South Dakota Dental Association

Focus Group Report – Pediatric Dental Care Access and Practice

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June 9, 2005

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Pediatric Dental Care Access and Practice
May 12, 2005
Summary of Findings

Focus Group Description

The focus group took place during the annual state conference of the South Dakota Dental Association. Time duration was one and one-half hours. Participants were recruited by the South Dakota Dental Association staff to represent dental practice across the state. The composition of the group included seven dentists in private practice and five dental office staff working in various areas of scheduling, office management, and fiscal services. The group was heavily skewed to Eastern South Dakota. One participant represented Western South Dakota. The response group was also skewed in that three dentists represented also had office personnel from the same office in the focus group. The dental practices represented both short term (3-5 years in practice) and long term (over 15 years in practice). The respondents also included office with multiple dentists and those with single dentist practices.

The facilitator, Margaret J. Sumption, broke the facilitation into five sections. Section One was designed prepare the participants through a description of dental practice nationally and within the state. Participants were asked to rank the quality of dental care children receive in South Dakota compared to other regions of the country. The second section of dialogue was designed to elicit understanding of "best practice" in pediatric dental care. The third section of communication was designed to define the current policies and practice regarding dental care access for pediatric patients who have Medicaid as their primary funding source. The fourth section of the communication was designed to elicit ideas regarding how the state could more effectively deliver pediatric dental prevention and treatment, including the role of other health care providers. The last section of the dialogue drew out the role of state association leadership and governmental leadership needed to address the concern of pediatric care access.

All participants stayed for the entire session. The session was videotaped for the sole use of the facilitator to document findings.

Issues for Consideration

The following are conclusions reached in analyzing the findings of the focus group survey research. These issues indicate patterns of behavior and practice which should be considered in developing programs and services to meet the needs of South Dakota children served by Medicaid. The issues are those presented by participants:

A clear bias regarding people who are Medicaid users

- Providers see parents as the "problem" – The view of participants is that parents see dental care low on the list of priorities, according to providers. The nutrition they provide for their children is poor. They don't know that they must brush their children's teeth. They see dental care as "reactive" and they don't see the need for ongoing routine care.

- Medicaid eligible families choose to be noncompliant with appointments and care – Office staff were especially harsh in their criticism of Medicaid eligible families as being willfully noncompliant, and not taking responsibility for the care of their children. Dentists in the focus group did not actively express these views but did not move to challenge the views held by office staff.

- Strengthen Social Services oversight – Not getting proper oral health should be seen as neglect or abuse, according to participants. These families should face the review of Child Protection.

- Regarding No-Show: Three strikes, you're out – Respondents want some type of strategy to demand compliance of Medicaid-eligible patients. There was discussion of some types of incentives, but no identified strategies were discussed. Participants felt that patients that are not compliant should be denied future service.

- Many practitioners believe that the pool of Medicaid recipients is too large – We need to assure that only the families who really need the service are eligible to participate.

Reimbursement and regulation actively deter providers from serving patients on Medicaid

- The problem is more than a "kid" problem – The reimbursement for kids on Medicaid isn't too bad. The reimbursements for adults, primarily disabled and elderly, are so poor that providers often just make a blanket decision not to provide care for anyone on Medicaid. Alternatively, providers believe that if they take the kids on Medicaid, then they will have to serve their adult parents as well.

- Administrative costs of Medicaid are burdensome – Having to buy card scanners, pay processing charges, and subject claims to stiff oversight makes serving Medicaid difficult to justify.

Prevention education is a key to success

- We need more emphasis on preventative education and care – We need to spend energy and resources on educating parents about the importance of good oral health. We have vision and hearing screenings in schools – why not oral health? One example was education for parents that "you know your child can brush their own teeth well when they can cut up a waffle and eat it on their own."

- The Interfaces Project is a good beginning – This program can support dental care access and build resources. We need to keep and build on it.

- ABCD program is good – We need to keep working on these types of programs to grow an understanding of and commitment to preventive and early interventive care.

