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“Seniors only want respect”: designing an oral health program for older adults

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Abstract

Aims—Persistent socioeconomic disparities in the oral disease burden contribute to pain and suffering among vulnerable and underserved populations who face systemic barriers to accessing oral health care, including older adults living in disadvantaged urban neighborhoods. The aim of this study is to gain the views of racial/ethnic minority older adults regarding what they believe would support them and their peers in visiting the dentist regularly.

Methods and Results—Focus groups were conducted and digitally audio-recorded from 2013 to 2015 with 194 racial/ethnic minority women and men aged 50 years and older living in northern Manhattan who participated in one of 24 focus group sessions about improving oral health for

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Ethics Statement: This research has been performed in accordance with the Declaration of Helsinki. The Institutional Review Boards at the Columbia University Medical Center [protocol AAAL4104(M01Y04)] and the NYU School of Medicine (protocol i12-02947_CR4) reviewed and approved all study procedures and all Health Insurance Portability and Accountability Act safeguards were followed.

older adults. Analysis of the transcripts was conducted using thematic content analysis. The majority of recommendations from racial/ethnic minority older adults to help older adults go to the dentist regularly were centered at the organization and provider level. The preeminence of respectful treatment to racial/ethnic minority older adults may be useful to underscore in oral health programs and settings.

Conclusion—There is a need for greater engagement of and attention to patients and other stakeholders in developing, testing, and disseminating interventions to close the gaps in oral health care disparities.

Keywords

aging; racial/ethnic groups; oral health programs

Introduction

From an oral public health perspective, two important concerns regarding older adults are the persistent socioeconomic disparities in the oral disease burden and the inability of certain groups to access oral health care.^{1,2} While the number of US middle-aged and older adults experiencing edentulism has decreased over the past 50 years, high-income households experienced a greater relative decline than low-income households.³ On the other hand, trends in tooth decay for US middle-aged and older adults have remained relatively stable; still, men, non-Hispanic Blacks, Mexican Americans, and those with fewer years of education and lower levels of income continue to experience more tooth decay.⁴

Dental insurance is a primary indicator of access to oral health care.⁵ Using data from the 2008 National Health Interview Survey (NHIS), findings were that the majority (73%) of persons under age 65 years with private health insurance had some type of dental coverage, yet this translates to 45 million persons with no dental coverage.⁵ Not unexpectedly, as income level decreased, the percentage of persons having dental insurance also decreased.⁵ And while US states must provide limited dental benefits for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP), states are not required to provide dental benefits for adults enrolled in Medicaid, although most states do provide limited benefits or benefits to certain subgroups, such as pregnant women.^{6,7} Even in states such as New York that provide certain dental benefits, adult Medicaid beneficiaries may face high out-of-pocket costs, making it difficult or impossible for them to afford dental care.⁶

A number of recommendations have been made to better ensure that all older adults have access to oral health care. These include amending existing state laws to maximize access to oral health care for impoverished older adults by allowing oral and general health professionals to practice to the full extent of their education and training in a variety of settings that serve this vulnerable population.⁷ The purpose of this article is to provide the perspectives of racial/ethnic minority older adults living in disadvantaged urban neighborhoods regarding what they believe would help older adults go to the dentist regularly, toward improving community- and clinic-based programs that serve this population.

Methods

Details of the recruitment and data collection methods utilized in this qualitative study have been included in a series of papers that emanated from data collected as part of focus groups that were conducted with racial/ethnic minority older adults from 2013 to 2015 in northern Manhattan, New York.^{8–10} Methods that are specific to the current study are detailed below.

Ethical safeguards

The Institutional Review Boards at the Columbia University Medical Center [protocol AAAL4104(M01Y05)] and the New York University School of Medicine (protocol i12-02947_CR4) reviewed and approved all study procedures. All applicable Health Insurance Portability and Accountability Act (HIPAA) safeguards were followed in the conduct and analysis of this study.

Guiding theory

An ecological model titled, *Factors that influence disparities in access to care and quality of health care services, by level* was derived from a systematic review of the complex factors that influence health equity.¹¹ A simplified schematic of this model is provided in Figure 1 that highlights the guiding theory for the present study: the levels of influence (4: Policy and community; 3: Organization and provider; 1: Individual patient) and their associated intervention targets; the health care processes involved (interactions between Health care providers and Other organizational members and stakeholders); and the outcome of interest (Patient experiences of care).

