



RESULTS-ORIENTED. RESPONSIVE. DATA-DRIVEN.

Oral Health 2014 Consumer Engagement Initiative

Final Report

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Abstract

As part of a comprehensive effort to reduce oral health disparities and to improve the oral health of people living in Florida, the Florida Institute for Health Innovation has coordinated multiple statewide oral health initiatives. As a grantee of the Dentaquest-funded Oral Health 2014 Initiative, a nationwide movement for oral health systems change, the Institute has focused on raising oral health awareness and improving access to preventative oral health care. In addition to activities on mobilizing medical and dental health providers, FIHI has chosen to pilot an Oral Health Consumer Engagement Initiative that directly engages communities served to evaluate care delivery and quality. The Institute hopes to identify barriers to accessing oral health care in these five Florida counties to inform decision-making and to assist in establishing a more consumer driven system.

Introduction

The Florida Institute for Health Innovation (FIHI), formerly known as the Florida Public Health Institute, is a non-profit, non-governmental organization whose mission is to create healthy and sustainable communities through innovation in public health policy and cross-sector collaboration. As one of several sister public health institutes throughout the United States, the Institute believes that today's health challenges require a unique way of working based on shared leadership; aligning root causes and strategy and measurable results. FIHI is committed to completing rapid research projects and to promoting a multi-sector systems approach to achieve a positive health impact. A critical analysis of our efforts in achieving these objectives is instrumental to our future success and desire to broaden our initiative.

The Institute is currently one of five southeast regional leaders working with the Dentaquest Foundation to facilitate a 12-state regional oral health agent network. FIHI is utilizing its expertise to help create connections, foster collaboration, and develop plans of action in order to align and maximize efforts towards improving oral health around the country. The Institute's prior initiatives in the state of Florida include:

- I. Conducting a county analysis of emergency department visits due to preventable dental conditions for both adults and pediatric patients*
- II. Conducting qualitative and quantitative research designed to assess oral health knowledge and skills and care gaps in primary care residents and physicians*
- III. Leading the state oral health coalition, Oral Health Florida, through a results-based strategic planning process resulting in a statewide roadmap for oral health*

The Pew Center found that 75.5% of Florida's Medicaid-covered children did not see a dentist in 2011. Further, the Centers for Medicare and Medicaid (CMS), ranked Florida as 50th in the United States for the percentage of Medicaid-eligible children who see a dentist in a given year. FIHI found that presented with these statistics is an opportunity and responsibility. The institute seeks to take collaborative action towards identifying and understanding the barriers

children around the state experience to receiving equitable dental care, and amending these causes.

Florida ranks 46 out of 50 with a Gini coefficient for income equality of 0.474, displaying a large income disparity among wage earners in all income categories [1]. Further, Florida is one of 12 states, according to the Census Bureau, where the majority of minority children under the age of 10 come from low income families [2]. When income and race or ethnicity are combined, 40% of black children and 30% of Hispanic children are members of families with incomes below the federal poverty threshold in the state of Florida [3]. While major factors affecting dental care could be cost and/or previous bad experiences [4], this is also something that needs to be evaluated at the community level as experience ranges across the state.

In preliminary research, various factors were identified as barriers to care-seeking for children's oral health among low-income caregivers. These included perceptions of the treatment and experiences with the dentist, feeling that the child did not yet need to see the dentist, costs, transportation, and time. These factors were statistically proven in other research to contribute to the poor oral health and low access to dental care among these children, though, factors that have ranked high in the past might not uniformly apply to all communities. These barriers were used to develop research tools and included care perceptions, treatment, quality of care and time, transportation and insurance issues. Although due to the variation in experience, tools were developed to allow the inclusion of other barriers unique to Florida residents.

It is important that researchers seek the input of oral health consumers from all communities. Consumers should be extended an invitation to participate in the planning process and to share their needs, concerns and barriers to care, as well as their suggestions for improvement. FIHI's Oral Health Consumer Engagement Initiative aims to do this by identifying and understanding the oral health needs and opinions of underserved communities around in Miami-Dade the state of Florida and their access to care and to incorporate this consumer voice into their evaluation. FIHI implemented this pilot program in Miami-Dade County. The protocol and core objectives were guided by a Steering Committee and network of stakeholders. The pilot consisted of a consumer engagement survey and focus group.

