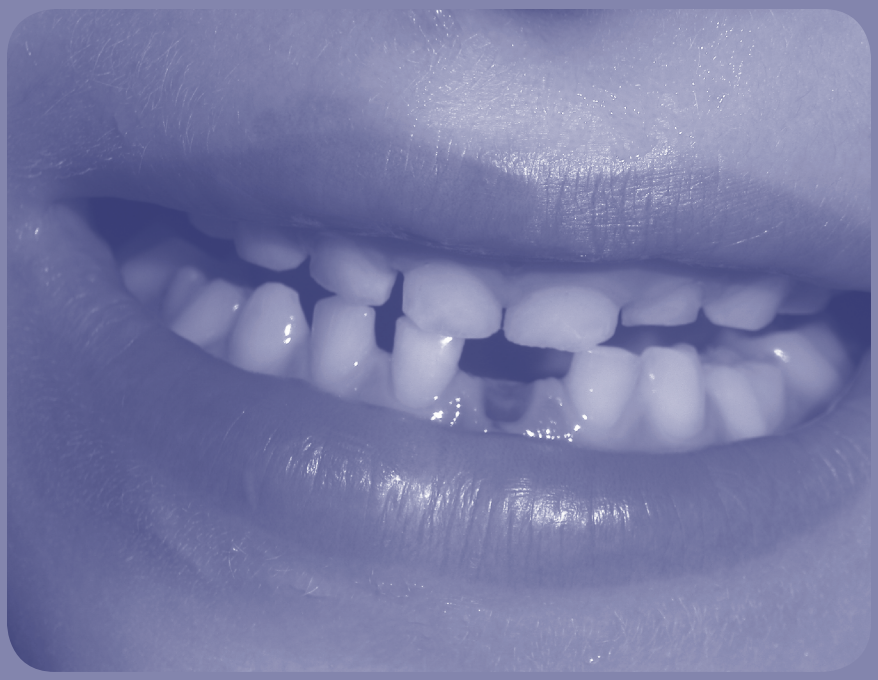

Kentucky's Cavity

Parents Voice Concerns about Children's Dental Care in Their Communities

Kentucky Youth Advocates

Funding provided by the Ford Foundation and the Kentucky Dental Health Coalition

Content and research by Lacey McNary, MSW

About KYA

Kentucky Youth Advocates is a non-profit, non-partisan children's advocacy organization. KYA delivers the messages of Kentucky's children to the state legislature, the community, and the media. We insist that our young citizens be given the opportunities and resources to ensure their health, safety, and productive development. KYA listens to children, their families, and service providers who are reluctant or unable to raise questions about existing policies. In short, we act as a liaison between the powerless and the powerful. KYA acts as a voice for Kentucky's most precious asset—its children.

KENTUCKY YOUTH ADVOCATES

2034 Frankfort Ave.
Louisville, KY 40206
(502) 895-8167
www.kyyouth.org

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Local coordinators:

Darlene Campbell, Family Resource Center Director, Leslie County
Faye Critchelow, Family Resource Director, Grayson County
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Loretta Maldaner, Purchase Area Health Education Center Director, McCracken County
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This report could not have been possible without the dedication of the 60 parents, grandparent guardians, and foster parents who shared their experiences and opinions with us. The parents from the six communities were honest, open and passionate advocates for their children. We honor them for their time and willingness to share, and we sincerely hope that the valuable information that they shared with us will help inform policymakers about the needs of children across the Commonwealth of Kentucky.

Introduction

This report gave parents a chance to talk about their experiences in obtaining dental health services for their children in their communities. Many of the problems, challenges, barriers, and experiences that parents spoke to us about have been documented in other research, some of which we present in this report to support the parents' observations. The power of personal stories and of parents taking time out of their busy days to talk about oral health speaks volumes about where Kentucky needs to go in order to increase the overall health of all of our children.

We know that low-income parents face many barriers when they try to access dental health care for their children. These barriers include: lack of transportation to dental offices, being uninsured, inflexible work schedules, too few providers who will see their children, and families own understandings about the importance of dental health to their family's overall health. These barriers will be explored in greater depth in this report as parents' voices are highlighted.

Not only do parents encounter barriers to getting their children the care they need, dentists also report many issues associated with serving low-income patients including no show appointments, extensive paperwork, and low reimbursement rates from Medicaid. While we acknowledge that dentists have a story to tell about dental health barriers, this project did not involve talking with dentists. We believe that dentists have existing venues to get their stories out, so we concentrated our efforts on those who do not have a seat at the solution table.

Why children's dental health matters

In a previous KYA report, entitled *Open Wide or Lock Jaw: Dental Health Access in Kentucky*, we documented that only one-third of Kentucky's low-income Medicaid or Kentucky Children's Health Insurance Program (KCHIP) enrolled children received dental services in 2002. For this report, we reviewed 2004 service statistics and found that the proportion of Medicaid enrolled children who received any dental services was essentially unchanged two years later (see chart on pg 16).[1] This is simply not acceptable as the effects of poor oral health are life long and costly, not only financially, but developmentally. In many ways, poor oral health is a quality of life issue as well as an economic development issue in that gaining entry into the employment marketplace may be difficult if one's appearance is not acceptable to the employer or oral pain and infection create an atmosphere of nonattendance at the workplace.

Kentucky currently ranks 49th in the nation in percent of people who have lost six or more teeth because of decay or gum disease.[2] The Kentucky Oral Health Program in the Department of Public Health discovered in its 2001 study that a shocking 47 percent of the 2 to 4 year olds that were examined were diagnosed with early childhood caries (cavities).[3] This is twice the national rate.

Children in Kentucky who are enrolled in the Medicaid or KCHIP programs are eligible to receive a limited number of dental health services. These services include annual dental exams, x-rays, emergency visits, extractions, root canal treatment, crowns, sealants, and braces if they are medically necessary.