Scientific approach

Focus groups were conducted with a sample of 194 racial/ethnic minority women and men aged 50 years and older living in northern Manhattan who participated in one of 24 focus group sessions about improving oral health for older adults. The investigators of the study selected focus groups over individual interviews because group discussions may facilitate greater disclosure by participants through reciprocity, i.e., disclosure by one participant may prompt greater disclosure by others.¹² Further, focus groups allow participants to respond to and elaborate on topics raised by fellow participants, thus facilitating discussion of a greater breadth and depth of topics.¹² Finally, focus groups may be less fatiguing than individual interviews, which may be particularly important when interviewing older adults.¹³

Focus group participants had to meet the following criteria: (1) aged 50 years or older; (2) attended a senior center or other community locale where older adults gather in northern Manhattan; (3) speak fluent English or Spanish; and (4) self-identify as African American, Dominican, or Puerto Rican (given the predominance of these population groups in the study area). The demographic characteristics of the focus group participants for the total sample and by gender are presented in Table 1.

Slightly more than half (53.6%) of the participants were women and just over one-third (37.1%) self-identified as African American, about one-third (35.6%) self-identified as Dominican, and just under one-third (27.3%) self-identified as Puerto Rican. In accordance

with the sampling strategy, no significant differences were found between women and men for age, race/ethnicity, time of last dental visit, or neighborhood of residence.

Participant recruitment

Field recruitment staff visited senior centers in northern Manhattan and directly approached older adults to explain the study, screen them for eligibility, and solicit participation in the focus groups. Senior centers were selected rather than places where older adults receive dental care in order to obtain a sample of individuals who did not necessarily have access to or seek dental care. Senior centers have been identified as important “third places” (as distinct from homes or “first places” and worksites or “second places”) where older adults may be targeted for health promotion activities.¹⁴ Third places are locations on neutral ground where people may gather, enjoy the company of others, and interact.¹⁴ Both field recruiters were bilingual in English and Spanish and possessed several years of experience working with racial/ethnic minority older adults and senior center directors in northern Manhattan.

To ensure geographic and demographic representation of northern Manhattan, approximately equal numbers of participants were recruited from senior centers in each of three northern Manhattan neighborhoods: Central/West Harlem (home to large numbers of African Americans), Washington Heights/Inwood (home to large numbers of Dominicans), and East Harlem (home to large numbers of Puerto Ricans). These three neighborhoods have historically been considered as racial/ethnic enclaves, and are communities with many recent immigrants and residents who qualify for Medicaid and other forms of public assistance. Further details of the recruitment and screening procedures are available elsewhere.¹⁵

Study units

The study design of 24 focus groups was selected *a priori* in order to obtain multiple groups of each demographic segment, thereby allowing conclusions about each demographic segment to be based on multiple focus group discussions rather than on a single focus group discussion. Consistent with standard focus group techniques,¹⁶ the groups were segmented based on important characteristics that may influence the issues discussed or the ability of the members to build rapport, namely, gender, ethnicity, language spoken (English or Spanish), and whether or not participants had visited a dentist in the past year. A total of 24 focus groups were conducted, including 12 groups of women and 12 groups of men. Within each gender set, four groups were conducted with African Americans, four groups were conducted with Dominicans, and four groups were conducted with Puerto Ricans. Within each gender/ethnic set, half of the groups were conducted with participants who had visited a dentist in the past year and half were conducted with participants who had not visited a dentist in the past year. Ten groups were conducted in English (including two groups with Puerto Ricans who preferred to speak English) and 14 groups were conducted in Spanish.

A total of 625 potential participants were screened for eligibility, of whom 564 were determined to be eligible to participate in a focus group. The 61 potential participants who were deemed to be ineligible for the study were excluded for the following reasons: ineligible ethnicity (n = 36); refused to sign the consent form or incomplete consent form (n

= 10); ill, blind, or incapacitated (n = 7); refused to answer the race/ethnicity question (n = 4); and younger than 50 years of age (n = 4).¹⁵ After accounting for those who were unable to be scheduled, not interested in participating, or whose gender/ethnic/dental care segment had been filled, a total of 277 older adults were scheduled to participate in a focus group. All told, 194 older adults (70.0%) actually attended a session, signed a written informed consent, and participated in a focus group. Details of the screening results, including the reasons for ineligibility and non-participation, are available elsewhere.¹⁵

