



Improving the Oral Health of Farmworker Children and Their Families: Focus Group at Western Forum for Migrant and Community Health

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Introduction

The National Association of Community Health Centers (NACHC) is developing a Roadmap to improve the oral health of farmworker children and their families, including the identification of facilitators that assist in this effort and barriers that need to be overcome. The [“Population Health Driver Diagram to Increase Use of Oral Health Care”](#) developed by the Public Health Foundation (PHF) with funding from the Office of Disease Prevention and Health Promotion of the U.S. Department of Health and Human Services provides a general framework for the development of this roadmap.

Migrant health centers, regional organizations, and national organizations have been addressing this topic for years. With the development of the Roadmap, NACHC hopes to gather and build on the work that is already being done, including the recent work between Migrant Head Start and the Migrant Health Center programs. At the 2014 National Farmworker Health Conference, NACHC held two sessions about improving the oral health of farmworker children and their families; information gathered during these two sessions was used to develop follow-up questions for discussion during a focus group held at the Western Forum for Migrant and Community Health. This report provides a summary of the feedback received during this focus group.

Overview of Focus Group Participants

A total of 11 individuals participated in the facilitated focus group discussion. Participants worked for healthcare organizations that provide oral health services to farmworkers in various parts of the United States, including California, Oregon, Arizona, and Washington.

Summary of Findings

Participants shared their experiences and expertise in providing oral healthcare to the children of farmworkers and farmworker families. While the focus group was intended to better understand the oral and primary healthcare needs of farmworker children, many participants stressed that it is critical for providers to also engage parents, as parents with good oral health (e.g. visits the dentist regularly, brushes and flosses teeth regularly, etc.) are more likely to understand and support their children’s oral health needs. As such, some of the responses below relate to the provision of integrated primary and oral healthcare services to farmworkers generally. The findings provide insight related to existing integration models and resources, as well as barriers and recommendations to address these challenges.

Existing Integration Models

Participants shared information about models for integration of primary and oral health care in three key settings: 1) community clinics; 2) Head Start and Early Head Start preschool programs; and 3) other community settings. The degree to which participants felt services had been successfully integrated varied, though almost all participants shared that services could be further integrated in many communities.

Clinical Integration

One participant shared the model their federally qualified health center has worked to integrate medical and dental services at multiple levels throughout the clinic. At this health center, the Medical Director is a dentist which reinforces that all providers are part of a larger healthcare team. Additionally, the provision of services is well-integrated; physicians conduct oral health screenings and refer to care while dentists conduct depression screenings on patients and refer to behavioral services. Additionally, dental and medical patient information are shared between medical and dental providers via a two-way

portal, allowing providers to view a patient's medical, dental, and behavioral encounters and information in the same system. The clinic has also integrated dental care into its accountability measures that all providers are working collectively to achieve.

Head Start/Early Head Start

Head Start performance standards require that providers attempt to connect children to a dental home within one year. This connection is facilitated when children are covered by state-funded health plans or other dental health insurance coverage. Otherwise, Head Start has access to emergency funds to pay for care when needed. One provider noted that in their state, while many dentists accept the state health plan, families are assigned a specific dentist through the plan and many do not always know who the dentist is. Head Start providers have access to the health plan web portal to identify which children have coverage and who their assigned dentist is. Children in this Head Start program do not move as much as in other communities so once they are connected to a dental provider, they are able to obtain ongoing care.

Other Community Settings

One participant described how in their region, specific space for dental care services is not available. Instead, the local community resource center provides space for services, as well as connects children and their families to oral health care services. The resource center has partnered with a community clinic in another city. Oral health clinicians come to the community center space to provide dental cleanings for children 0-5. Children are identified via Head Start and other programs that target young children.

Key Components to Integrated Primary and Oral Healthcare Models

Focus group participants were asked to share what components have helped existing healthcare models to successfully integrate dental and primary healthcare. Participants shared that the following are key components to successful models:

- **Support from leadership.** Integrated systems must have full support at the highest levels of the organization (e.g. Executive Directors, Board, and others must all support system integration);
- **Staff buy-in.** Primary care providers must fully buy-in to the integrated healthcare model;
- **Integrated staff meetings.** Meetings between primary care and dental staff should be integrated together to facilitate communication, etc.;
- **Integrated patient record system.** Patient records should include primary care, dental, and behavioral health information; and
- **Clear and measurable goals.** The goals of the integrated healthcare model should be articulated, specific and measurable. Clear and measurable oral health goals will also help to ensure accountability within the system.

