Dental Care Survey of People with Disabilities

To determine the dental care needs of people with disabilities in Delaware

Complete the questions in the pages that follow and submit it in the self-addressed stamped envelope to:

Center for Disabilities Studies
University of Delaware

461 Wyoming Road
Newark, DE 19716

University of Delaware | Center for Disabilities Studies

Please note that you must be at least 18 years of age to complete this survey.

Thank you for agreeing to complete this survey.

The information you provide is likely to improve access to dental care and oral health services for Delawareans with disabilities. It will be used to develop training for the dentists and oral hygienists in Delaware to help them become more sensitive to the needs and preferences of people with disabilities.

All data will be combined to ensure that there is no possibility of identifying you and your answers.

Your participation is voluntary. You may skip any questions that you would prefer not to answer. Please note that, if you answer all of the questions, it will be very helpful to determine the dental care needs of Delawareans with disabilities.

If you have any questions about the survey or need assistance in completing the survey, please contact Katie Rosch Hegedus (302) 831-3206 (khegedus@udel.edu).

When you complete and return the survey, you will be considered as having consented to participate in the survey.

Thank you for your willingness to participate.

1. Do you live in Delaware? (Check ONE box.)

   ☐ Yes
   ☐ No [**STOP the Survey.**]

2. In which county do you primarily live? (Check ONE box.)

   ☐ New Castle County
   ☐ Kent County
   ☐ Sussex County

3. Are you male or female? (Check ONE box.)

   ☐ Male
   ☐ Female

4. What is your age?

   _____ years

5. In what type of setting do you live?

   ☐ My home or apartment
   ☐ Family's or relative's home
   ☐ Community-based group residence (group home, community-based intermediate care facilities, or agency-operated apartment-type setting)
   ☐ Nursing home or other long-term care setting
   ☐ Other [Please specify:_____]

Experience with Access to Dental Care and Services

6. Is there a dentist you usually go to for your dental care? (Check ONE box.)

   ☐ Yes
   ☐ No **[Go to Question 17]**

7. How long have you been going to this dentist for dental care? (Check ONE box.)

   ☐ 1 year or less
   ☐ More than 1 year and up to 2 years
   ☐ More than 2 years and up to 5 years
   ☐ More than 5 years and up to 10 years
   ☐ More than 10 years

8. How do you usually get to this dentist? (Check ONE box.)
   ☐ Drive
   ☐ Am driven by a caregiver/family member/friend
   ☐ Taxi, bus, train, other public transportation including paratransit
   ☐ Walk
   ☐ Some other way

9. How long does it usually take to go to this dentist from your home? (Check ONE box.)

   ☐ Less than 30 minutes
   ☐ 31 to 60 minutes (1 hour)
   ☐ 61 to 90 minutes
   ☐ 91 to 120 minutes (2 hours)
   ☐ More than 2 hours

10. How many different dental offices/facilities did you visit before finding your current dentist? (Check ONE box.)

    ☐ None
    ☐ One
    ☐ Two to five
    ☐ Six to nine
    ☐ 10 or more

11. What type of facility do you primarily go to for your dental care? (Check ONE box.)

    ☐ Hospital
    ☐ Community health center
    ☐ Private general practice
    ☐ Private dental practice
    ☐ Hospital emergency room

12. Is the facility physically accessible regarding the following? (Please circle ONE answer for each statement.)

Parking spaces (For example, is wheelchair accessible parking available?)	Yes	No	Don't Know
Office space (For example, is there sufficient clear floor space for people using a wheelchair or other mobility device to turn?)	Yes	No	Don't Know
Dental equipment (For example, are exam tables/chairs for dental examinations/procedures accessible?)	Yes	No	Don't Know

13. Does the facility provide you with accommodations for communication with a dentist or other oral health professionals, if needed? (Check ONE box.)

    [Note: Accommodations can include communication devices, large print, braille, interpreter, etc.]

    ☐ Yes
    ☐ No
    ☐ Accommodations not needed

14. **During the past 12 months**, how often did your dentist or other oral health professionals listen carefully to you? Would you say…? (Check ONE box.)

    ☐ Never
    ☐ Sometimes
    ☐ Usually
    ☐ Always

15. **During the past 12 months**, how often did your dentist or other oral health professionals make it easy for you to ask questions or raise concerns? (Check ONE box.)

    ☐ Never
    ☐ Sometimes
    ☐ Usually
    ☐ Always

16. In general, how satisfied are you with the dental care you received **during the past 12 months**? Would you say…? (Check ONE box.)

