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Low-Income and Minority Patient Satisfaction with Visits to Emergency Departments and Physician Offices for Dental Problems

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Abstract

Objectives—Individuals lacking access to dentists may utilize hospital emergency departments (EDs) or physicians (MDs) for the management of their dental problems. This study examined visits by minority and low-income individuals to physicians and hospital emergency departments for the treatment of dental problems with the goal of exploring the nature of treatment provided and patient satisfaction with the care received.

Methods—Eight focus group sessions were conducted with 53 participants drawn from low-income White, Black, and Hispanic adults who had experienced a dental problem, and who had sought care from a MD/ED at least once during the previous twelve months.

Results—Toothache pain or more generalized jaw/face pain was the most frequent oral problem resulting in MD/ED visits. Pain severity was the principle reason for seeking care from MDs/EDs, with financial barriers most often mentioned as the reason for not seeking care from dentists. Expectations of MD/ED visits were generally consistent with care received; most participants limited their expectations to the provision of antibiotics or pain medication. Nearly all of the participants thought they would eventually need to see a dentist for resolution of their dental problem.

Conclusions—Physicians generally lack substantive training in dentistry and, therefore, are unlikely to provide definitive treatment.

Keywords

dental problems; hospital emergency departments; physician offices; minorities

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INTRODUCTION

Although we have a sound understanding of who uses dental services, our knowledge of the pain relief-seeking strategies used by the poor and minorities that lack a usual source of dental care is limited. There is a well-established association between toothache pain and the use of dental services. However, it is clear that not all individuals suffering from toothache pain or other dental problems seek relief from dentists (Riley, Gilbert, & Heft, 1999; Riley, Gilbert, & Heft, 2005; Gilbert, Shelton, Chavers, & Bradford, 2003). In addition, many individuals who experience dental problems might use self-care/home remedies (Gilbert, Stoller, Duncan, Earls, & Campbell, 2000; Cohen et al, 2009) or recover without receiving dental treatment (Duncan, Gilbert, Peek, & Heft, 2003). Individuals lacking access to dentists also may utilize hospital emergency departments (EDs) (Burt, & Schappert, 2004; Cohen, & Manski, 2006; Cohen et al, 2008) or physicians (MDs) (Burt, & Schappert, 2004; Cohen, & Manski, 2006; Cohen et al, 2008; Woodwell, & Cherry, 2002; Cohen, & Cotton, 2006; Lockhart, Mason, Konen, Kent, & Gibson, 2000) for the management of their dental problems. Some individuals may use these sites as an interim measure until such time that professional dental care is obtained.

Poor/minority individuals most often lack access to dentists (U.S. Department of Health and Human Services, 2000). In addition, these groups often face both a heavier burden of oral disease (U.S. Department of Health and Human Services, 2000; Green et al, 2003) as well as financial and other barriers to dental services (U.S. Department of Health and Human Services, 2000; Manski, Moeller, & Mass, 2001; National Center for Health Statistics, 2003). Although visits to MDs/EDs for the treatment of dental problems are well documented, the nature of treatment provided is not well understood (U.S. Department of Health and Human Services, 2000). Only a few studies have described the services provided in EDs (Burt, & McCaig, 2001; Lewis, Lynch, & Johnson, 2003) or patient satisfaction with those services. Similarly, with few exceptions (Lockhart, Mason, Konen, Kent, & Gibson, 2000) little data exist that describes the treatments provided by MDs, its effectiveness, nor with rare exceptions (Cohen & Cotton, 2006), patient satisfaction. Many individuals with dental problems who lack access to dentists will continue to seek care from MDs/EDs. This issue will grow in importance with an aging and increasingly diverse population, since these groups face significant financial obstacles to obtaining dental services (U.S. Department of Health and Human Services, 2000; Anderson, 2005).