As we discussed in our 2003 dental health report, children's oral health is a critical requirement for an overall healthy and productive child. Oral infections, particularly on

teeth, do not get better with time but worsen to the point of pain, swelling and disfigurement. Children with painful dental problems are prone to missing school, not being able to concentrate while at school, developing other health problems, and failing to properly develop. They also have problems eating and sleeping.[4] In a recent report, the American Dental Association discussed the life long problems associated with poor oral health: "Scientists are discovering that the connections between oral health and general health might be even stronger than first realized—with suspected associations between certain oral diseases and systemic diseases and conditions, including diabetes, cardiovascular disease, stroke, and pre-term low birthweight babies."[5]

Kentucky Youth Advocates focus group project

The focus groups were a natural next step in KYA's research and advocacy agenda after completing our first dental care access report in 2003. We wanted to hear from parents about what stands in their way of getting adequate dental services for their children. An in-depth view of the problem from the perspective of the recipients of the service gives policymakers a different lens to look through as they they integrate the various data, reports, and research available around dental health. A combination of scientific research and on-the-ground common sense analysis is important to the policymaking process.

Summary of common themes expressed by parents

As we conducted focus groups across the state and analyzed their feedback, several themes emerged that we will explore in more depth in this report.

- There aren't enough dentists who treat children enrolled in Medicaid or KCHIP.
- Even with the "medical card," dental care is expensive for families.
- Families often felt they were treated as second class citizens.
- Dental health is a community problem.

Finding 1

Too few dentists

In 2004 there were 508,242 children enrolled in Medicaid and KCHIP entitling them to free dental services, yet only 170,068 of them received any dental services, about 33%.[6] There are many reasons for this statistic. In order to get a real idea of what these numbers mean to families, we asked parents about their experiences with their children's dental health. Our questions included asking where they took their children to get care and what makes it difficult to get their children to the dentist. We repeatedly heard the same issues identified in the communities that we visited.

What the parents said about access to dental care:

When you are on Medicaid, your options are limited...

"I have called everyone in the yellow pages and asked them if they take the medical card—it's my first question—do you take the medical card—no—click—do you take the medical card—no—click."

"There are at least 5 dentists here and one who takes Medicaid – and he is not taking any new patients."

"We need more dentists in Gallatin County. There is not a dentist in Warsaw that takes Medicaid. The closest is Florence which is a good 35- 45 minutes away."

It's a long drive to see a dentist...

"It's a long drive...average travel to the dentist is a 45 minute drive one way."

"We need dentists right here in this town, not 20 miles from here, not 40 miles from here, to take all kids."

"If the drive wasn't so long you would not have to take the kids out of school so early and they would not be counted as absent."

"My child missed an entire day of school, and we had to drive all the way to E'town for an appointment."

"My child has special needs so I have to take him to Knott County, which is a very long ways from where I live, about two - three hours away."

Pediatric dentists are hard to come by...

"I had to take my kids clear to Cincinnati to the children's hospital to get caps on their teeth because there is no pediatric dentist in this county. It is a very long drive."

"One dentist takes children ages 0-3 depending on how controllable they are. If she can't control them she sends them to Corbin or London."

"We do not have a pediatric dentist. I tried to get my two and a half year old in to see the dentist the same day as my older one and they asked me how old she is. They told me that they don't see anyone under age 3."

"One place takes Passport, but they would not see my child because she needed a filling and they said they would not do it because she was too young. I was sent to Elizabethtown."

Getting off work to go to the dentist is a hardship...

"Getting off work to go to the dentist is big issue. I work 12 hour shifts. I usually work 60 hours a week. Getting time off work to do anything, even laundry, let alone sitting in a dental office for four hours is impossible. I only make $6.35 an hour and I need all the overtime that I can get. If I miss one minute over the amount of hours that you can miss in three months, they will fire you. They don't care if you have been there for fifteen years and have a glowing record."

"[Dentists are] closed on Saturdays - so you miss work or your child misses school. If they could just be open on a Saturday."

"You lose money for missing work and then you have to pay the dentist for what you got."

Nowhere to go in an emergency...

"So if on Friday afternoon you started feeling pain? You would have to suffer with it until Monday, even with children."

"You should have an emergency dental clinic. If you have something happen on the weekend what are you supposed to do? The emergency room [at the hospital] won't touch it. I don't know anyone who will help on the weekend."

"The hospital [here] does not do dental. If you have a dental emergency, you have to go to the children's hospital in Cincinnati."

Summary

One of the main issues raised by parents was the lack of dentists who provide services to families who rely on Medicaid or KCHIP for their health insurance. The data on dental care access in Kentucky backs up the parents' claims. In 2004, there were 2,265 licensed dentists in the state, but less than half (937) of these dentists billed Medicaid for services.[7] The National Conference of State Legislatures measured Medicaid provider strength by looking at the number of dentists that billed Medicaid over $10,000 for services. In their analysis they showed that although $10,000 may seem like a substantial amount of services, in actuality the billing dentist would have only served approximately 23 children or about two per month.[8] In 2004, 300 of the 937 Medicaid billing dentists, or about 32%, did not reach this threshold of activity.[9]

Because of the limited number of Medicaid dentists in our focus group communities, parents reported additional challenges in taking their children to the dentist due to lengthy travel times. Many of the families were forced to drive to a different county to get dental services for their children. Several parents utilize community health clinics that employee dentists. These dental clinics play a critical role in drawing dental providers to geographically challenged communities and are often the only dental care option for families.[10]

Even when there were dentists accepting Medicaid in the county, they often didn't treat young children. Dr. James Cecil of Kentucky's Oral Health Program reports that there are only about 50 to 60 pediatric dentists in Kentucky and approximately half regularly bill Medicaid for services.[11] Pediatric dentists are specially trained to treat children from birth through the teen years. They are known for their patience and skill in making sure a child has the most comfortable and positive visit possible. This special training is critical as most U.S. dental schools only require 5 hours or less of classroom instruction and less than 5 percent of clinical time solely devoted to children and adolescents.[12]

For many parents, getting off work to take their children to dental appointments during business hours is difficult. Although families of all income levels may find taking time off work is a hassle, for some it is virtually impossible. Since many low-income workers get paid hourly, they are literally losing income when they are off the job. Other low-income workers report that their employers simply will not grant time off to visit the dentist.