    ☐ Very satisfied **[Go to Question 18]**
    ☐ Somewhat satisfied **[Go to Question 18]**
    ☐ Less satisfied **[Go to Question 18]**
    ☐ Not at all satisfied **[Go to Question 18]**
    ☐ No dental service received **[Go to Question 18]**

17. What is the **main** reason you do NOT have a dentist you usually go to for dental care? (Check ONE box.)

    ☐ Seldom or never need dental care
    ☐ Could not afford care
    ☐ Do not know where to go for dental care
    ☐ No accommodation available for communication with dentist
    ☐ Dentist's office/clinic or dental equipment (for example, dental chair) not physically accessible
    ☐ Cannot find a dentist who is competent in working with individuals with disabilities
    ☐ My fear, apprehension, nervousness, or dislike of going to a dentist
    ☐ Concern that I will have trouble controlling my behavior
    ☐ Other [Please specify:_____]

18. **During the past 12 months**, were you **delayed** in getting dental care, tests, or treatments you or a dentist believed necessary? (Check ONE box.)

    ☐ Yes
    ☐ No [**Go to Question 20**]

19. What was the **main** reason you were **delayed** in getting dental care, tests, or treatments you or a dentist believed necessary? (Check ONE box.)

    - ☐ Could not afford care
    - ☐ Dentist's office/clinic or dental equipment (for example, dental chair) not physically accessible
    - ☐ Dentist too far away from where I live
    - ☐ No transportation
    - ☐ No appointments available
    - ☐ No accommodation available for communication with dentists or oral health professionals
    - ☐ Could not get time off work
    - ☐ Did not know where to go to get care
    - ☐ Fear, apprehension, nervousness, or dislike of going to a dentist
    - ☐ Concern that I will have trouble controlling my behavior
    - ☐ Need for anesthesia
    - ☐ Other [Please specify:_____]

20. **During the PAST 12 months**, did you see a dental specialist for your dental care/treatment? (Check ONE box.)

    [Note: Dental specialists can include orthodontists, periodontists, or oral surgeons.]

    - ☐ Yes
    - ☐ No [**Go to Question 22**]

21. Where did you see a dental specialist for your dental care/treatment **during the past 12 months**? (Check **ALL** that apply.)

    - ☐ Delaware
    - ☐ Maryland
    - ☐ Pennsylvania
    - ☐ New Jersey
    - ☐ Other state [Please specify:_____]

22. **During the past 12 months**, how many times have you gone to a **HOSPITAL EMERGENCY ROOM** because of any kind of dental care or dental pain? (Check ONE box.)

- ☐ None
- ☐ Once
- ☐ 2-3 times
- ☐ 4 times or more

23. About how long has it been since you last visited a dentist or a dental clinic for any reason? Include visits to dental specialists, such as orthodontists, periodontists, or oral surgeons. (Check ONE box.)

- ☐ Within the past year (anytime less than 12 months ago)
- ☐ Within the past 2 years (1 year but less than 2 years ago)
- ☐ Within the past 5 years (2 years but less than 5 years ago) **[Go to Question 25]**
- ☐ 5 or more years ago **[Go to Question 25]**
- ☐ Never **[Go to Question 25]**

24. What services did you receive during the last visit? (Check **ALL** that apply.)

- ☐ General exam, checkup or consultation
- ☐ Dental cleaning
- ☐ Sealant (thin layer of plastic coating painted onto teeth to prevent tooth decay)
- ☐ Fillings or inlays
- ☐ Dental crowns (cap that covers tooth), or dental bridge (device that bridges the gap created by one or more missing teeth)
- ☐ Dentures (false teeth which can replace missing teeth and that you can take out and clean daily) or removable partial dentures
- ☐ Root canal (removal of the nerve from inside the root of a permanent tooth)
- ☐ Periodontal scaling or root planing (deep tooth cleaning and removal of hard and soft deposits from teeth above and below gums)
- ☐ Follow-up visit for periodontal (gum) disease management
- ☐ Extraction (tooth pulled)
- ☐ Abscess or infection treatment
- ☐ Other oral surgery (mouth surgery)
- ☐ Braces or teeth straightening
- ☐ Treatment for temporomandibular joint disorders (pain in jaw joint and jaw muscles)
- ☐ Emergency treatment (for example, broken tooth, pain, etc)
- ☐ Other [Please specify:_____]

25. Do you have any kind of insurance coverage that pays for some or all of your routine dental care, including dental insurance, prepaid plans such as Health Management Organizations (HMOs), or government plans such as Medicaid? (Check ONE box.)

