children is a challenge for parents. Specialty care (such as endodontics and orthodontics) is particularly challenging, as few specialty providers accept Medicaid.
- Parental follow-up for urgent problems identified during the preventive health visit was also cited as a problem. Since follow-up is not part of the mandated completion of the DC Oral Health (Dental Provider) Assessment Form, it is difficult to encourage.
- There is little coordination of care that occurs across school, medical, or oral health care settings to ensure that parents get appropriate follow-up care for their child’s urgent oral health problems identified at their preventive visit.
- Although schools do promote oral health prevention, a uniform plan for educating students about oral health across all sites is lacking, and often there is limited time devoted to the topic. There are also very few programs that promote community-based prevention that also target parents.
- Many parents perceive quality to be lower at clinics that serve patients insured by Medicaid, often because of lack of continuity of care by the same provider at such clinics.
CHAPTER 4
Stakeholder Perspectives of the DC Oral Health (Dental Provider) Assessment Form

In this chapter, we summarize findings related to the DC Oral Health (Dental Provider) Assessment Form. As discussed in Chapter Two, the form is required for school-aged children in the District before they can attend school each year. We first discuss feedback about the original form (see Appendix A), collected principally from participants at the oral health forum and at focus groups. In response to initial feedback, the DC Pediatric Oral Health Coalition revised the original form, presenting two alternative options (see Appendixes B and C). After their development, we held a focus group to query providers (school health nurses and dentists) about their perceptions of the new forms, as well as additional suggestions to further improve the form. Feedback from the focus group about the new forms is presented in sections 4.1.3 and 4.1.4.

4.1 General Perceptions of the DC Oral Health (Dental Provider) Assessment Form

4.1.1 Perceptions of the Enforceability of the DC Oral Health (Dental Provider) Assessment Form

Overall, the mandate that parents complete and submit the DC Oral Health (Dental Provider) Assessment Form for school matriculation is not easily enforceable. Providers in the focus group acknowledged that DOH and the District of Columbia Public Schools system (DCPS) do not enforce the law that mandates parents to obtain an annual oral health assessment and complete the form prior to school entry, mainly because of potential negative consequences to the child (delay of entry to school). Providers felt that a lack of official regulation contributes to parents’ failure to complete the form, and poses a significant risk to the oral health of District children. As school nurses noted:

*The District needs to decide if they are going to enforce this form. Most parents think this is a school rule. If you told them it was the law, they may do it.*

*Because I have Head Start, I have less than 25% of health certificates…. I fought the registrars [telling them that] when they register [a] kid, look for these papers. [The parents say] ‘I’ll bring them next week,” next week doesn’t come, [next thing you know] they’re in sixth grade.*

4.1.2 Perceptions of the Original Version of the DC Oral Health (Dental Provider) Assessment Form

School nurses, who were responsible for collecting the DC Oral Health (Dental Provider) Assessment Form from parents after completion by dentists, often found the provider section difficult to interpret. In particular, they found that the tooth map prompted inconsistencies, as providers may incorrectly number teeth or writing could be illegible. As one school nurse commented:
I can’t decide what the dentist is trying to say. And we have to put them in a documentation system and sometimes it’s very hard to understand.

There is also a section in the form where providers write information or instructions to parents. Many parents, however, indicated that they do not understand what dentists write on the DC Oral Health (Dental Provider) Assessment Form. Providers also felt that the form was targeted toward clinicians and nurses rather than parents. As one provider noted:

I think this is just a form to the parents but is not a parent friendly form… For the average parent [it does] not [have] information they will understand.

As one school nurse noted:

[Parents] will understand words like plaque or cavity but not restoration, malocclusion, dentricle attachment.

The old form did not have a way to express whether urgent follow-up was needed and what level of risk was associated with oral health findings. As one provider suggested about the form:

Add a risk category which is something that is understood among medical providers—high, moderate, low so that puts up a red flag for those kids that need to be seen immediately.

