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Dental Practitioner's Perceptions of Underserved and Un-served Patients' Barriers to Oral Health Care

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Abstract

The purpose of this study was to investigate dental practitioners' perceptions of the barriers among underserved and un-served patients' seeking oral health care and their recommendations for improving access to oral health care for low-income families. Using a qualitative well documented analytical approach of focus group interviews of dental practitioners, four main themes emerged including: "Perceiving avoidant behavior", "Compromising patient access to care", "Helping the underserved, we've tried", and "Solving the access problem". The findings indicate that dental practitioners need to have a better understanding of oral and systemic health care disparities, cultural competency, humility and respect and recognize the importance of engaging the consumer in the oral health access movement. Future studies focusing on the impact of racial and systemic health, racial/ethnic variations and provider perspectives of need for care behaviors are recommended.

Keywords

Oral care equity; Dentist's attitudes; Oral health care disparities; Racial and ethnic oral health barriers

Introduction

Per a 2002 Institute of Medicine (IOM) report, racial and ethnic disparities within healthcare prevail [1]. The Sullivan Commission's report further highlighted the need for increased diversity, inclusion and balance in the U.S. health-care system [2]. The Commission's report concluded the health-care workforce has not kept paced with shifts in the U.S. population. A 2012 Agency for Healthcare Research and Quality report also highlights how low-income populations and racial/ethnic minorities' access to and quality of care lag behind other demographic groups [3]. Furthermore, there was an indication that while oral health has improved nationally, there remain major disparities in oral health among African Americans and Latinos compared to Caucasians [4]. Racial and ethnic disparities in access to and status of oral health are well documented [5-7]. These disparities warrant increasing the number of underrepresented minority oral health providers in the oral health workforce and enhancing cultural competency in the existing and future oral health workforce so that underserved patients receive better care. Increasing the number of underrepresented dentists is one solution. However, ensuring cultural competency in the provision of care, awareness, and communication is essential to assure that all oral health providers offer culturally competent care to the people they serve at the individual, group or population level.

There is a link between the diversity of the health-care workforce and health disparities; the Health Resources and Services Administration (HRSA) examined the belief that increased diversity in the health professions would lead to improved population health outcomes [8]. Evidence from this review showed that when underrepresented minority health professionals, particularly physicians serve minority and other medical underserved populations and that non-English-speaking patients experienced better interpersonal care, greater medical comprehension, and greater likelihood of keeping follow-up appointments when they see a language-concordant practitioner. Findings also indicate that minority health professionals are more likely to serve in areas with a high proportion of underrepresented racial and ethnic minority groups [9]. In a report on Wisconsin dental practices and Medicaid [10], minority dentists were twice as likely as non-White dentists to accept Medicaid patients. Research from Logan and colleagues focused on the southeastern US found that Black and Hispanic dentists were more likely to be Medicaid participants in Florida than others [11].

Health care professionals increasingly recognize that culture may influence patients' communication styles, beliefs about health, and attitudes towards health care. Data show the lack of cultural competence within the dental profession when compared to medicine and other disciplines but this by no means suggests that the other disciplines have been wholly successful Cultural competency is a construct that suggests that there is a set of behaviors, attitudes, and beliefs that can facilitate or impede one's ability to demonstrate competency within the context of racial/cultural understandings [12,13]. The development of cultural competence and social responsibility is an important element in the overall shaping of minds and attitudes of modern dental practitioners. Yet training modalities to achieve these competencies are not clearly defined, and outcome measurements are elusive [14]. Understanding the tenants of oral health care and the value placed on oral health care by cultural groups and country of origin is critical for the dental profession to evolve and provide culturally competent experiences for patients. While some providers assert that one of the reasons for low levels of utilization is due to lack of value by patients, new studies show linkages between lower levels of acculturation, socio-economic status, language and prior provider interaction and utilization [15].

To improve health care for the increasingly diverse U.S. population, cultural competency among health care providers is essential [16]. The purpose of this study was to elicit dental practitioners' perceptions of the barriers among underserved and un-served patients' seeking oral health care and their recommendations for improving access to oral health care for low-income families.