Data collection

Focus groups were conducted with an average of eight participants per group [standard deviation (SD) = 2.4; range = five to 14 participants]. Group discussions were held from October 2013 through June 2015 in two locations (one in Central Harlem and one in Washington Heights) to better ensure that participants did not need to travel far from their residential neighborhoods to attend a session. Importantly, all participants were offered the services of a taxi driver to pick them up at their homes or at a senior center, bring them to the focus group, and take them home afterwards. This strategy was crucial in assuring focus group attendance, particularly for older adults with mobility problems.

The focus groups were conducted by one of two senior qualitative researchers, one of whom spoke fluent Spanish. The first author (I.E.) is an experienced bilingual (English and Spanish) moderator who ensured that signed consent forms were obtained from all participants, audio-recorded the focus group, took notes during the conversation, and provided honoraria to each participant upon completion of the group discussion. To facilitate a conversational environment, a catered meal and beverages were provided prior to the start of all focus groups. After the meal, the lead qualitative researcher explained the purpose of the study and all participants provided written informed consent. Next, the assembled researchers and older adults participated in a semi-structured focus group interview using techniques that were originated by Merton et al.¹⁷ and elaborated on by Krueger and Casey.¹⁶ The groups were conducted using an interview guide, also known as a questioning route,^{16,18} that consisted of a series of semi-structured questions¹⁷ designed to explore the community-, interpersonal-, and individual-level factors that serve as facilitators or barriers to obtaining oral health care.¹⁹

The current report is largely based on conversations among group participants in response to the following prompt and questions. “One of the goals of our meeting today is to help seniors go to the dentist regularly. If you were in charge of designing a program for seniors, with all the money and resources you wanted, what would it offer? Where would it be located?” In addition, other questions on the guide prompted discussion related to designing a program, including: “Is there anything that social service organizations do or could do to encourage or help seniors go to the dentist? (Probe: Information, Referrals, Transport, Financial Assistance)”

Focus groups lasted an average of 1.3 hours (SD = 13 minutes; range = 55 minutes to 1.7 hours). Each participant received \$30 after the focus group discussion was completed.

Data analysis

All groups were digitally audio-recorded and transcribed for analysis. Groups that were conducted in Spanish were first transcribed in Spanish and then translated into English. To ensure accurate transcription and translation, the first author (I.E.) who is bilingual (English and Spanish) and was present at all focus group sessions compared the transcripts against the original audio recordings. Analysis of the transcripts was conducted using thematic content analysis.^{20,21} In order to enhance the validity of the coding scheme, multiple members of the study team began the data analysis by each independently reading the focus groups transcriptions to ascertain the topics discussed. Next, the study team met to discuss the topics identified and construct a list of topic codes. Although many of the recognized topics were directly explored with questions in the interview guide, several of the original guide topics were collapsed and unanticipated codes were identified and included in the analysis. Consensus was achieved among the research team members on the topic codes.

One of the topic codes was “Service Suggestions (including any ideas for programs).” To isolate the text in which participants discussed this issue, all transcripts were read to ascertain instances where ideas for desired oral health programs and services for older adults were discussed, and relevant sections of the text were extracted from the transcripts. Next, pertinent quotes were organized according to the levels and intervention targets provided in Figure 1. Care was taken to ensure representation of quotes by gender, race/ethnicity, whether or not participants received dental care in the past year, and language spoken.

Results

Focus group findings related to individual patient (level 1) needs of racial/ethnic minority older adults toward improving access to oral health care and quality of services are presented in Table 2.

For the intervention target, Patient education and clinical care, two themes were identified: oral health education and patient-centered care for older adults. In support of oral health education, an African American man with dental care in the past year explained: “Teach them more about hygiene... Because our people don’t know...” Advocating for patient-centered care for older adults, an African American man without dental care in the past year recommended: “...it gotta be something there the process will be like a little quicker. Because if you go to these places and you sit there two or three hours—you ain’t even want to sit there... people ain’t want to do that, ‘cause a lot of them got walkers, they got wheelchairs.”

For the intervention target, Biological, sociodemographic, and psychological factors, the single theme identified was respectful treatment. The following quote from an African American woman without dental care in the past year memorably conveys its primacy: “Seniors only want respect. We paid our dues so we need respect and we’re not stupid. As she said we can understand if you just explain it.”

