Oral Health Services
Consumer Engagement Research Report

June 2021

Florida Institute for Health Innovation

RESULTS-ORIENTED. RESPONSIVE. DATA-DRIVEN.

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- Agency for Persons with Disabilities (APD)
- Bridges of Boynton Beach
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- Camillus House & Health
- Catalyst Miami
- Children's Trust
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Executive Summary

The purpose of this report is to comprehensively examine the current realities of children's oral health in Florida in order to inform government leaders, policymakers, and other stakeholders working in public health and dental health. The report is intended to be used as a tool to guide the mission of organizations and agencies that work to evaluate and improve oral health care services and delivery in the state of Florida. Given the current legal status of oral healthcare, this report is well positioned to provide stakeholders, specifically the Agency for Health Care Administration (AHCA), the Department of Health and organizations in the field with information to guide policies and practices and to offer insight on how to prioritize and address consumer needs.

Oral Health in the U.S.

Since 1950, the United States has led incredible work in treating oral health as a public health necessity. Most gains have come as a result of effective prevention and treatment efforts such as community water fluoridation and school-based dental sealant programs. Community water fluoridation benefits 73 percent of Americans who get water through public systems (Centers for Disease Control and Prevention [CDC], 2020c) and dental sealants can prevent up to 80 percent of tooth decay. Despite this progress, 66.7 million Americans do not have dental coverage or access to dental services (National Association of Dental Plans [NADP], n.d.) and less than half of children ages 6 to 11 years have dental sealants (Griffin et al., 2016; CDC, 2021e). Furthermore, dental caries, or cavities, have remained the most common chronic disease of children age 6-11 and 12-19 since the Surgeon General's first-ever report on Oral Health in America detailed the link between oral health and overall health in 2000. Low-income children face increased difficulties accessing oral health, especially children who are Medicaid and CHIP beneficiaries (GAO, 2013). Research shows that poor oral health can lead to a variety of adverse health outcomes including cardiovascular disease, diabetes, poor mental health and stroke.

Oral Health in Florida

Similar to children across the United States, Medicaid-eligible children in Florida face numerous obstacles obtaining dental care. The KidCare Evaluation Final Report (Brishke et al., 2020) revealed that in Florida only 31.8 percent of 6–9-year-old children at elevated caries risk received dental sealants in CY 2019. Florida remains significantly behind national oral health rankings, with 47.4 percent of U.S. Medicaid-eligible children aged 0-20 receiving any dental service compared to only 38.8 percent in Florida, and only 35.5 percent of Medicaid-eligible children receiving any preventive dental service, compared to the national average of 43.9 percent (CMS, 2019). Findings from the survey of third grade students from 42 Florida elementary schools, showed that 45.5 percent had experienced caries and 25.1 percent had untreated decay with the prevalence being highest for non-Hispanic Black children (34.6%) and for children without any dental insurance (32.8%). Research shows that these disparities are strongly associated with race, class, gender, and ethnicity. This report supports this finding and also highlights the importance of location, race, language, and culture in communities that lack access to preventive dental health services.

Consumer Engagement Research: 2015-17

The Institute used both qualitative and quantitative research methods and public health evaluation specialists to better understand opportunities and obstacles that exist for families accessing dental health services. The research focuses on families and individuals enrolled in Medicaid-eligible programs in rural and urban sites in Florida. Through focus groups (n = 39) and surveys (n = 342) with Medicaid-eligible families, Institute staff assessed and analyzed the current state of dental health in urban and rural Florida.

Surveys

The survey results illuminate a number of important messages about parent/child experiences with the oral health care system in Florida.

Positive Findings

→ Having a regular dental home for their child does not affect parents/caregivers perceptions of their child's dental and overall health.

→ Overall, parents/caregivers with providers were happy with the care their child received.

Opportunities

→ Parents receive oral health care information from their child's primary care doctor.

→ Parents understand oral health care is important.

→ Parent's dental care utilization affects their child's dental home and health insurance status.

Action Required

→ Parent's dental care utilization affects their child's dental home status.

→ Trust in dental care providers is essential for parents to consistently seek care for their children.

→ Linguistic and cultural barriers exist for minority populations when accessing dental services.

→ Cost, lack of dental insurance, and issues navigating the oral health care system are the most common reasons parents have trouble accessing dental care for their children.

Focus Groups

The focus group results outline findings that present opportunities and underscore actions required, by topic area.

Knowledge and Care

As the data above suggest, a range of behaviors and attitudes exist within parents and their understanding of their children's dental health. The following key themes came from the focus group analysis:

→ Parents understand that oral health is important for many reasons.

→ Culture and language shape consumers' experience and knowledge of dental health.

→ Dental health needs to be normalized for parents and children.

→ Communication and experience in dental health needs improvement.

→ Transparency of processes.

Accessibility and Barriers to Oral Health

There are a number of structural barriers that prevent Medicaid-eligible families from accessing dental health services. However, there was also data indicating some families' positive experiences in dental offices. Data from the focus groups reveal dental health barriers and accessibilities related to the following areas:

→ Cost, appointment wait-times, and out-

dated or inconsistent misinformation are the most common reasons parents have trouble accessing dental care for their children.

→ Streamline administration and communication about services.

→ Transportation and Distance.

→ Medicaid needs to increase accessibility to oral health care services.

→ Professionalism and quality care.

Access Information

Parents rely on referrals and word of mouth to find dentists and other information on oral health in their communities. Technology (radio, TV, and the internet) and those who have access to it is also a theme that came up in focus groups. In order to ensure access to information on dentists, pamphlets, texts, and other media need to be culturally and linguistically appropriate and all methods of dissemination e.g. through doctors and schools explored.

→ Parents find oral health information via a variety of sources.

→ Mailings are the best way to get information to families.

→ Provide free or low-cost community-based services.

Consumer Experience and Policy: Rapid Health Impact Assessment

To comprehensively outline actions taken by the state or policies under consideration to address the findings above, a rapid Health Impact Assessment (HIA) was conducted. The HIA catalogues and assesses the oral health policy landscape of Florida to determine areas of growth and weakness, specifically as they relate to oral health access for Medicaid recipients. The assessment focuses on reporting the potential, and sometimes unintended, effects of policies and programs on the health of the population and reviews distribution of those effects within the population; outlines the health impacts of allocating resources for access to oral hygiene and health and examines how oral health barriers and limited access to dental care can have severe impacts on the well-being and general health of millions of Floridians; and describes policy changes from 2018 to present that will impact residents throughout the state. Understanding the passing and failing of proposed legislation will be of value to policymakers, stakeholders across governmental, medical, and community partnerships, and Medicaid recipients.

Opportunities to Shape the Consumer Experience and Oral Health Landscape

The recommendations below represent evidence-based policies and programs that can inform state, municipal, and Medicaid planning to improve oral health care services and delivery in the state of Florida.

State Surgeon General Recommendations

→ Co-locate medical and dental services to increase the provision of preventive oral health services.

→ Provide cultural competency training for medical and dental providers.

→ Restrict papoose utilization.

→ Contract with a research organization to conduct a statewide oral health needs assessment to inform an updated statewide oral health plan.

→ Utilize existing monitoring systems to build statewide oral health capacity.

→ Provide interprofessional education and training to improve Early Childhood Caries (ECC) management and access to preventive oral health services in vulnerable populations.

→ Utilize the American Dental Association Foundation's Tiny Smiles: Give Kids A Smile Program Tools and Resources.

→ Fund and expand the Dental Student Loan Repayment Program and promote participation in eligible Professional Postgraduate Dental training.

Agency of Health Care Administration (AHCA) Recommendations

→ Expand the scope of practice for Dental Hygienists.

→ Develop/update a comprehensive, user-friendly online oral health resource guide that allows consumers to search for specific services based on zip code, health plan and area of need.

→ Institute a toll-free number for both Medicaid beneficiaries and dental providers to improve dental appointment compliance.

→ Establish a Medicaid dental advisory committee.

→ Expand implementation and mandate usage of an integrated electronic health record system statewide within Florida's Medicaid Program.

→ Consider broadening the dental workforce to include dental therapists to improve community-level outcomes.

→ Find ways to motivate oral health providers and reduce obstacles to increase participation in Medicaid.

→ Establish a First Dental Home Initiative, modeled after Texas, to provide training to pediatric dentists about establishing a dental home for children who are at high caries risk.

→ Create programs for integration of oral health services with primary care.

Social Services and Oral Health Agencies

→ Mobilize a network of oral health consumer advocates to communicate barriers to and inequities in dental care to inform policy.

→ Community-based organizations should link clients to both dental homes and healthcare services.

→ Educate the public and elected officials about health outcomes and costs associated with oral health and emphasize the health risks associated with poor oral health, especially for emergency dental care.

→ Advocate Medicaid expansion in the state to increase the pool of eligible recipients.

→ Consider partnering with local dental hygiene programs for workforce intervention models.

→ Engage in community water fluoridation campaigns and advocacy work.

→ Conduct continuous public health economic evaluations and analysis at community and state levels to demonstrate cost-savings and inform policy decisions.

Best Practices for Replication Statewide

→ Expand the usage of medical/dental vans as a means of removing barriers to access.

→ Implement a Virtual Dental Home model in conjunction with tele-dentistry.

→ Conduct and promote interactive oral health education programs designed for and by Spanish/Haitian speaking families and led by designated community health educators.

→ Invest in case management and care facilitation to encourage partnerships between medical and dental homes.

→ Provide oral health education and treatment to expectant mothers in high-risk populations.

→ Expand the dental hygienist scope of work to provide oral health services and re-

ferrals.

→ Pilot Dental Care Coordinator interventions.

For helpful framing, we divided the report into the following sections: (1) background on oral health and children's oral health in Florida, (2) results from our 2017 study, (3) policy implications for consumer experience via health impact assessment, (4) efforts for collective impact, and (5) future recommendations, policy design, and legislative funding to support oral health outcomes for the children of Florida.

Background

Oral Health in the United States

It is well established that the health of the teeth and the mouth is central to a person's overall health and well-being. Yet, presently in the United States, children remain to be at an increased risk for oral and craniofacial diseases (US Department of Health and Human Services [HHS], 2000). In Healthy People 2020, a nationwide agenda promoting health in the United States, oral health in children and adolescents was highlighted as one of the primary targets for improving overall population health. Similarly, one of the main objectives of Healthy People 2030 is to increase the percentage of children, adolescents, and adults who received oral health care in the past year (CDC, 2020a).

Public health measures and goals surrounding children's oral health reflect the importance of this subject for state and federal programs and budgets. Dental caries (tooth decay) is one of the most common chronic health problems in the United States, impacting more than 90 percent of U.S. adults (CDC, 2016) with 1 in 4 of those adults suffering from untreated dental caries (CDC, 2021e). Dental caries, or cavities, have also remained the most common chronic disease of children age 6-11 and 12-19 since the Surgeon General's first-ever report on Oral Health in America detailed the link between oral health and overall health in 2000 (HHS, 2000). Poor oral health that results from a lack of regular treatment can cause pain and tooth loss, impede productivity, and potentially exacerbate many other chronic health conditions.

> **Dental caries, or cavities, have also remained the most common chronic disease of children age 6-11 and 12-19** since the Surgeon General's first-ever report on Oral Health in America detailed the link between oral health and overall health in 2000 (HHS, 2000).

APPROX.

66.7 M

Americans do not have dental coverage

While the United States continues to make progress in improving oral health through enhanced preventive care and services, many Americans

United States Spent

$26.9 M

on child and adolescent oral health.

lack access to preventive services. As of 2018, approximately 66.7 million Americans do not have dental coverage and many are less likely to use preventive dental services due to out-of-pocket costs (NADP, n.d.). In 2013, the United State spent $26.9 billion on child and adolescent oral health. This exceeds combined expenditures on asthma, upper respiratory tract infection, other infectious diseases, and anxiety (Bui et al., 2017). The NADP notes that individuals without dental benefits are 67 percent more likely to have heart disease, 50 percent more likely to have osteoporosis, and 29 percent more likely to have diabetes. Furthermore, disparities in access and treatment in oral health care are most prominent in vulnerable populations. According to the Government Accountability Office (GAO) (2008), low-income children face increased difficulties accessing oral health care and in their 2013 statement, GAO noted that children who were Medicaid and CHIP beneficiaries visited the dentist less often than privately insured children (GAO, 2013). Studies have found that often these disparities can manifest as short-term maladies such as tooth pain, or in long-term conditions, that further affect the child socially, economically, developmentally and their overall health.

Two specific health interventions have impacted oral health outcomes for communities across race and socioeconomic strata over the last 75 years: community water fluoridation and school-based dental sealant programs. These programs

Every

$1

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saves communities anywhere from

$1.10 to $135

in dental treatment costs

are shown to promote good oral health outcomes and prevent tooth decay. Community water fluoridation is the most effective way to deliver fluoride to the entirety of the full community population and evidence shows it can prevent tooth decay by 18-40 percent (CDC, 1999). Additionally, according to CDC (2020c), every $1 invested in water fluoridation saves communities anywhere from $1.10 to $135 dollars in dental treatment costs. Economic modeling suggests that if unfluoridated communities with populations of 1,000 or more received fluoridation, they would save "$2.5 billion in costs related to dental caries" annually (O'Connell et al., 2016). School-based dental sealant programs, equally effective, focus on sealing the chewing surfaces of permanent molar teeth. This practice usually targets schools that serve children from low-income families. Dental sealants can prevent up to 80 percent of tooth decay in the treated teeth but less than half of children ages 6 to 11 years have dental sealants (Griffin et al., 2016; CDC, 2021e).

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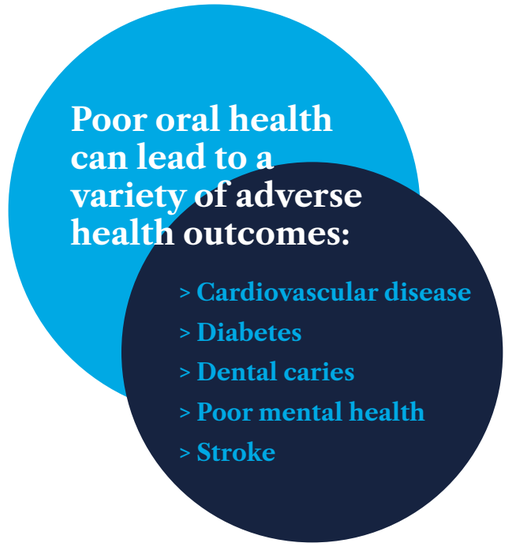
The effectiveness of fluoride varnish in preventing caries has similarly been reviewed, however research suggests that the infrequency of the visits to receive the varnish may be limited in reach and long-term impact (Milgrom and Cunha-Cruz, 2017). The application of fluoride varnish to teeth aids in tooth remineralization and helps prevent cavities by disrupting bacterial activity in the mouth. A systematic review (Marinho et al., 2013) conducted in the United Kingdom compared the effectiveness of fluoride varnish in preventing caries in children and adolescents. The findings showed an average of 43 percent reduction in decayed, missing and filled tooth surfaces (DMFT) in permanent teeth, and a 37 percent reduction in DMFT in primary teeth. Fluoride varnish has also been found effective in preventing early childhood caries, though not to the degree of preventing cavities in young permanent teeth. The application of fluoride varnish is recommended as a best practice by the American Academy of Pediatrics (AAP) and American Dental Association (ADA) (Marinho et al., 2013; Twetman & Dhar, 2015; ADA, 2006; AAP, 2014). Children at an increased risk for tooth decay (children that don't have access to preventative care or miss regular dental visits) and those that attend regular dental visits stand to benefit the most from fluoride varnish.

As research suggests, a combination of individual efforts (e.g., consumer engagement education), institutional efforts (e.g., supporting Medicaid-eligible families to access preventive dental services), and public health efforts (e.g., community water fluoridation) are all necessary to prevent dental caries in children as well as avert the long-term costs of poor health outcomes. While measuring the short and long-term impacts of (1) individual efforts; (2) institutional efforts; and (3) public health efforts is difficult, it is needed in order to move forward with designing cost-effective policies that reach Florida's most vulnerable children and their access to preventive dental health care.



Existing Health Conditions

Poor oral health can lead to a variety of adverse health outcomes, including cardiovascular disease and diabetes (Mayo Clinic, 2019). Data from the National Health and Nutrition Examination Survey showed an association between poor oral health and mental health that may adversely impact day-to-day activities (O'Neil et al., 2014). Evidence of the link between oral health and adverse health outcomes is as follows:

Cardiovascular Disease: Oral health and heart disease are connected by the spread of bacteria from the mouth to other parts of the body through the bloodstream. When oral bacteria reach the heart, they can attach themselves to any damaged area and cause inflammation. According to Mayo Clinic (2019), this can result in illnesses such as endocarditis, an infection of the

inner lining of the heart, clogged arteries and stroke. In 2019, Florida faced the second-highest number of heart disease-related deaths (47,144) in the country (CDC, 2021d).

Diabetes: A growing body of research is beginning to demonstrate that gum disease and diabetes are inextricably linked to one another. According to the American Diabetes Association (n.d.), not only are people with diabetes more susceptible to serious gum disease, but serious gum disease may have the potential to affect blood glucose control and contribute to the progression of diabetes. The Journal of the American Dental Association published a study that suggested oral health care providers can improve the overall health outcomes of patients with diabetes (Lamster et al., 2008). The literature the authors examined supported that periodontitis, or inflammation of the gums, is a complication of diabetes. The evidence also indicated that periodontitis is a risk factor for poor glycemic control and the development of other clinical complications of diabetes. Furthermore, patients with long-standing, poorly controlled diabetes are at risk of developing oral candidiasis, more commonly known as thrush (Lamster et al., 2008).

Dental Caries: Untreated dental caries are one of the most common childhood diseases, and among the most easily avoidable with regular preventive care. By age 8, more than half (52%) of children have had a cavity in their primary teeth and among adolescents ages 12 to 19, 57 percent have had a cavity in their permanent teeth (CDC, 2020d). Parents miss on average 2.5 days from work per year due to their children's dental problems (Seirawan et al., 2012). This amount to an estimated 34 million school hours lost each year because of unplanned dental care (CDC, 2020d).

Mental Health: Data from the National Health and Nutrition Examination Survey (Delta Dental, n.d.) demonstrated that nearly two-thirds of respondents who had depression reported having a toothache in the last year. Additionally, half of those with depression rated their teeth condition as fair or poor. According to Delta Dental (n.d.), this is due to the behavioral effects of stress, depression, and anxiety. Individuals suffering from mental illness are less likely to keep up with routine oral health or visit the dentist (Oral Health Foundation, n.d.). Furthermore, depression can raise one's cortisol levels weakening the immune system and leaving one susceptible to inflammation and gum disease (Delta Dental, n.d.). In Florida, over 660,000 adults and 181,000 children live with bipolar disorder, severe depression or schizophrenia, and nearly half the population will struggle with less devastating forms at some point in their lives (Santich & Kunerth, 2014). Yet, according to a 2017 report published by Mental Illness Policy Organization, Florida ranks just 41st in the percentage of total state expenditures allocated to mental illness, spending 1.1 percent (Jaffe & Torrey, 2017).

Stroke: Stroke and periodontal disease share a commonality in the form of vascular inflammation. Beck et al. (2008) found that older adults who had higher proportions of four types of gum disease-causing bacteria also had thicker carotid arteries, which is a predictor of stroke and heart attack. Furthermore, Renvert et al. (2006) found that people with acute coronary syndrome had higher levels of oral bacteria. The study additionally indicated that there may be an association between premature tooth loss and stroke occurrence.

The State of Children's Oral Health in Florida

Similar to children across the United States, Medicaid-eligible children in Florida face numerous obstacles obtaining dental care. Oral pain can inhibit a child's well-being, confidence and can greatly affect their scholastic outcomes; oral pain is also a leading cause of chronic school absenteeism for young students (Attendance Works, 2015). Among school-age children, tooth decay is the most common chronic disease and is five times more prevalent than asthma. According to a recent survey of third grade students from 42 Florida elementary schools, 45.5 percent had experienced caries and 25.1 percent had untreated decay with the prevalence being highest for non-Hispanic Black children (34.6%) and for children without any dental insurance (32.8%). Additionally, 20.6 percent needed early care and 3.0 percent needed urgent care (Saint-Hillien & Holicky, 2018). These statistics highlight the value of preventive dental care and the need to treat dental caries at a young age. Dental sealants can prevent up to 80 percent of tooth decay, however, according to the KidCare Evaluation Final Report, in Florida only 31.8 percent of 6-9 year-old children at elevated caries risk received dental sealants in CY 2019, and only 40.5 percent of eligible enrollees 1-20 years of age received preventive dental services. Florida KidCare is the umbrella program for Florida's Medicaid and CHIP programs (Brishke et al., 2020).

Florida has a population of approximately 4.2 million children under the age of 18 and of these children, 1.8 million (3 in 7) are covered by Medicaid, according to data collected by the Kaiser Family Foundation (KFF) (2019). Florida remains below the national average for U.S. dentists that participate in Medicaid or Children's Health Insurance Program (CHIP) for child dental services. Nationally, 43 percent of dentists participate in Medicaid or CHIP compared to 29.7 percent in Florida (ADA Health Policy Institute [HPI], 2020). The Florida Department of Health (FDOH) (Traul, 2020) 2017-2018 workforce survey revealed that majority of the respondents (78.2%) indicated that they were not enrolled as a Medicaid provider. The survey results also found that dentists cited "inadequate reimbursement" as the main reason for not enrolling in Medicaid or accepting new Medicaid patients (71.9%), followed by "too much paperwork" (40.9%), and "frequent changes in Florida Medicaid rules and policies" (32.3%). Of actively practicing dentists in Florida, 59.3 percent report performing any volunteer services over the last 24 months to provide access to dental care for Floridians in need. Approximately 16 percent of these dentists indicated that they had provided at least 25 hours of volunteer services within the last 24 months, with 6.6 percent reporting volunteering between 17-24 hours, 13 percent reporting between 9-16 hours, and 24 percent reporting providing 1-8 hours of volunteer services. Many of these volunteers participate in a single-day, large-scale initiatives to provide temporary relief and are not enough to cover Florida's vulnera-

45.5%
of surveyed third graders at 42 elementary schools in Florida had caries with
25% of those being untreated

Prevalence highest among:

34.5%
Non-Hispanic Black children

32.8%
Children without any dental insurance

$1.8 M
(3 in 7) of Florida's 4.2 million children are covered by Medicaid.

ble populations' dental needs. Additionally, it is important to note that these actions are derived from dentists' goodwill to help Floridians with less access, rather than from a consumer-based, systems response. Though these humanitarian efforts offered by Florida's providers do serve as additional support, Florida cannot rely on volunteer dentists to provide services and instead must address the underlying issues of poor oral health access and delivery.

Research shows that Florida's most vulnerable children continue to experience poor oral health outcomes when compared to the rest of the nation. For example, approximately 23 percent of Florida special health care needs (SHCN) children and adolescents did not have a preventative dental visit in the past year compared to 14.1 percent nationally (Holicky, 2016). In 2018, Toothbrush.org conducted a study that ranked Florida 43rd out of all 50 states in overall oral health wellness, 49th for the number of children with a dentist visit, and 48th for worst oral health condition (Toothbrush.org, 2018). According to the Centers for Medicare and Medicaid Services (CMS, 2019) Florida remained significantly behind national oral health rankings, with 47.4 percent of U.S. Medicaid-eligible children aged 0-20 receiving any dental service compared to only 38.8 percent in Florida, and only 35.5 percent of Medicaid-eligible children receiving any preventive dental service, compared to the national average of 43.9 percent.

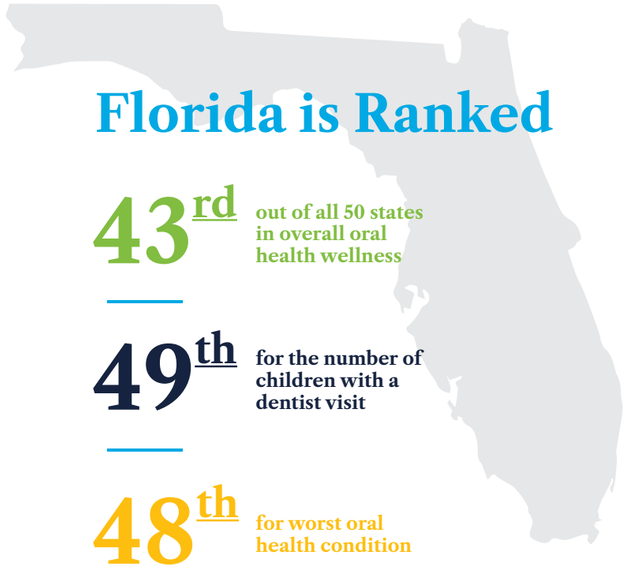
Dentist participation in Medicaid/CHIP:

43% Nationally -Vs- **29.7%** in Florida

Dentists in Florida report the following reasons for not participating in Medicaid/CHIP:

- **71.9%** Inadequate reimbursement
- **40.9%** Too much paperwork
- **32.3%** Frequent changes in Florida Medicaid rules and policies

Furthermore, poor oral health can have an economic impact. The number of ER visits in US for dental pain has nearly doubled over the past decade, despite hospitals not having trained staff or facilities that offer dental services (ADA, 2015). The use of ERs for dental services in Florida increased by 56 percent between 2005 and 2014 with visits exceeding 163,900 per year. (Tomar et al., 2016). Florida spent an estimated $234 million on dental-related ER visits annually between the respective years. Additionally, the study found that less than one third of those dental-related ER visits resulted in care other than evaluation and diagnosis. Medicaid was the primary payer for 38 percent of dental-related ER patients, follow by self-pay (38%). In 2019, Florida hospitals billed more than $630 million for preventable ER visits and hospital admissions stemming from preventable oral health issues and Medicaid paid for nearly 40% of the visits (Floridians for Dental Access, n.d.). These visits could have been prevented by a trip to a dental provider. Lack of Medicaid coverage for adult dental services and low provider participation as results of low reimbursement rates are contributing to increased lack of access to dental care and costly ER visits.



In 2019, Florida hospitals billed more than

$630 M

for preventable ER visits and hospital admissions stemming from preventable oral health issues

Medicaid paid for nearly 40% of the visits

Legal Implications Surrounding Oral Health in Florida

In 2005, the Public Interest Law Center, together with the Fort Lauderdale law firm of Boies, Schiller and Flexner, filed a class action lawsuit on behalf of the Florida Chapter of the American Academy of Pediatrics, the Florida Academy of Pediatric Dentistry, and five Florida families reliant on Medicaid for their children's health care. The suit contended the state Medicaid program was violating federal law by operating a health system for the poor that sets reimbursement rates too low to maintain enough providers in the program. According to the lawsuit, state health reports from the fiscal year of 2004 discovered that 44 percent of eligible children in Florida received no health care check-ups and that more than 500,000 Medicaid-enrolled children received no preventive health care services at all; furthermore, a reported total of 75 percent of Medicaid-enrolled children in Florida did not receive a dental examination (The Public Interest Law Center, n.d. - a).

As a result of the lawsuit, in December of 2014, the federal court ruled that the Florida Medicaid program was not providing eligible children with medical and dental care as required by federal law. The Court found that approximately one-third of Medicaid-eligible children in Florida were not receiving the preventive medical care they were required to receive, and that the children who did receive care traveled to other areas of the state and/or waited several months to obtain basic preventive care. For dental care, the numbers were worse, as 79 percent of Medicaid-enrolled children did not receive any preventive service at all (The Public Interest Law Center, n.d. - b). The Florida Medicaid program was found to violate federal law by improper terminations of eligibility for children, switching children from one provid-

er to another without their parent's knowledge, and failure to provide required outreach to inform eligible individuals of Medicaid services. This failure led to life-threatening delays in the provision of medical and dental care and contributed to the overwhelming bureaucratic barriers faced by low-income children and their families. In regard to both medical and dental care, the Court concluded that the low reimbursement rates established by Florida state officials were a significant factor in why parents of Medicaid-enrolled children were experiencing systemic failures such as delays in obtaining preventive dental care as discussed above. The Court held that an increase in Medicaid reimbursement rates would result in a significant increase in provider participation in the program and therefore an increase in access to dental care.

After more than a decade of litigation, a settlement agreement was approved in June of 2016 that requires state agencies, the most important of which is the Agency for Health Care Administration (AHCA), make substantial improvements in access to healthcare services so that children enrolled in Medicaid can access medical and dental care throughout Florida. Most notably, as of October 1, 2016, managed care plans[1] are required to offer Medicare-equivalent reimbursement rates for board-certified pediatricians that meet objective measures of access and treatment for children, as increased reimbursement rates have been found to result in an increase in the number of children receiving Medicaid services.

The Institute's staff sought to retrieve an update on the settlement and AHCA's adherence to the evaluation metrics; to date no such update was available and our team was unable to uncover any of the above information. At the time this report was released, the information was not available on AHCA's website. Attempts were made to reach the Public Records Coordination Office at AHCA and the Office of General Counsel, without response. This highlights that accountability and transparency are essential as we work together as a state committed to improving our oral health statistics in children.

According to Keiser Family Foundation (n.d.), Florida has not increased its Medicaid dentist reimbursement rates since 2012. Beginning in 2013, Medicaid dental services in Florida were offered both on a fee-for-service basis and though managed care plan, however, in 2016 dental services were "carved-out" from Managed Medical Assistance plan and in 2019 new dental managed care plans were implemented. Between 2013 and 2018 there were no fee-for-service dental rate increases despite fee-for-service dental services being provided. During the same timeframe, the data indicates that Florida increased the rates paid from Medicaid to Managed Care Organizations (MCOs) every year, however, we don't know if these increases were applied to reimbursing dental providers. The rates for MCOs continued to increase in 2019 and 2020, however, again we don't know we the increases were applied to reimbursement rates specifically for dental providers.

[1]Managed care plans are a type of health insurance that aim to provide quality health care at an affordable rate. They are dependent on a network of stakeholders, including health care providers, doctors, and facilities that establish a contract with an insurance provider to offer plans to their members. Members are provided assistance to help in finding the most affordable means of insurance services based on the healthcare providers who are in their network.

Table 1: FL medicaid dental services and dentist rate increases by year.

Year	FL Medicaid Dental Services	Dentist Rate Increases (fee-for-service)	MCO Rate Increases from Medicaid
2011		No	Yes
2012		Yes	Yes
2013	• Managed Medical Assistance (MMA) plan includes dental services. • Fee-for-service dental services.	No	Yes
2014		No	Yes
2015		No	Yes
2016	Dental services "carved-out" from MMA plan.	No	Yes
2017		No	Yes
2018		No	No
2019	• Integrated MMA and Long-term Care (LTC) program • No fee-for-service dental services. • Statewide Prepaid Dental Health program implemented.	No	Yes
2020		No	Yes

Sources: KFF (2020); AHCA (2018d)

Case Study: Medicaid Expansion in Texas

Similar litigation in Texas serves as an excellent example of how Florida state agencies can utilize this lawsuit result as an opportunity to improve medical and dental health outcomes for Florida children. When Texas settled their 14-year Medicaid lawsuit in 2007, they ranked as a bottom 10 state in providing dental services to their Medicaid-eligible children. The settlement agreement ensured that Texas operate their Medicaid program in compliance with specific guidelines, which included requirements to increase utilization of dental services through increased access to Medicaid dental providers. Under the guidance of an advisory committee comprised of dentists, doctors, and representatives from the state Medicaid agency, the agreement appropriated $707 million in state general revenue to "increase physician and dental reimbursement rates, improve out-

reach and education to Medicaid-enrolled families and improve the availability of medical and dental services in rural and border regions of the state" (Texas Medical Association, 2010). Funding that was already allocated within House Bill 1, the 2008-2009 appropriations act, was utilized to fund physician and dental rate increases. The remaining funds were projected to be paid for by applying a funding reduction across-the-board of .59 percent to all ten articles within the budget. To achieve these outcomes, the agreement allocated the following amounts to each act:

- → $203 million to fund a 25 percent increase in physician reimbursement.
- → $50 million for targeted rate increases for physician subspecialists.
- → $258.7 million to fund a 50 percent increase in dental reimbursement rates.
- → $150 million to implement medical and dental initiatives such as mobile dental clinics in underserved communities, loan forgiveness programs for physicians and dentists who agree to practice in underserved areas, and/or improved funding for physician training and graduate medical education.
- → $45 million to fund outreach, education, transportation initiatives, and a toll-free hotline.

This resulted in an increase in young patients accessing preventive care and a decrease in expensive procedures and hospitalizations. In 2015, a study conducted in Texas found that from 2007 to 2011–2012, preventive dental care utilization among Medicaid-eligible children increased from 65.9 percent to 80.7 percent in Texas. Additionally, unmet dental need was found to decline from 4.5 percent in 2007 to 2.4 percent in 2011–201 (Nasseh & Vujicic, 2015).

Today, Texas is among the top five states providing preventive dental services to children enrolled in Medicaid, providing a roadmap to better health and social outcomes for children by expanding access (Clark, 2016). With this settlement and other best practice models, Florida has the opportunity to capitalize on lessons learned and employ policy for best practices to significantly impact health outcomes for their most vulnerable children. Further, this is an opportunity for the state to work creatively with organizations, dedicated to improving oral health services for children, to improve the state of medical and oral health in Florida.

Oral Health Consumer Engagement Pilot (2014)

In 2014, with the help of partner organizations and pilot project funding from the DentaQuest Foundation, FIHI piloted the Oral Health Consumer Engagement project to better understand the story behind Florida's oral health statistics for the Oral Health Alliance. The Institute team subsequently designed a survey and conducted a focus group with parents in Miami-Dade County to gain a snapshot of the Medicaid services consumer experience regarding oral health care for children. Though, the sample size was small, the results were somewhat unexpected. The pilot revealed that while parents of Medicaid-eligible children in these two counties were aware of the importance of dental health for their children, they were often unable to access services due to the limited number of Medicaid providers in their area and lack of flexibility between appointment times provided and work schedules. Notably, parents shared how they felt less valued, received inappropriate and/or inadequate care, and felt that they couldn't complain about it since it was a free service. This Consumer Engagement pilot report is available upon request.

The preliminary findings of the pilot, in addition to Florida's oral health statistics, pointed to a need to investigate the experience of families as consumers of these services and the service delivery that was directly contributing to poor oral health outcomes in Florida's children. To understand if these preliminary patterns were consistent across the state, with support from the DentaQuest Foundation (now the DentaQuest Partnership for Oral Health Advancement), the Institute expanded the pilot into a 2-year statewide study to more broadly capture these experiences and understand the collective experience of parents and children throughout Florida. A brief literature review was conducted to provide a foundation for the study **(Appendix A)**. Then using a mixed-methods approach and qualitative and quantitative data collection - administering surveys and conducting focus groups – the Institute team sought to understand barriers and challenges when accessing or utilizing care and to capture positive experiences and referral sources.

Consumer Engagement Research: 2015-17

The Consumer Engagement research was conducted between 2015-17 and was IRB approved (Protocol #160021FIHI) with the purpose of conducting surveys and focus groups with parents to identify barriers to accessing and utilizing dental care for their children, in an effort to reduce oral health disparities. The IRB letter can be found in Appendix B. The Institute reached out to community organizations that primarily serve families enrolled in Medicaid, in rural and urban sites, statewide, to collect data from parents accessing community health centers and social service organizations or attending health fairs. A mixed-methods approach was used to collect qualitative and quantitative data, with tools, data and analysis reviewed by multiple public health specialists. This provided multiple sets of expertise, resulting in a comprehensive interpretation of what opportunities and obstacles exist for families. The focus groups (n = 39) and surveys (n = 342) were conducted to inform the following goals and objectives:

The Oral Health Consumer Engagement research goals:

1) Understand and offer insight into consumer experiences accessing oral health, including perceptions, challenges, barriers and positive experiences, through the collection of qualitative and quantitative data.
2) Provide the Florida state Medicaid agency, the Agency for Health Care Administration, the state Surgeon General and Florida Department of Health, and other state or local agencies or organizations involved in oral health care policies, systems, services and delivery in Florida, with best practices and strategies for systems change and policy development to improve access to and utilization of oral health care for Florida's populations.

