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A First Look: Determinants of Dental Care for Children in Foster Care

M Melbye, **CE Huebner, Ph.D., M.P.H.**,
Professor, Department of Health Services, School of Public Health; Adjunct Associate Professor, Pediatric Dentistry, School of Dentistry, University of Washington

DL Chi, D.D.S., Ph.D.,
Assistant Professor, Department of Oral Health Sciences, School of Dentistry; Adjunct Assistant Professor, Health Services, School of Public Health, University of Washington

H Hinderberger, M.S., and
Graduate Student, Oral Biology, School of Dentistry, University of Washington

P Milgrom, D.D.S.
Professor, Department of Oral Health Sciences, School of Dentistry; Adjunct Professor, Health Services, School of Public Health, University of Washington

Abstract

Purpose—This hypothesis-generating study sought to identify potential determinants of dental care use and oral health among children living in foster care.

Method—Using a grounded theory approach, fourteen key informant interviews were conducted among health and social services professionals experienced with children in foster care and families in western Washington State.

Results—The identified potential determinants of oral health and dental use among children living in foster care included: (1) linguistic and cultural barriers; (2) lack of dentists willing to accept children's Medicaid dental insurance; (3) lack of resources available to case workers (i.e. large caseload burden) (4) lack of federal funding for specialized dental care; (5) lack of systematic health record-keeping; (6) child transience, leading to the lack of a dental home; (8) foster parents' competing needs; (7) child behavior problems; and (9) lack of dental ‘buy in’ from adolescents.

Conclusion—Additional studies are needed to determine whether children living in foster care achieve oral health, and the extent of their unmet dental need.

Keywords

Foster Home Care; Access to Health Care; Delivery of Dental Care; Oral Health; Dental Care for Children; Pediatric Dentistry

Corresponding author contact information: Molly Melbye, D.D.S., M.P.H., 1959 N.E. Pacific St., Box 357475, Seattle, WA 98195-7475, Phone: 206-543-2034, Fax: 206-685-4258, melbye@uw.edu.

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Introduction

In accordance with the Child Abuse Prevention and Treatment Act,[1] the United States' Child Welfare System provides foster care for approximately three quarters of a million children each year[2] who are removed from their birth parents' homes chiefly for reasons of abuse and neglect. Children may also be removed from their birth homes for juvenile crime, serious parent-child conflict, or the need to treat serious physical or behavioral health conditions which cannot be addressed within the family.[3] Nationally, about one-third of children in foster care are age 5 and younger, one-fifth are between the ages of 6 and 10, and half are over 10 years old.[4, 5] About 60% of these children have an ethnic or racial minority background.[5]

The American Academy of Pediatrics (AAP) considers children in foster care to be a "discrete pediatric population with more intensive service needs than the general pediatric population or even other children who are poor."[6] They are also classified as children with special health care needs (CSHCN)[3, 7, 8] due to their high rates of chronic physical, developmental, behavioral and emotional conditions and their increased need for coordination of care. Indeed, research supports that children in foster care are known to have more intensive and complex service needs than their peers;[9-11] but also that their health problems often remain unresolved or can worsen while living in foster care.[3, 7-9, 12]

Little research has assessed the oral health of children in foster care or their use of dental services. Such gaps in knowledge are important because children in foster care are under the protection of the federal Child Welfare System. This program is authorized under Title IV-B of the Social Security Act, and requires State and County governments to monitor and assure the well-being of children in foster care.[13] What little is known suggests receipt of dental care is erratic between sub-populations of children within this highly vulnerable group, and that unmet dental need exists. For instance, a study of 2005 data from Iowa[14] found 56 to 65 percent of children in foster care had a diagnostic or preventive dental visit, yet only 6 percent received a restorative visit. Children in foster care also were more likely to have a diagnostic or preventive visit than was typical of Iowan children enrolled in Medicaid and State Children's Health Insurance Program. However, the differences were attributed to higher rates of utilization of diagnostic or preventive services among children living in group homes while in foster care. The study also found that living in foster family care negatively impacted the likelihood of children ages 0-6 utilizing dental services; however this was attributed to lower utilization patterns commonly observed in this age group. A second study examined utilization of health services among children enrolled in foster care [15] in California, Florida, and Pennsylvania. Based on claims and enrollment data, between 44 and 60 percent of the children received a dental visit in a 12-month period compared to 28 to 38 percent of children receiving Supplemental Security Income (SSI) or Aid to Families with Dependent Children benefits. However, utilization of dental care was found to be less common among several subgroups of the children, in particular, those who: were enrolled in foster care for part of a year (adjusted for months of coverage); did not have a chronic or disabling condition; were not enrolled in SSI; and had either a physical or mental condition, but not both. The study's author concluded that children without chronic or disabling conditions are "less connected to the health care system," which may explain