Parents also reported virtually no emergency dental care services in their communities. In a perfect world, people would never need to use the emergency room for dental problems because preventive measures would eliminate the need, but in reality only 5% or less of public oral health money is spent on prevention.[13] Particularly in rural areas, since access to preventive services is sparse, access to emergency services becomes the main option for treatment. Edelstein found that Medicaid enrolled children received emergency care such as extractions much more often than any sort of preventive care.[14] This topic was brought up in every community where focus groups were held.

Finding 2

Even with the "medical card," dental care is expensive

The focus group participants were a proactive cohort of parents in the state. They are conscientious caregivers who appreciate and realize the importance of keeping their children insured. They were able to offer their honest opinions and personal experiences of having their children enrolled in Medicaid or KCHIP. The parents described the available services as not being adequate to meet all of their children's complex dental problems or regular preventive visits. Since many low-income parents cannot afford expensive dental bills, their child's problems are often not treated, and the dental conditions worsen, much to the parents' chagrin.

What the parents said about the cost of dental health:

Even with Medicaid or KCHIP, dental care is still expensive...

"There has to be a lot of kids in the county that don't have any dental coverage at all and most dentists want money up front and they won't accept payments and a lot of parents don't have it. It depends on medical coverage for dental and money."

"You are still in poverty, and a lot of people make a little too much, like two or three dollars above the guidelines and by the time you buy food, clothes, house, there's not enough left to buy any kind of insurance."

"At the——Clinic, it takes two months to make an appointment and then you have to pay a security deposit of $25 and sometimes you don't have it. You pay and then you get it back when you show up. If you don't have it, they won't see you."

Parents are not sure what is covered under Medicaid or KCHIP, and often have wrong information...

"With the medical card [at the clinic] there is a four step process to getting a toothache fixed. You have to go in 4 separate times: initial visit, cleaning, x-ray, filling. This is a lot of time and gas."

"The state won't pay for x-rays and dental work on the same day so I have to return on another day. We had to reschedule, we had to go back twice."

"A lot of dentists don't like to take the medical card, because they say it takes too long to get paid. This is what we always hear."

Kentucky Medicaid and KCHIP cover the following dental services for children 18 and under:

- Oral exams (one per year)
- Emergency visits
- X-rays
- Extractions
- Fillings
- Root canal treatment
- Crowns
- Sealants
- Braces (for severe malocclusions)

Source: Kentucky Cabinet for Health and Family Services, Department for Medicaid Services

Medicaid is very helpful, but often it is not enough...

"If grown-ups have to go to the dentist every six months, children should be there every six months as well. Well, KCHIP only pays for once a year check ups."

"They only get seen once a year – why? I go twice a year, they only go once; this doesn't send the right message."

"My daughter chipped her tooth and the card would not pay until she got a cavity—what is the sense of waiting until she has spots? It was real tiny at first. I don't understand. The state could have saved money."

"My kids get less services [no pain reliever] so they won't go – they just won't open their mouth."

"You should not have to wait a month to get antibiotics for an abscessed tooth to go down. I have been there and done that and have lost teeth because of it."

Summary

Low-income children are at a greater risk of poor oral health and less likely to receive adequate preventive care than their higher income counterparts. Research published in the Journal of the American Dental Association found that children ages 2 to 5 years old who have not been to the dentist in the past year are more likely to experience cavities than children who have been to the dentist.[15] Another study recently published in the Journal of Public Health Dentistry showed that 75 percent of caries or cavities are found in 8 percent of children from age 2 to 5 years old.[16]

These studies outline the problem that the parents so eloquently told us about—their children cannot get the dental services they need to prevent dental problems. One of the main reasons the children have inadequate care is the prohibitive cost of dental care, even with Medicaid or KCHIP enrollment. These costs could include paying a required deposit to get an appointment, paying full price for appointments, paying for treatments that are not covered by Medicaid or KCHIP, and/or paying totally out of pocket in order to avoid the hassles that come with finding a Medicaid provider.

Parents also reported that they did not have a good understanding of what services they could and could not get for their children with the "medical card." In every county, there was discussion during the focus group conversations about what services their children are eligible for with the "medical card." Oftentimes the parents' analysis was incorrect, but we also heard about questionable dental office and clinic practices in several counties such as having families come back mulitple times to get a simple procedure completed. When parents talked about their experiences, it appeared that many providers instituted unnecessary steps which created additional burdens for the families.

The focus group participants discussed the fact that Medicaid and KCHIP services were often not adequate to meet all of their children's dental problems. Two things that were mentioned repeatedly was that children could only get their teeth cleaned once a year and many were not able to get braces on their children's teeth because it wasn't "medically necessary." The Kentucky Medicaid and KCHIP programs cover one cleaning per year for children as well as a few other basic dental services. The American Academy of Pediatric Dentistry recommends that all children age 2 and older receive at least two preventive dental visits per year.[17] Many parents that we talked to in the focus groups knew this widely accepted fact and they felt the state should at least cover that recommended minimum care.

Finding 3

Families felt they were treated as second class patients

Another issue that was brought up in every county was the ways in which families felt they were unfairly treated by the dental care professionals. The parents described being treated as "second class citizens" by dentists, receptionists, and clinic staff. This phenomenon was described by participants of every race, age, and gender. They asserted that the discrimination was based mainly on the fact that they had health insurance coverage through Medicaid or KCHIP, although racial discrimination was described as well.

What the parents said about how they are treated:

Noticeable second class treatment by dentists and office staff...

"The dentist in town who sees KCHIP patients will only see you in the morning and you have to wait 3-4 weeks to get in, even with an abscess."

"Now I can tell you, if I get there first, excuse my french, because I am just a black woman, and the only one sitting in there, he is going to see all the white folks and I am going to be the last one in there. I have done that too many times and I am not going back to him."

"This is my biggest complaint with the medical card was being treated poorly, and they make you feel like you were nothing. I did not like that."

"We need new dentists here in our town, somebody that will take the medical card and who does not make us stand around making us feel like we are a bunch of dummies. You know someone that is going to respect us. Don't treat me different just because I have a medical card."

