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Barriers to Oral Care Among African American Adolescents in Prince George's County, Maryland

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This is to certify that the doctoral dissertation by

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2018

Abstract

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MSc, University of Maryland University College, 2013

BA, University of Pittsburgh (Main Campus), 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Care Administration

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Abstract

When adolescents forgo oral health treatment, factors that hinder them from obtaining these services put them at risk of detrimental consequences in their oral and overall health. The purpose of this qualitative phenomenological study was to identify the various barriers that adolescents encounter causing them to defer oral treatment. Through this study, public health officials, school health care providers, the state, and parents could be made aware of these factors and work together to implement programs and supplemental aid to help adolescents become more knowledgeable of the importance of oral care and encourage them to desire and seek treatment. The oral health and behavioral conceptual models provided foundations for the development of the research questions, and they highlighted the selection of risk factors on the deferment process. Twenty adolescents who had oral health treatment/services in the past 12 months participated in the study. Interviews were transcribed verbatim and analyzed thematically. The results of this study show that oral health beliefs, as well as personal, behavioral, and environmental factors, shaped adolescents' decision to forgo oral health treatment. Financial barriers, dental fear, and transportation obstructed their capacity to seek care for themselves. The positive social change implications of this study include increasing the proportion of adolescents receiving oral health treatment yearly through the development of targeted interventions (such as school programs) that are designed to increase the adolescents' access to and use of dental care services. Such efforts would support the strategies implemented to achieve Healthy People 2020 objectives.

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Dedication

This study is dedicated to my entire family (Sir Engineer Valentine Soribe, Lady Carolyn Soribe, Chinedum Soribe, Chimaobi Soribe, Nneka Soribe, and Brandon McGinnis), who helped me through this long, hard journey. I may be the one receiving this doctoral degree, but you all have encouraged and supported me the entire way.

To my family: Thank you for always encouraging me to be the best that I can be. Thank you for helping me take all the necessary life steps that I needed to take to get me where I am today. From supporting me on my wedding day, the move into a bigger house, and most of all the birth of our first born child Giselle! It is because of you all that I was able to accomplish all of these and still stay on track for my doctoral degree.

FOR THIS, I AM FOREVER GRATEFUL!

To my father and mother (Valentine and Carolyn): Thank you for always having faith in everything that I do. You have always been there for me, and I cannot fathom life without either the two of you. I pray to God every day that I am a great parent to my children the way you both have been to my siblings and I. You two have always helped me to make my dreams come true and I pray that God blesses you both abundantly the way you have always blessed me. This is dedicated to you both!

To my dearest husband, Brandon: Words cannot express the gratitude, love, and joy that I have in my heart for you. You have always been my biggest supporter in anything that I've decided to do. Your belief in me and in the decisions that I make in life. You have never doubted nor questioned my reasoning. You have always stood by my side with such amazing resilience. I am honored that you have followed God, and

through him, you have chosen me to be your wife, life partner, and the mother of your children. I hope that I encourage you the way you encourage me. After the birth of our first born, you have continued to be the man, husband, and father that I need to help me ensure the completion of my journey. Thank you for taking over nightly feedings, and weekend daddy duties so that I can spend time at the library to make sure that I stay on track with my dissertation process.

I LOVE YOU ALWAYS AND FOREVER, AND FOREVER AND ALWAYS I WILL LOVE YOU

To my first born child Giselle Marie Oluomachukwu: In the book of 1 Samuel, chapter 1 verse 27, it says, “For this child I have prayed, and the Lord has granted the desires of my heart”. I thank God every single day for a sweet, and joyful child like you. Your father and I are extremely blessed that you are the fruit of our love. You are the one who encourages us to be the best that we can be so that not only will you follow our examples, but you will be proud of us as well. You are mommy’s moon and stars and,

I LOVE YOU MORE THAN ALL THE STARS IN THE SKY

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Chapter 1: Introduction to the Study

Introduction

Some objectives of Healthy People 2020 (U.S. Department of Health and Human Services [HHS], 2011) are to (a) reduce the proportion of children aged 3 to 5 years with dental caries experience in their primary or permanent teeth; (b) reduce the proportion of children and adolescents with untreated dental decay; and (c) increase the proportion of children, adolescents, and adults who have visited a dental office within the last 12 months. A recent report by The American Academy of Pediatric Dentistry (2015) stated that continuing to focus on oral health during the adolescent years is important because it further helps in the prevention process in adulthood.

Furthermore, the American Academy of Pediatric Dentistry (2015) highlighted that 5% of 12- to 19-year-olds have experienced tooth decay in at least one tooth, and 13% of adolescents have untreated caries. The authors also bring to attention that dental caries can continue throughout adolescence, and the same factors that influence caries risk in children still exist in adolescence. A report by the Institute of Medicine and National Research Council (2011) stated the lack of routine dental preventive care affects "a disproportionate number of vulnerable and underserved individuals" (p.573) including the uninsured and the underinsured. Medicaid and the Children's Health Insurance Program (CHIP) include provisions for routine dental care for children up to 19 years old. Unfortunately, one of the reasons that adolescents are not able to receive routine screening and checkups is that low reimbursement rates discourage many dentists from

accepting children and adolescents with Medicaid benefits, forcing caregivers to incur out-of-pocket expenses (Fisher-Owens et al., 2007).

To fill the gap in the literature related to the subgroup population of adolescents, I sought to identify the prevalent barriers that deterred adolescents from seeking oral health care services. Highlighting these barriers may assist public health officials and organizations to create and implement intervention services that could increase access to and promote the importance of dental services for adolescents, therefore reducing oral health disparities for this particular population.

The factors that deterred these adolescents from seeking oral care services indicate which structural, financial, and personal changes are needed, and these changes can be targeted so that citizens, health care providers, and public health officials could work together to make the necessary changes so that adolescents are able to receive the quality oral care they need and deserve. Low-cost dental services for insurance plans, increased reimbursements for providers who accept Medicaid patients, and a reduction in structural barriers to dental care (e.g., office hours, family reliability, reliable and available transportation) are brief examples of challenges that could be addressed and solutions could be employed if modifications are made in these areas to improve adolescent access.

Improvement in access to routine dental preventive care for children and adolescents achieves one of the Healthy People 2020 objectives for oral health (HHS, 2011). My research will provide targeted information in the area of public health and

health services by addressing barriers to access, helping to improve overall health, and promoting positive social change.

I constructed this chapter to highlight the absence of information regarding oral health care issues for adolescents on Medicaid through the illustration of the gap in the literature. I examine this topic in Chapter 2. In Chapter 1, I provide a description of the structure and objective of this research study, as well as a conclusion regarding the contribution(s) this research study may make in reducing oral health disparities in adolescents.

Background

Regular dental preventative care is a vital component of good overall health. Unfortunately, access to regular dental preventive care is lacking for many people in the United States (IOM, 2011). Several studies assessed barriers to obtaining oral health services, but researchers have primarily focused on access issues for either children or adults without a focus on adolescents. Mofidi, Rozier, and King (2002) illuminated several barriers to obtaining dental care for Medicaid-insured children as perceived by their caregivers. Outside of economic issues, the researchers found that structural, environmental, and interpersonal barriers affect children's ability to secure dental care through the perspectives of their caregivers. Vujiviv, Nasseh, and Wall (2013) analyzed 10 years of data from the Medical Expenditure Panel Survey (MEPS) and found dental service utilization increased for children but decreased for adults; the researchers implied that recent changes in public health care program benefits were responsible for the fluctuations in utilization rates. Researchers in general, have indicated that race/ethnicity

and insurance type influence children and adult dental service use, with insurance type moderating the dental service usage rates among racial and ethnic minorities. Kelly, Binkley, Neace, and Gale (2005) found similarities and differences in oral health beliefs and experiences of dental service users and nonusers, which helped shape how various groups approached oral health treatment/services. Users focused on preventing oral health disease, whereas nonusers perceived oral health care only important dental emergencies or for aesthetic reasons.

The research on barriers to preventive oral health care is divided among subgroups of the population: children and adults. These two subgroups can be further subdivided further into adolescents and older adults as well as demographics such as age, gender, race/ethnicity, and residence. Research also exists describing the relationship between dental service use and specific factors such as a parent's literacy level or language spoken at home as it relates to the child's dental health outcome (Miller, Lee, DeWalt, & Vann, 2010). Researchers indicated that poor parental dental health is associated with poor dental health in children (Dye, Vargas, Lee, Magder, & Tinanoff, 2011). Yet, no research has explored what adolescents sacrifice when they make decisions to forego dental health treatment/services. My intent in this study was to fill the gap in this topic.

To achieve the Healthy People 2020 oral health objectives set forth by the HHS, public health researchers should separate *adolescents* from the broad definition of *children* to determine what specific factors are influential in their decisions to not seek oral health treatment. Researchers and policymakers should not assume that health care

decisions made by the caregivers of adolescents who receive private insurance are influenced in the same manner with the same factors to the same degree as decisions made by the caregivers of adolescents who receive Medicaid. Nor should they assume that health care decisions made by caregivers of young children are the same as health care decisions made by caregivers of adolescents. Competing priorities and the interaction of determinants affect the health care decision process differently within these subgroups and should be identified and explored as targets for health improvements.

Problem Statement

This research study adds to previous literature on barriers to quality oral care. The research problem that I addressed is that when barriers to quality oral care are being discussed, many researchers address the barriers encountered by young children, adults, older adults, or those with special needs, although adolescents encounter many of the same barriers in many similar ways. Previous researchers have highlighted various reasons why oral care is not considered a priority to many low-income adolescent patients. Some of these broad factors are as follows: perceptions of oral health and disease, financial concerns, Medicaid, parental availability, and fear (Dodd, Logan, Brown, Calderon, & Catalanotta, 2014).

Various studies exploring caregivers of children, caregivers of those with special needs, and knowledge of oral health among older adults, were highlighted to use in the literary review. Behaviors, and complexities and barriers underlying access to oral health care in the United States are the viewpoints that I identified in the literature to address barriers to accessing quality oral health care (Duderstadt, 2014; Mulye et al., 2009).

The Patient Protection and Affordable Care Act (2010) was signed into law to address many health care challenges in the United States. One of the challenges this law addresses is the barriers that the underinsured, uninsured, and the publicly insured face in accessing oral health care services. The American Dental Association estimates that through the health insurance exchanges alone, an estimated 3 million children will gain dental benefits by 2018.

The problem is that although researchers highlighted various barriers regarding access to oral care, a gap exists in the literature regarding how these barriers faced by adolescents are being addressed. Therefore, I focused on the implementation of the Patient Protection and Affordable Care Act (PPACA) and its effects on the state of Maryland as it pertains to African American adolescents in Prince George's County.

Purpose

The purpose of this study was to explore and develop an in-depth understanding of African American adolescents' reasons for not seeking, and being able to access, oral care in the last year, by observing various barriers that these patients encounter. To further highlight these challenges, I conducted in-depth interviews so that I could highlight these barriers from the participants' perspectives and acknowledge the way the participants frame and structure their responses.

Research Questions

RQ1 : What are the experiences and perceptions about accessing quality dental care for Medicaid insured adolescents in Prince George's County, Maryland?

RQ2: How do past experiences with oral care services currently affect access to quality oral care services?

RQ3: What are the experiences or perceptions of Medicaid insured adolescents in Prince George's County, Maryland regarding oral health and how it affects their overall health and daily lives and activities?

RQ4: What forms of community support may be most helpful in promoting awareness to these patients regarding the importance of oral care?

Framework

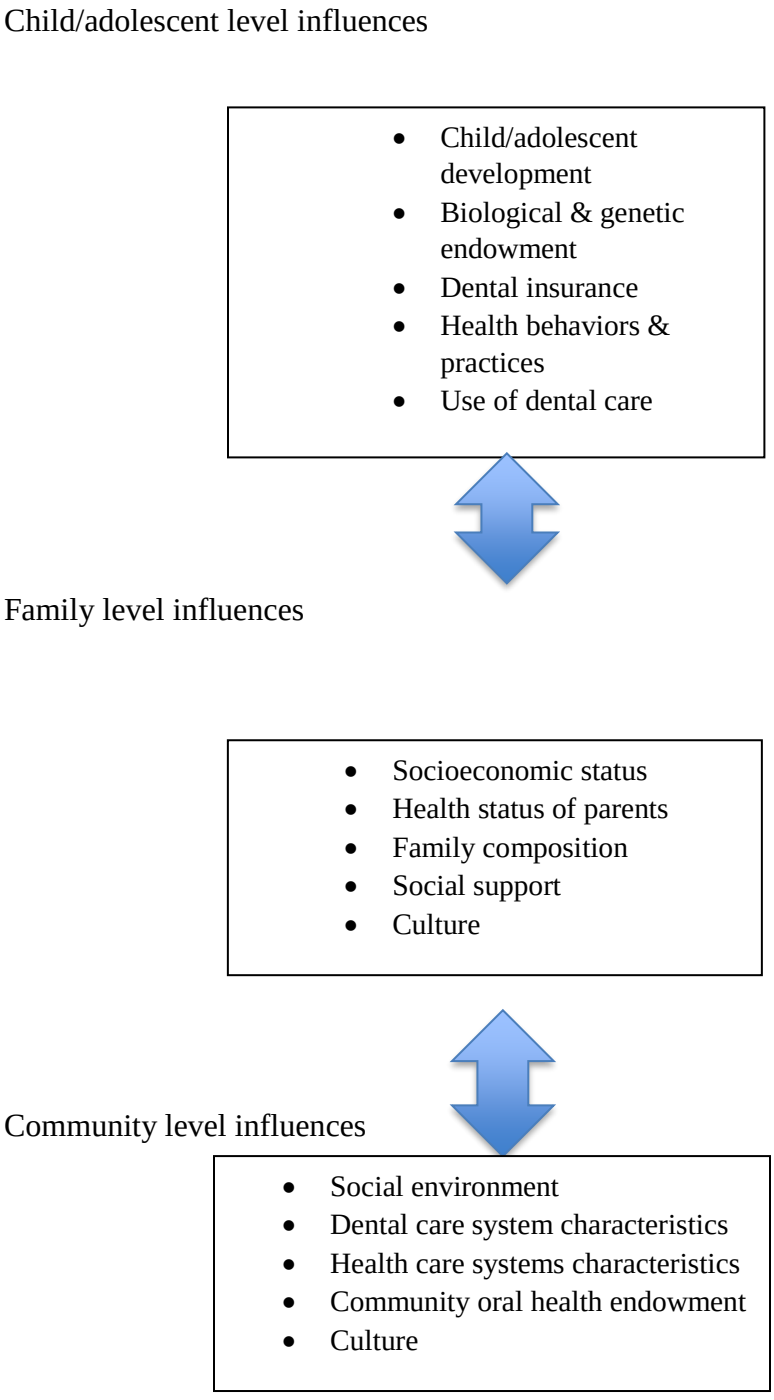
The theoretical base for this study was Andersen's (1995) behavioral model of families' use of health services and the Fisher-Owens et al. (2007) conceptual model on the influences of children's oral health. Andersen's behavioral model addresses the predisposing characteristics that leads to the enabling of resources that could be provided, which leads to the type of need acquired that turns into the actual use of health services. The Fisher-Owens et al. conceptual model addresses the different risk factors that children face when it comes to accessing quality health care, which are genetic, social, and environmental. In the Fisher-Owens et al. model, a standard biological model that includes social and environmental influences are explained. Some of these influences are family, community, and society on an individual's oral health. Figure 1 shows how the model takes into account genetic and biological factors, health behaviors, medical and dental care, structural environment, and other sociocultural factors that help contribute to oral health outcomes (Fisher-Owens et al., 2007).

Figure 1. Conceptual model on children's oral health (Fisher-Owens et al., 2007).

Primary determinants of health behavior	Health behavior	Health outcomes
Population characteristics	Personal health practices	Perceived health status
Health care system	Use of health services	Evaluated health status
External environment		Consumer satisfaction

I used the Fisher-Owens et al. (2007) model to examine what factors, situations, and experiences assembled to lead adolescents and their caregivers to forgo seeking oral care/treatment, which helped me consider the various determinants of the barriers to accessing oral health care services. The Andersen Behavioral Model (1995), figure 2, was also relevant to my research study because I was able to use this model to explain the factors that influence whether patients are susceptible to using health services. The first category of determinants are predisposing characteristics (demographics, social structure, and health beliefs). I used this model in my research study because it helps to highlight the predispositions of the participants and how they affect their decisions down the line to seek oral care, or to be aware of oral health.

Figure 2. Determinants based on the behavioral model (Andersen, 1995).