The Oral Health Consumer Engagement research main objectives:

1) Support the development of a statewide consumer engagement infrastructure to improve access to, and utilization of, preventive oral health care for Florida's populations.
2) Improve practices and policies in the state of Florida by sharing of consumer concerns to decision-making institutions, entities, groups and individuals, throughout the state of Florida.

Surveys

Methodology

The surveys were administered in English and Spanish across the state of Florida. Data collection was facilitated with the help of existing and new community partnerships made up of social service, philanthropic, and grassroots organizations that have direct contact with Medicaid-eligible populations. The Institute sought to partner with organizations located in disadvantaged and underserved communities, specifically targeting the top 10 counties in Florida with the highest number of Medicaid-eligible children (up to 20 years old) as of June 30, 2016, which included the following counties: 1) Miami-Dade; 2) Broward; 3) Hillsborough; 4) Orange; 5) Palm Beach; 6) Duval; 7) Polk; 8) Pinellas; 9) Lee; and 10) Osceola (AHCA, 2015). Existing partners received email communication outlining the Oral Health Consumer Engagement study and intent along with a request for continued partnership. Outreach to new partners involved referrals from the Florida Oral Health Alliance's Oral Health Consumer Advisory Council, as well as phone calls and emails to social service organizations in counties where the Institute lacked existing partnerships.

Study participants were selected based on the following inclusion criteria: participants were parents/caregivers of children up to 17 years old and full-time residents of the state of Florida. Surveys began with screening criteria that included a set of questions to determine participant eligibility and confirmed the following:

1) the participant voluntarily agrees to participate;
2) the participant is 18 years of age or older; and
3) the participant is willing to answer questions about their child's dental care.

The complete, full-length English version of the Consumer Engagement Survey can be found in **Appendix C**, and the Spanish version can be found in **Appendix D**; the online link for both surveys can be found in **Appendix E**.

Survey data was collected by Institute staff and community partners, as well as trained public health student volunteers and interns who attended community events, parent education classes, health fairs, and other community programs where parents in the target population could be reached. Institute staff scheduled calls with volunteers and community partners to review the survey collection protocol and provide a detailed overview of our study's goals and objectives prior to being in the field. Volunteers and interns were additionally required to complete a 15-minute webinar on proper data collection techniques prior to assisting in data collection; this webinar link can be made available upon request. A trained Institute researcher was always present and oversaw volunteers while they conducted the surveys and collected data.

The Institute's survey was comprised of 40 questions that included topics of basic demographic information, oral health practices and attitudes, barriers to accessing dental care for one's child, a child's first dental visit, satisfaction of dental care treatment, and source of oral health information. The survey required an approximate 10 minutes to complete and was offered in either English or Spanish and digital or print format. The English survey was translated into Spanish and proofread by Spanish-speaking Institute staff. SurveyMonkey, an online survey development cloud-based tool, was chosen to administer and store survey entries. The survey was designed using skip logic, which skips respondents to a future question or page in the survey based on the answer choice they select, in order to ensure respondents are answering questions relevant to them. Surveys were administered using both a paper format and mobile technology (i.e. iPad) depending on preference and convenience for participants. In order to apply the skip logic to paper surveys, two forms were used. Depending on how respondents answered question #4 (Does your child have a dentist that he/she visits regularly? Yes/No), they continued with either Form A or Form B (**Appendices C and D**). Institute staff and interns conducting the survey were responsible for administering the correct form to participants. The survey did not collect any information that could be traced back to specific respondents, and responses remained confidential and anonymous. The only identifying information collected was from respondents who chose to participate in our $100 Publix Gift Card raffle drawing/incentive. At the end of the online survey, a link brought respondents to a separate window that allowed them to enter their contact information should they be selected as the prize-winner. This information could not be tied back to their survey responses and was only made available to the Institute's staff and interns. For respondents who preferred a hard copy method, a separate form was used to collect personal information from those interested in signing up for the raffle prize drawing. Again, this information was kept separate from survey responses and could not be tied to individual responses; once winners were selected, this information was deleted/shredded.

Analysis and Results

Of the 422 administered surveys, 36 surveys were excluded based on respondents not successfully completing the inclusion form, or not meeting inclusion criteria. Three hundred and sixty-two (362) surveys were completed in English and a total of 24 surveys were completed in Spanish, bringing the total number of surveys to 386. After further review of the survey responses, 44 of the participants skipped the entire survey only filling out the inclusion form. Likewise, these surveys were excluded from any analysis beyond demographics and the first screening question, bringing the total number of surveys included in further analysis to 342.

Using a sample size calculator (Calculator.net) the Institute staff estimated the minimum sample size required to show quantified magnitude of the result being present in the population. To carry out this calculation, the parameters were defined as follows: confidence level = 90%; margin of error = 5%; population proportion = 50%; and population size of 2,773,238, the total number of Medicaid enrolled children in 2016. The results indicated that 273 surveys were needed to make statistical inferences about the population based on the sample. The Institute collected 342 eligible surveys, indicating statistically significant results.

Surveys completed in paper format were manually input by Institute staff into SurveyMonkey. Survey data from 386 surveys was exported via SurveyMonkey and analyzed with SPSS statistical analysis software. Using SPSS, the Institute staff first examined the distribution of responses by running frequencies of responses from the surveys and respondent demographics. Among the 386 surveys, the majority of respondents were between the age of 25-34 years old (40%) or 35-44 years old (30%). Approximately one-third of respondents identified as Black or African-American (30%), while 25 percent identified as Hispanic or Latino, 19 percent identified as White, and 13 percent identified as Haitian/Creole. Half of respondents (53%) were employed full-time at the time of the survey, while just under half (42%) reported an annual combined household income of less than $20,000 (the next highest percentage of respondents [26%] reported having an annual income of $20,000-$34,999). English was the most common primary language spoken among

respondents at 69 percent; followed by Spanish (14%) and Creole (10%). The majority of respondents lived in Miami-Dade County (40%), while 12 percent reported living in Hillsborough County and 9 percent reported living in Broward County; in total, respondents represented 24 of Florida's 67 counties. We surveyed respondents in 8 of the 10 counties in Florida with the highest reported number of Medicaid-eligible children in 2016 – only Duval and Osceola County were unaccounted.

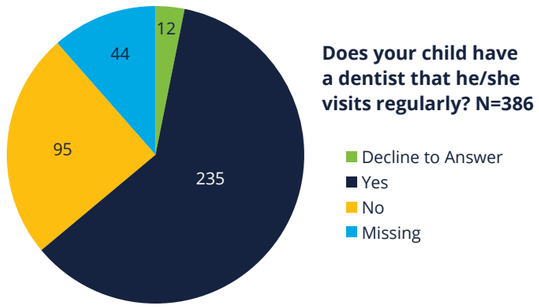


Figure 1: Respondents who reported having a regular dental home for their child, among all survey participants.

Of the total surveys administered (n=386), 61 percent of respondents (n=235) reported having a dentist that their child visited regularly, while 24 percent (n=95) reported they did not and 3 percent (n=12) declined to answer; respondents who declined to answer this question were skipped to the end of the survey and only answered demographic information. A total of 12 percent of respondents (n=44) did not answer the question and upon examining the data, it became clear they skipped the entire survey, only filling out the inclusion form up until this screening question. As stated above, these respondents were not included in further analysis, bringing the total number of surveys to 342.

Among the 342 eligible surveys, the data analyst examined the potential relationships between basic demographics (e.g. race, income, education, employment status) and other variables related to insurance status, overall health, dental health, treatment at the dentist office, type of insurance, etc. by running odds-ratio analyses. Of the 235 respondents who reported having a regular dentist for their child, 88 percent (n=206) reported that their child had health insurance; 3 percent (n=8) reported that their child did not have health insurance, and 9 percent (n=21) declined to answer. Medicaid was the most common type of health insurance among those who reported having a regular dentist (69%; n=140), followed by private insurance (19%; n=38), Kidcare/CHIP (6%; n=13), and Medicare (5%; n=10); 0.5% (n=1) responded 'Other' and 0.5% (n=1) declined to answer. Three individuals who reported having health insurance for their children did not specify the type of insurance.

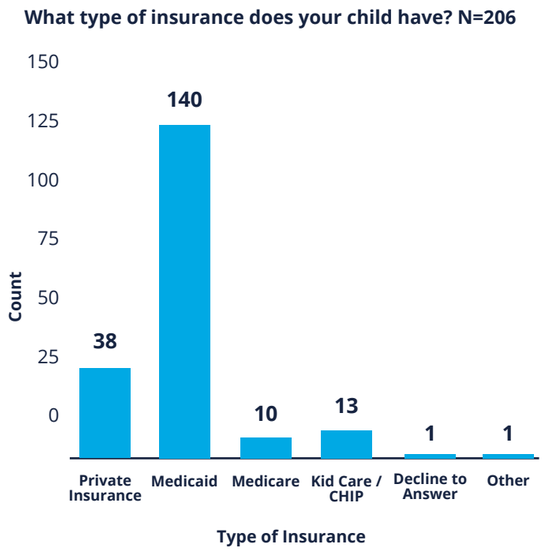


Figure 2: Children's health insurance type among those who reported having health insurance and a dental home for their child.

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

However, there was a difference seen depending on whether the respondents reported having a dental home for themselves. Seventy-six percent of parents/caregivers who had a regular dentist for their child, also reported having a regular dental home for themselves, while only 22 percent of parents/caregivers who did not have a regular dentist for their child, reported having a regular dental home for themselves.

Having a regular dentist for their child did not seem to affect parents/caregivers perceptions of their child's dental health and overall health, as the majority of respondents from both groups reported their child as having either 'excellent', 'very good', or 'good', dental health and overall health. Among respondents who reported their child visited a dentist regularly, 30 percent reported their child had 'excellent' overall health; of these, 20 percent reported having Medicaid, 8 percent reported having private insurance, and 2 percent reported having Kidcare/CHIP. Thirty-eight percent of respondents (38%) reported their child had 'very good' overall health; of these, 26 percent reported having Medicaid, 8 percent reported having private insurance, 3 percent reported having Kidcare/CHIP and 1 percent reported having Medicare. Thirty percent (30%) of respondents reported their child had 'good' overall health; of these, 20 percent reported having Medicaid, 4 percent reported having private insurance, 4 percent reported having Medicare, and 2 percent reported having Kidcare/CHIP. Only 1 percent (n=2) of respondents reported their child having 'not good or bad' overall health; these respondents reported having Medicaid. Additionally, only 0.5 percent (n=1) of respondents reported their child having 'very poor' overall health; again, this respondent reported having Medicaid.

Among the 235 respondents who reported their child had a dentist they saw regularly, 69 percent (n=162) reported ever having to cancel an appointment. The most common response when asked what reasons they had for cancelling an appointment was that 'the time was not convenient for me' (30%), followed by 'I couldn't find transportation' (12%), 'it was too expensive' (9%), 'the wait at the office was too long' (5%), and 'no one in the office spoke my language (3%); 12 percent of respondents replied 'other' and 31 percent declined to answer the question. Many respondents reported that they felt they were treated 'very well' (41%) or 'well' (43%) during their child's last dental visit. This theme was consistent even when broken down by primary language spoken, race, health insurance type, and education level. Barriers to accessing dental care and parent's experience when at the dentist office were key themes that were discussed in further detail during the focus groups in order to gather a complete picture into parent's experiences accessing dental care for their children.

Roughly one-fifth of respondents (19%) who reported their child had a dentist they saw regularly (n=235), reported that their dentist had used a papoose (a restraint to keep the child from moving during dental work or a dental exam) for their child during their dental visit. Among respondents who reported identifying as Haitian/Creole, almost half (47%) reported that their dentist had used a papoose on their child during a dental visit and over one-quarter (26%) of respondents who reported identifying as Black or African American reported the same. Five (5%) of respondents identifying as Hispanic or Latino and 3 percent of respondents identifying as White re-

ported that their dentist had used a papoose on their child during a dental visit.

47% of Haitian/Creole **&** **26%** of Black or African American

respondents reported that their dentists had used a papoose on their child.

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

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

Discussion

The survey results illuminate a number of important messages about parent/child experiences with the oral health care system in Florida:

Positive Findings

⟶ ***Having a regular dental home for their child does not affect parents/caregivers perceptions of their child's dental and overall health.*** Results show a majority of respondents from both groups (those that reported having a dental home for their child, and those that did not) viewed their child as having excellent, very good, or good dental health, and overall health.

⟶ ***Overall, parents/caregivers with providers were happy with the care their child received.*** Among respondents who reported having a regular dental home for their child, the majority of respondents reported that they felt they were treated very well or well during their child's last dental visit; it's important to note that this theme was consistent even when broken down by primary language spoken, race, health insurance type, and education level, indicating that dental experience statewide has largely been positive for this population surveyed.

Opportunities

⟶ ***Parents receive oral health care information from their child's primary care doctor.*** When parents/caregivers who reported not having a regular dentist for their child were asked how they found oral health care information for their children, the most common response was from their child's primary care doctor. This is significant, as it indicates the importance of making dental health care information accessible in pediatric primary care practices as well as the opportunity for pediatric primary care practices to offer medical-dental integration for preventive services, screenings, and guidance on establishing a dental home, providing another oral health access point for children who may not have dental insurance.

⟶ ***Parents understand oral health care is important.*** Among respondents who reported that they did not have a regular dental home for their child, the majority either strongly agreed or agreed with the statement that dental health was an important part of their child's overall health, even though they did not have a regular dental home for their child. This is important to note, as it demonstrates that while these parents do not currently have a regular dentist for their child, it is not because they are unaware of how important dental health is. Conversely, it reveals they place value on oral health, and suggests there are other barriers that prevent them from having a regular dentist for their child.

⟶ ***Parent's dental care utilization affects their child's dental home and health insurance status.*** Odds-ratio analysis showed that respondents who had a dentist they visited regularly were 2.69 times as likely to have health insurance for their children than respondents who did not have a dentist they visited regularly. Furthermore, respondents whose child had ever been to the dentist were 5.25 times as likely to have a dentist they themselves visited regularly than respondents whose child had never been to the dentist. Together, these results show the importance the parent/caregiver having an established dental home is on health insurance and overall dental status of their children. It indicates that services and initiatives should additionally be tailored to ensure parents have access to and are comfortable with oral health services as it will affect their child's oral health status.

Action Required

⟶ ***Parent's dental care utilization affects their child's dental home status***. Odds-ratio analysis showed that respondents who reported having a dentist they visit regularly are 7.16 times more likely to have a dentist their child visits regularly as well than respondents who do not have a dentist they visit regularly. This suggests, again, that there is value in the parents/caregivers establishing a dental home for themselves, as it affects the dental home status of their child/ren.

⟶ ***Trust in dental care providers is essential for parents to consistently seek care for their children.*** Odds-ratio analysis showed that respondents who had questions about their child's dental care that they wanted to ask but didn't were 8.28 times more likely to have had their dentist use a papoose on their child during a dental visit than respondents who did not have any unanswered questions about their child's dental care. This suggests that parents who have had their dentist use a papoose on their child have been uncomfortable in the practice setting, and have not been comfortable enough with their dentist to ask specific questions regarding their child's dental health and/or the services being provided to their child. Furthermore, having the dentist ever use a papoose on respondent's children was found to be a mitigating factor for having trust in the dentist treating the respondent's children (OR= 0.643; OR <1 is protective). This reveals that parents who trust their child's dentist are also less likely to have had their child put into a papoose, and suggests that parents who have experienced this do not trust their child's dentist and/or understand why it is being used; overall this indicates that those parents who have had their dentist use a papoose on their child are less likely to be comfortable asking questions and trust their dentist overall.

⟶ ***Linguistic and cultural barriers exist for minority populations when accessing dental services.*** As survey results showed, almost half of respondents who identified as Haitian/Creole and over one-quarter who identified as Black or African American had experienced their dentist using a papoose on their child. These statistics, coupled with the analysis above, indicate that being comfortable with, and trusting your child's dentist leads to more appropriate care and also suggests that there may be a cultural and language barrier present for the Haitian/Creole and/or Black or African American population when accessing dental

care for their children.

→ ***Cost, lack of dental insurance, and issues navigating the oral health care system are the most common reasons parents have trouble accessing dental care for their children.*** When asked what were some of the reasons why their children didn't visit the dentist, the most common answers were that it was too expensive, their child does not have health insurance, and they could not find a dentist for their child. Survey data shows these were the most common deterrents for families when accessing dental care for their children. Of the respondents that reported having a regular dentist for their Medicaid-eligible child/ren, 69 percent were enrolled in Medicaid and only 6 percent were enrolled in Kidcare/CHIP. Of the respondents who reported not having a regular dentist for their Medicaid-eligible child/ren, 17 percent reported that their child didn't have any form of insurance. These findings show enrollment can be improved and uninsured rates among Medicaid eligible children point to a need for effective outreach, enrollment and retention strategies to increase access to dental care.

Focus Groups

Methodology

Qualitative data was collected through focus groups to add nuance and narrative to the quantitative assessment. Focus groups with parents/caregivers of Medicaid-eligible children allowed Institute staff to hold in-depth conversations with our target consumers to better understand the barriers they encounter when accessing and utilizing dental care for their children. The open dialogue of the focus group sessions (4 in total) served as an opportunity for parents/caregivers to elaborate on the difficulties they face and for Institute staff to ask more probing questions to further understand their experiences.

Each focus group lasted between 45 and 90 minutes and included between 6-15 parent/caregiver participants, depending on location. The Institute aimed to keep the number of participants between 6-12; the number of participants was dependent upon how our partner organizations recruited their families and on interest in the focus group the day of the session. Each participant received a $20 Publix Gift Card for participation as a sign of appreciation for contributing their time to our research. A non-threatening, safe, and comfortable environment was created to aid parents/caregivers in sharing their perspectives and experiences. At the beginning of the focus group, the facilitator laid a foundation for open discussion by introducing the group and addressing the process. The facilitator addressed the purpose of the group discussion and introduced the additional Institute staff member or intern present in the room, designated to take notes. The guidelines of the session were made clear, in that there were no right or wrong answers to the questions asked as participants would be sharing their opinions, beliefs, and experiences only, and participants were asked to speak one at a time to respect the other individuals in the session. Privacy and confidentiality concerns were discussed and participants were made aware that the session would be audio recorded for research purposes. Participants were required to sign a consent form prior to participating in the session that documented their authorization to record the focus group and consent to participate in the study. This consent form, along with the entire Oral Health Consumer Engagement focus group facilitator's guide, can be found in **Appendix F**. The consent form also provided an overview of the research study, a description of the procedure, the associated benefits and risks, and a statement indicating our team's commitment to protect their privacy and confidentiality. Table tents with individual numbers (1-15) were passed out to all participants prior to beginning the session, and all participants were asked to refer to other individuals in the room by their assigned number, in order to ensure participant confidentiality and privacy.

The Institute relied on the partner organizations and network of Oral Health stakeholders throughout Florida to assist in either hosting focus groups, or to aid in establishing partnerships with new organizations they believed would be a good fit for our research. All invited participants were parents/caregivers of Medicaid-eligible children and were full-time residents of the state of Florida. The target number of focus groups was 10, to correspond to the ten counties represented in the survey to gather a complete picture of the barriers Florida parents face accessing dental care. Unfortunately, the Institute was unsuccessful in securing locations in the Panhandle and Northern region of Florida, as well as on the west coast, though multiple attempts were made via both recommendations from the partners and independent research and outreach during the period of April 2016 to March 2017 and from July 2018 to October 2018.

Analysis and Results

The Institute conducted four focus group sessions in counties with the highest number of Medicaid-eligible children in Florida. Focus groups with parents/caregivers were held throughout November 2016-March 2017 with 39 participants total in Broward County at the Jack & Jill Children's Center; in Miami-Dade County at Catalyst Miami; in Orange County at the Early Learning Coalition of Orange County; and in Palm Beach County at the Children's Home Society of Florida, BRIDGES West Palm Beach location. Thirty-six females and three males participated in the focus groups, ranging in age from 18-70 years old. Majority of focus group participants reported identifying as 'Black or African American' (n=25), followed by 'Haitian/Creole' (n=8), 'Hispanic or Latino(a)' (n=3) and 'Other' (n=2). The primary language spoken at home was English (n=34), though a few participants reported Creole (n=3) as their primary language, as well as Spanish (n=2). A majority of participants' children were insured through Medicaid (n=37), though one child was reported as uninsured. Similarly, the majority of focus group participants themselves were insured through Medicaid (n=20) or with private insurance through work (n=8), though a few had insurance through Medicare (n=4) or were uninsured (n=3). It is important to note that not every participant completely filled out their focus group participant information form, from which this data was collected. Detailed data for each individual focus group can be found in **Appendix G**. Finally, it is important to highlight that as French Creole is one of the most prevalent languages spoken at home in Miami-Dade County, the Institute had the opportunity to host a bilingual focus group with French Creole speakers. Translation was provided by Catalyst Miami's staff, which allowed for better engagement with the French Creole participants.

Audio data was stored and transcribed by Institute staff and the original audio recordings were deleted once the data had been transcribed. Focus group data is qualitative in nature, therefore, it is important to note that the responses of the participants in the focus groups reflected their own personal opinions and experiences. Focus group participants were candid in their responses and enthusiastic to share their experiences and concerns, which demonstrated the benefit of including and allowing for open-ended, qualitative data questions. Complete focus group transcriptions are available upon request. The results of the focus groups were classified into the following sections: (1) Knowledge and Care; (2) Barriers to Accessing Oral Health Services; and (3) Consumer Access to Information.

Knowledge and Care

In general, most parents understand the impor-

tance of preventive dental care. The parents note the importance for ***personal reasons***, "Who wants to sit next to someone in church with bad breath?"; ***cosmetic reasons***, "It's very important. It affects everybody's self-esteem, you know, you see your kids walking around with their heads down, not smiling, it's because of their teeth because their parents can't afford to get them fixed"; and ***general health concerns***, "you could have a toothache, but then symptoms take over your body, and you get a fever, or chills, or an abscess in your mouth." However, some parents' discussion show they don't view preventive dental health as important as other health issues, "if nothing is wrong visually, then why go to the dentist?" Thus, this data suggests a range of behaviors and attitudes exist within parents and their understanding of their children's dental health.

Many participants acknowledged the personal, linguistic, and cultural barriers to accessing dental care in their community. ***Culture*** and ***language*** shape consumers' experience and knowledge of dental health.

In Haiti, the head/mouth have the highest importance and care because your head is superior to the rest of your body. It is the number one priority in Haiti.

> ***"I can't find a dentist that speaks Creole, so my child does translations for me."***

The provider I go to speaks Creole and there are always Haitians there. They have good treatment. Familiarity and comfortability with language are important.

Data shows there is still progress to be made on the normalcy of going to the dentist twice a year for adults and children and the importance of having a consistent dental home for parents and children that treat patients with dignity and respect.

It's been 5 years since my husband/friend went to the dentist and back home we don't go to the dentist. And he said he had no problems since he was younger so he doesn't need to go.

It was OK, it was important to start. The first time we started was at age 2. It's important to start at that age so they can catch problems sooner. Also to get familiar with atmosphere so they're not scared later on.

It's not one of those like "Oooh yay, let's go to the dentist." I always kind of feel ugh about going. I know it's a necessity but I don't like it.

Some people don't like to go because of their experience with the dentist. I went to the dentist 3 months ago and my mouth was messed up and that made me not want to take my child because of what I experienced with the dentist.

I know we are supposed to go every 6 months. Most of the time it doesn't happen. We don't go every 6 months. Something else comes up.

Somebody implemented the preventive care, that's great, but what they can also do is something quarterly, maybe do community events and offer free dental care and do it per community or county or whatever and open it for a certain amount of people. I think this would help the community and also bring everyone together.

I feel like when the dentists are in the Medicaid office, they don't expect you to be asking questions so they don't seem that efficient at answering my questions. It's almost like they're more defensive, wondering why we're asking them questions.

Have your dental staff treat my Medicaid as if it were real, regular insurance. Be more professional with that.

The dentist needs to explain all the work they're going to be doing in their mouth, what caused it and what procedure they're doing that day.

> ***"If they accept the insurance they need to give good, quality service."***

Realistically though, there are levels so we have to be real there. We understand, we just would like more care to be given, more access to be given, we understand we're not going to experience the best dental care ever but at least give us decent care because we are paying into this ourselves.

Parents highlight the need to be **guided through processes that may be new to them and their children.**

My son was in pain, he went in, he's a child probably like 8, and they come out with this big needle and he's doing ok, they say it's going to hurt a little, and I'm glad they set the expectation, but at this point my son is fearful and he is wiggling a bit, and the dentist didn't do anything to calm him down, or talk to him, or walk him through it, and so I had to be the monster and scare him into sitting there, and the dentist walked out of the office and said he wouldn't do it. The dentist shrugged his shoulders and walked away. I don't think that was a good experience for my son.

> ***"The one time I went to this specific dentist, he was really rough. He shoved those metal things in there and it really hurt my face. At this specific dentist, you can't go back in the office with your kids either, which makes me uncomfortable. I think it's weird."***

They are quick to throw a pamphlet to Medicaid patients and don't like to take the time to explain anything.

One participant reported not being allowed to go back in the office with her child and she hated that and so did her kid – specifically not going back to that dentist because they were rude to her and wouldn't explain why she couldn't go back with her child.

Let the dentists know that this is not charity work and that they should treat them as such. People pay for this so they should be treating them like people.

Finally, it seems fear, and overcoming it, play a large role in how parents perceive dental health care for themselves and their children.

The chair looks like a torture setting, the tools are scary.

I am scared of needles.

My teenagers (17 & 19) are still afraid of the doctors and when I try to bring them they disappear.

I'm scared for myself hearing that metal in your mouth when you're getting a filling, it's scary.

I fear needles and that drill sound. The smell. I don't want to put my kids through that.

Someone might not be all the way sedated, and when that happened to my son, he wanted to fight the dentist.

After years of not going to the dentist, I had a root canal and that was not a great experience. I say to my kids go as you're supposed to so they don't have those same issues as I have had.

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

Barriers to Accessing Oral Health Services

There are a number of structural barriers that prevent Medicaid-eligible families from accessing dental health services. Data from the focus groups reveal barriers related to (1) cost; (2) limited Medicaid-eligible dental offices; (3) inconsistency of dental offices offering services to Medicaid eligible families and outdated information; (4) limited hours; (5) appointment wait times; (6) transportation and distance; and (7) general poor treatment from providers.

Cost

If you don't have Medicaid, it's really expensive to go to the dentist period.

Child is going to need braces, she's 11, and Medicaid won't cover it. There are services that Medicaid won't cover and it's too expensive without coverage.

Dental care and eye care are most expensive here; they prefer to go to Haiti to get procedures done instead of stay here.

I have the Jackson Card, and for up to 5 years, I originally had to pay $40 for dental cleanings and check-ups. Now that it's been over 5 years, I don't have it anymore and now it's $100 for the sliding scale fee.

First thing that comes to mind is hardship. I work a good job and I've never been able to afford dental care. Dentist does credit checks now, it's just like getting a car. I know they promote a lot of preventive care, but I have 5 children, and here's the thing, children are still going to get cavities even with this preventive care.

> ***"We can't afford it. We know plenty of people who have waited until they have an emergency and then they go to the hospital and wait to get billed later."***

Limited Options

Even if you have Medicaid not all doctors accept it. I have Coventry as a provider and it hasn't been stable. It has taken a long time to find a dentist. I don't have a dental home because it takes so long to find a doctor.

Medicaid should talk to health insurance so there's more coverage. It took 10 days for them to get back to me to say if my child's procedure would be covered.

Location should be considered when assigning managed care.

Inconsistency/Outdated Information

> ***"Managed care changes quite often and you don't have a permanent dental or medical home when it changes that often; you just find out that the managed care changed when you go to the doctor. It needs to stop changing so you can build rapport with one provider."***

The provider list is never updated – you'll call and they say, 'Oh, we haven't accepted Sunshine in years', or 'Oh, we stopped accepting Medicaid patients altogether', so the provider list pretty much is never useful.

Medicaid should call them when they are making changes because they shouldn't make changes without letting them know and there should be an updated providers list available for them.

Medicaid should call and ask them what they would prefer. Even when they get the updated list half the time the provider doesn't take their insurance, so there's a lot of disconnect. Perhaps because it's Medicaid and it's free those things have to go that way.

Limited Working Hours

The hours that they spend open - being open on Saturdays would be helpful.

Maybe they could make it more convenient for working parents, like longer hours. I think they could manage this better.

Appointment Wait Time

I just get up and leave because I'm not sitting here for 3 hours for them to clean my teeth for 5 seconds. It's the wait.

After 3 hours you want to leave. Why do I have an appointment if I'm not going to be seen at that time?

> ***"After I call for an appointment I have to wait for 2 months, and then when I go to the appointment, I have to wait for hours."***

Transportation/Distance

Right now I don't have a car and the dental office is far, the wait is horrible, and I work, I'm inconvenienced. I still take my child to dentist but that could be a factor.

Transportation is not an issue for me; it's proximity to my house. Just like they give proximity to schools (your kids go to school closest to your home), they should take that same model and apply it to healthcare providers.

My insurance company provides transportation which is helpful.

> ***Transportation is provided but it's not useful or helpful at all, it takes hours and will get you there 3 hours early so you have to sit there at the office forever waiting for your appointment and usually the dentist is late to begin.***

Don't recommend just any provider, it would be great if providers were assigned based on your district/zip code because that would make accessing care easier.

General Poor Treatment of Medicaid Patients

> ***The treatment in general for Medicaid patients, is kind of like whatever service I give you will be what you get. It's not a great situation.***

When she went, they strapped her down in that crazy thing [papoose] and I didn't like that. The next time she went she was scared and didn't want to go back there.

Consumer Access to Information

Parents rely on **referrals** and **word of mouth** to find dentists and other information on oral health in their communities. **Technology** (radio, TV, and the internet) and those who have access to it is also a theme that came up in focus groups.

> ***My primary care doctor has been really helpful with that [making referrals].***

I went to my Primary Care doctor and they gave me a list of dentists to be referred to. None of them accepted Coventry. I live in North Miami and only found 1 dentist that takes Coventry in Hialeah.

TV, cable network in South Florida

Supermarkets, Walmart, Presidente, churches and adult schools (where GED programs are)

Internet as well, but some people might not have access or have time to get online.

I use Google a lot and look at whatever comes up.

The radio; 1320 AM (Haitian radio stations).

Health fairs are usually really helpful and I feel like if resources were given to children's schools that could be helpful.

Discussion

The focus group discussion outlines findings that present opportunities and underscore actions required, by topic area.

Knowledge and Care

As the data above suggest, a range of behaviors and attitudes exist within parents and their understanding of their children's dental health. The following key themes came from the focus group analysis:

→ ***Parents understand that oral health is important for many reasons.*** The majority of focus group participants spoke about the importance of taking care of their mouth, teeth, and gums, especially for their children. Numerous individuals in the sessions cited dental health as an important factor that affects their child's self-confidence and relationships, as it can cause bad breath and cosmetic issues if their teeth aren't well taken care of. Parents felt down about not being able to provide better teeth and care for their children due to the barriers they encountered in the system. As well, parents were aware how oral health affects their children's overall health.

→ ***Culture and language shape consumers' experience and knowledge of dental health.*** Similar to the quantitative data, language and culture affect consumers' experience at the dentist. As of July 2018, Florida was the third most populous state with more than 21.3 million residents, 20 percent of which are people of color (U.S. Census Bureau, 2018). Results from FIHI's research show that there are language and cultural barriers present for both the Haitian/Creole communities in Miami-Dade County and for migrant populations in Wimauma when trying to access dental care for either themselves or their children. The fact that almost half of the Haitian/Creole population in Miami-Dade County that participated in the survey had a dentist use a papoose on their child and that one-third of Wimauma's participant population felt that their race impacts their ability to access quality dental care speaks to the higher issue of accessible, culturally appropriate dental care throughout the state. Further steps should be taken to ensure that all patients are comfortable with and understand their providers, are aware of and provide consent for procedures being performed on their children, and are not or do not feel discriminated against based on race. Our country's current demographic shift points to the great importance of creating public health interventions and tools to address the dental health of diverse populations.

→ ***Dental health needs to be normalized for parents and children.*** Based on results, some parents do not believe oral health needs to be prioritized like general health care. One discussant said "If nothing is wrong on the outside, why go?" This shows that these parents may not understand how important preventive care is for oral health, when considering health priorities.

→ ***Communication and experience in dental health needs improvement.*** Though it is not a main barrier to accessing oral health care, a majority of focus group participants reported their experience at the dentist as average. For consumers to access services, they need to be treated with dignity and respect, no matter what type of oral health insurance they have.

→ ***Transparency of processes.*** For many parents and children, the first time to a dentist's office can be stressful and anxiety inducing. However, dentists, their staff, and assistants can alleviate stress by talking children through processes and having other support systems in place to ensure patients and their parents feel safe.

Accessibility and Barriers to Oral Health

Barriers that prevent Medicaid-eligible families from accessing dental services:

- Cost.
- Limited Medicaid-eligible dental offices.
- Inconsistency of dental offices offering services and outdated information.
- Limited hours.
- Appointment wait times.
- Transportation and distance.
- Poor treatment from providers.

There are a number of structural barriers that prevent Medicaid-eligible families from accessing dental health services. However, there was also data indicating some families' positive experiences in dental offices. Data from the focus groups reveal dental health barriers and accessibilities related to the following areas:

⟶ ***Cost, appointment wait-times, and outdated or inconsistent misinformation are the most common reasons parents have trouble accessing dental care for their children.*** Some participants couldn't afford dental insurance, and without it, it is far too expensive to get seen by a dentist and pay out of pocket; furthermore, some parents have dental insurance but still can't afford services, as Medicaid doesn't cover everything. Misinformation and outdated resources about which dental providers accept which insurance was also a common reason parents had issues accessing dental care. The data show for families with inflexible work schedules, cost, wait times, and lack of dental offices serving Medicaid-eligible families near their community, parents are deterred from accessing services. This issue is not specific to one county in Florida, but instead is prevalent throughout the state's Medicaid-enrolled population. Delta Dental's Dental Care Cost Estimator is an online tool that provides estimated cost ranges for common dental care needs that are addressed out-of-network based on treatment category and zip code. To provide context into how much dental care services cost out-of-pocket and how much the cost can differ based on location, the Cost Estimator was used to show the estimated cost for the following services for cities located on both the East and West coast of Florida, as well as Northern Florida (Delta Dental, 2021). As the estimates show, parents are paying a few hundred dollars out-of-pocket for their child's dental checkup, regardless if they are a new or an established patient, and it is recommended that children see the dentist for a checkup twice a year (American Academy of Pediatric Dentistry [AAPD], n.d.). Fluoride varnish, which is estimated to cost anywhere between $50-$89 per single application depending on location, is recommended by the U.S. Preventive Services Task Force to be provided two to four times annually for children from the time of tooth eruption up to six years of age; if you quadruple this number, parents are now paying an estimated $200-$356 per year for a preventive service that is recommended to keep their children healthy (American Academy of Pediatric News, 2016).

Estimated out of pocket cost for parents is

$200-$356

per year

Table 2: The cost of a checkup for a new patient.

Checkup - New Patient - Child *Includes cleaning, exam, fluoride varnish, & bitewing X-ray (2)		
City	**Zip code**	**Estimated Cost**
Miami	33129	$340 - $559
Tampa	33601	$292 - $351
Tallahassee	32301	$277 - $319

Table 3: The cost of a checkup for an established patient.