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Methods

Participants: The Social and Behavioral Health Institutional Review Board of Morehouse School of Medicine approved this study. The Florida, Georgia and Mississippi Dental Associations were solicited for dentist participants who would agree to participate in focus groups for this study. After failing to receive favorable responses to the invitation, researchers solicited, via mail and email, private practice and public health dentists in Atlanta (GA), Jackson (MS) and Tampa (FL). Prior to the focus group interviews, signed letters of informed consent were obtained from each participant. Three separate focus group meetings comprised of six, seven, and three dental practitioners were conducted in Florida, Georgia and Mississippi by a moderator not associated with the analysis. The small number in the focus groups is adequate for valid analysis. A different moderator was used for each focus group. Participants included 15 dentists in clinical practice and one dental hygienist who had 20+ years of working in a clinical setting. Two participants had 5 or less years of experience in clinical practice, one had 6 and 10 and 16-20 years, three had 11-15 years, four had over 20 years; information for the remainder is unknown. Participants ranged from 35 to 65 years in age; the age of two is unknown. The sample included seven Caucasians, eight African Americans and one Asian, nine females and seven males. One dental practitioner worked in hospital dentistry, another worked in both hospital and correctional dentistry, two were endodontists, three were public health dentists, and five worked in a general/family practice. The practice setting of three dentists is unknown.

Study design

We used focus group (FG) methodology, to conduct this study. Focus group (FG) methodology allows for the collection of narrative data in a structured manner to highlight participants' experiences and beliefs. This methodology is a qualitative approach that relies on the use of skilled interviewer (moderator) to collect narrative data related to the shared experiences among a group of participants or to develop an understanding regarding a phenomenon [17]. FGs are a carefully planned encounter that takes place in a permissive, non-threatening environment. This approach affords interactions between interviewer and participant and among all participants. It is particularly well suited for this study because it encourages participants to come together at the same place and time for a common purpose. FGs rely heavily on skills of moderator (interviewer) who is expected to: (1) introduce the topic in to all participants in the same way, (2) ensure that the conversation remains on track, and (3) encourage all participants to respond to questions. The skilled moderator steers the conversation, listens unconditionally, and re-states what has been stated to ensure understanding [17-20]. Uses of a well-designed interview guide of questions were developed to encourage group members to relax, open up, think deeply, and consider alternatives. During a FG, a natural conversation typically emerges because individuals are allowed to laugh, tell personal stories, revisit earlier questions, and disagree with others and the researcher. The nature of this type of interaction allows participants to share alternative or contradictory viewpoints or experiences in a forum that allows for elaboration and evidence seeking prompts by the moderator. FG also allow for a variety of viewpoints to be shared, permits exploration and elaboration of what has been stated, and permits collection of a greater range of responses in shorter period of time and is cost effective. The interactions among participants enhance data collection by implicitly providing checks and balances on one another, which tends to ferret out false or extreme viewpoints. The extent of shared views or the extent of diversity and inclusion in viewpoints can be quickly assessed. FG dynamics may generate new thinking about a topic, which is likely to foster more in-depth discussion.

It is important to recognize that the analysis that accrues and overall findings are not generalizable and has limitations. Findings from FG are contextual, temporal and related only to the focus group(s) individuals that participated. Also, the number of questions that can be asked is restricted; the available response time for any participant to answer each question is necessarily limited in order to hear from everyone. The methodological rigor of using focus group rests with verifiability, creditability, dependability, and transferability of findings, processes that are synonymous with validity, reliability, internal validity, and generalizability [18,19].

Overall the intent of FGs is to provide an in-depth, contextually rich understanding of phenomena that accrues from participants' words and explains "why" something occurred, not "what" resulted. FGs provide trustworthy naturalistic data that may lead to important insights about human behaviors or perceptions by allowing all participants to say anything they would like in front of the whole group. While listening to the content of discussions researchers may observe something beyond talking, such as tone and emotions, which help them to learn or confirm not just the facts but also the meaning behind the facts. The focus group questions are listed in Table 1.

Each focus group meeting was 90 minutes. The interviews were audiotaped and transcribed verbatim by an individual not associated with the analysis. Focus group questions were designed to ascertain participants' (1) identification of the barriers to oral health care access

Table 1: Focus Group Questions.

Sl No	Questions
1	What barriers do you think have the most impact on access to oral health care in your state?
2	With respect to service delivery, has your practice been able to effectively provide care to all requested appointments during the last 12 months?
3	Locally, in your opinion, what policies have the biggest impact on increasing access to oral health care for children? For adults?
4	Other than improving reimbursement, how do you think our state can improve access to oral health care for low-income families?
5	Are you aware of the different types of emerging workforce models in dentistry?
6	Do you believe that you have adequate knowledge on the role of emerging workforce models in dentistry?
7	Do you believe that some of these emerging workforce models may serve a role in reducing the costs of care for individual patients and families?
8	How do you think that adding Advanced Dental Therapists or Dental Therapists to your practice would affect your practice?
9	Would you be willing to delegate some patient services to a midlevel provider if quality is not an issue?
10	What types of services would you be willing to delegate to a midlevel provider?
11	If you were to employ a midlevel provider in your office, what kind of supervision would you utilize?
12	Are there any conditions under which you find it acceptable to employ one of these new providers?

in their state, (2) ability to provide care to all requested appointments during the last 12 months, and (3) perceptions of how their state could improve access to oral health care for low-income families (Table 1) [20].