4.1.3 Perceptions About the Revised Versions of the DC Oral Health (Dental Provider) Assessment Form

The revised versions of the DC Oral Health (Dental Provider) Assessment Form were thought to be an improvement from earlier versions. All focus group participants, both school nurses and dentists, agreed that both versions of the revised form (see Appendixes B and C) are much easier to understand. Overall, providers preferred version B of the form (Appendix C) because of the boxes that noted urgency of follow-up. They feel that parents will be able to clearly complete their required sections on the form now that all sections are separate and clearly labeled. As one provider noted:

I do like how it’s separated between what the dentist fills out and what the parents fill out, because the other form was confusing.

It was the opinion of the focus group participants that the revised versions of the form will improve communication between parents, dentists, school nurses, and DOH administrators, but it needs edits. Oral health providers liked the categories listed in the “Findings” boxes in Version B of the form, but want to add X-rays to the list. As one provider noted:
I like the boxes. These are the basic things... add a box for radiographs....There are certain ages of children that don’t need them, but I have seen 8- and 9-year-olds who have never had them before and they should have gotten them by that age.

Providers felt that a statement that District law mandates completion of the form should be visible on the form. This could potentially increase rates of parental compliance.

4.1.4 Format of Revised Version of the DC Oral Health (Dental Provider) Assessment Form

School nurses, who enter the information from the form into the DOH database, highlighted that the boxes for writing the information are small, which makes the data difficult for them to read. They also expressed concerns that the “Emergency Contact” box may be confusing for parents, as it does not specify a space for the name and phone number separately. As one school nurse commented:

The boxes are small, aren’t they? Make the space larger because we nurses have to enter all of this information by hand.

Nurses and dentists both felt that it was important to keep the form short—limited to one page front and back. They also discussed having versions of the form in other languages, particularly Spanish.

4.1.5 Electronic Transmission of the DC Oral Health (Dental Provider) Assessment Form

Some providers thought that a mechanism to complete the form electronically could allow more streamlined completion of information of the form, ensure that the form would not get lost, and decrease the time spent by school nurses who have to manually enter the data. Given varying levels of computing comfort by parents, some participants thought this might not be a feasible option. Scanning forms in for transmission to school nurses, however, was thought to be a reasonable alternative. As one provider noted:

The children will get the form and they will come back two months later asking for the form [again] and the school nurse doesn’t get it. It will be nice if it will be reported or tracked at the dental area before they leave but is time consuming.

4.2 Summary

- The newer versions of the DC Oral Health (Dental Provider) Assessment Form were viewed as favorable by providers given the removal of the tooth map, the shorter length confined to one page, and the box that allowed identification of problems denoting follow-up as urgent.
• Availability of the form in alternate languages as well as clear indication of the mandatory nature of the form’s completion were additional suggestions made by providers who participated in the focus groups.
• Some participants felt that a mechanism to complete the form electronically or scanning forms would allow data entry to be more streamlined.
CHAPTER 5
Stakeholder-Generated Recommendations

In this chapter, we present recommendations from stakeholders gathered through focus groups and from the oral health forum and survey input. Participants were queried about recommendations to improve pediatric oral health care in the District with probes to explore types of interventions and potential collaborations that should be considered. This section presents some of these recommendations from parent and provider perspectives.

5.1 Access to Care

**Incentives to encourage dentists to accept Medicaid are needed.**
Focus group participants expressed similar concern about administrative rates and hurdles associated with Medicaid. Many thought that Medicaid reimbursement rates for oral health should be increased.

**Incentives to encourage dentists to practice in underserved communities should be expanded.**
Focus group participants felt that loan repayment programs and other incentives to encourage providers to practice in underserved communities should be expanded.

**Provider insurance information should be made readily available to parents.**
Often, parents may not be aware of what oral health benefits are covered by their insurance. They also may not be aware of which providers accept Medicaid or other insurance that they may have. Improved and up-to-date resource lists are needed to help inform parents of their coverage benefits and provider availability by insurance type. As providers commented:

> [There is a need for] centralized databases that let parents know where they or their children can receive services based on their amount of and type of insurance coverage.

> Create a resource manual with services covered, recommendations, and age-specific parent information sheets.

Parents also expressed the need for such resource lists. As one parent commented:

> We need more information… like a directory, a booklet to show us where we can go.

