PERCEPTIONS OF DENTAL CARE EXPERIENCES AND HEALTH TECHNOLOGY READINESS IN TENNESSEE

AIDPH
AMERICAN INSTITUTE OF DENTAL PUBLIC HEALTH

harmony health™

REPORT CONTRIBUTORS

AUTHORS & EDITORS

Annaliese Cothron, DHSc, MS, CPH
Co-Founder & Executive Director // AIDPH

Kendra Flowers, RDH, MSDH
Interim Executive Director // Harmony Health

Tina Saw, BA, DDS
Founder & CEO // Oral Genome

Elizabeth Couture
Graphic Design and Production Specialist // AIDPH

Christine Coffey
Director of Communications // AIDPH

ACKNOWLEDGEMENTS

This research and report was commissioned and funded by the Tennessee Department on Disability and Aging.

SUGGESTED CITATION

The American Institute of Dental Public Health and Harmony Health Foundation. Perceptions of Dental Care Experiences and Health Technology Readiness in Tennessee. Chicago, IL: November 2025. https://doi.org/10.58677/CNRQ1093

BACKGROUND AND PURPOSE

Tennesseans deserve good oral health and well-being. Oral healthcare access and outcome metrics indicate that Tennesseans struggle to maintain optimal oral health, pay too much out of pocket for care, and often do not access or utilize dental care effectively. Poor oral health often creates poor overall health, generating cardiovascular concerns, exacerbating diabetes, and even impacting employability. Certain marginalized groups, like people with disabilities, are often more impacted by social and structural barriers to dental care, as a result, have disproportionately poorer oral health outcomes. This project sought to understand self-reported oral health behaviors, assess readiness for technology-supported oral healthcare, and identify pervasive oral healthcare barriers that Tennesseans experience.

Developmental disabilities, as defined by the Centers Access to Care and Oral Health Outcomes

Tennessee offers dental care to children and adults through TennCare, the state Medicaid program.[1] The Tennessee Department of Health also offers comprehensive and emergency dental services to children and adults through health department dental clinics located in rural counties.[2] Data from the 2024 Behavioral Risk Factor Surveillance System (BRFSS) indicate that nearly 66% of adults nationally visited a dentist or dental clinic in the last year. In Tennessee, only 64% of Tennesseans without disabilities and 47% of those with disabilities reported annual dental visits.[3,4] Positive trends have been observed over the past decade among Tennessee seniors, with increases in dental visits leading to a decrease in dental disease.[5] Despite the increase in dental visits, over 18% of aging Tennesseans are edentulous, the ultimate outcome of profound oral disease.[6] Taken together, data indicate that Tennesseans access dental care on par with national indicators; however, subgroups of Tennesseeans experience higher barriers to care and, as a result, have poorer oral health.

The Role of Technology in Oral Health and Hygiene

Technology can support oral health and hygiene between dental visits. While still an emerging field, promising observations underscore the readiness of many communities to adopt technology into their health practices. Dental patients are responsive to the use of "E-Oral Health Technologies" to facilitate health and improve access to care.[7] For specific populations, like people with intellectual and developmental disabilities (IDD), technology can reduce feelings of anxiety and provide effective oral health guidance for both patients and caregivers.[8] Adoption of mobile apps in healthcare broadly and dental care has explicitly steadily increased over the past decade, creating opportunities to leverage both consumer readiness and technology development to facilitate oral health and hygiene.[9] To date, technology readiness within the general Tennessee population has not been assessed. This project evaluates consumer-reported attitudes toward mHealth technology and the ability to adopt technology-supported oral healthcare within the state of Tennessee.

Purpose

A survey was developed and administered to a sample of Tennessee residents to assess oral health outcomes, dental care utilization patterns, attitudes and beliefs about dental care quality, and perceptions of technology-assisted oral healthcare, including the use of mHealth applications.

The following questions guided the survey development, data collection, and data interpretation for this project:

1. How do Tennesseans perceive the quality and cost of their dental care?
2. How does dental insurance influence the perceived quality and cost of dental care access and utilization in Tennessee?
3. How does disability status impact self-reported oral health outcomes and utilization patterns?
4. Are Tennesseans ready to adopt technology solutions for oral health and hygiene?