Data analysis

The data were open coded by one of the authors. Each transcription was analyzed as a separate set before proceeding to the next transcription using line-by-line coding, and both initial coding and focused coding. Initial coding was provisional, comparative, and grounded in the data [21]. Using this iterative process, fragments of data including words, lines, segments and incidents are closely studied. Gerunds, consistent with process coding, were used to connote observable and conceptual action in the data [22]. Process coding highlights how actions intertwine with the dynamics of time. Thus, the codes stayed close to the data, revealing the actions and the story from which they were taken. This stage led to the focused coding stage where selected initial codes were compared against extensive data.

Reading and coding line-by-line supported the process of initial coding and rendered supporting quotations more accessible. The data were analyzed inductively. The analytical process involved coding; refining codes; identifying examples to support the categories; analyzing within categories; looking for themes across categories; making a master outline to illustrate relationships; and locating quotations to support the outline. Inductive analysis is a systematic approach used when there is a large amount of data to process. This approach helps ensure that the analysis represents the social situations being examined or the perspectives of participants that are being studied [23]. Use of the constant comparative method assisted in moving data to better fitting codes and codes to other categories or themes. The development and refinement of categories was based on data that looks and feels alike and was supported on rules of inclusion. This process resulted in some themes coalescing and others expanding. Inductive analysis provides an approach to carefully condensing the data and allowing themes to emerge from the data without the restraints imposed by quantitative approaches or a-priori assumptions. In deductive analysis such as hypothesis testing or experimental research, key themes may be obscured or remain invisible because of the preoccupation and adherence to data collection and analysis procedure imposed by investigators. Inductive analysis results in thematic analysis, a search for themes that result from observing patterns within the data. The themes that emerge arise directly from an analysis of the raw data, in this case, the collection three focus group transcripts and thus were representative of all three focus groups.

Results

Four main themes emerged from the data including: "Perceiving avoidant behavior", "Compromising patient access to care", "Helping the underserved, we've tried", and "Solving the access problem". For the main theme "Perceiving avoidant behavior", two subthemes were identified, "Identifying external barriers" and "Lacking value and knowledge for dental care". For the main theme, "Compromising patient access to care" one subtheme, "Thwarting treatment options" was identified (Table 2).

Perceiving avoidant behavior

"Perceiving avoidant behavior" refers to describing the reasons why people do not go to the dentist, for example fear or costs. Dentist participants reported that under- and un-served patients do not seek dental care, particularly preventive services. Overall, they attributed reluctance to see a dentist as due to a lack of "money, education", or improper attitude. They claimed that avoidant behavior occurred because many patients do not prioritize oral health care and that it "is not really what's high on people's list." Another participant described this behavior as patient's unwillingness "to put aside a savings to pay for a cleaning twice a year." One other participant stated that when patients are "not in pain, there's no perceived need to go". Others reported that individuals do not appreciate the importance of "preventive" care when there is an absence of oral health pain or an inability to afford care.

Sometimes individuals fear dentists, especially those who "have been exposed to an episode when they felt like they weren't in control." These situations combined with an experience of oral pain may amplify a patient's reluctance to seek care. Patients who have had painful encounters with a dentist and are generally fearful of oral health care sometimes transfer their experiences across generations. As one participant explained, "So the fear factor sets in and then a lot of times, adults will affect children for example where they've experienced problems associated 30 years ago. [Essentially] they assimilate that to their child and then instill in them a mindset of fear even before they have an opportunity to experience." Fear deters some individuals from going to the dentist or perpetuates "people to delay treatment."

Many of the participants described patients as suffering from a poor dental IQ. They surmised that patients failed to recognize the integral connections between oral and systematic health. One participant suggested the development of a dental IQ should begin in kindergarten. Others reported that patients lack an understanding of why it is important to maintain good oral health. Oftentimes, "people think that their only option is to pull the tooth". Another participant suggested, "See people, they don't realize that teeth are very important and it is a part of the human body. Every tooth has a blood vessel that goes to the heart and a nerve that goes to the brain and there have been instances in which I know of, of course I'm telling my age I guess because you all, some of you probably have not known of anyone to die from like an abscessed tooth."