Checkup - New Patient - Child *Includes cleaning, exam, fluoride varnish, & bitewing X-ray (2)		
City	**Zip code**	**Estimated Cost**
Miami	33129	$310 - $514
Tampa	33601	$249 - $301
Tallahassee	32301	$234 - $268

Table 4: The cost of an emergency visit dental exam.

Emergency Visit - Dental Exam		
City	**Zip code**	**Estimated Cost**
Miami	33129	$119 - $175
Tampa	33601	$92 - $112
Tallahassee	32301	$88 - $103

Table 5: The cost of a fluoride varnish.

Fluoride Varnish		
City	**Zip code**	**Estimated Cost**
Miami	33129	$65 - $89
Tampa	33601	$53 - $65
Tallahassee	32301	$50 - $54

⟶ ***Streamline administration and communication about services.*** Issues with quickly and easily identifying dental providers and which insurance plans they accept were cited multiple times by the majority of participants. A few parents mentioned how difficult it is to build rapport with one dental provider because managed care plans change so often, they don't have a permanent dental home. Many participants said Medicaid should improve communication with their members to update them on when their plans change (one participant noted her plan changed but was never notified by Medicaid), and provide them with an updated provider list when changes occur. It was very common that lack of support from managed care plans when coordinating care and difficulty navigating dental services was a primary barrier for parents identified throughout the research. In regard to services that individuals found helpful when attempting to access dental care, it was common that participants mentioned more community- and school-based services as being helpful and needed to increase dental care access. This is important for grassroots organizations and local community-based organizations to consider moving forward as they attempt to engage their communities in oral health services and activities, as they can target their communications and activities to community centers and schools. Furthermore, the link to primary care doctors providing access to oral healthcare information is critical and points to the need to integrate medical and dental care in a more thoughtful manner to increase the provision of oral health care to the maximum number of individuals.

⟶ ***Transportation and Distance.*** Some participants mentioned that while transportation is not an issue for them, dental office proximity to where they live is. A few individuals discussed how they thought districts/zip codes should be considered when assigning managed care plans; similar to how children are assigned to schools based on their district, they recommended that managed care plans be assigned based on what providers in your district accepted specific insurance plans.

⟶ ***Medicaid needs to increase accessibility to oral health care services***. Participants noted that wait-time when in the office is a major issue. Individuals mentioned increasing office hours on specific weekdays and opening the office on the weekend for a few hours, to better accommodate working parents and provide more appointment times. Participants suggested increasing locations or increasing the number of Medicaid dental providers in general.

⟶ ***Professionalism and quality care.*** Data shows a majority of participants did not feel valued when accessing services. Incentives for dental health providers are limited, and therefore are reflected in services. Patients desire to be treated with dignity and respect while seeking services. When looking at the data quantitatively, respondents

reported that their overall experience at the dentist's office was primarily positive and majority reported feelings of satisfaction after their most recent dental visit. However, when questions about experience at the dental office were discussed in the focus groups, an interesting theme emerged. Many participants discussed feeling treated by their dental providers as though their care was charity work and they attributed this to the fact that they had Medicaid (despite paying monthly premiums for Medicaid, just like any other insurance type). Furthermore, multiple parents' told stories where they were placed in a circumstance of not being allowed to attend the appointment with their child and/or were disapproving of the way the dentist handled their child. What's relevant to note is that these specific individuals described this as an average experience, regardless of the fact that they were uncomfortable with the overall treatment. *This potentially speaks to the bigger issue of how the Medicaid population expects to be treated, and suggests that they've normalized inadequate behavior and treatment.*

Access to Information

Parents rely on referrals and word of mouth to find dentists and other information on oral health in their communities. Technology (radio, TV, and the internet) and those who have access to it is also a theme that came up in focus groups. In order to ensure access to information on dentists, pamphlets, texts, and other media need to be culturally and linguistically appropriate and all methods of dissemination e.g. through doctors and schools explored.

⟶ ***Parents find oral health information via a variety of sources.*** Many parents cited using the Internet, specifically Google, to find out information about dental or oral health. TV, cable networks, and the radio were frequently mentioned as a means for learning about dental health. However, a few participants made the point that not everyone has access to the Internet, or has cable TV, and discussed how it would be most helpful for them to have informational flyers in places their community members typically frequent.

⟶ ***Mailings are the best way to get information to families.*** Many parents stated that they preferred receiving information in the mail still, and there was also discussion about targeting the information to the languages they know their consumers speak.

⟶ ***Provide free or low-cost community-based services.*** A couple of participants mentioned a dental van that came to their neighborhood when they were younger that offered free, teeth-cleaning services, which was very convenient. Additionally, participants noted that community events and health fairs were useful in finding information, and if there were more community events that offered free dental care services, that would benefit a lot of people and help bring the community and dental workers together. Providing services where the community already is would be smart, and advertising for these services in appropriate areas (churches, adult schools, supermarkets, etc.,) are options.

Consumer Experience and Policy: Rapid Health Impact Assessment

To comprehensively outline actions taken by the state or policies under consideration to address the findings above, a rapid Health Impact Assessment (HIA) was conducted. The HIA catalogues and assesses the oral health policy landscape of Florida to determine areas of growth and weakness, specifically as they relate to oral health access for Medicaid recipients. The assessment focuses on reporting the potential, and sometimes unintended, effects of policies and programs on the health of the population and reviews distribution of those effects within the population. The assessment outlines the health impacts of allocating resources for access to oral hygiene and health and examines how oral health barriers and limited access to dental care can have severe impacts on the well-being and general health of millions of Floridians. The assessment also describes policy changes from 2018 to present that will impact residents throughout the state. Understanding the passing and failing of proposed legislation will be of value to policymakers, stakeholders across governmental, medical, and community partnerships, and Medicaid recipients.

Policy and Funding Landscape

In June of 2018, The Agency for Healthcare Administration (AHCA), Florida's chief health policy and planning entity, signed statewide contracts with Managed Care of North America (MCNA) Dental, DentaQuest of Florida, and Liberty Dental of Florida (AHCA, 2018a). These three Managed Care Organizations (MCOs) have been tasked with providing dental services for adults and children who needed to enroll in a second plan for dental care. Prior to this transition, dental care was included as a covered benefit that plans in Florida's Medicaid managed-care program were required to provide. However, in 2016, then-Florida Governor Rick Scott signed HB 819 into law which defined dental services as no longer required as a benefit within Medicaid HMOs. As a result, dental services were "carved out' from the list of mandated benefits and instead statewide Prepaid Dental Health Plan program was implemented by February 2019. The 5-year contracts are set to expire in 2023.

Federally Qualified Health Centers (FQHCs) have also played a role in addressing the oral health needs of consumers by providing safety net services. There are 47 FQHCs in Florida (National Association of Community Health Centers, 2019). Many of these FQHCs have increasingly utilized mobile units to increase access to affordable, quality health care for Florida's vulnerable populations (FACHC, 2018). In 2016, the state of Florida had 222 dental health professional shortage areas (HPSAs) (Holicky, 2016) and this number continues to increase. As of 2019, there are 240 HPSAs in Florida in addition to 128 medically underserved areas (MUAs) and medically underserved populations (MUPs) leaving 5.5 million people without routine dental care (Florida House of Representatives, 2019). This could be attributed to lack of incentives for both medical and dental providers to participate in Florida's managed care programs because of the state's low Medicaid reimbursement rates. Without safety net providers, many individuals, including children, do not have access to dental care.

In Florida there are

240 HPSAs

128 MUAs and MUPs

5.5 M

Floridian's are living in areas with limited or no access to dental care.

State Medicaid Managed Care Program

AHCA is responsible for administering the Statewide Medicaid Managed Care (SMMC) program, in which most Florida Medicaid recipients are enrolled. Beginning in 2013, the SMMC program fully integrated medical care, dental care, behavioral health, and transportation into statewide man-

aged care with fee-for-service dental services. In 2016, Florida legislature directed the agency to "carve-out" dental services from the Managed Medical Assistance (MMA) plan. In 2019, statewide Medicaid Managed Care fully integrated medical care, long-term care, behavioral and transportation without fee-for-service dental care and implemented new dental plans with Managed Care of North America (MCNA) Dental, DentaQuest of Florida, and Liberty Dental of Florida.

Under the new Statewide Medicaid Managed Care plans, AHCA awardees became responsible for administering dental health services in hopes of creating avenues toward improved oral health services for recipients. According to AHCA (2018c), this transition was expected to:

→ Double the primary care providers in each network.
→ Guarantee access to after-hours care and, where available, telemedicine.
→ Establish higher standards and accountability for transportation services.
→ Provide over 55 expanded benefits offered by health plans.
→ Provide extensive adult dental benefits offered by dental plans.
→ Establish smoother processes for complaints, grievances, and appeals.
→ Continue to provide comprehensive dental care, including all medically necessary dental services, to children (ages 0-20):

- Dental Exams
- Dental Screenings
- Dental X-rays
- Teeth Cleanings
- Fluoride Application
- Sealant Application
- Oral Health Education
- Space Maintainers
- Fillings & Crowns

It has been two years since the implementation of the statewide Prepaid Dental Health Plan (PDHP) program and it is unknown if the transition has accomplished any of the goals outlined above. For example, under the PDHP program, all plans agreed to provide the same expanded package for adult dental services, however, the scope of the services is unknown. Under federal Medicaid law, adult dental coverage is optional. The Florida Medicaid adult dental benefits are limited to dentures and emergency services and any additional services are optional under the state law (Swerlick, 2021). This year, Florida representatives filed a bill (HB 1117/SB 1552) to expand adult dental benefits, indicating that Florida is not providing extensive benefits as expected from the transition. Furthermore, according to recent data presented by CareQuest Institute for Oral Health (2020), Medicaid adult dental benefits in Florida to this day cover emergency-only dental services. The provision of the so called 'extensive adult dental benefits' is under the discretion of AHCA and the dental plans and can be changed at any time.

The plans also committed to higher performance in the following three areas (AHCA, 2018c):

1. Potentially preventable dental related events.
   - Five percent average reduction in dental related emergency department visits within the first year.
   - Nine percent average reduction in dental related emergency department visits within the five-year contract.
2. Improve child access to dental care.
   - Annual dental visits: An average three percent increase year-over-year above the annual target in the ITN.
   - Preventative dental: An average one percent increase year-over-year above the annual target in the ITN.
3. Initial oral health assessments
   - Dental plans will complete oral health assessments on at least 50% of all children, pregnant women, and enrollees with developmental disabilities, within 60 days of their enrollment into the plan

Between July 2019 and June 2020, there were approximately 3.9 million Florida Medicaid recipients enrolled in the Dental Plan program (DentaQuest - 45%, Liberty - 33%, MCNA - 22%), however, only about 13 percent utilized the services in the first three quarters (July 2019 - March 2020) before dropping to 5 percent in the last quarter (April 2020 – June 2020) due to the safety measures implemented as a result of the pandemic (AHCA, 2020a). The plans also committed to three Performance Improvement Projects (PIPs), one of which is increasing the rate of enrollees accessing preventive dental services. In the Combined Q3 and Annual Report (AHCA, 2020a), AHCA stated that the external quality review showed that "all three dental plans received an overall Met validation for the Preventative Dental Services for Children PIP," however, the reports to attest to this validation were not included. The reports are also not available online. Due to lack of transparency about the services, we don't know if the plans are in fact providing appropriate dental services or if the recipients have appropriate access to them.

Currently, in order to qualify for Florida Medicaid, you must be a resident of the state of Florida, and you must be either pregnant, a parent or relative caretaker of a dependent child(ren) under age 19, blind, have a disability or a family member in your household with a disability, or be 65 years of age or older. Furthermore, for a household size of 2, your maximum income level (per year, and before taxes) must be below $23,169 (CMS, n.d.). Under Florida Medicaid, coverage for the following dental services is offered for children ages 0-20: dental exams; dental screenings; dental x-rays; teeth cleanings; fluoride; sealants; oral health education; space maintainers; fillings and crowns; root canals; periodontics; prosthodontics; orthodontics; extractions; sedation; and ambulatory surgical center or hospital-based dental services (AHCA, n.d.). Table 6 lists these benefits and provides a description of the services, coverage frequencies and limitations as outlined in DentaQuest of Florida enrollee handbook. Some services, such a braces, require permission from the recipient's dental plan before the dentist can perform the service and these services must be rendered medically necessary in order for the dental plan to pay for them.

To qualify for Florida Medicaid for

Household size of 2

your maximum income level (per year, and before taxes) must be below

$23,169

Table 6: DentaQuest Florida Medicaid Dental Benefits for Children ages 0-20.

Service	Description	Coverage / Limitation
Dental Exams	A review of your tooth, teeth, or mouth by a dentist	• Complete exams are covered 1 time every 3 years. • Check-up exams are covered 2 times every year. • Emergency exams are covered as medically necessary.
Dental Screenings	A review of your mouth by a dental hygienist	• Covered 2 times every year. • May be done in a school or Head Start program.
Dental X-Rays	Internal pictures of teeth with different views	All types of dental x-rays are covered

Teeth Cleanings	Basic cleanings that may include brushing, flossing, scrubbing, and polishing teeth	• Covered 2 times every year. • May be done in a school or Head Start program.
Fluoride	A medicine put on teeth to make them stronger	Fluoride is covered: • 4 times every year for children that are 0-5 years old. • 2 times every year for children that are 6-20 years old. May be done in a school or Head Start program
Sealants	Thin, plastic coatings painted into the grooves of adult chewing surface teeth to help prevent cavities	• Cover sealants 1 time every 3 years for each adult chewing (back) tooth. • May be done in a school or Head Start program.
Oral Health Instructions	Education on how to brush, floss, and keep your teeth healthy	• Cover oral health instructions 2 times every year. • May be done in a school or Head Start program.
Space Maintainers	A way to keep space in the mouth when a tooth is taken out or missing	Covered as medically necessary.
Fillings and Crowns	A dental service to fix or repair teeth	Covered as medically necessary.
Root Canals	A dental service to fix the inside part of a tooth (nerve)	Covered as medically necessary.
Periodontics	Deep cleanings that may involve both your teeth and gums	Covered as medically necessary.
Prosthodontics	Dentures or other types of objects to replace teeth	• 1 upper, 1 lower, or 1 set of full dentures. • 1 upper, 1 lower, or 1 set of partial dentures. • 1 flipper to replace front teeth. • 1 improvement for denture fit and comfort (reline) for each denture every year. PRIOR AUTHORIZATION REQUIRED
Orthodontics	Braces or other ways to correct teeth location	Covered as medically necessary PRIOR AUTHORIZATION REQUIRED
Extractions	Braces or other ways to correct teeth location	Covered as medically necessary PRIOR AUTHORIZATION REQUIRED
Sedation	A way to provide dental services where a patient is asleep or partially asleep	Covered as medically necessary
Ambulatory surgical center or hospital-based dental services	Dental services that cannot be done in a dentist office. These are services that need to be provided with different equipment and possibly different providers	Covered as medically necessary for any dental services needed PRIOR AUTHORIZATION REQUIRED

Source: DentaQuest Foundation for Oral Health Advancement (2020).

The AHCA's Role with Oral Health

As the result of a 10-year-old Medicaid class action lawsuit, AHCA committed to meet national norms by 2019 for the percentage of children on Medicaid receiving preventive care, and additionally agreed to partake in actions that would bring Florida's Medicaid program up to national norms in preventive dental care by no later than 2021 (The Public Interest Law Center, n.d. - c). These actions were intended to ultimately increase access to and utilization of pediatric dental services, and include a combination of the following: "(1) studies of and enhancements to network adequacy requirements; (2) perpetuation of Florida's state oral health action plan (through which AHCA is attempting to develop in-depth knowledge of the barriers to the receipt of dental care to help target interventions); (3) increased development of performance improvement projects; (4) intensive participation in oral health coalitions; and (5) increased outreach to communicate the availability of dental services to Medicaid children" (Pediatric Society v. Dudek, 2016).

Metrics for improvement evaluation were established as follows:

> (1) Meeting or exceeding a statewide weighted average of all MMA Plans that is equal to or exceeds the 2014 national Medicaid mean for the HEDIS Annual Dental Visit measure;
> (2) Meeting or exceeding the 2014 national average for the child Core Set PDENT measure (CMS-416 Report Line 12b divided by line 1b); and
> (3) Meeting or exceeding the 2014 national average for the CMS-416 report Dental Treatment Service measures (CMS-416 Report Line 12c) (NO.:05-23037).
>
> The following interim benchmarks were established for reporting years from 2017-2021 for each applicable evaluation metric:

According to the settlement, if the Florida SMMC MMA Program statewide fails to meet the applicable interim benchmarks by respective years, AHCA will implement the following actions in the following contract year (e.g. if AHCA has not met the benchmark for 2019, as reported from the 2018 data, they will implement these actions in the 2019 Contract Year) (Florida Pediatric Society v. Dudek, 2016):

> (1) A corrective action plan will be designed to achieve the interim benchmarks set forth above;
> (2) AHCA will afford all eligible MMA Plan network providers that provide dental services to MMA Plan enrollee children under the age of 21 a reasonable opportunity to earn increased payment rates for dental services; and
> (3) AHCA agrees to seek increases in capitation rates.

Dental providers will have the opportunity to earn reimbursement rates at least at the 50th percentile of commercial dental insurance rates for pediatric dental services in Florida; AHCA will be required to seek additional funds if necessary to support those increased reimbursement rates (The Public Interest Law Center, n.d. - c).

Figure 3: AHCA interim benchmarks.

	Year the Measurement is Reported[a]				
	2017	2018	2019	2020	2021
Preventive Dental (CMS 416, Line 12b divided by line 1b; Child Core Set PDENT)	30%	32%	35%	38%	42%
Dental Treatment Services (CMS 416, Line 12c)	14%	16%	18%	20%	22%
Annual Dental Visit (HEDIS ADV)	45%	46%	47%	48%	49%

Source: Pediatric Society v. Dudek, 2016

Without an update on the settlement, the Institute used AHCA's performance measure scores for Medicaid (AHCA, 2020b) which displays that AHCA failed to meet at least one benchmark every year from 2018 to 2020 (Table 5). The scores for the respective dental plans were averaged to calculate the overall score. The results for 2021, as reported from the CY 2020 data, are not currently available.

Table 7: Percentages of Florida Medicaid-eligible families receiving selected services (R) vs. AHCA interim benchmarks (B).

	2017		2018		2019		2020		2021	
	B	R	B	R	B	R	B	R	B	R
Preventive Dental	30%	34.2%	32%	33.6%	35%	37.4%	38%	36%	42%	
Dental Treatment Services	14%	14.4%	16%	12.7%	18%	13.4%	20%	14%	22%	
Annual Dental Visit	45%	47.6%	46%	43.8%	47%	48.5%	48%	50%	49%	

Source: Performance Measure Data Submission for Medicaid (AHCA, 2020b).

Policy: 2018-2021

The 2018 and 2019 legislative sessions prioritized environmental crises and gun violence. The 2017 hurricane season, namely Hurricane Irma, impacted the following year's Florida state budget and reallocated funds to address school-based gun violence, mental health, and substance abuse. At the federal level, Florida received $616 million in funding to support long-term recovery efforts following Hurricane Irma through DEO's CDBG-DR Program (Sullivan, 2017). Senate Bill 7026, the Marjory Stoneman Douglas High School Public Safety Act, was approved by the Florida legislature and signed by Governor Scott in March 2018 (SB 7026, 2018). Along with amending firearm regulations, prohibiting bump stocks, and increasing school safety measures, this bill authorized $69 million to the Department of Education to fund mental health assistance, $67 million for school guardian programs, $97.5 million for the Office of Safe Schools, and over $98 million in grants for improving the physical security of school buildings (SB 7026, 2018). Inarguably, hurricane preparedness and curbing gun violence in schools are essential to the well-being of families and children across the state. Yet funding limitations left oral health bills, as documented below, unfunded, leaving many families without access to oral healthcare.

The 2020 legislative session was scheduled to convene in January; however, several legislatures suspended their sessions or limited their activity due to the pandemic outbreak. The session was expanded by one week due to uncertainty around coronavirus which also delayed the decision of Florida's $93.2 billion state budget until the end of June 2020 (Florida Chamber of Commerce, 2020). The budget allocated much of the funds to K-12 (raising teacher salaries) and higher education, the environment, followed by transportation and infrastructure, Florida's child welfare system, the opioid epidemic, and public safety (Executive Office of the Governor, 2020). The budget also provided an estimated $25 million to match $27 million in federal funds for COVID-19 response. Finally, the budget cut spending in several areas to leave an additional $300 million in reserve to deal with the virus (Florida TaxWatch, 2020)

As the result of the economic fallout of the COVID-19 pandemic, Florida was facing an approximately $2 billion budget gap for the 2021-2022 fiscal year including $1.2 billion shortfall in general revenue for Medicaid. Legislative leaders warned of budget cuts especially in areas of education and healthcare – the state's two largest spending sectors (WUSF, 2021). Despite projections of decreased revenues, Florida passed a record $101.5 billion state budget, which includes $10.2 billion in American Rescue Plan dollars from Congress. The lawmakers are using $6.7 of the $10.2 billion and the rest is going into reserves, bringing the state reserves to the highest in Florida's history at $6 billion.

This policy and procedure catalogue serves as a decision-making tool to inform local and regional leaders on how to maximize positive oral health outcomes through prioritizing the most optimal and far-reaching oral health policies and practices.

Oral Health Policy and Procedure 2018

Policy/Legislation	Synopsis	Passed/Not Passed
Medicaid Dental Carve Out	AHCA announced that it would sign statewide contracts with MCNA Dental, DentaQuest of Florida and Liberty Dental Plan of Florida. In the past, dental care was included as a covered benefit that health plans in the Medicaid managed-care program were required to provide, but has now been "carved out." Services for adult and pregnant dental benefits are built into the carve out. Took effect in 2019.	P
SB 108/HB 293: Florida Kidcare Program	Establishing the Kidcare Operational Efficiency and Health Care Improvement Workgroup as a task force administratively housed in the Department of Health to maximize the return on investment and enhance the operational efficiencies of the Florida Kidcare program, etc.	NP
HB 369/SB 764: Dental Student Loan Repayment Program	Establishes Dental Student Loan Repayment Program to support dentists who practice in public health programs in underserved areas; requires DOH to establish program.	NP
HB 683: Dentistry	Requires DOH to conduct a study on affordability, access, & delivery of dental care in this state; requires the department to submit a report on findings of the study to Governor & Legislature by specified date; provides for expiration of study.	NP
SB 1498: Dental Therapy	Authorizing Medicaid to reimburse for dental services provided in a mobile dental unit that is owned by, operated by, or contracted with a health access setting or another similar program; requiring the chair of the Board of Dentistry to appoint a Council on Dental Therapy; requiring a practitioner of dental therapy to post and display her or his license in each office where she or he practices; authorizing a dental therapist to perform specified services under the general supervision of a dentist with authorization and within the terms of a written collaborative management agreement if certain criteria are met, etc.	NP
HJR 911: Medicaid Expansion	Proposes an amendment to the State Constitution to expand Medicaid coverage to include persons under age 65 with income equal to or below 138 percent of federal poverty level.	NP
SJR 1136: Medicaid Expansion	Proposing an amendment to the State Constitution to enhance access to affordable health care by expanding the availability of Medicaid coverage, etc.	NP
HB 1385: The Healthy Florida Program	Creates Healthy Florida program for the purpose of comprehensive universal single-payer health care coverage; creates Healthy Florida board & public advisory committee; provides requirements including those related to preemption, conflicts of law, powers & duties of board, funding, eligibility & enrollment, health care benefits, providers, care & services, federal health programs & funding, collective negotiations, & prohibited acts; provides rulemaking authority.	NP
SB 1872: Health Care Coverage	Citing this act as the "Healthy Florida Act"; creating the Healthy Florida program, to be administered by the Healthy Florida Board; requiring the State Surgeon General of the Department of Health to establish a public advisory committee to advise the board on policy matters; providing that every resident of this state is eligible and entitled to enroll under the Healthy Florida program; providing health care provider qualifications for participation in the program, etc.	NP

HB 3611: Dental Lifeline Network	Provides an appropriation of $170,000 for the Dental Lifeline Network - Florida Donated Dental Services Program. Note: Was estimated to potentially serve between 401-800 physically and developmentally disabled individuals in the target population.	NP
HB 2497: Suncoast Community Health Centers	Provides an appropriation of $500,000 for the Suncoast Community Health Centers - Plant City Pediatric Dentistry Clinic.	NP
HB 3051: Agape Community Health Center	Provides an appropriation of $500,000 for the Agape Community Health Center, Inc. Mobile Dental.	NP
HB 4379: Premier Community Healthcare Group	Provides an appropriation of $520,016 for the Premier Community Healthcare Group - Mobile Dental Bus.	NP
Specific Appropriation 451: Community Smiles	$283,643 from the General Revenue Fund shall continue to be provided to Community Smiles to partner with the Miami Children's Hospital pediatric dental residency program (recurring base appropriations project).	Recurring base appropriations
Specific Appropriation 451: University of Florida College of Dentistry	$714,519 from the General Revenue Fund shall continue to be provided to the University of Florida College of Dentistry to provide services through a network of community-based clinics (recurring base appropriations project).	Recurring base appropriations

Oral Health Policy and Procedure 2019

Policy/Legislation	Synopsis	Passed/Not Passed
SB 126: Eligibility for Medicaid Assistance and Related Services	Expands Medicaid eligibility to specified families, etc. More than 800,000 residents would gain coverage.	NP
SJR 284: Medicaid Expansion	Proposing the creation of a new section of the State Constitution to require amending the state Medicaid plan to provide Medicaid coverage to persons under age 65 who have an income equal to or below 138 percent of the federal poverty level, etc.	NP
HB 587/SB 290: Medicaid School-based Services	Revising applicable provisions for the reimbursement of school-based services by the Agency for Health Care Administration to certain school districts; deleting a requirement specifying the use of certified state and local education funds for school-based services; revising a requirement for the agency's reimbursement of school-based services to certain private and charter schools, etc.	NP
HB 411/SB 302: Nonemergency Medical Transportation Services	Authorizes Medicaid non-emergency transportation services to be provided to a Medicaid recipient by certain transportation network companies (Lyft, Uber) or transportation brokers, subject to compliance with certain requirements; requiring the Agency for Health Care Administration to update the Non-Emergency Transportation Services Coverage Policy by a specified date, etc. Signed by Governor on 6/7/2019.	P
HB 649/SB 684 : Dental Therapy	Authorizing Medicaid to reimburse for dental services provided in a mobile dental unit that is owned by, operated by, or contracted with a health access setting or another similar setting or program; requiring the chair of the Board of Dentistry to appoint a Council on Dental Therapy effective after a specified timeframe; authorizing the board to require any person who applies to take the examination to practice dental therapy in this state to maintain medical malpractice insurance in a certain amount, etc.	NP
HB 843: Health Care	Establishing the Dental Student Loan Repayment Program to support dentists who practice in public health programs located in certain underserved areas; requiring the Department of Health to establish the Donated Dental Services Program to provide comprehensive dental care to certain eligible individuals; requiring a hospital to notify a patient's primary care provider within a specified timeframe after the patient's admission; requiring a licensed facility, upon placing a patient on observation status, to immediately notify the patient of such status using a specified form; prohibiting certain health maintenance organizations from employing step-therapy protocols under certain circumstances, etc.	P but not funded

Oral Health Policy and Procedure 2020

Policy/Legislation	Synopsis	Passed/Not Passed
SJR 224: Medicaid Expansion	Proposing an amendment to the State Constitution to require amendment of the state Medicaid plan to provide Medicaid coverage to persons under age 65 who have an income equal to or below 138 percent of the federal poverty level, etc. Would allow Floridians to vote on whether to expand Medicaid eligibility to those under 65 with income equal or below 138% of Federal Poverty Level.	NP
HB 81: Health Care for Children (original bill SB 190)	Revising applicable provisions for the reimbursement of school-based services by the Agency for Health Care Administration to certain school districts; deleting a requirement specifying the use of certified state and local education funds for school-based services; revising a requirement for the agency's reimbursement of school-based services to certain private and charter schools, etc.	P
SB 152: Dental Therapy	Authorizing Medicaid to reimburse for dental services provided in a mobile dental unit that is owned by, operated by, or contracted with a health access setting or another similar setting or program; requiring the chair of the Board of Dentistry to appoint a Council on Dental Therapy effective after a specified timeframe; requiring the board to adopt certain rules relating to dental therapists; providing application requirements and examination and licensure qualifications for dental therapists; limiting the practice of dental therapy to specified settings, etc.	NP

Oral Health Policy and Procedure 2021

Policy/Legislation	Synopsis	Passed/Not Passed
SJR 276: Medicaid Coverage	Proposing the creation of a new section in the State Constitution to require amendment of the state Medicaid plan to provide Medicaid coverage to persons under age 65 who have an income equal to or below 138 percent of the federal poverty level, etc. Would put Medicaid expansion on the 2022 general election ballot.	NP
HB 341/SB 698: Optional Payments for Medical Assistance and Related Services (Medicaid Expansion)	Extends Medicaid eligibility under 65 years of age, not pregnant, and whose income does not exceed 133 percent of the poverty line.	NP
HB 443/SB 556: Eligibility for Medical Assistance and Related Services	The Agency for Healthcare Administration authorized to make payments for medical assistance and related services on behalf of specific individuals eligible for Medicaid (Floridians making up to 133 percent FPL).	NP
HB 961/SB 604: Dental Therapy	Authorizes Medicaid to reimburse for dental services provided in mobile dental unit that is owned by, operated by, or contracted with health access setting or another similar setting or program; requires chair of Board of Dentistry to appoint Council on Dental Therapy within specified timeframe; authorizes dental therapist under general supervision of dentist to administer local anesthesia & operate X-ray machine, expose dental X-ray films, & interpret or read such films if specified requirements are met.	NP
HB 645/SB 238: Postpartum Medicaid Coverage	Authorizes AHCA to make payments for medical assistance & related services during specified period to certain Medicaid-eligible postpartum women; authorizes agency to seek federal waiver approval or submit state plan amendments as necessary. Note: Extends the period of eligibility for Medicaid for postpartum women to the 365-day period of beginning on the last day of the pregnancy. Increases the eligibility limit to 185 percent of the most current federal poverty level.	P
HB 201/SB 1244: Florida Kidcare Program Eligibility	Increases income eligibility threshold for coverage under Florida Kidcare program; authorizes AHCA to seek federal waiver approval or submit state plan amendments as necessary; requires agency to examine graduated family contribution rates for newly qualifying families under program; provides guidelines for such rates; requires agency to increase income eligibility threshold for coverage under program each fiscal year until meeting specified income threshold.	NP
SB 852: Medicaid Modernization	Authorizing Medicaid to reimburse for certain remote evaluation and patient monitoring services, etc.	NP
HB 1117/SB 1552: Medicaid Coverage for Adult Dental Services	Requires reimbursement of certain adult dental services by AHCA under Medicaid program; prohibits reimbursement for such services if provided in mobile dental unit; requires that minimum benefits provided under Medicaid prepaid dental health program cover certain adult dental services.	NP

Policy Implications

Florida has seen a gradual increase in oral health utilization rates this decade, especially among children. The Dental Student Loan Repayment Program (HB 369; SB 764) presented an avenue to encourage dentists to practice in underserved communities but went without passage in 2018 before being reconsidered as part of Health Care bill (CS/HB 843) in 2019. Florida was one of only five states without a dental student loan repayment program prior to CS/HB 843's passage, the program has not been funded.

The Dental Therapy Bill (HB 961/SB 604) authorizes new providers, called licensed dental therapists, to perform tasks under the general supervision of dentists and provides a scope of practice for dental therapists. The bill would also allow the Board of Dentistry to appoint and establish members of the Council of Dental Therapy. The bill (HB 961/SB604) was introduced again in the 2021 legislative session, but failed without a hearing. Dental therapists are currently permitted in 13 states and tribal jurisdictions (Holland et al., 2020). According to the Florida Department of Health, Florida CHARTS (2021), Florida currently has 56.7 licensed dentists per 100,000 Florida residents, compared to a national average of 61.4 (ADA HPI, 2021). The rates vary greatly across the state where Dixie, Glades, Lafayette and Union counties do not have any licensed dentists and Alachua, Martin and Palm Beach counties have rates significantly greater than the statewide rate. Data and evidence support that adding these mid-level providers would help address the shortage and increase access to care. Dental therapists have been shown to decrease no show-rates, appointment wait times and travel, increase number of patients seen and patient satisfaction (Chi et al., 2018). Additionally, because dental therapists can work under remote supervision of a dentists, they can work in a wide variety of settings such as schools, FQHCs, nursing homes, etc. (Catalanotto, 2021). Dental therapy was also found to be safe and cost-effective. A 2019 bill analysis conducted by the Florida Senate Committee on Children, Families, and Elder Affairs found that the Florida Department of Health anticipated an estimated revenue for the first two years of licensure of to be approximately $2,277,069, and an estimated revenue for the following two years to be $1,912,892, offsetting the state government sector impact of $584,408 for the first two years of licensure (Committee on Children, Families, and Elder Affairs, 2019).

Dixie Glades Lafayette Union counties do not have any licensed dentists.

Florida continues to face challenges in accessing dental care and it has only gotten worse amidst the pandemic. The Legislator's did not expand Medicaid in 2021 though the American Rescue Plan Act offered $3.5 billion in additional federal funding (Cross-Call, 2021) . This funding would have covered Florida's full cost of providing coverage. Furthermore, according to the Florida Policy Institute (2019), Florida was estimated to see an additional $198 million in net savings from expanding Medicaid in FY 2022-23. This was an opportunity for Florida to expand access and address inequities in health coverage but the bill (SJR 276) failed without a hearing, leaving thousands of Floridians without health insurance.

Florida was estimated to see an additional

$198 M

in net savings

from expanding Medicaid in FY 2022-23

Although Florida did not pass SJR 276, the lawmaker extended postpartum Medicaid coverage from 60 days to 12 months, allocating $240 million of the state and federal funds to this initiative (Morgan, 2021). The lawmakers also avoided deep budget cuts; however, the current budget fails to meet the needs of thousands of Floridians, especially those that were affected by COVID-19 the most. The lawmakers did not expand Medicaid leaving $3.5 billion on the table and failed to use $3.5 billion of the $10.2 billion American Rescue Plan funding from Congress leaving it in the reserve. Expanding policy to be more comprehensive, centered on equity, and leveraging cost-saving opportunities for the state, such as expanding Medicaid or authorizing dental therapy, presents a more long-term strategy with return on investment.

Alignment Efforts: Consumer Engagement Impact, 2017-20

Collective Impact

Throughout the Consumer Engagement process, the Institute has involved its partners, sharing insight gained and using the findings to guide strategic oral health work with the Florida Oral Health Alliance and the Oral Health Alignment Network. Specifically, the Alliance is statewide network that focuses on raising oral health awareness and improving access to oral health services through a group of broad-based, multi-sector stakeholders. The Oral Health Alignment Network was comprised of grantees funded by the DentaQuest Partnership for Oral Health Advancement and the Oral Health Progress and Equity Network. The Alignment Network collaborated to raise public awareness about oral health disease rates and advocate for improved oral health delivery and systems change. The Alignment Network committed to:

1. Raise oral health as a social justice, systemic issue.
2. Identify and address social determinants of oral health.
3. Extend care to everyone.

FIHI's Oral Health Alignment Network partners included Catalyst Miami, Florida Voices for Health (FVH), Oral Health Florida (OHF), and the Tampa Bay Healthcare Collaborative (TBHC).