Individuals in underserved communities in South Florida were asked to participate in the survey at several childcare centers located in their respective communities. A focus group was assembled at a childcare center in Miami-Dade County. This was to glean key themes from individuals representing these communities, to gain a more in-depth understanding of the oral health experiences. The following report details the research strategy for the Consumer Engagement Initiative, including stakeholder engagement, survey design and development and focus group methodology and implementation.

Objectives

FIHI's Oral Health Consumer Engagement Initiative, a component of the DentaQuest Foundation's Oral Health 2014 deliverables, has two main objectives:

- 1) *The development of a statewide consumer engagement infrastructure to improve access to, and utilization of, preventative oral health care for Florida's vulnerable populations.*
- 2) *The sharing of consumer concerns to decision-making institutions, entities, groups and individuals throughout the state of Florida.*

Data gathered throughout this initiative could potentially provide the Institute and the state with information regarding relevant and useful strategies that will improve the overall health and well-being of people living in Florida.

Methodology

The following sections explain in detail the three pilot research components: the formation of a steering committee, the development and administration of a consumer survey, and the organization and facilitation of focus groups around the community.

Steering Committee

Building upon the Institute's collaborative leadership principles, the first step in this initiative was the establishment of a stakeholder network. This group was selected using a snowball method, and intended to include both traditional and non-traditional leaders that had a strong interest in improving oral health. The result was a diverse group representing various organizations and populations around the state of Florida. These included health professionals, community partners, private and public organizations, and universities and colleges and were facilitated by the Institute's Program Manager. Committee members collaboratively contributed their expertise to provide insight on patients' needs and perspectives during monthly conference calls. As a group, they identified indicators of success to advise the design of strategies for change. This process promoted a problem-solving environment built on trust and support; these components are vital in moving the oral health initiative forward. The committee was instrumental in helping the Florida Institute for Health Innovation connect with the community.

Consumer Engagement Survey

A consumer survey targeting families with children covered by Medicaid was proposed as a method to identify and understand consumer's perspectives about barriers to accessing and/or utilizing dental care in Florida. The development was informed by existing oral health surveys and under the advising of the Steering Committee.

Survey Design

The survey design was guided by successful survey models of health care consumer engagement and vetted through the Steering Committee for revision and input. Survey themes, question format, and objectives were reviewed by committee members. The 23-question

Consumer Engagement Survey required an estimated 10 minutes to complete. Survey development took place between February 2014 and April 2014. The final survey link is provided in Appendix A. The survey contained the following themes, which were adapted from previous best practice models:

- Demographics
- Barriers to access
- Barriers to utilization
- Child's first dental visit
- Source of oral health information
- Satisfaction with dental care received
- Interactions in a dental office setting

SurveyMonkey, an online survey development cloud-based tool, was chosen to administer and store survey entries. Responses were aggregated and participation was voluntary. This research tool was designed to collect information regarding the caregivers' demographic information, oral health practices, and attitudes. The survey did not collect any information that could be traced back to specific respondents, and responses were to remain confidential and anonymous. The only identifying information was presented in the last question where caregivers are asked whether they would like to engage with the Institute in further conversation on the topics surveyed; in this instance, their name and contact information was collected. When this information was provided the survey response was not anonymous to the Institute, but remained anonymous to the public. This anonymity exception is explained both at the question description and in the first page within the consent and eligibility description.

Due to the large Hispanic/Latino population in Florida, especially South Florida, the Steering Committee recommended that the survey be available in both English and Spanish. The Project Coordinator was a native Spanish speaker and translated the survey from English to Spanish. FIHI's Social Media Coordinator was also a native Spanish speaker and served as a proofreader for the translation.

There was no incentive offered for the completion of the survey. There were also no benefits listed for the survey participants.