Lacking value and knowledge for dental care

"Lacking value and knowledge for dental care" refers to individuals' lack of information and understanding about the role of dentistry. Some practitioners asserted that parents "did not understand the concept of oral health or [view] it as priority. One participant reported that some patients "don't want to pay the price for dental care." They are, "willing to pay for a cell phone, they're willing to pay for a tattoo, they're willing to pay for piercing, but they're not necessarily willing to pay for just dental care that would keep them in a better state of oral health." One participant described the challenge of explaining limited treatment options to patients. "You can't just come in and order and I'm sorry that your insurance only covers this. Then I have to explain just in terms of fraud. Okay, if I just give you what you want but I don't properly treat you and then your health, your periodontal disease, whatever, continues to decline, then I'm liable and I'm questioned if my charts ever… you know, like why were you doing it?"

Another participant compared dental care to seeing an ophthalmologist. "People are the same way about their eyes. They're not going anywhere until there's a problem." As one participant pointed out, people tend to be as unaware of general health as they are of the ways that stress impacts wellbeing.

Others asserted that patients would "rather get a tattoo which is

Table 2: Main Themes from Participants.

Themes/Subthemes	Conceptual Definitions	Representative Examples
Perceiving avoidant behavior[1]	Describing the reasons why people do not go to the dentist	"That's a fearful situation and I think it deters a lot of activity for people to delay their treatment".
Identifying external barriers[2]	Neglecting to see a dentist for reasons that are not person-centered	"Whether or not they have transportation to get to the offices".
Lacking value and knowledge for dental care[2]	Individuals' lack of information and understanding about the role of dentistry.	"Responsibility. Priorities, just priorities. Dentistry's usually not a high priority".
Compromising patient access to care[1]	Getting approvals takes unnecessary time.	"That's a hindrance to people getting care is the change in the Medicaid and CHIP programs that we're getting faced with. It creates situations where the person just can't get what they need."
Thwarting treatment options[2]	Reimbursing dentists is inequitable.	"I see quite a few patients who purchase that tagalong Obamacare and it's really like a poor discount plan. It's not much of a discount and I haven't been able to convert anyone who has Obamacare into treatment".
Helping the underserved, we've tried[1]	Explaining what they have done to help under- and unserved dental patients.	"I've had clinics set up to where right beside a low income housing project, unfortunately we ended up having to close it because no one would come in for care and yet they were the community that was supposedly seeking or desiring the care".
Solving the access problem[1]	Offering ideas about how to solve the access problem	"I spoke with several department health clinics and also our federally qualified health centers here Tampa and they would be very willing to have a coordinator help those individuals who usually no-show to show up for their appointments, see what their transportation barriers are, see what their access issues are".

[1]Denotes main themes
[2]Denotes sub-themes

about the same cost as a cleaning." By way of example, one participant opined that, "100% of people need healthcare more than they need maybe a season ticket." One participant observed, "Some of those patients that come in that have the $200 tennis shoes and iPhones and things like that but they want to get all this work done and don't want to pay. You kind of look at, where are your priorities? "His observation implied the incongruity between "what they want versus what they need."

One of the participants remarked that, "misconceptions or misperceived notions, are really rooted and grounded in cement" by the time patients reach ages 18, 25, or 30 years. Another participant reported that failure to seek oral health care was a due to a lack of "education and priorities." One other participant claimed that many people who do not see a dentist on a regular basis seem to "feel like [their teeth are] are a separate part of their bodies or that they don't think their mouth is important."

Another participant reported that a lot of the patients he sees "don't seek services until it's painful or it's too late and unfortunately even then, they'll go to emergency rooms and receive antibiotics and pain medication." One participant explained that there were two types of patients, those who could and those who could not afford care. Yet both were delaying visits to the dentist: "Fairly frequently I'll see somebody come in my office that I think they probably haven't been to the dentist in 15 years and they have significant problems, but yet these are well educated people, people of financial means, so what was keeping that person from coming into the office? The same thing sometimes with people with Medicare - Medicaid rather - we'll see somebody come in and they've had Medicaid for five years but yet this is their first visit to the dentist, so just so many facets to providing the care."