A sample of 1,043 respondents was recruited through a market research firm to complete a survey evaluating perceptions of dental care, personal beliefs around technology and healthcare access, and connections to people with intellectual and developmental disabilities (IDD). The purpose of this survey was to assess attitudes toward oral health availability and affordability among the general population in Tennessee, while also considering a subpopulation of respondents with a connection to a person with IDD.

METHODOLOGY

A total of 1,043 respondents participated in a statewide survey designed to evaluate Tennesseans' perceptions of dental care, personal beliefs around technology and healthcare access, and connections to people with intellectual and developmental disabilities (IDD). The purpose of this survey was to assess public attitudes toward the availability, affordability, and accessibility of oral health care across Tennessee, and to examine a subpopulation of respondents with personal or familial connections to individuals with IDD.

Participants were recruited by a market research firm using a proprietary research panel. Sampling procedures were structured to approximate the demographic composition of Tennessee's adult population, accounting for factors such as age, gender, and geographic region. Eligibility criteria included residency in Tennessee and age 18 or older. Respondents participated voluntarily after providing informed consent. The survey was administered over a three-week period, with the majority of respondents completing the questionnaire electronically and a smaller subset completing it by phone. All participants were drawn from an established panel database and were compensated according to standard panel protocols. The firm applied quality control measures to ensure valid responses, including verifying participant eligibility and removing incomplete surveys.

The questionnaire consisted of 17 items. Six items were Likert-style measures assessing agreement or frequency on a five-point scale, nine captured demographic characteristics, and two were open-ended questions that requested elaboration on personal experiences and beliefs. Attitudinal and experiential items were presented as a matrix of statements rated on a five-point Likert scale ranging from strongly disagree to strongly agree.

For the purposes of cross-tabulation and ease of interpretation, responses were collapsed into binary categories (agree vs. disagree) for final analysis. Respondents who selected "not applicable" were excluded from item-level calculations.

Survey items were informed by validated public health instruments, including existing measures of oral health access, affordability, and technology readiness, and supplemented with new items specific to Tennessee's oral health environment. Participation was anonymous and voluntary, and all data were de-identified prior to analysis. Responses were stored on secure, password-protected servers accessible only to the research team.

Quantitative data were analyzed using descriptive statistics to summarize population trends and identify differences across subgroups, including insurance status and connection to an individual with IDD. Cross-tabulations and frequency analyses were used to explore relationships between variables. Open-ended responses were reviewed qualitatively and used to contextualize quantitative findings through illustrative quotes and thematic observations.

RESULTS

Demographics

The final analytic sample included 1,043 Tennessee respondents aged 18 years and older. Educational attainment varied widely among respondents: approximately one-third reported a high school diploma or equivalent, one-third reported some college or an associate degree, and just under one-third reported a bachelor's degree or higher. Overall, this distribution represents slightly lower educational attainment compared to national benchmarks but does not reflect substantial deviation from state-level patterns.

Employment characteristics indicated a comparatively lower rate of full-time employment (44.5%) in this sample and a higher proportion of individuals reporting unemployment (12.5%) compared to state and national averages. Among respondents who selected "other" for employment status, qualitative comments indicated that these individuals were primarily receiving Social Security or disability benefits, suggesting functional unemployment. Collectively, these findings indicate a sample with elevated unemployment and economic vulnerability relative to the general population.