These two models were combined and then linked to the research questions. The different levels of determinants shown in the Fisher-Owens et al. (2007) model, and the different levels of Andersen's (1995) health behavior helped to immediately highlight the identified risk factors that lead to oral health issues, and the barriers to accessing oral care services. The presentation of factors could help adolescents and caregivers to be aware of the importance of health care use. All of these tools will help public health leaders and agencies to redefine their oral health promotion strategies and incorporate adolescents a bit more. In Chapter 2, an explanation of the utilization of the Fisher-Owens et al. model and the Andersen model is given to highlight the factors of the adolescents, their decisions not to seek oral care, and the barriers that hindered them from receiving oral health service .

Nature of the Study

The design for this research study was qualitative phenomenological. In this type of research, "A description of the common meaning for several individuals of their lived experiences of a concept or phenomenon. The basic purpose of phenomenology is to reduce individual experiences with a phenomenon to a description of the universal essence" (Creswell, 2009, p. 76). In this study, I attempted to understand why a participant acts and reacts the way they do when experiencing a life issue (phenomenon). The method that I used to conduct this type of research was purposive sampling (selective sampling) in the homogenous form. I selected this design because I wanted to collect data

from participants that highlighted their experiences regarding oral care services in Prince Georges County, Maryland, under the Affordable Care Act.

Definitions

Determinants of Health

Factors that are combined that affects the health of individuals and communities. Determinants of health include the social and economic environment, the physical environment, and the person's individual characteristics and behaviors (World Health Organization, 2016).

Health Behavior

A combination of knowledge, practices, and attitudes that together contribute to motivate the actions taken regarding health (Farlex Partner Medical Dictionary, 2012).

Health Outcomes

The effect that health care activities have on people. The outcomes focus not on what is done for patients, but the results from what is done (World Health Organization, 2009).

Behavioral Factor

Any specific behavior or behavioral pattern that strongly yet adversely affects health (Psychology Dictionary, 2005).

Environmental Factor

The surroundings and external conditions, especially as affecting human lives (The National Institutes of Health, 2016).

Societal Factor

Social determinants of health reflect the social factors and physical conditions of the environment in which people are born, live, learn, play, work, and age (World Health Organization, 2016).

Risk Factor

Any attribute, characteristic, or exposure of an individual that increases the likelihood of developing a disease or injury (World Health Organization, 2016).

Assumptions and Limitations

The primary assumption surrounding this project was that adolescents on Medicaid do not have the same oral health care use issues as adolescents who receive private insurance coverage. As previously stated, the additional components of structural, financial, and environmental barriers that adolescents on Medicaid face are not similar to those of adolescents who receive private insurance coverage regarding oral health treatment and care. These barriers that adolescents on Medicaid face may affect their ability to obtain oral health care services by sacrificing some aspect of their daily life routine. Research indicates that the percentage of adults receiving dental care has declined, whereas the percentage of children receiving dental care has increased (Wall, Vujicic, & Nasseh, 2012). Although Wall et al. (2012) provided highlights regarding the difference in the use of oral care services it did not highlight comparable differences of oral health care use of the different stages in childhood (children vs. adolescents). Nonetheless, research studies do not note the comparable oral health use between adolescents on Medicaid and adolescents with private insurance coverage to highlight the

barriers to accessing oral health treatment and services. I aimed to bring attention to this shortfall as a new outlet for research.

The second assumption of this study was delaying dental treatment due to various barriers will become a more significant issue in an adolescent's overall health (Decker, 2011). One of the barriers to accessing oral care is lack of or lapse in dental insurance coverage. Some caregivers have agreed that they should lead by example by being more health literate and knowledgeable regarding oral health so that their adolescents are able to be the same when it comes to knowing and obtaining the care they deserve. Unfortunately, being insured (or having some type of coverage) does not guarantee receipt of health and dental care services; issues with access and out-of-pocket fees often present impediments even for families with coverage (DeVoe et al., 2007; Kenney, Marton, & Klein, 2011).

Yin (2009) considered interviews as a staple of case studies, phenomenological studies, and phenomenological evidence but cautioned researchers to corroborate answers whenever possible through alternative data sources. Therefore, a third assumption of this study was that the participants would provide truthful responses to the interview questions. Inherent in all qualitative interview data collection is the potential for response bias, especially when questions pertain to sensitive information (Patton, 2002; Yin, 2009). Development of rapport with participants, ensuring responses will be kept confidential, and sequencing questions from relatively innocuous toward more personal questions should elicit truthful answers from interviewees (Patton, 2002). Another assumption concerning participant responses was that the sample size (10) would be

sufficient to answer the research questions; however, the least number of participants who could be interviewees until saturation and redundancy was reached was 10.

My study was a phenomenological qualitative research study because I sought to identify the essence of human experiences about a phenomenon as described by participants. In this process, I bracketed or set aside my own experiences to understand those of the participants in the study (Creswell, 2009). One design challenge in conducting a phenomenological study is that the subjectivity of the data leads to difficulties in establishing reliability and validity of approaches and information. Phenomenological studies are often criticized for the lack of scientific rigor (Crowe, Creswell, Robertson, Huby, Avery, & Sheikh, 2011; Yin, 2009). Rigor is considered the highlight of effective research. However, qualitative researchers can use several strategies to improve the rigor of their study. Crowe et al. (2011), recommended using transparency to address the lack of rigor in a qualitative study; transparency can be achieved by delineating the steps of the study process in specific detail. Patton (2002) suggested establishing researcher credibility and, therefore, scientific rigor, through audit trials, interview notes, triangulation, and acknowledging rival conclusions.

Another design limitation of the phenomenological study approach is limited generalizability or transferability to other settings or contexts (Yin, 2009). Yin (2009) considered phenomenological studies as an opportunity to “Expand and generalize theories”, (p.35) not provide mathematical and statistical support for current theories. Researchers can add to a reader’s capacity to transfer important constructs from the study

to their own situation by thoroughly restricting the case and meticulously describing the procedures.

In qualitative studies, it is up to the researcher to collect and analyze the data. Because the researcher is involved (in-depth), the possibility of researcher bias becomes more prevalent. One strategy to reduce the influence of researcher bias is to acknowledge and report the potential sources of bias within the study (Creswell, 2009). Triangulation, the use of multiple sources of data, investigators, and methods also reduces the possibility of bias during data analysis (Patton, 2002).

To address the potential limitations of my study, I used multiple strategies designed to reduce the effect of the limitations stated above. The study was restricted by time and place enabling the collection of a sufficient volume to generate an accurate description of the phenomenon. Next, I meticulously highlighted the exact steps in the qualitative phenomenological study, established transparency, and improved its scientific rigor. During this study, I implemented audit trails, notes, and validation to help facilitate scientific rigor. Using these strategies not only addressed design limitations but they also enhanced transferability of the result to similar situations.

Scope and Delimitations

I sought to explain the issue of the barriers to accessing oral health care services by interviewing adolescents who encountered various challenges pertaining to accessing oral health care services. I illustrated what these challenges are, how it deterred these adolescents from seeking oral services/treatment, what situations and risk factors led to the deferment regarding seeking care, and how these challenges have affected the

adolescent's perceptions of their overall health. These factors also served to highlight the need to distinguish the category of adolescence to account for the differences in access challenges for children, adolescents, and adults.

I chose to emphasize this category after informal discussions with adolescents on the challenges they faced with obtaining oral health care services. The initial conversations highlighted the various circumstances that adolescents faced that forced them to defer seeking health services providing attention to oral and overall health. Not many of these adolescents were aware of the dangers of forgoing preventive dental care and at the same time were not able to afford potential out-of-pocket expenses for oral health services. Combined with the research, reporting an association between poor dental health and cardiovascular disease, the awareness that dental deferment is detrimental will support the assertion that good oral health is crucial and should not be sacrificed.

Participants in this study are adolescents in Prince George's County, Maryland. Residents in Prince George's County are relatively homogenous with approximately 65% of the population identifying as Black or African American (U.S. Census Bureau, 2014). Twenty-one percent of Prince George's County residents speak a language other than English at home, and 86% of residents have at least a high school diploma (U.S. Census Bureau, 2014). Participants in this study are Prince George's County adolescents who had not accessed health services in the last 12 months. This study focused on recruiting participants who comprehended, spoke, and wrote English fluently regardless of ancestry. Results may not be transferrable to adolescents who receive private insurance coverage

and have received oral health treatment within 12 months or in situations involving barriers to accessing oral health care. However, the results may be transferable to participants with similar characteristics in a similar setting.

Significance

The findings of this study could make substantial contributions to the field of health care administration, health sciences, and public health and result in significant social change. One contribution to the field of health science may be acknowledging adolescents as a separate group in research, analyzing information collected from this group, and using it to add to the other various factors that attribute to the disparity of accessing quality oral health care services. Focusing on information from adolescents and their caregivers, these results may also contribute to the advancement of dental health practice and policy by obtaining consent and allowing these adolescents to describe their experiences with accessing oral care services and the differences, if any, that the implementation of the PPACA made in accessing oral care. My results also revealed other issues that need to be addressed and what has changed in the last 12 months in their health coverage that may have affected or addressed these barriers to oral health services. In addition, the study focused on a population (African American adolescents ages 13-18 years) that the PPACA includes but not many other research studies have focused on. Various leaders and policy makers could look at this research study to find ways to educate adolescents and caregivers about what oral health is, and the importance of it pertaining to overall health. Furthermore, policy makers could help these adolescents find ways to overcome these barriers by working with public health agencies to come up with

local programs that help to promote oral health with easier accessibility. This study has the possibility to promote positive change across the United States as it pertains to African American adolescents and their access to oral health care services.

Summary

Oral health is an important component of overall health but is often sacrificed when various challenges are encountered. Unfortunately, poor oral health has more consequences than only dental caries and periodontal diseases. Poor oral health has been associated with increased rates of cardiovascular disease and stroke, among others. These conditions warrant improving oral health care services use rates. Factors that deter seeking oral health care services for adolescents on Medicaid is a phenomenon that has been studied frequently in the past and should be explored to identify what factors (barriers) lead to not desiring dental treatment/services so that public health officials, caregivers, and providers can address these challenges. In Chapter 2, I present a detailed account of relevant literature pertaining to the barriers to accessing oral health care for adolescents on Medicaid, and in Chapter 3, I describe the methodology that I used to explore this phenomenon. I present the findings of this study through the perspectives of the participants who experienced any barrier(s) to accessing oral health care services in the past 12 months in Chapter 4. Finally, in Chapter 5, I present an interpretation of the findings within the current literature, as well as the limitations of the study, the future direction(s) for research, and recommendations for practices.

Chapter 2: Literature Review

Introduction

Various cases and circumstances might lead an adolescent or their caregiver to forgo oral care and/or treatment. Some of these cases can be minute in the short term but can cause long-term harm to the person in need of care. Previous studies have linked the negligence of oral health to other health care issues such as heart disease, diabetes, and stroke (Institutes Of Medicine, 2011). Highlighting the relationship between forgoing oral health services and the possibility of experiencing the diseases mentioned previously is something that needs to be addressed so that it can be presented to adolescents as a way to educate them on potential harms to their overall health. The purpose of this study was to explore and develop an in-depth understanding of African American Medicaid patients (adolescents) not desiring dental care services by observing various barriers that these patients encounter regarding oral health.

Klein, McNulty, and Flatau (1998) reported that many teenagers depend on multiple sources of care, and they rely on school personnel as important sources of health information. While they are seeking preventive care from the school's providers, they also highlight that many of the adolescents in their study did not know where to go to seek further treatment (Klein et al., 1993). A lot of this information is still relevant post the Patient Protection and Affordable Care Act (2010). Furthermore, after the mandate of the Affordable Care Act, Dodd et al. (2014) focused on how adolescents on Medicaid perceive oral health and oral health care, and how these decisions can bring about long term effects of dental diseases on childhood learning capabilities as well as behavioral and social development.

I present a detailed literature review relating to the barriers to the oral health care phenomenon. The first section includes the search terms that were used to locate articles relevant to this research topic. Second, I provide descriptions of the two conceptual frameworks that highlight the evidence of certain factors that impacted these adolescents and their caregivers to forgo oral health treatment/care. Finally, I present an analysis of the literature presented as it relates to the barriers to oral health care for African American adolescents to establish the need for this study.

Literature Search Strategy

When I conducted this research study, I used three search engines: Google Scholar, the Walden University Library (CINAHL and MEDLINE Simultaneous Search), and PubMed. The search terms are: *dental health or oral health*, *Medicaid*, *African American*, *adolescent,* or *barriers.* During this research process, it was initially difficult to find the barriers to oral care with a focus on adolescents. Many of the articles pertained to children (as a whole age group) and their caregivers. The purpose of the study was to focus on adolescents only (between the ages of 13 and 18 years). Since I encountered this, I began to type in the targeted age range, which helped to further focus the results of my search as well as incorporating the concepts that were related to the conceptual framework of my study. Some of the terms that I used were *behavioral factor*, *environmental factor*, *societal factor*, *risk factor*, *determinants of health,* and *socioeconomic status*. When reviewing articles that were related to the research study, I checked the reference page to see if there were other research studies that had just as much relevance.

Conceptual Frameworks

Oral Health Conceptual Model

Although action occurred to address the challenges regarding the barriers to oral health care/treatment, many reports have documented the prevalence of dental caries in adolescents. Because the prevalence of dental caries is population epidemic, the Fisher-Owens et al. (2007) conceptual model is structured to focus on the determinants to all children's oral health. This framework is designed to encompass various factors such as social, environmental, and biological to acknowledge how these factors operate within a specified period. Furthermore, the Fisher-Owens et al. (2007) model uses various levels to highlight the interactions of these factors that are influential to the purpose of my research study (child, family, and community).

The purpose of the Fisher-Owens et al. (2007) conceptual model is to make people aware of the importance of oral health and where it stands compared to systemic health. According to Fisher-Owens et al., the conceptual model, "Provides examples of discrepancies between policy and needs and examples of successful interventions that integrate oral health care with informed policy" (p. 404). These researchers used various approaches to identify the different determinants of oral health behaviors. This model states that, "Influences do not act in isolation but rather via complex interactions" (Fisher-Owens et al., 2007, p. 511). This model also goes into detail regarding the different factors that are influential to health such as individuals and families and how they live, work, and travel within and among their communities. Because I addressed these epidemics (lack of oral health care and the prevalence of dental caries among

children and adolescents), I provide strong evidence as to why and how this particular model makes a significant contribution to the field of oral health research (Fisher-Owens et al., 2007).

The Fisher- Owens et al. (2007) conceptual model has been used and tested to determine its accuracy on helping to improve oral health outcomes in children and adolescents. Isong, Zuckerman, Rao, Kuhlthau, Winickoff, and Perrin (2010), tested the conceptual model with 6,107 child-parent pairs highlight the aspect of the conceptual model where child/adolescent influences are affected by and in correlation to family level influences (parents), which in turn is affected by community level influences (public health laws, accessibility, and cost). In this study, Isong et al. (2010) conducted an assessment from the data source, National Health Interview Survey (2007), and its Child Health Supplement where they analyzed the estimates of health care utilization and access that were obtained through in home interviews with an adult. Comparisons were made between the dependent (child dental visits, and deferred child dental care because of cost) and independent variables (parent dental visits, and deferred parent dental care because of cost), of the risk factors that are associated with the behaviors and influences of the lack of oral health care/treatment. The results of the study indicated that there are factors that could predict whether or not a child or adolescent had a dental visit in the previous 12 months.

Dodd et al. (2014) conducted a study of 100 adolescents ranging from ages 10-18 years who are of low socioeconomic status. Their status was determined because they resided in 1 of 2 federally designated medically underserved and Dental Health

Professional Shortage Areas in North Florida. Their sample consisted of 52% boys, 80% black, and 91% non – Hispanics/Latino. These individuals provided their perceptions of oral health and dental care access. The researchers conducted semi structured interviews with adolescents who lived in 2 rural, low income communities. Their objective for the research was to identify the adolescents' knowledge of oral health, oral health care seeking behaviors, and perceptions of parental attitudes toward health care. Dodd et al. Analyzing the data they collected, these researchers were able to identify the difficulties that these adolescents encountered when seeking dental care are: finances, transportation, issues related to Medicaid use, parents, and fear.

Using the qualitative methods research approach, these researchers (Dodd et al., 2014), were able to note that the first and second barriers (finances and transportation), was perceived by these adolescents as gas prices, traveling for an extended period of time, finding a provider who accepts Medicaid, and the lack of access to public transportation. When asked to go in depth regarding transportation, respondents usually replied with, "Most people don't have rides to go" (p. 804). The third barrier (Medicaid), was also discussed during these interviews. Dodd, et al. discovered that most of the participants highlighted the rules and regulations of their state's Medicaid program, and the shortage of Medicaid providers in their communities as being barriers to accessing oral health care services. The fourth barrier that was noted was parental availability. Dodd et al. noted that even though appointments were made by these adolescents' parents, sometimes these parents are unable to take the day off or find time to help their child/children make their appointment. The final barrier that was identified was fear

which in this case referred to not liking needles, the dentist themselves, or the dental environment as being harsh and unfriendly, Dodd et al. , suggested that relevant, age appropriate, oral health education combined with, at minimum, preventive oral health care services would benefit students at all grade levels. They also suggest that access to school-based oral health care would address some of the issues faced by parents when attempting to access oral health care for their children (p. 807).