Others asserted that the public should modify its behavior and become educated about the importance of dental care. One suggestion was that patients needed to "have [a] proper education and attitude towards dental treatment," though no one suggested whose role it was to educate the public or otherwise described how an educational process directed towards improving dental knowledge might be implemented. Another participant stated that "most all diseases in the United States – are behavioral," while quantifying his estimate at 75%. According to one participant even if Medicaid was continuously provided, "there's no way to sustain this model and then provide care for those individuals, especially [among individuals who lacked an education and ensure that they] would maintain and come in for their appointments." These comments implied a "them versus us" mentality, whereby "those patients need to…." Ironically, none of the participants discussed or suggested what actions the dental profession could implement to resolve the matter of providing care to un- or under-served patients. While laying blame at the foot of parents, one participant suggested that, "Parents should be more involved in developing the responsible behavior in their children and not necessarily have all the people that neglect themselves start at the school level and be treated there." Concurring, one participant pointed out that, "you can have 40 providers in my town sitting there waiting on somebody to come, but if the parents aren't going to actually bring the child in it doesn't matter what kind of person you have their trained to do it." Overall, participants expressed the sentiment that the patients "need to get informed."

Several participants asserted that Medicaid patients were "notorious for not showing up." One participant conveyed, "I know pediatric dentists who do take Medicaid, for example, and they'll do the same thing. They'll set aside a whole morning or a certain day per week for Medicaid patients and their no-show rate is atrocious." Another participant explained that "People who accept Medicaid typically have to double book or triple book because they expect a significant number of the patients to not show up. That is something that everyone that takes Medicaid says."

Identifying external barriers

"Identifying external barriers" refers to neglecting to see a dentist for reasons that are not person-centered, for example transportation. Participants also identified impediments to receiving dental care including factors beyond the patient's control such as a "lack of transportation, inadequate bus services", "an individual whose mother did not pursue care for the person," "location" of the dental providers office, lack of financial resources, language, and "not really understanding the way the insurance works." These factors mirror the complex financial challenges that face families who cannot afford dental care [24].

Compromising patient access to care

"Compromising patient access to care" refers to getting approvals takes unnecessary time.

One of participants commented that, "I have two workers that run the front desk for me and they tell me, 'we spent all morning long dealing with prior approval,' and we can't provide the services that these people need if we're hindered to where we can't do it." This participant elaborated and pointed out, that "it's just not practical for us to spend that much staff time getting permission to do something that the patient needs, [when] two years ago or three years ago [where] we could have just went ahead and provided [it]."

Another participant described the changes in Medicaid and CHIP programs as "a hindrance to people getting care" because they "create situations where the person just can't get what they need." One of the participants reported that, "these programs are so difficult to work with that we actually almost have to coerce dentists into participating." Agreeing with him, a participant opined that, "these CAN programs are not working. You've got to do something different." Describing the process as obfuscating, one participant explained, "when I submit this, they're going to give me the approval maybe for another tooth but the main one that's causing them a problem, they can't do it." Some participants referenced the Affordable Care Act and testified that it "definitely has some provisions in for children's care." Even though it was intended to "increase the reimbursement rate for kids" most of the participants were unaware of the details of these provisions or whether it had "actually [been] phased in. Reporting that she had "quite a few patients who purchase that tagalong Obamacare" one participant described it as "a poor discount plan. It's not much of a discount and I haven't been able to convert anyone who has Obamacare into treatment". Others classified the provisions of the plan as sounding good in theory but mired by "big waiting periods", "very poor" discount plans, or delays in coverage that were so long that "by that time [coverage became available that] the person could be dead."

Thwarting treatment options

"Thwarting treatment options" refers to reimbursing dentists at too low a level, and does not reflect changes in dentistry.

Most of the participants explained the paltry reimbursement rates. "We're not even at the breakeven point on Medicaid services that we perform. It's probably less than half of what your usual customary services are." Others stated pointed out how Medicaid impacts their practice earnings. "I think many dentists would be willing to see Medicaid patients […] if it was funded enough to where you could at least cover your overheard. The problem is, when you get $0.23 on the dollar and it cost you $0.70 on the dollar to provide the services." Another participant stated, "It seems to be like we're expected to lose money by treating Medicaid eligible people." One other reported, "The amount of funds that are actually being provided to the patients has not increased […]." One participant asked, "Where's the incentive for those of us that practice to actually see the underserved for any financial gain? It's just charity." More poignantly, a participant stated, "If I can be able to save somebody's life by pulling an abscessed tooth or doing a root canal" [then] "why can't I get something for that?" Another participant asserted that, "[we need to] find a way to get the entitlement programs working in a manner where we can provide the treatment" and address the "extremely limited" options that entitlement programs currently provide for adults. Echoing this concern, a dentist in Mississippi pointed out that, "The only thing I can do for adults is take teeth out and do some kind of rudimentary palliative things, but as far as doing fillings or cleanings or anything like that, we do have not coverage for that, and there again, that falls back to the programs."