"I'm a single mom. Given all the different things I have to pay for right now, don't get me wrong, we all appreciate the medical card very much - or else we would not be here tonight. You know, we are all in different situations for some reason; we are all in the same pool. But just because we are in hard times, does not mean that we should be treated as low class citizens, because we aren't."

"When you call and ask them if they take Kentucky Medicaid and they either say 'what's that' or 'no we don't accept that,' and they make you feel less than a person. You get to the point that you just don't even call anymore."

"It's the receptionists. It's not what they say, it's the tone of their voice and how they say it. When you tell them you have Medicaid you can hear the smirk and the sarcasm in their voice."

"I don't know what can be done to make it better, because all dentists have different personalities. Apparently there are some good dentists, but it is just getting to those dentists that is hard. But when you are on a fixed income and have the medical card, you don't have the means to get to these people."

Parents have seen both worlds...

"Doctors are a lot friendlier with insurance than with KCHIP. They take the time to get close. This is one reason that some people do not apply for the card – they would rather do without than be treated differently."

"It really upsets me, the way people treat you when you have a medical card. There was a time when I did have regular insurance. One of the dentists makes you feel like

you are nothing. I will not be on assistance forever, they should not treat me like I am nothing."

"It is demeaning—their body language and the way they act; you can tell that your children do not get the same care as other children"

"I have experienced the difference in treatment, when I had a good job and had insurance. There is discrimination because of medical coverage not just racial issues."

"When my husband and I were working, we had really good insurance. When I took the kids to the dentist, they were very thorough and patient with the child. When we had insurance, we could go back with the kids and watch him work. When you have the medical card it's like—you wait outside because you will get the child upset and make it hard on us."

"We have been lucky to find a good dentist and doctor. He is very good, but you do have to wait for his paying patients to get service before you get service. This is the only gripe that I have about him, but he is a good dentist."

"There is a lot of prejudice with the medical card, it's like you are the underdog, you can't get what the top dogs get because you have that little piece of paper."

Dental office experiences not "family friendly"...

"The — — Clinic does not have a pediatric dentist and I have a problem with that—they don't know how to handle kids. When I took my daughter there, she had to get x-rays and they used adult sized bite things. I reckon it hurt her; she was screaming. I said that's enough we are never coming back here."

"Oh yes, he has asked me to leave the room before, because Jimmie (not real name) was so frightened, and if I was there with my hand on his shoulder, he knew mommy was there, and nobody was going to hurt him because mommy was there."

"My child won't open their mouth and the dentist says, 'if he's not going to open his mouth, there is nothing I can do,' they don't do anything to calm him down."

Summary

The issue of discrimination among health care providers is neither a new issue nor does it solely belong to the dental profession. Medical and dental journals have published many articles about the problem of discrimination and the need for a ramping up of cultural competency training.[18] These issues are not only described in the professional journals, but by parents around the country. In other focus group studies with low-income caregivers, similar experiences were described. Researchers concluded that once caregivers actually received access to dental health services, they still had to get through multiple barriers in the dental health settings, such as receiving poor care and dealing with office staff and dentists who were insensitive.[19] In other words, dentists can become the barrier to dental care provision by not practicing in a culturally competent manner. These behaviors often exacerbate the problem of people using the emergency room for treatment, especially in rural areas.[20]

Many parents felt they were not treated well in comparison to those who have "real" health or dental insurance. In fact, one of the main findings in a report put out by the Institute of Medicine states that bias, stereotyping, and prejudice may be contributors to healthcare disparities between racial and ethnic groups.[21] Several of the parents we met compared the different experiences they personally had with private health insurance coverage and with the "medical card."

Parents also reported that dental offices were often not "family or child friendly." Since general dentists do not necessarily have training in the social, environmental and developmental context of children's health, they may not view this issue as important.[22] The parents felt this was a barrier to care, citing such examples as:

- Not being allowed to be with their children during dental procedures;
- Dentists not using appropriately sized equipment on the children; and
- Office staff not making an effort to ensure that children felt comfortable in the dental setting.

Finding 4

Dental health is a community problem

Parents talked about dental health not only being important for overall health, but for being able to learn in school, for success in life, and critical for self confidence and child development.

What the parents said about dental health in their community:

Dental health is important for more than just looks...

"It's not that you don't care, it's not because you are neglecting, it's actually embarrassing."

"Our family is very concerned about my daughter's mouth."

"A lot of people don't think about the relation of health and teeth. They don't know what kind of effect the teeth have on the rest of the body – I didn't know."

"It affects their self esteem—big time—and to me I think that is really important for all kids to have in school."

"Missed school? Yes, if you have a child, they have missed school because of teeth. If that child's teeth hurt – are they going to be sitting there worried about the work that they are doing? No, they are going to be worrying about those teeth and if you keep them home because you can't get into the dentist, someone will be coming to your house. It is a lose-lose situation."

"It keeps his self confidence a lot higher up with nice smile. Our four year old just got his teeth fixed and he just keeps grinning."

Dental health is not a community priority...

"I think adults associate dental and pain and therefore they don't want to put their children through that. I mean it is hard to convince your kids to go when you don't want to go yourself."

"For most people, their teeth are the last thing that they think of, there is a big misconception, especially in this region, especially when you are young. You can't blame anybody, but it's just the way it is has been and no one takes that time to think about it. It doesn't get the attention it should."

"When children grow up in that environment, it becomes acceptable to them because they don't know anything else. If you are around it long enough you don't think it's dangerous."

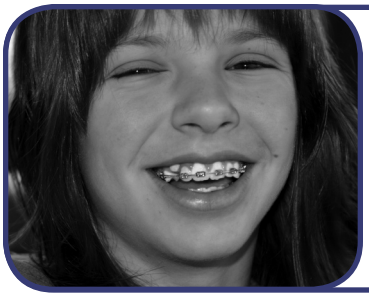
"You know what makes me mad? Is that some people wait and wait and wait to take their child to their first dental check up. They don't do it right away. Some of them wait until they go to school. They get a medical card, why do they wait so long?"

"I know so many grown ups with two teeth in their head because they never went. They can't eat properly. These are grownups and how are children supposed to think about the dentist?"