The purpose of this study was to gain a better understanding of this under-explored pattern of non-dentist health professional care. The findings from this study will aide in the development of low-income/minority population specific data that may be used in the development of quantitative studies leading to a more comprehensive understanding of the use of EDs and MDs for dental problems and ultimately to improvements in the care provided.

METHODS

Focus group interviews were used to gather qualitative data pertaining to factors influencing the participant's decision to seek treatment for dental problems from MDs/EDs, as well as their treatment expectations, and satisfaction with care received. Focus groups are particularly helpful in understanding the language used by a group around a particular issue, and identifying and clarifying important aspects of a particular experience (Meadows, Verdi, & Crabtree, 2003; Trotter & Schensul, 1998)

Eight focus group sessions were held across Maryland; two in Baltimore City (one Black and one Hispanic), two in the Washington DC area (one Black and one Hispanic), two in Western MD (both White), and two in Eastern MD (one Black and one White). Focus groups were held

during both the day and early evening to maximize participant availability, and were held in locations near the communities in which they resided.

Participants were drawn from low-income non-Hispanic White, non-Hispanic Black, and Hispanic adults over the age of 20 who had experienced a dental problem and who had sought care from a MD/ED at least once during the previous twelve months. There were a total of 53 participants (see Table 1). In addition to seeking recruits through the University of Maryland Statewide Health Network, the investigators also used secondary recruitment strategies via message boards and screening at health advocacy organizations, local community organizations, places of worship, and local health departments.

Project staff developed a screener to guide the recruitment process and conducted telephone conference calls with organizations that agreed to assist with recruitment. Potential participants were given a toll-free number to call. When they called, a member of the research team explained the purpose of the focus group again, answered questions, and conducted the screening interview. For those who met the screening criteria, we described the focus group, provided the time/location of the group, and told them that they would receive $40 to cover their time and any incidental expenses involved in participating. Focus groups included both men and women of varying ages, but were homogeneous in terms of race.

An experienced moderator and a co-moderator who took notes conducted the groups. Focus group sessions were audiotaped to aid in the subsequent analysis and ensure that the actual language and word choice of the participants was captured. The moderators debriefed after each group. Multiracial/ethnic focus group staff was matched to the race/ethnicity of the groups to reduce initial barriers to communication and contribute to building rapport. The same moderator and co-moderator conducted all Black focus groups. Similarly, the same moderator and co-moderator conducted all Hispanic groups. The same moderator and co-moderator conducted two of the White focus groups, but there was a change in the moderator for the third group due to a change in staff. Hispanic focus group sessions were conducted in Spanish. Moderators used a focus group guide to direct the discussion. This structured interview guide included questions in complete, conversational sentences, prepared in appropriate sequence for the facilitator to follow. Groups generally lasted 90–120 minutes. At the completion of each group, participants were asked to complete a short written questionnaire covering sociodemographic, general health status, and health service utilization-related variables.

After each group, the moderators prepared a two to three page summary of the discussion using the broad categories from the interview protocol as structure. Information from the moderators notes as well as the audio recordings of the groups were used in preparing the summaries. After the eight focus groups, the recordings were transcribed and the transcriptions were analyzed using QSR NVivo (NVivo, 2002), a qualitative data analysis software program, in order to sort the text data into the broad categories from the interview protocol. We then conducted additional analyses to identify recurring themes within each coding category and to summarize the findings.

The research protocol was reviewed by the University of Maryland Baltimore Office for Research Studies and judged exempt from IRB review; however, a written informed consent was obtained from all participants at the beginning of each focus group session.