Pediatric providers also expressed an interest in having access to such resources to help direct them to appropriate sites for referral for oral health care. As one pediatrician noted:
I need an online directory by wards listing dental providers who accept Medicaid. … I also need to know who does sedation dentistry. I need to know what services are covered by insurance.

**Expanded hours for oral health care are needed.**

Oral health appointments set during weekday hours may be prohibitive for parents who work or for children enrolled in school. Although some clinics do offer extended evening and weekend hours, appointment slots during these time periods may be limited. Parents and providers felt that expanded hours during the late afternoon or evening time periods would make appointments more readily accessible.

**School-based oral health care should be expanded.**

Although some schools do offer screening and education programs on-site, sponsored by many oral health programs in the area, such as Kid Smiles, the nurse must invite these programs. Parents and providers felt that preventive care should be offered to children in schools on a more uniform basis.

Providers thought that, to promote oral health in schools, it is important to engage the school system at all levels, with leadership from principals in schools, who often set priorities for educational initiatives. As one school nurse stated:

> One of the most important groups in the city is the principal group because the principals…set the policies that happen in their schools…. If you get strong principals who are pro-dental, you would have a better outcome.

Some providers also thought that having school-based oral health clinics would improve care. Others noted that having more mobile clinics available to serve children on-site was another plausible option for improving access to oral health care.

**5.2 Coordination of Care**

**Interventions to improve follow-up are needed.**

Both parents and providers felt that reminders for appointments are helpful. A number of potential interventions were suggested, including automated reminders via calls (robocalls), text messaging, email reminders, and phone calls. As one provider stated:

> Automated reminders, either a phone call or text message reminding the parent that the child is due for follow-up or has an upcoming appointment, would likely be helpful.

Such messages have to be tailored to the individual, as some parents thought that individuals with less technological proficiency would fare better with postcards. As one parent stated:
Not all of us mothers in DC have access to a computer or the Internet. It’s better if someone calls from the office and leave(s) a message on the answering machine.

**Increased coordination of care among medical providers is needed.**
More collaboration among pediatricians, dentists, and school nurses is needed to improve rates of follow-up. Some dentists suggested such interventions as co-location of oral health providers and pediatricians as one option to improve follow-up. As one provider noted:

*[There is a need for] improved communication and partnerships between the medical and oral health communities.*

**Better communication between local oral health providers and schools is needed to improve collaboration.**
Currently there is no standard mechanism to ensure that parents pursue follow-up care that a dentist may recommend during a child’s annual preventive visit. Although recommended follow-up is included on the DC Oral Health (Dental Provider) Assessment Form, it is up to parents to pursue any further evaluation. The revised versions of the form added a section to indicate whether the follow-up needed is urgent to help improve parental motivation to get necessary treatment. Currently there is no formal established role of the school nurse in ensuring that follow-up has been met for oral health although parents perceive this as a need. A mechanism in which school nurses can notify pediatricians of the need for further care as well as report back to dentists about the receipt of follow-up care is also needed to help ensure that care is completed. As one provider stated:

*[Schools should follow] up with school evaluation forms to ensure comprehensive care is being provided and not just exams.*

**Oral health stakeholders should work collaboratively across disciplines to improve care in the District.**
Providers felt that to promote good oral health it is important for multiple stakeholders to come to the table to work together. The stakeholders they thought should be involved included the DOH, DCPS, and parents, providers, insurers, nutritionists, and community organizations. Many providers also thought that oral health societies could help engage members to be involved in improving oral health for children. As one provider stated:

*Dental providers, service organizations, DC governmental officials, public and private insurance organizations, school board representatives, administrators, teachers, parents, community organizers, and church leaders should all be at the same table to have the discussion and create and implement a…series of plans to fix the problems that exist.*
Parents also expressed a desire to be involved in helping to promote oral health among District children. As one parent stated:

\[\text{I don't know much about dentistry, but I know what to do for my child's dental health. Perhaps we could be involved as mothers, in a campaign.}\]

5.3 Oral Health Promotion

Schools should incorporate oral health as part of the standard health curriculum. Although many school nurses have limited sessions on oral health, often through outside speakers, most participants felt that this education should be expanded and integrated as a standard part of the health curriculum.