Access to smartphone technology and the number of devices respondents owned were evaluated. Respondents reported owning an average of 2.49 electronic devices (e.g., smartphones, tablets, or computers). This response is consistent with Pew Research Center findings on national technology ownership and use, indicating a representative panel related to technology use and access.[10]

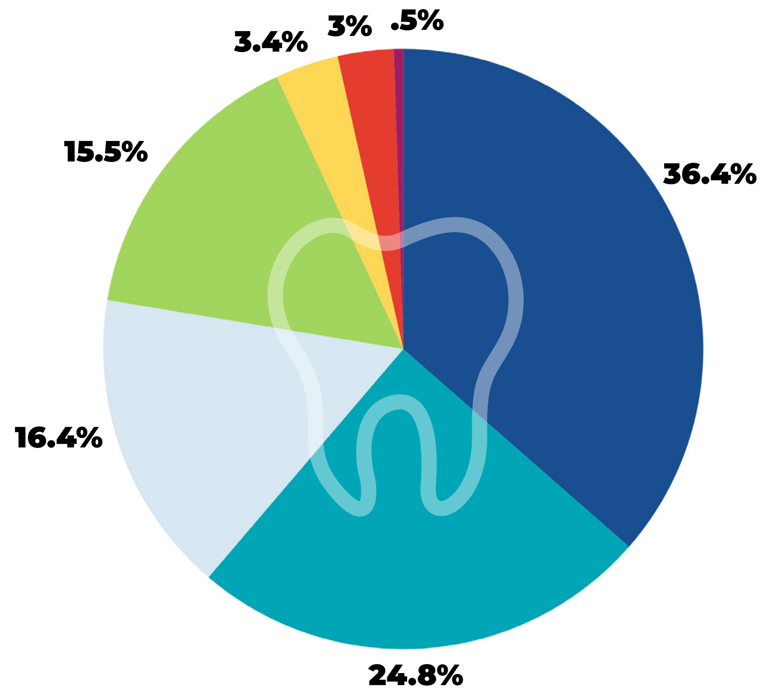
Approximately 65% of respondents reported either having a disability themselves or maintaining a close relationship with someone who has a disability, which aligns with national prevalence estimates for households affected by disability. A little over one-third of respondents indicated a close relationship with someone with an intellectual or developmental disability (IDD). Among this subgroup, the most common connection type was as a family member, representing about one-quarter of the overall sample.

Dental Care Access and Utilization Patterns

Dental insurance coverage varied across the sample. The number of Tennesseans without dental insurance (24.7%) was higher than national estimates, an expected trend given the elevated unemployment rate in this cohort. Conversely, private insurance coverage was lower than average, while public insurance enrollment (e.g., Medicaid or other government-sponsored plans) was also below national levels.[11] Most respondents (65.3%) receive dental care in a private dental office, which mirrors national trends. Nearly 17% of respondents indicated that they do not typically go to the dentist, which is an unexpectedly low indication of dental care utilization.

Overall, respondents reported mixed experiences with accessing and affording dental care in Tennessee. Approximately 65.4% agreed that it was easy to find a dentist who accepted their insurance plan, and 62.7% reported that they could obtain an appointment when needed. Fewer respondents (59.4%) reported being able to manage out-of-pocket dental costs even with insurance coverage, suggesting persistent affordability challenges. When asked about their dental care utilization in the past year, 63.1% of respondents reported a routine dental visit. One in five (21.0%) reported dental pain or infection during the past year, and a similar proportion (18.8%) reported self-medication to manage a dental problem. Shockingly, 5.8% reported self-extracting a tooth to relieve pain. Use of emergency medical settings for dental problems was also substantial: 12.2% of respondents reported seeking care in an emergency department or urgent care center, a rate more than twice the national average for non-traumatic dental visits.[12]

Dental Insurance Type



- **Private insurance through an employer**
- **No dental insurance**
- **Medicare/MA**
- **Medicaid/TennCare**
- **Subscription/Membership plan**
- **VA or DoD Dentist**
- **Other**