Weyant, Manz, Corby, Rustveld, and Close (2007), Kelly, Binkey, Neace, and Gale (2005), and Isong, Zuckerman, Rao, Kuhlthau, Winickoff, and Perrin (2009), all used the Fisher-Owens et al. model to some capacity as well as others to explain the different factors that influenced the oral health experiences of children, and adolescents as well as their caretakers. These three studies highlighted the overall values that proved to be influential in oral health decisions of all of the participants in these studies. The studies conducted by Weyant et al. and Isong et al. focused on parents' or caregivers' experiences in Pennsylvania and in Massachusetts. Kelly et al. focused on the psychosocial, structural, and cultural barriers to seeking dental care among caregivers of Medicaid enrolled children. The results of all four studies indicated that barriers to accessing oral health care stems from psychosocial, structural, and cultural factors that intersect with the participants' perceptions of how they access and utilize oral health services and oral health care in general.

Other researchers such as Dodd, Watson, Choi, Tomar and Logan (2008), revealed that the participants in their study (African Americans), lacked knowledge of the severe consequences of not seeking oral health care which was influenced by cultural

influences, specifically lack of education and awareness. Another study that has implications of utilizing the Fisher-Owens et al. (2007) model, is a research study conducted by Fisher-Owens, Isong, Soobader, Gansky, Weintraub, Platt, and Newacheck (2010), they studied oral health disparities that were caused by factors other than race/ethnicity such as child, family, and community/state. Although the pre-adjusted report helped researchers to identify race/ethnicity as being a main factor, the authors showed that other factors such as socioeconomic status, and insurance coverage were factors as well. Upon completion of the study, they suggested that efforts should be targeted at the social, economic, and other factors that could potentially be related to racial and ethnic status which would be effective in addressing oral health disparities.

The authors of these research studies suggest that Medicaid administrators, public health officials, and schools should all work together to create programs and policies to encourage and build trust between citizens and health care professionals to create a link to access oral health care services that not only provides and promotes quality, but awareness as well.

Access to Medical Care Behavioral Model

Andersen (1995) progressed the work of the access to medical care services model which was initially developed in 1960 to provide an understanding of the reasons as to why families use health services, and to provide definitions of what access to health care is. How Andersen , expanded on the behavioral model is by shifting the focus from the demographic social and economic characteristics of the family as a unit to focusing on the individual as the unit of analysis. He also discusses the importance of including

family characteristics to the individual as the unit for analysis. Andersen, explains how the behavioral model evolved into one where it takes an individual's external environment (physical, political, and economic factors), to understand their decisions to obtain health care. Attention is also brought to an individual's diet, exercise, and self care as factors to obtaining health services from health care providers that influences their overall health.

In a study conducted by Dye et al. (2011), the authors seek to describe if there is a correlation between the oral health of young children and their mothers. They focused on obtaining data from the Third National Health and Nutrition Examination Survey and gathered a sample of 1,184 mother/child pairs for children ages 2-6. The method of this study was conducted to identify behavioral barriers that prevent children from getting the oral care they need. The authors used the behavioral model to highlight the correlation between a mother and her perceptions of oral care, and how her behavior affects a child's oral health status. Another study that briefly uses the behavioral model was conducted by Choi (2011), this author talks about the comprehensive health reform in 2014. Since millions more citizens gained eligibility for adult dental care, it could make a low income adult inclined to seek oral care for themselves or their children. Results of this study show when more adults gained dental coverage, this will increase the probability of a dental visit. Dental coverage can be influential as to whether or not these adults seek oral care for their children. Sheppard, Howell, and Logan (2013) focus on just African Americans and what their barriers are to receive screening for oral care. Some of their barriers were behavioral factors such as fear/defensive avoidance, and low social

attention (meaning that throughout their lives, they have not paid attention to the importance of oral health, nor did they seek to).

Literature Review

This review considered the factors that influenced the perceptions of Medicaid patients on the barriers to accessing oral health care and services. In 2013, Dodd et al. conducted a qualitative study on the barriers faced by adolescents who lived in rural Florida. Their results indicated a need for improved oral health knowledge, better access to care, and school-based dental care. Their results also highlighted the need to further examine the nonfinancial factors such as: fear, parental availability, and Medicaid which all fall into the categories of psychological, environmental, sociological, and cognitive in oral health care seeking behaviors. These results corresponded with the constructs of the two conceptual frameworks which are utilized to guide my research study. The next section of this literature review is constructed to highlight current and potential barriers that affect adolescents'/caregivers' decisions to not seek oral health care/services. The three primary categories: 1. Community (i.e. social, physical, and community oral health environments). 2. Family (i.e. family structure/composition, socioeconomic status, and culture). 3. Child (i.e. dental insurance, health behavior and practices, and physical and demographic attributes) were taken from the Fisher-Owens et al. (2007) model. Each primary category is further segmented based on the determinants of this model and incorporated in my qualitative research study.

Financial Barriers

Dental insurance coverage

Public health researchers and policy analysts assumed that the main barrier for patients to obtain dental care is dependent upon financial affordability and public oral health care to improve access to dental insurance coverage for these patients. (Dodd, Logan, Brown, Calderon, Catalanotto, 2014). Reported oral health perceptions and dental care behaviors among rural adolescents. Several study participants highlighted the costs associated with dental care as a reason why services and treatment are not sought. Adolescents who did have access to regular dental care talked about costs in general as well as the cost of dental insurance (even with high cost sharing copays and deductibles) which were also factors that prohibited accessing dental care services/treatments (Dodd et al.,2014). Study participants who did not have dental insurance, including those who were Medicaid recipients and described dental care services /treatments that were not emergencies to be of an extra financial burden that they did not deem to be necessary.

An assessment of the various barriers to access that contribute to children's and adolescents' underuse of oral health services by Isong, Zuckerman, Rao, Kuhlthau, Winickoff, and Perrin (2010) indicated that children and adolescents without dental insurance coverage were less likely to receive the recommended dental visits compared to those who had private dental coverage. They also highlighted that children and adolescents who lacked dental coverage or who received Medicaid were less likely to have had a dental visit in the past 13 months compared to their counterparts who had dental insurance coverage. On the contrary, Weyant, Manz, Corby, Rustveld, and Close

(2007) found that dental insurance coverage was not the only issue when it came to the perceptions of adolescents regarding the barriers to accessing oral health care services. The psychological aspect of their research had results that indicated that adolescents based their perceptions of their oral health status as well as their access to it more on their personal symptoms as well as their caregivers. So this became not only an issue in the face of dental coverage or financial barriers, but an issue of structural and cultural barriers as well.

Indirect expenses

Out-of-pocket expenses such as copays, deductibles, and services not covered by insurance plans contribute to the financial unaffordability of obtaining and/or maintaining ways to accessing oral health care services. Adolescents highlighted how their caregivers were not always readily available to take them to the dentist because they could potentially face wage loss. Not only do caregivers deal with wage loss, but caregivers also face the barriers of transportation costs, and securing childcare for their other children which further compounds the affordability concern of procuring medical and dental care for not only themselves, but for their children as well (Jones, Shi, Hayashi, Sharma, Daly, and Ngo-Metzger, 2013; Wallace and MacEntee, 2013).

Structural Barriers

Structural barriers are obstacles that are within the social and physical environment that impedes access to and receipt of oral and health care services. Such barriers that are included are geographic distance and transportation issues, school policies and workday expectations (Sbaraini, and Schwartz, 2007). Often, impediments

due to structural barriers are compounded by indirect costs from time, childcare, and transportation fares.

Transportation

An obstacle that is present to caregivers and adolescents seeking oral health care for themselves and their families is transportation. Lack of reliable transportation can be hindrance to these families, but also needing to rely on other family members, accessing public transit, or if there is a Medicaid provided transportation would make being able to honor standing dental appointments difficult. Participants in the Kelly, Binkey, Neace, and Gale (2005) study, highlighted problems when it came to the use of public transportation in order to be able to access health care appointments, while other participants felt that Medicaid-provided transportation service was not convenient. Another study that presented similar results regarding transportation difficulties was conducted by Ahn, Burdine, Smith, Ory, and Phillips (2011), where these researchers highlighted that almost half of the participants in their study perceived community transportation to be a barrier to accessing dental care services.

Workday expectations

In certain studies, workday requirements are actual barriers for caregivers who seek oral health care services. In these studies, most dental offices follow various work day schedules which are: Monday through Friday, 8 AM to 5 PM. This requires caregivers to leave work to be able to attend their appointments scheduled for themselves or their children. If caregivers have already utilized their vacation or sick leave, caregivers tend to lose their wages in order to take their unpaid leave (Kelly et al., 2005).

If caregivers have already made plans regarding transportation or requesting work leave to uphold a current appointment, it could also be challenging for them if the dentist had to reschedule patients' appointments because these patients/caregivers would have to make alternate plans regarding transportation and work schedule.

A review of the literature of the effect of labor policies on child health found when parents cannot leave work to care for a child (illness or preventive checkups), they are pressed "to compromise either their child's needs or their work responsibilities and risk income or job loss" (Heymann, Earle, and McNeill, 2013).

Personal Barriers

There are many factors that serve as barriers to caregivers and adolescents in regards to seeking and obtaining oral health care services. Barriers include, but are not limited to: language (Mejia, Weintraub, Cheng, Grossman, Han, Phillips, and Gansky, 2011), and health literacy, oral health beliefs and culture (Miltiades, 2013), genetic and biological factors (IOM, 2011), dental fear (Goettems, Ardenghi, Romano, Demarco, and Torriani, 2012), and education level and occupation (Guarnizo-Herreno, and Wehby, 2012).

Health literacy

Jackson (2006), asserted receiving oral health information was not enough to prevent or reduce oral health issues. Instead, the ability to read, comprehend, and implement the recommended oral health procedures was a necessary step in the process. A study conducted in 2010 by Miller, Lee, DeWalt, and Vann, indicated that caregiver literacy level was associated with a child's oral health status, but not with their oral health

knowledge. Vann, Lee, Baker, and Divaris (2010), indicated similar results in their study of female caregivers. The mothers who had lower literacy scores were less likely to report daily brushing and flossing behaviors in their children. Caregivers with poor health literacy may not be aware of the necessity for good oral health behaviors for themselves as well as their children. If access to and usage of oral health care services were improved, the benefits in reducing oral health disparities would be prevalent.

Oral health beliefs and culture.

A qualitative study of oral health beliefs of Mexican American women by Miltiades (2013), highlighted the differences in the cultural understanding of the importance of oral health; cultural oral health beliefs include misconceptions and misinformation that are passed down through family members from generation to generation resulting in many generations having poor oral health. Results from Kelly et al., 2005, indicated that caregivers who had not accessed dental services for their children presented a mentality of dental fatalism (tooth loss is inevitable) and physical health is more important than dental health with dental issues treated at home with home remedies. Handwerker and Wolfe (2010), hypothesized a "shared cultural understanding" of oral health knowledge and behaviors that viewed dental problems as a cosmetic issue not a disease (p.89). The results also suggested poor oral health is not due to access issues, but with an individual's inability to follow standard oral health practices, irrespective of socioeconomic status, gender, race/ethnicity, or insurance status.

Dental fear

In various studies conducted by Lara, Crego, and Romero-Maroto (2012); Lin, Yen, Chen, Liu, Chang, Chen, and Huang (2013), and Smith and Freeman (2010), the parental level of dental fear predicted the child's level of dental fear through social modeling. Goettems, Ardenghi, Romano, Demarco, and Torriani (2012), found that a high level of maternal dental anxiety was associated with untreated dental caries in their children. The researchers posited that since dental anxiety often results in dental care avoidance, dentally anxious mothers could be impeding access to oral health care services for their children. It is surmised that when caregivers miss a child's dental appointment, they are conveying negative oral health beliefs and attitudes to their children. Participants in the study conducted by Margaritis, Koletsi-Kounari, and Mamai-Homata (2012), admitted that their oral health anxiety was a learned behavior from observing family members' and friends' reactions to dental care. However, participants also disclosed a desire to overcome their dental anxiety to prevent modeling this behavior for their children.

Dental experiences

Prior dental experiences can positively or negatively influence a caregiver's decision to seek out oral treatment for themselves and their children. Handwerker and Wolfe (2010), asked respondents for their perspectives on the aspects of a dental visit that would encourage or discourage them to return for following visits. Reasons such as interactions with staff, wait times, explanations of procedures, and cost were listed as barriers to receiving dental care. Other studies cited past dental experiences as an

influential factor in their oral health discussions. Several caregivers mentioned lack of dental experiences and resulting poor oral health status as the catalyst for gaining oral health services for their children. Other caregivers expressed frustration, dissatisfaction, and distress from previous dental procedures had shaped their decision to hinder the same reactions for their children.

Summary and Conclusions

Vujicic, Nasseh, and Wall (2013), assessed a ten year span of MEPS data (2000 – 2010) and highlighted the increase of dental care utilization of children. However, it is unknown if the findings consider the relationship between a caregiver and an adolescent. The lack of information on this subgroup of the population, adolescents who do not obtain oral health care, makes it imperative that research is conducted to determine what factors lead to this decision.

This literature review outlined the various factors that can influence and impact an adolescent's access to and utilization of oral health services. The two conceptual frameworks suggested three primary categories; family level influences (financial barriers), community level influences (structural barriers), child level influences (personal barriers), and various subcategories that affect oral health care decisions. The next chapter includes information on how this study highlighted the experiences that potentially led to adolescents not accessing oral health care and on which factors pertained to that perception through selection of participants and interview questions, clarification of coding and analysis procedures, and interpretation of results.

Chapter 3: Research Method

Introduction

The barriers that adolescents face with regard to wanting and looking for oral health care/services can have significant health repercussions on an adolescent into adulthood, which makes highlighting these barriers and addressing them a crucial piece of the oral health disparities puzzle. In this research study, I sought to ask adolescents their perceptions of the overall importance to wanting and accessing oral health services due to the challenges they face. In the previous chapter, I focused on relevant literature to present various potential factors that could influence oral and overall health care decisions of adolescents. In this chapter, I describe the selection of and rationale for the methodological design of the study, as well as define the procedures that I used to answer the research questions.

Research Design and Rationale

The barriers to accessing oral health services for adolescents on Medicaid is a phenomenon that has not been given much attention. I define this concept as the perceptions of adolescents on what they consider to be obstacles that they face that deter them from seeking or receiving oral health treatment/services. For this study, my intent was to go into detail regarding barriers to accessing oral health services for African American adolescents on Medicaid by reporting the experiences of those who encountered these barriers in one way or another. The design of this qualitative phenomenological study was guided by four overarching research questions:

1. What are the experiences and perceptions to accessing quality dental care for Medicaid insured adolescents in Prince George's County, Maryland?
2. How do past experiences with oral care services currently affect access to quality oral care services?
3. What are the experiences or perceptions of Medicaid insured adolescents in Prince George's County, Maryland regarding oral health and how it affects their overall health and daily lives and activities?
4. What forms of community support may be most helpful in promoting awareness to these patients and regarding the importance of oral care?

Research Design

Qualitative research is used to explore human behavior and perceptions by collecting, analyzing, and interpreting the words and actions of individuals or groups. Yin (2011) described five features of qualitative research that provided a more applicable designation across disciplines than a narrow, structured definition. According to Yin, five characteristics distinguish qualitative research from other methods of research:

1. Studying the meaning of people's lives, under real-world conditions.
2. Representing the views and perspectives of the people in the study.
3. Covering the contextual conditions within which people live.
4. Contributing insights into existing or emerging concepts that may help to explain human social behavior.
5. Striving to use multiple sources of evidence rather than relying on a single source alone.

Qualitative research was the appropriate approach to explore and understand how adolescents and their caregivers make their decisions to not seek oral care due to the barriers they may or have encountered. In qualitative research, participants are not strictly limited to labels or stereotypes, but they are allowed to illustrate their actions and express their feelings about their barriers in their own words.