why those children “may have undiagnosed dental conditions.” The author's hypothesis is supported by recent findings indicating some children who are chronically ill may have greater access to dental care because of their “better integration into the health care system.”[16]

These findings raise two questions: whether all children in foster care are receiving appropriate dental services, to which they are entitled by law; and the extent to which they are integrated into the health care system. The purpose of this study was to identify the dental needs and potential determinants of dental care use by children in foster care in Washington State, a system that serves approximately 11,000 children annually. The study method was key informant interviews with health and service professionals who play a role in integrating children in foster care into the health care system.

Methods

This qualitative, cross-sectional study is based on semi-structured key informant interviews with health and social services professionals who have experience working with children in foster care and their families. An interview guide was created based on a social-ecological framework of health[17] that posits direct influences of family and community environments on health, as well as indirect influences in the form of policies or financing as potential barriers to optimal health.[18] A grounded theory approach was used in sampling, data collection and analysis.[19] The semi-structured interview format facilitated the development of new domains of interest. For example, the pivotal role of case workers in scheduling and keeping dental appointments for children in foster care was revealed during the first interview. Consequently, the question “Do you think social workers influence whether foster children receive dental care?” was incorporated into the interview guide and case workers were sought for interviews.

Participant selection

Using a theoretical sampling process,[19] a purposive sample was drawn from urban areas in the western region of Washington State. A snowballing technique[20] was used to expand the sample, until saturation of concepts was achieved. Fourteen of 15 individuals who were approached agreed to participate; the person who declined did so because of a lack of time for the interview. Interviewees included: two case (social) workers experienced in child intake, placement and case services at a state child welfare agency; three case worker supervisors at a state child welfare agency, each with prior case work experience; two dentists, who worked in a pediatric dental setting; four pediatricians, including an emergency pediatrician, a child psychologist, an adolescent pediatrician experienced in the group home setting, and one specialized in treating children in foster care; a speech and hearing pathologist, who delivered care to children in a foster care therapy program; a professional, full-time tutor for children in foster care; and an administrator of a child welfare organization with extensive leadership experience in the child welfare system.

Interview questions and data collection

The social-ecological model was adapted to elicit information about the laws and policies designed to protect children in foster care, the professionals charged with assuring an effective system of care, individuals in the children's daily life, and how characteristics of the children themselves could affect their oral health and use of dental care. The interview guide included ten pre-determined domains of potential influence and 29 questions, 22 of which were used for data analysis. Two questions that were included, for example, were: "what issues seem to prevent foster parents from getting their foster children to the dentist?" and "do you think race plays a role in whether children in foster care receive dental care?" During analysis, responses to seven questions that lacked clarity or distinctiveness were omitted. The interviews were conducted by telephone and each took approximately 30 minutes. Detailed notes were taken during each interview, and interviews were digitally recorded and transcribed for later analysis. The Institutional Review Board of the University of Washington approved the study and informed consent was obtained from interviewees prior to recording their interviews.

Data analysis

After each interview, two members of the research team independently transcribed and hand coded the data using an inductive approach.[20] An initial coding frame was used, then refined and expanded after the third interview. Coding was finalized after the last interview using constant comparison methodology.[19] High concordance (98%) was found between the two raters. Frequencies of the final, calibrated codes were tabulated in Microsoft Excel 2007.