As the Consumer Engagement work developed, the Oral Health Alliance and Oral Health Alignment Network have been periodically updated on the activities and findings of the research. This research and the results have presented opportunities to utilize this insight as our collective work has evolved. Likewise, these groups have collected additional data to further inform our shared understanding of the oral health services consumer experience and to strengthen our shared mission of improving oral health outcomes in the state.

The work of each organization within the Alignment Network is discussed in **Appendix H.**

Opportunities to Shape the Consumer Experience and Oral Health Landscape: 2021 and Beyond

In sharing this report, we hope to inform Florida's state health care agencies with insight on understanding the consumer experience in our state, planning for meaningful systems change, and crafting policy that best supports an improved dental care delivery system. The 2016 Florida Medicaid lawsuit and settlement agreement has created a foundation for thoughtfully addressing these challenges and working together to improve access to dental care and preventive services for Medicaid-eligible children in the state of Florida by 2021. We anticipate that this report can inform the mission of any organization or state agency working to understand or improve oral health care services and delivery in the state of Florida and that this information can guide policies and practices in the future to improve oral health outcomes for Florida's children and families.

The recommendations below represent evidence-based policies and programs that can inform state, municipal, and Medicaid planning to improve oral health care services and delivery in the state of Florida. Recommendations were developed for specific audiences including: (1) the Florida Surgeon General and Florida Department of Health; (2) the Agency for Health Care Administration; (3) Social Service and Oral Health Organizations; and (4) Agencies/Dental Practices responsible for the implementation of evidence-based models.

I. STATE SURGEON GENERAL RECOMMENDATIONS

→ ***Co-locate medical and dental services to increase the provision of preventive oral health services.*** A nationwide movement towards increased coordinated care is improving the effectiveness, efficiency and safety of the American health care system. The Institute of Medicine (2003), now known as the National Academy of Medicine, has identified targeted care coordination as a key strategy to improve outcomes for patients, providers and payers. Innovative co-location and integrated care models are at the forefront of this movement and are exploring new ways of delivering care that blend the expertise of multiple providers to offer patients more comprehensive and person-centered care. Community Health Centers (CHSs) are major safety-net providers for low-income and uninsured individuals and families. Co-locating medical and dental services on-site at CHSs enhances the opportunity to provide integrated care. Integrating primary care and oral health services in one setting is an innovative model that increases the efficiency of both medical and oral health professionals in preventing disease because it allows for information-sharing and consultation in a systematic and sustained manner. The healthcare team can identify underlying causes of disease and engage patients in disease risk reduction and prevention. Parents who do not have a dental home for their child often turn to a primary care doctor for

dental health information. Capitalizing on this interaction and providing dental health preventive services and/or information in this setting can improve dental health encounters for children statewide. North Carolina's Into the Mouths of Babes program provides a promising framework Florida can follow to prevent early childhood caries in low-income children (Rozier, Sutton, Bawden et al., 2003). Pediatricians, family physicians, and providers in community health clinics participating in the program are reimbursed by Medicaid to provide preventive dental services for children and caregivers that includes risk assessments, screenings, referrals, fluoride varnish applications, and counseling. Providers are required to participate in continuing medical education lectures, and are provided with practice guidelines for patient interventions, case-based problems, practical strategies for implementation, a toolkit with resource materials, and follow-up training. Program results show the successful integration of preventive dental services into primary care practices and provides a promising blueprint for Florida's clinicians to increase access to preventive dental services for young children eligible for Medicaid whose access to care is minimal.

→ ***Provide cultural competency training for medical and dental providers.*** As Florida Consumer Engagement research shows, specific populations are struggling to find culturally competent and language-specific oral health care providers in their area. Training staff on culturally-competent oral health care may improve the patient experience by providing individuals with culturally-competent dental providers and a more comfortable practice environment. Parents who participate in long term oral health care for their children may benefit from more person-centered, quality care. These trainings could be developed by grassroots and community-level organizations who are experts in this subject matter area.

→ ***Restrict papoose utilization.*** The act of strapping children down with a papoose while providing oral health care services needs reconsideration from policymakers and legislators. Results from the Consumer Engagement research show that papoose utilization in Florida is disproportionately experienced by Haitian/Creole and black children. Continuation of the practice should be scrutinized to ensure parents are not put in a position where they feel they must accept a traumatic experience for their child in order to receive oral health services. Increasing verbal communication will cultivate trust in the patients and children, decrease and/or end the need for papooses in dentistry offices, and ultimately increase patient's experiences, perceptions, and utilization of oral health services. According to AAPD (2020), the "majority of dental schools spend fewer than five classroom hours on behavioral guidance techniques" and "42 percent of institutions reported fewer than 25 percent of students had one hands-on experience with passive immobilization for non-sedated patients, while 27 percent of programs provided no clinical experiences," noting lack of knowledge of utilization. If necessary, protective stabilization should only be used in the rarest of circumstances and after thorough consideration of "patient's oral health needs, emotional and cognitive development levels, medical and physical conditions, and parental preferences." (AAPD, 2020).

Among 42 dental institutions:

25% of students had no hands-on experience with passive immobilization for non-sedated patients.

27% of programs provided no clinical experiences," noting lack of knowledge of utilization

→ ***Contract with a research organization to conduct a statewide oral health needs assessment to inform an updated statewide oral health plan.*** Florida's vast geography and diverse population can make it difficult to develop an effective population health improvement plan, as community needs vary depending on particular region, density, culture, etc. In 2011, the state of Maryland contracted with a research organization to develop a strategy that would improve oral health for Maryland's most vulnerable children. The strategy was threefold: 1) conduct an extensive needs assessment; 2) develop and implement interventions; and 3) develop an appropriate system to measure and track outcomes (Horowitz & Kleinman, 2012). These findings were then utilized by Maryland's statewide oral health coalition, the Maryland Dental Action Coalition, to inform their Maryland State Oral Health Plan and contribute to the design of a statewide oral health literacy campaign. Florida's Surgeon General should consider modeling this approach and contract with a reputable research organization to conduct a similar statewide oral health needs assessment that will eventually inform an updated statewide oral health plan and literacy campaign that can be developed by Florida's statewide oral health coalitions. Partnering with a research organization and a statewide coalition would enable organizations that are experts in the varying oral health needs of Florida's communities to contribute to the development of such a comprehensive and targeted oral health plan and campaign, further contributing to their favorable impact on children's oral health in Florida.

→ ***Utilize existing monitoring systems to build statewide oral health capacity.*** There are many examples of states utilizing their existing surveillance systems to build their internal statewide oral health capacity. One such system that has been utilized in various ways is PRAMS, the Pregnancy Risk Assessment Monitoring System. PRAMS is an ongoing surveillance system designed to collect data on maternal attitudes and experiences before, during, and shortly after pregnancy. The system is managed by the Centers for Disease Control and Prevention and state health departments. Currently 47 states participate in PRAMS (CDC, 2021a). In Maryland, ongoing PRAMS datasets have been utilized to assess oral health literacy and usage among pregnant women and to influence provider counseling on the importance of teeth cleanings during pregnancy (CDC, 2021b); in Rhode Island, PRAMS data was utilized to promote and advocate for the integration of oral health care as part of prenatal care (Oh et al., 2011); and in New York, PRAMS data has been used to justify requests for funding to implement oral health interventions for Medicaid-enrolled pregnant women (CDC, 2021c). As dental caries are infectious, and can be passed from mother to child, pregnancy presents an important opportunity to address oral health care and affect children's oral health outcomes. The Florida 2009-2015 PRAMS (FDOH, 2019) dataset, managed by FDOH, shows that 85.5 percent of mother knew the importance of caring for teeth and gums during pregnancy and 23.3 percent needed to see a dentist for a problem, however, only 13.8 percent went to a dentists or dental clinic about a problem. Furthermore, only 46.6 percent had a professional teeth cleaning within 12 months before pregnancy and 37.8 percent had their teeth cleaned during pregnancy; 43.8 percent had a dental or other healthcare professional talk to them about how to care for teeth and gums and 55.2 percent had a physician, nurse or healthcare professional talk to them about visiting a dentist or DH. FDOH should utilize the Florida PRAMS dataset to its fullest extent to build internal oral health capacity for the state and improve future oral health outcomes for Florida's vulnerable children.

→ ***Provide interprofessional education and training to improve Early Childhood Caries (ECC) management and access to preventive oral health services in vulnerable populations.*** As research shows, early childhood caries (ECC) are the

most common chronic childhood disease that is most prevalent among pediatric populations with limited access to pediatric dental services (Bernstein et al., 2015). As discussed in our findings, Medicaid-eligible children, parents, and caregivers often rely on their primary care homes and doctors for the majority of their oral health information. It is recommended that the Surgeon General promote and provide greater opportunities for interprofessional education and training in preventive oral health for pediatric physicians and staff working in Florida's pediatric practices, Federally Qualified Health Centers, and community health centers. By doing so, physicians can be better equipped to enhance children's oral health during a critical developmental stage for children. The *Smiles for Life* National Oral Health Curriculum is a best-practice example of interprofessional training that the Surgeon General can promote for pediatric staff in Florida. *Smiles for Life* is a national, online oral health curriculum offering extensive educational resources for inter-professional training with the goal of integrating oral health and primary care. This curriculum, which has been endorsed by the AAP, ADA, and American Dental Hygienists Association among numerous others, consists of eight 60-minute modules covering core areas of oral health relevant to health professionals. To cite a few, the Child's Oral Health course addresses the prevalence, etiology, and consequences of ECC. By participating in this module, clinicians will be equipped with the tools needed to not only better serve young patients, but share information and the value of oral health with children and families. The Relationship of Oral and Systemic Health course addresses the nature, prevalence, and consequences of oral disease throughout the life cycle with a focus on correlations between oral and systemic health. Clinicians will learn their role in preventing oral disease, addressing frequently encountered oral problems, and working as part of an interprofessional team to promote oral health among their patients. CEUs are available for this curriculum and all courses can be viewed **here**.

→ ***Utilize the American Dental Association Foundation's Tiny Smiles: Give Kids A Smile Program Tools and Resources.*** Every member of an interprofessional healthcare team plays a role in educating and informing parents, caregivers and families on the importance of oral health. Learning to communicate about oral health and prevent dental disease is vital to addressing oral health in practice, understanding the role of oral health allies, and learning how to collaborate and advocate to achieve optimal oral health for community members and families. A wealth of resources are available to assist clinicians in communicating about these topics with their patients. The ADA Foundation's Tiny Smiles: *A Give Kids A Smile Program*, available to educators, and medical and dental professionals, provides free and ample tools, resources, tips, and activities to raise awareness about the oral health needs of children. It is recommended that the Surgeon General promote and share this **program** so that Florida educators, dentists and any medical professional involved in oral health can better engage with patients and contribute to the shift towards value-based oral health care.

Dental students face upwards of

$250,000 to $300,000

in debt upon graduation

→ ***Fund and expand the Dental Student Loan Repayment Program and facilitate eligible Professional Postgraduate Dental training institutions to seek additional funding.*** The Student Loan Repayment Program presents an avenue to encourage dentists to practice in underserved and dental care health professional shortage areas (DHPSAs). The dental student loan repayment program bill (HB 369/SB 764) was introduced in 2018 and went without passing. The program was re-implemented as part of the Health Care bill (CS/HB 843) in 2019 but remained unfunded. Passing the bill was half the battle, it is now recommended that Florida Dental Association, who pushed for the program in 2019, work with FL Department of Health and AHCA to fund the program.

Research shows that, when compared to health professions of pharmacy, medicine, optometry and veterinary medicine, dentists had the largest increase per year in debt from 2010 to 2016 (Chrisholme-Burns et al., 2019). Dental students face upwards of $250,000 to $300,000 in debt upon graduation and often can't afford to practice in underserved area due to high payments and low-Medicaid reimbursements (Miller, 2019). The unfunded program was to be established by the Florida Department of Health to help repay student loans and incentivize dentists to treat Medicaid and other low-income patients in a shortage area or an underserved community. Under the program the students would be eligible to receive up to $50,000 in financial assistance per year towards repayment of their student loans who may receive funds up to five years. To be eligible for the financial assistance, dentists must exclusively practice in federally-designated DHPSAs or medically underserved areas. Florida Department of Health could consider redesigning the current program and creating a more flexible, hybrid program where dentists can practice in both low-income areas and their practice of choice allowing for greater flexibility to increase revenue. In 2016, dentist median income was estimated to be $40,000 less compared to physicians (Chrisholme-Burns et al., 2019) and with this significant debt-to-income ratio, the current program may not be enough of an incentive to practice in low-income areas. The program can be redesigned to require the dentists to practice x number of hours per week or on the basis of x number of dollars per hours. The current program is also limited to 10 new dentists per fiscal year and can be expanded to include more dentists to incentivize greater participation. The updated program would benefit dentists who desire assistance paying off student loans and provide high-quality dental care in hard-to-reach areas and underserved populations. Furthermore, FL Department of Health can work with and encourage eligible dental schools that provide Professional Postgraduate Dental (PGD) training to seek funding

from Health Resources and Services Administration (HRSA). HRSA is a federal agency focused on improving health care for underserved populations and provides Oral Health Training and Workforce Program grants for state oral health workforce programs, faculty development, loan repayments and postdoctoral training programs. The funding specifically for PGD training supports postdoctoral training in general, pediatric and public health dentistry (HRSA, n.d.). According to the Oral Health Workforce Research Center (OHWRC) (2019) study of practice patterns among HRSA-funded dental residency completers, 30 percent reported practicing in DHPSA areas and 43 percent reported working in medically underserved areas. These dentists also were found to participate in Medicaid at a greater rate than all dentists (63% vs 38% nationally) and saw a significant number of Medicaid patients compared to privately insured patients. Additionally, almost all of the graduates felt prepared to meet the needs of underserved populations as a result of their training. The results of the study highlight the impact of HRSA-funded dental programs in addressing oral health disparities and Florida should consider taking advantage of this opportunity on a statewide level.

II. AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA) RECOMMENDATIONS

⟶ ***Expand the scope of practice for Dental Hygienists.*** Traditionally, the role of DHs consisted primarily of providing prophylactic services in private dental health care settings under the direction of a dentist; however, the roles, functions, and settings in which they work have evolved over time to meet the needs of various populations, including low-income children, Medicaid-eligible patients, and the elderly. Present day hygienists provide prophylactic and preventive services as well as oral health education. The scope of practice for DHs is defined by each state's laws and regulations that describe the educational and certification qualifications for licensing, the settings in which services may be provided, the range of allowable services, and the required levels of professional supervision (Langelier, Baker, Continelli & Moore, 2016). In 2001, the Oral Health Workforce Research Center (OHWRC) at the Center for Health Workforce Studies (CHWS) at the University of Albany, New York, School of Public Health, developed the Dental Hygiene Professional Practice Index (DHPPI), a numerical tool to measure the professional practice environment of DHs at the state-level. The Index was updated in 2014 and was used to score the scope of practice in all fifty states and the District of Columbia. The states with high scores, indicating more independent DHs, were significantly correlated with utilization of oral services and better health outcomes (Langelier, Baker, Continelli & Moore, 2016). Florida was found to have a 'limiting' scope of practice in both 2001 and 2014. The Index was revised and updated in 2016 to include both current and emerging roles as well as extended functions of DHs (Langelier, Baker & Continelli, 2016). This time, Florida was found to have a 'satisfactory' scope of practice showing expanded roles for DHs. State categorized as 'satisfactory', such FL, TX and VA, often limit DHs scope of practice in public setting due to lower supervision and require that the dentist sees the patient first to determine the need for preventative services. Florida, although showing some expansive permissions, would benefits from further expanding DH legal scope of work to become a persistent innovator in workforce strategies to address oral health care needs of Florida's most vulnerable populations. States ranked as 'excellent' included ME, VT, NM, CO, MN, AZ, NV, CA, OR and WA (Langelier, Baker & Continelli, 2016).

Dental therapy has been

Authorized in 13 States

and/or tribal jurisdictions: Alaska, Oregon, Minnesota, Maine, Vermont, Washington, Arizona, Michigan, New Mexico, Idaho, Montana, Nevada, and Connecticut

⟶ ***Consider broadening the dental workforce to include dental hygienists or dental therapists to improve community-level outcomes.*** Dental therapy is relatively new in US but has been recognized as a successful tool in over 50 countries around the world. As of 2021, dental therapy has been authorized in 13 US states and/or tribal jurisdictions: Alaska, Oregon, Minnesota, Maine, Vermont, Washington, Arizona, Michigan, New Mexico, Idaho, Montana, Nevada, and Connecticut, (Holland et al., 2020). Furthermore, there are currently three dental therapy programs in US, two in Minnesota and one in Alaska (Lynch, 2020) and additional programs are being tested and implemented at Skagit Valley College (Washington State), Vermont Technical College (Vermont), Pacific University (Oregon), and Minnesota State University (Minnesota). Dental therapy generally includes various routine preventive services and restorative treatments. Most dental therapists (DTs) generally work under the supervision of a dentist in a rural or low-income region to increase access to routine, local dental care. Global literature indicates similar quality of care between dentists and DTs, increased access to dental care, decrease in dental disease and cost associated with dental care (Yang, Chen & Wanchek, 2017). In Alaska Native communities, the Alaska Native Tribal Health Consortium began training Dental Health Aid Therapists (DHAT) in 2006 using a model in place for decades in New Zealand. Evaluation studies of the program show the following results: DHATs provide similar quality of care as dentists do; community members report shorter wait times and satisfaction with DHATs; and a positive correlation between DHAT treatment days and preventive care utilization and negative correlation with extractions (Chi et al., 2018); increased oral health knowledge among the residents; fewer patients with 'large cavities' and more children with cavities; reduced disease prevalence and severity of oral health disease; and improvements in prevention-oriented educational efforts in school, clearly demonstrating improved oral health outcomes (Chi et al., 2019). Studies in Minnesota show similar findings and model a strong correlation between utilizing of DTs and increased access to care. Apple Tree Dental, a large non-profit community dental provider that serves low-income patients, many of whom are Medicaid-eligible in Minnesota, is among initial employers of DTs and currently employs ten DT/advanced DTs. An examination of quality and type of services provided by various clinical professionals before and after introduction of DTs at Apple Tree Dental found increased capacity to provide oral health services; increased organizational capacity in terms of number of clinicians employed and number of dental centers; increase in number of patients beings seen by dentists, providing more services and producing higher average service values. (Langelier, 2020). Today, more dentists are becoming champions of dental therapy (The National Coalition of Dentists for Health Equity, 2021) and more states are deliberating dental therapy legislation. In Florida, legislators have attempted to pass dental therapy legislation since 2018 (SB1498); 2019 (SB 684 / HB 649); 2020 (SB 152) and 2021 (HB 961). As access to dental health services remains a problem in Florida, DTs could be an effective tool to addressing oral health inequalities particularly in

underserved communities. Lack of access to quality dental care in Florida is a social justice issue. It is recommended that AHCA come alongside key DT stakeholders including Floridians for Dental Access, Florida Policy Institute, James Madison Institute, Florida legislators and interested state colleges such as Miami-Dade College to move Florida toward passing and adopting the national model for licensing and certification of DTs (National Dental Therapy Standards Consortium, 2019). By bringing DTs to Florida, we can increase access to care, help achieve equity and cut overall cost.

⟶ ***Develop/update a comprehensive, user-friendly online oral health resource guide that allows consumers to search for specific services based on zip code, health plan and area of need.*** AHCA could develop and continuously update a comprehensive oral health resource guide that allows consumers to search for specific services based on their zip code, specific health plan, or area of need. Many parents voiced frustration over the Medicaid dental provider directory not being updated and providing incorrect information. Such a resource is difficult to maintain as Medicaid providers change frequently. It may be more feasible for AHCA to consider offering a resource that shows where to access free oral health services in each county or zip code for those who do not have a specific health insurance plan. **Aunt Bertha** is an existing online tool that connects people and programs where people can find social services via an open access search, nonprofits can coordinate their efforts and costumers can integrate social care into the work they already do. People can search by zip code and then further categorize by area of need (housing, food, transit, health, care, education, etc.) and type of service (e.g. health – dental, medical, addition and recovery, etc.). This tool can be leveraged to help identify free and low-cost dental services and is a great example of innovations in the field that AHCA can look to for guidance moving forward. AHCA could additionally consider obtaining funding for this type of project and outsourcing it to a subject matter expert.

⟶ ***Institute a toll-free number for both Medicaid beneficiaries and dental providers to improve dental appointment compliance.*** Improving dental appointment compliance can improve utilization of dental services. Several states have implemented various strategies to focus on clients who miss appointments. For example, Maine instituted a toll-free number that beneficiaries can call for assistance with transportation, finding a dentist and other appointment-related services. Furthermore, dentists participating in MaineCare can alert the state to missed appointments and request assistance by calling an established toll-free number provided by the Maine Bureau of Health (McPherson, 2008). The state or contacted staff then contact the patient and discuss the importance of keeping appointments, review cancellation policy, and offer assistance with cancelling/scheduling and transportation to and from the appointment. AHCA could consider instituting toll-free numbers to help facilitate compliance and motivate Medicaid beneficiaries to maintain their appointments by solving appointment related barriers such as transportation.

⟶ ***Establish a Medicaid dental advisory committee.*** Many best practices can be pulled from Texas' class action Medicaid lawsuit that alleged numerous failings in the state's efforts to ensure all children enrolled in Medicaid were receiving appropriate preventive and specialty care services. To assist the state in allocating the funds for the required physician rate increases, the Texas Medical Association requested that the Health and Human Service Commission reconstitute an advisory board to oversee the process. The Physician Payment Advisory Committee (PPAC) was composed of primary and specialty care physicians from across Texas and ensured all major state specialties were represented in the committee and in the decision process. As AHCA has committed to meet national norms for the percentage of children on Medicaid receiving preventive care by 2019, and to meet national norms in preventive dental care by no later than 2021, they are required to increase reimbursement rates for dental providers if they fail to meet these benchmarks by 2021. Our Rapid Health Assessment indicates that AHCA failed to meet at least one benchmark every year from 2017 to 2020. The data for 2021 is not currently available. AHCA would benefit from establishing a Medicaid dental advisory committee comprised of medical and dental providers, a pediatric state unit (i.e. Florida Academy of Pediatric Dentistry), Florida Medical Association, Florida Dental Association and other oral health stakeholders to ensure that remaining benchmarks are met and moving forward facilitate further progress, offer guidance about appropriateness of services, inform the program officials of current practice techniques and policies, identify administrative issues of concern, etc. Centers of Medicare & Medicaid Services (CMS), in their Guide to Children's Dental Care in Medicaid (2004), encourages the establishment of Medicaid dental advisory groups. According to CMS, in several states' communications between Medicaid and dental advisory groups have been critical to building improved relationships between Medicaid and dentists, and increasing dentist participation in Medicaid. As Florida's oral health policy landscape is similar to Texas' prior to their settlement agreement, it would be advantageous for AHCA to capitalize on their best practices and suggestions from CMS to assist in increasing access to oral health care services for Florida's most vulnerable children.

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⟶ ***Expand implementation and mandate usage of an integrated electronic health record system statewide within Florida's Medicaid Program.*** An Electronic Health Record (EHR) is a digital record of a patient's health information that contains the patient's records from multiple providers and delivers a more comprehensive, long-term view of a patient's health as it typically includes their demographics, medical history, test results, prescribed medications, and history of present illness. If AHCA were to implement one single EHR throughout the state Medicaid program, it would allow for one digital record to follow patients throughout the multiple areas in which they receive care. In 2011, AHCA established a state Health Information Exchange (HIE), which serves as a hub for sharing of records between providers participating in local HIE entities via Encounter Notification Service (ENS), direct messaging, PROMPT, a care management tool, and "query" exchange, a health information exchange method that allows pro-

viders to search for patient's information across many clinical data sources locally, statewide or nationally (Florida HIE Services, n.d.). HIE is also responsible for administering the Medicaid Promoting Interoperability Program, a CMS program, to encourage eligible professionals and hospitals to foster the adoption of certified electronic health record technology (CEHRT) in exchange for incentive payments (AHCA, 2018b). An assessment of HIE landscape in Florida (2018) revealed that EHR adoption is widespread among facilities, community health centers and FQHCs that are eligible for Medicaid EHR Incentive program, however, HIE utilization is limited where only 51 percent of the outpatient and 60 percent of inpatient respondents had the capability to exchange patient information with providers outside their practice. Efficient record systems streamline and standardize care across the entire population based on best practices in all administrative and clinical areas. An integrated EHR system provides advantages in terms of continuity and quality of care, information sharing, avoiding duplication of services, and enhancing communication among providers. Examples of such integrated systems include Epic, eClinicalWorks, and NextGen; these systems allow providers to input clinical information, electronically prescribe medications, schedule appointments, billing, and provides patients with easy access to their own health care information.

⟶ ***Find ways to motivate oral health providers and reduce obstacles to increase participation in Medicaid.*** Dentist participation in Medicaid is an ongoing concern for Florida. Nationally, 43 percent of dentists participated in Medicaid or CHIP compared to 29.7 percent in Florida (ADA HPI, 2020). AHCA should consider contracting a subject matter expert to conduct a study on provider motivations for participating in Medicaid to increase engagement. Identifying participation predictors such a urbanicity, gender and race that have been shown to have an impact on dentist participation in Medicaid, would allow AHCA to target motivating factors for participation during provider outreach (Reynolds et al., 2019). In addition to identifying motivating factors, AHCA should consider way to reduce existing obstacles. In Florida, dentists cite numerous obstacles to treating Medicaid patients including "inadequate reimbursement" as the main reason followed by "too much paperwork" and "frequent changes in Florida Medicaid rules and policies." (Traul, 2020). State Medicaid agencies across US have undertaken a variety of successful approaches to reducing obstacles for participation to improve access to dental care for Medicaid-eligible children (Chazin, 2014). Virginia, in addition to Medicaid reimbursement increases, replaced multiple claim forms with a single form that mirrors commercial payers and eliminated preauthorization for basic restorative care, doubling the number of enrolled Medicaid providers and increasing the number of annual visits by Medicaid enrolled children. The Medicaid agency in Arizona charged its contracted plans to encourage centralized credentialing, reporting, etc. across plans for consistency. AHCA could model these approaches to incentivize dental providers to participate. Additionally, AHCA could partner with interested local health departments (HDs) in counties that have low provider participation and develop a pilot program with the primary goal of increasing provider participation and utilization of dental services as was done in Maryland's St. Mary's County Pilot Dental Program (astdd, 2013). The respective local HDs should lead the development and administration of the pilot to address their providers' previous reasons for not participating by including higher reimbursement rates, reduced administrative burden, facilitation of credentialing and contracting process with Florida Medicaid dental plan, etc. St. Mary's pilot was successful and now the program remains to be supported though the St. Mary's Health Department.

⟶ ***Establish a First Dental Home Initiative, modeled after Texas, to provide training to pediatric dentists about establishing a dental home for children who are at high caries risk.*** Dental caries (tooth decay) is one of the most common chronic health conditions among adults and children in the United States. In Florida, according to 2016-2017 Third Grade Oral Health Screening, nearly half of the children had dental caries. Among Head Start children ages 3-6 in 2017-2018 (FDOH, 2021a), 24 percent had untreated decay and 34.3 percent had caries, an increase of 15.4 percent and 6.9 percent respectively from 2014-2015. Providing children with access to routine dental care has the potential to prevent dental caries. The Texas First Dental Home (FDH), established in 2008, is a legislatively supported, Medicaid-based dental initiative, aimed at improving the oral health care of children from 6 to 35 months of age. The initiative initiates early preventative dental services, promotes oral health to parents and caregivers via communications and education, and trains licensed general and pediatric dentists to establish a dental home for children beginning at 6 months of age (Texas Health Steps, n.d.). The children are eligible for a maximum of 10 visits beginning at six months and the primary caregiver/parent must be present for the entirety of the visit. An evaluation study (Thompson, McCann & Schneiderman, 2017) of the initiative found that parents' knowledge and health practices for their children improved with FDH compared to non-FDH children, highlighting the importance of caregiver participation. FDH visits include caries risk assessment, dental prophylaxis, oral hygiene instructions with primary caregiver, fluoride varnish, anticipatory guidance, and establishment of a three-month recall schedule. Additionally, to encourage more providers to participate, Texas Medicaid simplified its billing for FDH visits by providing a bundled, enhanced reimbursement of $142.07 which includes dental procedures previously non-reimbursable for routine preventive services - oral hygiene instruction and nutritional counseling. Within the first year of implementation of FDH, 815 dentists completed training and 674 billed for dental services (CMS, 2010). According to National Academy for State and Health Policy (Thompson, 2021), the utilization of FDH services has increased with approximately 71 percent of children ages 6-35 months receiving at least one FDH visit in FY of 2019. Texas, similar to Florida, had its dental benefits carved-out to three dental maintenance organizations (DMOs) - DentaQuest, MCNA Dental and United-Healthcare Dental – who help manage the dental care needs of the Medicaid recipients, including participation in FDH, and are required to "implement a process to detect underutilization of FDH services; verify a provider's qualifications to submit claims for FDH services; and publish provider directories and note which are FDH providers." (V. Thompson, 2021). Given a similar environment, it is recommended that AHCA, in collaboration with its contracted dental plans – DentaQuest of Florida, MCNA Dental and Liberty Dental of Florida – establish a similar initiative in Florida to educate pediatric providers about establishing a first dental home, increase dental services utilization and thereby decreasing dental caries.

⟶ ***Create programs for integration of oral health services with primary care.*** The need for integration of medical and dental services has become increasingly apparent and governmental and professional bodies strongly support integration as a strategy to help reduce disparities in access to dental care. Community Health Centers have led the way in developing and adopting various models to achieve integration (Maxey, n.d.) - providing on site dental services, utilizing DHs as a liaison between primary and dental care, utilizing dental outreach coordinator to serve as a 'hub" for interprofessional collaboration, etc. Additionally, around the nation, states are using other forms of medical dental integration (MDI)

such as coordinating oral health services with primary care and training PCPs to provide dental services. In Arizona, managed care plans require primary care physicians (PCPs) to complete an oral evaluation beginning at 6 month of age and make a referral to a dentist, if needed. PCPs are also expected to assist in identifying noncompliant patients and report missed appointment to the health plans (McPherson, 2008). Alabama trains and reimburses PCPs to understand oral health screening guidelines, apply fluoride varnish, and refer children to a dental home by their first birthday (Chazin, 2014). More recently, the CDC Division of Oral Health has awarded funding to the National Association of Chronic Disease Directors (NACDD) to develop a national framework for MDI (CDC, 2020b). The goal of the partnership is to develop recommendations and strategies to form a national MDI framework for dental public health, clinical dentistry, and primary medical care settings. Similarly, with support from the DentaQuest Partnership for Oral Health Advancement and Quantum Foundation, FIHI has developed an MDI model that embeds DHs into pediatric primary care practices to increase preventive dental services to children, ages 6 months up to 6 years old. The model integrates three oral health services: 1) provision of fluoride varnish (FV) application; 2) oral health risk assessment and anticipatory guidance; and 3) warm hand-off referrals to establish a dental home for children. The model has been piloted in three pediatric practice sites. Within their project setting, medical assistant's (MA) have been responsible for setting up and administering the FV application (reimbursed at $22.68), and physicians for conducting the oral health risk assessments; the Registered Dental Hygienist (RDH) is responsible for providing guidance and support on these services and providing anticipatory guidance and warm hand-off dental referrals for families in need of a dental home. Variations in the type of personnel used, FTE allocation and utilization rates can be varied based on the practice needs. The FIHI MDI model is available upon request.

Florida Institute for Health Innovation

MDI model

embeds DHs into pediatric primary care practice. The model integrates three oral health services:

1) Provision of fluoride varnish (FV) application.
2) Oral health risk assessment and anticipatory guidance.
3) Warm hand-off referrals to establish a dental home for children.

III. SOCIAL SERVICE AND ORAL HEALTH AGENCIES

⟶ ***Mobilize a network of oral health consumer advocates to communicate barriers to and inequities in dental care to inform policy.*** Florida Voices for Health (FVH) and Catalyst Miami are two examples of organizations that work to mobilize a network of oral health consumer advocates to drive policy change. FVH has been facilitating a digital media campaign with its partners that aims to highlight the plight of many local families and their struggles to access necessary oral health care for their children. They have shared the stories of many families via their website and social media pages with the hope of engaging consumer advocates and guiding them on how to enact policy change. Catalyst led an Oral Health Leaders program that trained community members to advocate for improved oral health in their community. Both organizations have been successful in elevating patient experiences through the use of storytelling and PhotoVoice.

⟶ ***Community-based organizations should link clients to both dental homes and healthcare services.*** Community based organizations were a commonly cited support for individuals attempting to access and utilize oral health care services. Community-based and school-based organizations are well positioned to engage the local community and ultimately increase access to and utilization of oral health care services. Community organizations can ensure that dental information is integrated into their resources. They can additionally work directly with their partners (e.g. schools, boys and girls clubs, YMCA, WIC centers, etc.) to disseminate this information. They have a unique opportunity to engage a larger portion of local consumers and often have well-established relationships with the communities they serve.

⟶ ***Educate the public and elected officials about health outcomes and costs associated with oral health and emphasize the health risks associated with poor oral health, especially for emergency dental care.*** While there is general knowledge of the consequences of poor oral hygiene as it pertains to teeth and gums, the larger impact on the body is still not common knowledge. Officials and stakeholders alike would benefit from the knowledge that poor oral health can negatively impact every facet of the body, and ideally this knowledge would behoove stakeholders to push towards collective action. Critical to allocating adequate funding to support new models of care is the need to educate policy-makers about the financial benefits of community-based prevention and early intervention services. According to the National Conference of State Legislators (NCSL) (2018), social services and oral health agencies should identify and establish relationships with

Florida is

1 of 12 states

that has not adopted Medicaid expansion.

state legislators that have the greatest influence concerning oral health issues- contact them, meet with them and establish their respective organizations as dependable and knowledgeable sources of key oral health issues. Mobilize a coalition and network with stakeholders, foundations, organizations and individuals that have similar oral health goals and objectives, and advocate as a group. Prioritize the issues that are the most critical, frame messages for effective communications in awareness campaigns and resources for dissemination via multiple channels that include the state legislators and their staff, relevant foundations, media, state agencies, membership organizations, etc. The Florida Oral Health Alliance, Florida Voices for Health, OPEN Florida, Miami Dade Oral Health Network, etc. serve as excellent examples of organizations working to educate Florida policy-makers about oral health.

⟶ ***Advocate for Medicaid expansion in the state to increase the pool of eligible recipients.*** Since the passage of the Patient Protection and Affordable Care Act and subsequent 2012 Supreme Court ruling that made the expansion of Medicaid optional for states, 39 states (including Washington, D.C.) have opted into expansion (KFF, 2021). Despite a significant population of uninsured residents, Florida remains one of the few states that has not approved Medicaid expansion.

The Medicaid dental carve-out and the implementation of a statewide Prepaid Dental Health program (PDHP), which was completed in February 2019, intended to expand adult and pregnant dental benefits, increase the pool of eligible recipients, and allow previously uninsured to access necessary preventive dental services at little to no cost to them. As indicated in our Rapid Health Impact Assessment, it is unknow if the transition to PDHP has accomplished any of the intended outcomes. In the 2021 legislative session, Florida legislators introduced several Medicaid expansion bills including Medicaid expansion (SJR 276), Medicaid coverage for adult dental services (HB 1117/SB 1552), and Medicaid postpartum coverage (HB 645/ SB 238) which was the only bill to pass, expanding postpartum coverage from 60 days to the 365-day period. Since the pandemic, Florida unemployment rate more than doubled and over 750,000 people have signed up for Medicaid (FVH, 2021). Currently 4.5 million Floridians rely on Medicaid for health care and researchers estimate that over 1 million Floridians would have gained coverage under the expansion. However, yet again Florida lawmakers chose not to expand Medicaid leaving thousands of Floridians without health coverage. Social services, oral health agencies and other oral health stakeholders must continue to advocate for Medicaid expansion and advancement of oral health equity in Florida.