Sample Selection

Target populations for this project were ideally caregivers for children in families covered by Medicaid. However, as with any pilot project, participant recruitment can be difficult. Therefore, data was ultimately gathered from any child caregiver, who was a resident of Florida and willing to complete the survey. Members of the Steering Committee played a central role in suggesting key locations in target communities to collect survey data. These were primarily childcare centers; data was collected during Oral Health team visits from the Child Issues Committee at the Miami Consortium for a Healthier Miami Dade, Redlands Christian Migrant Association, and health fairs in South Florida neighborhoods.

A timeline of survey participant recruitment events may be found in Appendix B.

Data Collection

Two methods were used to collect the data for the Consumer Engagement Survey: paper format or mobile technology/iPad. Participants were asked to choose their preferred method. Mobile technology/iPad allows the data to be instantly saved to the SurveyMonkey online database, considerably decreasing data entry time and potential for errors. This tool enabled easy administration and monitoring of the data, allowing researchers to observe trends as more data was gathered. Due to the use of technology that may be unfamiliar to survey respondents, the Steering Committee also felt that it was important to have an FIHI team member who was familiar with the survey and the mobile format present at the survey sites to answer questions or provide explanations. The hope was that participants would be more likely to complete the survey and enjoy the process, thereby increasing the accuracy and efficacy of the data collected.

Results

The following data highlights results from the Consumer Engagement Survey. As of December 31st, 2014, a total of 65 surveys have been collected and analyzed, 24 in Spanish and 41 in English.

Demographic statistics revealed the majority of survey respondents came from Miami-County. Participants in the Consumer Engagement Survey were represented as follows: Brevard County (1.72%), Broward County (18.96%) and Miami-Dade County (79.31%). Similar to the general population of those counties, a large percentage of the respondents in Miami-Dade County were primarily Spanish-speaking as shown in Figure 1.

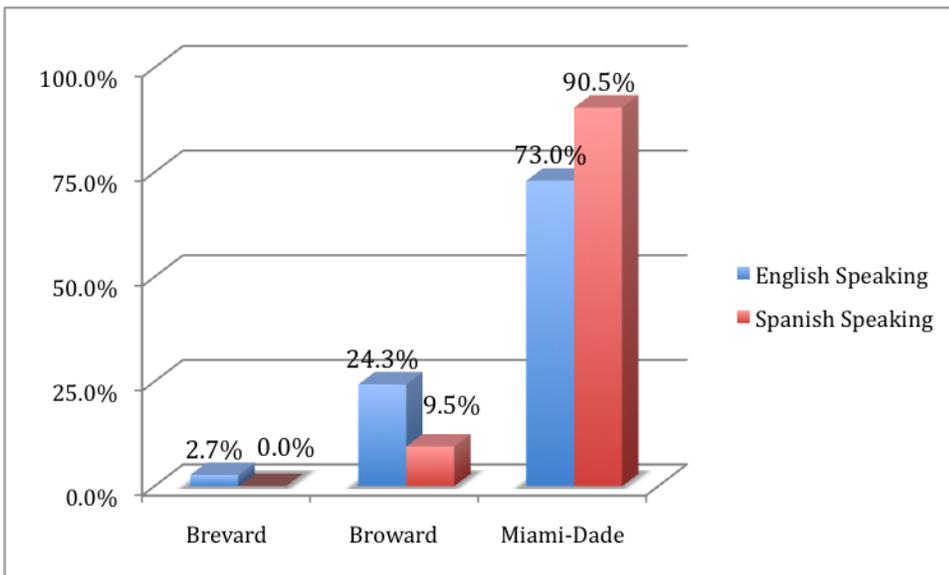


Figure 1: Native Language of Participants by County

Not all participants provided their race. However, for those who did, participants' ethnicity was varied with nearly 45% identifying as Hispanic, 32% as Caucasian, 20% as African

American or Black and less than 1% as Haitian. A variety of questions were asked to gauge the oral health habits and knowledge of participants. These questions gathered information on whether participants and/or their children regularly visit the dentist, age of their child's first dental visit, frequency of dental visits and barriers to accessing dental care. The data was parsed by primary language spoken to determine if any further trends are evident.