Results

The interview data reveal both potential barriers to, and facilitators of good oral health and use of dental care among children living in foster care. The primary themes that emerged are grouped as factors within a distal/intermediate domain, or an immediate/individual domain based on the Patrick et al. model of oral health disparities:

- Distal and intermediate factors (system- and community-level political, social and cultural forces: cultural and linguistic barriers to obtaining dental care and following through on treatment plans; a shortage of dental providers willing to accept Medicaid insurance, particularly orthodontists; and a child's increased residential transience impacting on continuity of dental care.)
- Immediate and individual factors (pathways within communities and families which can influence intermediate and distal factors: the impact of professional, family and child knowledge, beliefs and behaviors on access to dental care.)

Distal and intermediate factors

Culture and language barriers—Most interviewees who addressed this question (n=10) said that language plays a role in whether a child in foster care receives dental care. One case worker described how foster parents for whom English is a second language avoid speaking English. She said many would avoid communicating with dental staff, inevitably preventing them from following through with their child's recommended dental treatment.

Six of ten interviewees who responded to our question said that ethnicity or culture plays a role in whether foster parents make a dental appointment for their child. For example, a caseworker observed how some families have “different cultural ideas” about whether regular dental care is important. Most interviewees said that the child's race was not a determinant of whether a child received dental care.

Limited Medicaid provider availability—Six of the ten interviewees who answered the question “do foster parents have a hard time locating a Medicaid dentist” said it is sometimes or always difficult. Others said case workers typically provide foster parents with such information. One case worker said the real issue faced by foster parents is finding “good quality” dental care for their child. For example, many foster parents she works with complain about a particular Medicaid dental office that “advertises heavily” in the community. “People just don't like ‘em,” she said. Two interviewees elaborated on our question, saying how locating a specialist who accepts Medicaid insurance is a particular challenge, and that adequate funding for such services does not exist. One case supervisor explained how orthodontic care is not approved by Medicaid except among extreme cases which are deemed “medically necessary,” excluding from care all children with a glaring esthetic need. “Cosmetic procedures are [viewed] different[ly] in dental than in medical” said one case worker, but shouldn't be, because cosmetic dental care “is just not a luxury item.”

Residential transience: Impact on continuity of care—Interviewees felt the continuity of dental care for children in foster care was compromised by their frequent moves in and out of foster care and between placements. All interviewees who answered our question (*n=11*) said that after moving, children typically do not continue to obtain dental care from the same provider. One physician said that for children in foster care, transience causes dental care to go “by the wayside.” Another physician explained how transience can benefit children because it causes them to be examined more frequently. However, most interviewees voiced concern with the lack of continuity of care faced by children in foster care. “We lose kids when they go back to their parents,” said the speech pathologist “because the birth parents don't follow up, or they're out of the area.” In her experience, she said “therapeutic care is almost always interrupted upon (the child) returning (to the birth) home.”

Residential transience can also promote an ad-hoc approach to health information sharing, further compromising a child's access to quality dental care. For example, one interviewee described how dental records are informally passed from a child's dentist to their foster parents, at which point, “it's up to them to pass it to the next health provider.” One interviewee said that transience may be an especially relevant barrier to continuity of care among adolescents, since they tend to experience more placements than children and infants. The problem with residential transience, according to one case worker, is that “dental gets dropped when a kid gets bounced around from home to home.”

Immediate and individual factors

Facilitating access to dental care: The roles of individuals and organizations

The role of dentists and physicians: Dentists and physicians were not knowledgeable about when dental needs are assessed among children living in foster care (n=7). Social services workers, however, were very well informed on this topic (n=5). For example, according to one case worker, it is not uncommon to see “disagreement (between case workers and physicians) about when to have kids come to the dentist,” especially “whether babies should be seen before teeth erupt, after teeth erupt, or when they're about 2-3 years old.”

The role of caseworkers: When asked “do you think social workers influence whether a foster child receives dental care,” interviewees unanimously answered ‘yes’. “I think they make a big impact…they really encourage us,” said one dentist of case workers, explaining how it takes teamwork to convey the importance of routine dental care to foster families. The speech pathologist saw case workers as an important informational and decision-making resource to health providers. “In terms of getting information and providing the most appropriate care,” she said “I would put the foster parent and the social worker on equal footing.”