- Add dental care to the nutrition education strategy – The role of nutrition in dental health and the need for regular dental care should be included in the Governors Healthy People program and the Sioux Falls Growing Healthy Initiative. This would be a good way to educate parents.

- We MUST educate parents – Heavy emphasis must be given to educating parents regarding the need for preventive care and regular dental checkups.

Collaboration with the medical community is a challenge to be addressed

- Expand physician practice to include fluoride varnish – This would help to get kids the preventative care they need faster and with greater compliance.
- Having physicians write prescriptions will NEVER WORK – There are not enough dentists to take the volume this would produce.
- In order to be successful, dentists must serve WHOLE families – In order to have systemic change, dentists must agree to serve whole families, teach parents, treat the parents, treat the kids, and provide the preventative care kids need.

Create new resources to meet the needs of children and adults

- The Care Mobile is increasing the number of referrals to dentists – The need for a dental home for patients is still critical. If the Care Mobile can get kids stable, then dentists can keep up their care.
- We need an adult Care Mobile – The greatest burden on the system is care for adults with disabilities and for elderly in nursing homes. We need a way to get these folks served effectively.
- Continue to promote new dentists into service – We need more practitioners in order to meet the need for dental care.
- Promote professional responsibility – Every dentist has to do a little to meet the needs. Right now, 10% of dentists are doing 90% of Medicaid. If we don't all step up, we can expect to get regulated into care.
- Not enough dentists **really** take Medicaid **–** Providers say they take Medicaid but really don't. We need to spread out the numbers to more dentists or the industry will face governmental mandates like those being seen in other states.

Questions Regarding Policy and Practice

The following questions were asked specifically by the South Dakota Dental Association prior to the planning of the focus group research. The information provided for each has been collected from the analysis of the videotaped focus group session.

*What age do you tell parents they need to start bringing their child in for their first check-up?*

The concurrence of the group is that a child should be seen for the first time by age one. They believe this is "best practice". Some respondents indicate that they routinely tell new parents to bring their child in at age one for a brief review of the child's oral health. One dentist indicated that he does not charge for the visits by patients under age three but encourages parents

to bring their children annually up to age three to address any concerns that might develop before that age.

One dentist indicated that he has made outreach contact to pediatricians in his community, asking them to promote routine early dental care for their patients. He said that often, pediatric medical office staff make appointments directly for patients needing care.

There is no indication that dentists routinely do outreach to draw in young patients other than the example noted above. Most see their role in serving young children who are part of the families they are already serving.

*If your policy is age three or higher, do you ever accept younger patients?*

The policy of all dentists in the group is that patients will be accepted and encouraged to be seen from age one or the presence of a first tooth. None of the respondents indicated any formalized policy with regard to treatment age.

Again, it is noteworthy that none of the respondents identified any clear pattern of outreach to assure that young patients are served from the age of one. The only example was noted above came about because a new dentist was building his practice and connected to pediatricians as a way of completing this marketing effort.

*What supports do you need to increase your ability to see young patients?*

All respondents agreed that the their ability to see young patients is limited by the attitudes, skills, and practices of parents. They believe that if parents make routine preventative dental care a priority, they can assure that children will get seen.

It must be noted that there is a strong tone of bias among many of the respondents regarding the attitudes, skills, and practice of families served by Medicaid. They believe that families served by Medicaid don't see coverage by Medicaid as a "privilege". They believe that lack of full compliance by Medicaid families should result in expulsion from coverage the program.

The dentists were also in strong agreement that the system of Medicaid reimbursement and quality assurance review hinder their capacity and willingness to provide early pediatric care. The believe that the reimbursement rates for young children are low, but manageable. They are angered that they must buy extra equipment (card readers) to get more prompt reimbursement, get charged surcharges for each transaction, face numerous look-behind review processes, and deal with the much larger "no-show" rate among Medicaid patients without consideration in the program to cover these out-of-pocket costs. They also expressed concern that patients go on and off Medicaid which often leaves the dental bill unpaid.