Figures 2 and 3 below show an interesting dichotomy found among the participants in the Consumer Engagement Survey. English-speaking parents/caregivers indicated they saw a dentist more regularly than their children (76% versus 54%) whereas Spanish-speaking parents/caregivers saw a dentist less regularly than their children (56% versus 83%). When asked why their child didn't have a dentist, the top responses among English-speaking parents/caregivers were that they could not find a dentist for their child (40%), could find a dentist that accepts their dental insurance (30%), or felt that their child did not need a dentist (30%). Among the Spanish-speaking respondents, 67% indicated that their child does not have dental insurance coverage and 33% reported they could not find a dentist that accepted their insurance. Primary methods for finding a pediatric dentist for both populations included asking friends and family for referrals. English-speakers also utilized referrals through their private insurance companies whereas Spanish-speakers asked their child's doctor for a referral or used the Medicaid booklet.

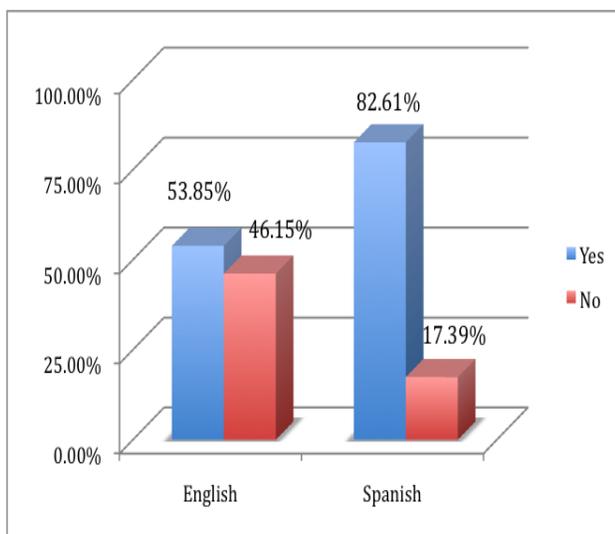


Figure 2: Child Regularly Visits Dentist

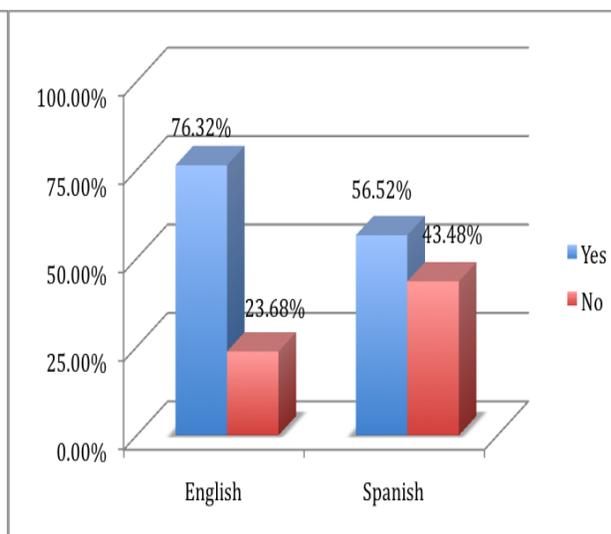


Figure 3: Regularly Visit Dentist

Figures 4 and 5 below depict the age of the participant's child at the time of their first dental visit. Spanish-speaking participants in this survey indicated that they take their child to the dentist much earlier than English-speaking participants. Sixty-five percent of the Spanish-speaking participants had taken their child to the dentist by age two, whereas only 26% of English-speakers indicated the same.