The role of foster care organizations: caseload and culture: When asked “do you think foster children receive the dental treatment they need” five interviewees said foster children receive the dental treatment they need, regardless of competing needs of foster parents or caseworkers, six interviewees disagreed. Several interviewees explained how the size of a case worker's caseload can have a major influence as to how much effort they make to ensure a child receives dental services. Social work was described among interviewees as a “high burnout,” “high turnover” career, with one pediatrician lamenting: “Their lives can be completely crazy, so I could see how, depending on whether [dental care is] a priority in the head of a specific case worker…that could play a big role in whether or not kids are getting into appointments.” A case supervisor with over 10 years of experience said “if there's no evidence of decay or pain, then dental is not a priority.” Several interviewees also talked about ways in which organizational culture can affects a case worker's has the capacity to ensure the dental needs of children on their caseload are being met. For example, an administrator in a private foster care organization explained how his organization has “better retention” of case workers compared to many state-run counterparts, and that case workers are encouraged to “focus on a long-term relationship” with children and their foster parents. In contrast, a case worker from the State system explained how her role is only to supervise or oversee care, and primarily interacts with parents. “The reality is,” she said, “I see the children less than I see the parents, and the children don't really see me as somebody they can call or talk to as a safe person; they're just like, ‘oh, you're here because you're supervising my visit,’ or ‘you're transporting me to the dentist…’.”

The role of foster parents: Overall, about half the interviewees felt foster parents are motivated to obtain dental care for their child, and described them as resourceful in getting the child's dental needs met. There was, however, considerable discussion of the competing demands on foster parents. Several interviewees talked about how being a foster parent can

be “overwhelming,” and how “multiple children at home can increase difficulty of getting one child seen” for dental appointments. Several dental and medical care providers questioned whether foster parents are resourceful or motivated to have their child seen by a dentist. One pediatrician said “if the kid is having behavioral issues at home, taking them to get a dental exam probably sounds like a nightmare [to foster parents]….” Emotional and financial resources can also vary, according to interviewees. One pediatrician acknowledged that, even though guidelines exist to ensure foster parents schedule and follow through on their child's dental appointments, their competing needs can decrease adherence. “Often times,” he said “(foster parents) have a bunch of kids in their house to take care of, and even though they're trained and there are lots of rules and regulations about it, I think there are barriers to having optimal…dental care be provided.” One case worker said that having a foster parent who is alert and assertive about a child's dental needs is important because quality “health and dental care is based on who's going to advocate for you.”

The role of young children and adolescents: When asked “do you think child behavior plays a role in whether foster children receive dental care” eight interviewees said it did, and four did not. One interviewee said dentists seemed “more than able to cope” with any difficult child behavior she had witnessed. Most interviewees, however, conveyed that children with behavioral problems may have more unmet dental need than children who have none. For example, one case worker pointed out how “screaming children can't sit still” for dental care.

Four interviewees explained how the behavior and attitudes of adolescents, in particular, were determinant of their receipt of dental care. For example, one case worker explained that in his organization's adolescent unit “dental needs are probably not even in the top 100 of things that are going on in a caseload.” These four interviewees also talked about how adolescents can refuse dental care, one explaining how Washington State law permits them this right. “Adolescents are where the major behavioral difficulties stack up,” said a case supervisor because, “if they don't feel they need it, they're not gonna go (to the dentist)….”

The oral health of children in foster care—Several questions were asked of interviewees on oral health of children in foster care. When asked “can you tell if a child in foster care has a dental problem,” seven interviewees answered yes, many citing cases of chronic neglect. “The ones that have toothaches are [the ones that have recently been admitted] to foster care,” according to one dentist. Another dentist observed that the children she has treated who live in foster care tend to have “a lot of cavities” and poor oral health. When asked “do foster kids' teeth seem to get better as they get older” nine interviewees could answer the question, but their responses were varied.