1 in 5

reported **dental pain or infection** during the past year

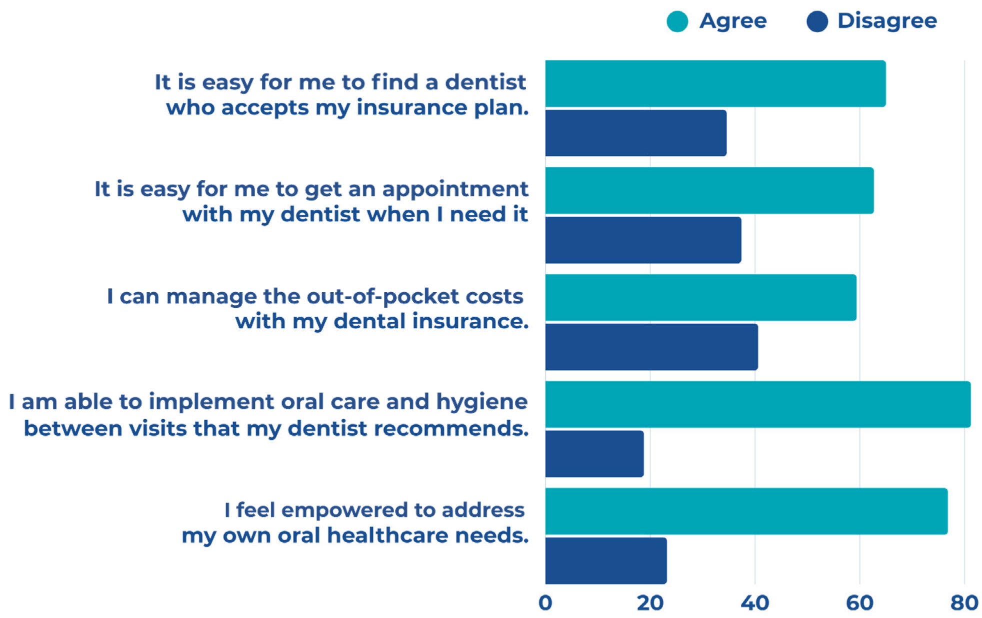
18.8%

reported **self-medication** to manage a dental problem

5.8%

reported **self-extracting a tooth** to relieve pain

Respondent's Attitudes Toward Dental Care Access and Self Care



In contrast, self-efficacy and preventive care behaviors were rated more positively. A large majority (81.2%) reported that they were able to implement oral hygiene practices recommended by their dentist between visits, and 76.8% felt personally empowered to address their oral health needs. Only 8.2% of respondents indicated difficulty affording basic dental hygiene products, indicating that oral hygiene resources are perceived as both affordable and accessible.

17%

of Medicaid beneficiaries **reported visiting an emergency department or urgent care for dental issues within the past year**- which is

5 to 6

TIMES HIGHER

than national estimates.

EMERGENCY VISITS

among uninsured and privately insured respondents **were also elevated;**

(13.2% and 9.4%)

suggesting systemic barriers that lead to delayed or crisis-driven care.

Dental Insurance Influence on Access and Outcomes

Dental insurance type was analyzed in relation to respondents' reported access to care, utilization patterns, and oral health experiences. Insurance status was recoded into four primary categories—none, Medicaid, Medicare, and private/employer-sponsored coverage—with a small number of respondents grouped under "other." Likert-style items were collapsed into binary agree/disagree responses for analysis, and cross-tabulations were used to assess relationships between insurance type and selected outcomes.

Across all groups, a private dental office was the most common setting for receiving care, though patterns differed markedly by insurance type. Nearly 89% of privately insured respondents typically sought care in private practices, compared to 69% of those with Medicare, 48% with Medicaid, and 42% of uninsured respondents. Respondents covered by Medicaid or without insurance reported the most diverse range of care settings, including free clinics, community health centers, and mobile units, or indicated that they did not typically visit a dentist at all. Approximately one-third of Medicaid respondents reported either not going to the dentist or seeking care through free community events, highlighting persistent access gaps within these populations. Perceived access to dental care was strongly connected to insurance type. Only 33.8% of Medicaid beneficiaries agreed that it was easy to find a dentist who accepted their plan, compared to 84.2% of those with private insurance and 72.3% of those with Medicare. A similar trend appeared for scheduling appointments: 31.0% of Medicaid respondents and 45.4% of uninsured individuals agreed that it was easy to get an appointment, compared to 70.9% of Medicare and 81.9% of privately insured respondents.