Serious limitations recognized in the entitlement programs were the service provisions for children with special healthcare needs. Once they become adults, "they pretty much fall off the map and then the next time they show up is when they're in a terrible crisis and there's really not much else that can be done." He asserted that future initiatives needed to focus on special needs' populations "because [they] become harder and harder to take care of as they get older. [Often at that point] there's so many [needs and then] there's just nothing else for them." Another participant pointed out the challenges associated with finding specialty providers for children with special healthcare. She pointed out that, "the reimbursement rates are so low in most cases that you can't find someone that will take care of them and [then this is compounded by interaction between the] medical and dental types of things."

Helping the underserved, we've tried

"Helping the underserved" refers to explaining what participants have done to help under- and un-served dental patients.

Dentists described the myriad ways that they had assisted low-income patients, through pro bono work and volunteering their services at locations other than their own office. One dentist described his experiences working in the Head Start program. "They would actually have a community transportation where they would bring in numerous children at one time and you would dedicate the whole afternoon or morning to doing the Head Start children." However once the program eliminated transportation it was left up to the family. "You would set up appointments with them all the time but they just wouldn't show up. They didn't even have the responsibility for the transportation or the knowledge to be able to value what we're trying to give them." Another participant explained that he had set up his clinic "right beside a low income housing project. Unfortunately we ended up having to close it because no one would come in for care and yet they were the community that was supposedly seeking or desiring the care."

One of the participants reported that she knew "doctors [who]

practice[d] on Saturdays to accommodate their clients who work all week." Another individual explained that even when the dental community responded to the needs of a community and "ben[t] over backwards for them" that unfortunately" [they] still don't show up for care." Another dentist described his role in bringing the Mission of Mercy project to Tampa, the first of its kind in the state. "We provided $1 million of service over a two day period to 1,660 patients." Others described the volunteerism that was offered... "There are so many of them that want to come out and volunteer for things and do it for free. They do it out of the goodness of their heart, first of all, and then second, so that they don't get caught up in the problems of the Medicaid system and [or are] expected to treat people at a cost that is burdensome to them. So they're much better off volunteering their service, however we know that [this is] not a proper safety net for people that are in need because you don't want to rely on people having to volunteer their services in order to meet a need for those people."

Characterizing the experience of helping others, one participant said that he believed that dentists felt more reward than the people that were actually receiving the care." He asserted that these dentists "weren't looking for remuneration. They were spending time out of their office losing money to come and yet they were much more rewarded than the people sitting they're trying to make money at their office. They had such a genuine feeling of paying back to the community that that's important for us."

A Mississippi dentist explained that if somebody can't afford treatment "and they're hurting and they don't have a penny I'm going to do something to get them out of pain. It's just what I do." However he qualified his position towards generosity stating "but I can't do that to the extent that I'm going to go bankrupt."

Another participant shared the work of his out of state foundation and described the homeless shelter clinic that they funded in Phoenix. He explained they that their work started in a homeless shelter and later grew into a dental clinic comprised out of volunteers. Another participant described volunteer work in Fort Worth. "They provide transportation for those children to the dental offices and they set up a network of volunteer dentists." After screening a child, dental hygiene program "will triage and say, Okay, here's what this child needs." Providers in the community volunteer and may offer to treat for example, three children for the agency in a particular year and then they specify the procedures that they can do. The success of the program relies heavily on a community dental health coordinator who makes the appointment and guarantees that the child will be there." The program has, "had phenomenal success and have not spent one dime on a provider other than the community health coordinators taking and getting these children to be seen. It is amazing what some people are able to put together in communities because they've got plenty of providers."

Despite extensive descriptions of the ways in which they assisted un- and underserved patients, these efforts are sporadic and unsustain. Moreover with the exception of the Tampa initiative, all of the periodic clinics occurred outside Florida, Georgia and Mississippi.

Solving the access problem

"Solving the access problem" refers to offering ideas about how to solve the access problem.

Dental participants offered ideas for resolving the access problem. Suggestions included having a community advocate that would assist patients and forming public private partnerships to screen and transport children to places where they could receive care and improving entitlement programs. Several participants recommended using "dental health aid therapists and CDHC people" who could "guide people through the system" or "help those individuals who usually no-show to show up for their appointments, [identify] transportation barriers, [and] see what their access issues are". Others recommended looking to the "public private partnerships where you're having federal grants and federal monies [sent] to FQHCs and department of health clinics through the state" and funding dentists for their work "at whatever their overhead level is" would "probably put a big dent in the access to care issues". One participant recommended convening, "a community-based advocacy group that could identify and provide solutions together". Another suggestion offered was the concept of "paying it forward, where people volunteer their service for people in need [at community agencies like the] Salvation Army, Children's Home, Boys and Girls Club" [and then] if someone is in need of dental care, the volunteer hours in those agencies and earn points towards care."