    [Note: Routine dental care can include diagnostic and preventive services such as dental exams, x-rays and cleanings, as well as basic services such as fillings or simple tooth pulling.]

    - ☐ Yes
    - ☐ No

26. Which of the following is your best estimate of the total combined income of your household in 2015, including income from all sources such as wages, salaries, Social Security or retirement benefits, and so forth? (Check ONE box.)

    - ☐ Less than $15,000
    - ☐ $15,000 to less than $25,000
    - ☐ $25,000 to less than $35,000
    - ☐ $35,000 to less than $50,000
    - ☐ $50,000 to less than $75,000
    - ☐ $75,000 or more
    - ☐ Do not know

27. This question is about the amount of money paid **during the past 12 months** for your dental care. **During the PAST 12 MONTHS**, about how much did you or your family spend out of pocket for your dental care? (Check ONE box.)

    [Note: Please do NOT include health insurance premiums (money you pay every month to have insurance), over the counter drugs (medicines you can purchase without doctors' orders), or costs for which you were or will be reimbursed (paid back).]

    - ☐ Nothing ($0)
    - ☐ Less than $500
    - ☐ $500 to less than $2,000
    - ☐ $2,000 to less than $3,000
    - ☐ $3,000 to less than $5,000
    - ☐ $5,000 or more
    - ☐ Do not know

28. Have you received sedation (being made calm or sleepy by use of drugs) for your dental treatment in the past? (Check ONE box.)

    ☐ Yes
    ☐ No **[Go to Question 31]**

29. If you have received sedation (being made calm or sleepy by use of drugs) for dental treatment, what type of sedation was used? (Check **ALL** that apply.)

    ☐ General anesthesia (put completely to sleep)
    ☐ Sedation (given gas or medicine to make you sleepy)
    ☐ Local anesthesia (applied or injected medicine to numb a specific area in the mouth)

30. Where did you receive the anesthesia or sedation (being made calm or sleepy by use of drugs)?

    ☐ Private dental office/clinic
    ☐ Hospital
    ☐ Outpatient surgical center
    ☐ Other [Please specify:_____]

31. How confident are you filling out medical/dental forms by yourself? (Check ONE box.)

    ☐ Extremely confident
    ☐ Quite confident
    ☐ Somewhat confident
    ☐ A little confident
    ☐ Not at all confident

Oral Health Status and Care

32. How would you describe the condition of your mouth and teeth? (Check ONE box.)

    ☐ Excellent
    ☐ Very Good
    ☐ Good
    ☐ Fair
    ☐ Poor

33. How many of your permanent/adult teeth have been removed because of tooth decay, infection, or gum disease? Do not include teeth lost for other reasons, such as injury or getting braces. (Check ONE box.)

    ☐ None
    ☐ 1 to 5
    ☐ 6 or more, but not all
    ☐ All

34. How often do you limit the kinds or amounts of food you eat because of problems with your teeth or dentures (false teeth which can replace missing teeth and that you can take out to clean daily)? Would you say…? (Check ONE box.)

    ☐ Very often
    ☐ Fairly often
    ☐ Occasionally
    ☐ Hardly ever
    ☐ Never

35. How often **during the past 12 months** have you had difficulty doing your usual jobs or attending school because of problems with your teeth, mouth or dentures? Would you say…? (Check ONE box.)

    ☐ Very often
    ☐ Fairly often
    ☐ Occasionally
    ☐ Hardly ever
    ☐ Never

36. **During the past 6 months**, have you had any of the following problems? (Please circle ONE answer for each statement.)

A toothache or sensitive teeth?	Yes	No
Bleeding gums?	Yes	No
Receding gums?	Yes	No
Broken or missing teeth?	Yes	No
Loose teeth not due to an injury?	Yes	No
Broken or missing fillings?	Yes	No
Difficulty eating or chewing?	Yes	No
Dry mouth?	Yes	No

37. **In the last seven days**, how many days did you brush your teeth with or without help from another person? **[0-7 days]**

    - _____ day(s)

38. **In the last seven days**, how many days did you use dental floss or any other device to clean between your teeth with or without help from another person? **[0-7 days]**

    - _____ day(s)

Disabilities and Health Conditions

39. Are you deaf or do you have serious difficulty hearing? (Check ONE box.)

    □ Yes
    □ No

40. Are you blind or do you have serious difficulty seeing, even when wearing glasses? (Check ONE box.)

    □ Yes
    □ No

41. Do you have serious difficulty walking or climbing stairs? (Check ONE box.)

- ☐ Yes
- ☐ No

42. Do you use any aids such as a walker, grab bars in the bathtub or any other special equipment for personal care or everyday activities (because of an impairment or a physical or mental health problem)?