31.7%
of Medicaid beneficiaries
reported self-medicating
for a dental issue
in the past year

compared to

>

25.2%
of **uninsured**
&
12.6%
of **privately-insured**
respondents

Affordability concerns were prevalent across all groups but most pronounced among those with no insurance (65.1% disagreed) and Medicaid coverage (54.5% disagreed) regarding their ability to manage out-of-pocket costs. In contrast, 75.9% of privately insured and 63.4% of Medicare respondents reported that dental costs were manageable. While affordability was the most commonly cited barrier, private insurance offered the greatest perceived financial protection. Emergency care for dental pain or infection was disproportionately common among lower-income and publicly insured populations. Seventeen percent of Medicaid beneficiaries reported visiting an emergency department or urgent care for dental issues within the past year, five to six times higher than national estimates (1.5–3.5%). Emergency visits among uninsured and privately insured respondents were also elevated (13.2% and 9.4%, respectively), suggesting systemic barriers that lead to delayed or crisis-driven care.

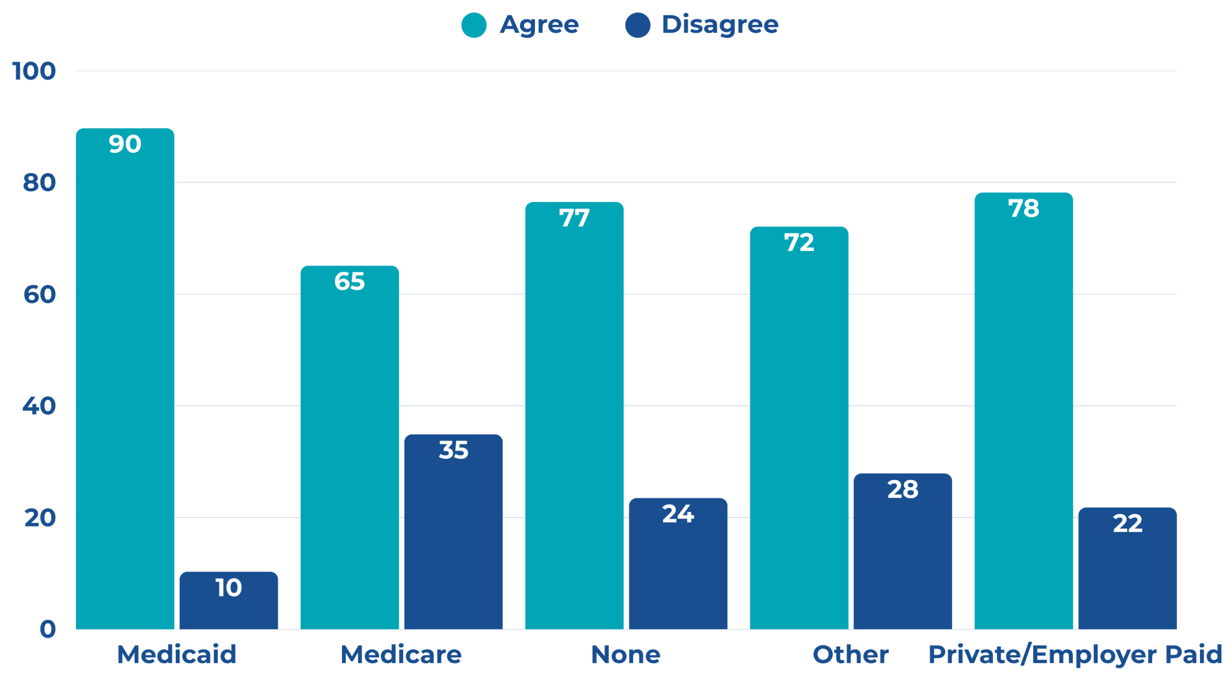
Self-management behaviors and oral health outcomes similarly varied by insurance coverage. Nearly one-third (31.7%) of Medicaid beneficiaries reported self-medicating for a dental issue in the past year, compared with 25.2% of uninsured and 12.6% of privately insured respondents. Although less frequent, reports of self-extraction were still concerning: 9.3% of Medicaid beneficiaries and 9.7% of those in the "other" insurance category indicated removing their own tooth, compared with 3.1% among those privately insured. Reports of dental pain or infection were highest among Medicaid beneficiaries (29.2%) and uninsured respondents (24.0%), exceeding levels seen in the privately insured group (18.8%). Difficulty affording basic dental hygiene products was relatively uncommon overall, but slightly more prevalent among Medicaid (12.4%) and uninsured respondents (11.6%) than among privately insured respondents (4.5%).