Three respondents talked about how oral health outcomes depend on oral hygiene habits of the individual child, in addition to access to dental care. For example, one dentist said “…(if) we can get them on the right track, they'll be fine -but the ones that don't take care of their teeth-it's the same issues over and over.” Three interviewees said oral hygiene was tied to emotional health and parent's role modeling. For example, a case manager said “behaviorally challenged kids don't brush as much (as they need to),” and a physician explained how stress “doesn't lend itself to brushing [one's] teeth regularly.” Another

physician talked about how oral hygiene among children in foster care is poor because they haven't had the proper modeling from birth parents to “set up the life-long habits you need to take good care of your teeth.”

Discussion

Consistent with the social-ecological framework of health, our findings revealed potential barriers to and facilitators of use of dental care and oral health at multiple levels. Next we discuss these findings and identify several hypotheses warrant further investigation.

Macro-level factors

Although Child Welfare Services (CWS) policy is designed to allow States flexibility in the implementation of their CWS programs,[21] all children served by Medicaid are entitled to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) dental exams as part of Title V of the Social Security Act. Washington State law requires an (EPSDT) oral health screening be scheduled within the first 30 days of a child's placement into foster care, at which time a dental referral should be provided for all children 1 year of age and older. At the macro-level, our study found that this requirement is not routinely met, and was contingent on the availability of dental providers willing to accept Medicaid insurance (the primary insurance for most children in foster care).[21] In this way, macro-level barriers are similar to those faced by other low-income and racial and ethnic minority children who experience a higher incidence of dental disease but less access to care than their non-poor peers.[22,24] Unlike their Medicaid-enrolled peers however, children in foster care are ensured such services by law. Courts “bear the ultimate responsibility” for the well-being of children in foster care,[24] including enforcing the receipt of mandated dental services. Future studies should examine whether insurance limitations (i.e. Medicaid), and a lack of dental providers willing to accept Medicaid insurance influence whether children in foster care receive needed dental services.

Organizational-level factors

Lack of Caseworker Resources—Our data revealed that between and within organizations, individuals assign different priorities to meeting dental EPSDT requirements, and sharing health records. At the organizational level, our findings illustrate how a child's access to (and quality of) dental care depended on the burden of a case worker's caseload. If such dental service findings generalized to most children in foster care this would not be new news since, in medicine “most [child welfare] agencies have continued to struggle with significant resource shortages in the face of increasing caseloads, … [and] children's health care has not been a priority for the child welfare system.”[12]

Lack of Coordination of Care: The Need for a Dental Home—Our findings indicated that coordinating dental care services for children in foster care can be complicated by a lack of systematic record-sharing, and exacerbated by a child's residential transience. Lack of coordinated care is a well-documented barrier to medical health services among children in foster care,[6, 12, 21] resulting in “sporadic, crisis-oriented, and poorly accessible”[6] medical care.

Guidelines developed by AAP exist for addressing the coordination of care issues faced by children living in foster care and CSHCN, the foremost being a Medical Home.[6,25,26] According to AAP, the Dental Home falls "within the philosophical complex of the Medical Home," [6,25] and "pediatric primary dental care needs to be delivered in a similar manner." Having a Dental Home increases a child's chance of receiving preventive and routine oral health care,[27] especially among low-income children. Unfortunately, it remains unclear whether the Dental Home model is feasible for all children in foster care. The AAP recognizes that "maintaining children and adolescents in Medical Homes and [completing] timely transfers of medical information [are] formidable tasks" among such a highly mobile and transient population. Thus, a "health care management" model has also been proposed by AAP to address this barrier.[6] It is unknown, however, whether this approach is effective for improving health service delivery. Future studies should examine whether children living in foster care lack access to coordinated dental services, including a health care home.

Community, familial- and individual-level factors

Like other children,[18] access to dental care among children living in foster care may depend on their individual relationships, including those with foster parents, case workers, and health care providers. Next we discuss how these individuals influence a child's oral health and access to dental care.