→ ***Consider partnering with local dental hygiene programs for workforce intervention models.*** Partnerships between academic institutions and social service or community organizations are innovative ways to improve health outcomes for particular communities while effectively utilizing available personnel and resources. In Illinois, the Dental Sealant Grant Program was a school-based sealant program that aimed to decrease the rate of dental caries in vulnerable children by increasing the rate of dental sealants; the unique aspect of this program was that it was fully staffed and managed by the Southern Illinois University in Carbondale's Dental Hygiene Program (Miller et al., 2005). In Maine, a partnership was formed between an Early Head Start Program and a dental hygiene program at a private university to implement a project that focused on infant oral care and early childhood caries (Beaulieu et al., 2000). This project was highly beneficial to both parties as it assisted the Early Head Start Program in meeting certain health goals in a cost-effective manner and provided the dental hygiene students with professional working knowledge on the issues of dental caries in very young children. Utilizing dental hygiene students as the primary workforce in certain partnerships is an effective tool to improve oral health outcomes in infant and school-age children by increasing access to oral health services, while simultaneously providing real-world experience to students and expanding their public health knowledge. A few of these primary stakeholders participate in Florida's oral health coalitions, but stronger efforts can be made to engage a higher quantity of specific partners and to forge partnerships and pilot programs between such entities.

→ ***Engage in community water fluoridation campaigns and advocacy work.*** Drinking fluoridated water reduces dental decay by 25 percent in children and adults and adding fluoride to water is one of the most cost-effective ways of preventing dental decay (FDOH, 2021b). Furthermore, cessation of community water fluoridation has been shown to significantly increase the number of caries-related procedures and treatment costs for Medicaid-eligible children and adolescents. It was also found that children of younger age underwent more dental caries procedures compared to the older children who benefited from fluoridated community water before its cessation (Meyer et al., 2018). Many dental, medical and public health organizations support community water fluoridation (CWF). In 2018, 77 percent of Floridians served by community water systems received fluoridated water. FDOH provides state funds and technical assistance through their Public Health Dental Program (PHDP) to help communities in their efforts to authorize fluoridation and start-up costs. On the local level, Oral Health Florida (OHF) is engaged in water fluoridation work through their Fluoridation Action Team, which collaborates with local communities to support access to community water fluoridation. Other state organizations located in areas (counties of Charlotte, Clay, Columbia, Dixie, Flagler, etc.) where the water is not fluoridated should consider engaging their local stakeholder networks to consider campaign work for fluoridation in their own communities. The Campaign for Dental Health (n.d.), a program of the American Academy of Pediatrics, works to ensure that people of all ages have access to community water fluoridation by sharing facts about oral health and preventive strategies. The campaign provides oral health and water fluoridation infographics, videos and resources that local organizations can use for advocacy efforts.

77%

of Floridians served by community water systems received fluoridated water.

Additionally, state organizations and oral health agencies can consider implementing a community diagnosis process, which was proven successful in Tennessee in implementing community water fluoridation by collecting local, community-level data on children's oral health, utilizing that data to identify communities with dissimilar oral health needs and resources, and effectively presenting the data to stakeholders responsible for determining and prioritizing the health needs in their communities (Brumley et al., 2001). Furthermore, these organizations may consider developing a state-based community water fluoridation plan, similar to the 2013-2018 plan developed by the South Carolina Division of Oral Health to strategically outline goals and objectives and utilize a framework to monitor implementation and progress (South Carolina DHEC, n.d.). As community water fluoridation has been found to offer significant cost savings, it is in the best interest of state and local organizations to advocate for this if their communities do not currently have access to fluoridated water (Griffin et al., 2001).

→ ***Conduct continuous public health economic evaluations and analysis at community and state levels to demonstrate cost-savings and inform policy decisions.*** A very small percentage of U.S. healthcare spending is dedicated to public health prevention. Public health professionals must address population health needs with increasingly low funds and it is critical that public health practitioners use economic evaluation to provide insight into the value of public health interventions, demonstrate cost-savings and inform policy decisions. Economic evaluation data can provide important evidence of the scalability and sustainability of a particular public health programs/ intervention and can help community and state leaders make decisions about investment and implementation. Evidence shows that both local and national public health interventions are substantially cost-saving and offer a considerable return on investment (ROI) (Masters et al., 2017), however, research also shows that there is a paucity of high-quality economic evaluation specifically in the field of child oral health (Rogers et al., 2019). Although, economic analysis does not provide a complete picture of the value; it does provide the decision-makers with a metric that can facilitate further discussion about efficient resource allocation. Common economic evaluations include

cost-benefit, cost-effectiveness, cost-utility and ROI analyses. Community and state oral health agencies and organizations need to invest in economic evaluation particularly around online oral health education and resources and make this information readily available for evidence-based decision making.

IV. BEST PRACTICES FOR REPLICATION STATEWIDE

→ ***Expand the usage of medical/dental vans as a means of removing barriers to access.*** Federally Qualified Health Centers have worked to address the oral health needs of consumers by providing safety net services such as mobile units to increase access to affordable, quality health care for Florida's most vulnerable individuals and families. According to the Florida Association of Community Health Centers (FACHC) (2018), vans not only offer convenience, but also can be less intimidating for consumers who may be fearful of formal institutions and can help address transportation and proximity issues highlighted in the research. In 2017, 87 percent of those served by dental vans in Florida were children but only 13 (11 dental and 4 medical and dental units) of 44 vans had the capacity to offer dental services. As of June 2020, there are 53 Florida health mobile units. Of those, 17 are dental alone, 6 are hybrid (medical and dental services), 2 are dental with limited medical services and 1 is dental, hearing, and optical (FACHC, 2020). A list of Florida health centers with mobile units by type can be found in Appendix M. By increasing the number of mobile units equipped to offer dental services, a larger number of Florida Health Centers can offer services in nearby schools and communities to assist children and families and aid in lessening barriers to access.

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(11 dental and 4 medical and dental units)

vans had the capacity to offer dental services

→ ***Implement a Virtual Dental Home model in conjunction with tele-dentistry.*** The Virtual Dental Home (VDH) model is a community-based oral health delivery system where individuals can receive diagnostic, preventive, and early intervention services in addition to referrals if advanced care is required. This model is equipped to serve a wide population, and has shown successful outcomes in sites throughout California (Glassman et al., 2012). These services are delivered in a community setting where the patients receive education, social and health services, significantly reducing the need to travel to receive dental care. The model utilizes telehealth technology and Electronic Health Records (EHR) to connect dental hygienists and expanded-function dental assistants within the community with dentists stationed in dental offices, thereby facilitating access to the full dental team for care. The settings for care include schools, Head Start sites, community centers and nursing homes (Glassman et al., 2012). Implementing a VDH in conjunction with tele-dentistry in a Florida school setting would provide an opportunity to treat children on the site. As previously underscored, oral health issues are among the leading causes of chronic school absenteeism in young children (Attendance Works, 2015a).; school-based tele-dentistry programs, such as this one, have the opportunity to significantly impact students' academic success. In 2019, the members of the House Health Quality Subcommittee approved the telehealth bill (HB23) to kick-start telehealth in Florida. AHCA should consider partnering with both the Telehealth Advisory Council, as well as federal-, state-, and/or community-level organizations to pilot a similar model within the school setting, before replicating it statewide to improve oral health practices within the state of Florida.

→ ***Conduct and promote interactive oral health education programs designed for and by Spanish/Haitian speaking families and led by designated community health educators.*** As has been discussed, specific communities are struggling to find culturally competent and language-specific oral health care providers in their area, which can lead to a lack of communication and distrust between patients and providers. Nationally, interactive oral health education programs that are led by lay community health educators in underserved and culturally diverse communities have been found to increase caregiver's oral health knowledge and self-reported behaviors (Hoeft et al., 2016; Ponce-Gonzalez et al., 2019). Community health educators are better able to communicate with members of their own communities, assisting with the translation of specific oral health terms and practices in a way that resonates with their participants. These educational programs can be developed in partnership with an array of stakeholders, from grassroots and community-level organizations and state oral health agencies, to improve patient engagement with oral health practices and knowledge.

→ ***Invest in case management and care facilitation to encourage partnerships between medical and dental homes.*** The Kids Get Care program in Seattle, Washington is a public-health department sponsored program that connects children with necessary medical, dental, developmental and mental health services using a case management model leveraging community education and outreach, and the integration of dental and medical services, and case management. Case management models have been found to increase access to preventive services for children who may be underutilizing preventive medical and dental services. By providing case managers and patient navigators to support families, these programs can link them to necessary services. With the Kids Get Care program, cross-training was provided to primary care providers leading to a substantial increase in children being screened for oral health issues and receiving preventive fluoride varnish applications (Wysen et al., 2004). In a simulation model comparing the cost of fluoride varnish to Medicaid children, the program was found to achieve cost savings of $300,000 compared to regular practice. Likewise in South Carolina, the 'More Smiling Faces' program utilized patient navigators in a case management model to increase Medicaid patients' attendance at scheduled appointments by reminding them of upcoming appointments, following up with those who missed appointments, and helping families to remove access barriers related to transportation, child-care, etc. (Missouri Foundation for Health, 2008). Statewide investments in case management models would be widely beneficial for Medicaid-eligible children in Florida, and stakeholders should consider public-private partnerships to provide these

comprehensive preventive services to improve access to oral health services for children.

⟶ ***Provide oral health education and treatment to expectant mothers in high-risk populations.*** It is known that dental caries are infectious and can be transmitted between mother and child. Furthermore, the presence of periodontal disease in expectant mothers has been found to be associated with adverse birth outcomes (Larsen et al., 2016). A mother's knowledge of her own health and subsequent actions could have a significant impact on the health of the child. The Prenatal Care Assistance Program (PCAP) at Brookdale Hospital and Medical Center Department of Dental Medicine and Oral Maxillofacial Surgery in Brooklyn, NY provides oral health education, counseling and treatment to expectant mothers from minority, low socio-economic status, impoverished, or high-risk populations. The program "employs obstetricians, nurses, social workers, a nutritionist, oral and maxillofacial surgeons, general dentists, pediatric dentists" and support staff to provide comprehensive obstetric and prenatal care (Larsen et al., 2016). All expectant mothers visiting an obstetrician/gynecologist are referred for a dental consultation. The children of mothers that partook in PCAP, had fewer and less severe dental caries, and fewer extractions. Through collaborative work among healthcare professionals, this program promotes general health of the mother and reduces the risk of caries of their children. Programs, such as this one, should be developed and expanded to educate and provide treatment for expectant mothers in high-risk populations to promote and improve oral health status of their children.

⟶ ***Expand the dental hygienist scope of work to provide oral health services and referrals.*** As noted above in the recommendations section for AHCA, Florida would benefit from expanding the scope of practice for Dental Hygienists as it is not yet a 'favorable' or an 'excellent' place to practice in terms of regulations and their ability to provide direct preventive and educational services (Langelier, Baker & Continelli, 2016). Kansas is an excellent example of a state that changed its supervision requirements allowing DHs to expand their scope of practice to address the disparities in access to care. In 2003, Kansas expanded its regulations to allow DHs to provide services in public health settings by introducing an Extended Care Permit (ECP) program which has three levels. Under ECP-I permit, DHs with experience are permitted to provide preventive care and diagnostic services in certain community-based sites with sponsorship from a dentist instead of direct supervision (Langelier, Baker & Continelli, 2016). This legislative change in addition to the "hub and spoke" model of service delivery, provided an opportunity for programs such as Smiles for Miles to provide care to children that lack access. (Simmer-Beck et al., 2011). The program demonstrated significantly reduced rates of decay, increase in restorations and decreased urgency of dental restorative needs (Summer-Beck et al., 2015). Currently Kansas has three levels of ECP program where ECP-II allows DHs with more hours of experience to serve complex patients and ECP-III permits trained DHs to provide temporary restorations, perform denture adjustments, simple extractions, and administer local anesthetics (Langelier, Baker & Continelli, 2016). Expanding DH scope of practice may be an effective way to deliver dental care to underserved populations and improve oral health status of Florida children.

⟶ ***Pilot Dental Care Coordinator interventions.*** In fiscal year of 2019, only 35.5 percent of Medicaid/CHIP-eligible Florida children ages 0 to 20 received any preventative dental services (CMS, 2019). Furthermore, as the Consumer Engagement research shows, there are structural barriers related to cost, administration, communication, distance, and accessibility that prevent Medicaid-eligible families from accessing and utilizing dental services. In 2006, ADA (n.d.), launched the Community Dental Health Coordinator (CDHC) Program to provide oral health education, patient navigation, and care coordination to connect patients with dentists. CDHCs are community health workers, typically dental assistants or hygienists, that practice under the supervision of a dentist. CDHCs often grow up in communities in which they work, which gives them cultural insight to identify the barriers specific to their communities as well as provide tailored solutions to overcome those barriers (ADA, n.d.). Research shows that care coordination interventions have been found to reduce personal and structural barriers and increase dental care utilization in Medicaid-insured children (Binkley et a., 2010). According to Florida Dental Association, Florida's 2020 updated Action for Dental Health includes a strategy to establish CDHC education programs and incorporate CDHCs into the dental teams (fda, 2020). The Dental Care Coordinator intervention is an evidence-based model that should be implemented statewide.

References

Agency for Health Care Administration (AHCA). (n.d.). Florida Medicaid Dental. Retrieved on February 13, from http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Quality/clinical_quality_initiatives/oral_health/index.shtml

Agency for Health Care Administration (AHCA). (2015, July). Medicaid Eligible Reports. Retrieved from https://ahca.myflorida.com/medicaid/Finance/data_analytics/eligibles_report/index.shtml

Agency for Health Care Administration (AHCA). (2018a, April 24). AHCA Announces the Award of New Contracts for the Statewide Medicaid Managed Care Program. https://ahca.myflorida.com/Executive/Communications/Press_Releases/pdf/PressReleaseSMMCReprocurement4242018.pdf

Agency for Healthcare Administration (AHCA). (2018b, September 2). As Is Assessment Health Information Exchange (HIE) Study. http://www.fhin.net/floridaHie/docs/HIEStudyAsIs_Assessment.pdf

Agency for Health Care Administration (AHCA). (2018c, October). Statewide Medicaid Managed Care Changes Impacting People in IBudget Waiver. https://www.apd.myflorida.com/providers/docs/Statewide%20Medicaid%20Dental%20Plan%20Powerpoint.pdf

Agency of Health Care Administration (AHCA). (2018d, October). Statewide Medicaid Managed Care Dental Program Overview. https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Dental_Overview_Final_121918.pdf

Agency for Health Care Administration (AHCA). (2020a). Florida Medicaid Managed Medical Assistance Waiver Combined Q3 and Annual Report. https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/MMA_DY14_Annual_Report_CMS20201030.pdf

Agency for Health Care Administration (AHCA). (2020b). Performance Measure Data Submission for Medicaid. Retrieved on February 13, from https://ahca.myflorida.com/medicaid/quality_mc/submission.shtml

American Academy of Pediatric Dentistry (AAPD). (2020). Use of Protective Stabilization for Pediatric Dental Patients. The Reference Manuel for Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 311-7.

American Academy of Pediatric News. (2016, September 6). Fluoride Varnish Application by Pediatricians Should be Paid with No Cost-Sharing. Retrieved on March 20, 2021 from http://www.aappublications.org/news/2016/09/06/PPAAC090616

American Academy of Pediatrics (AAP). (2014). Maintaining and improving the oral health of young children. Pediatrics, 134(6), 1224-1229. doi:10.1542/peds.2014-2984

American Academy of Pediatric Dentistry (AAPD). (n.d.). Frequently Asked Questions (FAQ). Retrieved on February 13, from https://www.aapd.org/resources/parent/faq/

American Dental Association (ADA). (n.d.). Solutions: About CDHC. Retrieved on February 22, 2021, from https://www.ada.org/en/public-programs/action-for-dental-health/community-dental-health-coordinators?utm_source=vox&utm_medium=page-link&utm_content=new-dental-care-model-1

American Dental Association Council on Scientific Affairs. (2006, August). Professionally applied topical fluoride Evidence-based clinical recommendations. http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/report_fluoride.ashx

American Dental Association (ADA). (2015, June 28). From the Emergency Room to the Dental Chair - Action for Dental Health. https://www.ada.org/en/public-programs/action-for-dental-health/er-referral

American Dental Association (ADA) Health Policy Institute (HPI). (2020). Dentist Participation in Medicaid or CHIP. [Fact sheet]. Retrieved on May 5, 2021 from https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIGraphic_0820_1.pdf?la=en

American Dental Association (ADA) Health Policy Institute (HPI). (2021). Workforce. Retrieved on April 13, 2021 from https://www.ada.org/en/science-research/health-policy-institute/dental-statistics/workforce

American Diabetes Association. (n.d.). Diabetes and Oral Health. Retrieved on February 13, from https://www.diabetes.org/diabetes/complications/keeping-your-mouth-healthy

Attendance Works. (2015a, September 1). Mapping the Early Attendance Gap: Charting a Course for Student Success. https://www.attendanceworks.org/wp-content/uploads/2017/05/Mapping-the-Early-Attendance-Gap_Final-4.pdf

Attendance Works. (2015b, September 6). Bringing Dental Care to Schools. https://www.attendanceworks.org/bringing-dental-care-to-schools/

Aunt Bertha. (2020, December 17). Retrieved March 29, 2021, from https://company.auntbertha.com/

Beaulieu, E., Dufour, L. A., & Beaudet, R. (2000). Better oral health for infants and toddlers: a community based program. Journal of dental hygiene : JDH, 74(2), 131–134.

Beck, J. D., Eke, P., Heiss, G., Madianos, P., Couper, D., Lin, D... & Offenbacher, S. (2005). Periodontal Disease and Coronary Heart Disease. Circulation, 112(1), 19–24. https://doi.org/10.1161/CIRCULATIONAHA.104.511998

Bernstein, J., Gebel, C., Vargas, C., Geltman, P., Walter, A., Garcia, R. I., & Tinanoff, N. (2016). Integration of Oral Health Into the Well-Child Visit at Federally Qualified Health Centers: Study of 6 Clinics, August 2014-March 2015. Preventing chronic disease, 13, E58. https://doi.org/10.5888/pcd13.160066

Binkley, C. J., Garrett, B., & Johnson, K. W. (2010). Increasing dental care utilization by Medicaid-eligible children: a dental care coordinator intervention. Journal of public health dentistry, 70(1), 76–84. https://doi.org/10.1111/j.1752-7325.2009.00146.x

Brishke, J., Haviaras, J., Imran, F., Masood, A., & Shenkman, E. (2020, December 4). The Florida KidCare Program Evaluation: Calendar Year 2019. https://ahca.myflorida.com/Medicaid/recent_presentations/2020/CY2019_KidCareReport_FINAL_122820.pdf

Brumley, D. E., Hawks, R. W., Gillcrist, J. A., Blackford, J. U., & Wells, W. W. (2001). Successful implementation of community water fluoridation via the community diagnosis process. Journal of public health dentistry, 61(1), 28–33. https://doi.org/10.1111/j.1752-7325.2001.tb03352.x

Bui, A. L., Dieleman, J. L., Hamavid, H., Birger, M.,

Chapin, A., Duber, H. C., … Murray, C. J. L. (2017). Spending on Children's Personal Health Care in the United States, 1996-2013. JAMA Pediatrics, 171(2), 181–189. https://doi.org/10.1001/jamapediatrics.2016.4086

Calculator.net (n.d.). Sample Size Calculator. Retrieved on April 12, 2021 from https://www.calculator.net/sample-size-calculator.html?type=1&cl=95&ci=5&pp=50&ps=2773238&x=75&y=13

Campaign for Dental Health. (n.d.). Retrieved on April 13, 2021 from https://ilikemyteeth.org/share/

CareQuest Institute for Oral Health, Inc. (2020, February). Healthy Mouths: Why they matter for adults and state budgets. Boston, MA. DOI:10.35565/CQI.2020.1001

Catalanotto, F. A. (2021, January 21). The Case for Dental Therapy in Florida. [Unpublished]. Department of Community Dentistry and Behavioral Sciences, University of Florida College of Dentistry.

Centers for Disease Control and Prevention (CDC). (1999, October 22). Achievements in Public Health, 1900-1999: Fluoridation of Drinking Water to Prevent Dental Caries. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4841a1.htm

Centers for Disease Control and Prevention (CDC). (2016, September 22). Hygiene-Related Disease: Dental Caries (Tooth Decay). Retrieved on March 31, 2021, from https://www.cdc.gov/healthywater/hygiene/disease/dental_caries.html

Centers for Disease Control and Prevention (CDC). (2020a, December 23). Healthy People 2030: Oral Health Objectives. Retrieved on March 31, 2021, from https://www.cdc.gov/oralhealth/about/healthy-people.html

Centers for Disease Control and Prevention (CDC). (2020b, October 15). CDC Announces Medical – Dental Integration Partnership. Retrieved on March 12, 2021, from https://www.cdc.gov/oralhealth/about/md-integration.html

Centers for Disease Control and Prevention (CDC). (2020c, September 8). Community Water Fluoridation. Retrieved on March 31, 2021, from https://www.cdc.gov/fluoridation/index.html

Centers for Disease Control and Prevention (CDC). (2021a, March 12). Participating PRAMS States. Retrieved March 26, 2021, from https://www.cdc.gov/prams/states.htm

Centers for Disease Control and Prevention (CDC). (2021b, January 27). Data to Action Success Story: Maryland. Retrieved March 16, 2021, from https://www.cdc.gov/prams/state-success-stories/Maryland.html

Centers for Disease Control and Prevention (CDC). (2021c, January 27). Data to Action Success Story: New York. Retrieved March 16, 2021, from https://www.cdc.gov/prams/state-success-stories/New-York.html

Centers for Disease Control and Prevention (CDC). (2021d, February 5). Heart Disease Mortality by State. Retrieved on February 13, from https://www.cdc.gov/nchs/pressroom/sosmap/heart_disease_mortality/heart_disease.htm

Centers for Disease Control and Prevention (CDC). (2021e, January 13). Division of Oral Health at a Glance. Retrieved on March 31, 2021, from https://www.cdc.gov/chronicdisease/resources/publications/aag/oral-health.htm

Centers for Medicare & Medicaid Services (CMS). (n.d). Florida Medicaid. https://www.benefits.gov/benefit/1625

Centers for Medicaid and Medicare Services (CMS) | Medicaid.gov. (2004, October). Guide to Children's Dental Care in Medicaid. https://www.medicaid.gov/sites/default/files/2019-12/child-dental-guide.pdf

Centers for Medicaid & Medicare Services (CMS). (2010, October). State of Texas Medicaid Dental Review. https://www.mchoralhealth.org/PDFs/CMSReview_TX.pdf

Centers for Medicaid and Medicare Services (CMS). (2016). Unduplicated Number of Children Ever Enrolled. https://www.medicaid.gov/sites/default/files/2019-12/fy-2016-childrens-enrollment-report.pdf

Centers for Medicaid and Medicare Services (CMS). (2019). Early and Periodic Screening, Diagnostic, and Treatment. Annual Reporting Data Files. Retrieved on April 7, 2021 from https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

Chazin, S. (2014, October). Medicaid Contracting Strategies to Improve Children's Oral Health Care Access. Centers for Health Care Strategies, Inc. https://www.chcs.org/media/Medicaid-Contracting-Strategies-to-Improve-Childrens-Oral-Health-Access.pdf

Chi, D. L., Lenaker, D., Mancl, L., Dunbar, M., & Babb, M. (2018). Dental therapists linked to improved dental outcomes for Alaska Native communities in the Yukon-Kuskokwim Delta. Journal of public health dentistry, 78(2), 175–182. https://doi.org/10.1111/jphd.12263

Chi, D. L., Hopkins, S., Zahlis, E., Randall, C. L., Senturia, K., Orr, E., Mancl, L., & Lenaker, D. (2019). Provider and community perspectives of dental therapists in Alaska's Yukon-Kuskokwim Delta: A qualitative programme evaluation. Community dentistry and oral epidemiology, 47(6), 502–512. https://doi.org/10.1111/cdoe.12492

Chisholm-Burns, M. A., Spivey, C. A., Stallworth, S., & Zivin, J. G. (2019). Analysis of Educational Debt and Income Among Pharmacists and Other Health Professionals. American journal of pharmaceutical education, 83(9), 7460. https://doi.org/10.5688/ajpe7460

Clark, M. (2016). Part 7: In Texas' about-face, an example for Florida. Retrieved from http://medicaid.heraldtribune.com/part-7-in-texas-about-face-an-example-for-florida/

CloudResearch. (2020, May 8). Determining Sample Size: How Many Survey Participants Do You Need? Retrieved on April 27, 2021 from https://www.cloudresearch.com/resources/guides/statistical-significance/determine-sample-size/

Committee on Children, Families and Elder Affairs. (2019). Bill Analysis and Fiscal Impact Statement. The Florida Senate. https://www.flsenate.gov/Session/Bill/2019/684/Analyses/2019s00684.pre.cf.PDF

Cross-Call, J. (2021, February 25). House Bill Gives States Incentive to Quickly Expand Medicaid, Cover Millions of Uninsured. Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/house-bill-gives-states-incentive-to-quickly-expand-medicaid-cover-millions-of

DentaQuest Partnership for Oral Health Advancement. (2020, October). Florida Medicaid Dental Program: Enrollee Handbook. Retrieved on April 18, 2021 from https://dentaquest.com/getattachment/State-Plans/Regions/Florida/Member-Page/Member-Documents/florida-med-

icaid-handbook-en.pdf/?lang=en-US

Delta Dental. (n.d.). The connection between oral and mental health. Retrieved on February 2, 2021, from https://www.deltadental.com/grinmag/us/en/ddpa/2017/wellness/oral-and-mental-health-connection.html

Delta Dental. (2021). Cost Matters. Retrieved on February 13, from https://www.deltadental.com/us/en/cost-estimator.html

Executive Office of the Governor. (2020, June 29). Governor Ron DeSantis Signs the Fiscal Year 2020-2021 Budget. https://www.flgov.com/2020/06/29/governor-ron-desantis-signs-the-fiscal-year-2020-2021-budget/

Executive Office of the Governor. (2021, January 28). Governor Ron DeSantis Announces His "Florida Leads" Budget Proposal for FY 2021-2022. https://www.flgov.com/2021/01/28/governor-ron-desantis-announces-his-florida-leads-budget-proposal-for-fy-2021-2022/

Florida Association of Community Health Centers. (2018, October). Mobile Health Units at Florida Community Health Centers: Services, Encounters, Patients. 2017. Retrieved on March 13, 2021, from https://drive.google.com/file/d/13WyFosNWyBZoFfWcP4FZN2T1pVVSR1Zt/view

Florida Association of Community Health Centers. (2020, June). 2020 Directory of Florida Community Health Center Mobile Health Units. 2https://www.fachc.org/assets/FACHC%202020%20Florida%20Mobile%20Health%20Program%20Directory.pdf

Florida Chamber of Commerce. (2020). 2020 Legislative Session Summary. https://www.flchamber.com/advocacy/2020-legislative-session-summary/

Florida dental association (fda). (2020). Florida's Action for Dental Health Comprehensive Report. Retrieved on February 23, 2021, from https://dentalhealthfl.org/#verticalTab4

Florida Department of Health (FDOH). (2019). Prenatal Oral Health Care Trends, Florida, 2009-2015. http://www.floridahealth.gov/programs-and-services/community-health/dental-health/reports/_documents/PRAMSOralHealthCareDataReportFINALVersion8.30.2019.pdf

Florida Department of Health (FDOH). (2021a, January). Oral Health Status of Florida's Head Start Children, 2017-2018. http://www.floridahealth.gov/programs-and-services/community-health/dental-health/reports/_documents/HeadStart2017-2018DataBrief_FINAL.pdf

Florida Department of Health (FDOH). (2021b, March 10). Community Water Fluoridation. Accessed on April 12, 2021 from http://www.floridahealth.gov/programs-and-services/community-health/dental-health/fluoridation/index.html

Florida Department of Health (FDOH), Florida CHARTS. (2021). Total Licensed Florida Dentists. Retrieved on April 13, 2021 from http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0326

Florida HIE Services. (n.d.) Retrieved March 16, 2021, from https://www.florida-hie.net

Florida House of Representatives. (2019). House of Representatives Staff Analysis: Final Bill Analysis. https://www.flsenate.gov/Session/Bill/2019/843/Analyses/h0843z1.HMR.PDF

Florida Pediatric Society v. Dudek. Settlement Agreement. | Civil Rights Litigation Clearinghouse. (Southern District of FL June 17, 2016). https://www.clearinghouse.net/chDocs/public/PB-FL-0017-0016.pdf

Florida Policy Institute. (2019, June). Potential Budget Savings and Revenue Gains From Medicaid Expansion in Florida. https://uploads-ssl.webflow.com/5cd5801dfdf7e5927800fb7f/5d63fe75e29367e53dfbe8fa_RT_Medicaid_Expansion_Savings_NEW.pdf

Florida TaxWatch. (2020, March 19). 2020 Florida Legislative Session Wrap-Up. Retrieved in March 20, 2021 from https://floridataxwatch.org/Research/Full-Library/ArtMID/34407/ArticleID/18851/2020-Florida-Legislative-Session-Wrap-Up

Florida Voices for Health (FVH). (2021). Medical Expansion in the 2021 Legislative Session. Retrieved on March 13, 2021, from https://www.healthyfla.org/single-post/medicaid-expansion-in-the-2021-florida-legislative-session

Floridians for Dental Access. (n.d.). By the Numbers. Retrieved on April 25, 2021 from https://www.floridiansfordentalaccess.com/bythenumbers

Glassman, P., Harrington, M., Mertz, E., & Namakian, M. (2012). The Virtual Dental Home: Implications for Policy and Strategy. Journal of the California Dental Association, (40)7, 605-611.

Government Accountability Office (GAO). (2008, September). Medicaid: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay. https://www.gao.gov/assets/gao-08-1121.pdf

Government Accountability Office (GAO). (2013, September). Dental Services: Information on Coverage, Payments, and Fee Variation. Retrieved on March 20, 2021 from https://www.gao.gov/products/gao-13-754

Griffin, S. O., Jones, K., & Tomar, S. L. (2001). An economic evaluation of community water fluoridation. Journal of public health dentistry, 61(2), 78–86. https://doi.org/10.1111/j.1752-7325.2001.tb03370.x

Griffin, S.O., Wei, L., Gooch, B.F., Weno, K., & Espinoza, L. (2016). Vital Signs: Dental Sealant Use and Untreated Tooth Decay Among U.S. School-Aged Children. MMWR. Morbidity and Mortality Weekly Report, 65, 1141-1145. https://doi.org/10.15585/mmwr.mm6541e1

Health Resources & Services Administration (HRSA). (n.d.). Postdoctoral Training in General, Pediatric, and Public Health Dentistry. Retrieved March 16, 2021, from https://www.hrsa.gov/grants/find-funding/hrsa-20-005

Hoeft, K. S., Barker, J. C., Shiboski, S., Pantoja-Guzman, E., & Hiatt, R. A. (2016). Effectiveness evaluation of Contra Caries Oral Health Education Program for improving Spanish-speaking parents' preventive oral health knowledge and behaviors for their young children. Community dentistry and oral epidemiology, 44(6), 564–576. https://doi.org/10.1111/cdoe.12250

Holicky, A. (2016, August). Florida's Burden of Oral Disease Surveillance Report. Florida Department of Health. https://www.astdd.org/www/docs/fl-burden-of-disease-document-08-17-16.pdf

Holland, M., Kottek, A., Mertz, M., & Mertz, E. (2020, November 25). Expanding Dental Therapy Education Programs. Dimensions of Dental Hygiene. Retrieved on March 21, 20201 from https://dimensionsofdentalhygiene.com/expanding-dental-therapy-education-programs/

Horowitz, A. M., & Kleinman, D. V. (2012). Oral health literacy: a pathway to reducing oral health disparities in Maryland. Journal of public health dentistry, 72 Suppl 1, S26–S30. https://doi.org/10.1111/j.1752-7325.2012.00316.x

Institute of Medicine. (2003). Priority Areas for National Action: Transforming Health Care Quality. Washington, DC: The National Academies Press. https://doi.org/10.17226/10593.

Jaffe, D., & Torrey, E. (2017, December 12). Funds for Mental Illness: Is Your State Generous or Stingy? https://mentalillnesspolicy.org/wp-content/uploads/Funds4TreatingMentalIllnessFinal.pdf

Kaiser Family Foundation (KFF). (October, 2019). Medicaid in Florida Fact Sheet. Retrieved on March 20, 2021 from http://files.kff.org/attachment/fact-sheet-medicaid-state-FL

Kaiser Family Foundation (KFF). (2020). State Reporting Provider Rate Increases. Retrieved on April 24, 2021 from https://www.kff.org/medicaid/state-indicator/states-reporting-provider-rate-increases/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22florida%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Provider%20Rate%20Increases__Dentist%20Rate%20Increases%22,%22sort%22:%22asc%22%7D

Kaiser Family Foundation (KFF). (March 31, 2021). Status of State Medicaid Expansion Decisions: Interactive Map. Retrieved on April 7, 2021 from https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

Lamster, I. B., Lalla, E., Borgnakke, W. S., & Taylor, G. W. (2008). The relationship between oral health and diabetes mellitus. Journal of the American Dental Association (1939), 139 Suppl, 19S-24S. https://www.ncbi.nlm.nih.gov/pubmed/18809650

Langelier, M., Baker, B., & Continelli, T. (2016, November). Development of a New Dental Hygiene Professional Practice Index by State, 2016. Oral Health Workforce Research Center, Center for Health Workforce Studies, School of Public Health, SUNY Albany. http://www.oralhealthworkforce.org/wp-content/uploads/2018/02/OHWRC_Dental_Hygiene_Scope_of_Practice_2016.pdf

Langelier, M., Baker, B., Continelli, T., & Moore, J. (2016, March). A Dental Hygiene Professional Practice Index by State, 2014. Oral Health Workforce Research Center, Center for Health Workforce Studies, School of Public Health, SUNY Albany. http://www.chwsny.org/wp-content/uploads/2016/03/DH_Professional_Practice_Index_By_State_2014.pdf

Langelier. M., Surdu, S., & Moore. J. (2020, August). The Contributions of Dental Therapists and Advanced Dental Therapists in the Dental Centers of Apple Tree Dental in Minnesota. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany. https://www.chwsny.org/wp-content/uploads/2020/09/CHWS_Contributions_of_DTs_ADTs_at_Apple_Tree_Dental_2020.pdf

Larsen, C. D., Larsen, M. D., Ambrose, T., Degano, R., Gallo, L., & Cardo, V. A., Jr (2016). Efficacy of a Prenatal Oral Health Program Follow-up with Mothers and their Children. The New York state dental journal, 82(3), 15–20.

