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RESEARCH ARTICLE

Oral Health Needs and Experiences of Medicaid Enrollees With Serious Mental Illness

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Introduction: Chronic dental diseases are among the most prevalent chronic conditions in the U.S., despite being largely preventable. Individuals with mental illness experience multiple risk factors for poor oral health and need targeted intervention. This study investigated experiences of Kansas Medicaid enrollees with serious mental illness in accessing dental services, examined their oral health risk factors, and identified oral health needs and outcomes.

Methods: Survey data were collected from October 2016 through February 2017 from 186 individuals in Kansas with serious mental illness enrolled in Medicaid. Data were analyzed quantitatively (descriptive and bivariate statistics) and qualitatively (for major themes).

Results: Despite Medicaid coverage of dental cleanings, 60.2% of respondents had not seen a dentist in the last 12 months. Reasons included out-of-pocket costs, lack of perceived need, uncertainty about coverage, difficulty accessing providers, fear of the dentist, and transportation issues. High rates of comorbid physical health conditions, including diabetes and cardiovascular disease, and current or former tobacco use were also observed.

Conclusions: Medicaid dental benefits that cover only dental cleanings and low levels of oral health knowledge create barriers to utilizing needed preventive dental care. Lack of perceived need for preventive dental services and lack of contact with dentists necessitates the development of targeted oral health promotion efforts that speak to the specific needs of this group and are disseminated in locations of frequent contact. The Medicaid population with serious mental illness would be an ideal group to target for the integration of chronic oral, physical, and mental health prevention services and control.

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INTRODUCTION

Chronic dental diseases are among the most prevalent chronic conditions in the U.S., despite being largely preventable.[1] Poor oral health is a significant public health problem with physical, psychological, and social implications. Oral health affects physical health by causing pain, infection, and tooth loss, which can impact sleep, metabolic and hormonal processes, and affect nutrition.[2,3] Tooth loss and mouth pain can also negatively impact speech, self-esteem, interpersonal relationships, and access to housing and create barriers to employment.[4–6] Utilization of dental services can facilitate prevention of chronic dental diseases and increase the likelihood of maintaining natural teeth.[7] Substantial inequalities in oral health and utilization of preventive dental services exist,[8] and although some comprehensive initiatives may reduce these inequalities broadly, certain high-risk populations should be targeted for interventions.[9]

Medicaid is a means-tested public health insurance program administered by states that covers some low-income populations.[10] Dental benefits through Medicaid

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have improved access to dental services for children,[11] and increased the percentage of children receiving preventive dental services under Medicaid between 2000 and 2012 (23.2% to 42.4%).[12] However, despite risk factors for poor oral health and the potential for negative health outcomes, coverage of dental services for adults is optional under Medicaid and most states do not cover these services comprehensively. In fact, four states cover no dental services, 13 cover only emergency services, 17 offer limited coverage, and only 16 states and the District of Columbia offer extensive dental coverage.[13] Research has shown that lack of Medicaid coverage for dental care is associated with increased emergency department visits for preventable dental problems.[14–17]

In 2015, a total of 9.1 million adults on Medicaid had a diagnosed mental health condition.[10] This population of Medicaid enrollees experiences numerous risks to oral health compared with the general population, including (1) use of medications that cause dry mouth or hypersalivation[18–21]; (2) higher rates of smoking and substance use[19,20]; (3) less healthy diets[22]; (4) overall poor physical health[23]; and (5) social issues, such as high rates of homelessness and poverty.[18,20,23] Underutilization of dental services, especially preventive services, among individuals with serious mental illness (SMI) is another risk factor.[24] As a result, individuals with SMI have higher rates of tooth decay and missing teeth than the general population.[25] Poor oral health, in turn, can contribute to cardiovascular disease, diabetes, and poor glycemic control.[26–29] People with SMI are already at risk for cardiovascular disease and diabetes due to medication and lifestyle factors.[24,30]

In Kansas, the Medicaid program, known as KanCare, is administered through three MCOs. These MCOs cover either one or two dental cleanings per year for adult enrollees, with no coverage for fillings or other restorative services. Dentures are covered only for some individuals aged 65 years and older.[31] Approximately 26,600 adults with SMI are enrolled in KanCare.[32] SMIs include schizophrenia, schizoaffective disorder, psychotic disorders, major depressive disorders, bipolar disorders, borderline personality disorder, anxiety disorders, and eating disorders.[32,33] Drawing on data from a larger study examining the overall healthcare experiences of Kansas Medicaid enrollees with SMI,[34] this paper specifically examines oral health risk factors, utilization of dental services, barriers to accessing dental services, and their implications for this population.

METHODS

Study Sample

Between October 2016 and February 2017, a survey was administered to 189 Kansas Medicaid enrollees with SMI. The study was reviewed by the University of Kansas IRB. A study information document was read to all participants and verbal consent obtained. Six community mental health centers (CMHCs) across Kansas, representing urban, suburban, and rural settings, assisted in recruiting participants with SMI. The CMHCs used fliers, newsletters, and mailings to reach potential participants. The survey was administered by the authors either in person at a local CMHC or by telephone using a toll-free number. Sampling was purposive and completed when all demographics were represented, and qualitative comments reached saturation.[35]

Measures

The survey included structured and open-ended questions, many coming from existing federal surveys, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Measures of age, race/ethnicity, gender, education, employment, living arrangements, self-rated health, current/former tobacco use, having a care coordinator, having any physical health condition, and whether the respondent had seen a dentist in the last 12 months came from fixed-response survey questions.[34] Specific mental and physical health conditions came from open-ended questions. Respondents who had not visited a dentist in the past 12 months were specifically asked why using an open-ended question. Additional data on oral health and dental experiences were commonly volunteered in response to general open-ended questions asked of all respondents about what they liked and what needed improvement in their health plan, unmet health services and support needs, and other experiences with KanCare they wanted to share.

Analysis

Descriptive statistics were calculated, and bivariate comparisons made on key variables between respondents who had visited a dentist in the past 12 months and those who had not. Quantitative analyses were conducted using StataSE, version 14. Responses to all open-ended questions were transcribed and entered into NVivo, version 11 Pro, for coding and analysis. Major themes related to oral health needs and experiences are reported here and quotes from respondents are provided to illustrate themes and important findings.

RESULTS

Of the 189 respondents, three were excluded from the analyses because of nonresponse to the question regarding seeing a dentist in the past 12 months, resulting in a final sample size of 186. Sample demographics are provided in Table 1. Respondents ranged in age from 18 to 83 years and were primarily female (68%). More than half (59%) were white, and <10% identified themselves as Hispanic. The most common level of education was a high school diploma or General Educational Development (high school equivalency) test (38.2%). Less than one in six reported being employed for pay. A majority of respondents were renting a home or apartment. However, 5.5% of the sample self-identified as homeless, and some