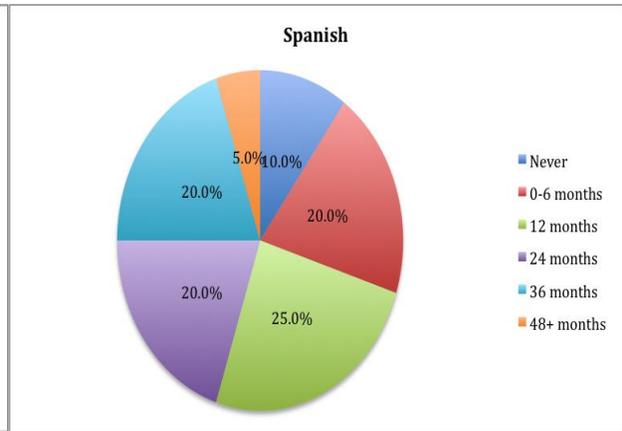
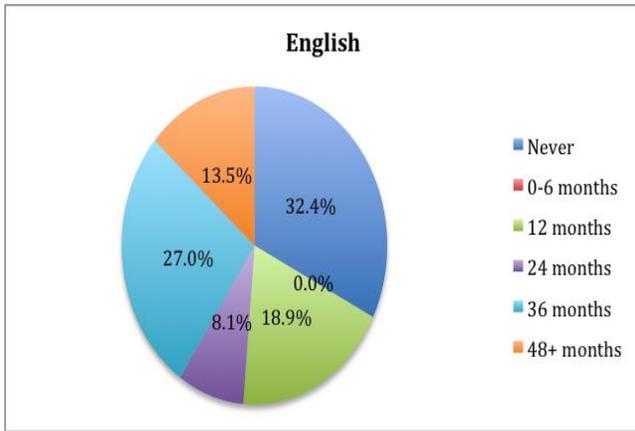


Figure 4: First Dental Visit English

Figure 5: First Dental Visit Spanish

When asked to select perceived barriers to care the data revealed that the majority of responses were technical or logistics related rather than a dissatisfaction with care or feeling that dental care was not important. The data suggests that the gap in care is an access-driven one rather than a lack of education in the community on the importance of dental care. Participants ranked the following factors as barriers to accessing dental care for their child:

- Need to set appointments months in advance (36.11%)
- Difficulty in finding a dentist (33.33%)
- Offices not open on the weekend or after work hours (30.56%)
- Long waits in the office (27.03%)
- Dental care costs too much (19.44%)
- Fear of the dentist (8.57%)

Focus Group

Early in the proposal of this project it became evident that there was a need to have a more in-depth conversation with caregivers to understand the barriers they encounter when accessing and utilizing dental care for their children. This dialogue would serve as an opportunity for caregivers to elaborate on the barriers they face and for the researchers to ask more probing questions. The Focus Group Guide is available upon request.

Selection Process

Participants were selected using a snowball sampling strategy combined with participant suggestions from the Steering Committee, from their network of Oral Health stakeholders throughout Florida. A connection with the Children’s Issues Committee at the Consortium for a Healthier Miami Dade offered an introduction to directors at the Liberty Academy Preschool, located in Liberty City, Miami. Liberty City is a predominantly African American community (95%) with a median household income of \$18,000 [5]. The administration at the childcare center allowed FIHI to use their venue and assisted in the recruitment of parents to participate in a pilot focus group.

When conducting a focus group it is of utmost importance to create an environment in which participants feel comfortable and safe. This is vital in aiding parents and caregivers to share their perspectives and experiences. A non-threatening environment helps unveil any emotions or reactions participants might have regarding the discussion topic. Hosting the pilot focus group session at Liberty Academy provided a local, well-known venue to welcome parents. The desired focus group participants were parents or caregivers of children aged 0 to 17 years, who were full-time residents of the state of Florida. The pilot focus group at Liberty Academy had a total of six participants who were parents or caregivers of children aged 1 to 5 years.

Methods

The focus group was led by two FIHI personnel: a facilitator and a recorder. The facilitator opened discussion and drove the conversation forward using the Focus Group Moderator Guide. Participants were made aware of the purpose and desired end goals of the discussion and were provided with information on privacy and confidentiality standards. The recorder was present as a silent observer and assistant to the facilitator. FIHI staff was responsible for ensuring all required forms were completed and that all sessions were recorded via audiotape.