Perceptions of Technology-Supported Oral Healthcare and Patient Empowerment

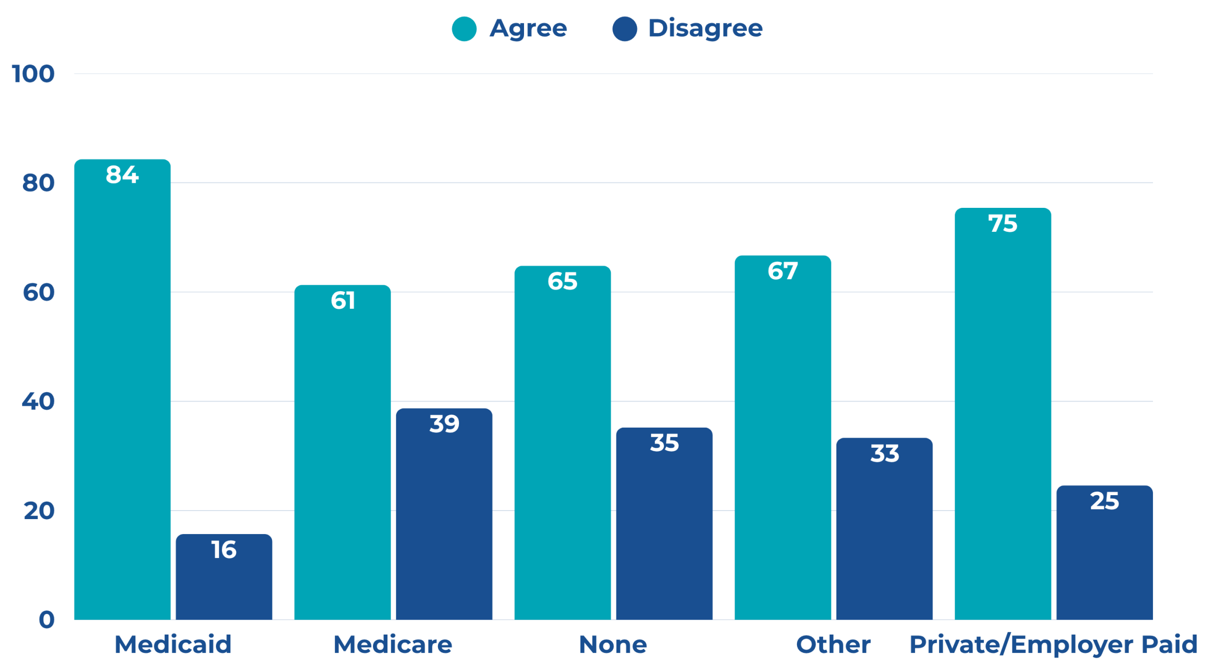
Respondents expressed broad acceptance of technology in healthcare and a strong interest in applying solutions to oral health habits and hygiene. Across the full sample, 84.4% reported feeling comfortable using healthcare technology at home, and 75.5% indicated that they frequently use technology to understand or improve their health. Similarly, 77.2% wanted more technology options to support dental care at home, and 71.5% agreed that feedback from an app or personal health device would help them improve their oral health.