As a phenomenon that has not had much attention, the barriers to oral health for African American adolescents on Medicaid was best studied with a strategy that explores barriers encountered by children and adults. This particular research study could have been studied using a narrative approach, but the essence of narrative inquiry is to collect information via biographies from a single person or a small group, such as a family. The life experiences that are gathered are retold by the researcher into a chronological framework (Creswell, 2007). The narrative analysis could have been an appropriate strategy for the barriers to accessing oral health care services, but the research might not have been able to obtain all of the barriers that influenced adolescents and their caregivers to deter seeking oral care from a provider.

However, Yin (2011) described a cross-person narrative approach that incorporated life experiences from several people around a particular event or issue; unfortunately, this type of strategy cannot have provided the in-depth analysis of an issue that the phenomenological approach can. Grounded theory was another qualitative approach considered, but the purpose of this particular approach is to collect data to generate a theoretical framework for future research (Patton, 2002). Grounded theory may be useful to develop a framework to explain the perceptions of the participants as

they go through accessing oral health services, and why they are discouraged to do so. However, at this juncture, more information was needed on this issue, thus necessitating the in depth analysis found in a phenomenological research.

Finally, phenomenology is a strong strategy for the barriers to oral care because it allowed for the discovery of shared experiences of adolescents and caregivers who have encountered issues in accessing oral health care treatment/services (the phenomenon of interest). Researchers who use a phenomenological design analyze the collected data for communal themes among participants to develop a textual and structural description of their experiences that creates an overarching essence of the phenomenon (Creswell, 2007). According to Patton (2002), phenomenologists seek to determine the meaning of the experiences of participants to assist in understanding how they make sense of their experiences of the phenomenon. Because the purpose of this study was to explore the experiences of the barriers to accessing oral health treatment/services and how it influenced them not to pursue such services, phenomenology was the most suitable strategy to answer the research questions previously listed. Based on the definition of a qualitative phenomenological study from the first chapter, this type of research strategy examines the experiences of a real-life event in depth, understanding the importance of variances in the contextual conditions that brought about the event (Yin, 2009). Therefore, a phenomenological approach was the most appropriate choice for exploring barriers to accessing oral health care.

Role of Researcher

A researcher's personal bias and values are two factors that has the potential to influence data collection and interpretation. Because of this, the researcher's role in a qualitative research study should be carefully examined and acknowledged. Typically, the role of the researcher is categorized as either a participant or observer with different levels of interaction between the researcher and participants, if the researcher's roles are on the participant end, it would mean that more direct interaction between those involved, and if the researcher's roles are on the observer end then less direct interaction would occur between the two parties. Qualitative interview studies typically fall closer toward the observer end as the researcher does interact with participants during the interview process by observing the participant's nonverbal communication, emotional state, and demeanor during the interview, then incorporating those annotations in the report (Yin, 2011). However, the research is neither completely engrossed in covert observation of a participant's daily life, nor overtly participating in daily activities with the subject.

The qualitative researcher also assumes the role of research instrument in the field during participant observations and interviews (Patton, 2002; Yin, 2011). Patton (2002), suggested adopting a stance of empathetic neutrality that balances the judgement- free condition of objectivity with the understanding- rich purpose of subjectivity that is inherent in qualitative research. In this study, I used various instruments in the data collection process and sought to attain empathetic neutrality in the relationship between myself and the interviewee.

Creswell (2009), and Yin (2011), recommend including statements of the researcher's personal background and experience with the topic of study and acknowledge the potential for biases that arise from those experiences. I have never been a Medicaid beneficiary nor have I been personally impacted by Medicaid reform under the Affordable Care Act.

Additional ethical issues related to the researcher as an instrument and interactions between researcher and participants should be anticipated prior to beginning the study with possible resolutions addressed. Since the researcher is a stranger, they may encounter resistance from the participants which would reduce the quality of information they provide. The researcher should strive to build rapport with the participants that enables the participant to feel comfortable in disclosing responses to personal, sensitive questions (Patton, 2002).

Methodology

Population and Sampling Strategy

Participants in this study are Prince George's County adolescents who have received Medicaid from the state of Maryland within the last two years. Participants were recruited using a purposive criterion sampling strategy. According to Palinkas, Horwitz, Green, Wisdom, Duan, and Hoagwood (2013), purposive criterion sampling studies all cases that meets some predetermined criterion of importance. The purpose of this study is to speak with adolescents who are Medicaid beneficiaries and determine what factors led to barriers arising that would deter them from seeking oral health treatment/services, participants must have met the specific criteria that identified them as

such. Participants are African American adolescents who are Medicaid beneficiaries, who reside in Prince George's County, Maryland, and who have not received oral health treatment/services in the last 12 months. Recruitment concentrated on reaching participants whose primary language is English.

Determining what would be an appropriate sample size for a qualitative research study depends on the amount of information elicited through in depth inquiry. Creswell (2007), suggested in between 5 and 25 participants for a phenomenological study, while Yin (2009), stated that large numbers of instances improved confidence in study findings. Patton (2002), on the other hand, recommended designating a minimum sample size that can be expanded until saturation and redundancy have been reached. Saturation and redundancy refer to the point at which no new information is obtained from participant interviews. Onwuegbuzie and Leech (2007), reminded researchers that the amount of time spent in contact with each case can also affect the saturation and redundancy level. I conducted at least 10 interviews to ensure that saturation and redundancy was reached as well as no new themes and patterns were found. Ten was chosen as the minimum number of participant because barriers to oral health treatment/services for adolescents on Medicaid is a phenomenon that has not been studied in depth.

Participants were recruited via flyers that were posted in local community centers, libraries, coffee shops, and communal territories. The flyers provided a brief description of the study and list pertinent qualifications, compensation, and contact information (see Appendix A). The flyer has tear-away tabs so that interested participants were able to contact the researcher at their leisure. If potential participants contacted me via the

telephone, I was prepared to answer any questions they had regarding the study and/or participation in the study. I then asked that the participants mail or email a copy of consent form for participants and their caregivers to sign prior to an interview (see Appendices B, C, & D).

The qualifications of potential participants were verified through a short qualifier questionnaire given to the participants over the phone or by email when they contacted me. The qualifier questions were structured to determine if potential participants had or had not obtained oral health treatment/services in the last 12 months, and if they were willing to be interviewed for the research study (if they did not obtain such services). A determinant of eligibility is that adolescents use English as their primary language. I excluded adolescents who did not use English as their primary language. Answers to this qualifier questionnaire established the potential participants' suitability as a candidate for interviewing and their willingness to be interviewed. Candidates who qualified to participate were interviewed at neutral spaces such as the library, over the telephone, or in their classrooms. Participants' identities were kept confidential to the fullest extent of the law. This is explained on Appendices A-D which ensures that they are protected by the informed consent process. Additional follow-up interviews, if needed, were scheduled at the participant's convenience.

Instruments

Data from this study was collected at two points: The qualifying survey and the interview. The initial qualifying questions were given when the caregivers contacted me to confirm that the participant met the participant criteria. The screening

questions included whether or not the participant has received oral health care treatment/services within the last 12 months and if they were willing to be interviewed for a research study. If the participant responded with a "no" to the first question and a "yes" to the second and third questions, they were considered to participate in the study. If the participant responded with a "yes" to the first question, they did not meet the criteria for inclusion and were not considered to participate in the study. The text for the qualifier questions are found in Appendix C.

The second data collection instrument was standardized and composed of open ended questions that provided the opportunity for the participant to determine the most important information to present (see Appendix C). As the barriers to accessing oral health services for adolescents on Medicaid was a previously unstudied phenomenon, there aren't many published instruments that exist pertaining specifically to adolescents.

The aim for this study was to identify and explore the factors that lead to an adolescent not seeking and obtaining oral health services/treatments through the words of those who had experienced it. Therefore, the interview questions focused on permitting the interviewee to determine how to answer the question utilizing their own words. This type of inquiry followed Patton's recommendation for open-ended questions. Patton (2002) defined open-ended questions as allowing,

> The person being interviewed to select from among that person's full repertoire of possible responses those that are most salient…[permitting] those being interviewed to take whatever direction and use whatever words they want to express what they have to say (p. 354).

The open-ended nature of the questions let the participant direct the flow of the interview around the topic of the importance of dental and overall health in their family.

The format of the Medicaid barriers interview questions was structured in a way that the first three questions were utilized to develop rapport with the participants as well as help to provide background information for the first research question. Interview questions four through seven related to research questions two and three. Interview questions eight through ten related to research question four.

Procedures for Recruitment. Participation, and Data Collection

Recruitment Flyer

1. I posted recruitment flyers at local coffee shops, libraries, and community centers. The flyer provided a brief description of the study, participant criteria, compensation, and researcher contact information.
2. If a potential participant contacted me, I answered any questions the individual had regarding the study and/or participation in the study. I then offered to mail or email a copy of the informed consent form to the participant and caregiver for review.
3. I also confirmed participant eligibility via the qualifier questionnaire.
4. Once the participant criteria were met, I scheduled an interview period with the participant at a neutral location at a time convenient to the participant.

Interview

1. Once the participant joined me for the interview, I thanked them for participating in the study, restated the purpose, and discussed the consent form.

2. I then asked the participants to sign two copies of the consent form-one for the participant and one for the researcher.
3. I also asked the participants if they would allow the interview to be tape-recorded to assist in accurately recounting the interview. I explained to the participant that if they refused to be recorded that it would not affect their participation, and they can decline to answer any question at any time or even withdraw at any time without any reprisals. I also explained the procedures for securely storing the audio and subsequent transcriptions, as well as eventual disposal of these records.
4. At the end of the interview, I thanked the participant for sharing their experiences, offered to provide a copy for the transcribed interview, and provided a request for follow up meeting to present the findings for accuracy and validity.

Field Notes

1. Field notes were written during each interview, converted to fuller notes at the end of each interview or at the most opportune time, and were augmented my perceptions and clarifications.
2. Full field notes were integrated into data analysis for the use in the interpretation of findings.

Data Analysis Plan

Qualifiers. The data that was collected from the qualifier questionnaire was not kept or used after a participant is found to be eligible to participate. If the questionnaire was in paper format, then it was shredded, and if it was electronic, it was deleted. The

sole purpose of the questionnaire was to determine the eligibility of potential participants without initiating, and terminating the interview after the participant is found ineligible.

Interviews. The data that was collected from each interview was transcribed verbatim by myself and uploaded into the qualitative software program, NVivo 10 for Windows. Each interview was coded in this software program to enable concept mapping, memoing, and illustrated report generation. According to Patton (2002), coding will provide the researcher the opportunity to immerse themselves into the data, as well as incorporate their personal reflections as part of the memoing process. Thematic codes will be determined through a combination of *a priori* and emergent coding; *a priori* codes will be selected from the reviewed literature, while emergent codes will be generated from participant responses. Examples of *a priori* codes from the literature included topics such as indirect costs, transportation, and culture/family. These topics will be further categorized into larger codes like barriers or factors to oral health services/treatment access. The utilization of both *a priori* and emergent codes is encouraged by Creswell (2007) as a means to enhance thematic analysis of participant responses.

Field notes and memos. Including the full field notes and memos serves multiple purposes in data collection. Converting field notes after fieldwork has many advantages, but is not always feasible. The researcher converted field notes as soon as possible after the interview to elaborate incomplete notes and reflect on the events of the day (Yin, 2011). The conversion of field notes can also stimulate recall, evoke reminders, suggest themes, and clarify the researcher's own understanding of the phenomenon (Yin, 2011).

Field note conversion can serve as a form of data verification and a point of initial analytical comparison, as well (Yin, 2011).

Memoing is another analytic technique used in qualitative research as a form of self-reflection and process documentation. Creswell (2007) aligned memoing with the grounded theory approach, but Yin (2011) advocated memoing for all qualitative approaches as a system for tracking ideas. Memoing was crucial during the analysis of the barriers to oral health treatment/services study data because I coded the interview responses for themes, comb the findings for patterns, and modify ideas that transformed results into an exploratory description of the phenomenon.

Issues of Trustworthiness

Rigor in qualitative research is established differently than in quantitative research. Rigor in quantitative research is determined by utilizing internal validity, generalizability (external validity), reliability, and objectivity. In qualitative research, rigor is ascertained on the attribute of trustworthiness using credibility, transferability, dependability, and confirmability (Wisdom, Cavaleri, Onwuegbuzie, and Green, 2012). Credibility of the research and the researcher can be strengthened by utilizing multiple strategies throughout the research process. Yin (2011) listed several practices that can be implemented to support credibility such as long-term field involvement, rich data, member verification, rival explanations, and triangulation. Creswell (2007) added peer review, clarifying researcher bias, external audits to this inventory of strategies. Credibility of the researcher can be strengthened by disclosing any associations with participants and research sites and acknowledging personal biases about the topic of

study (Patton, 2002); the researcher for this study will need to clarify their personal biases and affiliations which can be done as stated in the previous section by detailing their role in conducting the study. The design of the barriers study prevented long-term field involvement, but I employed beneficiary member verification, rival explanations, and rich, thick description to improve the credibility of the research. After the interviews, the information was transcribed, and participants were contacted if they permitted additional communication so that the accuracy of the themes are validated. Rival explanations were instituted during the analysis to provide support or contradict my interpretation of the data. Thick, rich description of the findings will enable readers to appreciate and understand the phenomenon of the study (Patton, 202; Yin, 2011); by using thick, rich description to communicate the outcomes of the study, I was able to engage the readers in the contextual realities that resulted in adolescents not being able to access oral health care treatment/services. By doing this, the readers are helped to better understand what barriers and factors brought about the lack of access to oral services and why adolescents and caregivers feel personal dental deferment is a necessary health decision.

Transferability is the term used by qualitative researchers that corresponds to external validity or generalizability of the findings to apply to other populations. Thomas, and Magilvy (2011), asserted the responsibility to determine the transferability of findings to their particular situation falls to the audiences, but the researcher is responsible for providing a thick, rich description of the phenomenon along with "sufficient contextual information". The findings of the barriers study may or may not be

transferable in medical access settings or to barriers involving adolescents who receive private insurance coverage.

Reliability in qualitative research is known as dependability and it relates to the consistency of the results when the study is replicated using the same procedures as the initial study. Several strategies exist for promoting dependability including precise documentation of procedures (Thomas and Magilvy, 2011), author reflexivity and double coding (Wisdom, Cavalier, Onwuegbuzie, and Green, 2012). Strategies utilized to enhance credibility and transferability also address issues of dependability; employing external audits, triangulation, peer review, and thick description of the procedures can establish the dependability of results (Thomas and Magilvy, 2011; Wisdom, Cavalier, Onwuegbuzie, and Green, 2012). In this study, I utilized detailed documentation of procedures, reflexivity, and double coding to strengthen dependability of the research. By providing detailed documentation of procedures as a component of this chapter, my intent was to strengthen the dependability of the study for other researchers by enabling reproducibility that could result in similar results. Reflexivity involves the recording of the researcher's own thoughts, perceptions, emotions, and processes as the study progresses; self-reflection through journaling and memoing provides another form of audit trail that can be used to inform or alter the researcher's approach to the study. Double-coding involves coding a segment of the data, a waiting period, and the recoding the same segment to compare results. This code-recode is foreseen to work well with the barriers study design, because it afforded me the time to collect and/or transcribe later interviews after the initial coding of the first set of interviews. The second coding pass of

the initial interviews also benefited from potential new codes that emerged from later interviews.

Objectivity is a central precept of establishing methodological rigor in quantitative research. In qualitative research, objectivity is difficult due to the interactive relationship between observer/interviewer and participants; the qualitative counterpart to objectivity is confirmability, or the verification that the findings are based on the data from the participants (Wisdom, Cavaleri, Onwuegbuzie, and Green, 2012). Thomas and Magilvy (2011) considered confirmability to be achieved when credibility, transferability, and dependability are established. Additionally, strategies to achieve confirmability are similar to the prior components of trustworthiness including triangulation, external audits, and reflexivity. Thomas and Magilvy (2011), suggested diagramming audit trails for both the collection of data and the development of conceptual ideas as a method of supporting confirmability. I employed various strategies for enhancing the credibility, transferability, and dependability that could apply to confirmability. I utilized audit trails and reflexivity for the other attributes of trustworthiness to help improve the confirmability of the study.

Ethical Procedures

When approval from Walden's Institutional Review Board was granted, I posted recruitment flyers at local coffee shops, libraries, and community centers. Participants were informed of their rights as study participants via the informed consent form (located in Appendix C). Each participant was asked to sign two copies of the form, one which was kept with the study documents, and the other which was returned to the participant.

Information that indicated personal identification was removed and participants were assigned a numerical value based on the order of the interview to ensure confidentiality. Participation in the study was voluntary and posed no risk to the safety and wellbeing of participants. Participation in this study may or may not make participants uncomfortable which can also be similar to that felt in daily life, such as stress or becoming upset due to the personal nature of the research subject. If any participant experiences stress or anxiety, they could refuse to answer the question(s) or terminate the interview with no reprisals.