RESULTS

Characteristics of Study Subjects

The sociodemographic background of participants is shown in Table 1. Among the 53 participants across the 8 focus groups, 24 participants were Black, 13 were White, and 16 were

Hispanic. The majority of participants were female (77.4%) and reported an annual income of $10,000 or less (50.9%). Information pertaining to the general health status and dental service utilization background of the participants which was collected at the completion of the focus groups appear in Table 2. Approximately one-half of the participants considered themselves to be in fair/poor overall health. The participants' assessments of their dental health were more negative with 80.8% considering it to be fair/poor. As expected, the majority of participants (76.5%) reported that they never visited the dentist or only visited when they had a dental problem. Participants were more likely to have reported making regular, non-symptomatic medical visits (60.4%). In general, the participants rated their pain as being very painful with 63.0% rating it as 9 or 10. Participants were split between those who did and did not have any kind of health insurance. Among those with health insurance, the majority had medical assistance (58.6%); only 19.2% of the participants reported having dental insurance.

Dental Problem Experience

Participants were asked to describe the type of dental problem that caused them to seek care from an MD/ED. Responses included (multiple responses possible): toothache pain (n=16), jaw/face pain (n=12), infections (n=9), abscesses (n=9), bleeding gums (n=5), trauma (n=4), burning mouth (n=3), loose teeth (n=7), broken teeth (n=6), as well as trouble with dentures, crowns, defective fillings, and assorted other problems (n=8). There was no dramatic difference associated with race/ethnicity.

Participants were asked the length of time between the appearance of first symptoms and care seeking. Responses ranged widely from many years (20–30 years) to mere hours (3–4 hours). *"It don't take long because when I feel pain, I go straight to the hospital. I might give it like 3–4 days."* Some participants mentioned that their dental problems started when they were adolescents. *"I think it all started about 24 years ago, in my late teens. When my mother took us to this quack dentist, instead of him giving us fillings, he gave us root canals. Every one of my siblings with root canals have crumbled. And it's been going on and on up through all my adult years."* Most participants had experienced similar dental-related problems in the past.

Reasons for Seeking Care from MDs/EDs

Participants were asked why they visited a MD/ED for their dental problem rather than a dentist. Most often participants stated that they sought treatment from a MD/ED due to the severity of their pain. When questioned why they did not seek pain relief from a dentist, the most cited reason related to financial barriers. *"My insurance won't cover it and I didn't have the cash to do it because I'm on a fixed income. I just couldn't afford to go to a dentist." "It's just affording a dentist…It's not like they can bill you and you can make payments or anything, they want money, they always want money up-front. I mean, it's not like a co-pay fee, they want a couple of hundred dollars." "We don't have any money and we don't have any way." "They have to decide if they want groceries or teeth pulled, what are you going to do?"*

Some participants went to their MD for other concerns and were diagnosed with dental problems while they were there. *"I went to my regular checkup and this time when I went I was complaining of weight loss. He said he's had more people that can't eat right because they can't chew their food. He said that's why I'm losing weight and that's when he referred me to a dentist."* Others reasons for seeking care from MDs/EDs included: no available dentists (dentists not accepting appointments or a long time before an available appointment) and no dentists that accepted payment plans. Some participants stated that the problem occurred after usual office hours. *"It wasn't during business hours, nothing was open."* Other participants mentioned a fear of dentists or past unpleasant dental experiences. *"I'm terrified of dentists. For a long time when I had insurance, I was apprehensive about going because of the fear that was instilled upon me as a child because of this crazy dentist"*.

Most participants stated that they preferred to go to a dentist but didn't because of the factors mentioned above. *" I'm sure everybody would rather go sit in a dentist's office and have the problem taken care of than sit in the emergency room, just for a temporary fix." "I would prefer to go to the dentist right away but it may be insurance, it may be money, it may be getting off work, whatever reason, you can't go right away. So, if I have to go to a doctor, I'll go to get me over that hump until I can get to a dentist."* Some participants explained how going to the ED was a waste of money for the government and, if dental care was provided instead, it would be cheaper overall. *"It doesn't make sense. If you could get medical assistance for all of the emergency room visits, it would have been so much cheaper for them to just pay for your dental care. They're just wasting money and the problem's not getting taken care of, it's just getting numbed."*