Education should incorporate practical aspects of oral health care. Many parents wanted their children trained on how to properly brush and clean teeth. Providers and school nurses cited one option as having children brush teeth after meals as a means of showing children how to properly brush teeth.

Education should focus on the entire family. Both parents and dentists agreed that, while it is important to educate children about the importance of oral health, education should be targeted to the entire family. These parental education initiatives should occur in the school, at pediatric offices, and in the broader community. Such education can incorporate education initiatives into school parental functions, such as Parent Teaching Association (PTA) meetings or through school-based health fairs.

Health care providers should stress the importance of oral health care early during the child's care continuum. Dentists stressed that it is never too early to learn about oral health. Some dentists thought such education could even occur in the prenatal period, with obstetricians teaching parents about the need to get oral health care prior to birth of their infant. As one oral health provider stated:

\[\text{It would really be nice if the OB/GYN or pediatric physician can educate the parents [about] the importance of oral health, so it's not already too late when they actually get to see me for the first time.}\]

Medical education should stress the incorporation of oral health care education as part of general pediatric practice. Participants felt that medical school education should be expanded to teach medical students and residents how to provide basic oral health education. Such education should stress to medical providers the need for good oral health as part of long-term health promotion.
Improved community-based and culturally appropriate outreach is needed. Expanded community-based outreach is needed; such outreach can include media campaigns that can reach a broad audience. Participants noted that it would be important for such outreach to be culturally and linguistically appropriate to appeal to the diverse communities present in the school system.

More data are needed about oral health trends in the District. Although there are some limited data available from reporting to the DOH about the initial preventive health visit, little data are available about follow-up and overall access to and barriers to care. Focus group and oral health forum participants noted the need for more data about oral health in the District. Such data can help promotion efforts be better targeted to address particular problematic areas.

5.4 Quality
The concept of an oral health home, in parallel with the medical home model, should be considered.
Establishing an oral health home for every child in the District would promote continuity of care by linking children to a consistent provider and could potentially improve perceptions of quality. As part of this oral health home, providers suggested using patient navigators to help parents understand how to access oral health appointments and ensure follow-up. As one provider stated:

[There is a need for] patient navigators that need to [help] navigate in this complex system.

Parents also expressed the need to have one site and provider identified that knew their child well and could provide consistent care. One parent stated:

For me, that consistency of the dentist would be great, to have the same dentist for the rest of my child's life, that would make the difference for me.

5.5 The DC Oral Health (Dental Provider) Assessment Form
The District of Columbia government should enforce completion of the DC Oral Health (Dental Provider) Assessment Form. Participants felt that completion and submission of the DC Oral Health (Dental Provider) Assessment Form should be enforced by DCPS and DOH. Although taking the child out of school is not a viable option, participants felt that parental penalties should be considered as a means of mandating completion of the form.
A mechanism to transmit the DC Oral Health (Dental Provider) Assessment Form electronically would improve communication and ease data entry burdens. Providers felt a mechanism that would allow online data entry or scanning and faxing of the DC Oral Health (Dental Provider) Assessment Form from oral health providers to schools would streamline data entry and reduce potential loss of forms.

5.6 Summary

- Participants felt that access can be improved by providing incentives for providers to accept Medicaid and to practice in underserved community. In addition, a resource list indicating covered services and providers that accept Medicaid for both parents and providers would be helpful.
- Increased coordination of care between oral health and medical providers as well as with school nurses can improve follow-up care. In addition, improving care requires engaging stakeholders across multiple government agencies as well as providers, parents, and the broader District community.
- Health promotion should be expanded both in schools and in the broader community to better educate parents about the importance of preventive care. Such promotion should include community-based and culturally and linguistically appropriate media campaigns. In addition, oral health education should be expanded as part of medical school education so that primary care providers can better educate parents about the importance of oral health. Further data are needed to understand oral health in the District so that promotion efforts can be better targeted.
- The concept of an oral health home that promotes patient navigation and continuity of providers can potentially help improve parents’ perception of quality, while also improving follow-up for oral health services in children.
- The revised versions of the DC Oral Health (Dental Provider) Assessment Form are an improvement, but streamlined approaches for completion of the form and further enforcement of the mandate that requires its completion are needed.
CHAPTER 6
Conclusion