Summary

The parents we talked to expressed a real desire to ensure that their children's dental health needs did not go untreated. That commitment to their children's dental health means going to great lengths to get their children to the dentist and keep them out of pain. Although the findings of the focus groups cannot be generalized to every low-income family in Kentucky, the discussions counter the popular belief that some parents just don't care about dental health.

The participants also discussed how their communities dealt with dental health. They admitted that they and other community members are generally reactive rather than preventive when it comes to taking care of their mouth. Other concerns include lack of school-based services, lack of education about the importance of dental care, and lack of community-based dental services.



Conclusion

Much health research has highlighted the complex and multifaceted problems that compromise the dental health of low-income children. We cite this research in this report. But perhaps of more import, our focus group project asked the parents of these Kentucky children to tell us "in their own words" about their children's dental health, dentists, and coverage of dental care through Medicaid and the Kentucky Children's Health Insurance Program. We were especially struck by the representation by parents of their children's treatment as second class citizens. As a group, the low-income parents we spoke with understood the importance of dental health and sought out dental care for their children, but they were simply not able to access the same kind of dental care that most other Kentucky children receive.

We recognize that the solutions to the problems we examine in this report are complex and require many different approaches. If the solution were easy, we would have solved the problems long ago. But solve the problems, we must. Despite the challenges posed, the problems deserve our resolute and urgent attention. Poor dental health impacts individual children, overall school performance, community economic development, and the future health of the state. It is not by accident that a market for products bearing the motto "Kentucky: Got Teeth?" exists on the web. It will take the commitment of high level policymakers as well as local community members, the dental community and families to erase this embarassing and unhealthy image and ensure that all Kentucky's children have bright smiles. Now is the time to make Kentucky's oral health a priority.

KYA policy recommendations

Increase access to dental care by removing barriers to dentists' participation in Medicaid and KCHIP

"If one [dentist] could stay open on Saturday, they'd have a lot of people come in. There are three dentists in town, if they each took one weekend a month it would make a huge difference."

"There needs to be an 1-800 hotline so parents can complain about the problems, but that is kind of a catch-22. If the dentists get too many complaints, they may stop taking any KCHIP kids."

In order to recruit and retain dentists, increasing the Medicaid reimbursements to the usual and customary rate is a must. Unlike doctors, dentists have extremely high overhead costs in setting up their practices. They have to purchase high cost equipment and hire staff, and they rarely have a hospital or diagnostic center to which they can refer their patients. Oftentimes reimbursement rates do not even cover the dentists' overhead costs, so they actually can lose money on each Medicaid or KCHIP patient they serve.[23]

Offering incentives for dentists to provide more "charitable care" is another way to ensure that low income children are seen by a dentist. According to the ADA's 2000 Survey of Current Issues in Dentistry, 74 percent of private practice dentists provided services free of charge or at a reduced rate. A national estimate of the value of this care was $1.25 billion or $8,234 per dentist.[24]

KCHIP redistributed dollars present another opportunity for the state to expand dental services for children. These dollars are allocated to Kentucky after other states have not used them and, therefore, are ideal for special one-time projects or incentive programs for dentists.

Increase dentists' cultural competency in working with their diverse patients

"If they feel comfortable in the office, your children can feel okay about going back by themselves. The place we went had more of a friendly environment. He just goes back like it is nothing"

"If we want to go back there and hold our little children's hands while they get their teeth fixed we should be able to do that."

By educating dental providers and office staff about the importance of being culturally competent, trust and respect can be built among all patients who live in their service areas. An article released in April 2005 in the Journal of Medical Care showed that cultural competence training does improve health professionals' knowledge, attitudes, and skills. The authors found evidence in their review of literature that patients were more satisfied with health professionals who received the training. It was also found that although patients had positive experiences, they did not necessarily have better compliance with given treatments because of the dentist's competency training. This is an area that needs to be studied in greater detail in order to be able to measure health outcomes.[25]

Another way to increase the cultural capacity of dentists and access to dental care by underserved groups is to recruit a more diverse group of students into the dental schools. Research shows that African-American and Hispanic-American dentists disproportionately serve African-Americans, Hispanic-Americans, and low-income people.[26] Not only is recruitment of racially and ethnically diverse dentists important, but an effort needs to be made to get more people from rural areas into the profession of dentistry including dental hygiene.

Utilize school-based health centers and other school-based programs in the provision of dental health services

"Screen for teeth in the schools—like head lice and ears/eyes. I think they are more worried about head lice than kids teeth or anything else."

"Having kids brush at preschool helps me do it at home. My kids love to brush their teeth now. They should do it in elementary school like they do at Head Start. They brush their teeth after lunch."

Schools have a lot at stake in partnering with healthcare providers. The 2000 Surgeon General's report found that 51 million school hours are lost each year to dental illness.[27] School-based health centers are a very effective way to bring dental services to children who may not otherwise receive the care. There are 14 school-based health centers located in eight counties in Kentucky and all offer dental services or supports for the students to access dental services.[28] Unfortunately at this point, these centers are not funded by the state and are at risk of closing when their private sector funding runs out.

Copy successful local community, public, and private programs and services that serve low-income families

"More public education for parents and their kids. More reminders need to come along. To remind us—oh yeah I do need to brush more often."

"One of the things that would help is to have a mobile service that comes to the school system plus getting them to their local dentists for their regular checkups, this would help. At least they would have a chance to get some sort of care, some sort of help"

University programs are vital in serving thousands of children who otherwise would receive no dental services. Through the use of mobile dental vans, university-based clinics like the University of Kentucky's Walk-in Clinic, and other partnerships with the private sector such as University of Louisville's Colgate Kids and Smile Kentucky Programs thousands of children are able to see a dentist. [Ed. Note - Both of these university programs were highlighted in a national publication that outlined the best practices in the field of dental education.[29]]

Local community programming aimed at increasing health outcomes for children is critical in the provision of dental care in communities where there is a shortage of Medicaid enrolled dental providers. Examples of successful community programs include the following:

- The First Baptist Church in Frankfort, Kentucky has a partnership with the Franklin County Health Department to offer free dental services to low-income community members;
- The Mountain Missions Project in Eastern Kentucky has made children's dental services a priority;
- The Purchase Area Health Education Center, West Kentucky Community and Technical College Dental Assisting/Dental Hygiene program, and the University of Louisville School of Dentistry have collaborated to operate the Purchase Area Dental Clinic which is a free clinic for children run by volunteer dentists.
- The Nathaniel Mission in Lexington collaborates with the University of Kentucky College of Dentistry in providing no-cost outreach dental services using dental students and resident dentists under the supervision of dental faculty.
- The University of Kentucky Colleges of Medicine and Dentistry have recently developed a clinic as part of the UK Rural Health Center in Hazard to provide oral and general health services for seven counties in Appalachian Kentucky to those who have no other access to dental and medical care.