Only a few focus group participants were able to identify systems in their region that have integrated primary and oral healthcare models. Most shared that the systems in their region have not yet integrated primary and oral healthcare.

Key Barriers to Integrated Primary and Oral Healthcare Models

Participants were asked what barriers need to be overcome to expand the integration of primary and oral healthcare. Generally speaking, participants discussed system- and patient-level barriers. Some of the barriers shared by participants related specifically to oral healthcare, while others related to primary and oral healthcare more generally.

System-Level Barriers

Participants shared the following system-level barriers to providing oral healthcare services:

- **State laws restrict oral healthcare provision.** Some state laws restrict services that dental hygienists can provide, such as oral health screenings or sealants on school campuses. These laws vary state by state;
- **State-funded healthcare does not cover oral healthcare.** State-funded healthcare coverage and the extent to which oral healthcare is included also varies by state; and
- **There are not enough dentists that offer low-cost or subsidized care.** Many communities have few private dentists willing to provide low-cost care. Additionally, Dentists associated with community health centers are already at capacity, making it challenging to address the needs of all patients.

Participants shared that the following present barriers to healthcare provision more generally:

- **Healthcare coverage does not follow patients across regions and/or states.** Qualified health plan coverage does not follow client across health plan regions. Medicaid also does not follow the client across states. This means that whenever a family moves to another region and/or state, they must re-apply for healthcare coverage. This is particularly challenging for migrant farmworker families;
- **The insurance eligibility criteria are confusing.** This makes it difficult for families, as well as providers, to know which insurance will cover families;
- **There are insufficient numbers of Medicaid slots available.** Demand for Medicaid coverage is greater than Medicaid availability; and
- **Patients do not always attend scheduled visits.** For a variety of reasons, families may not show up to scheduled visits. This increases the cost to offer services.

Family-Level Barriers

Focus group participants shared a few barriers that impede families from engaging in oral healthcare. Participants shared that it can be challenging for farmworkers and their children to visit the dentist even when care is readily available. Some barriers related to healthcare provision more generally, while others related to oral healthcare specifically.

Participants shared that the following were barriers for farmworker families to obtain healthcare generally:

- **Lack of transportation.** Some farmworker families do not have reliable transportation to services. Lack of reliable transportation is particularly challenging in rural areas where the distance between services and the location of families' homes/work may be especially far;
- **Standard hours of operation do not often align with farmworker schedules.** Many healthcare providers operate during typical business hours (e.g. 9am-5pm), the hours when farmworkers need to work. This means that farmworkers may need to take time off of work to get to an appointment and, often, lose wages as a result; and
- **Mobile population.** Many farmworker families move often. This can make it challenging for families to receive continuous services. For example, families may have moved before attending their dental visit, especially since dental visits may take weeks to schedule.

Participants shared two key barriers for farmworker families to obtain oral healthcare. First, families may be unfamiliar with recommended oral health guidelines. For example, some families may be unaware that children should begin to see a dentist even before they have teeth or that children should begin to brush their teeth regularly even before their adult teeth grow in. Other families may be accustomed to going without oral healthcare until there is a specific need for care, such as a toothache. As such, providers may need to offer education to families about preventive oral healthcare. These messages need to be repeated, in different forms (e.g. outreach workers, radio announcements, etc.). Secondly, families may not have the financial resources to pay for oral healthcare services. Some respondents shared that it is challenging for families to pay for healthcare services generally. It can be

particularly challenging for families to pay for oral healthcare services over other basic necessities, even when costs are subsidized.

Strategies to Address Key Barriers

Focus group participants were asked for their recommendations to address barriers that impede the integration of primary and dental healthcare.