Expectations of Visit to MDs/EDs

Participants were asked about their expectations for care when they went to the MD/ED. Participants generally wanted any treatment that would relieve their pain. *"Most people, if they don't have insurance, they usually go to the emergency room. When you go to the emergency room, somebody's going to be there, to help you out, and give you something for the pain."* They expected the provider to "… *actually look at their dental problem, for them to do x-rays, and for them to give them some kind of medicine such as an antibiotic or pain medicine"*. *"I expect him to at least look at my mouth and I'm hoping that they will give me something, even if they only give me an antibiotic." "I went to the doctor recently and I was hoping that I could be given something until I could get to a dentist." "I wanted to get something for the pain. I wanted the pain to stop."* Other participants stated that they expected the provider to pull their tooth or fix their fillings. *"I expected them to pull it; I thought they was going to take it out."* A few participants also expected the MD to refer them to a dentist.

Participants were asked if they thought a visit to the MD/ED would completely treat their dental problem; none thought that it would. *"I've never known anyone to go the emergency room with a dental problem and it got taken care of right there."* The majority of participants felt that they would eventually have to seek care from a dentist. *"That's not their (physicians) area. It's not their field. When you go to a dentist, they were trained for teeth."*

Diagnosis, Treatment, and Health Education/Promotion Received During MD/ED Visits

Participants were asked to describe their visit to the MD/ED. Most mentioned the MD looked at their "problem" and provided them with a shot for pain, or prescriptions for antibiotics and pain medicine. Several participants stated that often the ED would give them enough medicine to last until they could get to a pharmacist. *"They ask you your symptoms and they take a look. Mostly every time, they give me an antibiotic for an infection. I do get a pain medicine and an antibiotic and then a follow-up for any type of dentistry I can afford. They say you need to follow-up with a dentist or we'll see you back here again for the same problem, and they do."* Some participants received x-rays, blood tests, and temporary fillings. *"They prepped me up, [I was] thinking they was going to pull my tooth but they didn't. They gave me antibiotics and took blood and x-rays. Then they say okay, we're referring you to [another institution] have them pull your tooth."* Some participants suggested having a dentist on staff at the ED. *"I think they should have a flat-out dental ER, just a place where you can go for dentists. Anything, emergency, low income, no insurance and still be able to get help, like any other healthcare."*

The majority of participants stated that they received very little, if any, information about their dental problem. A few stated they received information about their treatment, the medications, and follow-up care, but only a couple of respondents stated that they actually received information concerning the cause of their problem or how to prevent it from reoccurring.

"This hospital is only a band-aid station. What I wanted was somebody to tell me what was going on and what to do about it, what to do to prevent it, and what to do to make it better. The only thing I could find out is what I already knew…" "They'll give you a pill and they charge you like a couple of dollars for that little pill and then they'll write a prescription out for you. They didn't tell me anything about preventing it or something like that." "I don't recall them giving me any information as to telling me what went wrong with my teeth."

Almost all participants were advised to see a dentist. Several participants were given referrals or a list of dentists to call. *"From what the doctor's saying, I would need to go to a dentist. It was just a temporary fix to alleviate the pain until I could go to the dentist. I know I need to go to the dentist to really have it checked out and really be diagnosed, to be dealt with. So the doctor was something to get me out of some pain until I could get to a dentist and the doctor did say I should go"*

Satisfaction with Medical Care Received

Participants were asked how difficult it was to be seen in the ED. Most participants complained of long ED waits; participants described sometimes sitting for 3 to 6 hours. In one group, participants mentioned that larger hospitals often had longer wait times and unfriendly workers, while they received more personalized care from smaller hospitals. In general, respondents reported that the visit was quick once they actually were seen. *"The emergency room always takes a long time, so we had to wait before a doctor could see him, but when we got taken back to the clinic rooms, the doctor was able to come see him very quickly. They treated him very well."*