No focus group findings were related to family, friends, and social support (level 2) so this level was omitted from Figure 1. The only intervention target in the original ecological model¹¹ at level 2 is Ongoing support from family and friends.

Focus group findings related to policy and community (level 4) and organization and provider (level 3) needs of racial/ethnic minority older adults toward improving access to oral health care and quality of services are presented in Table 3.

For the intervention target, Neighborhood and community resources at the policy and community level, three themes were identified: neighborhood-based locations, bus and van services, and neighborhood-based providers. A Dominican woman without dental care in the past year supported neighborhood-based locations (translated from Spanish): “Well, it would have to belong to the area... that it be located at a convenient location.” A Puerto Rican woman with dental care in the past year suggested bus and van services (translated from Spanish): “...a small bus used by many centers here in Manhattan... They go pick up and drop off seniors... They will go wherever they have to take you.” Finally, an African American woman without dental care in the past year advocated for neighborhood-based providers: “...They say oh he’s here and he’s in your community, he’s blocks way or you can take the bus straight there. That helps you. Seniors need that.”

Most of the focus group findings about improving access to oral health care and quality of services were at the organization and provider level. For the intervention target, Organizational motivation, resources, staff attributes, climate, and teamwork, four themes were identified: dental schools, geriatric dentists, volunteer dental services, and language translation. A Dominican woman without dental care in the past year complimented a student at a dental school (translated from Spanish): “...a student took care of me. And he was very nice...” The need for geriatric dentists was recognized by an African American woman with dental care in the past year: “Geriatric ones, yeah, who will work with you... because there are... I see poor people who can’t even sit down. That they can help these folks...” Volunteer dental services were championed by an African American woman without dental care in the past year: “...doctor, certified doctor, certified dentist volunteer their time once a week or something on a Tuesday so and so will be here and so and so.” Finally, language translation was deemed essential to a Dominican woman without dental care in the past year (translated from Spanish): “And also that there be bilingual people there so they can help those seniors who don’t speak the language.”

The intervention target, Patient programs and services, insurance and affordability, and provider- and system-level supports encompassed six themes with overlap: health services center, health screening and monitoring, public insurance representatives, affordable rates, health information and exchange opportunities, and patient navigators. For instance, an African American woman without dental care in the past year recommended a health services center that provides health screening and monitoring: “I would suggest a one-stop screening center.” Public insurance representatives and affordable rates were also deemed vital. An African American man with dental care in the past year argued: “...what you need to do really if you are opening this program like you said the building, what you need to do is start talking to Medicare and Medicaid, so they can communicate with you all.” A

Dominican woman with dental care in the past year suggested (translated from Spanish): “Or offer payment plans so that [the] person doesn’t have access to have what they [want] done, and be able to pay for it.” A Puerto Rican woman without dental care in the past year believed in health information and exchange opportunities (translated from Spanish): “Communication [between patients and dental providers] is also very important.” Finally, a Dominican woman without dental care in the past year championed patient navigators: “... People who can orient you and help them get their things done.”

Discussion

This qualitative study adds to the public health dentistry literature by providing the perspectives of racial/ethnic minority older adults on what they believe would help older adults to go to the dentist regularly. To meaningfully address this question, it was important to sample older adults in third places¹⁴ rather than those seeking dental care to ensure representation of older adults who both received and did not receive dental care in the past year. Previous analyses of these data found that Medicaid recipients reported problems with affording copayments for care, complicated health and social issues, the need for vision and dental care close to home, and confusion about and stigmatization with Medicaid coverage.¹⁰ Yet these same older adults proposed strategies at multiple levels to address what they and their peers needed in order to access regular dental care. We are currently working with dental providers across institutions to improve local community-based oral health programs guided by these findings.

At the individual patient level, oral health education and patient-centered care for older adults were deemed essential, in concert with previous findings.^{22,23} The novel result of the preeminence of respectful treatment to racial/ethnic minority older adults may be useful to underscore in oral health programs and settings, above and beyond any emphasis on cultural sensitivity,²² cultural competency,²⁴ or cultural safety.²⁵ Dental and staff training ought to emphasize how critical it is to treat impoverished racial/ethnic minority older adults with dignity toward better ensuring they return for needed preventive care and dental treatment throughout their lives.