- ☐ Yes
- ☐ No

43. Has a doctor, health care provider, teacher, or school official ever told you that you have any of the following conditions? (Check **ALL** that apply.)

- ☐ Speech or language impairment
- ☐ Epilepsy or seizures
- ☐ Learning disability
- ☐ Intellectual disability, also known as mental retardation
- ☐ Autism
- ☐ Asperger's syndrome
- ☐ Cerebral palsy
- ☐ Down syndrome
- ☐ Developmental disabilities other than learning disability, intellectual disability, autism, Asperger's syndrome, cerebral palsy, or down syndrome
- ☐ Traumatic brain injury
- ☐ Spinal cord injury
- ☐ Muscular dystrophy
- ☐ Attention Deficit Disorder (ADD) or Attention Deficit Hyperactive Disorder (ADHD)
- ☐ Asthma
- ☐ Other respiratory disease (e.g., lung cancer, chronic obstructive pulmonary disease [COPD], etc.)
- ☐ Angina or coronary heart disease
- ☐ Depressive disorder (including depression, major/clinical depression, dysthymia, or minor depression)
- ☐ Heart attack (myocardial infarction)
- ☐ High blood pressure (hypertension)
- ☐ Congenital heart disease
- ☐ Diabetes [Note: Do NOT include pre-diabetes or borderline diabetes]

44. Because of a physical, mental, or emotional condition such as those listed in Questions 39-43, do you have serious difficulty concentrating, remembering, or making decisions? (Check ONE box.)

    ☐ Yes
    ☐ No

45. Do you receive help or supervision with personal care such as bathing, dressing or getting around the house because of an impairment or a physical or mental health problem such as those listed in Questions 39-43? (Check ONE box.)

    [Note: If you receive help or supervision in any of the activities mentioned above, please choose YES.]

    ☐ Yes
    ☐ No

46. Do you receive help or supervision using the telephone, paying bills, taking medications, preparing light meals, doing laundry, or going shopping because of an impairment or a physical or mental health problem such as those listed in Questions 39-43? (Check ONE box.)

    [Note: If you receive help or supervision with any of the activities mentioned above, please choose YES.]

    ☐ Yes
    ☐ No

47. Are you limited in any way in the ability to work at a job, do housework, or go to school because of an impairment or a physical or mental health problem such as those listed in Questions 39-43? (Check ONE box.)

    [Note: If you are limited in any of the abilities mentioned above, please choose YES.**]**

    ☐ Yes
    ☐ No

48. Are you limited in participating in social, recreational or family activities because of an impairment or a physical or mental health problem such as those listed in Questions 39-43? (Check ONE box.)

    [Note: If you are limited in <u>any of the activities mentioned above</u>, please choose YES.**]**

    - ☐ Yes
    - ☐ No

49. In general, how would you describe your health? (Check ONE box.)

    - ☐ Excellent
    - ☐ Very good
    - ☐ Good
    - ☐ Fair
    - ☐ Poor

Demographic Information

50. Are you of Hispanic, Latino/a, or Spanish origin? (Check ONE box.)

    - ☐ Yes
    - ☐ No

51. Which one or more of the following would you say is your race? (Check **ALL** that apply.)

    - ☐ White
    - ☐ Black or African American
    - ☐ Asian
    - ☐ American Indian or Alaska Native
    - ☐ Native Hawaiian or Pacific Islander
    - ☐ Other [Please specify: _____]

52. Are you now...? (Check ONE box.)

- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated
- ☐ Never married
- ☐ Living with someone without marrying

53. What is the highest grade or year of school you completed? (Check ONE box.)

- ☐ Up to Grade 11 (Not completed high school)
- ☐ Grade 12 or GED (High school graduate)
- ☐ 1 to 3 Years of College (Some college or community college)
- ☐ 4 Years of College or more (College graduate)

54. Which of the following best describes your current employment status? (Check ONE box.)

- ☐ Employed full-time for wages
- ☐ Employed part-time for wages
- ☐ Self-employed
- ☐ Out of work
- ☐ A homemaker
- ☐ A student
- ☐ Retired
- ☐ Unable to work

Thank you for taking the time to complete this survey. The information you have shared will be used to develop training for the dentists and oral hygienists in Delaware. This training will help them become more sensitive to the needs and preferences of people with disabilities.

Use this space below to provide additional comments or concerns you have about your access to dental care and oral health services in Delaware.

If you have any further questions about this survey, please contact Katie Rosch Hegedus at 302-831-3206 or by email at khegedus@udel.edu.

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