Participants who received care from an MD generally reported more satisfaction in terms of wait times and the treatment provided than participants who went to EDs. One participant reported being able to contact her physician after hours and still being able to receive care. *"My primary care doctor don't care for you to go to the emergency room. Even if you get sick on the weekend, you call him and he'll have another doctor call you who's going to meet you."* When patients visited MDs, they established a more personal relationship with the health care provider. Patients stated that MDs spent more time with them and seemed more concerned about problems than EDs. *"…I mean, she breaks it down, I mean, like you all were saying, if you show an interest in your health, you know, she totally has no problem with sitting there, I mean, you can spend like a half an hour, 45 minutes just talking…"*

Next, participants were asked about satisfaction with their treatment. In general, participants were dissatisfied with ED care. Many stated that the antibiotics and pain killers were temporary and that their dental problem was still a concern. *"No, the only thing he gave me was three pain pills and then he gave me a prescription. The time was really late at night and there was no pharmacy open. I was still in pain and the pharmacy still wasn't open." "I was very dissatisfied because they didn't do anything. They gave me a weak antibiotic and a narcotic and sent me home. The problem is not solved. It's still there."* Some participants were satisfied with the treatment because it alleviated their pain. *"I have to say I was satisfied because I left there and I wasn't in pain. I felt that I was satisfied because they tried to do something."*

Lastly, participants were asked about their experience with the medical personnel they encountered. Experiences varied by location and race/ethnicity. Many participants felt discriminated against because of their race. Black participants in one group in particular stated that Whites and Hispanics received better services and treatment than Blacks in the area. Several participants mentioned being ignored or not looked at by the MDs. *"They're looking at you and they're saying you're too damn stupid to go to the dentist, why are you here?"* Others voiced concerns about feeling disrespected. *"Well, I don't really have the patience to*

deal with the fact that you think I'm not significant so you're going to have me sitting here in pain for 4 or 5 hours, so, you know."

Nevertheless, participants generally (particularly in the rural areas) stated that they would return to the same place for treatment, not because the experience was positive, but because it was the only option to receive care. *"We don't have much choice. You pretty much have to. If you want any kind of help, that wouldn't be much, you're going to have to." "If I had a recurring problem, I would go to a different hospital, but, I would still rather just go to the dentist and try to deal with it."* Urban participants generally had more treatment options, with more hospitals to choose from and with nearby dental schools.

DISCUSSION

Overwhelmingly, pain from toothaches or more generalized jaw/face pain was the most frequent oral problem resulting in MD/ED visits. This finding is generally consistent with other reports (Cohen et al, 2008; Lockhart, Mason, Konen, Kent, & Gibson, 2000; Anderson, Richmond, & Thomas, 1999). Similarly, consistent with other reports, the severity of pain was the principal reason reported for seeking care from MDs/EDs rather than dentists, with financial barriers most often mentioned as the reason for not seeking dental care (Cohen et al, 2008; Lockhart, Mason, Konen, Kent, & Gibson, 2000). Across groups, financial barriers were the main reason for visiting MDs/EDs. Financial barriers to accessing needed dental services have long been recognized (U.S. Department of Health and Human Services, 2000). Also consistent with other reports, the participants indicated that they preferred seeking care from a dentist but could not due to financial and other barriers (Cohen et al, 2007; Cohen et al, 2008).

Participants' expectations of their MD/ED visit were generally consistent with the care they received; most participants didn't expect the MD/ED to provide care beyond antibiotics or pain medications. They considered MD/ED visits to be short-term fixes or "band-aids" for their problems. None of the participants reported receiving definitive care. Consideration should be given by hospitals, based on an analysis of their dental problem-related utilization, to incorporating a dentist into the ED staff. This would provide an opportunity for patients to receive more definitive care for their dental problem while at the same time alleviating the workload of the medical staff.