Lynch, A. (2020, November 25). Update on Dental Therapy in the United States. Dimensions of Dental Hygiene. Retrieved on March 20, 2021 from https://dimensionsofdentalhygiene.com/update-dental-therapy-united-states/

Marinho, V. C. C., Worthington, H. V., Walsh, T., & Clarkson, J. E. (2013). Fluoride varnishes for preventing dental caries in children and adolescents. The Cochrane Database of Systematic Reviews, (7), CD002279. https://doi.org/10.1002/14651858.CD002279.pub2

Masters, R., Anwar, E., Collins, B., Cookson, R., & Capewell, S. (2017). Return on investment of public health interventions: a systematic review. Journal of Epidemiology and Community Health, 71(8), 827-834. doi:10.1136/jech-2016-208141

Mayo Clinic. (2019, June 4). Oral health: A window to your overall health. Retrieved on February 27, 2021, from https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475

Maxey, H. (n.d.). Integration of Oral Health with Primary Care in Health Centers: Profiles of Five Innovative Models. National Association of Community Health Centers. https://www.nachc.org/wp-content/uploads/2015/06/Integration-of-Oral-Health-with-Primary-Care-in-Health-Centers.pdf

McPherson, K. (2008). State Strategies to Improve Dental Compliance in Missouri's Medicaid Population. Missouri Foundation for Health. https://www.ada.org/~/media/ADA/Public%20Programs/Files/StateLeg_State_Strategies_to_Improve_Dental_Compliance_in_MO_Medicaid_population.PDF?la=en

Michigan Department of Health & Human Services (MDHHS). (n.d.). Healthy Kids Dental. Retrieved on March 16, 2021, from https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_4845_77918---,.html

Milgrom, P. M., & Cunha-Cruz, J. (2017). Are Tooth Decay Prevention Visits in Primary Care Before Age 2 Years Effective? JAMA Pediatrics, 171(4), 321–322. https://doi.org/10.1001/jamapediatrics.2016.4982

Miller, D. (2019, June 26). Dental Student Loan Repayment Program Signed into Law. WUSF Public Media. Retrieved on February 19, 2021 from https://wusfnews.wusf.usf.edu/health-news-florida/2019-06-26/dental-student-loan-repayment-program-signed-into-law

Miller F. Y. (2005). The utilization of dental hygiene students in school-based dental sealant programs. Journal of dental hygiene : JDH, 79(4), 11.

Morgan, I. (2021). For families trying to make end meet, Florida moms and babies will get an extension for Medicaid health care. Florida Phenix: Quality Journalism for Critical Times. Retrieved on May 3, 2021 from https://www.floridaphoenix.com/2021/04/28/for-families-trying-to-make-ends-meet-fl-moms-and-babies-will-get-an-extension-for-medicaid-health-care/

National Association of Community Health Centers. (2019). Florida Health Center Fact Sheet. Retrieved on March 31, 2021 from https://www.nachc.org/wp-content/uploads/2019/02/Florida_21-2.pdf

National Association for Dental Plans (NADP). (n.d.). Industry Overview. Retrieved on February 23, 2021, from https://www.whydental.org/about/industry-overview#five

National Conference of State Legislators. (2018, March). State Legislators: Who They Are and How to Work With Them: A Guide for Oral Health Professionals. Retrieved on March 12, 2021, from https://www.ncsl.org/Portals/1/HTML_LargeRe-

ports/OralHealth_3.htm

National Dental Therapy Standards Consortium. (2019, January). National Model Act for Licensing or Certification of Dental Therapists. https://www.dentaltherapy.org/resources/file/Dental-Therapist-National-Standards-Report-and-Model-Act_FINAL.pdf

Nasseh, K., & Vujicic, M. (2015). The Impact of Medicaid Reform on Children's Dental Care Utilization in Connecticut, Maryland, and Texas. Health Services Research, 50(4), 1236–1249. https://doi.org/10.1111/1475-6773.12265

O'Connell, J., Rockell, J., Ouellet, J., Tomar, S. L., & Maas, W. (2016). Costs And Savings Associated With Community Water Fluoridation In The United States. Health Affairs (Project Hope), 35(12), 2224–2232. https://doi.org/10.1377/hlthaff.2016.0881

Oh, J., Leonard, L., Fuller, D., & Miller, K. (2011). Less than optimal oral health care during pregnancy in Rhode Island women: oral health care as a part of prenatal care. Medicine and health, Rhode Island, 94(5), 141–143.

O'Neil, A., Berk, M., Venugopal, K., Kim, S.-W., Williams, L. J., & Jacka, F. N. (2014). The association between poor dental health and depression: findings from a large-scale, population-based study (the NHANES study). General Hospital Psychiatry, 36(3), 266–270. https://doi.org/10.1016/j.genhosppsych.2014.01.009

Oral Health Workforce Research Center (OHWRC). (2019, July). Practice Patterns of Postgraduate Dental Residency Completers From Select Long-Term HRSA-Funded Primary Dental Care Training Programs. https://www.chwsny.org/wp-content/uploads/2019/07/OHWRC_Practice_Patterns_of_Postgraduate_Dental_Residency_Completers_2019.pdf

Ponce-Gonzalez, I., Cheadle, A., Aisenberg, G., & Cantrell, L. F. (2019). Improving oral health in migrant and underserved populations: evaluation of an interactive, community-based oral health education program in Washington state. BMC oral health, 19(1), 30. https://doi.org/10.1186/s12903-019-0723-7

Renvert, S., Pettersson, T., Ohlsson, O., & Persson, G. R. (2006). Bacterial Profile and Burden of Periodontal Infection in Subjects With a Diagnosis of Acute Coronary Syndrome. Journal of Periodontology, 77(7), 1110–1119. https://doi.org/10.1902/jop.2006.050336

Reynolds, J. C., McKernan, S. C., Damiano, P. C., & Kuthy, R. A. (2019). A tale of two public dental benefit programs: Iowa dentist participation in traditional Medicaid versus a Medicaid expansion program. BMC oral health, 19(1), 89. https://doi.org/10.1186/s12903-019-0771-z

Rogers, H. J., Rodd, H. D., Vermaire, J. H., Stevens, K., Knapp, R., El Yousfi, S., & Marshman, Z (2019). A systematic review of the quality and scope of economic evaluations in child oral health research. BMC Oral Health, 19(1), 132. doi:10.1186/s12903-019-0825-2

Rozier, R. G., Sutton, B. K., Bawden, J. W., Haupt, K., Slade, G. D., & King, R. S. (2003). Prevention of early childhood caries in North Carolina medical practices: implications for research and practice. Journal of dental education, 67(8), 876–885.

Saint-Hillien, L., & Holicky, A. (2018). Oral Health Status of Florida's Third Grade Children 2016-2017. Florida Department of Health. http://www.floridahealth.gov/programs-and-services/community-health/dental-health/reports/_documents/oral-health-third-grade-2016-2017.pdf

SB 7026 Establishes the Marjory Stoneman Douglas High School Public Safety Act – Florida Key Votes. (2018). Retrieved on January 18, 2020, from https://votesmart.org/bill/24440/62450/establishes-the-marjory-stoneman-douglas-high-school-public-safety-act#.XFyNks9KjaY

Seirawan, H., Faust, S., & Mulligan, R. (2012). The Impact of Oral Health on the Academic Performance of Disadvantaged Children. American Journal of Public Health, 102(9), 1729–1734. https://doi.org/10.2105/AJPH.2011.300478

Simmer-Beck, M., Gadbury-Amyot, C. C., Ferris, H., Voelker, M. A., Keselyak, N. T., Eplee, H., Parkinson, J., Marse, B., & Galemore, C. (2011). Extending oral health care services to underserved children through a school-based collaboration: part 1: a descriptive overview. Journal of dental hygiene : JDH, 85(3), 181–192.

Simmer-Beck, M., Walker, M., Gadbury-Amyot, C., Liu, Y., Kelly, P., & Branson, B. (2015). Effectiveness of an Alternative Dental Workforce Model on the Oral Health of Low-Income Children in a School-Based Setting. American journal of public health, 105(9), 1763–1769.
Smiles for Life: A National Oral Health Curriculum. (n.d.). Retrieved March 12, 2021, from https://www.smilesforlifeoralhealth.org

South Carolina Department of Health and Environmental Control (DHEC) | Division of Oral Health. (n.d.). South Carolina Community Water Fluoridation Plan 2013-2018. https://scdhec.gov/sites/default/files/docs/Health/docs/WaterFluoridation.pdf

Sullivan, B. (2017, November 28). HUD GRANTS $616 MILLION TO HELP FLORIDA RECOVER FROM HURRICANE IRMA [HUD Archives: News Releases]. https://archives.hud.gov/news/2017/pr17-106.cfm

Swerlick, A. (2021, February). Updating Florida Medicaid's Adult Dental Benefits Would Improve Beneficiaries' Overall Health and Save State Dollars. Florida Policy Institute. https://uploads-ssl.webflow.com/5cd5801dfdf7e5927800fb7f/602aa126832c47a0aa3ac7c9_PB_Medicaid_Dental_Benefit_FINAL.pdf

Texas Health Steps. (n.d.). First Dental Home | Section 3: Scheduling, Treatment Plan, Documentation, and Billing. Retrieved on March 16, 2021, from https://www.txhealthsteps.com/static/warehouse/1076-2010-Jun-8-7c06br1a1rk-yar7csn96/section_3.html#sub5

Texas Medical Association. (2010, July 23). Agreement in Principle: Frew vs. Hawkins. https://www.texmed.org/template.aspx?id=5748

The National Coalition of Dentists for health Equity. (2021, February 26). A Position Statement. Dental Therapy: Expanding the Dental Team to Improve Access to Dental Care and Diversity the Dental Workforce. https://ff3c5807-7788-488c-b394-827cc12a93f7.filesusr.com/ugd/f76a56_05c0fb1361674d-67b91eb554c2f1dffc.pdf

The Public Interest Law Center. (n.d. - a). Florida Medicaid Program Not Providing Children with Federally Guaranteed Rights to Medical and Dental Care, Federal Court Finds. Retrieved on February 13, from https://www.pubintlaw.org/cases-and-projects/florida-medicaid-program-not-providing-children-with-federally-guaranteed-rights-to-medical-and-dental-care-federal-court-finds/

The Public Interest Law Center. (n.d. - b). Florida Medicaid Settlement. Retrieved on February 13, from https://www.pubintlaw.org/law-center-

news/flsettlement/

The Public Interest Law Center. (n.d. – c). Settlement Agreement Reached in Florida Medicaid Case to Improve Medical and Dental Care for Florida Children. Retrieved on February 10, 2021 from https://www.pubintlaw.org/cases-and-projects/settlement-agreement-reached-in-florida-medicaid-case-to-improve-medical-and-dental-care-for-florida-children/

Thompson, C. L., McCann, A. L., & Schneiderman, E. D. (2017). Does the Texas First Dental Home Program Improve Parental Oral Care Knowledge and Practices?. Pediatric dentistry, 39(2), 124–129.

Thompson, V. (2021, January). Texas Improves Access to Routine Oral Health Services for Very Young Children. National Academy for State Health Policy. https://www.nashp.org/texas-improves-access-to-routine-oral-health-services-for-very-young-children/

Tiny Smiles: A Give Kids A Smile Program. (n.d.). Retrieved March 12, 2021, from https://www.scholastic.com/givekidsasmile/index.html

Toothbrush.org. (2018, June). Which States Have the Best Oral Health in 2019? Retrieved on February 22, 2021, from https://www.toothbrush.org/2018-us-oral-health/

Traul, R. (2020, August). 2017-2018 Workforce Survey of Dentists. Florida Department of Health (FDOH). http://www.floridahealth.gov/programs-and-services/community-health/dental-health/reports/_documents/FloridaWorkforceSurveyReportofDentists2017-2018FINAL.pdf#Workforce%20Report%20of%20Dentists%202017-2018

Twetman, S., & Dhar, V. (2015). Evidence of Effectiveness of Current Therapies to Prevent and Treat Early Childhood Caries. Pediatric Dentistry, 37(3), 246–253. https://www.ncbi.nlm.nih.gov/pubmed/26063553

U.S. Department of Health and Human Services (HHS). (2000). Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health. https://www.nidcr.nih.gov/sites/default/files/2017-10/hck1ocv.%40www.surgeon.fullrpt.pdf

WUSF Public Media. (2021, March 1). Top Issues for 2021 Florida Legislative Sessions. Retrieved on February 13, from https://wusfnews.wusf.usf.edu/politics-issues/2021-03-01/top-issues-for-the-2021-florida-legislative-session

Wysen, K. H., Hennessy, P. M., Lieberman, M. I., Garland, T. E., & Johnson, S. M. (2004). Kids get care: integrating preventive dental and medical care using a public health case management model. Journal of dental education, 68(5), 522–530.

Yang, Y. T., Chen, B., & Wanchek, T. (2017). Dental Therapists: A Solution to a Shortage of Dentists in Underserved Communities?. Public health reports (Washington, D.C. : 1974), 132(3), 285–288. https://doi.org/10.1177/0033354917698114

Appendices

Appendix A. 2016 Literature Review

Appendix B. IRB Letter

Appendix C. Consumer Engagement Survey in English (Paper Format)

Appendix D. Consumer Engagement Survey in Spanish (Paper Format)

Appendix E. Consumer Engagement Survey (Online Format)

Appendix F. Focus Group Moderator Guide

Appendix G. Focus Group Summary

Appendix H. Alignment Efforts: Consumer Engagement Impact, 2017-20

Appendix I. Catalyst Miami Survey in English

Appendix J. Catalyst Miami Survey in Spanish

Appendix K. Tampa Bay Healthcare Collaborative Achieving Oral Health Equity in Tampa Bay Infographic

Appendix L. Tampa Bay Healthcare Collaborative Achieving Oral Health Equity in Wimauma, FL Infographic

Appendix M. Florida Health Centers With Mobile Units by Type 2020

Appendix A. 2016 Literature Review

Purpose

While statistics point to the importance of making oral health a priority, a deeper understanding of the consumer's perspective is needed to drive effective change in dental care delivery and to identify targeted solutions for tackling oral health disparities facing Florida's children. This review seeks to uncover best practices, barriers and insights in oral health consumer research to guide state consumer research, facilitate evidence-based practice, and inform policy recommendations.

Background

In the Surgeon General's Report on Oral Health (2000), dental and oral diseases were identified as a "silent epidemic", which called for a national effort to improve oral health among Americans.[2] At the time, 39 million Americans lacked health insurance, more than 100 million lacked dental insurance, and healthcare spending was at $1.4 trillion a year. In 2009, healthcare spending rose to $2.3 trillion a year, the number of uninsured rose to 47 million and the number of individuals without dental insurance rose to 100 million. As a result of this national call for action, significant progress has been made to improve oral health care across the last decade. Collaborative efforts between pediatricians, family physicians and key child health advocates led to the reauthorization of the State Children's Health Insurance Program in 2009, helping to expand children's access to oral health care.[3] From 2000 to 2013, the percentage of Medicaid enrolled children who visited a dentist in the past year increased from 29 to 48%.[4]

Despite positive national trends, the state of oral health care in Florida remains challenged by major disparities facing its most vulnerable children. In 2011, Florida was ranked 50th for having the lowest number of Medicaid-covered children (25%) who saw a dentist that year, according to the Pew Charitable Trusts.[5] In 2015, Florida remained significantly behind national oral health rankings, with 47% of U.S. Medicaid-eligible children receiving any dental service (as supervised by a dentist) compared to only 35% in Florida, and 45% receiving preventive dental care nationally compared to just 33% in Florida.[6] The Florida Department of Health's 2014-2015 oral health survey of 26 Head Start (HS) centers across the state found that an estimated 17.8% of HS children have early childhood caries, 20.9% have untreated decay, 17.3% need early care and 4.6% need urgent care. According to a 2013-2014 survey of third grade students from 41 Florida schools, 43.1% had experienced caries, 23.4% had untreated cavities, 18.3% needed early care and 4.9% needed urgent care.[7]

The impact of poor oral health extends far beyond dental problems. In fact, poor oral health has been shown to lead to many days of missed school, lower grade-point averages and additional health challenges for Florida's vulnerable children. In Florida, dental pain was the number one reason why children missed school.[8] Oral health problems have also caused significant health care spending in Florida. In 2014, $31,524,982.00 in charges were attributed to dental-related Emergency Department (ED) visits among children ages 0-20 alone; making up 13.4% of total dental-related ED visit charges in the state.[9] A new report published in the 2016 Journal of Public Health Dentistry cited that dental-related visits to the ED have increased each year between 2005 and 2014 from 104,642 to 163,900. Additionally, dental charges tripled during this period from $47.7 million to $193.4 million. Medicaid (38%) and self-pay (38%) made up the highest percentages of primary payers of dental-related ED visits in 2014.[10]

Methodology

PubMed/Medline was searched in August 2016 for U.S.-based articles published in peer-reviewed journals within the last five years (2011-2016). The initial search included terms 'oral health care delivery United States' and yielded 217 articles. Three additional searches were conducted using terms 'oral health consumer United States', 'oral health care access', and 'oral health children Florida', yielding 72, 28, and 22 articles, respectively. Articles were then limited to those providing public access and consisting of 12 pages or less. The total number of articles reviewed was 25.

Results

The literature indicates that to close the expanding gap in oral disease rates and to improve dental care delivery for Florida's children, it is important to understand the consumer perspective to guide strategy development. Strategies that incorporate feedback from consumers, are patient-centered, and consider underlying consumer beliefs and challenges when accessing or receiving dental care, are necessary for shaping effective solutions.

One important factor for improving oral health among children is understanding the beliefs, awareness and practices of their mothers. According to Gold and Rahbari (2015), a mother's frequency of dental visits and oral hygiene habits are significantly related to the frequency of dental visits and hygiene habits of their toddlers. Findings also suggested that questionnaires regarding pregnant women and mothers of young children can reveal their level of dental and oral health awareness, and that good oral health behavior depends upon a mother's understanding of oral health and her ability to act on information.[11]

Research also shows that it is critical to design oral health education materials from a patient's perspective, not the provider's. Dodd et al. (2014) reported that the literacy level of patient education materials is often too high and that special attention should be given to ensure information is presented at a reading level no higher than a sixth-grade level. The study also called for oral health materials to be reviewed by a public health educator and evaluated based on cultural appropriateness and topic relevance to ensure messages are tailored to the target audience. Materials should also be readily available in clinics and in a format in which patients can easily take and keep for future reference.

[2] U.S. Department of Health and Human Services. (2000). Oral Health in America: A Report of the Surgeon General. Rockville, MD: National Institute of Dental and Craniofacial Research. Retrieved from: www.nidcr.nih.gov/AboutNIDCR/SurgeonGeneral/default.htm.
[3] Satcher, David. (2009). Children's Oral Health: The Time for Change is Now. Academic Pediatrics, 9, 380-382. doi: http://dx.doi.org/10.1016/j.acap.2009.09.020
[4] American Dental Association Health Policy Institute. (2015). *Florida's Oral Health Care System* [Fact sheet]. Retrieved from http://www.ada.org/en/science-research/health-policy-institute/oral-health-care-system/Florida-facts
[5] The Pew Charitable Trusts. (2013, June). Children's Dental Issue Brief. Retrieved from http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2013/insearchofdentalcarepdf.pdf
[6] Florida Department of Health, Public Health Dental Program. (2016, August). *Florida's Burden of Oral Disease Surveillance Report Version 1.1.*
[7] Florida Department of Health, Public Health Dental Program. (2016, August). *Florida's Burden of Oral Disease Surveillance Report Version 1.1.*
[8] Carson, Stephanie. (2014). Dental Problems Number One Reason FL Kids Miss School. Public News Service. Retrieved from: http://www.publicnewsservice.org/2014-08-25/health-issues/dental-problems-number-one-reason-fl-kids-miss-school/a41254-1
[9] Tomar, S. L. (2016, March 7). [Dental-Related ED Visits Florida CY]. Retrieved from: http://media.news.health.ufl.edu/misc/cod-oralhealth/docs/actionteams/data_collection/Dental_ED_Visits_ByCounty_CY2014.pdf
[10] Boylston Herndon, J., Carden, D.L., Catalanotto, F.A., Dodd, V.J., & Tomar, S.L. (2016). Trends in dental-related use of hospital emergency departments in Florida. Journal of Public Health Dentistry, 76, 249-257. doi: 10.1111/jphd.12158
[11] Gold, J., & Rahbari, M. (2015). Knowledge and Behaviors Regarding Early Childhood Caries Among Low-Income Women in Florida: A Pilot Study. The Journal of Dental Hygiene, 89, 132-138. Retrieved from: http://jdh.adha.org/content/89/2/132.abstract

Study findings consistently highlighted similar barriers reported by oral health consumers in accessing services including lack of insurance/affordability, cultural/language barriers, and a healthcare provider's inability to communicate effectively.

Lack of Insurance/Affordability

Daly et al. (2013)[12] assessed the utilization, unmet need and satisfaction of oral health services among 4,562 patients in 2009 who received care at Federally Qualified Health Centers nationally. Affordability and lack of insurance coverage were cited as specific reasons for difficulty accessing dental care. Dodd et al. (2014) reported findings from more than 1700 telephone surveys among residents in rural communities in northern Florida between 2009 and 2011, which revealed that low levels of financial security was a major issue for low dental care utilization rates.[13] Gold and Rahbari (2015) surveyed more than 100 Medicaid-eligible participants in Florida and found that 78% of women did not receive dental care during pregnancy with 14% citing a major reason being "no insurance".[14]

Cultural and Language Barriers

Oral health barriers were cited as disproportionately evident among underserved populations including those living in rural areas, immigrants, racial/ethnic minority groups, homeless, and those with disabilities or chronic diseases. According to Miller and Shaefer (2011)[15], dental care is the largest unmet need for low-income children and oral disease is the most prevalent chronic disease of childhood in the U.S. Crall (2011)[16] cited the need to educate low-income and immigrant groups on the determinants of oral health and reshape their attitudes about oral health care as a result of cultural and language barriers that make it especially difficult for them to navigate the highly complex U.S. health care system.

Individuals with low health literacy skills also face additional oral health challenges. Dodd et al. (2014) reported that low health literacy causes patients to have difficulty describing dental problems to their dentist and understanding dental conditions described by their healthcare provider. The study also found a low routine use by dentists of communication techniques that could help better serve patients with low health literacy, such as patient-friendly materials and aids, interpersonal communication and use of the teach-back method.[17]

Provider Communication

Studies targeting Hispanic and Latino groups cited provider communication, convenient office hours, and the mother's perception of the importance of preventive care as key factors for influencing the use of dental services.[18] Findings from 320 in-depth interviews with Latina mothers living in the Midwest revealed that in addition to receiving oral health services in their native language, the provider's ability to demonstrate understanding of their questions and concerns, and the ability to calm their child and elicit the child's cooperation during the visit, were of utmost importance. In addition, Dodd et al. (2014) points out that effective communication between a dentist and their patients has been shown to increase utilization of dental services by lessening patients' anxiety, increasing patient perceptions of provider competence and increasing satisfaction with care.[19]

Environmental Factors

Environmental factors were also underlined as having a direct impact on oral health. For example, Fisher-Owens et al. (2016)[20] cited access to fluoridated water as having significant implications on oral health status. The study also cited distance to available dentists and higher Medicaid payment levels as key factors affecting receipt of timely preventive oral health care.

Florida

Cultural Attitudes and Beliefs

Similar to other studies focusing on Latino populations, Carrion et al. (2011)[21], who interviewed migrant farmers and their families in Florida, highlighted the direct impact of Latino mothers' attitudes and beliefs on oral health practices among family members in the home. Mothers reported receiving oral health care as part of their prenatal care, however, services ceased after the birth of the child. Findings also revealed that there was a lack of awareness of pediatric dentists in the community who accepted Medicaid.[22]

Social and Environmental Impact

The August 2016 Florida Department of Health Burden of Oral Disease Surveillance Report indicated that persisting oral health inequities for children in the state stem from a lack of access to preventive dental measures, such as dental sealants, screenings, and water fluoridation. The report also highlighted the social and environmental impact of oral health problems facing children in the state. For example, untreated dental and oral problems cause oral-facial pain, which could lead to an inability to chew, bite and swallow foods, poor nutrition, sleep deprivation, depression and adverse psychosocial outcomes. Children with oral health conditions may avoid conversation, smiling or non-verbal expressions to hide their mouth and teeth.[23]

[12] Daly, C., Hayashi, A.S., Jones, E., Ngo-Metzger, Q., Sharma, R., Shi, L. (2013). Access to Oral Health Care: The Role of Federally Qualified Health Centers in Addressing Disparities and Expanding Access. *American Journal of Public Health*, 103. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23327254

[13] Dodd, V.J., Guo, Y., Logan, H. Marks, J.G...Riley, J.L. (2014). Health Literacy: A Pathway to Better Oral Health. American Journal of Public Health, 104. doi: 10.2105/AJPH.2014.301930

[14] Gold, J., & Rahbari, M. (2015). Knowledge and Behaviors Regarding Early Childhood Caries Among Low-Income Women in Florida: A Pilot Study. The Journal of Dental Hygiene, 89, 132-138. Retrieved from: http://jdh.adha.org/content/89/2/132.abstract

[15] Miller, Matthew, & Shaefer, H. Luke. (2011). Improving Access to Oral Health Care Services Among Underserved Populations in the U.S.: Is There a Role for Mid-Level Dental Providers? *Journal of HealthCare for the Poor and Underserved*, 22, 740-744. doi: 10.1353/hpu.2011.0068

[16] Crall, James J. (2011). Improving Oral Health and Oral Health Care Delivery for Children. *Journal of the California Dental Association, 39*, 90-100. Retrieved from http://www.pubpdf.com/pub/21485933/Improving-oral-health-and-oral-health-care-delivery-for-children

[17] Dodd, V.J., Guo, Y., Logan, H. Marks, J.G...Riley, J.L. (2014). Health Literacy: A Pathway to Better Oral Health. American Journal of Public Health, 104. doi: 10.2105/AJPH.2014.301930

[18] Barrett, R.E., Chavez, N., Gajendra, S., Hall, W., Kim, Y.O.R., Telleen, S. (2011). Access to oral health services for urban low-income Latino children: social ecological influences. *Journal of Public Health Dentistry*, 72, 8-18. doi: 10.1111/j.1752-7325.2011.00275.x

[19] Dodd, V.J., Guo, Y., Logan, H. Marks, J.G...Riley, J.L. (2014). Health Literacy: A Pathway to Better Oral Health. *American Journal of Public Health*, 104. doi: 10.2105/AJPH.2014.301930

[20] Fisher-Owens, S.A., Gansky, S.A., Isong, I.A., Newacheck, P.W., Platt, L.J., & Soobader, M.J. (2016). Geography matters: state-level variation in children's oral health care access and oral health status. *Public Health*, 134, 54-63. Retrieved from www.elsevier.com/puhe

[21] Carrion, Iraida V., Castañeda, Heide, Kline, Nolan, Martinez-Tyson, Dinorah. (2011). Barriers Impeding Access to Primary Oral Health Care Among Farmworker Families in Central Florida. *Social Work in Health Care*, 50, 828-844. doi: 10.1080/00981389.2011.594491

[22] Carrion, Iraida V., Castañeda, Heide, Kline, Nolan, Martinez-Tyson, Dinorah. (2011). Barriers Impeding Access to Primary Oral Health Care Among Farmworker Families in Central Florida. *Social Work in Health Care*, 50, 828-844. doi: 10.1080/00981389.2011.594491

[23] Florida Department of Health, Public Health Dental Program. (2016, August). *Florida's Burden of Oral Disease Surveillance Report Version 1.1*.

Best Practices

Targeting Hispanic/Latino Consumers

Multiple studies focused on the oral health disparities among Hispanic/Latino groups, pointing to the importance of including this population in our research to better understand how to address their unique needs. Latino parents, independent of socioeconomic status, are two times more likely than their non-Hispanic white counterparts to report their children's oral health as fair or poor. In addition, caregivers who are non-U.S.-born are more likely to wait until their child is older to take them to the dentist.[24]

When surveying this group, it is critical to maximize confidentiality. Carrion et al. (2014)[25] emphasized maximizing confidentiality when interviewing this group as many parents may be undocumented. Oral consent can help facilitate recruitment as well as clearly communicating that participants will remain anonymous within the study. Given that more recent immigrants may face additional challenges including health literacy and language barriers, it may be beneficial to capture the number of years survey respondents have lived in the U.S. Additional considerations when surveying this population include pre-testing survey questions to ensure an accurate translation and that questions reflect the level of education of the target audience. For example, Barrett et al. (2011)[26] noted that Spanish surveys were pilot-tested with Latino mothers using a cognitive method to evaluate whether items had the intended meaning once interpreted by respondents. If differences were found, they were reconciled and revised questions were retested.

Survey Participant Recruitment

Several studies offered ideas for practical incentives and survey delivery tactics that could be applied to ensure that researchers efficiently and effectively engage oral health consumers in their studies. For example, several studies offered a gift card ranging from $15 to $25 to survey participants after survey completion. When seeking feedback from mothers, Barrett et al. (2011)[27] noted success in working with school principals and Head Start centers who agreed to publicly post survey recruitment flyers. Gold and Rahbari (2015) recruited pregnant women and mothers to complete surveys throughout Florida at primary care and pre-natal clinics, as well as at Women, Infants, and Children (WIC) breastfeeding classes held at the Seminole County Health Department. Following survey collection, participants were given oral hygiene education materials and referrals for Medicaid dental homes were provided upon request.[28] Another effective strategy included training staff to deliver computer-assisted interviews in the field.[29]

[24] Carrion, Iraida V., Castañeda, Heide, Kline, Nolan, Martinez-Tyson, Dinorah. (2011). Barriers Impeding Access to Primary Oral Health Care Among Farmworker Families in Central Florida. *Social Work in Health Care*, 50, 828-844. doi: 10.1080/00981389.2011.594491

[25] Carrion, Iraida V., Castañeda, Heide, Kline, Nolan, Martinez-Tyson, Dinorah. (2011). Barriers Impeding Access to Primary Oral Health Care Among Farmworker Families in Central Florida. *Social Work in Health Care*, 50, 828-844. doi: 10.1080/00981389.2011.594491

[26] Barrett, R.E., Chavez, N., Gajendra, S., Hall, W., Kim, Y.O.R., Telleen, S. (2011). Access to oral health services for urban low-income Latino children: social ecological influences. *Journal of Public Health Dentistry*, 72, 8-18. doi: 10.1111/j.1752-7325.2011.00275.x

[27] Barrett, R.E., Chavez, N., Gajendra, S., Hall, W., Kim, Y.O.R., Telleen, S. (2011). Access to oral health services for urban low-income Latino children: social ecological influences. *Journal of Public Health Dentistry*, 72, 8-18. doi: 10.1111/j.1752-7325.2011.00275.x

[28] Gold, J., & Rahbari, M. (2015). Knowledge and Behaviors Regarding Early Childhood Caries Among Low-Income Women in Florida: A Pilot Study. *The Journal of Dental Hygiene*, 89, 132-138. Retrieved from: http://jdh.adha.org/content/89/2/132.abstract

[29] Daly, C., Hayashi, A.S., Jones, E., Ngo-Metzger, Q., Sharma, R., Shi, L. (2013). Access to Oral Health Care: The Role of Federally Qualified Health Centers in Addressing Disparities and Expanding Access. *American Journal of Public Health*, 103. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23327254

Discussion

Limitations

Selection bias in the sampling process and the use of self-reported data were cited as a major limitations in numerous consumer studies. Daly et al. (2013)[30] noted that recall and social desirability bias may impact the reliability of self-reported information. Barrett et al. (2011)[31] pointed out that mothers' responses about their child's oral health may be based on her knowledge of the "right answers". Similar studies will face the same challenges without a complementing verification of mothers' responses with medical record reviews or oral health exams of their children. This highlights the importance of recognizing the potential for reporting error.

Assessing Non-traditional Oral Health Experiences

Research studies that investigated alternate entry points to oral health access in order to overcome barriers reported a positive impact on dental care utilization and cited numerous benefits for underserved populations. Naughton (2014)[32] concluded that independent practices by dental hygienists resulted in high patient satisfaction, encouraged visits to the dentist, lowered fees charged to patients, and made preventive services more readily available to Medicaid patients, compared to a traditional dental office, with no increased risk to the health or safety of the patient. Biordi et al. (2015)[33] found that the use of a nurse practitioner-dietitian work model at WIC sites increased dental workforce capacity by providing preventive dental health services to low-income families, such as fluoride application for children and dietary counseling for parents and caregivers. Baker et al. (2014)[34] recommended training primary care providers to deliver preventive oral health services such as screening and risk assessment, parental oral health counseling, fluoride varnish application, and referrals to a dentist, when needed, in medical settings, to improve access and increase utilization for young Medicaid enrollees. Dodd et al. (2014) suggested providing navigators or guides in dental offices as a way to smoothly deliver critical health information to patients and improve patients' communication with the healthcare system. Navigators could serve to help patients fill out forms, obtain information on health conditions, and explain diagnostic information and guidelines in more detail to improve patients' self-care.[35]

With the advent of these innovative strategies and new approaches to combating oral health disparities being tested across the country, it may be helpful to evaluate whether patients have had experience with these non-traditional methods. This could include assessing perceptions, preferences and experiences with dental therapists, dental services received at a primary care physician office, WIC center or FQHC. It may also be helpful to record whether patients are enrolled in other social service programs such as Head Start or WIC to assess if this has any impact on dental care utilization.

[30] Daly, C., Hayashi, A.S., Jones, E., Ngo-Metzger, Q., Sharma, R., Shi, L. (2013). Access to Oral Health Care: The Role of Federally Qualified Health Centers in Addressing Disparities and Expanding Access. *American Journal of Public Health*, 103. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23327254

[31] Barrett, R.E., Chavez, N., Gajendra, S., Hall, W., Kim, Y.O.R., Telleen, S. (2011). Access to oral health services for urban low-income Latino children: social ecological influences. *Journal of Public Health Dentistry*, 72, 8-18. doi: 10.1111/j.1752-7325.2011.00275.x

[32] Naughton, Doreen. (2014). Expanding Oral Care Opportunities: Direct Access Care Provided by Dental Hygienists in The United States. *Journal of Evidence-based Dental Practice*. Retrieved from http://dx.doi.org/10.1016/j.jebdp.2014.04.003

[33] Biordi, D.L., DiMarco, M., Fitzgerald, K., Heitzer, M., Huff, M., Marino, D...Thacker, S. (2015). Improving Access and Provision of Preventive Oral Health Care for Very Young, Poor, and Low-Income Children Through a New Interdisciplinary Partnership. *American Journal of Public Health*, 105. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/25689183

[34] Baker, Diane, Divaris, Kimon, Kranz, Ashley M., Lee, Jessica, & Vann Jr., William. (2014). North
Carolina Physician-Based Preventive Oral Health Services Improve Access and Use Among Young Medicaid Enrollees. *Health Affairs*, 33. doi: 10.1377/hlthaff.2014.0927

[35] Dodd, V.J., Guo, Y., Logan, H. Marks, J.G...Riley, J.L. (2014). Health Literacy: A Pathway to Better Oral Health. American Journal of Public Health, 104. doi: 10.2105/AJPH.2014.301930

Evaluating Oral Health Knowledge and Preferences

Numerous studies highlighted prominent gaps in current research around oral health and consumer engagement and offered recommendations for future studies. To be specific, these studies recommended investigating the characteristics and mechanisms that make it possible for health centers to address racial and ethnic disparities in access to care, identifying more evidence to guide the design and implementation of outreach programs, and launching patient education campaigns and other approaches to activate patient engagement around oral health issues.[36] Future qualitative research is also needed to explore parents' perceptions of their children's preventive oral health needs and how to raise awareness at a population level.[37] In addition, Dodd et al. (2014) was one of the first studies to examine the relationship between oral health and health literacy, and called for more research in this area to help inform interventions targeting improved oral health.[38]

Conclusion

It is evident that additional research is needed to more effectively understand the barriers to oral health care for Florida's children, especially among low-income and minority families. Several best practices revealed in the literature can be applied to strengthen consumer engagement research through improving data collection and quality, and survey participant recruitment. These include pre-testing bilingual survey questions with the target audience to ensure accurate translations and maximizing confidentiality during data collection to create a safe and comfortable environment for survey participants. In addition, partnering across sectors can help expand the reach of survey collection to reach parents at a variety of locations such as schools, health clinics, and government/social service agencies. It is also important to include survey questions that assess usage of dental services in non-traditional settings, oral health knowledge, cultural beliefs, health literacy levels, and participation in other social service programs to be able to evaluate the many factors that contribute to dental care utilization and barriers to care. It is intended that these findings and recommendations be used to guide future consumer engagement research with the goal of improving oral health care for Florida's children.