All physical documentation pertaining to the study is kept in a locked file box with access only to myself. After five years, I will destroy all audio-recorded tapes. All electronic file is kept on a separate password protected flash drive which is also be stored in the lock box. These files and documents will be kept for five years per university requirements and discarded appropriately.

Summary

In this chapter, I described and delineated the procedures of the barriers study followed to align with the research purpose. I also identified and justified the selected study design to provide the best opportunity to answer each research question. I then highlighted my role in the study as an observer and instrument of data collection. The methods that were utilized to recruit participants, collect data during the interviews, and an analysis of the results are described in detail. I highlighted several strategies that were implemented to strengthen the trustworthiness of the research as well as presented

measures that were done to preserve the participants' safety and wellbeing, confidentiality, and security of data.

I report the results of the barriers study in the next chapter. First, I describe the characteristics of participants involved in the study. Next, I detail the specific procedures that were utilized during data collection and analysis. Finally, I present the findings from the interviews that will describe the barriers phenomenon using the participants' own words.

Chapter 4: Results

Introduction

The purpose of this chapter is to show the results of the barriers to oral health study. In this study, I have highlighted the understudied case of adolescents on Medicaid not receiving adequate oral health treatment/services. I focused on this phenomenon by presenting the experiences of 20 adolescents who were forced to forgo seeking oral health treatment/services. The underlying research questions determined the design of this qualitative study to help gain information as to why adolescents on Medicaid were not accessing oral health services. The four research questions that formed the foundation of the study are presented below:

1. What are the experiences and perceptions to accessing quality dental care for Medicaid insured adolescents in Prince George's County, Maryland?
2. How do past experiences with oral care services currently affect access to quality oral care services?
3. What are the experiences or perceptions of Medicaid insured adolescents in Prince George's County, Maryland regarding oral health and how it affects their overall health and daily lives and activities?
4. What forms of community support may be most helpful in promoting awareness to these patients and regarding the importance of oral care?

This chapter contains four sections. In the first section, I describe the participants' demographics and characteristics. In the second section, I explain how I collected and analyzed data (including codes and categories). In the third section, I discuss the results

of the study, quoting the participants who encountered barriers to accessing oral health treatment/services. Finally, in the fourth section, I provide evidence of trustworthiness by explaining strategies implemented to ensure credibility, transferability, dependability, and confirmability.

Demographics

Nine females and 11 males participated in this research study. All of the participants are in high school, and their ages ranged from 16 to 18 years. Most of them had some type of discounted dental access via dental insurance, dental discount plan, or state Medicaid. Table 1 shows the details of the participants' demographics, highlighting their age, gender, and what type of dental coverage they had or lacked.

Table 1

Demographics

Characteristic	Female (*N*= 9)	Male (*N* = 11)
Age range (years)		
16	4	5
17	2	0
18	3	6
Child dental insurance status		
Dental insurance	0	3
No insurance	2	2
Medicaid/CHIP	7	6
Dental discount card	0	0

Once approval was obtained from the Prince George's County School District, I placed flyers in different middle and high schools and explained the research study. The

flyers (see Appendix A) described the study, eligibility criteria for participation, my contact information, and how the study was to take place. I posted flyers in school hallways, guidance offices, and libraries. I also provided flyers to teachers, librarians, and staff to distribute to adolescents should they ask for a copy. Consent forms were also available at these locations so that potential participants could have full details of the study. These forms were clearly marked so that potential participants would know which would apply to them. The flyers and consent forms were intended to help potential participants screen themselves, but prior to their acceptance into the study, I administered screening questions to confirm participant eligibility (see Appendix A). Participants completed the screening questions prior to being given the survey to complete, and after the survey was completed, the screening questions I re- administered them to confirm eligibility and that data was not collected from any participant who did not meet the eligibility criteria.

The purposive criterion sampling strategy was effective in obtaining the optimal sample size for this study. I established the predetermined criterion of importance which was barriers to seeking oral health care services and the researcher asked the participants at their discretion to provide information regarding their personal barriers that would make them interested in participating in the study. Purposive criterion sampling strategy studies all cases that meets some predetermined criterion of importance (Palinkes et al., 2013).

The criteria for inclusion in this study were that adolescents should be between the ages of 13 and 18 years, on Maryland Medicaid, have seen a dentist in the past year,

live in Prince George's County, Maryland, and interested in participating in a study that determines the issues that adolescents face when seeing a dentist. This last criterion ensured that the adolescents were aware of the decisions that they and their parents made as to whether they sought oral health care. These criteria ensured that eligible participants would be able to provide data that would answer the research question of the study related to (a) defining factors perceived to contribute to adolescent decision making regarding their oral health, (b) personal experiences regarding the importance of oral health care, and (c) their impending adulthood and their perceptions of community support that might be most helpful in teaching adolescents about the importance of oral health care and an overall healthy lifestyle. The final sample size was 20, which Creswell (2009) reported is sufficient for a phenomenological study. The parents of all participants aged 17 years or younger gave their consent, in addition to the participant themselves assenting.

Data Collection

The data collection process began by contacting the school district and obtaining approval from their Evaluation, Teaching, and Research Department by email to briefly go through the screening questions and to schedule times where I could come in and introduce myself, the study, and handed out the research questions. The information packets contained the consent forms for the participant's parents (see Appendix C), and assent forms for these adolescents (Appendix D). When I arrived at the different schools, the participants were asked the screening questions (see Appendices A & B) to collect personal information about them and ensure they met the eligibility criteria. Those that

were eligible for the study, and their parents (when necessary), were again given an explanation of the purpose and nature of the study, including the research questions, the need for their signed consent and the consent of their parents/guardians (where applicable), the confidentiality procedures, the voluntary nature of the study, and the benefits and risks of participation. Participants were told that their privacy and identity would be protected, and that their real names would not be used, and they would be identified alphanumerically. In addition, participants and parents were told there would be a monetary reward of $10 for their participation at the end of the study.

Data was collected from 20 participants during January - May, 2017. I received approval from the Prince George's County School District to go into various middle/high schools and reach out to administration regarding the research study. Once I received signed approval from the principal, I was then assigned to a teacher or administrator who moderated the data collection process. Students were asked qualifier questions and if they were eligible to take the survey, they were given a consent and assent form to read and sign, and then asked to take their consent forms home to their parents to sign. The students were also given interview questions to complete at home so as to not disrupt class time. The students were instructed to return everything to the designated administrator/teacher. The survey packet included interview questions which consisted of thirteen open questions, the qualifier questions, the consent form, and the assent form. Compensation was accepted by all participants; $10 cash was available after the completion of every interview packet that was attached to a signed consent/assent form.

Participants whose eligibility status was confirmed, who were in between the ages of 13-18, and who gave their consent, were given the study instrument to complete (see Appendix B). This consisted of semi-structured open-ended questions about their oral health and their lifestyles, their perceptions and experiences regarding seeking oral care, and the types of community support that might be most helpful in teaching adolescents best practices for oral care and a healthy lifestyle. The researcher asked eligible participants under the age of 18 years who did not have signed consent of their parents to take the information packet and have their parents sign the consent form (see Appendix C); the participants were asked to bring their signed assent form (see Appendix D) or to sign it in the researcher's presence.

The recruitment flyer (see Appendix A) was posted in school hallways, guidance offices, and libraries in mid-January 2017 after holiday break, and on March 2017, data collection began. When I visited each school, they started by saying; "Thank you for taking the time to meet with me to participate in this important study". At this time, the I reminded participants of the purpose of the study and told them that it was understood the sensitive nature of the topic and encouraged them to try as much as possible to be open and honest with their information about their experiences regarding oral care. I also reminded them that they were free to not answer any question that they did not feel comfortable with answering. I reassured all participants that their identities would not be revealed, and that their information would only be used to identify common themes and patterns among all the participants' responses.

The interviews were completed on paper and were immediately transcribed using Excel, and saved on an external hard drive. To commence the data collection process, I posted flyers in schools, and libraries. At the end of the first round, I left flyers at four libraries, six coffee shops, four grocery stores, and twelve middle and high schools and receiving no responses, other strategies were considered. As the primary target participants were African American adolescents, I decided to schedule meetings with various administrators in middle/high schools in Prince George's County, Maryland. Twenty schools were contacted, and five schools (administrators) accepted meetings. I received a lot of outreach from those administrators whom they met with and on March 17, 2017, the first interview was conducted and by May 26, 2017, a minimum of 15 participants had been attained and were interviewed. At least 15 participants were recruited to provide information on all perspectives regarding barriers to oral care with additional participants to help reach saturation and redundancy. The last five interviews were transcribed and no new themes were found meaning the study reached saturation and redundancy. Once I reached interview 13, a break occurred because I had to find other schools with eligible participants. Another break took place in between interviews 15-20 due to slow turnaround time. During these breaks, I took the opportunity to begin coding and transcription of the interviews already done, and work on a stronger strategic approach for the other interviews.

Data Analysis

The data analysis strategy included information from interviews that were coded, field notes, and memos. I began by creating NVivo nodes which included the *a* priori

terms highlighted by the literature review using both conceptual frameworks. Three primary barrier codes from the Fisher-Owens et al. (2007) model were the input into the software. The primary barrier codes were categorized into different sectors therefore becoming financial, personal, and structural. Finally, the personal barrier component was then subdivided again into even smaller codes from the Fisher-Owens et al. (2007) model. In Table 2, the original procedure of the coding structure is displayed. This table shows my input of the different barrier codes, then broke them down in their categories, and based on how many times that code (barrier) was discussed in the questionnaire is what shows under reference column.

Table 2

Initial Coding Structure

Code	Sources[a]	References[b]
Barriers	20	220
Financial	20	50
Direct financial barriers	0	40
Indirect financial barriers	20	10
Personal barriers	20	120
Dental fear	13	15
Education/occupation	3	7
Genetics & health	15	10
Language/literacy	2	0
Beliefs/culture	0	40
Structural barriers	20	35
Attitudes	14	30
Transportation	3	20
Work expectations	0	0

[a]Sources = number of participants who were coded under this node.
[b]References = number of individual responses coded under that node for all participants.

After the initial coding process, I ran a report that created a coding summary by node for the work expectations category. I then reviewed each line of coded text within

that node in order to highlight and remove any codes that did not align with the original structure. Codes such as: insurance issues, social acceptability of the adolescent, emotional ramifications of the adolescent, trust and priority were added to the list of nodes, and work expectations, and language/literacy were removed. Once the final list of codes were established, the researcher then reviewed the interviews and any text not originally coded under these were coded appropriately where applicable.

All of the data received was double coded; the interviews were coded upon initial receipt and then recoded two weeks later to ensure dependability. The second round produced similar results with little variation. To go into detail, three nodes did not show a significant difference in the number of coded references. The two nodes that had discrepancies showed reduced references. They are: oral health beliefs/culture and attitudes. Once everything was reviewed, it was noticed that in the first stages of coding, I highlighted mostly short phrases and coded them, while during round two, I coded an entire response. I noticed a node that had the most references and made that a priority. When I reviewed everything, it was noticed that a priority code was not established. In the second round, the priority code was developed and implemented and shorter phrases within each participant response were coded as such.

Thematic concepts were then created to encompass these new codes. I continued to analyze the thematic concepts therefor providing the final thematic categories utilized to assess the participant responses. A lot of the memos were combined with emergent themes including low priority for dental care, and others did not result in useable

thematic categories. Table 3 shows the various codes, and then a common theme was created. The description column talks about everything that was included in the theme.

Table 3

Code to Theme Conversion

Code	Theme	Description
Direct Financial Issues Indirect Financial Issues Insurance Issues	Financial Barriers	Comprehensively includes all underlying monetary issues. This includes cost of care, out-of-pocket expenses, transportation fees, and insurance related matters.
Oral Health Beliefs Priority Genetics/Health Dental Fear Education/Occupation	Health Perception	Consists of the participant's perception of the value of oral health care as it relates to themselves.
Attitude Trust	Personal Perception	Incorporates the participants' perception of attitude and trust towards dental professionals.
Emotional Ramification Social Acceptability of Adolescent	Psychosocial	Covers the external and internal significance of oral health status and oral health care-related decisions.

The next phase of data analysis consisted of me looking at the frequency of the themes regarding certain research questions. The themes that were reported the most for each research question is shown in Table 4 with their corresponding frequencies under each research question. The legend below the table describes the meaning of frequency and percentage pertaining to data analysis.

Table 4

Frequency of Themes by Research Question

Research Question	Theme	Frequency[a]	Percentage[b]	Participant Number[c]
What are the experiences and perceptions to accessing quality dental care for Medicaid insured adolescents in Prince George's County, Maryland?	Health Perception	50	52	C1-5,10 L3-6
	Personal	10	16	C2,3, C5-8, L9
	Perception	12	15	C1-7,10,11,L8,L9
	Financial Barriers			
How do past experiences with oral care services currently affect access to quality oral care services?	Financial Barriers	15	32	C2,3,C5,6, L8,L9
	Personal	22	29	C8,C10, L1-3, L5-7
	Perception	18	13	
	Health Perception			C1-3, L5, L9
What are the experiences or perceptions of Medicaid insured adolescents in Prince George's County, Maryland regarding oral health and how it affects their overall health and daily lives and activities?	Financial Barriers	22	32	C1-7, L3-9
	Personal	22	32	C2-6, C9-11, L6-9
	Perception	16	23	C1-3, L5-9
	Health Perception			
What forms of community support may be most helpful in promoting awareness to these patients and regarding the importance of oral care?	Health Perception	9	43	C7-11
	Personal	7	33	C1-10, L1-9
	Perception			

[a] Frequency = number of times theme was coded for all participants for each research question.
[b] Percentage = frequency counts divided by the total number of theme counts for each research question expressed as a percentage.
[c] The number assigned to the participant.

During the data analysis process, it is an invaluable tool for researchers to incorporate discrepant cases. This is beneficial overall, because it provides additional detail to what or may not be considered "typical" or "normal." I did not encounter any discrepant cases within the participant sample. The aspects that may have caused a discrepancy in the participant responses were tied into the conceptual models in order to provide a complete definition of barriers to oral care for African American adolescents in Prince George's County, Maryland.

Results

The purpose of this study was to determine what issues led to adolescents not wanting or caring to seek oral health care. The 13 interview questions (see Appendix B) were constructed to answer the overarching research questions. For each research question, I reported the most frequently recorded themes and presented the best responses that highlighted that theme. Primary Research Question: What are the barriers to oral health care for African American adolescents in Prince George's County, Maryland.

Interview Questions 3, 5 ,8, 9, and 10 served as touch points for the comparative and thematic analysis to establish what factors influenced their decision to forgo seeing a dentist. The most frequently cited reasons were health perception, personal perception, and financial barriers.

Health Perception

This perception was one that was one of the most commonly reported factor that influenced the adolescents' decision to not care to seek oral treatment at any given time; more than half had at least one statement coded under this theme. For example, Participant C1 stated, "I am unsure" when it comes to the benefits of seeing a dentist, and that "seeing a dentist is not important to someone's overall health in the long run"

Participant L1 stated, "I am not sure of any health benefits when it comes to seeing a dentist."

Participants C5 and L4 reported that "Keeping my teeth clean would help me to want to see a dentist more because I know that it is a benefit," and participant L4 reported similarly.

Participant C10 reported that they agreed that not seeing a dentist is effective on day to day health and overall health eventually.

Personal Perception

The personal perception theme was created to encompass both positive and negative attitudes towards dental care, as well as perceived attitudes regarding dental professionals. Personal perception toward oral care often manifested into some form of distrust either on the dental professional side or on the side of the adolescent. Eleven of the 20 participants (C3, C4, C5, C6, C9, C10, L1, L2, L3, and L4) noted personal perceptions from dental providers influenced their decision.

Participant L4 stated, " I do not think that it is important that seeing a dentist would affect my overall health."

Participant C8 echoed the same sentiment, stating, "It is not really important to see a dentist because if I want to know about what is going on with my health, I would just go to a doctor."

Complimentary attitudes toward the dental profession wasn't too frequently found in the participants' responses related to dental visits for themselves with several participants stating that they rarely go to see the dentist. They feel that as long as they maintain brushing their teeth twice a day and flossing (participants C1, C2, C3, C4, C5, C8, C9, C10, C11, L1, L3, L4, L7, L8, & L9), the need to see a dentist was not urgent. Six out of the twenty participants (C6, C7, C11, L2, L5, L6) reported favorable attitudes towards their dentist due to past experiences.

Participant C10 mentioned in her questionnaire that, “I don’t mind seeing a dentist, but my parents tell me that they cannot afford it, and that our insurance doesn’t cover it.”