In conclusion, this report demonstrates a number of issues related to pediatric oral health in the District, particularly for children insured by Medicaid. In the District, children are more likely to report fair or poor oral health than the national average. Wards 1, 7, and 8 have particularly high percentages of children with fair or poor oral health. There is evidence of a disparity in oral health care usage between children insured by Medicaid and all children in the District. Despite this need, oral health providers in the District are clustered such that populations east of the Anacostia River may have trouble accessing them. It is unclear how many oral health providers serve Medicaid beneficiaries, but available evidence suggests that the number is low. Although District law requires children to have a completed DC Oral Health (Dental Provider) Assessment Form prior to commencing school, it is unclear how this law is enforced given compulsory education requirements.

Data from our stakeholder focus groups demonstrated that access to oral health services is a challenge for parents in the District. Specialty care is particularly challenging, as few specialty providers accept Medicaid. Parental follow-up for urgent problems identified during the preventive health visit was also cited as a problem. Since follow-up is not part of the mandated completion of the DC Oral Health (Dental Provider) Assessment Form, it is difficult to encourage. In addition, there is little coordination of care across school pediatric or oral health care settings to ensure that parents get appropriate follow-up care for their child’s urgent oral health problems identified at their preventive visit. Although schools do promote oral health prevention, they lack a uniform plan for educating students about oral health across all sites, and often there is limited time devoted to the topic.

Providers viewed the revised versions of the DC Oral Health (Dental Provider) Assessment Form as favorable, given the removal of the tooth map, the shorter length confined to one page, and the box that allowed identification of problems denoting follow-up as urgent. Some focus group participants felt that a mechanism to complete the form electronically or scanning the form would allow data entry to be more streamlined.

Stakeholders in our focus groups felt that, in general, greater coordination of care between oral health and medical providers as well as with school nurses is needed to improve follow-up care. In addition, improving care requires engaging stakeholders across multiple government agencies as well as providers, parents, and the broader District community. There is also a need to expand health promotion in schools and in the greater District metropolitan area to better educate parents about the importance of preventive care. Such promotion should include community-based and culturally and linguistically appropriate media campaigns.
Further data are needed to understand oral health in the District, including data about barriers and facilitators of oral health care. There are limited data about oral health status and oral health care use and follow-up by age, insurance, and ward in the city. In addition, more information is needed to assess the number of oral health providers who serve children and persons covered by Medicaid in the District, including what factors impact their decisions to provide (or not provide) care to these populations. Such data can guide promotion efforts and target priority geographic areas.

Future work should focus on improving this data collection, as well as focusing on better ways to educate parents about the importance of oral health prevention. In addition, approaches to expand oral health education in schools as well as targeting parents in such initiatives should be explored.

Our study had several limitations. While RAND did integrate information from prior focus groups, the protocol and the administration of the forum, survey, and all but one of the focus groups were developed and conducted by an outside contractor. In addition, focus groups were not stratified by age or grade of the child, so assessing differences by school level was not possible.
APPENDIX A
The DC Oral Health (Dental Provider) Assessment Form Original Version

District of Columbia Oral Health (Dental Provider) Assessment Form

Part 1. Child’s Personal Information
Child’s Last Name
Child’s First & Middle Name
Date of Birth
Gender: □ M □ F
School or Child Care Facility:

Parent/Guardian Name
Telephone 1: □ Home □ Cell □ Work
Home Address:

Emergency Contact:
Telephone 2: □ Home □ Cell □ Work
City/State/Zip of Other than D.C.:

Race/Ethnicity: □ White Non Hispanic □ Black Non Hispanic □ Hispanic □ Asian or Pacific Islander □ Other

Primary Care Provider (Medical):

Dental/Dental Provider:
□ Medicaid □ Private Insurance □ None
□ Other

Part 2. Child’s Clinical Examination (to be completed by the Dental Provider) (Please use key to document all findings on line next to each tooth)