Citations

https://stacks.cdc.gov/view/cdc/11862 CDC 2011

https://www.cdc.gov/chronicdisease/pdf/aag-oral-health.pdf CDC 2016

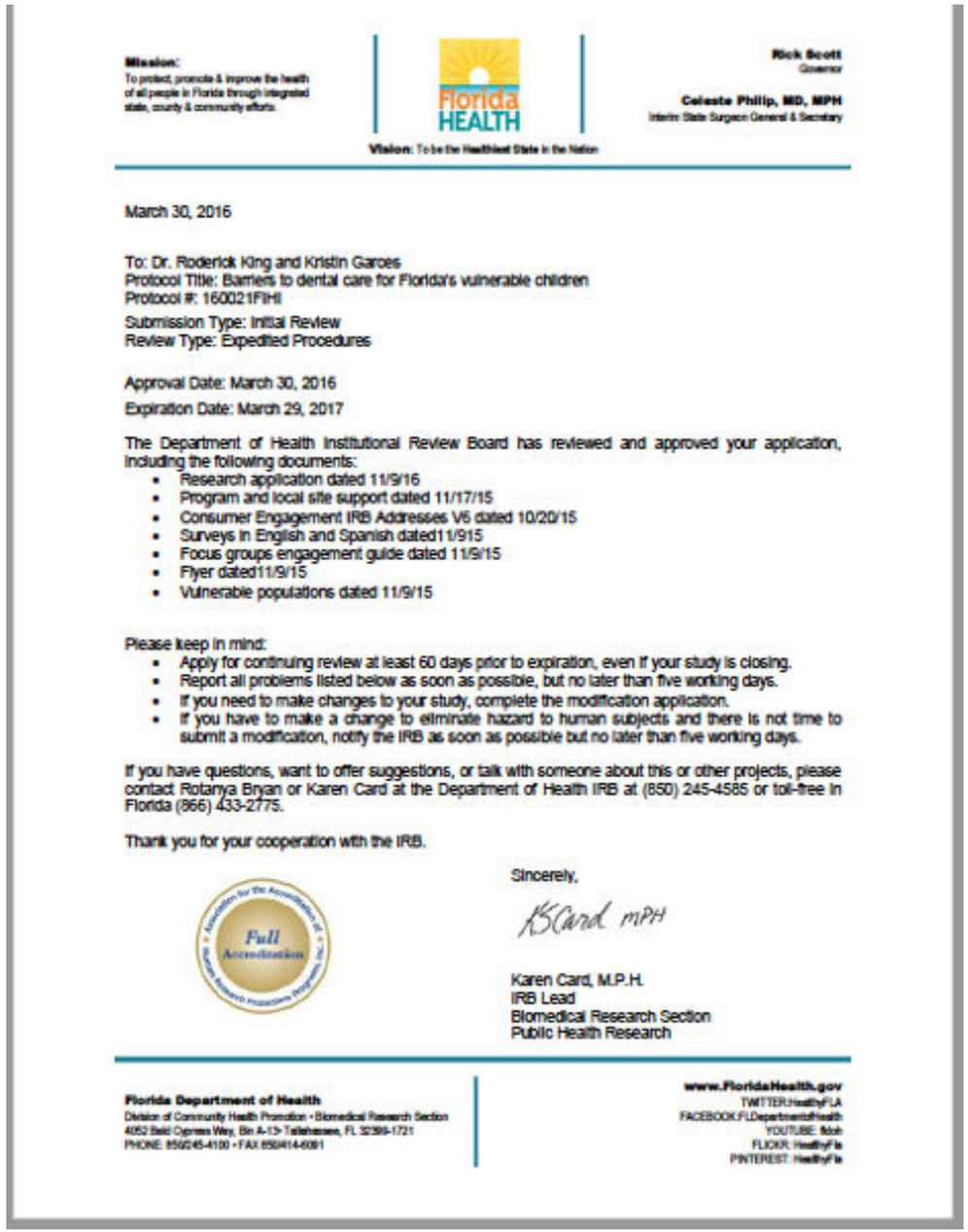
US Department of Health and Human Services, Public Health Service, Office of the Surgeon General. Oral health in America: A report of the Surgeon General. Rockville, MD: National Institutes of Health, National Institute of Dental and Craniofacial Research; 2000, p. 33-59.

[36] Daly, C., Hayashi, A.S., Jones, E., Ngo-Metzger, Q., Sharma, R., Shi, L. (2013). Access to Oral Health Care: The Role of Federally Qualified Health Centers in Addressing Disparities and Expanding Access. *American Journal of Public Health*, 103. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23327254

[37] Bell, Janice F., Huebner, Colleen E., & Reed, Sarah C. (2012). Oral Health Need and Access to Dental Services: Evidence from the National Survey of Children's Health, 2007. *Maternal Child Health Journal*. doi: 10.1007/s10995-012-0992-0

[38] Dodd, V.J., Guo, Y., Logan, H. Marks, J.G...Riley, J.L. (2014). Health Literacy: A Pathway to Better Oral Health. American Journal of Public Health, 104. doi: 10.2105/AJPH.2014.301930

Appendix B. IRB Letter



Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Florida HEALTH

Rick Scott
Governor

Celeste Philip, MD, MPH
Interim State Surgeon General & Secretary

Vision: To be the Healthiest State in the Nation

March 30, 2016

To: Dr. Roderick King and Kristin Garces
Protocol Title: Barriers to dental care for Florida's vulnerable children
Protocol #: 160021FIHI
Submission Type: Initial Review
Review Type: Expedited Procedures

Approval Date: March 30, 2016
Expiration Date: March 29, 2017

The Department of Health Institutional Review Board has reviewed and approved your application, including the following documents:

- Research application dated 11/9/16
- Program and local site support dated 11/17/15
- Consumer Engagement IRB Addresses V6 dated 10/20/15
- Surveys in English and Spanish dated11/915
- Focus groups engagement guide dated 11/9/15
- Flyer dated11/9/15
- Vulnerable populations dated 11/9/15

Please keep in mind:

- Apply for continuing review at least 60 days prior to expiration, even if your study is closing.
- Report all problems listed below as soon as possible, but no later than five working days.
- If you need to make changes to your study, complete the modification application.
- If you have to make a change to eliminate hazard to human subjects and there is not time to submit a modification, notify the IRB as soon as possible but no later than five working days.

If you have questions, want to offer suggestions, or talk with someone about this or other projects, please contact Rotanya Bryan or Karen Card at the Department of Health IRB at (850) 245-4585 or toll-free in Florida (866) 433-2775.

Thank you for your cooperation with the IRB.

Sincerely,

KCard MPH

Karen Card, M.P.H.
IRB Lead
Biomedical Research Section
Public Health Research

Association for the Accreditation of Human Research Protection Programs, Inc. Full Accreditation

Florida Department of Health
Division of Community Health Promotion • Biomedical Research Section
4052 Bald Cypress Way, Bin A-13• Tallahassee, FL 32399-1721
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TWITTER:HealthyFLA
FACEBOOK:FLDepartmentofHealth
YOUTUBE: fdoh
FLICKR: HealthyFla
PINTEREST: HealthyFla

Appendix C. Consumer Engagement Survey in English (Paper Format)

INCLUSION FORM
Please keep this sheet with you should you have any questions following the survey.

The Florida Institute for Health Innovation (FIHI) and the Florida Oral Health Alliance invite you to participate in a survey that will help us to better understand the barriers that people face when trying to access dental care for their children. By answering this survey, you will help the Oral Health Alliance understand the barriers Florida residents face when accessing dental care for their children. Our goal is to improve dental care practice and policy in the state.

This is a research project being conducted by the Florida Institute for Health Innovation (FIHI). Please read the following before participating:

*Your participation in this survey is **voluntary**.
*Your responses to this survey will be **anonymous**.
*You may refuse to take part in the research or exit the survey at any time.
*If you are not comfortable answering a question or you do not wish to answer you can select 'decline to answer.'
*There are no risks involved in participating in the survey.
*There are no direct benefits to participating in the survey.
*Your participation or lack of participation will not affect the dental services available to you or your child.
*The survey should take approximately 10 minutes to complete.

If you have any questions or concerns, please contact Kristin Garces with the Florida Institute for Health Innovation by email at kgarces@flhealthinnovation.org or by phone at (561) 838-4444.

If you want to talk with someone independent of the research team for questions or concerns about the research you can contact the Florida Department of Health Institutional Review Board. An Institutional Review Board is a group of people who review research to ensure participants are protected and the research is conducted in an ethical way. You can contact the IRB at: (850) 245-4585

By selecting 'Yes, I agree' you understand this section and volunteer to participate in the survey.

You have read the study information.
You voluntarily agree to participate.
You are 18 years of age or older.

a. Yes, I agree.
b. No, I do not agree to take the survey.

1. Would you like to answer a survey about your child's dental care?
a. Yes
b. No

2. How many children between the ages of 3 to 17 live in your home? _____

Thinking about your child or children, choose one between the ages of 3 to 17 to answer the following questions.

3. How old is your child? _____

4. Does your child have a dentist that he/she visits regularly?
a. Yes
b. No
c. Decline to answer

If 'Yes,' request Form A, if 'No,' request Form B.

FORM A

1. Does your child have any form of health insurance?
   a. Yes
   b. No
   c. Decline to answer

2. If yes, what type of insurance does your child have?
   a. Not applicable
   b. Private Insurance
   c. Medicaid
   d. Medicare
   e. Kidcare/CHIP
   f. Other_____
   g. Decline to answer

3. Thinking about your child's last dental visit, how do you feel you were treated?
   a. Very well
   b. Well
   c. Neither well nor poorly
   d. Poorly
   e. Very poorly
   f. Decline to answer

4. How did you find a dentist for your child?
   a. A Medicaid provider list online
   b. Medicaid provider list handbook
   c. Through private insurance
   d. The yellow pages
   e. Internet search
   f. Family and friends
   g. My child's doctor
   h. Through social services
   i. My child's school
   j. Other_____
   k. Decline to answer

5. How would you rate your child's overall health?
   a. Excellent
   b. Very good
   c. Good
   d. Not good or bad
   e. Poor
   f. Very poor
   g. Decline to answer
   h. Not sure

6. How would you rate your child's dental health?
   a. Excellent
   b. Very good
   c. Good
   d. Not good or bad
   e. Poor
   f. Very poor
   g. Decline to answer
   h. Not sure

7. Do you have a dentist you visit regularly?
   a. Yes
   b. No
   c. Decline to answer

8. How old was your child when he/she first went to the dentist?
   a. Newborn – 2 years
   b. 3-5 years old
   c. 6-8 years old
   d. 9-11 years old
   e. 12-14 years old
   f. Do not remember
   g. Decline to answer

9. How often does your child visit the dentist?
   a. Every 3 months
   b. Every 6 months
   c. Once a year
   d. Every 2 years
   e. When my child has a problem or mouth pain
   f. Decline to answer

10. In the past, have you ever cancelled a dental appointment for you or your child for any of the following reasons? (Circle all that apply)
   a. I couldn't find transportation
   b. No one in the office spoke my language
   c. It was too expensive
   d. The wait at the office was too long
   e. The time was not convenient for me
   f. Other_____
   g. Decline to answer

11. At your child's last dental appointment, how happy were you with the dental care provided?
   a. Very happy
   b. Somewhat happy
   c. Neutral
   d. Somewhat disappointed
   e. Very disappointed
   f. Decline to answer

12. Did your dentist ever use a papoose for your child during their visit?
Papoose: a restraint to keep your child from moving during dental work or a dental exam.
   a. Yes
   b. No
   c. Decline to answer

Please think about your child's last dental visit when answering the following questions.

13. Did the dentist listen to everything you had to say?
   a. Yes, everything
   b. Most
   c. Some
   d. A little
   e. No
   f. I didn't speak to the dentist.
   g. Decline to answer

14. Did you understand everything the dentist said?
   a. Yes, everything
   b. Most
   c. Some
   d. A little
   e. No
   f. I didn't speak to the dentist.
   g. Decline to answer

15. Did you have questions about your child's dental care that you wanted to ask but didn't?
   a. Yes
   b. No
   c. Decline to answer

16. Did you trust the dentist treating your child?
   a. Yes
   b. No
   c. Decline to answer

17. Has your child's dentist ever discussed any of the following with you? (Circle all that apply)
   a. Cavities
   b. Flossing
   c. Oral Hygiene
   d. Sealants
   e. Malocclusion
   f. None
   g. Decline to answer

18. Parent gender?
    a. Male
    b. Female
    c. Decline to answer

19. In which county do you live? _____

20. What is your age?
    a. 18-24 years old
    b. 25-35 years old
    c. 35-44 years old
    d. 45-54 years old
    e. 55-64 years old
    f. 65 – 74 years old
    g. 75 years or older
    h. Decline to answer

21. What is your annual combined household income?
    a. Less than $20,000
    b. 20,000 to 34,999
    c. 35,000 to 49,999
    d. 50,000 to 74,999
    e. 75,000 to 99,999
    f. 100,000 to 149,000
    g. 150,000 or more
    h. Decline to answer

22. What is the last grade you completed?
    a. Some grammar school
    b. Grammar school (up to 6th grade)
    c. Middle school (up to 8th grade)
    d. Some high school (up to 11th grade)
    e. High school diploma or GED
    f. Some college/university
    g. Technical or Associate degree
    h. Undergraduate degree
    i. Advanced degree
    j. No formal education
    k. Decline to answer

23. How do you identify your race?
    a. American Indian or Alaska Native
    b. Asian
    c. Black or African American
    d. Haitian/Creole
    e. Hispanic or Latino
    f. Native Hawaiian or Pacific Islander
    g. White
    h. Other
    i. Decline to answer

24. What is your current employment status?
    a. Full time
    b. Part time (one job)
    c. Part time (multiple jobs)
    d. Student
    e. Unemployed for less than one year
    f. Unemployed for one year or more
    g. Retired
    h. Decline to answer

25. What is your current relationship status?
    a. Single
    b. Married
    c. Widowed
    d. Divorced
    e. Separated
    f. Civil Union
    g. Domestic partnership
    h. Decline to answer

26. In what language do you communicate the most?
    a. Spanish
    b. English
    c. Creole
    d. Portuguese
    e. Russian
    f. Other_____
    g. Decline to answer

Thank you very much for your participation in this survey!

Again, if you have any questions or concerns, please contact Kristin Garces at kgarces@flhealthinnovation.org or 561.838.4444

FORM B

1. Has your child ever been to the dentist?
    d. Yes
    e. No
    f. Decline to answer

2. Does your child have any form of health insurance?
    a. Yes
    b. No
    c. Decline to answer

3. If yes, what type of insurance does your child have?
    a. Not applicable
    b. Private Insurance
    c. Medicaid
    d. Medicare
    e. Kidcare/CHIP
    f. Other_____
    g. Decline to answer

4. How would you rate your child's dental health?
    a. Excellent
    b. Very good
    c. Good
    d. Not good or bad
    e. Poor
    f. Very poor
    g. Decline to answer
    h. Not sure

5. Do you have a dentist you visit regularly?
    a. Yes
    b. No
    c. Decline to answer

6. How would you rate your child's overall health?
    a. Excellent
    b. Very good
    c. Good
    d. Not good or bad
    e. Poor
    f. Very poor
    g. Decline to answer
    h. Not sure

7. Please state how much you agree with the following statement.
Dental health is an important part of my child's overall health.
    a. Strongly Agree
    b. Agree
    c. Do not agree or disagree
    d. Disagree
    e. Strongly disagree
    f. I'm not sure
    g. Decline to answer

8. What are some of the reasons your child doesn't visit the dentist? (Circle all that apply)
    a. The dentist is too far
    b. I have trouble finding transportation
    c. No one in the office speaks my language
    d. It is too expensive
    e. The waits are too long at the office
    f. The office is not open when I can go
    g. I cannot get an appointment
    h. Not enough time to take my child to the dentist
    i. I cannot find a dentist for my child
    j. My child does not have dental insurance
    k. I cannot find a dentist who takes my child's insurance
    l. My child does not need dental care
    m. Decline to answer
    n. Other_____

9. Where do you find dental health information for your child?
    a. My child's doctor
    b. Online
    c. Family/friends
    d. My child's teachers
    e. My child's school

f. I do not know where to find this information
g. Other _____
h. Decline to answer

10. Parent gender?
a. Male
b. Female
c. Decline to answer

11. In which county do you live? _____

12. What is your age?
a. 18-24 years old
b. 25-35 years old
c. 35-44 years old
d. 45-54 years old
e. 55-64 years old
f. 65 – 74 years old
g. 75 years or older
h. Decline to answer

13. What is your annual combined household income?
a. Less than $20,000
b. 20,000 to 34,999
c. 35,000 to 49,999
d. 50,000 to 74,999
e. 75,000 to 99,999
f. 100,000 to 149,000
g. 150,000 or more
h. Decline to answer

14. What is the last grade you completed?
a. Some grammar school
b. Grammar school (up to 6th grade)
c. Middle school (up to 8th grade)
d. Some high school (up to 11th grade)
e. High school diploma or GED
f. Some college/university
g. Technical or Associate degree
h. Undergraduate degree
i. Advanced degree
j. No formal education
k. Decline to answer

15. How do you identify your race?
a. American Indian or Alaska Native
b. Asian
c. Black or African American
d. Haitian/Creole
e. Hispanic or Latino
f. Native Hawaiian or Pacific Islander
g. White
h. Other
i. Decline to answer

16. What is your current employment status?
a. Full time
b. Part time (one job)
c. Part time (multiple jobs)
d. Student
e. Unemployed for less than one year
f. Unemployed for one year or more
g. Retired
h. Decline to answer

17. What is your current relationship status?
a. Single
b. Married
c. Widowed
d. Divorced
e. Separated
f. Civil Union
g. Domestic partnership
h. Decline to answer

18. In what language do you communicate the most?
a. Spanish
b. English
c. Creole
d. Portuguese
e. Russian
f. Other_____
g. Decline to answer

Thank you very much for your participation in this survey!

Again, if you have any questions or concerns, please contact Kristin Garces at kgarces@flhealthinnovation.org or 561.838.4444

Appendix D. Consumer Engagement Survey in Spanish (Paper Format)

INCLUSION FORM
Por favor, aguante esta información si tiene cualquier pregunta después la encuesta.

El Florida Institute for Health Innovation y el Florida Oral Health Alliance le invitamos a participar en una encuesta para ayudarnos a comprender mejor las dificultades y desafíos que encuentra la gente en el acceso de salud bucal o dental para sus niños. La información ayudará el Oral Health Alliance (Alianza de Salud Bucal) a comprender mejor las barreras al acceso de atención dental para sus niños. Nuestra meta es a mejorar el acceso de cuidado dental en Florida .

Este proyecto es una investigación realiza por Florida Institute for Health Innovation (Instituto de Florida por Innovación de Salud). Por favor, lee el siguiente antes de su participación:

* Su participación en esta encuesta es **voluntaria**.
* Las respuestas en esta encuesta será **anónima**.
* Usted puede negarse a participar en la investigación, o terminar la encuesta en cualquier momento.
* Si no se siente cómodo a responder a una pregunta o si no desea responder, puede seleccionar “se niega a responder.”
* No hay riesgo en la participación de la encuesta.
* No hay beneficios directos por participación en la encuesta.
* Su participación o falta de participación no afectará a los servicios dentales disponibles para usted o para sus hijos.
* La encuesta dura aproximadamente 10 minutos para completar.

Si usted tiene cualquiera pregunta, por favor comunícese con Kristin Garces del Florida Institute for Health Innovation a: kgarces@flhealthinnovation.org por e-mail o por teléfono a (561) 838-4444.

Si usted quiere hablar con alguien independiente del equipo de investigación para preguntas o inquietudes acerca de la investigación puede ponerse en contacto con el IRB (Junta de Revisión Institucional) del Departamento de Salud de la Florida. Esta Junta de Revisión Institucional es un grupo de personas que revisan la investigación para asegurar que los participantes están protegidos y la investigación se lleve a cabo de una forma ética. Puede ponerse en contacto con el IRB al: (850) 245-4585

Si selecciona “Sí, yo estoy de acuerdo” significa que usted entienda esta sección y que su participación en la investigación es voluntario.

Usted ha leído la información de arriba.
Está de acuerdo de participar voluntariamente.
Tiene 18 años de edad o más.

a. Sí, estoy de acuerdo.
b. No, no estoy de acuerdo.

1. ¿Le gustaría contestar una encuesta acerca del cuidado dental de su niño?
   a. Sí
   b. No

2. ¿Cuantos niños entre las edades de 3 a 17 años, viven en su casa?_____

Pensando en sus hijos, elija uno entre las edades de 3 a 17, para responder a las preguntas siguientes.

3. ¿Cuantos años tiene su hijo? _____

4. ¿Su hijo tiene un dentista que él/ella visita regularmente?
   a. Sí
   b. No
   c. Se niega a responder

Si respondió ‘Sí,’ solicita formulario A, si respondió ‘No,’ solicita formulario B.

FORM A

1. Tiene su hijo/a algún tipo de seguro de salud?
   a. Sí
   b. No
   c. Se niega a responder

2. Si respondió que ‘sí,’ ‘¿Qué tipo de seguro tiene su hijo/a?
   a. No está aplicable
   b. Seguro privado
   c. Medicaid
   d. Medicare
   e. Kidcare/CHIP
   f. Otro_____
   g. Se niega a responder

3. ¿Pensando en la última visita al dentista para su hijo/a, como se siente usted fue tratado/a?
   a. Muy bien
   b. Bien
   c. Ni bien ni mal
   d. Mal
   e. Muy mal
   f. Se niega de responder

4. ¿Cómo encontró un dentista para su hijo/a?
   a. Lista de proveedores en el sitio web de Medicaid
   b. Manual de lista de proveedores de Medicaid
   c. Por seguro médico privado
   d. Por los Yellow Pages
   e. Una búsqueda en el internet
   f. Familia/Amigos
   g. Por el médico de mi hijo/a
   h. Por servicios sociales
   i. Por la escuela de mi hijo/a
   j. Otro_____
   k. Se niega a responder

5. ¿Cómo calificaría la salud de su hijo/a?
   a. Excelente
   b. Muy buena
   c. Buena
   d. No es buena o mala
   e. Mala
   f. Muy mala
   g. Se niega a responder
   h. No estoy seguro

6. ¿Cómo calificaría la salud dental de su hijo/a?
   a. Excelente
   b. Muy buena
   c. Buena
   d. No es buena o mala
   e. Mala
   f. Muy mala
   g. Se niega a responder
   h. No estoy seguro

7. ¿Tiene usted un dentista que usted visita regularmente?
    a. Sí
    b. No
    c. Se niega a responder

8. ¿Qué edad tenía su hijo/a cuando él/ella fue por primera vez al dentista?
    a. Recién nacido a edad 2
    b. Edad 3-5
    c. Edad 6-8
    d. Edad 9-11
    e. Edad 12-14
    f. Edad 15-17
    g. No recuerdo
    h. Se niega a responder

9. ¿Con que frecuencia visita su hijo/a al dentista?
    a. Cada 3 meses
    b. Cada 6 meses
    c. Una vez al año
    d. Cada 2 años
    e. Cuando mi hijo/a tiene un problema o dolor en la boca
    f. Se niega a responder

10. ¿En el pasado, ha cancelado una cita dental para usted o su hijo/a para unas de las razones siguientes? (Marque todas las que corresponden)
    a. No pude encontrar transporte
    b. Nadie en la oficina hablaba mi idioma
    c. Era demasiado caro
    d. La espera en la oficina era demasiado largo
    e. El tiempo no era conveniente para mi
    f. Otro_____
    g. Se niega a responder

11. ¿En la última cita de su hijo/a con el dentista, estaba feliz con el cuidado dental?
    a. Muy feliz
    b. Bastante feliz
    c. Neutral
    d. Poco infeliz
    e. Muy infeliz
    f. Se niega a responder

12. ¿Su dentista ha usado un papoose alguna vez para su hijo/a durante su visita?

Papoose: una restricción utilizado así que la persona no se mueve durante trabajo dental o un examen dental.
    a. Sí
    b. No
    c. Se niega a responder

Por favor, piense en la última visita dental de su hijo/a para contestar las preguntas siguientes.

13. ¿El dentista escuchaba a todo lo que tenía que decir?
    a. Sí, todo
    b. La mayor parte
    c. Algunas cosas
    d. Pocas cosas
    e. No
    f. No hablé con el dentista.
    g. Se niega a responder

14. ¿Entendía todo lo que el dentista decía?
    a. Sí, todo
    b. La mayor parte
    c. Algunas cosas
    d. Pocas cosas
    e. No
    f. No hablé con el dentista.
    g. Se niega a responder

15. ¿Tuvo preguntas acerca del cuidado dental de su hijo/a que le quería preguntar pero no lo pido?
    a. Sí
    b. No
    c. Se niega a responder

16. ¿Confiaba en el dentista que cuidaba a su hijo/a?
    a. Sí
    b. No
    c. Se niega a responder

17. ¿El dentista de su hijo/a ha hablado consigo sobre unos de los siguientes? (Marque todas las que corresponden)
    a. La caries
    b. El uso de hilo dental
    c. Higiene bucal
    d. Selladores dental

e. Maloclusión dentario
f. Ninguno
g. Se niega a responder

18. Sexo del participante?
a. Hombre
b. Mujer
c. Se niega a responder

19. ¿Condado donde vive?_____

20. ¿Cuántos años tiene usted?
a. 18-24 años
b. 25-35 años
c. 35-44 años
d. 45-54 años
e. 55-64 años
f. 65-74 años
g. 75 años o mas
h. Se niega a responder

21. ¿Cuál es su ingreso familiar combinado anual?
a. Menos de $20,000
b. 20,000 a 34,999
c. 35,000 a 49,999
d. 50,000 a 74,999
e. 75,000 a 99,999
f. 100,000 a 149,999
g. 150,000 o más
h. Se niega a responder

22. ¿Cuál es el último grado que ha completado?
a. Pocos años de la escuela primaria
b. Escuela primaria (hasta 6º grado)
c. Escuela secundaria (hasta el 8º grado)
d. Algunos grados secundario (hasta 11avo grado)
e. Diploma de la escuela secundaria o GED
f. Algunos años del/a colegio/universidad
g. Titulo técnico o asociado
h. Licenciatura
i. Grado avanzado
j. No tenía educación formal
k. Prefiere no responder

23. ¿Cómo identifica su raza?
a. Nativo/a americano/a o nativo/a de Alaska
b. Asiático/a
c. Negro/a o Afro-Americano/a
d. Haitiano/a
e. Hispano/a o latino/a
f. Nativo/a de Hawái o de las islas del Pacifico
g. Blanco/a
h. Otro
i. Se niega a responder

24. ¿Cuál es su situación de trabajo?
a. Tiempo completo
b. Tiempo parcial (uno trabajo)
c. Tiempo parcial (varios trabajos)
d. Estudiante
e. Desempleado/a menos de un año
f. Sin empleo durante un año o más
g. Jubilado/a
h. Se niega a responder

25. ¿Cuál es su estado civil?
a. Solo/a
b. Casado/a
c. Viudo/a
d. Divorciado/a
e. Separado/a
f. Unión civil
g. Asociación domestica
h. Se niega a responder

26. ¿En cual idioma se comunica más?
a. Español
b. Ingles
c. Criollo
d. Portugués
e. Ruso
f. Otro_____
g. Se niega a responder

¡Muchas gracias por su participación en esta encuesta!

Una vez más, si tiene alguna pregunta o quiere más información, por favor comuníquese con Kristin Garces por: kgarces@flhealthinnovation.org o por teléfono a (561) 838.4444

FORM B

1. ¿Su hijo/a ha visitado alguna vez el dentista?
    d. Sí
    e. No
    f. Se niega a responder

2. ¿Tiene su hijo/a algún tipo de seguro de salud?
    a. Sí
    b. No
    c. Se niega a responder

3. Si respondió que 'sí,' '¿Qué tipo de seguro tiene su hijo/a?
    a. No está aplicable
    b. Seguro privado
    c. Medicaid
    d. Medicare
    e. Kidcare/CHIP
    f. Otro_____
    g. Se niega a responder

4. ¿Cómo calificaría la salud dental de su hijo/a?
    a. Excelente
    b. Muy buena
    c. Buena
    d. No es buena o mala
    e. Mala
    f. Muy mala
    g. Se niega a responder
    h. No estoy seguro

5. ¿Tiene usted un dentista que visita regularmente?
    a. Sí
    b. No
    c. Se niega a responder

6. ¿Cómo calificaría la salud de su hijo/a?
    a. Excelente
    b. Muy buena
    c. Buena
    d. No es buena o mala
    e. Mala
    f. Muy mala
    g. Se niega a responder
    h. No estoy seguro

7. Por favor, indique si está de acuerdo con la oración siguiente.
Salud dental es un parte importante de la salud de mi hijo/a.
    a. Muy de acuerdo
    b. De acuerdo
    c. No estoy de acuerdo o en desacuerdo
    d. En desacuerdo
    e. Totalmente en desacuerdo
    f. No estoy seguro
    g. Se niega a responder

8. ¿Cuáles son algunas de las razones que su hijo/a no visita al dentista? (Marque todas las que corresponden)
    a. EL dentista está muy lejos
    b. Es difícil a encontrar transporte
    c. Nadie en la oficina hablaba mi idioma
    d. Es demasiado caro
    e. Las esperas son muy largas en la oficina
    f. La oficina del dentista no está abierta cuando estoy disponible a ir
    g. No puedo conseguir una cita
    h. No tengo tiempo suficiente a llevar a mi hijo/a al dentista
    i. No puedo encontrar un dentista para mi hijo/a
    j. Mi hijo/a no tiene seguro dental
    k. No puedo encontrar un dentista que acepta el seguro de mi hijo/a
    l. Mi hijo/a no necesita cuidado dental
    m. Otro_____
    n. Se niega a responder

9. ¿Dónde podría encontrar información sobre salud dental para su hijo/a?
    a. El médico de mi hijo/a
    b. Por el internet
    c. Familia/Amigos
    d. Por los maestros de mi hijo/a
    e. La escuela de mi hijo/a
    f. No sé dónde podría encontrar esta información
    g. Otro_____
    h. Se niega a responder

10. Sexo del participante?
    a. Hombre
    b. Mujer
    c. Se niega a responder

11. ¿Condado donde vive?_____

12. ¿Cuántos años tiene usted?
    a. 18-24 años
    b. 25-35 años
    c. 35-44 años
    d. 45-54 años
    e. 55-64 años
    f. 65-74 años
    g. 75 años o mas
    h. Se niega a responder

13. ¿Cuál es su ingreso familiar combinado anual?
    a. Menos de $20,000
    b. 20,000 a 34,999
    c. 35,000 a 49,999
    d. 50,000 a 74,999
    e. 75,000 a 99,999
    f. 100,000 a 149,999
    g. 150,000 o más
    h. Se niega a responder

14. ¿Cuál es el último grado que ha completado?
    a. Pocos años de la escuela primaria
    b. Escuela primaria (hasta 6º grado)
    c. Escuela secundaria (hasta el 8º grado)
    d. Algunos grados secundario (hasta 11avo grado)
    e. Diploma de la escuela secundaria o GED
    f. Algunos años del/a colegio/universidad
    g. Titulo técnico o asociado
    h. Licenciatura
    i. Grado avanzado
    j. No tenía educación formal
    k. Prefiere no responder

15. ¿Cómo identifica su raza?
    a. Nativo/a americano/a o nativo/a de Alaska
    b. Asiático/a
    c. Negro/a o Afro-Americano/a
    d. Haitiano/a
    e. Hispano/a o latino/a
    f. Nativo/a de Hawái o de las islas del Pacifico
    g. Blanco/a
    h. Otro
    i. Se niega a responder

16. ¿Cuál es su situación de trabajo?
    a. Tiempo completo
    b. Tiempo parcial (uno trabajo)
    c. Tiempo parcial (varios trabajos)
    d. Estudiante
    e. Desempleado/a menos de un año
    f. Sin empleo durante un año o más
    g. Jubilado/a
    h. Se niega a responder

17. ¿Cuál es su estado civil?
    a. Solo/a
    b. Casado/a
    c. Viudo/a
    d. Divorciado/a
    e. Separado/a
    f. Unión civil
    g. Asociación domestica
    h. Se niega a responder

18. ¿En cual idioma se comunica más?
    a. Español
    b. Ingles
    c. Criollo
    d. Portugués
    e. Ruso
    f. Otro_____
    g. Se niega a responder

¡Muchas gracias por su participación en esta encuesta!

Una vez más, si tiene alguna pregunta o quiere más información, por favor comuníquese con Kristin Garces por: kgarces@flhealthinnovation.org o por teléfono al (561) 838.4444

Appendix E. Consumer Engagement Survey (Online Format)

Spanish: https://www.surveymonkey.com/r/DCS9XXC
English: https://www.surveymonkey.com/r/consumerengagement2016

Appendix F. Focus Group Moderator Guide

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Consumer Engagement Focus Group Guide

DentaQuest Foundation, Florida Oral Health Alliance 2016

Last updated: November 2016

Acknowledgements
The Florida Institute for Health Innovation would like to thank the DentaQuest Foundation and Oral Health Alliance team for their patronage and counsel on this project. FIHI would also like to thank Kentucky Youth Advocates for kindly sharing their resources to help assemble materials for this guide. Finally, we are very grateful to our state partners who have generously committed their time, efforts and resources to helping FIHI complete this study.

Background
The Pew Charitable Trusts June 2013 Children's Dental report entitled In Search of Dental Care: Two Types of Dentist Shortages Limit Children's Access to Care examined children's limited access to dental care, estimating that children covered by private insurance are 30% more likely to have been seen by a dentist than children covered by Medicaid or other government programs. Florida ranked first in the nation as having the highest percentage of children covered by Medicaid who did not see a dentist in 2011 – 75.5%. In 2015, Florida remained significantly behind national oral health rankings, with 47% of U.S. Medicaid-eligible children receiving any dental service (as supervised by a dentist) compared to only 35% in Florida, and 45% receiving preventive dental care nationally compared to just 33% in Florida .

Purpose
In an effort to reduce these oral health disparities among Florida's children, the Florida Institute for Health Innovation (FIHI) is conducting consumer engagement focus groups with parents to identify barriers to accessing dental care.

Research Question
- What are the barriers parents encounter in accessing dental care?
- What are methods parents perceive that we (policy-makers, providers, NGOs) can use to make dental care more accessible?

Target population
FIHI has targeted counties with the top 15 highest number of Medicaid-eligible children based on 2016 data for the consumer engagement study. Surveys were collected in all 15 counties. The top 4 counties with the highest number of Medicaid-eligible children were selected as locations to host parent focus groups. These included Miami-Dade, Broward, Hillsborough and Palm Beach counties.

The data on Medicaid-eligible children and the total number of individuals eligible for Medicaid was retrieved from the Agency of Health Care Administration. The remainder of indicators were retrieved from the August 2016 Florida Form CMS-416.

Participant selection process
Using a snowball sampling strategy and suggestions from our partner organizations and network of Oral Health stakeholders throughout Florida, FIHI has been given the opportunity to host focus groups in four locations. Invited participants are parents/caregivers of children (3-17 years old) and are full time residents of the state of Florida.

Focus group setting
As researchers, it is of utmost importance to create an environment in which participants feel comfortable and safe. These factors are vital in aiding parents/caregivers to share their perspectives and experiences. A non-threatening environment will help unveil any emotions or reactions participants might have regarding the discussion topic.