These efforts are critical in creating public awareness, education, and services to people in Kentucky and vital in changing community perceptions about the importance of dental health. The U.S. Surgeon General recommends that one of the main areas for community members, policymakers, and health care providers' action is to change the popular notion that oral health is not part of an overall healthy body.

Continue the forward motion and policy improvements that Kentucky has implemented in recent years

"I just pray that they never take off dental care for children. That sets your life, I mean you have got to have teeth. Not just for looks, but for your health."

"We know things are hard for the state and everybody is taking cutbacks, but there are a few ways to give people dental health and still let them feel like human beings."

Kentucky received an overall grade of C in Oral Health America's 2003 National Grading Project. Some of the areas that Kentucky received an A in included fluoridation and funding a full time oral health director.[30] Kentucky has also recently started fluoride varnish and dental sealant programs that are designed to be proactive preventive approaches to treating children's health. In 2003, 10,000 children received dental sealants.[31] Twenty-three local and district health departments currently participate in the dental sealant program.[32] During the first six months of the 2005 fiscal year 11,000 fluoride varnish applications were completed statewide.[33] Policymakers need to continue to make improvements for the dental health of those who live in Kentucky, especially for the children.

2004 Dental access data

Counties	# Licensed Dentists	# Dentists who Billed Medicaid for Services	Medicaid or KCHIP Eligible Recipients under 21 Years Old	# of Recipients under 21 who Received any Dental Care	% of Recipients under 21 who Received any Dental Care
Adair	5	2	2,532	886	35%
Allen	5	3	2,270	656	29%
Anderson	7	3	1,594	466	29%
Ballard	1	1	968	324	33%
Barren	17	9	4,849	1,456	30%
Bath	1	1	2,011	616	31%
Bell	11	8	6,323	2,826	45%
Boone	69	16	5,934	1,354	23%
Bourbon	14	5	2,130	768	36%
Boyd	38	19	6,499	2,281	35%
Boyle	24	17	3,154	1,039	33%
Bracken	1	2	1,115	300	27%
Breathitt	5	5	3,372	1,278	38%
Breckinridge*	5	4	2,710	1,239	46%
Bullitt*	22	6	6,081	1,058	17%
Butler	1	1	2,011	572	28%
Caldwell	5	2	1,604	527	33%
Calloway	16	8	3,154	945	30%
Campbell	36	14	7,190	1,846	26%
Carlisle	1	1	645	207	32%
Carroll*	3	1	1,368	79	6%
Carter	9	4	4,820	1,758	36%
Casey	2	1	2,619	1,020	39%
Christian	25	8	8,588	2,061	24%
Clark	21	9	4,069	1,424	35%
Clay	6	5	5,114	1,676	33%
Clinton	3	2	1,861	667	36%
Crittenden	1	1	1,074	303	28%
Cumberland	3	3	1,163	457	39%
Davies	53	25	10,780	3,440	32%
Edmonson	2	2	1,715	612	36%
Elliott	3	2	1,433	573	40%
Estill	4	5	2,585	977	38%
Fayette	321	103	21,425	4,715	22%
Fleming	3	5	1,983	607	31%
Floyd	29	18	8,451	3,170	38%
Franklin	28	4	4,241	1,111	26%
Fulton	1	0	1,419	377	27%
Gallatin	1	1	1,208	264	22%
Garrard	3	2	1,967	642	33%
Grant	7	2	3,341	826	25%

Counties	# Licensed Dentists	# Dentists who Billed Medicaid for Services	Medicaid or KCHIP Eligible Recipients under 21 Years Old	# of Recipients under 21 who Received any Dental Care	% of Recipients under 21 who Received any Dental Care
Graves	12	7	4,864	1,576	32%
Grayson*	7	4	3,673	1,537	42%
Green	3	2	1,493	512	34%
Greenup	12	7	4,850	1,676	35%
Hancock	4	3	909	219	24%
Hardin*	58	9	10,116	4,528	45%
Harlan	8	10	6,761	2,538	38%
Harrison	7	2	2,058	637	31%
Hart	3	4	2,661	794	30%
Henderson	20	10	5,228	1,559	30%
Henry*	3	2	1,827	513	28%
Hickman	1	1	620	209	34%
Hopkins	17	16	6,069	2,091	34%
Jackson	3	1	2,522	550	22%
Jefferson*	638	131	73,814	30,155	41%
Jessamine	15	4	4,666	1,409	30%
Johnson	5	7	4,302	1,597	37%
Kenton	69	20	14,485	3,337	23%
Knott	4	3	3,388	1,446	43%
Knox	7	11	7,234	2,824	39%
Larue*	4	4	1,743	482	28%
Laurel	16	9	9,407	3,229	34%
Lawrence	4	4	3,103	993	32%
Lee	2	2	1,593	497	31%
Leslie	4	3	2,476	1,058	43%
Letcher	7	7	4,603	1,630	35%
Lewis	3	3	2,646	982	37%
Lincoln	2	1	3,597	1,322	37%
Livingston	1	1	1,108	295	27%
Logan	9	6	3,351	1,038	31%
Lyon	2	2	572	198	35%
McCracken	52	21	7,751	2,304	30%
McCreary	3	2	4,257	1,636	38%
McLean	2	1	1,279	441	34%
Madison	29	12	7,584	2,163	29%
Magoffin	7	5	3,057	1,203	39%
Marion*	4	5	2,206	468	21%
Marshall	9	2	3,000	1,007	34%
Martin	2	4	3,018	1,091	36%
Mason	13	10	2,292	663	29%
Meade*	3	3	2,914	785	27%
Menifee	1	0	1,370	203	15%
Mercer	7	1	2,328	745	32%
Metcalfe	1	4	1,573	529	34%
Monroe	6	6	1,702	652	38%
Montgomery	11	14	3,439	1,100	32%
Morgan	5	6	2,353	830	35%
Muhlenberg	9	5	4,388	1,571	36%
Nelson*	14	12	4,290	1,691	39%
Nicholas	2	2	1,016	348	34%
Ohio	7	4	3,684	1,286	35%