The target focus group was between 5 -12 participants, with sessions lasting between 45-90 minutes. Layout of the room, including chairs and tables, were in a circular arrangement, rather than a classroom instruction setting, to help participants feel more included in the conversation and to establish the facilitator as a guide, rather than an instructor, during discussion. It was explained to participants that no risks greater than those experienced in ordinary conversation were anticipated and that their participation was completely voluntary.

Data obtained through a focus group is qualitative in nature. It is important to note that the responses of the participants in the focus group reflected their own personal opinion and experiences and cannot be applied or interpreted to the population at large. In order to do so, a statistically relevant number of focus groups would need to be conducted.

Common Themes

The following data was collected during the pilot focus group held on October 18th at Liberty Academy Preschool and evaluated by FIHI for common themes.

Focus group participants were very candid and enthusiastic to share their experiences. This demonstrated the benefit and importance of keeping questions open and allowing the participants the flexibility to express themselves. All group participants were parents of children attending the Liberty Academy Preschool. Common among their responses was a consistent consideration of the needs of other parents in their community and how the issue of dental care access either personally inhibits or enables them in various ways. The group additionally considered possible solutions at both the local and state levels. Examples of some of the questions and responses are detailed below. It is important to note that the answers have been paraphrased and are not direct quotes of any particular participant.

“Compared to the rest of the body, how would you describe the importance of taking care of your children’s mouth and teeth?”

→ *Just as important.* Oral health is connected to overall health. Bacteria and plaque,

for example, can build up and affect the rest of your body functions.

“What are some reasons people might not take their children to the dentist?”

- *Work schedules.* Many parents work multiple jobs, and even have to work during the weekends. It is hard to take time off of work to take children to the dentist, especially multiple days for multiple children. In many cases, children from the same families are not scheduled for appointments on the same day. Doctors need to look at it as a family unit.
- *It can wait.* Some people do not consider oral health as important or might need to work and therefore do not consider taking their child to the dentist a priority. In addition, if the child currently has baby teeth many consider that it can wait.

“What methods do you use to seek information about oral health?”

- *TV shows.* Morning talk shows sometimes have a designated “health day.” Many people watch them and can receive basic but important health information.
- *Internet.* Ready and available information anytime.

“What have been your experiences with dentists who accept Medicaid for your children?”

- *Harder to schedule.* Less doctors available who accept Medicaid.
- *Lack of flexibility.* Parents feel they have to go through a lot of restrictions and limitations to receive appropriate care. They advocate that just because they are receiving this benefit, does not mean that they should “jump through hoops.”
- *Feeling less valued.* Parents that felt they had received inappropriate care or treatment felt they could not complain about it since it was a free service.

“If you were in a room full of state decision-makers what would you tell them they need to do to help parents learn about taking care of babies and children’s teeth and preventing dental issues?”

- *Cut the red tape.* Increase communication modules; ask the community directly what they want. We do not all want to take advantage of the system.
- *Increase pay out for Medicaid.* We understand why dentists and physicians are not inclined to take Medicaid patients, we need to facilitate a system where everyone is getting paid for the service they provide.
- *Provide children checkups in school settings.* Most parents do not have the time to take their child to the dentist even if they could, if children were screened in childcare centers or schools then it would alleviate this problem and increase preventative services.

“Do you or does someone you know believe they were treated differently in a dental setting because of race, ability to pay, or type of insurance?”

- *Cannot verify or deny.* As a minority group, racism is always questioned when unfair treatment is received, however we try and move past it. Cannot verify or deny if it is present in a dental setting.
- *Stereotypes are present.* Example: gold teeth for African Americans. A fashion

statement is stereotyped often.

Evaluation

The Focus Group supported the findings in the survey that most challenges in seeking dental care for children were logistics issues rather than perception or experience related barriers. All participant discussion suggests a more effective way of addressing the gap in oral health would be to make care more consumer friendly and adapted to consumer schedules with lifestyle considerations. Further, based on this research, Florida residents do not experience the negative treatment documented in other states and are willing to collaboratively approach ensuring their children receive dental care. Finally, internet and television based oral health education should be further explored.