*If a patient is referred by a medical provider, how likely would you be to take the referral? (What if they are a Medicaid patient?)*

All practices represented indicated they would take a young child, if referred and in need of care. Providers indicated that they would not deny a child care if they are referred by a doctor. There was concern by many respondents regarding compliance with care. They believe that families served by Medicaid are traditionally are less compliant with recommendations for ongoing preventative care (brushing, eating proper diet, not going to sleep with a bottle, etc), less

likely to make or keep routine appointments, and that if they serve the young child, they may be pressured to see the whole family, adding to their burden of low reimbursement care. A note here is that participants believe that pediatric care is reimbursed better than adult care through the Medicaid program.

*What is the possibility that your office would be willing to report back to the primary care provider the work that had been completed on a child?*

There is s strong bias among the respondent group to make the paperwork process easier, not more complicated. Any additional paperwork or reporting burden is seen negatively.

*What would be your preferred way of accepting referrals from a medical provider:*
Call from medical office
Written prescription
Verbal referral
Medicaid referral center

The respondents were quick to point out that a prescription from medical doctors would "cripple the system." They believe that dentists in most areas of the state would be unable to absorb the numbers of children to be seen if doctors started prescribing care. This is especially true as not all dentists take patients on Medicaid.

There was active support for the use of the Care Mobile as a way to get lots of kids seen and get their care up to date. Once their care is up to date, according to one dentist, it is more manageable to keep their preventative and interventive care up to date in the office. There was a strong commitment to children having a "dental home," with little consensus regarding how this could be accomplished.

Participants in the focus group expressed discomfort that the dental profession in South Dakota is not "stepping up" to meet the dental needs of poor children and families. They indicated that the professionals say they take Medicaid when, in reality, the numbers most dentists in the state serve are very few. One dentist summed it up by saying that "if we don't clean it up – it will be mandated – other states have gone this way."

*How far out are you currently scheduling patients?*

Most dentists are scheduling 2-3 months out. One dentist indicated that in Sioux Falls the scheduling timeline has dropped from a high of 6 months out to current 2-3 months.

*Would your willingness to accept a referral be affected if the patient were willing to fill a canceled appointment?*

Participants were clear that serving Medicaid funded patients has no financial margin. The reason they take Medicaid patients is because they have made a strategic decision to serve these patients as a contribution to their communities.

*Tell us about your cancellations vs. no shows.*

There was concurrence among the group that no-shows are a critical problem with Medicaid eligible patients. One clinic brought statistics that 85% of their no-shows by new patients in a typical month are patients on Medicaid.

One provider in the group uses a unique strategy to address the no-show rate for less compliant patients. They have identified set days internally known as "Medicaid" days. On these days, patients are double/triple-booked. In his several year history, this provider says he rarely falls more than 45 minutes behind and catches up quickly throughout the day. He believes customer services is not adversely affected by this strategy and he makes more efficient use of his overhead and staffing.

*Does your office use fluoride varnish as a preventive agent?*

The use of fluoride varnish was wide-spread among the respondents. All use the technique and believe in its value as a preventative strategy.

In a discussion regarding Care Mobile, one dentist talked about this as being a way to "catch up" on kids with lots of problems, get them stable with fillings, etc. and then when she sees them, she can effectively keep up with their ongoing care. There was STRONG sentiment among the group that best practice is still having a "dental home". Even with the Care Mobile filling a void, the system must still work to get these kids connected to a dental provider.

*Does your office have set policies on Medicaid? If so, please share examples.*
Examples: No show policies
New vs. existing Medicaid patients
Turnover
Caps?
Scheduling
Age limits

None of the providers identified a "set policy" on service to patients who are referred on Medicaid. Most indicated that is their regular practice to take children on Medicaid. Many indicate that refusing to serve adult on Medicaid is a far more common practice.

One office manager indicated that it is very common to receive calls from up to a 100 miles away from prospective patients who have heard that they take patients on Medicaid. These patients have been turned down in their home communities, indicating that this practice is common.