Perceptions of technology use and self-management of oral health varied by insurance status. Medicaid beneficiaries reported the highest engagement with healthcare technology, with 82.7% indicating frequent use of technology for health improvement and 89.7% expressing a desire for additional technology options for at-home dental care. These responses were higher than those among privately insured respondents (79.0% and 78.2%, respectively). In contrast, Medicare beneficiaries consistently demonstrated lower agreement across most technology-related statements, suggesting potential age-related or digital literacy barriers influencing comfort and interest in new

I want more technology options that improve my dental care at home:



If I had feedback from an app or other personal healthcare device, I would be able to improve my own dental health:



Self-efficacy indicators followed a similar trend. High levels of comfort with healthcare technology were observed across all insurance categories, with agreement rates above 75% in every group. The highest comfort levels were reported among privately insured (87.0%), uninsured (85.2%), and Medicaid respondents (85.4%). Among those with private insurance, 92.8% reported being able to implement oral care recommendations between visits, compared with 66.7% of Medicaid beneficiaries and 67.9% of uninsured respondents. Feelings of empowerment to address personal oral healthcare needs were strongest among privately insured individuals (87.9%) and lowest among Medicaid participants (63.5%). Interestingly, while Medicaid respondents were less likely to feel empowered to manage their own oral health, they reported a slightly greater interest in technological solutions to support self-care.

Connection to Disability as an Influence on Oral Healthcare

Disability status and exposure were analyzed in relation to dental care experiences, attitudes, and beliefs, as well as selected demographic variables. Because disability was not a mutually exclusive category, respondents who self-identified as having a disability and those who reported a family member with a disability were analyzed independently. Likert-style questions were collapsed into binary categories (agree/disagree), and "not applicable" responses were excluded from analysis.

Among respondents who self-identified as having a disability, Medicaid (18.7%) and Medicare (21.4%) coverage were the most frequently reported public insurance types, while 23.8% of respondents with disabilities reported private or employer-sponsored coverage. Approximately 25.8% of respondents with disabilities lacked dental insurance altogether. Among respondents with disabilities, 54.8% agreed that it was easy to find a dentist who accepted their insurance, and 54.9% agreed that it was easy to obtain an appointment when needed. Slightly less than half (47.6%) indicated that they could manage out-of-pocket dental costs. Among respondents with disabilities, 57.1% reported a routine dental visit within the past year. 13.1% had visited an emergency department or urgent care for a dental issue, and 24.6% reported self-medicating for dental pain. While the ultimate sample was small, among those with disabilities, 7.9% reported self-extracting a tooth, while 28.6% experienced dental pain or infection during the prior year. 11.9% reported difficulty affording basic dental hygiene products, and 22.2% selected none of the above.

25.8%
of respondents with disabilities **lacked dental insurance** altogether.

13.1%
had **visited an emergency department or urgent care** for a dental issue.

24.6%
reported **self-medicating** for dental pain.

More positive self-reported beliefs and attitudes were observed for self-management, technology adoption, and patient empowerment: 73.0% reported that they could implement oral hygiene practices between visits, and 68.3% felt empowered to address their own oral healthcare needs. Respondents with disabilities reported high levels of technology use and comfort. 74.5% indicated frequent use of technology to improve their health, and 79.6% wanted more technology options to support dental care at home. 71.8% believed that receiving feedback from a health app or device could help them improve their dental health, and 84.5% felt comfortable using healthcare technology in their homes.

Limitations

While the findings of this study provide valuable insights into Tennesseans' experiences, attitudes, and beliefs related to oral healthcare and technology, several limitations should be considered when interpreting the results. The study sample was recruited through a market research panel and may not fully represent the general adult population of Tennessee. Although demographic quotas were applied to approximate statewide distributions, participation was voluntary and limited to individuals with access to technology or telephone services. As a result, the survey likely underrepresents Tennesseans without stable internet access or limited digital proficiency. All responses were self-reported and subject to recall and social desirability bias. Several analytic variables were recoded or collapsed for interpretive clarity. Likert-scale items were converted to binary agree/disagree categories, which simplifies interpretation but may reduce nuance and obscure moderate responses. Disability status was not a mutually exclusive or discrete variable. Respondents could self-identify as having a disability and/or as having a family member with a disability, leading to possible overlap across groups.