Few participants were satisfied with the information they received concerning their oral problem. Information relating to the cause of their problems or methods for preventing recurrence was lacking. It appears that MDs/EDs should increase their educational efforts. The importance of health literacy in reducing health disparities has received increased attention (National Institute of Dental and Craniofacial Research, 2005; Rudd & Horowitz, 2005). Ultimately, the vast majority of participants were told to visit a dentist. This pattern of treatment was consistent with that reported elsewhere (Cohen et al, 2008; Lockhart, Mason, Konen, Kent, & Gibson, 2000).

Nearly all of the participants stated that they sought care from an MD/ED aware that they would eventually need to see a dentist. This finding differed considerably from a state-wide survey of Maryland adults where only approximately one-third of the respondents seeing MDs reported needing follow-up care from a dentist (Cohen, & Cotton, 2006). This difference did not appear to be related to the nature of the presenting problems, which were similar in both studies, but may be related to differences in the selection of the survey sample, that is, random versus purposive.

Participants seeing MDs were generally more satisfied than those who visited EDs. Lengthy ED waits were particularly problematic. Somewhat paradoxically, although participants were aware that EDs would not provide definitive care, many appeared to resent that their ED visit

did not resolve their problem. Many Blacks expressed concerns about racial discrimination; they felt they received poorer care than Hispanics or Whites. Concerns about racial disparities in health care have increased (Institute of Medicine Committee, 2002; Like, Steiner, & Rubel, 1996). Evidence exists that providing culturally sensitive care may result in more effective treatment for racial/ethnic minorities (Tucker et al, 2003). In particular, efforts at improving care must address issues of respect and communication (Hobson et al, 2003).

These findings should be interpreted with caution. The results are based on the comments of a relatively small number of low-income individuals and therefore cannot be generalized to higher income groups or the population at large. The findings, however, reflect the views of low-income Hispanic, Black, and White populations in Maryland. Focus groups and other culturally appropriate methods are needed to identify relevant group-specific treatment patterns (Siriphant, 2001). This is particularly important when attempting to understand the factors that influence the care decisions of minority populations.

Many low-income/minority individuals with oral health problems are likely to continue to use MDs/EDs for treatment. This raises several issues. EDs usually lack dental services, and therefore do not provide definitive treatment (Burgess, Byers, & Dworkin, 1990). Similarly, MDs generally lack substantive dental training (Pennycook, Makower, Brewer, Moulton, & Crawford, 1993; Graham, Webb & Seale, 2000) and, therefore are unlikely to provide definitive treatment. Several reports have provided guidelines to MDs on the management of oral problems (Comer, Caughman, Fitchie, & Gilbert, 1989; Clark, Album, & Lloyd, 1995; Pyle & Terezhalmy, 1995); such guidelines have proven useful in the ED setting (Ma, Lindsell, Jauch, and Pancioli, 2004). More recently, several family practice residency programs have begun to provide emergency dental training including clinical experiences with tooth extraction (Beetstra et al, 2002; Jenkins, 2006). Such programs will undoubtedly enhance physician's ability to provide effective emergency dental services. Continued studies are needed to determine the adequacy of the management of oral problems by MDs/EDs.

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Table 1

Sociodemographic Background of Focus Group Participants (n=53)

	Number (%)
Age	
21–25	2 (3.8)
25–34	12 (22.6)
35–44	14 (26.4)
45–54	16 (30.2)
55–64	5 (9.4)
65 and over	4 (7.5)
Gender	
Male	12 (22.6)
Female	41 (77.4)
Race/Ethnicity	
White	13 (24.5)
Black	24 (45.3)
Hispanic	16 (30.2)
Highest Grade	
1–5	3 (5.7)
6–8	2 (3.8)
9–11	9 (17.0)
12	15 (28.3)
Some college or technical school	11 (20.8)
College graduate	13 (24.5)
Marital Status	
Married	21 (39.6)
Separated	5 (9.4)
Divorced	9 (17.0)
Widowed	4 (7.5)
Never Married	14 (26.4)
Income	
$5,000 or less	15 (28.3)
$5,001–$10,000	12 (22.6)
$10,001–$15,000	10 (18.9)
$15,001–$20,000	2 (3.8)
$ 20,001–$30,000	5 (9.4)
$30,001 or more	2 (3.8)
Don’t know	5 (9.4)
No response	2 (3.8)

Total percentages do not always equal 100% due to rounding.