In contrast to a qualitative study of patients diagnosed with type 2 diabetes that found informal social networks were important in the everyday management of their disease,²⁶ the present study failed to identify themes directly related to family, friends, and social support, termed level 2 in our guiding theory.¹¹ This may be due to the way the questions were asked or the topic was discussed in the focus groups, even with prompts from the qualitative researchers. Another explanation is that older adults view monitoring their blood sugar as more important than obtaining oral health care,²⁷ a finding based on key informant interviews with senior center directors. Hence, they may not believe their oral health and health care needs merit such social support, perhaps because they view oral health as less of a priority than general health.

The majority of recommendations from racial/ethnic minority older adults to help older adults go to the dentist regularly were centered at the organization and provider level. This affirms recent research findings that the implementation of patient aligned care teams for

minority veterans varied with respect to the racial/ethnic composition of a facility.²⁸ In another study, facility factors accounted for 43% of the racial/ethnic disparity in delay of breast cancer diagnosis.²⁹ Thus, interventions that target the organization and provider level may likewise prove effective in improving access to dental care. The ideas that were offered by racial/ethnic minority older adults—including creating a health services (“one-stop”) center and utilizing a team approach to oral health care that includes public insurance representatives, health information and exchange opportunities, and patient navigators—call for a re-design of the oral health care system to meet the needs of vulnerable and underserved segments of US society that currently lack access to care.⁷ This might include reimbursing support staff such as public insurance representatives and patient navigators for their critical roles in ensuring that racial/ethnic minority older adults receive the dental benefits they are entitled to and are able to access the dental care they need.

Finally, the proposals of racial/ethnic minority older adults for improving access to oral health care at the policy and community level, i.e., neighborhood-based locations, bus and van services, and neighborhood-based providers, are consonant with calls to develop community-based models that encourage older people to improve and maintain their oral health.³⁰ Examples include dental school clinics that are both respected by racial/ethnic minority older adults and provide respectful dental care to community members,⁸ and community-based oral and general health screening programs for racial/ethnic minority adults.²⁷

The limitations of this study include that the focus group participants were recruited from third places¹⁴ in northern Manhattan and may not be generalizable to older adults who are institutionalized or living in other locales. Further, the participants self-identified as African American, Dominican, or Puerto Rican, and it cannot be known with certainty whether or not the experiences of other racial/ethnic older adults are consistent with the findings presented here. Finally, the topic on designing an oral health program for older adults was situated at the end of the topic guide, and participants may have been fatigued by the time these ideas were debated.

Notwithstanding these limitations, this qualitative study provides novel perspectives on ways to enhance the outcome of patient experiences of care. There is a need for greater engagement of and attention to patients and other stakeholders in developing, testing, and disseminating interventions to close the gaps in oral health care disparities.¹¹ We are currently funded on a feasibility and acceptability study using a community health worker model to improve access to oral health care for Chinese American adults. This study will leverage earlier research with the Sikh American community using a participatory model that successfully enrolled participants in dental coverage programs and located local dentists that accepted their insurance.^{31,32} Such models will provide guidance on improving access to care to for racial/ethnic minorities and underserved communities, including older adults, that may be adapted for diverse settings.

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Figure 1.

This graphic is derived from the conceptual model, *Factors that influence disparities in access to care and quality of health care services, by level* created from the analysis of findings from systematic reviews by Purnell et al.¹¹ The focus in this simplified schematic as well as in this article is on factors at the policy and community, organization and provider, and individual patient levels and their associated intervention targets that may result in improved patient experiences of care through community-based programs and service delivery. As no focus group findings were related to family, friends, and social support (level 2), this level was omitted from the figure.

Table 1

Characteristics of participants in focus groups for the total sample and by gender, New York, NY, 2013–2015.