At the beginning of the focus group, the facilitator will lay a foundation for open discussion by introducing the group and addressing the process. The purpose and desired end goals of the discussion will also be addressed along with privacy and confidentiality concerns. The facilitator will introduce any other researchers in the room and make participants aware that they will be tape recorded for research purposes.

Each focus group should have between 5 -12 parents, with sessions lasting between 45-90 minutes. Layout of the room (i.e. chairs, tables) should be in a circle arrangement, not a classroom instruction setting. This type of layout will help participants feel more included in conversations and establish the facilitator as a guide, not as an instructor during discussion.

Focus Group Guide Checklist
- Focus group guide information
- Participant consent form
- Blank duplicates parent consent form
- Participant information form
- Focus group sign-in sheet
- Script/discussion guide
- Facilitator guide
- Recorder guide

Roles and responsibilities
- Facilitator: Kristin Palbicke Garces, MPH
- Recorder: Danielle Lewald
- Observer: TBD
- Participants

Materials checklist
- Two writing utensils
- A notepad or laptop
- Name tags or badges
- Recording equipment:
  A tape recorder
- Consent forms (enough copies for all participants)
- Participant information forms
- Extra pens for participants to sign consent forms
- Focus group guide
- Recorder guide
- Facilitator guide

Florida Institute for Health Innovation
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Oral Health Consumer Engagement Focus Groups

FOCUS GROUP CONSENT FORM: Adult Participation in a Focus Group

What is the research?

- You have been asked to take part in a research study by the Florida Institute for Health Innovation.
- The purpose of this study is to identify barriers experienced by parents when seeking dental care for their children.

Why have I been asked to take part?

- You are a parent or caregiver with a child.
- You have expressed interest in being part of the discussion.

Procedure

If you participate in this study, you will be in a group of approximately 5 -12 parents. There will be a facilitator who will ask questions and facilitate the discussion, and a note-taker to write down ideas and talking points expressed within the group. The conversation will be recorded to help researchers remember what was said.

Voluntary Participation

- This discussion is voluntary—you do not have to take part if you do not want to.
- If you do not take part, it will have no effect on your child.
- If any questions make you feel uncomfortable, you do not have to answer them.
- You may leave the group at any time for any reason.

Risks

No risks greater than those experienced in ordinary conversation are anticipated.

Benefits

There are no direct benefits for taking part in this group discussion. The information provided will help us understand any obstacles that might be present regarding accessing dental care for Florida families. This information will be shared with stakeholders in your community and around the state in efforts to improve any oral health care system challenges that are highlighted today.

Privacy and Confidentiality

- Your privacy will be protected.
- Your name will not be used in any report that is published.
- The discussion will be kept strictly confidential.

All participants and researchers in the room will be asked to respect the privacy of the other group members and asked not to disclose anything said within the context of the discussion. However, it is important to understand that other people in the group with you may not keep all information private and confidential. The recorded conversation will only be used to remind staff what participants contributed.

Audiotape Permission

I have been told that the discussion will be recorded only if all participants agree.
I have been told that I can state that I don't want the discussion to be taped and it will not be.
I can ask that the recording be turned off at any time.

I agree to be audio-recorded ___Yes ___No

Questions

I have been given the opportunity to ask any questions I wish regarding this evaluation. If I have any additional questions about the evaluation, I may call Kristin Garces at the Florida Institute for Health Innovation at (561) 838-4444.

I have received (or will receive) a copy of this form.

By signing this consent form, you are indicating that you fully understand the above information and agree to participate in this focus group.

_____ Yes, I would like to take part in the focus group.

_____ No, I would not like to participate in the focus group.

_____	_____	_____
NAME	SIGNATURE	DATE

_____

FACILITATOR/RECORDER

In my judgment, the participant(s) voluntarily and knowingly gave informed consent and has the legal

capacity to give informed consent to participate in this study.

_____ _____

Signature of facilitator/recorder **Date**

Florida Institute for Health Innovation
2701 N. Australian Ave., Suite 204
West Palm Beach, Florida 33407
Phone Number: (561) 838-4444
www.flhealthinnovation.org

A copy of this consent was given to the participant _____ (initial and date)

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Focus Group Participant Information Form

This information will be kept confidential. It will be used to:

- *Get your contact information so we can send you the final report if you want it*
- *Give us an overview of all focus groups participants around the state*

Name: _____ Age: _____

County of Residence: _____ Gender (please circle): Female Male

Race/Ethnicity (please circle all that apply): White Black or African American Hispanic or Latino/a Asian American Indian or Alaskan Native Native Hawaiian or Pacific Islander Haitian/ Creole Other: _____

Is English the language you speak most at home? Yes No

If no, what other language would you say you speak most at home? _____

Number of children in household: _____

Are you the children's parent or guardian? (Please circle one)

Please place an X for the type of health insurance you and your children currently have and if possible provide us with a name	**You**	**Your Children**
Uninsured		
Medicaid		
Kidcare		
Medicare		
Individually Purchased (specify name of insurance)		
Insured through work (specify name of insurance)		
Signed up on through Health Insurance Marketplace (healthcare.gov, using a navigator, etc.)		

Please answer the following questions about your child's dental history:

Children's ages	Has this child been to the dentist? (Circle one)	If yes, age at first dentist visit	Age of first tooth brushing	Number of cavities
	Y N	___ Years old	___ Years old	
	Y N	___ Years old	___ Years old	
	Y N	___ Years old	___ Years old	
	Y N	___ Years old	___ Years old	

How long ago was YOUR last visit to the dentist? _____

_____

Would you like a copy of the final report? (Please circle) Yes No

If yes, please provide your address below

Address: _____

City: _____ **Zip Code:** _____

Email address: _____

Florida Institute for Health Innovation

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Discussion Guide

Welcome

Note: Introduce moderator and assistant.

"Hello, my name is _____, I am with _____ and will be the group's facilitator. Thank you for being here today. I would also like to introduce _____ who will be taking notes of our discussion."

Purpose: Introduce purpose and objectives for the session

→ *The Florida Institute for Health Innovation is doing this project to find out from parents what they think about dental care for their children and in their community. We are hosting four sessions like this around the state of Florida to have these discussions with parents.*

→ *You were selected because you expressed an interest in participating. We value your knowledge, beliefs and opinions about dental care for your children, yourself, and your community.*

Guidelines

We would like to set a couple of ground rules for the group so that we can have a calm conversation on this topic.

(Preferably posted on a whiteboard or a wall where participants can see)

→ *There are no right or wrong answers, only different points of view.*
→ *Please try to avoid using names during discussion.*
→ *You don't need to agree with others, but you must listen respectfully as others share their opinions.*
→ *It is important for you to share your views.*
→ *Since the sessions are being recorded, please speak one person at a time and refrain from side conversations.*

**Rules for cellular phones and pagers if applicable. For example:

We ask that you silence your phones or put them on vibrate. If you must respond to a call, please do so as quietly as possible and rejoin us as quickly as you can.

Confidentiality

We would like to ask everyone in the room today to respect the privacy of the other group members and not to disclose anything said within the context of our conversation. In other words, we ask that what is said here, stays here.
Any information gathered here today will remain confidential. Your name will not be released to any outside

sources or be in any reports.

Consent

→ Assure that everyone has filled out a consent form, including an audio recording consent.
→ Have the recorder (note-taker) or additional volunteer in the room take care of this. Make sure that they are given a copy of the consent form for their records.
→ Make sure to ask if anybody has any questions.

Does anyone have any questions about this process before we begin?

Dissemination of Information/Thank you

This project is being funded by the DentaQuest Foundation and will be presented to other organizations around the state country that are interested in improving the dental care and lives of families.

We will also be sharing your thoughts and ideas with health professionals and community leaders to help them make our lives better by building on the strengths and fixing some of the weaknesses that you talk about today.

Thank you so much for sharing your views so we have a more accurate picture of the needs of Florida families. We will provide you with a copy of the report when it is complete, if you are interested.

Opening question - (Icebreaker)

Note: The focus group session should last between 45-90 minutes

(Skip) At this point we would like to do an exercise so everyone can get to know a little bit about each other.

→ Can be as simple as an introduction: "Tell us your name, where you live, and tell us one thing you would like us to know about your children."

Part One: Prevention Values

We would like to start the conversation by learning a little bit about your knowledge, beliefs, and opinions about dental care. This can be for you, your children, or your community.

Transition Question

• Question #1: *When you hear the words, 'dental health' or 'oral health' what do you think?*
  → *Any particular feelings?*
  → *What words come to mind?*

Guiding Questions

• Question #2: *"Compared to the rest of the body, how important is taking care of your children's mouth and teeth?"*
  → *How important is dental health to overall health?*
  → *What are your thoughts on brushing your child's teeth?*
  → *What about taking your child to the dentist to get his/her baby teeth checked?*

• Question #3: *"Why should or shouldn't children go to the dentist?"*
  → *What do you think might happen if your child/children doesn't receive regular dental care?*
  → *Are there any problems that could develop?*
  → *How often should children go to the dentist?*

Part Two: Accessibility and Barriers

"Next we are going to talk about some of the barriers to receiving dental care. You can talk about your experience or the experience of someone you know."

• Question #4: *"What are some reasons people might not take their children to the dentist?"*
  → *What are some things that might make it difficult to get your children to the dentist?*
  → *Can you describe a time that something made it difficult?*

• Question #5: *"What do you think is the best way to find a dentist?"*
  → *How do you find information about dental or oral health?*
  → *What do you think is the best way to get this information?*
  → *Would there be a better way to find a dentist or get dental health information?*

Part Three: Communication and Experience:

"Let's talk about your experiences with dentists or other dental workers."

Note to moderator: Look over parent group profiles at the beginning of the session. Identify whether they have Medicaid or not. If so, please ask the following question.

• Question #6: *"What have been your experiences with dentists who accept Medicaid for your children?"*
  → *How have you been treated by the dentist and their staff?*
  → *In your opinion, how important is the type of insurance you have to the care you receive from your dentist?*

• Question #7: *"How have you felt about the dental care your child has received?"*
  → *What specific things have made you happy or unhappy with you or your child's dental service?*
  → *If you have been unhappy what improvements do you think could be made?*

• Question #8: *"If you had a magic wand, how would you improve the dental care in your home or community?"*
  → *What could dentists/dental workers do to make it easier for your child to get health care?*
  → *What else should change?*

Ending questions

- Question #9: *"If you were in a room full of state decision-makers what would you tell them they need to do to improve dental health for children?"*
- Question #10: *"Is there anything you think we could have talked about but didn't?"*

"We would like to thank you once again for being part of this group today. We will have a few group discussions like this one and the information will help us in making dental care more accessible, pleasant and user-friendly in the future.

Facilitator Guide			
Opening Question (Ice Breaker): Tell us your name, where you live, and tell us one thing you would like us to know about your children. (7 minutes)			
Topic: (Part One) PREVENTION VALUES Your knowledge, beliefs and opinions about dental care for your children, yourself and your community.			
Type	**Question**	**Probes**	**Time allotted**
Transition	Q1. When you hear the words, 'dental health' or 'oral health' what do you think?	What are some of the feelings you have? What words come to mind?	7 minutes
Guiding	Q2. Compared to the rest of the body, how important is taking care of your children's mouth and teeth?	How important is dental health to overall health? What are your thoughts on brushing your child's teeth? What about taking your child to the dentist to get his/her baby teeth checked?	10 minutes
Guiding	Q3. Why should or shouldn't children go to the dentist?	What do you think might happen if your child/children do/does not receive regular dental care? Are there any problems that could develop? How often should children go to the dentist?	10 minutes
Topic: (Part Two) ACCESSIBILITY AND BARRIERS Barriers that people in the community might encounter when trying to access dental care. Participants are welcomed to share personal incidents or general views			
Guiding	Q4. What are some reasons people might not take their children to the dentist?	What are some things that might make it difficult to get your children to the dentist? Can you describe a time that something made it difficult?	10 minutes
Guiding	Q5. What do you think is the best way to find a dentist?	How do you find information about dental or oral health? What do you think is the best way to get this information? Would there be a better way to find a dentist or get dental health information?	10 minutes
Topic: (Part Three) COMMUNICATION AND EXPERIENCE Experiences with dentists or other dental providers and dental office staff			
Guiding	Q6. What have been your experiences with dentists who accept Medicaid for your children?	How have you been treated by the dentist and their staff? In your opinion, how important is the type of insurance you have to the care you receive from your dentist?	10 minutes
Guiding	Q7. How have you felt about the dental care your child has received?	What specific things have made you happy or unhappy with you or your child's dental service? If you have been unhappy what improvements do you think could be made?	9 minutes
Guiding	Q8. If you had a magic wand, how would you improve the dental care in your home or community?	What could dentists/dental workers do to make it easier for your child to get health care? What else should change?	10 minutes
Ending Questions (7 minutes)			
Q9. If you were in a room full of state decision makers what would you tell them they need to do to improve dental health for children? Q10. Is there anything you think we could have talked about but didn't?			

References

Guidelines used for focus groups

Krueger, R. Designing and Conducting Focus Group Interviews. : University of Minnesota. http://www.eiu.edu/~ihec/Krueger-FocusGroupInterviews.pdf

(2005). Guidelines for Conducting a Focus Group. : Eliot & Associates. http://assessment.aas.duke.edu/documents/How_to_Conduct_a_Focus_Group.pdf

Toolkit for Conducting Focus Groups . : OMNI. http://www.rowan.edu/colleges/chss/facultystaff/focusgrouptoolkit.pdf

Focus group methods and reports

Focus Group Facilitator Guide. (2012). U.S. Department of Health and Human Services. http://www.healthit.gov/sites/default/files/econsent_focus_group_guide.pdf

(2012). Public Health Focus Groups. : Corona Insights. http://www.co.grand.co.us/DocumentCenter/Home/View/2451

Oral health information and consumer engagement resources

Hogan, S., Hill, I., & Howell, E. (2009). Dental Care in the Los Angeles Healthy Kids Program: Successes and Challenges. : The Urban Institute. http://www.urban.org/uploadedpdf/412171-dental-care-LA.pdf

King, R. S. Problems With Access To Dental Care For Medicaid-Insured Children: What Caregivers Think. American Journal of Public Health, 53-58. Retrieved July 9, 2014, from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447388/

Parent Focus Group Report . : Center for Children's Health. https://www.centerforchildrenshealth.org/SiteCollectionDocuments/CCHAPSReports/CCHAPS-PARENT_FOCUS_GROUP_REPORT.pdf

Appendix G. Focus Group Summary

- A focus group was conducted in Broward County at the Jack & Jill Children's Center on November 10, 2016. A total of 12 parents/caregivers participated in this focus group that were between the ages of 18-52; 10 participants were female and 2 participants were male. Majority of participants (7 of 12 individuals) identified as Black or African American, while two identified as Hispanic/Latino, one identified as Haitian/Creole, and one responded with 'Other'. All participants spoke English at home as their primary language and all children/dependents were insured with Medicaid. Majority (60%) of parents/caregivers were insured with Medicaid as well, while 30% were insured through their work, and 10% were uninsured.
- A focus group was conducted in Miami-Dade County at Catalyst Miami on November 16, 2016. A total of 6 parents/caregivers participated in this focus group and all were females between the ages of 32-51. All of the participants identified as Haitian/Creole, and 50% of the individuals spoke French Creole at home as their primary language while 50% spoke English. Majority of the children/dependents (5 of the 6) were insured through Medicaid and one was uninsured. Only two parents/caregivers provided answers for their insurance type; they were both insured through Medicaid. As French Creole is one of the most prevalent languages spoken at home in Miami-Dade County, we had the opportunity to host a bilingual focus group with French Creole speakers; translation was kindly provided by Catalyst Miami's staff.
- A focus group was conducted in Orange County at the Early Learning Coalition of Orange County in conjunction with their Baby Institute on September 15, 2018. A total of 6 parents/caregivers participated in this focus group and all were females between the ages of 30-70. Majority of participants (four of the six individuals) identified as Black or African-American, one individual identified as Haitian/Creole, and one individual identified as Hispanic/Latina; the primary language spoken at home for all participants was English, except for one individual who's spoken language at home was Spanish. All of the participants' children/dependents were insured through Medicaid; 4 of the 6 (66%) parents/caregivers were insured through Medicaid as well, while one individual (17%) was insured through Medicare, and one individual (17%) was insured through their employer.
- A focus group was conducted in Palm Beach County at the Children's Home Society of Florida's BRIDGES West Palm Beach location on October 24, 2018. A total of 15 parents/caregivers participated in this focus group that were between the ages of 23-69; 14 participants were female and 1 participant was male. Majority of participants (14 of the 15 individuals) identified as Black or African American and one individual identified as Moorish American. Additionally, 14 of 15 participants spoke English as their primary language at home, and one individual answered that they did not speak English but did not specify their primary language. All of the children/dependents were insured through Medicaid; almost half of the parents/caregivers (47%) were insured through Medicaid as well, 20% were insured through their work, 20% were insured through Medicare, and 13% were uninsured.

As Appendix G indicates, data collection was divided into four overarching sections to assess parents and caregivers experience, knowledge, and understanding of oral health and oral health services. Questions were asked on behalf of parents and their children, or of someone participants know. The first group of questions focused on (1) Parents/caregivers knowledge; these questions focused on knowledge, beliefs,

and opinions on dental care and oral health in general. The second set of questions addressed (2) Barriers to oral health services; questions were asked about what barriers parents/caregivers faced when accessing and receiving dental care for their children. The third section focused on (3) Direct experiences with dental health providers; these questions highlighted experiences that parents/caregivers had with dentists and dental office staff while seeking care for their child. The last section solicited (4) Participants suggestions/recommendations on how to improve oral health access and dental care in their community.

Appendix H

Alignment Efforts: Consumer Engagement Impact, 2017-20

Catalyst Miami

Catalyst Miami is a social services organization that invests in people to build prosperity, cultivates leaders to strengthen families, and accelerates change through partnerships. Catalyst Miami's mission is to develop and support individual leadership and strong organizations that work together to improve health, education, and economic opportunity throughout Miami's multicultural communities. They are a member of the Miami-Dade Oral Health Network, which is a community-centered grassroots initiative committed to improving and eliminating oral health disparities through education, assessment, policy/program development, and collaboration.

As part of their work for the DentaQuest Partnership for Oral Health Advancement, Catalyst Miami is conducting an ongoing oral health education and awareness campaign to connect with community members and the general public to educate them on the importance of oral health and the connection it has with overall health. Two components of the campaign include educating the public on what resources exist within their own communities to assist them in maximizing the oral health services available to them and conducting surveys to better educate them on the importance of oral health within overall health. The focus of the surveys is to ensure that the community understands oral health, not merely as a matter of personal agency, but also in the context of a public health and social justice issue.

Upon creating the survey, Catalyst's staff met with their partners in the Miami-Dade Oral Health Network to discuss the language in the survey and incorporate input and comments from their partners; FIHI participated in this process. All surveys were conducted in-person by Catalyst staff at health, fitness, and wellness fairs throughout Miami-Dade County, and were offered in both English and Spanish; these surveys can be found in Appendix I and Appendix J, respectively. Respondent demographics were varied, and included senior citizens, as well as low-income parents and families. All respondents received a free grab bag as a sign of appreciation for their participation.

Catalyst Miami's work in demonstrating that oral health is a social justice issue has greatly aided the Alignment Network in further highlighting specific attitudes and beliefs held by consumers. Additionally, this data highlights the costs associated with ER visits and the potential impacts on Florida's economy. Catalyst's work, in turn, aims to demonstrate the systemic issues that consumers in the Miami area have faced and elucidate the potential benefits of removing barriers to dental care.

Tampa Bay Healthcare Collaborative

TBHC is a membership-based, nonprofit organization that led the "Achieving Oral Health Equity in Tampa Bay (AOHE) Initiative." The AOHE Initiative focuses on developing community collaborations and building community capacity to increase awareness of the importance of oral health to overall wellness. AOHE is part of the Oral Health Progress and Equity Network (OPEN) – a national effort to improve the oral health of all.

Tampa Bay Healthcare Collaborative (TBHC) created a pair of infographics that highlighted the key findings from both sets of their surveys (modeled after the FIHI Consumer Engagement surveys) as part of their Achieving Oral Health Equity in Tampa Bay initiative; the Achieving Oral Health Equity in Tampa Bay Infographic can be found in Appendix K and the Achieving Oral Health Equity in Wimauma, FL Infographic can be found in Appendix L. TBHC collected recommendations within their surveys as well. These recommendations were broken down into care, community, financing, and policy recommendations, with overlap existing between sections. Key recommendations included instituting incentives for dentists to work in underserved populations and integrating dental services through programs such as the Supplemental Nutrition Assistance Program (SNAP) and Women, Infants, and Children (WIC) by treating dental health as a nutrition issue. Like Miami-Dade, Wimauma and Tampa Bay at large has a significant minority population that possesses its own set of cultural considerations when addressing dental care. The work conducted by TBHC supports the Alignment Network by demonstrating the areas where Florida's delivery of dental services can be enhanced are not limited to any one region within the state.

Florida Voices for Health

FVH is a consumer advocacy organization and coalition of community organizations, businesses, and individuals that works to ensure that the stories and the interests of hard-working, low and moderate-income Floridians are represented in the health reform debate and health care system. In addition to running the Head to Feet: People's Campaign for Dental Health, they advocate for Florida Medicaid expansion, and provide educational and informational resources to strengthen the Medicaid system within Florida.

During and following the Consumer Engagement research, Florida Voices for Health (FVH) completed a story-banking project that collected consumer stories describing challenges in accessing oral health care. These stories were featured on their website and highlighted many of the experiences that mirror those represented in the Consumer Engagement findings.

FVH has served as an effective grassroots advocacy partner of the Alignment Network. FVH hosts informational and training webinars and coalition calls to keep partners abreast of upcoming legislation and share calls to action. FVH additionally works to guide the Alignment Network on policy and advocacy and ensures our organizations work in parallel towards a more equitable and accessible health care system.

Oral Health Consumer Advisory Council

As part of the Institute's Oral Health 2020 initiative and the work to support the Florida Oral Health Alliance, the Institute, along with some of our Alliance partners, formed and facilitates a statewide Oral Health Consumer Advisory Council (CAC) to provide a deeper understanding of the barriers to oral health care and to inform state programs and policies. This statewide consumer group gathers the perspective of those that are typically unheard, including people working with disenfranchised families and children, as well as the people who experience the consequences of inequity. The council includes representatives from the Florida Foster and Adoptive Parent Association, both of whom assist in understanding the unique barriers disadvantaged groups face. The CAC meets monthly to share feedback and experiences that help to inform oral health strategies, test interventions, and make recommendations based on the challenges, needs and strengths of Florida's communities.

The Council has discussed a variety of topics including the efficacy of silver diamine fluoride as a means of fighting cavities, oral health messaging and proper framing, policy updates as a result of the dental carve out, school-based oral health initiatives, and ongoing efforts to highlight network impact stories. Common discussions during the CAC meetings centered on identifying barriers and supports to oral health care, as well as a need for new approaches and policies to activate increased utilization of oral health care services. The council identified the following as top barriers and supports to accessing oral health care for their children:

Barriers:

- Transportation
- Lack of support from Managed Care Plans in coordinating care
- Difficulty navigating services and understanding how to access available services
- Shortage of Medicaid dental providers, especially in rural, low-income areas.
- Lack of dental providers that will treat special-needs children
- Lawmakers do not understand wider implications of oral health.
- Language barriers
- Gaps in water fluoridation in many parts of the state

Supports:

- School-based oral health programs
- Mobile dental vans/clinics
- Required oral health screenings and outreach programs (i.e. Head Start)

Appendix I. Catalyst Miami Survey in English

Oral Health Community Survey

CATALYST MIAMI

1. What is your Zip Code?
_____

2. How often, on average, do you brush your teeth? (Mark only one oval).
- o Zero times a day
- o Once a day
- o Twice a day
- o Three times a day

3. How often, on average, do you floss? (Mark only one oval).
- o Zero times a day
- o Once a day
- o Twice a day

4. How often, on average, do you visit a dentist? (Mark only one oval).
- o Once every 6 months
- o Once every 9 months
- o Once a year
- o Twice a year
- o I don't visit a dentist

5. Do you have health insurance that covers dental care? (Mark only one oval).
- o Yes
- o No
- o Not sure

6. How often do you use health insurance to receive dental care? (Mark only one oval).
- o Every time
- o Most of the time
- o Some times
- o Never
- o I don't have health insurance that covers dental care

7. Which you needed dental care but weren't able to get it? (Mark only one oval).
- o Yes
- o No
- o Not sure

8. If yes, why were you unable to receive dental care? (Mark only one oval).
- o Too Has there been a time in the last six months in w expensive
- o Too far
- o I don't like going to the dentist
- o Language barrier
- o Other: _____

9. Have you ever gone to the emergency room to receive dental care? (Mark only one oval).
- o Yes
- o No
- o Not sure

10. Have you ever gone to urgent care to receive dental care? (Mark only one oval).
- o Yes
- o No
- o Not sure

11. Do you think you should be responsible for paying for the full cost of your own oral care? (Mark only one oval).
- o Yes
- o No
- o Not sure

12. Can a person with poor overall health have good oral health? (Mark only one oval).
- o Yes
- o No
- o Not sure
- o Other:_____

13. Do you think chronic diseases are related to oral health? (Mark only one oval).
- o Yes
- o No
- o I don't know
- o Other_____

14. Do you think you should have access to oral care regardless of income? (Mark only one oval).
- o Yes
- o No
- o Not sure

15. Do you think the government should provide partial oral care insurance to you? (Mark only one oval).
- o Yes
- o No
- o Not sure

16. Do you think the government should provide complete oral care insurance to you? (Mark only one oval).
- o Yes
- o No
- o Not sure

17. On a scale of 1 to 10 (1=bad and 10= excellent), how would you rate your overall oral health?

_____

Appendix J. Catalyst Miami Survey in Spanish

ENCUESTA COMUNITARIA SOBRE LA SALUD ORAL (Homestead)

CATALYST MIAMI

¿Cuál es su código postal?

_____

1. ¿Con qué frecuencia, en promedio, te cepillas los dientes?
   - o Cero veces al día
   - o Una vez al día
   - o Dos veces al día
   - o Tres veces al día

2. ¿Con qué frecuencia, en promedio, usa hilo dental?
   - o Cero veces al día
   - o Una vez al día
   - o dos veces al día

3. ¿Con qué frecuencia, en promedio, visita a un dentista?
   - o Una vez cada 6 meses
   - o Una vez cada 9 meses
   - o Una vez al año
   - o No visito al dentista

4. ¿Tiene seguro de salud que cubre la atención dental?
   - o Si
   - o No
   - o No estoy seguro

5. ¿Con qué frecuencia utiliza el seguro de salud para recibir cuidado dental?
   - o Cada vez que voy al dentista
   - o La mayoría de las veces
   - o Algunas veces
   - o Nunca
   - o No tengo seguro de salud que cubra el cuidado dental

6. ¿Hubo un momento en los últimos seis meses en el que necesitó cuidado dental pero no pudo obtenerlo?
   - o Si
   - o No
   - o No estoy seguro

7. Si respondió no, ¿por qué no pudo recibir atención dental?
   - o Demasiado caro
   - o Demasiado lejos
   - o No me gusta ir al dentista
   - o No hablo ingles
   - o Otro: _____

8. ¿Alguna vez ha ido a la sala de emergencias para recibir cuidado dental?
   - o Si
   - o No
   - o No estoy seguro

9. ¿Alguna vez ha ido a la sala de emergencia para recibir cuidado dental?
   - o Si
   - o No
   - o No estoy seguro

10. ¿Crees que deberías de ser responsable de pagar el costo total de tu propia atención oral?
    - o Si
    - o No
    - o No estoy seguro

11. ¿Puede una persona con mala salud oral tener buena salud en general?
    - o Si
    - o No
    - o No estoy seguro

12. ¿Crees que las enfermedades crónicas están relacionadas con la salud oral?
    - o Si
    - o No
    - o No estoy seguro

13. ¿Crees que deberías tener acceso a la atención oral sin importar tus ingresos?
    - o Si
    - o No
    - o No estoy seguro

14. ¿Cree que el gobierno debería proporcionar un seguro parcial de atención oral para familias de ingresos moderados a bajos?
    - o Si
    - o No
    - o No estoy seguro

15. ¿Piensa que el gobierno debería proporcionar un seguro completo de cuidado oral para familias de ingresos moderados a bajos?
    - o Si
    - o No
    - o No estoy seguro

En una escala de 1 a 10, (1 = malo y 10 = excelente), ¿cómo calificaría su salud oral general?

_____

Appendix K. Tampa Bay Healthcare Collaborative Achieving Oral Health Equity in Tampa Bay Infographic

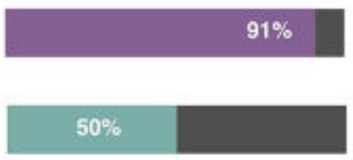
Achieving Oral Health Equity
In Tampa Bay

Promoting oral health as essential to lifelong good health and well-being.

Achieving Oral Health Equity in Tampa Bay (AOHE), an initiative of the Tampa Bay Healthcare Collaborative focuses on creating significant systems and public policy change. As a member of the Oral Health 2020 Network, we are committed to health equity and social justice – ensuring good oral health for all.

As part of this effort, TBHC administered over 600 surveys, facilitated 6 focus groups and conducted numerous interviews with stakeholders to better understanding the community's current attitudes, perspectives, and beliefs regarding oral health and dental services. Highlights of the findings are shared in this document.

Importance vs. Condition



91% of respondents agree that oral health is important

50% of respondents describe the condition of their teeth and gums as 'poor' or fair'

38% of respondents avoid "smiling and laughing" due to the condition of their teeth

Knowledge vs. Behavior

92% believe regular checkups will prevent dental health problems

however

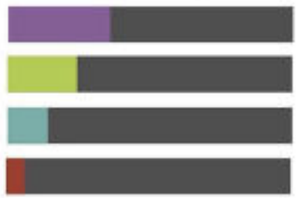
35% only visit the dentist when they have a toothache

33% of respondents reported visiting the dentist within the last 6 months

27% reported it had been 1-2 years

20% reported it had been 2-4 years

2% reported never visiting the dentist



*13% of respondents did not know and 5% selected other

Identifying Barriers to Accessing Dental Care

Survey respondents were asked to identify barriers to getting dental care and/or reasons they delayed or avoided scheduling a dental appointment. **The following areas were identified:**

50%
of respondents reported delaying care due to cost

Equity and Social Justice

Residents were asked if they had ever felt discriminated against by a dentist or dental professional because of certain characteristics.

13% of the respondents felt discriminated based on insurance

12% of respondents felt discriminated based on income

7% of respondents felt discriminated against because of race

5% of respondents felt discriminated due to age

69% reported not feeling discriminated against

26%
of respondents felt that their race impacts their ability to access quality dental care

*Note – total exceeds 100%, respondents were able to select ALL that apply

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Appendix L. Tampa Bay Healthcare Collaborative Achieving Oral Health Equity in Wimauma, FL Infographic

Achieving Oral Health Equity
In Wimauma, FL

Promoting oral health as essential to lifelong good health and well-being.

Achieving Oral Health Equity in Tampa Bay (AOHE), an initiative of the Tampa Bay Healthcare Collaborative focuses on creating significant systems and public policy change. As a member of the Oral Health 2020 Network, we are committed to health equity and social justice – ensuring good oral health for all.

As part of this effort, TBHC administered nearly 300 surveys and facilitated 2 focus groups in Wimauma, Florida to better understand the community's current attitudes, perspectives, and beliefs regarding oral health and dental services.
Highlights of the findings are shared in this document.

Importance vs. Condition

90% of respondents agree that oral health is important

51% of respondents describe the condition of their teeth and gums as 'poor' or fair'

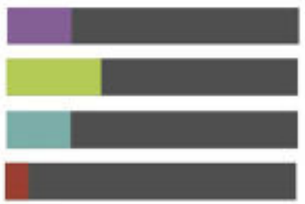
48% of respondents avoid "smiling and laughing" due to the condition of their teeth

Knowledge vs. Behavior

96% believe regular checkups will prevent dental health problems

however

29% only visit the dentist when they have a toothache



23% of respondents reported visiting the dentist within the last 6 months

33% reported it had been 1-2 years

23% reported it had been 2-4 years

8% reported never visiting the dentist

*13% of respondents did not know and 5% selected other

Identifying Barriers to Accessing Dental Care

Survey respondents were asked to identify barriers to getting dental care and/or reasons they delayed or avoided scheduling a dental appointment.
The following areas were identified:

Equity and Social Justice

Residents were asked if they had ever felt discriminated against by a dentist or dental professional because of certain characteristics.

12% of respondents felt discriminated against because of race

8% of the respondents felt discriminated based on insurance

10% of respondents felt discriminated based on income

3% of respondents felt discriminated due to Gender

74% reported not feeling discriminated against

34% of respondents felt that their race impacts their ability to access quality dental care

*Note – total exceeds 100%, respondents were able to select ALL that apply

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Appendix M. Florida Health Centers With Mobile Units by Type 2020

COMMUNITY HEALTH CENTER, CITY	TYPE OF MOBILE UNIT				
	MEDICAL	DENTAL	MEDICAL DENTAL HYBRID	OTHER	OTHER TYPE
Agape Community Health Center, Jacksonville	1	1P*	None	None	NA
Bond Community Health Center, Tallahassee	1	None	None	None	NA
Borinquen Medical Centers, Miami	None	None	1	None	NA
Brevard Health Alliance, Melbourne	None	None	1	None	NA
Camillus Health Concern, Miami	1	None	None	None	NA
Care Resource Community Health Center, Miami	None	None	None	2	Outreach, Screening, Testing
Central Florida Health Care, Winter Haven	None	None	1	1	Medical and Behavioral
Community Health Centers of Pinellas, St. Petersburg	None	None	1	1P*	Outreach, Screening, Testing
Community Health Northwest Florida, Pensacola	1	1 + 1P*	None	None	NA
Empower U Community Health Center, Miami	1	None	None	None	NA
Family Health Centers of Southwest Florida, Ft. Myers	None	1	None	None	Also, Hearing and Vision Screening
Florida Community Health Centers, West Palm Beach	1P *	None	None	None	NA
Genesis Community Health, Boynton Beach	None	1	None	None	NA
Health Care District of Palm Beach County, West Palm Beach	None	None	None	1	Medical and Behavioral
Healthcare Network, Immokalee	None	None	2	None	NA
Jessie Trice Community Health System, Miami	None	None	None	1	Outreach, Screening, Testing
MCR Health, Palmetto	1	1	None	1	Optical
Neighborhood Medical Center, Tallahassee	None	None	1	None	NA
New River Community Health Center, Starke	1P*	None	None	None	NA
*P=Planned					

COMMUNITY HEALTH CENTER, CITY	TYPE OF MOBILE UNIT				
	MEDICAL	DENTAL	MEDICAL DENTAL HYBRID	OTHER	OTHER TYPE
Orange Blossom Family Health, Orlando	1	2	None	None	NA
Osceola Community Health Services, Kissimmee	None	None	None	1	Medical, Dental, Behavioral
Pancare of Florida, Panama City	5	6	None	1	Optical
Premier Community HealthCare Group, Dade City	None	1	None	None	NA
Project Health, Sumterville	1	1	None	None	NA
Rural Health Network Monroe County, Key West	None	None	1P*	None	NA
Sulzbacher Health Center, Jacksonville	None	None	None	1	Medical, Behavioral, Social
Suncoast Community Health Centers, Brandon	1	2	None	None	NA
Tampa Family Health Centers, Tampa	1	2	None	None	NA
True Health, Sanford	None	None	None	1	Behavioral
*P=Planned					

Source: Florida Association of Community Health Centers. (2020, June). *2020 Directory of Florida Community Health Center Mobile Health Units.* https://www.fachc.org/assets/FACHC%202020%20Florida%20Mobile%20Health%20Program%20Directory.pdf