Table 2

General Health Status and Dental Service Utilization Background of Participants

		African American (n = 24)		Hispanic (n = 16)		White (n = 13)		Total Participants (n = 53)	
Question	**Response**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**
How would you rate your overall health?	Excellent/Very Good	5	(20.8)	1	(6.3)	3	(23.1)	9	(17.0)
	Good	6	(25.0)	4	(25.0)	7	(53.8)	17	(32.1)
	Fair/Poor	13	(54.2)	11	(68.8)	3	(23.1)	27	(50.9)
How would you rate your dental health?	Excellent/Very Good	2	(8.7)	1	(6.3)	1	(7.7)	4	(7.7)
	Good	2	(8.7)	3	(18.8)	1	(7.7)	6	(11.5)
	Fair/Poor	19	(82.6)	12	(75.0)	11	(84.6)	42	(80.8)
Which statement describes the way you made visits to a dentist?	I never go/only go when I have a dental problem	15	(65.2)	13	(86.7)	11	(84.6)	39	(76.5)
	I go occasionally, (even if there is no problem)/ regularly (to have my teeth checked)	8	(34.8)	2	(13.3)	2	(15.4)	12	(23.5)
How long ago was your last visit to a dentist?	1 year ago or less	17	(70.8)	10	(62.5)	8	(61.5)	35	(66.0)
	More than 1 year ago	7	(29.2)	6	(37.5)	5	(38.5)	18	(34.0)
Which statement describes the way you made visits to a medical doctor?	I never go/only go when I have a medical problem	5	(20.8)	9	(56.3)	7	(53.8)	21	(39.6)
	I go occasionally, (even if there is no problem)/ regularly (for a physical exam)	19	(79.2)	7	(43.8)	6	(46.2)	32	(60.4)
How long ago was your last visit to a doctor?	1 year ago or less	21	(87.5)	15	(93.8)	13	(100.0)	49	(92.5)
	More than 1 year ago	3	(12.5)	1	(6.3)	0	(0.0)	4	(7.5)
Do you currently have health insurance or medical assistance?	Yes	12	(50.0)	5	(31.3)	9	(69.2)	26	(49.1)
	No	12	(50.0)	11	(68.8)	4	(30.8)	27	(50.9)

		African American (n = 24)		Hispanic (n = 16)		White (n = 13)		Total Participants (n = 53)	
Question	**Response**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**
If so, what type? (includes multiple responses)	Traditional	4	(26.7)	1	(20.0)	2	(22.1)	7	(24.1)
	Medical Assistance	7	(46.7)	4	(80.0)	6	(66.7)	17	(58.6)
	Medicare	4	(26.7)	0	(0.0)	1	(11.1)	5	(17.2)
Do you currently have dental insurance?	Yes	4	(16.7)	3	(18.8)	3	(25.0)	10	(19.2)
	No	20	(83.3)	13	(81.3)	9	(75.0)	42	(80.8)
How would you rate the pain from your most recent dental problem? (0 Mild – 10 Worst)	0 to 5	3	(13.6)	2	(15.4)	1	(9.1)	6	(13.0)
	6 to 8	4	(18.2)	4	(30.8)	3	(27.3)	11	(23.9)
	9 or 10	15	(68.2)	7	(53.8)	7	(63.6)	29	(63.0)

Cell counts not totaling 24 for African Americans, 16 for Hispanics, 13 for Whites, or 53 for the total are due to item non-respondents in the group. Percentages are based on the actual number responding to each question. Total percentages do not always equal 100% due to rounding.