Counties	# Licensed Dentists	# Dentists who Billed Medicaid for Services	Medicaid or KCHIP Eligible Recipients under 21 Years Old	# of Recipients under 21 who Received any Dental Care	% of Recipients under 21 who Received any Dental Care
Oldham*	24	4	2,106	382	18%
Owen	5	4	1,487	414	28%
Owsley	1	1	1,206	360	30%
Pendleton	2	1	1,776	487	27%
Perry	16	14	5,753	2,107	37%
Pike	34	30	10,704	4,213	39%
Powell	4	2	2,683	937	35%
Pulaski	32	22	8,888	3,243	36%
Robertson	0	1	327	95	29%
Rockcastle	3	3	2,665	875	33%
Rowan	12	10	2,756	932	34%
Russell	8	9	2,823	935	33%
Scott	14	6	3,739	982	26%
Shelby*	14	3	3,205	1,329	41%
Simpson	8	5	2,083	528	25%
Spencer*	3	3	1,098	123	11%
Taylor	7	7	3,015	843	28%
Todd	2	2	1,699	423	25%
Trigg	3	2	1,256	367	29%
Trimble*	1	2	1,183	522	44%
Union	7	1	1,760	515	29%
Warren	65	29	11,119	3,404	31%
Washington*	5	4	1,285	594	46%
Wayne	5	4	3,693	1,313	36%
Webster	3	2	1,833	470	26%
Whitley	24	16	7,924	3,088	39%
Wolfe	1	1	1,790	594	33%
Woodford	11	4	1,750	441	25%
Other	n/a	n/a	26	2	8%

* Counties served by Doral Dental Services

KY 2004 Total	2,263	937	508,242	170,068	33%
KY 2002 Total	2,169	871	476,854	153,559	32%
KY 2001 Total	2,192	870	460,600	135,421	29%

Source: Kentucky Department of Medicaid Services, Kentucky Board of Dentistry, and Doral Dental Services.

Focus group project description

Qualitative data

KYA conducted six focus groups across the state in August and September 2004. The focus group counties were selected based on the proporation of children enrolled in Medicaid or KCHIP who accessed dental care during 2002. Anderson and McCracken counties were selected from among the group of counties with average dental utilization rates. Grayson and Leslie Counties represented the group of counties with higher than average rates. Gallatin and Jackson Counties were selected from the counties across the state with lower than average dental utilization rates (see chart below). We did not conduct a group in the major metropolitan areas in the state as these are being completed by other entities.

With the help of local contacts, KYA recruited county residents whose children received health care coverage through state-funded programs, Medicaid and the Kentucky Children's Health Insurance Program (KCHIP). Since we did not do focus groups with higher-income families, we could not compare their experiences with these lower-income families to see if the problems mentioned are problems across the board, but many of the issues that were raised seem to be specific to families with lower incomes. As is stated in a report by the Center for Policy Alternatives, the common risk factor for most health problems is poverty.[34]

Sixty parents and guardians participated in the focus groups. Participants were, on average, 33 years old, and the majority (88 percent) were female. The racial makeup of the groups was 91 percent White and 9 percent African-American, which almost exactly mirrors the state as a whole. The participants had an average of 2.2 children. In addition, we surveyed participants about their health coverage and dental access and that of their children. Of the 54 responses on parents' health insurance coverage, 48 percent received Medicaid, 31 percent were insured through work, and 20 percent were uninsured. On the question of parental dental access, 10 percent of the 49 respondents reported never going to the dentist, 24 percent had been to the dentist in the current year, 39 percent during the past 1-2 years, 14 percent during the past 3-4 years, and 12 percent 5 or more years ago.

Participants also reported the health care coverage of their children; of the 52 survey responses, two-thirds reported that their children were covered by Medicaid and the remaining one-third reported that their children were covered by KCHIP.

Quantitative data

The focus group findings are supplemented by data from the Kentucky Department of Medicaid Services, Doral Dental Services, the Kentucky Board of Dentistry, and Kentucky KIDS COUNT.

Focus group counties

County	# Children	# of Children enrolled in Medicaid and KCHIP in 2003	% of all children in the county who are enrolled in Medicaid or KCHIP	% of Children in Poverty	% of Medicaid / KCHIP Eligible Children who Received any Dental services	# Licensed / # of Medicaid dentists
McCracken	15,638	6,378	41%	22%	29%	52/19
Anderson	5,218	1,286	25%	9%	29%	7/3
Grayson	6,184	3,181	51%	25%	50%	8/3
Gallatin	2,301	819	36%	17%	17%	1/1
Jackson	3,689	2,424	66%	37%	19%	2/0
Leslie	3,050	2,356	77%	39%	44%	4/3

Source: 2003 Kentucky KIDS COUNT Databook and the Kentucky Department of Medicaid Services.