Consumer Survey Evaluation

Based on the exclusion to anonymity of FIHI researchers explained in the consent and eligibility survey description and question 23, FIHI was able to obtain a list of survey participants that provided permission to be contacted. A short four-question customer service survey was designed to evaluate participants' experience with the Consumer Engagement Survey. This is a summary of those evaluations completed by parents that attended the focus group at Liberty Academy on October 18, 2014. Most participants found the topics interesting, easy to understand, and felt they had the opportunity to share their opinion: 'Strongly agree' or 'Agree,' 4 versus 1 'Strongly disagree' for each of these questions. Similarly, participants felt the facilitator was effective and professional, that participants, as parents or caregivers, felt they could make a difference by sharing opinions and experiences, and would be willing to participate in a future focus group: 'Strongly agree' or 'Agree,' 4 versus 1 'Strongly disagree' for each of these questions. This demonstrates that participants felt proactive and empowered to address gaps in oral health care and displayed a trust for researchers.

Conclusions

This pilot provided great insight that will be used to develop 2015 Consumer Engagement research. Key themes were noted throughout such as participants' willingness to seek dental care for their children, cultural differences along language lines, low percentages of individuals having negative experiences with the dentist, and consistency with where individuals seek information about oral health. The goals of future research will be to expand the sampling radius and monitor the trends in data. It will be important to capture the cultural diversity and variety of experience in the state of Florida to appropriately adapt research tools and programming. Participants demonstrated a level of trust and confidence with researchers and an interest in the improvement of oral health delivery.

Recommendations

Compiled below are recommendations to improve or enhance the Consumer Engagement research tools for future programming. Follow-up research will be conducted in 2015.

- *More recruitment and structure in the Steering Committee.* The Steering Committee should be expanded to include members representing various locations throughout the state and an even greater diversity in expertise and experience. The structure of the Steering Committee should be revised to include more in-person meetings to enhance dialogue and to enrich committee discussions.
- *Revision of the Consumer Engagement Survey.* Researchers found this survey was not, in fact, a good medium to evaluate participant feelings. The survey additionally should be revised to more closely correspond to English-speaking versus Spanish-speaking respondents to further extract differences among the two communities in dental care seeking behaviors. Additionally surveys should be linked to the counties where they were taken during analysis. Analysis demonstrated variation by location and notable differences in care-seeking behavior by community. Questions regarding negative feelings during dental care visits should be minimized or omitted. This survey revealed high levels of satisfaction with treatment and quality of care.
- *Revise research protocol to include quantitative data collection.* This could best be achieved during the revision of the survey to include questions that can be coded into variables and analyzed for demographic statistics and to generate Odds Ratios.
- *Expand data collection plan to include communities around the state of Florida.* 2015 data should be collected around the state of Florida to compile a true representation of experiences and voices from a variety of communities.

As research is expanded there should be a greater focus on documenting and then developing programming to address the logistical or technical barriers that currently exist. There was a notable difference in Spanish-speaking versus English-speaking responses suggesting research should be divided among cultural or language lines to most appropriately capture data. Medicaid payout to dentists should be further reviewed and new media outlets explored for dispersing oral health information. School-based check-ups should be examined for potential best practice model.

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Appendix

Appendix A. Consumer Engagement Survey

English survey: <https://www.surveymonkey.com/s/oralhealthconsumer>

Spanish survey: <https://www.surveymonkey.com/s/SPANISHoralhealthconsumer>

Appendix B. Consumer Engagement Data Collection Schedule

Dates	Location
April 2014	Childcare center in South Miami, FL; oral health team with the Consortium of a Healthier Miami-Dade
May 2014	Childcare center in South Miami, FL; oral health team with the Consortium of a Healthier Miami-Dade
June 2014	Childcare center in South Miami, FL; oral health team with the Consortium of a Healthier Miami-Dade
July 2014	Childcare center in South Miami, FL; oral health team with the Consortium of a Healthier Miami-Dade
August 2014	Back to school event in Homestead, FL