Participant L6 perceived their dentist visit as very encouraging and informative: “I would definitely go to see a dentist again, because I learn a lot every time I go. My dentist makes me want to take good care of my teeth because he encourages me to do so.”

Participant C7 said that, “I try to go to the dentist whenever my parents remember to make an appointment. I am pretty impressed with how my dentist can see an issue with my teeth, and let me know what happened for me to get to that point.”

Financial Barriers

Financial barrier was a repeatedly cited factor impacting whether or not these students were able to see a dentist when they should with eight of the 20 participants (C3, C7, C8, C10, C11, L2, L5, and L9) answering the reason that they haven’t seen a dentist was attributed to finances.

Participant C8 said finances was the biggest reason that prevented her from seeing a dentist. Participant C3 had a direct financial barrier from the lack of insurance coverage: “I have heard my parents talking to each other before about us not having insurance and that being a big reason why we do not go to a dentist, and that they can’t afford to pay for one on their own.”

Psychosocial Coping

Psychosocial coping was the last factor that was gathered from the participants’ responses for research questions two through four. Sixty percent of participants (C1-3,

C5,C6, C9,C10, C11, L4-7) made statements referencing the effect of the emotional ramifications of them not seeing a dentist as well as the desire to be able to see a dentist so that it would help them better their self-esteem.

Participant C6 stated, “It is weird to me that my parents tell me about what could happen to my teeth if I don’t see a dentist, but then they never schedule for me to see one.”

Participant C9 said that she has had poor oral health issues, and even had trouble when she had a root canal, and because of this, she is afraid to see a dentist.

Participant L6 said that growing up he did not understand the importance of braces and why he needed them. As he got older, he eventually learned that braces would actually help him to be able to take better care of his teeth such as brushing and flossing.

Participant L4 said that she would like to see a dentist because she knows that it would help with her appearance, as well as increase her self -confidence.

Many of the same themes resonated throughout the interview questions related to the main research questions; specifically the themes of financial issues which is seen in Questions 1, 2, and 3. Personal perceptions, health perceptions, and psychosocial coping were asked in all four research questions. To avoid redundancy, brief descriptions of the results of each research question is presented.

Research Question 1: What are the experiences and perceptions to accessing quality dental care for Medicaid insured adolescents in Prince George’s County, Maryland?

Interview Questions 2, 3, 5, 8, and 12 provided information for the thematic analysis that detailed the behavioral and environmental factors that affected adolescents

and their access to oral care. The majority of the responses focused on financial barriers, and personal perceptions toward dentists.

Financial Barriers

Students expressed that money could have influenced their parents to not seek oral care for them with 12 of the 20 participants (C2, C3, C5, C6, C8, C10, L3, L4, L5, L6, L9, L10) reporting financial obstacles when it came to seeking oral care.

Personal Perception

Of the 20 participants, ten (C3, C6, C7, C10, C11, L2 – 6) exhibited negative personal perceptions towards seeing a dentist which influenced their decision to not inquire about seeking oral care.

Research Question 2: How do past experiences with oral care services currently affect access to quality oral care services?

Interview Questions 3 and 5 brought about information regarding the thematic analysis that detailed the experiences of these adolescents that made them not want to see a dentist. Issues regarding finances, their personal views, and their views on health were the recurring themes from the participants' responses.

Financial Barriers

Financial barrier was a theme that almost half of the participants stated in their responses, especially those who also shared that they had not seen a dentist recently.

Health Perception

Health perception was a thematic category that was brought up a few times describing why adolescents did not ask for oral care to their parents with some of the participants (C8-11, & L7-9) reporting some type of fear.

Personal Perception

Six of the participants (C7, C8, L3, L6, L8, L9) had concerns with being uncomfortable seeing a dentist, and being uncomfortable with certain procedures that they may have when it comes to seeing a dentist for reasons that are not medically necessary.

Research Question 3: What are the experiences or perceptions of Medicaid insured adolescents in Prince George's County, Maryland regarding oral health and how it affects their overall health and daily lives and activities?

Participant responses from interview Questions 1, 2, 3, 5, and 12 provided explanations for the comparative and thematic analyses regarding how these adolescents viewed themselves when it came to oral hygiene. Health perception was a recurring theme as a response to these questions, but psychosocial coping was not to be eliminated.

Health Perception

Nine of the twenty participants (C3-5, C8, C9, L5-8) fell into the category of health perception as an important theme when participants described how their not seeing a dentist affected their perception of themselves and their self-esteem.

Psychosocial Coping

Seven of the twenty participants (C5-7, C9, L8, & L9) had a negative perception of themselves because of the barriers they encountered. In turn, it has had an effect on them wanting to continue to see a dentist.

Research Question 4: What forms of community support may be most helpful in promoting awareness to these patients regarding the importance of oral care?

Information from interview Questions 10, 11, and 12 showed information for the comparative and thematic analysis to show how the participants perceived potential community support promoting oral care awareness. The participants' responses to these questions brought focus to how these adolescents viewed health, and that good oral health was not necessarily important to have good overall health. Psychosocial coping also influenced participants' responses showing their desire to want to live a healthier lifestyle when it comes to oral hygiene.

Health Perception

There are some participants who did not consider oral health care to be a priority compared to medical care. Approximately 53% knew that maintaining proper oral hygiene was a part of keeping their whole body healthy.

Table 5

Summary of Results

Research question	Thematic category	Selected extracts
What are the experiences and perceptions to accessing quality dental care for Medicaid insured adolescents in Prince George's County, Maryland?	Financial barriers	"I never knew of my family to have dental insurance or not. I just know that I don't go because my mom says she can't afford it."
	Personal perception	"There was that one dentist she was nice, but she made me feel uneasy because she told me that she needed to drill my teeth".
		" I feel that seeing a dentist is sometimes overrated, I don't think that it really matters."
How do past experiences with oral care services currently affect access to quality oral care services?	Financial barrier	"I am pretty sure that I need some work done with my teeth, but I can't do anything about it because my mom pays for it."
	Health perception	"I've had one experience at the dentist. After leaving my appointment, I felt the difference with my teeth.:
	Personal perception	"I really like my dentist, but there are times when I can't get to the dentist because my dad has to work."

What are the experiences or perceptions of Medicaid insured adolescents in Prince George's County, Maryland regarding oral health and how it affects their overall health and daily lives and activities?	Health perception Psychosocial coping	"I have been told growing up that it is very important to take care of your teeth, and when you get older you will need them." "I would hate to have my teeth missing because I didn't take care of them. I don't think I would go out and be around my friends."
What forms of community support may be most helpful in promoting awareness to these patients and regarding the importance of oral care?	Personal perception	"Social media ads." "Posters in libraries." "Coming inside our school."

Items for Consideration

The participants brought up a couple of issues that lead to decisions being made to not seek oral care/treatment especially through their caregivers. Issues such as dental procedures, not trusting a dentist compared to their doctor, and not having a complete understanding of the importance of seeing a dentist may have influenced the participants' responses. Issues regarding health education, and health prevention methods are clarified in Chapter Five with subtopics named: Health perceptions (taking care of teeth), personal perceptions (trust), and implications (proper communication).

Trustworthiness

Credibility

I implemented strategies within the data collection and analysis stages to ensure a high degree of trustworthiness. To strengthen the credibility of the study, I strategically

composed the study so that there was not any bias towards the participants nor did they have any affiliation with the participants. Member verification was useful to authenticate various themes. I also used thick, rich description of the findings. Approximately six weeks after the completion of data analysis, I reached out to each participant to follow up and review/verify the key themes identified in their responses. Seven of the participants agreed to meet with the researcher face-to-face. Others did not respond to three separate requests for the member check meeting. The seven in person meetings lasted less than 15 minutes each and the participants verified that their responses matched the results.

Transferability

The results from the oral care study may not be transferrable to situations involving forgoing seeking oral care due to accessibility. However, using thick, rich description to illustrate the experiences of the participants may present a suitable account of the phenomenon so that readers could utilize their best judgement to apply the findings to other situations.

Dependability

Dependability had been ensured because I implemented strategies such as: detailed documentation of the data collection and analysis, the use of double coding, as well as some others to enhance credibility and transferability. In Chapter 3, I explained the method of recruitment, data collection, and analysis as well as noted any deviations in that chapter. I provided the same explanations for the interview coding, field notes, memos, and emergent themes. Double coding was used during this extended period of waiting (data collection from 20 participants). Interviews from the first set of participants

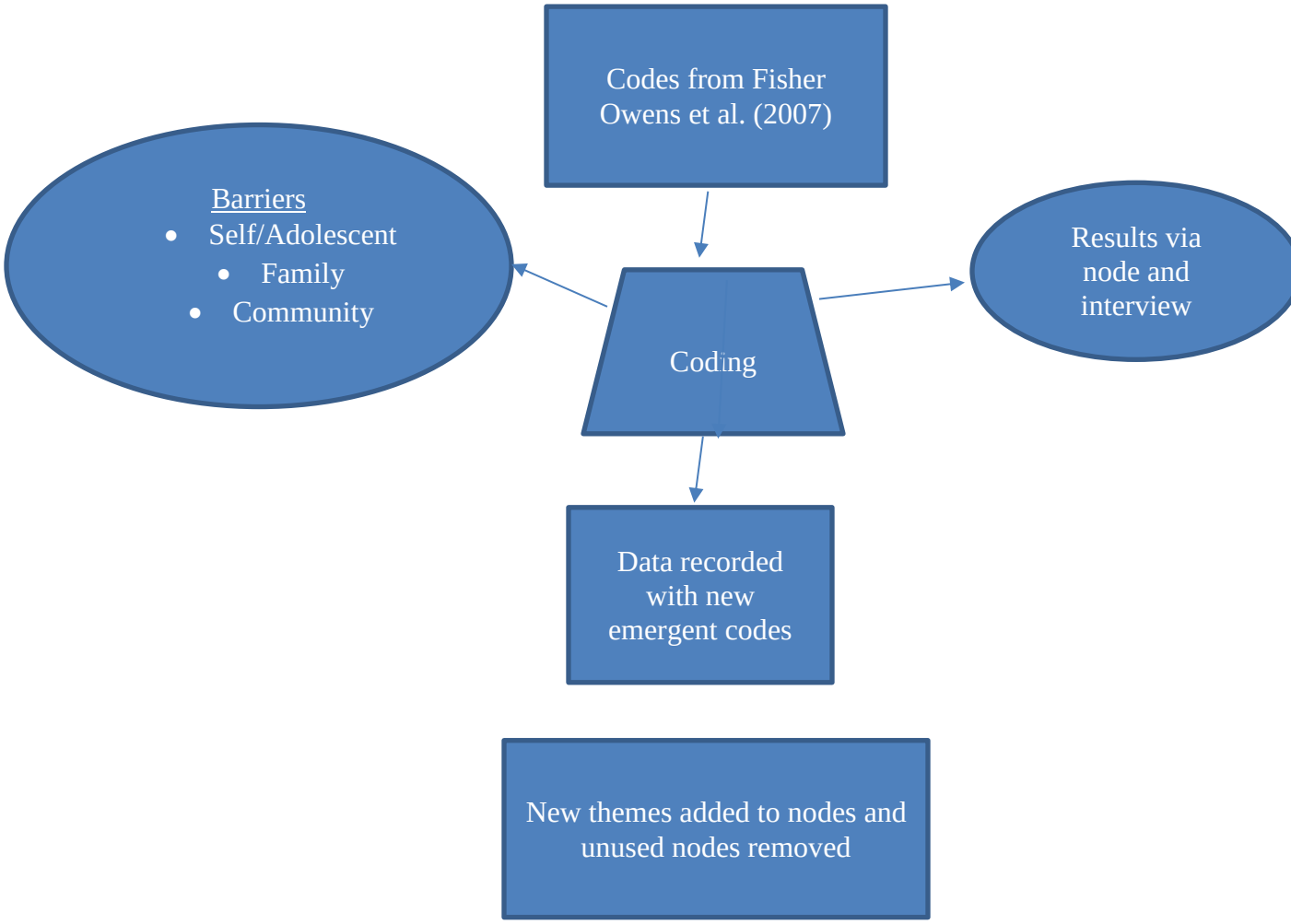
(L1, L2, L3, L4, L5, L6, L7, L8, & L9) were transcribed and coded then repeated two months later while the second batch of participants (C1, C2, C3, C4, C5 , C6, C7, C8, C9, C10, & C11) were completed, transcribed, and coded. The double-coding process is pertinent because it compares from the first round to various coding categories attained during analysis.

Confirmability

Confirmability was accomplished when I established transferability, and dependability because they all in some way enhance trustworthiness. In addition to the audit trails, I used diagrammed audit trails of data collection and the development of thematic concepts. Figures 1 and 2 show the data collection process and how the conceptual ideas evolved.

Figure 3: Data Collection Process

Figure 4: Conceptual Ideas



Summary

The results of the barriers to oral care study showed that the health perceptions of adolescents (whether or not oral health was important to overall health) had a big impact on whether or not they saw a dentist. Majority of the participants did not think that oral care was important to overall care therefore, it was not important to seek oral care on a regular basis. Financial barriers and personal perceptions were factors that actually hindered them from being able to see a dentist whether it is direct or indirect.

In the next chapter, I discuss my findings of the barriers to oral care study and compare it to the conceptual frameworks and literature stated in Chapter 2. Next, I describe the limitations to trustworthiness that came from conducting this research. Then, I provide recommendations on particular areas in need of future research according to the strengths and limitations of the current research study. Finally, I highlight the implications that the barriers to oral care study has on various levels of social change, and recommendations for the field of oral care.

Chapter 5: Discussion, Limitations, and Recommendation

Introduction

The purpose for conducting this study was to define the various factors and situations that cause adolescents not to seek oral care or to make it a priority. The association between poor oral health and increased rates of certain chronic diseases has become a popular, yet unconfirmed research topic (Cullinan et al., 2009; Lockhart et al., 2012). Therefore, a research study such as barriers to oral care for adolescents was imminent. Using the phenomenological approach, I composed a questionnaire of 13 questions and asked those questions to 20 participants to find out why these adolescents were not seeing a dentist regularly, what their experiences were, and how these experiences affected their views on the importance of oral health. The results of these questionnaires highlighted information about preconceived thoughts that led to not seeking oral care and the potential consequences of that decision.

The results of this research study indicated that responsibility falls on financial barriers, personal perceptions, and health perceptions when it came to adolescents not being able to seek and obtain oral care. It was apparent that adolescents want the opportunity to take care of their teeth because they know that it is important to their health and well-being, but financial barriers such as cost, copays, out of pocket expenses, and insurance issues impeded their ability to access quality oral care despite finances. The desire to be fully confident in appearance especially around friends somewhat motivates them to be more inquisitive when it comes to oral health/treatment. The participants who prioritized oral care at least made attempts to be aware of the necessity

of oral care and have discussions with their parents. Finally, the consequences of oral care prioritization and the inability to show the positive effects of proper oral care can be detrimental to the emotional state of adolescents as reported by the participants.

Interpretation of Results

I designed this research study to highlight the factors that came into play when making the decision to not seek oral care. Barriers to oral care for adolescents is a new topic, and I found only limited studies directly related to the topic. In the literature review presented in Chapter 2, I used two conceptual models as its foundation to develop the framework for the study. These models served as a perspective to view the findings of the study as well as provide a foundation for coding the responses. The Andersen Behavioral Model (1995) supplied the broad categories (demographics, social structure, environment, and health beliefs). The Fisher-Owens et al. (2007) model provided distinct codes in these categories that were initially selected for coding.

Even though I used these two conceptual models, they did not present the full picture of the barriers to accessing oral care. I did not use conceptual models that strictly pertain to dental care access for adolescents. The Andersen model (1995) was created to explain factors that influence whether or not adolescents are able to utilize oral health services, and the Fisher-Owens et al. (2007) model explains various factors that are barriers that in turn effect children's oral health outcomes. I found different themes in the participants' responses while noting the themes from the Fisher-Owens et al. model (2007). This model highlights a child's self-esteem and parental coping skills as factors of oral health behaviors. It was also noted that the social support of peers was associated with good

health and that social exclusion can lead to poor health habits, which could affect oral health (Fisher-Owens et al., 2007). On the other hand, the Andersen (1995) model highlighted various themes, but these themes were not factors that affected the participants' decision for not seeking oral care.

In this chapter, I compare the findings of the study to the literature review in Chapter 2 to prove, disprove, or to add to the knowledge base of barriers to oral care. The themes of my findings—psychosocial coping, financial barriers, personal perception, and health perceptions—which were made the overarching categories using the conceptual codes from the Fisher-Owens et al. (2007) model to further prove how the researcher's findings support, and are supported by, research in each area of my findings.