Birth and foster parents—Our findings indicate that foster parents' motivation and ability to ensure receipt of needed dental services for their children may differ. Interviewees chiefly attributed this to a parent's competing needs as well as their child's behavior. Competing needs is a barrier identified in the literature[24] that may prevent parents from ensuring their children receive needed dental care. For example, among parents of preschool aged children[28] who were interviewed for behavioral determinants of tooth brushing their young children, two of the most commonly cited (89%) barriers were a lack of time and an uncooperative child. As with other low-income families,[22,23] our findings suggest that proximity to, and choice of a dental provider may also be a determinant of care. Finally, language and culture differences among foster families may be potential barriers to a child's receipt of dental services when living in foster care.

Case workers—At the individual level, more information is needed to determine the extent to which a case worker's personal beliefs, behaviors and attitudes impact a child's access to dental care.

Dentists—Our findings indicate there is a shortage of dentists, in particular dental specialists, who are willing to treat children insured by Medicaid. As with other children who are poor,[23] our findings suggest that dentists' choice to accept Medicaid is a pivotal determinant of children's ability to access needed dental services when living in foster care. Additionally, through their ability to provide anticipatory guidance and counseling, dentists were also seen as potential facilitators of dental care, once a child encountered care.

Physicians—Physicians were also seen as facilitators of access to dental care among children living in foster care through their ability to refer and educate. Specifically, timely

dental referrals and reinforcement of the need for regular dental care with foster parents and case workers were seen as important determinants of a child's receipt of dental care. Physicians are known to play an important role in promoting oral health with children and adolescents.[29] However, variation in the aptness and consistency of physicians to provide these services was perceived by interviewees.

Children and Adolescents—Adolescents' beliefs, behaviors and attitudes about dental care (and to a lesser extent, child behaviors) were perceived to affect their oral health and receipt of dental care. Specifically, adolescents were seen as decision-makers, who, as much as their adult caretakers, need to ascribe value to dental care before they are willing to receive it. Future studies should examine whether individual stakeholders' ascribed value to dental care along with their competing needs influence whether a child receives needed dental care.

Oral Health of Children in Foster Care

Interviewees did not agree on whether the oral health of children living in foster improves with age. Research is needed to determine the extent of unmet dental need in this population.

Recommendations for Health and Service Professionals

Based on our preliminary findings and clinical best practices outlined in the literature, the following are early recommendations for health and social service professionals.

Case workers—Because children living in foster care depend jointly on case workers and foster parents to ensure their oral health,[6] case workers are compelled to use their best effort toward ensuring each child receives timely, coordinated EPSDT dental services.

Dentists—Of foremost importance, is dentist's decision to accept Medicaid insurance for children enrolled in foster care. Dentists must acknowledge their pivotal role as a barrier or determinant of dental care among these children. Clinically, dentists may be able to facilitate oral health and access to dental care by delivering anticipatory guidance[27] and by troubleshooting the challenges associated with making and keeping a child's dental appointments with a child's caretakers.

Physicians—Physicians can encourage foster parents, adolescents and case workers to make and keep dental appointments. Physicians should also familiarize themselves with current pediatric dental examination guidelines.[30] For example; all children should be routinely examined by a dentist, including babies before their first birthday.

Limitations

This was a hypothesis-generating study designed to motivate future studies, and guide education and interventions. As such, the goals were achievable with a small, purposive sample, but limit external validity. The urban setting of this study is unlikely to capture the barriers for children in foster care statewide since children who live in rural settings experience poorer access to dental care.[31] Furthermore, Washington State delivers more dental services to children enrolled in Medicaid than most other states.[32]

Conclusion

Studies of medical health service delivery among children living in foster care find them in relatively poor health, and lacking access to medical care.[6] These preliminary data suggest, in accordance with the medical health services literature, a similar pattern may exist for their oral health and access to dental services. Our study identified the following potential barriers to use of dental care and oral health among children living in foster care: (1) linguistic and cultural barriers; (2) lack of dentists willing to accept children's Medicaid dental insurance; (3) lack of resources available to case workers (i.e. large caseload burden) (4) lack of federal funding for specialized dental care; (5) lack of systematic health record-keeping; (6) child transience, leading to the lack of a dental home; (8) foster parents' competing needs; (7) child behavior problems; and (9) lack of dental 'buy in' from adolescents. From here, additional studies are needed to determine whether these children achieve oral health, and the extent of any unmet dental need.

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