Strategies to Address System-Level Barriers

In general, many participants noted that a lack of funding prohibits the provision of oral healthcare to farmworker families and their children. In turn, a few respondents noted that the financial incentives are not always in place to make the case for integrating dental and healthcare. Recommendations to address key system-level barriers included:

- **Partner with existing community resources.** For example, providers may wish to partner with community programs like Head Start or Boys and Girls Clubs to enroll children and their families in services, and/or as locations to provide oral health services. Head Start also hosts a family night every month that providers have used as a platform to visit the parents to talk about oral health. First 5 (in California) has also provided financial support toward care workers that engages in community outreach (e.g. connecting with families by visiting the farms and local preschools);
- **Prioritize referrals based on risk.** For example, families that have a higher need of dental services, or greater risk factors, may be referred in place of those that have low need or less risk factors;
- **Identify and partner with local oral healthcare providers** (dentists, oral hygienists) that are willing to serve uninsured patients and/or patients from underserved communities;
- **Partner with local medical schools** to provide dental students opportunities to work with underserved communities. Reaching out to dental care workers early in their career may encourage them to continue working with underserved communities as they progress in their career; and
- **Support cost-benefit studies** on the impact of providing preventive oral healthcare. In the long-term, such studies will help make the case for why it is important to fund oral healthcare for farmworker children and their families.

Strategies to Address Patient-Level

Participants shared recommendations to support farmworker children and their families to obtain primary and oral healthcare services. All participants agreed that it is important for oral health services to be affordable to farmworkers and their families. Participants felt differently about what would be considered affordable to farmworkers and their families. Some participants shared that offering oral health services at a discounted price helps families to feel more ownership over services; they argued that when families pay for services, even if it is a small amount, the likelihood that they will participate in services increases. Other participants argued that it is important that services be offered for even lower fees or for free; given that some families do not have a history of receiving oral healthcare, these participants argued that even small fees may turn families away from services. Other recommendations include:

- **Provide transportation to services** to ensure children and their families can travel to appointments;
- **Offer mobile healthcare units** that provide primary and oral healthcare services in locations convenient to farmworkers and their children;
- **Ensure that front desk staff are culturally sensitive** and welcoming. Participants noted that it is critical for front desk staff to speak Spanish and for staff to attend trainings so that they understand diverse cultures;

- **Continually assess patient satisfaction levels** with oral healthcare to continually improve oral healthcare services; and
- **Engage children and their parents in oral healthcare.** As referenced in prior sections of the report, participants shared that when parents are able to maintain their own oral health, they are better able to support their children's' oral health.

Resources Available to Support Integration of Primary and Oral Healthcare

Participants shared a few resources that they thought would be helpful to inform primary and oral healthcare integration efforts. Resources included:

- [Smiles for Life](#) produces educational resources for clinicians and educators to integrate oral health and primary care;
- [Bright Futures](#) produces a booklet with useful information;
- [Washington Dental Service Foundation](#) offers training for primary healthcare providers in Washington State on patients' dental needs; and
- [Health Initiative of the Americas \(HIA\)](#) offers a community health worker training.

The resources referenced here may be good starting places for systems interested in integrating primary and oral health services.

Measuring Success

Participants were asked what indicators would show that they have successfully integrated primary care and oral healthcare models. Participants shared that successfully integrated primary and oral healthcare models would be able to measure and show that the ratio of dental to medical visits has increased. This would indicate that families are receiving more oral healthcare services.

Additionally, some participants shared that they felt it was important to track the number of children that have a dental home, as well as number of children that needed oral health treatment and received needed dental treatment; Head Start was referenced as one program that did a fairly good job at tracking this information for both children and their parents. Participants also said that successful systems would be able to show a decrease in rampant decay (seven or more cavities) over time.

Finally, participants stressed that primary and oral health are closely intertwined and, as such, children and their families' oral health outcomes often impact their health outcomes as a whole. In turn, participants shared that a successfully integrated primary and oral healthcare model would show that families' oral health, and health more generally, have improved.

Conclusions

Focus group participants provided information on various approaches to integrating primary health and oral healthcare for farmworker children and their families. These include clinical and community settings. For each model, participants shared that support at multiple levels; referral mechanisms to identify patients and connect them to care; as well as education to ensure community health workers and healthcare providers understand the importance of oral health care, are imperative elements to support these efforts. While participants cited many system and patient-level barriers, they also offered recommendations to address these barriers in order to maximize the impact of services offered, as well as strengthen the support for efforts to address oral health care needs.

This focus group was one conversation designed to inform NACHC's efforts to develop a Roadmap to improve the oral health of farmworker children and their families. It is expected that while this

conversation was informative, additional conversation to elaborate on effective models and trainings, as well as identify ways to replicate these models, are needed.

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