Participants suggested using the "loan repayment plan for new students", to incentivize them "to open their offices even a satellite office in lower income neighborhoods or areas." Another suggested "increasing the number of volunteer dentists in the state by giving them student loan repayment when they can go back to a nonprofit clinic." One participant described using expanded duty auxiliaries "particularly in treating children." Use of mobile van was pro-offered and then dismissed "because they're not there all the time and they start treatment" but because they are always going "somewhere else and then the follow-up things that need to be done [could potentially be] swept under the rug."

One participant mentioned that the hardest part is "the screening process and getting the children who need the help, finding who they are legitimately, and getting them to the place where we can deliver the care." Another participant agreed and opined that a failure to identify children who needed care was the result of "an underutilization of services provided by the dental community" particularly hygiene services. The corporate dental model was referenced as possible solution. One participant recommended incorporating public/private partnerships to capitalize on their collective resources including staffing to reach out to underserved areas. Another participant suggested brokering an agreement between "private practicing dentists and public health dentists" that could be funded by Kellogg to provide dental care to areas where practices when not accessible.

Others suggested the need to "re-evaluate oral health as a priority for government", to "get in touch with the insurance people that will actually listen to us and let them know that dentistry is expensive just like medicine." One participant stated that the insurance is the problem and asserted that Obamacare "is not worth anything." Still one other participant suggested that they needed to be talking to lobbyists and then indicated, "but we cannot fund them". Lamenting the lack of lobbyists, one participant stated, "generally, the people with the money rule, okay, and unfortunately we don't have any millionaire/billionaire dentists up there lobbying Congress or lobbying state legislatures for tax breaks, tax relief, so we can build our offices and get tax incentives."

The idea of having a single payer was suggested by several participants. This approach would alleviate some of the cumbersome procedures among third party providers. The one insurance concept

was echoed by another participant who suggested that going to your dentist "should be just like you're going to the psychiatrist."

One of the participants suggested implementing "local policies to increase access for children" such as the use a "requirement from schools, like immunization, that required a dental certificate because there was a school here in town that did that for a long time and that did more good to help children get seen before school started." Another participant recommended increasing an "awareness of the medical community, in terms of public health, particularly pediatrics, of the need for the early visits and trying to incorporate that into the risk assessments for the child" and developing a "system with a dental certificate for kids starting school." While offering this novel idea, one participant suggesting creating "a dental card, like they have an EBT card for your groceries" in which the patient would become the manager of their own oral health care." He opined that in this way, "We trust them to make the best decision about their grocery buying [then] can we trust them to make the best decision about their dental care buying and it puts a little bit of responsibility back on them."

All of the participants stressed the need to educate the families and individuals about the importance of oral health care. One participant pointed out that, "we can't do a lot but we can start educating mom at that point or parents or grandparents." In his role as the state dental association president, one participant explained that he intended to make connections with school nurses throughout the state, "to let them know about dental needs and dental care, make sure all school nurses know [for example] that if a tooth gets knocked out on the playground that if they'll put it in a cup of milk we can put that tooth back in."

Others approaches to teaching were suggested by a participant who stated that they could let mothers or soon-to-be mothers know during "prenatal visits or at the health department or wherever that by the time this child gets its first tooth you need to have an appointment at the dentist and let them start seeing them at six months." Remarkably while discussing ways to solve the access issues, none of the participants' suggestions pertained directly to their own practice procedures, policies or office functions or focused on ways to establishing a dental home for patients.

Discussion

Four main themes emerged from this focus group study of dental providers including: "Perceiving avoidant behavior", "Compromising patient access to care", "Helping the underserved, we've tried", and "Solving the access problem". The findings illuminate the importance of engaging ensuring that the current dental workforce and practitioners develop cultural competency, humility and competency. Overall participants blamed underserved patients' lack of access to dental care on poor reimbursement, patients' lack of priorities, and the patients' lack of perceived value, understanding and knowledge of the importance of seeking dental care. The focus group participants also identified barriers that thwarted service-seeking behaviors. They described their service of giving care without fees via foundation work and serving patients in homeless shelter clinics, celebrating the efforts of community workers who convened clinical days, and spoke of the reward of giving back to communities. Although they lauded their own generosity of service, they did not acknowledge the sporadic and temporal nature of volunteerism or that philanthropy is not a system of care [25]. Respondents furthermore neglected to mention that the service initiatives that they supported averted a model of sustainability, one that is needed to address the long-standing issues plaguing under- or unserved dental patients. At no point during the group interviews did they express curiosity or ask if their own practices, patient interactions, office procedures, or patient care environments were welcoming or address the cultural needs of underserved and un-served patients [25]. Health disparities and the variables in the social context, viz., the social determinants of health neither were not raised [9] nor were potential sustainable and inclusive strategies a part of the dialogue.