Sample Statistics		Total Sample	Women	Men
Participants		N = 194	n = 104	n = 90
Focus groups		N = 24	n = 12	n = 12
Mean of age in years (standard deviation)		69.5 (10.0)	69.8 (10.3)	69.2 (9.7)
Characteristics		% (n)	% (n)	% (n)
Age group in years	50 – 54	9.3% (18)	8.7% (9)	10.0% (9)
	55 – 59	5.2% (10)	7.7% (8)	2.2% (2)
	60 – 64	17.5% (34)	13.5% (14)	22.2% (20)
	65 – 69	16.5% (32)	19.2% (20)	13.3% (12)
	70 – 74	20.1% (39)	17.3% (18)	23.3% (21)
	75 – 79	16.0% (31)	17.3% (18)	14.4% (13)
	80 – 84	8.2% (16)	7.7% (8)	8.9% (8)
	85 – 89	3.6% (7)	3.8% (4)	3.3% (3)
	90+	3.6% (7)	4.8% (5)	2.2% (2)
Race/ethnicity	African American	37.1% (72)	38.5% (40)	35.6% (32)
	Dominican	35.6% (69)	33.7% (35)	37.8% (34)
	Puerto Rican	27.3% (53)	27.9% (29)	26.7% (24)
Last dental visit	Within past year	54.1% (105)	52.9% (55)	55.6% (50)
	1–3 years ago	27.3% (53)	31.7% (33)	22.2% (20)
	>3 years ago	18.6% (36)	15.4% (16)	22.2% (20)
Primary language	English	42.3% (82)	46.2% (48)	37.8% (34)
	Spanish	48.5% (94)	45.2% (47)	52.2% (47)
	Both	9.3% (18)	8.7% (9)	10.0% (9)
Neighborhood	Inwood	6.7% (13)	12.5% (13)	0.0% (0)
	Washington Heights	27.3% (53)	18.3% (19)	37.8% (34)
	East Harlem	29.4% (57)	28.8% (30)	30.0% (27)
	Central Harlem	14.4% (28)	15.4% (16)	13.3% (12)
	West Harlem	11.9% (23)	16.3% (17)	6.7% (6)
	Other	10.3% (20)	8.7% (9)	12.2% (11)

Note: Women and men did not differ significantly on any of the characteristics listed above, in accordance with the sampling strategy.

Table 2

Focus group findings related to individual patient level needs of racial/ethnic minority older adults toward improving access to oral health care and quality of services, New York, NY, 2013–2015.

Intervention targets	Themes and representative quotes (focus group participant characteristics)
Patient education and clinical care	<p><i>Oral health education</i></p> <p>...if you teach them oral education and they start seeing what a bad mouth can do to the rest of the body... (African American women without dental care in the past year)</p> <p>...to have people come in who will talk and recommend for seniors to go to the dentist because of how important it is for their health... outreach. (Puerto Rican women with dental care in the past year, translated from Spanish)</p> <p>Teach them more about hygiene... Because our people don't know... You know, how to do different things. You know to help themselves... About how to take care of themselves... (African American men with dental care in the past year)</p> <hr/> <p><i>Patient-centered care for older adults</i></p> <p>...it gotta be something there the process will be like a little quicker. Because if you go to these places and you sit there two or three hours—you ain't even want to sit there... people ain't want to do that, 'cause a lot of them got walkers, they got wheelchairs. (African American men without dental care in the past year)</p> <p>It's for the seniors who don't have access to that... [a clinic for seniors because the needs are different] (Dominican women without dental care in the past year, translated from Spanish)</p> <p>...I would put in there the assurance to seniors that the materials used to do their dentures will be a little softer—not something so rough that it will bother them or that won't hurt them a lot at the beginning because they bother you a lot. Maybe made with a silicone that's softer, that attaches to the gum and that adjust to the gum... (Dominican women without dental care in the past year, translated from Spanish)</p> <p>Being a senior, they should have access to anything that they need for their mouth. If they need dentures, it should be done and over with. If they need a filling: it should be done and over with. Being a senior should, should qualify for those extra little benefits... (Puerto Rican women without dental care in the past year)</p> <p>To have a hall just for seniors like me. In other words, dental health services just for seniors my age... and for them to be able to do cosmetic work as well. (Puerto Rican women with dental care in the past year, translated from Spanish)</p>
Biological, sociodemographic, and psychological factors	<p><i>Respectful treatment</i></p> <p>Seniors only want respect. We paid our dues so we need respect and we're not stupid. As she said we can understand if you just explain it. Some things are modern or updated or tech, I don't know what the tech is. Never mind all of that. Come down basically and tell me well this is wrong and this may relate to this. We got a new process and it's not gonna hurt as much as it may be hurt 10 to 20 years ago. It's something new. You'll be alright. That's all I ask for. (African American women without dental care in the past year)</p> <p>We adapt very well to people who show us respect... Seniors like respect because we've paid our dues. We really have. We've suffered some real indignities and now that we've gotten older, they got worse. (African American men without dental care in the past year)</p> <p>...We've earned our stripes. We did the battle. We did everything. You know what I'm saying?... Just take care of seniors. Take care of us. We ain't got but a short time to be here anyway. So take care of me while I'm here. You know? (African American women with dental care in the past year)</p>

Table 3

Focus group findings related to policy and community level and organization and provider level needs of racial/ethnic minority older adults toward improving access to oral health care and quality of services, New York, NY, 2013–2015.