Endnotes

1 Kentucky Cabinet for Health Services, Department for Medicaid Services. (2004) Dental Access Report.
2 Willis, D. and Butters, J. (2002). Kentucky Adult Oral Health Survey, Louisville, KY: University of Louisville, School of Dentistry.
3 Hardison, J.D. et.al. (2002). Final results: 2001 Kentucky Children's Oral Health Survey. Lexington, KY: Division of Dental Public Health, College of Dentistry, University of Kentucky.
4 National Center for Education in Maternal and Child Health and Georgetown University. (2001). Oral Health and Learning. http://www.mchoralhealth.org/pdfs/learningfactsheet.pdf.
5 American Dental Association. (2004). State and Community Models for Improving Access to Dental Care for the Underserved—A White Paper. http://www.ada.org/prof/resources/topics/topics_ access_whitepaper.pdf.
6 Kentucky Cabinet for Health Services, Department for Medicaid Services. (2004) Dental Access Report.
7 Ibid.
8 National Conference of State Legislatures. (2001). Increasing Dentists' Participation in Medicaid and SCHIP. http://www.ncsl.org/programs/health/forum/oralhealth.htm.
9 Dr. James Cecil, Administrator, KY Oral Health Program. (2004). Personal Communication.
10 American Dental Association. (2004). State and Community Models for Improving Access to Dental Care for the Underserved—A White Paper. http://www.ada.org/prof/resources/topics/topics_ access_whitepaper.pdf.
11 Kentucky Youth Advocates. (2003). Open Wide or Lock Jaw: Children's Dental Health Access in Kentucky. www.kyyouth.org.
12 Romer, M., Dougherty, N., and Amores-Lafleur E. (1999). Predoctoral Education in Special Care Dentistry:Paving the Way to Better Access? Journal of Dentistry for Children 66(2):132-135.
13 Center for Policy Alternatives. (1999). Oral Health for All: Policy for Available, Accessible, and Acceptable Care. http://www.wkkf.org/pubs/Health/CommunityVoices/Pub678.pdf.
14 Ibid.
15 Dye, B.A., Shenkin, J.D., Ogden, C.L., Marshall, T.A., Levy, S.M., and Kanellis, M.J. (2004). The Relationship between Healthful Eating Practices and Dental Caries in Children Ages 2–5 Years in the United States, 1988–1994. Journal of the American Dental Association 135(1):55–66.
16 Macek, M.D., Heller, K.E., Selwitz, R.H., and Manz, M.C. (2004). Is 75 Percent of Dental Caries Really Found in 25 Percent of the Population? Journal of Public Health Dentistry 64(1):20–25.
17 Mathematica Policy Research for the Centers for Medicare and Medicaid Services. (2004). SCHIP Takes a Bite Out of the Dental Access Gap for Low Income Children. http://www.mathematica-mpr.com/publications/PDFs/schipdental.pdf.
18 Mouradian, W.E., Berg, J.H., and Somerman, M.J. (2003). Addressing Disparities Through Dental-Medical Collaborations, Part 1. The Role of Cultural Competency in Health Disparities: Training of Primary Care Medical Practitioners in Children's Oral Health. Journal of Dental Education 67(8):860-868.
19 Mofidi, M., Rozier, G., and King, R. (2002). Problems with Access to Dental Care for Medicaid-Insured Children: What Caregivers Think. American Journal of Public Health 92(1):53-58.
20 Center for Policy Alternatives. (1999). Oral Health for All: Policy for Available, Accessible, and Acceptable Care. http://www.wkkf.org/pubs/Health/CommunityVoices/Pub678.pdf.
21 Formicola, A.J., Stavisky, J. and Lewy, R. (2003). Cultural Competency: Dentistry and Medicine Learning From One Another. Journal of Dental Education 67(8):869-875.
22 Center for Policy Alternatives. (1999). Oral Health for All: Policy for Available, Accessible, and Acceptable Care. http://www.wkkf.org/pubs/Health/CommunityVoices/Pub678.pdf.
23 National Conference of State Legislatures. (2001). Increasing Dentists'Participation in Medicaid and SCHIP.
24 American Dental Association. (2004). State and Community Models for Improving Access to Dental Care for the Underserved—A White Paper. http://www.ada.org/prof/resources/topics/topics_ access_whitepaper.pdf
25 Beach, M.C., Price, E.G., Gary, T.L., Robinson, K.A., Gozu, A., Palacio, A., Smarth, C., Jenckes, M.W., Feuerstein, C., Bass, E.B., Powe, N.R., and Cooper, L.A. (2005). Cultural Competence: A Systemic Review of Health Care Provider Educational Interventions. Medical Care 43(4):356-373.
26 Center for Policy Alternatives. (1999). Oral Health for All: Policy for Available, Accessible, and Acceptable Care. http://www.wkkf.org/pubs/Health/CommunityVoices/Pub678.pdf.
27 John Webb, Kentucky Child Now. (2005). Personal Communication. www.kychild.org.
28 U.S. Department of Health and Human Services. (2000). Oral Health in America: A Report of the Surgeon General. http://www.surgeongeneral.gov/library/oralhealth/.
29 American Dental Education Association. (2004). Best Practices in Dental Education. http://www.adea.org/DEPR/Best_Practices_in_Dental_Education_2004.pdf.
30 Oral Health America. (2003). Keep America Smiling: Oral Health for All: Policy for Available, Accessible, and Acceptable Care. http://www.wkkf.org/pubs/Health/CommunityVoices/Pub678.pdf.
31 US Center for Disease Control. (2003). Synopses of State and Territorial Dental Public Health Program: Synopses by State - Kentucky 2003. http://www2.cdc.gov/nccdphp/doh/synopses/index.asp.
32 Kentucky Cabinet for Health and Family Services. (2005). Kentucky Epidemiologic Notes and Reports. Division of Epidemiology and Health Planning. http://chfs.ky.gov/dph/epinotes.htm.
33 Ibid.
34 Center for Policy Alternatives. (1999). Oral Health for All: Policy for Available, Accessible, and Acceptable Care. http://www.wkkf.org/pubs/Health/CommunityVoices/Pub678.pdf.

"The day that we as a nation decide to provide oral health education to families of newborns, public health measures such as community water fluoridation, and regular dental visits to every American will mark the birth of the first generation that could grow up essentially free of dental disease."

- American Dental Association, 2004

"Although dental problems don't command the instant fears associated with low birth weight, fetal death, or cholera, they do have the consequence of wearing down the stamina of children and defeating their ambitions."

- Jonathan Kozol

"How about this for a state motto – Kentucky, Got teeth?"

- Jay Leno

KENTUCKY YOUTH ADVOCATES

2034 Frankfort Ave.
Louisville, KY 40206
(502) 895-8167
www.kyyouth.org