Research profiles the reasons that many dentists do not provide care for the poor [11]. The major reasons appear to be: (1) a perception of social stigma from other dentists for participating in Medicaid, and (2) the lack of specialists to whom Medicaid patients can be referred. While non-Whites, Hispanics and African Americans were a part of the study, however analysis relative to concern about social stigma for Medicaid participation across racial groups was not a focus of this study. Before this study, little was known about attitudes and perspectives that perpetuate the existence of health disparities which are aligned along racial, ethnic and socioeconomic lines. Findings from this study show that a lack of cultural competency and awareness is not limited to racial lines but that social class is also a powerful factor. This finding is somewhat remarkable given that over 50% of the respondents were African Americans [26], which are more likely to provide care to communities of color [10,11]. While non-Whites, Hispanics and African Americans were a part of the study, the findings suggest that perceptions about the oral healthcare needs of racial groups were shared among the participants irrespective of their racial group.

Findings from this study suggest that the need for cultural competence stems in part from a lack of understanding or appreciation about the social context which links to social determinants that influence health status and health seeking behavior; it is not a racial/ethnic issue. It is important to consider a cultural approach to providing oral health care based on clinical and empirical evidence in current practices by reviewing how cultural competence, and inclusionary medicine are taught beginning in dental schools [27]. As the United States population becomes more diverse, it is imperative to take steps aimed at to eliminating the current gap in care and prevent longstanding and or new disparities from emerging while recognizing that cultural competence can no longer be viewed as an elective skill [26]. Medicine and medical education has led the way in expanding cultural competency training for future and current professionals. Recognizing lack of diversity, inclusion and cross-cultural skills contributes to health disparities research developed by schools such as Morehouse School of Medicine has expanded cultural competence training to move providers towards cultural humility for providers [28,29]. Dentistry can learn from medicine by implementing programs that aim to cultivate a culture where staff, faculty and practitioners work towards the elimination of stereotyping and bias and the reduction of oral health disparities [25,30].

Participants did not express awareness or knowledge regarding the competing needs among underserved and un-served patients. For example, asserting that patients chose not to pay for dental cleanings negates understanding individuals whose income is below poverty. For a family whose earns $24,000 annually, paying $264 for two prophylaxes per year that does not include radiographs (an additional $50) are a substantial investment. Making this type of financial commitment may be untenable when a family is struggling to pay rent or mortgage and utilities or ensure adequate food is provided. Realizing the limitation of Medicaid and how extractions are the only

covered services for adults leaves members of low-income populations with the perception that the absence of oral pain is equivalent to the best oral health they can afford.

Limitations

All individuals participated during each the focus group. No one remained silent. However, the researchers acknowledge that some participants may not have felt comfortable voicing their opinion or may have felt pressure to conform to the group consensus opinion. Based on the diversity of viewpoints shared within each focus group, the researchers did not believe that this was the case. Other limitations inherent to the use of focus groups and the use of different moderators (e.g., dominant voices, moderator influences, difficulty in making generalizations to the larger student body) as well as the general lack of literature on the rigorous analysis of the conversational processes are acknowledged. Despite effort to systematize data collection through the use of a standardized protocol, we cannot determine that potential for moderator influence.

Conclusions

Culturally sensitive care requires that dentists show cultural competency when performing oral health interventions. By engaging the community in culturally competent manners the oral health workforce can begin to address the prevalence of oral health disparities. To advance the field of oral health and address the demographic shifts within the United States the existing dental workforce as well as other health practitioners must develop a commitment and dedication cultural competency, humility and respect. The focus of cultural competency should become a required portion of dental education and the focus of continuing education efforts for practicing dentists. There is a need to develop multi-modal delivery systems for cultural competence training and to assess levels of cultural competence among for oral health professionals that engage cultural norms, social determinants as well as consumer voices to adapt to the current needs of the population. Future research is needed to explore patients' experiences within the existing oral health infrastructure to future illumination the urgency of cultural competence in today's dental offices and clinics.

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