Intervention targets	Themes and representative quotes (focus group participant characteristics)
Policy and community level	
Neighborhood and community resources	<p><i>Neighborhood-based locations</i></p> <p>...you need to have a place where it's easy access for them to go. Not a long drawn out place for them to go. Something right there, where they might just have to go three blocks. (African American men without dental care in the past year)</p> <p>Well, it would have to belong to the area... that it be located at a convenient location. (Dominican women without dental care in the past year, translated from Spanish)</p> <hr/> <p><i>Bus and van services</i></p> <p>...a small bus used by many centers here in Manhattan... They go pick up and drop off seniors... They will go wherever they have to take you. (Puerto Rican women with dental care in the past year, translated from Spanish)</p> <p>...You wouldn't need to go to the dentist if there was a bus that comes to your house... In Puerto Rico they have buses that go for the elderly people to fix their teeth and everything. (Puerto Rican men with dental care in the past year, translated from Spanish)</p> <hr/> <p><i>Neighborhood-based providers</i></p> <p>...maybe even to work with some of the dentists that's in the neighborhood? (African American women with dental care in the past year)</p> <p>...They say oh he's here and he's in your community, he's blocks way or you can take the bus straight there. That helps you. Seniors need that. (African American women without dental care in the past year)</p>
Organization and provider level	
Organizational motivation, resources, staff attributes, climate, and teamwork	<p><i>Dental schools</i></p> <p>Or, the dental school work with and maybe on a certain day or certain time... (African American women with dental care in the past year)</p> <p>Even some of the doctors from the dental school, if they would be willing to come out and talk to you know the seniors or to have us come and meet some of them (African American women with dental care in the past year)</p> <p>...a student took care of me. And he was very nice... I have always gone to private dentists. And I went to get some dental work done. And he was very, very different. And it was a student... He sat me down, he found me the right place, talked to me, took x-rays—very nice. (Dominican women without dental care in the past year, translated from Spanish)</p> <hr/> <p><i>Geriatric dentists</i></p> <p>...those dentists who are specialized in aging populations. (Dominican women without dental care in the past year, translated from Spanish)</p> <p>Geriatric ones, yeah, who will work with you... because there are... I see poor people who can't even sit down. That they can help these folks... (African American women with dental care in the past year)</p> <hr/> <p><i>Volunteer dental services</i></p> <p>...doctor, certified doctor, certified dentist volunteer their time once a week or something on a Tuesday so and so will be here and so and so. (African American women without dental care in the past year)</p>