Psychosocial Coping

Psychosocial coping deals with the significance and consequences of oral health status and decisions regarding oral health in the personal aspect. Social stigmas presented by the participants (such as acceptance) motivated them to periodically inquire about oral care and seeing a dentist; however, the decision to forgo seeing a dentist did not rest solely on the student and presented emotional ramifications on some of the participants. Previous research showed malocclusion and dental deformities negatively affect the psychosocial development of a young person (Scapini, Feldens, Ardenghi, & Kramer, 2013; Scheffel et al., 2014). The participants in the barriers to oral care study believed that not taking care of their teeth would definitely cause low self-esteem, low self-confidence, or bullying. These are reasons named that the participants stated would be motivators to seek oral care themselves or via their caregivers.

Emotional Consequences

The participants' decision for not prioritizing oral care did not impact the participants negatively (low self-esteem); participants did not make mention of possible negative emotional consequences on the perceptions of themselves. Research regarding adolescents and oral care is extensive and broad, but very little could be applied to the findings of this particular study as related to the emotional consequences for not seeking oral care and the detriments of that decision in the long run. While the outcome of the barriers to oral care study may not result or suggest loss of life, the decision to forgo seeking oral treatment can produce a negative emotional impact that strategies implemented by public health officials could intervene and take action. In a study done by Stewart, Pyke-Grimm, and Kelly (2012), the emotional toll that treatment decisions had on caregivers that had adolescents with some form of oral or gum disease; a similar negative emotional ramification of the consequences of not seeking oral care/treatment was resonated among the study's participants.

Personal Perception

The personal perception theme consisted of the participants' perception of attitude and trust towards oral care professionals. The participants in this study briefly spoke about possessing a negative attitude towards oral care professionals and portrayed some form of mistrust. Few participants expressed strong negative responses regarding this theme, but it was enough for this theme to be created.

Attitude

Some of the participants' responses reflected negativity when it came to the dental profession, because these participants encountered an adverse event such as bad experiences during a dental service. Previous research results indicated attitudes toward dental care can influence a person's preventive dental behaviors (Syed, Bilal, Dawani, & Rizvi, 2013).

Trust

Trust was another issue highlighted by the participants that became a factor when it came to an adolescent not prioritizing oral care. Just like attitude, trust and distrust may have also come from prior experiences. One of the participants went on to share how the dentist did not explain the process to her; and so, she was caught off guard during the duration of the visit, and that is what impacted her negative attitude towards dentists. This example shows that the lack of communication between professionals and patients, or not knowing the effectiveness of preventive care, can shape the participants' views and how they interact with professionals. Moving forward, Dyer, Owens, and Robinson (2014) found trust in dental providers was influenced by prior negative experiences, but could be negated by a positive interpersonal relationship with the provider. A study by Sbaraini, Carter, Evans, and Blinkhorn (2012) indicated trust was highly valued in the dental provider – patient relationship and led to more open, respectful communication between both parties.

Financial Barriers

Direct Financial Barriers

My findings aligned with previous literature presented in Chapter 2 highlighting that financial barriers and lack of insurance are impediments to seeking oral care. In 2012, the American Dental Association (ADA) stated that financial barriers to dental care access were considered a fundamental source for the declining rates of dental utilization. A study by Hargreaves, Struijs, and Schuster (2015) compared the access and affordability to medical and oral care in the United States and the Netherlands and found that U.S. children and adolescents had fewer annual doctor and dental contacts in 2012. It was reported that U.S. children and adolescents tend to forgo medical and oral care due to paying high out-of-pocket fees, and having unpaid medical bills, as well as lack of insurance coverage. In detail, it was noted that in both the United States and Netherlands, those with below average health were classified as low-income compared to higher income children; this information was supported by the same occurrence noted among low-income Dutch children compared to their higher income Dutch peers. The results of the barriers to oral care study implicated that many adolescents do somewhat value the importance of dental care but their environment (family, finances, education, and culture) is a determinant of their proactivity in seeking oral care.

Insurance Issues

The results of this study partially revealed the impact that insurance problems may have on access to and receipt of oral care/treatment. A study done by DeVoe,

Tillotson, Angier, and Wallace (2014) found that children who reported not having medical/dental coverage was linked to the lack of or discontinuity of the parent's insurance coverage status which predicted a child's insurance coverage gap. This study also indicated that although a person is being covered by insurance it is not indicative of the utilization of health care services.

Dental Fear

The barriers to oral health research study highlights how dental fear plays a role in whether or not an adolescent decides to seek oral care/treatment via self, parent, or school. About 40% of participants declared that based on prior experiences with a dental professional, they purposely chose to not care to see a dentist. Further probing identified that these dental fears stemmed from unprofessionalism, pain resulting from dental visit, or stories heard from other adolescents who have had prior dental visits that were upsetting. In fact, one participant (L9) who professed his dental fear described how he felt when he visited a dentist, but also stated that if given the opportunity, he would visit another physician and see if that experiences would be different.

Limitations

The limitations to the trustworthiness of this research was a topic of discussion in Chapter 1 as well as the measures implemented to address these limitations. The implementation of multiple strategies was necessary to focus on improving the trustworthiness of this study. Some strategies were: providing an explanation of the implementation process reporting rival explanations, and utilizing member checks. There are four limitations to this research study. The first limitation is that I was not able to

triangulate the data to highlight credibility, dependability, and confirmability. Data from various sources were not able to be compared and contrasted nor was I able to synthesize information from other research studies. To promote the trustworthiness of the study, I implemented other strategies such as rival explanations where I organized the data obtained and thought about other possible ways to view and analyze the data. The second limitation is that the research's design is school based with the schools as the primary sources of the population sample, which could possibly limit the generalizability of these findings to adolescents who are in school. The third limitation to the study was the possibility of researcher bias because I was the one who obtained all of the data directly. To reduce the possibility of this occurring, I ensured that their personal information and position with the research topic at hand was clarified (Creswell, 2009; Yin, 2011). I also provided an environment that was relaxed so that participants would freely answer the questions that were asked (Patton, 2002). The final limitation could be due to not conducting a pilot study to ensure that there is no ambiguity in the questions, and to make sure that the wording of the questionnaire is comprehensible.

Recommendations

I highlighted two factors identified by the Andersen (1995) and Fisher-Owens et al. (2007) frameworks that were not found to have an impact on why the participants in this study were not able to receive oral care recently These factors are: health status of parents, and social support. Participants in the Bozorgmehr, E., Hajizamani, A., Mohammadi, T.M. (2013) study reported that there was a significant relationship between a parent's history of having dental problems and that of their children. Majority

of the participants did not mention anything regarding their parent's or guardian's dental health as being a factor of them not being able to see a dentist, nor did they mention having any dental issues. Social support was not found to be an issue with this study's participants; however, it was brought up briefly because some participants talked about how it would be nice if they were able to receive reminders or advertisements in school reminding them of the importance of oral health, so that they are prompted to go to the dentist. Language and literacy were not found to influence the participants when it came to their barriers of accessing oral care services; although one of the qualifiers is that participants were fluent in speaking and comprehending English regardless of ethnicity which could have reduced the possibility that language would have been a barrier for the participants. The literacy aspect was not influential either because the participants were all high school students so literacy was not limited to those with lower levels of education per se.

There is a possibility that low oral health literacy played a part in the participant's understanding of the importance of regular checkups and preventive care, despite the knowledge and awareness they have when it comes to practicing good oral health.

The data collection process was difficult because the researcher was dealing with minors and so there were a lot of gatekeepers (as there should be), but the delay in responsiveness and lack of participation from administration was detrimental to the progression of the research study. It is suggested that in the future, administration is made aware of potential third party researchers. If they are made aware of the target population

and the implications for social change, then there is rapport, and knowledge has been established to make the data collection process easier.

With health perception a primary factor influencing barriers to accessing oral care, future research should highlight the impact that education (awareness of the importance of oral care) has on the barriers to oral care. If adolescents are taught and encouraged to maintain oral health as adults they will be able to make better decisions to ensure they visit their dentist annually. The ACA mandates dental care for children and adolescents, but does not provide logistics on how incentives could be given to providers to see patients on Medicaid. Stronger communication strategies should be implemented to make sure that parents remain aware of the status of their coverage so it does not lapse. Because of coverage and affordability, frequent switching of health care providers is eminent, and it could impact the capacity to develop a strong patient-provider relationship which in turn highlights mistrust, negative perceptions, and poor adherence to treatment plans (Dovidio & Fiske, 2012; Roing & Holmstrom, 2012; Syed et al., 2013).

Implications

The results of this research study highlighted that adolescents were not completely aware of the true importance of maintaining oral health. This is despite what they may have learned via their external environment regarding the association between poor oral health and poor overall health. The Healthy People 2020 objectives for adolescent health included the need to,

“ Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year, and increase the proportion of low-income children and adolescents who received any preventive dental service during the past year” (HHS, 2011). The results of this study highlighted that cost, negative attitudes, insurance, and health and personal perceptions have a significant impact on access to oral care for adolescents. Since these factors have been identified, there are strong indicators of areas where policy changes and public health program implementations should be focused on. Specific financial barriers highlighted by the participants such as; out-of-pocket expenses, insurance, and affordability were the main topics of concern, and there are actions that should be implemented to address these concerns. Some actions include but are not limited to: eliminating any financial obstacles, ensure Medicaid coverage to all adolescents, provide better incentives to providers, which would encourage them to see adolescent patients who receive Medicaid, reducing copays and deductibles, and even considering combining medical and dental insurance into one entity. If financial barriers are eliminated, and public health officials promote awareness in schools regarding the impact of oral care on overall health, there is a possibility that access to oral care would improve and utilization would increase. There would be no deterrence due to cost, and adolescents would have the knowledge of where to go or who to talk to when they have concerns about access to oral care. Another concern that should be addressed is finding a way to reduce the mistrust and negative perceptions towards those in the dental profession. Dyer, Owens, and Robinson (2014), highlighted that “Positive experiences, related to interpersonal interaction and a sense of being cared for” (p.172) can reduce the

lack of trust in the dental profession. Concerted efforts will need to be made by dental professionals and public health officials to work closely to construct ways to build a trustful, mutually beneficial relationships between professional and patient. The positive social change implications of this study include increasing the proportion of African American adolescents receiving oral care/treatment by focusing on developing and providing the necessary tools for adolescents to be able to: 1. Know when to see a dentist, 2. Know the importance of seeing a dentist, and 3. Know that they have a right to obtain quality dental care. This is in conjunction to the publicly funded programs that intervene to help increase access and use of dental care services for adolescents and help to ensure that objectives in Healthy People 2020 are achieved. If public health officials work on eliminating or reducing financial, personal, and structural barriers as well as other negative perceptions, barriers to oral care will decrease which will help to improve adolescent oral health status.

Implications for Research and Theory

Although this is one of few studies to determine barriers that caused adolescents to forgo seeking oral care/treatment, the findings could have implications in the research and theory aspect of the lack of utilization of oral health services. The qualitative phenomenological study methodology was applied to highlight the barriers that influenced adolescent decisions. This culminated in various descriptions of the dynamics that were involved in that behavior. The findings of the research study showed that adolescents not wanting to seek oral care is not the primary reason to forgo treatment; however, affordability (finances and insurance), and lack of knowledge of the importance

of oral care were the driving forces behind them not visiting a dentist. If a quantitative methodology were applied to this topic, all of the information that is highlighted in this study would not have been attained in the comprehensive range that it was as an exploratory study. I was able to benefit from using open ended questions to obtain information from various perspectives and from multiple participants to show the array of factors that are influential in the creation of barriers to oral care utilized to develop the rich description of this phenomenon.

Also, the findings from this study implicate that adolescents should be categorized separately from children to be able to further determine various barriers that influence them to not seek oral care as opposed to a child who may not be completely aware of barriers, and therefore may not have a perception regarding oral care. Awareness must be given to the possibility that barriers to accessing oral care for adolescents are influenced by competing priorities of various determinants that may not be experienced or considered by children or adults; the frequency of health perceptions, personal perception, and psychosocial coping would not be prevalent had the study been conducted on children. This study has highlighted that grouping children and adolescents (such as comparing utilization rates, or barriers to accessing oral care), may not provide the whole perspective when it comes to strictly adolescents. Focusing on these specific barriers will be helpful for public health officials and professionals to strategize various policies to implement as interventions that intentionally focus on these barriers to increase dental utilization in African American adolescents.

I felt that the Andersen (1995) and Fisher-Owens et al. (2007) models, were the frameworks to utilize because it helped to provide a solid source for the composition of the literature review as well as the list of *a priori* codes. There were some themes that emerged in the data collection that were not highlighted in either framework thus solidifying the concept that adolescents should be separately categorized when discussing barriers to accessing oral care.

I gained a lot of insight while conducting this study. Such as developing a better understanding of why adolescents do not prioritize oral care. Adolescents feel indifferent between oral and overall health. Mistrust of providers due to past experiences is prevalent, and most importantly, their families cannot afford to see a dentist.

Recommendations of Practice

Majority of the participants in this study reported financial barriers being the main reason why they have not received oral treatment recently. This is proof that oral care affordability is still a painstaking issue as well as lack of community involvement to promote the importance of oral care. These challenges are the foundations to even bigger challenges and disparities in oral health. It is very important that public health professionals work with schools in their district or jurisdiction to ensure that adolescents are being spoken to, and that outside help is provided to make sure they are seeing a dentist or implement a program where dentists could visit schools annually and provide checkups.

According to the United Nations Educational, Scientific, and Cultural Organization (2011), schools are the best place to implement intervention programs

regarding oral care. This is the case because students can be accessed from childhood to adolescence every year which are the most influential stages in a person's life. Health Promoting Schools (HPS) is a strategy that could improve the awareness of the importance of oral care. Utilizing a school to become a HPS requires attention of dental professionals, school administration, as well as public health professionals. In this type of program, specific preventive care would be provided through schools, as well as oral health education. In detail, school based or mobile clinics would be on site to provide services such as oral health screenings, treatment of children, and basic dental care (Jurgensen and Petersen, 2013).Oral health education comes into play utilizing various techniques and topics of discussions such as: diet, oral hygiene, benefits of oral health, etc. Various dental hygiene products can be promoted at these events such as Colgate, Crest, Aqua Fresh, etc. Whitening strips can be promoted at these events since the students expressed concern with their appearance and battling low self-esteem. Mouthwash and toothpaste strips are also good items to have on this mobile.

Implementing practical recommendations to reduce disparities in oral health for African American adolescents will require policy changes to focus on the promotion and awareness of oral health in schools and communities. Although these policies do not guarantee service utilization, it is important to help provide a solid foundation and reinforcement from parents at an early age. Policy changes that target oral health education in adolescents would increase the opportunity of dental utilization because they would be equipped with the information and knowledge needed to know what is best for them regarding their oral health.

Conclusion

In this study, I highlighted information that suggests that its findings are consistent with similar studies. Adolescents from low income households (Medicaid beneficiaries), compared to other adolescents, are less likely to receive the recommended oral care/treatment, are less likely to have seen a dental professional, and are more likely to forgo seeking oral care due to cost or lack of awareness (Hargreaves, Struijs, and Schuster, 2015). Participants in this study were able to describe financial, and personal determinants that prevented them from seeking oral care. These findings indicated that for adolescents, forgoing oral care/treatment was not solely caused by affordability, but also by lack of information and knowledge of the importance of preventive and oral care/treatment. Future research into the barriers to oral care for African American adolescents should focus on removing knowledge barriers so that communities are in the position to participate in promoting awareness of the importance of oral care.

References

Ahn, S., Burdine, J. N., Smith, M. L., Ory, M. G., & Phillips, C .D. (2011). Residential rurality and oral health disparities: Influences of contextual and individual factors. *Journal of Primary Prevention, 32*(1), 29-41. doi: 10.1007/s10935-011-0233-0

American Dental Association. (2012, April). Breaking down barriers to oral health for all Americans: The role of finance. Retrieved from http://www.ada.org/~/media/ADA/Public%20Programs/Files/barriers-paper_role-of- finance.ashx

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36*(1), 1-10. doi: 10.2307/2137284

Blanton-Lillie, M., Hoffman, C. (2005). The role of health insurance coverage in reducing racial/ethnic disparities in health care. *Health Affairs, 24*(2), 398-408. Retrieved from http://content.healthaffairs.org/content/24/2/398.abstract

Bozorgmehr, E., Hajizamani, A., Mohammadi, T. M. (2013). Oral health behavior of parents as a predictor of oral health status of their children. *ISRN Dentistry, 13*, 1-5. doi:org/10.1155/2013/741783

Casamassimo, P. S., Lee, J. Y,.Marazita, M. L., Milgrom, P., Chi, D. L. & Divaris, K. (2014). Improving children's oral health: An interdisciplinary research framework. *Journal of Dental Research, 93*(10), 938-942.doi:10.1177/0022034514547273

Centers for Medicare and Medicaid Services. (2011, April). *CMS oral health strategy:*

Improving access to and utilization of oral health services for children in Medicaid and CHIP programs. Retrieved from http://www.medicaid.gov/Medicaid-CHIP-Program-Information/BY-topics/Quality-of-Care/Downloads/CMS-Oral-Health- Strategy.pdf

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches*. Los Angeles, CA: Sage Publications.