Tooth #     Tooth #     Tooth #
1           17          A          K
2           18          B          L
3           19          C          M
4           20          D          N
5           21          E          O
6           22          F          P
7           23          G          Q
8           24          H          R
9           25          I          S
10          26          J          T
11          27          
12          28          
13          29          
14          30          
15          31          
16          32          

Key (Check Appropriate)
S - Sealants  X - Missing teeth
● Restoration  Non-restorable/Extraction
1D-One surface decay  UE- Unruptured Tooth
2D-Two surface decay
3D-Three surface decay
4D-More than three surface decay

Part 3. Clinical Findings and Recommendations (Please indicate in Finding column)

<table>
<thead>
<tr>
<th>Findings</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Gingival Inflammation</td>
<td>Y N</td>
</tr>
<tr>
<td>2. Plaque and/or Calculus</td>
<td>Y N</td>
</tr>
<tr>
<td>3. Abnormal Gingival Attachments</td>
<td>Y N</td>
</tr>
<tr>
<td>4. Malocclusion</td>
<td>Y N</td>
</tr>
<tr>
<td>5. Other (e.g. cleft lip/palate)</td>
<td></td>
</tr>
</tbody>
</table>

Preventive services completed □ Yes □ No

Part 4. Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. Treatment □ is complete. □ is incomplete. Referred to

Dentist/Dental Provider Signature  Print Name  Date

Address

Phone

Fax

Part 5. Required Parent/Guardian Signatures

Parent or Guardian Release of Health Information. I give permission to the signing health examiner or facility to share the health information on this form with my child’s school, childcare, camp, or Department of Health

PRINT NAME of parent or guardian

SIGNATURE of parent or guardian  Date

27
## District of Columbia Oral Health (Dental Provider) Assessment Form

** Purpose: ** Assessment of child's oral health status and needs.

### Part 1: Child's Personal Information

- **Child's Last Name:**
- **Child's First & Middle Name:**
- **Date of Birth:**
- **Gender:** M/F
- **School or Child Care facility:**
- **Grade:**

<table>
<thead>
<tr>
<th>Parent/Guardian Name</th>
<th>Telephone 1: Home Cell Work</th>
<th>Home Address:</th>
<th>Ward</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact:</th>
<th>Telephone 2: Home Cell Work</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity:</th>
<th>White</th>
<th>Non Hispanic</th>
<th>Black</th>
<th>Non Hispanic</th>
<th>Hispanic</th>
<th>Asian or Pacific Islander</th>
<th>Other</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Primary Care Provider (Medical):</th>
<th>Dental/Dental Provider:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Type of Dental Insurance:</th>
<th>Medicaid</th>
<th>Private Insurance</th>
<th>None</th>
</tr>
</thead>
</table>

### Part 2: Required Parent or Guardian Signatures

**Parent or Guardian Release of Health Information:**
I give permission to the signing health examiner or facility to share the health information on this form with my child's school, childcare, camp, or Department of Health.

**SIGNATURE of parent or guardian**

**Date:**

### Part 3: Child’s Findings and Recommendations

<table>
<thead>
<tr>
<th>Findings</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gingival inflammation</td>
<td>Y N</td>
</tr>
<tr>
<td>Plaque and/or calculus</td>
<td>Y N</td>
</tr>
<tr>
<td>Abnormal gingival attachments</td>
<td>Y N</td>
</tr>
<tr>
<td>Malocclusion</td>
<td>Y N</td>
</tr>
<tr>
<td>Treated dental caries</td>
<td>Y N</td>
</tr>
<tr>
<td>Untreated dental caries</td>
<td>Y N</td>
</tr>
<tr>
<td>Sealants on permanent molars</td>
<td>Y N</td>
</tr>
<tr>
<td>Cleft lip and palate</td>
<td>Y N</td>
</tr>
<tr>
<td>Preventative services completed</td>
<td>Y N</td>
</tr>
</tbody>
</table>

**What kinds of preventative services were completed?**

### Part 4: Final Evaluation/Required Dental Provider Signatures

**This child has been appropriately examined. Treatment is completed, is not complete, under treatment, refused treatment, not necessary.**

**Recommendation for Treatments:**

---

**DOS/DMD Signature**

**Print Name**

**Address**

**Fax**

**Phone**

**Date**

---

**District of Columbia Health Code:**

This form replaces the Dental Appraisal Form used for entry into DC Schools, all Head Start programs, childcare providers, camps, after school programs, sports or athletic participations, or any other District of Columbia activity requiring a physical examination. 