Intervention targets	Themes and representative quotes (focus group participant characteristics)
	<p>Get the dentist who want to volunteer their services. Who want to do, say if something costs a hundred dollars, they want to do a tenth of it. You know what I mean? (African American women with dental care in the past year)</p> <hr/> <p><i>Language translation</i></p> <p>They should speak Spanish. (Dominican women with dental care in the past year, translated from Spanish)</p> <p>And also that there be bilingual people there so they can help those seniors who don't speak the language. (Dominican women without dental care in the past year, translated from Spanish)</p>
Patient programs and services, insurance and affordability, and provider- and system-level supports	<p><i>Health services center</i></p> <p>I would suggest a one-stop screening center. One stop for everybody and you just go to the next office, go to the next office, didn't have to go out of the building... I think a one-stop center is the best thing that could happen to any community... People would just go, spend, take a morning and do all the screening and then once a month they'll do it or something or every other week. Because it's easy. They don't have to travel any place. (African American women without dental care in the past year)</p> <p>...Do you know what would help? That it wouldn't only be for dental, something else right there that calls a person's attention, because sometimes you go, it's like a store you go to buy one thing but shopping you see other things, you see? Something else, dental and I would add something else, I don't know what. (Dominican women with dental care in the past year, translated from Spanish)</p> <p>All kinds of doctors there. So they don't have to go to another place. I know that would be very attractive to seniors. (Dominican women without dental care in the past year, translated from Spanish)</p> <p>Walk in places that you going to and get certain things done. You don't have that no more. If people had a place set up for seniors, you could call it Senior Dental and they could just walk in there and believe me, it would make a big deal. (African American men without dental care in the past year)</p> <hr/> <p><i>Health screening and monitoring</i></p> <p>...That offered a screening of everything even if they're just a screening, okay. And, then I refer you back to your own dentist or back to a regular dentist. A screening is just the main thing people of our age like. Just screen us and tell us what they think is wrong, figures above that or that tooth should come out because it's doing that. (African American women without dental care in the past year)</p> <p>...That they would monitor your pressure. That they monitor your blood sugar. Imagine having a tooth taken out with elevated blood sugar. It won't heal. You can get infections... (Dominican men without dental care in the past year, translated from Spanish)</p> <hr/> <p><i>Public insurance representatives</i></p> <p>...have representatives from Medicaid and Medicare like that... if somebody on staff right there can sign them up or get them started on the process... (African American men without dental care in the past year)</p> <p>...what you need to do really if you are opening this program like you said the building, what you need to do is start talking to Medicare and Medicaid, so they can communicate with you all, so the people that you are going to have come there, already now that when you call, they already say we are going to do this, instead of sending them home for another 2 weeks, that in that building when we get there with our Medicare and Medicaid, are we still going to go through the same problems, are we going to another dentist, come back another week or two or we will call you when we are ready, what are you telling me different, nothing, think about it fellows. (African American men with dental care in the past year)</p> <hr/> <p><i>Affordable rates</i></p> <p>Or offer payment plans so that [the] person doesn't have access to have what they [want] done, and be able to pay for it. (Dominican women with dental care in the past year, translated from Spanish)</p> <p>I would give seniors a discount on work that they need to do and it's out of pocket. And that gives them a discount so that they would be able to afford it. (Puerto Rican women without dental care in the past year)</p>

Intervention targets	Themes and representative quotes (focus group participant characteristics)
	<p>Let's set it up so folks would make a contribution, like some people might make donations ... Whatever you can give. (Puerto Rican Women without dental care in the past year, translated from Spanish)</p> <hr/> <p><i>Health information and exchange opportunities</i></p> <p>...Also at the centers they should have someone able to explain things to you, someone who can answer your questions, that will take you to the different places, do presentations, so people can be informed of the things that are done there. Communication is also very important. (Puerto Rican women without dental care in the past year, translated from Spanish)</p> <p>I would build a specialized center in each community and make the community go to that center with the guarantee that when they come out of it, they will have all of the information at that center. If it's information for women and for men. Dental problems. Vision problems. Hearing problems. Breast problems for women and so on... (Dominican men with dental care in the past year, translated from Spanish)</p> <p>A program where they go and talk. Like this one, you come talk, you come explain, you know what I mean? In the way you are doing it. (Dominican women with dental care in the past year, translated from Spanish)</p> <hr/> <p><i>Patient navigators</i></p> <p>...People who can orient you and help them get their things done. Things they can't do on their own. And also, as she said, someone who will remind them and might also need to help them because she might be losing her balance. She's not remembering and her mind is faltering. And that would be good. (Dominican women without dental care in the past year, translated from Spanish)</p> <p>...That you raise awareness when you go to the doctor, and that someone there talks to you while you wait, giving you information so you will lose all fear of the dentist. (Dominican women without dental care in the past year, translated from Spanish)</p> <p>Since it's a center, it'd be important also to have people to can inform and educate seniors. To call: you have to come to the dentist if you are not there. You have to come see the doctor if you are not there. People who will orient and help guide the folks who need to get checked. That they have to go. Remind them of their appointments. (Dominican women without dental care in the past year, translated from Spanish)</p> <p>...if you have a good office, you have a follow up person. Ms. So and So did you go? How are you feeling today? People like hearing caring about them, you know, especially seniors... You know, you hire a clerk to follow up and you have a list... the follow up is important and the caring. It's just a way of caring for people, caring about their condition almost on a[n] individual basis. (African American women without dental care in the past year)</p>