Crowe, S. Creswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. *BMC Medical Research Methodology, 11,* 1-9. doi:10.1186/1471-2288-11-100

Cullinan, M., Ford, P., & Seymour, G. (2009). Periodontal disease and systemic health: Current status. *Australian Dental Journal, 54*, S62-S69. doi:10.1111/j.1834-7819.20098.01144.x

Decker, S.I. (2007). Medicaid physician fees and the quality of medical care of Medicaid patients in the USA. *Household Health, 5,* 95-112. Retrieved from http://link.springer.com/article/10.1007%2Fs11150-007-9000-7

Decker, S. L. (2011). Medicaid payment levels to dentists and access to dental care among children and adolescents. *Journal of the American Medical Association, 306*(2), 187-193.doi: 10.1001/jama.2011.956

DeVoe, J. E., Baez, A., Angier, H., Krois, L., Edlund, C., & Carnet, P. A. (2007). Insurance + access ≠ health care: Typology of barriers to health care access for low-income families. *Annals of Family Medicine, 5*(6), 511-518. doi:10.1370/afm 748

DeVoe, J. E., Tillotson, C. J., Angier, H., Wallace, L. S. (2014). Predictors of children's

health insurance coverage discontinuity in 1998 versus 2009: Parental coverage continuity plays a major role. *Maternal and Child Health Journal, 18*(6), 248-255. doi: 10.1007/S10995-014-1590

Dietrich, T., Sharma, P., Walter, C., Weston, P., Beck, K. (2013). The epidemiological evidence behind the association between periodontists and incident atherosclerotic cardiovascular disease. *Journal of Clinical Periodontology, 40*(14), 70-84. doi:10.1111/jcpel2062

Dodd, V. J., Logan, H., Brown, C .D., Calderon, A., Catalanotto, F. (2014). Perceptions of oral health, preventive care, and care –seeking behaviors among rural adolescents. *Journal of School Health, 84*(12), 802-809. doi:10.1111/josh.12215 Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/25388597

Dovidio, J. F., & Fiske, S. T. (2012). Under the radar: How unexamined biases in decision- making processes in clinical interactions can contribute to health care disparities. *American Journal of Public Health, 102*(5), 945-952. doi:10.2105/AJPH.2011.300601

Duderstadt, K. G. (2014). Impact of affordable care ace on children's oral health: States hold the key. *Journal of Pediatric Health Care, 28,* 565-567. doi:10.1016/j.pedhc.2014.08.014

Dyer, T. A., Owens, J., & Robinson, P. G. (2014). The acceptability of care delegation in skill- mix: The salience of trust. *Health Policy*, *117*, 170-178. doi: 10.1016/j.healthpol.2014.02.013

Edelstein, B. L., Chinn, C. H. (2009). Update on disparities in oral health ad access to

dental care for America's children, *Academic Pediatrics*. Retrieved from http://www.sciencedirect.com/science/article/pii/S1876285909002587

Fiscella, K., Franks, P., Gold, M. R., Clancy, C. M., (2002). Inequality in quality: Addressing socioeconomic, racial, and ethnic disparities in health care, *Journal of the American Medical Association, 283*(19). Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/10815125

Fischer-Owens, S. A., Gansk, S. A., Platt, L. J., Weintraub, J. A., Soobader, M. J., Bramlett, M. D., Newacheck, P. W. (2007). Influences on children's oral health: A conceptual model, *Journal of American Pediatrics, 120*(3). Retrieved fromhttp://www.ncbi.nlm.nih.gov/pubmed/17766495

Goettems, M. L., Ardenghi, T. M., Romano, A. R., Demarco, F. F., Torriani, D. D. (2012). Influence of maternal dental anxiety on the child's dental caries experience. *Caries Research, 46*(1), 3-8. Doi:10.1159/000334645

Guarnizo-Herreno, C., Wehby, G. L. (2012). Explaining racial/ethnic disparities in children's dental health: A decomposition analysis. *American Journal of Public Health, 102*(5), 859-866.doi: 10.2105?AJPH.2011.300548

Handwerker, W., Wolfe, S. (2010). *Where bad teeth come from: Cultural and causal force. Human Organization, 69* (4), 398-406. Retrieved from http://sfaa.metapress.com/content/632228X07100X654

Hargreaves, D. S., Struijs, J. N., Schuster, M. A. (2015). US Children and adolescents

had fewer annual doctor and dentist contacts than their Dutch counterparts., 2010-2012. *Health Affairs, 34*(12), 2113-2120. doi: 10.1136/archdischild-2015-309794

Health behavior. (n.d.). Farlex Partner Medical Dictionary (2012). Retrieved on February 12, 2016 from: http://medicaldictionary.the.freedictionary.com/ Healthbehavior

Heymann, J., Earle, A., McNeill, K. (2013). The impact of labor policies on the health of Young children in the context of economic globalization. *Annual Review of Public Health, 34* (1), *355-372*. Doi: 10.1146/annurey-publhealth-031912-114358

Hudson, J. L. (2009). Families with mixed eligibility for public coverage: Navigating Medicaid, CHIP, and uninsurance, *Health Affairs 28(4), 253-258*. doi: 10.1377/hlthaff.28.4.w697

Iezzoni, L. I., (2011). Eliminating health and health care disparities among the growing population of people with disabilities, *Health Affairs*, *30*(1), 1947-1954. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/21976339

Institute of Medicine (2011). Advancing oral health in America. Washington, DC: The National Academic Press.

Institute of Medicine and National Research Council (2011). Improving access to oral health care for vulnerable and underserved populations. Washington, DC: The National Academies Press.

Jackson, R. (2006). Parental health literacy and children's dental health: Implications for

the future. *Pediatric Dentistry, 28*(1), 72-75. Retrieved from http://www.ingentaconnect.com.ezp.waldenulibrary.org/content/aapd/pd

Jackson, S. L., Vann, W. F., Kotch, J. B., Pahel, B. T., Lee, J. Y. (2011). Impact of poor oral health on children's school attendance and performance. *American Journal of Public Health, 101*(10). doi: 10.2105/AJPH.2010.200915

Jones, E., Shi, L., Hayashi, A. S., Sharma, R., Daly, C., Ngo-Metzger, Q. (2013). Access to oral health care: the role of federally qualified health centers in addressing disparities and expanding access, *American Journal of Public Health, 103*(3), 488-493. doi: 10.2105/AJPH.2012.300846

Jurgensen, N., & Petersen, P. E., (2013). Promoting oral health of children through schools- Results from a WHO global survey 2012. *Community Dental Health*, 30, 204-218.

Kaur, P., Singh, S., Mathur, A., Makkar, D. K., Pal Aggarwal, V., Batra, M., Sharma, A., Goyal, N. (2017). Impact of dental disorders and its influence on self esteem levels among adolescents. *Journal of Clinical and Diagnostic Research*, *11*(4), ZC05-ZC08. doi: 10.7860/JCDR/2017/23362.9515

Kelly, S. E., Binkey, C. J., Neace, W. P., & Gale, B. S. (2005). Barriers to care-seeking for children's oral health among low-income caregivers. *American Journal of Public Health, 95*(8), 1345-1351. doi: 10.2105/AJPH.2004.045286

Kenney, G. M., Marton, J., Klein, A. E. (2011). The effects of Medicaid and CHIP policy changes on receipts of preventive care among children. *Health Services Research, 46*(1), 298-318. doi: 10.1111/j.1475-6773.2010.02299

Koh, H. K., Sebelius, K. G. (2010). Promoting prevention through the Affordable Care Act. *New England Journal of Medicine*, 363. doi: 10.1056/NEJMp1008560

Lara, A., Crego, A., & Romero-Maroto, M (2012). Emotional contagion of dental fear to children: The fathers' mediating role in parental transfer of fear. *International Journal of Pediatric Dentistry, 22*(5). 324-330. doi: 10.1111/j.1365-263x.2011.01200x

Lin, Y.-L., Yin, Y.-Y., Chen, H.-S., Lin, Y.-C., Chang, C.-S., Chin, C.-M., Huang, H.-L. (2013). Child dental fear in low-income and non low-income families: A school-based survey study. *Journal of Dental Sciences, 9*(2), 165-171.doi.org/10.1016/j.jds.2013.02.022

Logan, H. L., Guo, Y., Dodd, V. J., Seleski, C. E., Catalanotto, F. (2013). Demographic and practice characteristics of Medicaid-participating dentists. *Journal of Public Health Dentistry, 74*, 139-146. doi: 10.1111/jhpd.12037

Margaritis, V., Koletsi-Kounari, H., Mamai-Homata, E. (2012). Qualitative research paradigm in dental education: An innovative qualitative approach of dental anxiety management. *Journal of International Oral Health, 4*(1), 11-22. Retrieved from http://www.jioh.in/

Mejia, G. C., Weintraub, J. A., Cheng, N. F., Grossman, W., Han, P. Z., Phipps, K. R., & Gansky, S. A. (2011). Language, literacy, and lack of sealants. *Community Dentistry and Oral Epidemiology, 39*(4), 318-324. doi: 10.1111/j.1600-0528.2010.00599.x

Miles, M. B., Huberman, A. M. (1994). *Qualitative data analysis*, (2nd ed.). Thousand

Oaks, CA: Sage Publications

Miller, E., Lee, J. Y., DeWalt, D. A., Vann, W. F. (2010). Impact of caregiver literacy on children's oral health outcomes. *Pediatrics, 126*(1), 107-114. doi: 10.1542/peds.2009-2887

Miltiades, H. B. (2013). Early childhood experiences, cultural beliefs, and oral health of Mexican American women. *Hispanic Health Care International, 11*(2), 87-94. doi: 18.1891/1540-4153.11.2.87

Mofidi, M., Rozier, R. G., King, R. S. (2002). Problems with access to dental care for Medicaid-insured children: What caregivers think. *American Journal of Public Health, 92*(1). Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/11772761

Mulye, T. P., Park, M. J., Nelson., C. D., Adams, S. H., Irwin, C. E., Brindis, C. (2009). Trends in adolescent and young adult health in the United States. *Journal of Adolescent Health*. doi:10.1016/jadohealth.2009.03.013

Nasseh, K., Vujicic, M., O'Dell, A.(2013). *Affordable Care Act expands dental benefits for children but does not address critical access to dental care issues.* Health Policy Resources Center Research Brief. Retrieved from: American Dental Association Website: http://www.ada.org/sections/professionalResources/pdfs/ITPRCBrief_0412_3.pdf

Okunseri, C., Okunseri, E., Garcia, R. I., Visotcky, A., Szabo, A. (2013). Predictors of dental care use: Findings from the national longitudinal study of adolescent health. *Journal of Adolescent Health, 53,* 663-670.doi:10.1016/j.jadohealth.2013.05.013

Patton, M. Q. (2002). Qualitative research and evaluation methods (3rd ed). Thousand Oaks, CA: Sage Publications, Inc.

Roing M., & Holmstrom, I. K.(2014). Involving patients in treatment decisions-a delicate balancing act for Swedish dentist. *Health Expectations, 17*(4), 500-510. doi: 10.111/j.1369-7625.2012.00778.x

Sbaraini, A., Carter, S. M., Evans, R. W., Blinkhorn, A., (2012). Experiences of dental Care: What do parents value? *BMC Health Services Research, 12*(1), 177.doi: 10.1186/1472-6963-12-177

Scapini, A., Feldens, C. A., Ardenghi, T. M., & Kramer, P. F. (2012). Malocclusion impacts adolescents' oral health-related quality of life. *Angle Orthodontist, 83*(3), 512-518. doi: 10.2319/062012-509.1

Schoen, C., Osborn, K., Squires, D., Doty, M. M (2013). Access, affordability, and insurance complexity are often worse in the United States compared to ten other countries. *Health Affairs, 32*(12), 2205-2215.doi:10.1377/hlthaff.2013.0879

Smith, P. A., & Freeman, R. (2010). Remembering and repeating childhood dental treatment experiences: Parents, their children, and barriers to dental care. *International Journal of Pediatric Dentistry, 20*(1), 50-58. doi: 10.1111/j. 1365-263x.2009.01004.x

Stewart, J. L., Pyke-Grimm, K. A., & Kelly, K. P. (2012). Making the right decision for my child with cancer: The parental imperative. *Cancer Nursing, 35*(6), 419-428. doi: 10.1097/NCC.0b013e3182431071

Syed, S., Bilal, S., Dawani, N., & Rizvi, K. (2013). Dental anxiety among adult patients and its correlation with self-assessed dental status and treatment needs. *Journal of Pakistan Medical Association*, 63(5), 614-618. Retrieved from http://www.jpma.org.pk/

United Nations Educational, Scientific and Cultural Organization (UNESCO) (2011): UNESCO Institute for Statistics. *Global Education Digest 2011*. Montreal: UNESCO.

Vujicic, M., Nassej, K. (2010). A Decade in dental care utilization among adults and children (2001-2010), *Health Services Research,49*(2), 460-476. doi:10.1111/1475-6773.12130

Vujicic, M., Nasseh, K., & Wall, T. (2013). *Dental care utilization declined for adults, increased for children during the past decade in the United States.* Health Policy Resources Center Research Brief. Retrieved from: American Dental Association website: http:// www.ada.org/sections/professionalResources/pdfs/HPRCBRIEF_0213_2.pdf

Waite, D. (2011). A simple cared trick teaching qualitative data analysis using a deck of Playing cards. *Qualitative Inquiry, 17*(10), 982-985. doi.org/10.1177/1077800411425154

Wall, T., Nasseh, K., Vujicic, M. (2011). Financial barriers to dental care declining after a decade of steady increase. *Health Policy Institute Research Brief.* American Dental Association. Retrieved from http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief_1013_1.pdf.

Wallace, B. B., MacEntee, M. (2013). Access to dental care for low-income adults: Perceptions of affordability, availability, and acceptability. *Journal of Community Health, 37*(1), 32-39. doi: 10.1007/S10900-011-9412-4

Wisdom, J. P., Cavaleri, M. A., Onwuegbuzie, A. J., & Green, C. A. (2012). Methodological reporting in qualitative, quantitative, and mixed methods health services research articles, *Health Services Research, 47*(2), 721-745. doi: 10.1111/j.1475-6773.2011.01344.x

The World Health Organization (2013). Retrieved from http://www.who.int/mediacentre/factsheets/fs323/en/

Wu, L., Gao, X., Lo, E. C. M., Ho, S. M. Y., McGrath, C., & Wong, M. C. M. (2017). Motivational oral health in adolescents. *Journal of Adolescent Health, 3*(10), 1-6. doi: 10.1016/j.jadohealth.2017.03.010

Thomas, E., Magilvy, J. K. (2011). Qualitative rigor or research validity in qualitative research, *Journal for Specialists in Pediatric Nursing, 16*(2), 151-155. doi: 10.111/j.1744-6155.2011.00283.x

Yin, R. K. (2009). *Case study research: Design and methods (4th ed)*. Thousand Oaks, CA: Sage Publications, Inc.

Yin, R. K. (2011). Qualitative research from start to finish. New York, NY: The Guilford Press.

Appendix A: Study Instruments

Qualifier Questions

- Are you 13-18 years of age?
- Have you seen a dentist in the last 12 months?
- Is your medical insurance coverage provided by Maryland's Medicaid?
- Do you live in Prince George's County, Maryland?
- Would you be interested in participating in a research study to determine the issues that people face that prevents them from seeing a dentist.

Interview Questions

1. Please share with me why you think seeing a dentist may or may not be important.
2. What do you think about going to a dental wellness visit, and how do you think it would affect your general health?
3. Describe any situations and obstacles you encountered when it came to seeing a dentist.
4. How does not being able to see a dentist make you feel about yourself and your health?
5. How does what you are experiencing impact how you see dentists?
6. What health advantages do you know of that would encourage you to go to a dentist.
7. What have your parents told you about dental wellness as it relates to your health?

8. Please share with me as many reasons as you can think of as to why you don't go to the dentist?
9. If you had to go to your regular doctor or go to a dentist, who would you go to and why?
10. Is there anything else you would like to share with ne about why you haven't gone to the dentist?
11. What forms of community support may be most helpful in making you more aware of how important it is to see a dentist?
12. Do you think that not seeing a dentist effects what you do on a day to day basis regarding your health?
13. Have you ever been to the dentist? If so, how was your visit?