The form was approved by the DC Department of Health and follows the American Academy of Pediatric Dentistry (AAPD) Guidelines on Mandated School-Based Oral Health Examinations. AAPD recommends that a child be given an oral health exam within 6 months of eruption of the child's first tooth and no later than his/her first birthday. The DC Department of Health recommends that all children 3 years and older have an oral health examination performed by a licensed dentist and have the DC Oral Health Examination Form completed. This form is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) for the health provider, and the Family Education Rights and Privacy Act (FERPA) for the DC schools and other providers.
## District of Columbia Oral Health (Dental Provider) Assessment Form

### Part 1: Child's Personal Information (to be completed by the parent or guardian)

<table>
<thead>
<tr>
<th>Child's Last Name</th>
<th>Child's First &amp; Middle Name</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>School or Child Care Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Parent/Guardian Name**

<table>
<thead>
<tr>
<th>Telephone 1</th>
<th>Work</th>
<th>Home Address</th>
<th>City/State (if other than D.C.)</th>
<th>Zip code</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Home</em></td>
<td><em>Cell</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Emergency Contact**

<table>
<thead>
<tr>
<th>Telephone 2</th>
<th>Work</th>
<th>City/State (if other than D.C.)</th>
<th>Zip code</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Home</em></td>
<td><em>Cell</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Race/Ethnicity:**
- [ ] White
- [ ] Non Hispanic
- [ ] Black
- [ ] Non Hispanic
- [ ] Asian
- [ ] Pacific Islander
- [ ] Other

**Primary Care Provider (Medical):**

<table>
<thead>
<tr>
<th>Dentist/Dental Provider</th>
<th>Type of Dental Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>Medicaid</em> <em>Private</em> <em>None</em></td>
</tr>
</tbody>
</table>

**Part 2: Required Parent or Guardian Signatures**

*Parent or Guardian Release of Health Information*

I give permission to the signing health examiner or facility to share the health information on this form with my child's school, childcare, camp, or Department of Health.

**PRINT NAME of parent or guardian**

**SIGNATURE of parent or guardian**

**Date:**

### Part 3: Child's Findings and Parent Recommendations (please indicate in findings column)

<table>
<thead>
<tr>
<th>Findings</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gingival inflammation</td>
<td>Y N</td>
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<td>Y N</td>
</tr>
<tr>
<td>Clasp and palate</td>
<td>Y N</td>
</tr>
<tr>
<td>Preventive services completed</td>
<td>Y N</td>
</tr>
</tbody>
</table>

**What kinds of preventative services was completed?**

- [ ] Flossing
- [ ] Fluorides
- [ ] Oral Hygiene

### Part 4: Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. Treatment ___ is completed, ___ is not complete, ___ under treatment, ___ refused treatment, ___ not necessary

**This child has urgent needs and has been referred to**

**Recommendation for Treatments:**

**DOS/DMAF Signature**

**Print Name**

**Address**

**Fax**

**Telephone**

**Date**

---

**District of Columbia Health Certificate**

This form is used for the Dental Assessment of children for entry into DC schools, all dental care providers, and the Department of Health. This form is used to collect information on a child's oral health status, including gingival inflammation, plaque and calculus, and abnormally gingival attachments. The form is used to determine if a child is in need of dental care and to provide guidance on the type of care needed. The form is also used to track the progress of children's dental care and to ensure that they are receiving the appropriate level of care. This form is used to identify children who may be at risk for oral health problems and to ensure that they are receiving the appropriate level of care. The form is used to track the progress of children's dental care and to ensure that they are receiving the appropriate level of care.
References


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   http://www.rand.org/pubs/working_papers/WR630.html

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