DISCUSSION AND STRATEGIC RECOMMENDATIONS

Supporting the oral healthcare needs and perceived barriers is critical to advancing solutions that create healthier Tennessee communities. This report detailed a new understanding of how Tennesseans regard their dental care needs during visits and between visits, along with a self-reported accounting of barriers to optimal oral health. Tennessee stakeholders can use this information to create interventions, consider policy solutions, and invest in strategic recommendations.

Strengthen Access and Affordability

Pronounced disparity in the dental care that Tennesseans can afford, and subsequently access or utilize, was a clear defining factor in reported oral health outcomes. Cost of care was a reported barrier among Medicaid and uninsured respondents, and as a result of this barrier, respondents in this category reported profound outcomes, including self-medication for pain, self-extractions for relief, and visits to the emergency department at disproportionately high rates. This is a profound result of financial barriers, providing stakeholders with a clear opportunity to address the cost of dental care. Strengthening Medicaid by increasing provider participation and lowering out-of-pocket fees, considering the cost of care for beneficiaries, and addressing emergent dental needs are critical components of access and affordability. Importantly, the use of emergency departments for non-traumatic dental conditions should be investigated in the state, targeting locations with high numbers of users to avert care in safety net clinics. Ensuring that dental needs are met in the dental office through routine care, especially prevention, reduces taxpayer costs to fund care and improves the quality of life for Tennesseans with unmet dental needs.

Advance Technology-Supported Oral Healthcare Delivery

The results detailed in this report indicate strong consumer readiness for digital and at-home technologies in Tennessee, across all insurance programs and beneficiary types. High comfort and interest in using health technology indicate strong readiness for interventions such as mobile applications, teledentistry platforms, and personalized oral hygiene feedback systems. Investing in consumer-facing technology solutions can facilitate effective oral health and hygiene while helping patients to feel empowered in their self-care between dental visits. These types of solutions are particularly important for Tennesseans who have limited access to dental care but have access to technology. Survey respondents indicated a strong desire to leverage technology in ways that would benefit their own oral health and well-being. Recognizing this opportunity, the Tennessee Department of Disability and Aging created a technology credentialing platform[13] to increase adoption of mHealth technology for Tennessee consumers, a program that stakeholders can leverage in developing health interventions. Solutions that can be accessed via smartphone, engage consumers directly in their oral healthcare, and can reduce barriers to accessing or utilizing care are particularly helpful.

Address Disparities Among Tennesseans with Disabilities

People with disabilities, especially people with an intellectual or developmental disability, face distinct barriers in accessing dental care. These communities often have geographic and structural challenges to utilizing dental care, a complication that creates pervasive poor oral health outcomes. Provider confidence is critical to addressing low dental care access for people with disabilities in Tennessee. Integrating disability competency into dental and hygiene curricula alongside required continuing education among Medicaid providers can improve provider preparedness and patient dental care experiences. Public health planning should also ensure that Medicaid dental coverage and provider networks explicitly include accommodations for patients with disabilities, such as longer appointments, assistive equipment, or mobile services. Pilot tests of novel technology, such as point-of-care salivary testing and smart toothbrush attachments, have shown promising results, particularly among people with IDD and could be leveraged toward self-care.[14]

The findings from this survey reflect opportunities to leverage technology while recognizing high costs of dental care continue to drive profound oral health outcomes. Most Tennesseans value and prioritize their oral health, yet affordability, insurance gaps, and uneven provider participation continue to limit access to consistent, preventive care. These barriers are particularly acute for Tennesseans with Medicaid, those without insurance, and individuals with disabilities, groups who experience higher rates of pain, self-treatment, and emergency dental use. Clear comfort with technology signals a new opportunity to expand preventive strategies and patient engagement beyond the dental chair. Leveraging Tennessee's growing digital health infrastructure, strengthening Medicaid and safety-net programs, and embedding disability-affirming care across provider training can collectively move the state toward a more connected, integrated, and prevention-focused oral health system.

REFERENCES

1. Tennessee Department of Finance and Administration, Bureau of TennCare. Dental services. TennCare. Accessed November 10, 2025. https://www.tn.gov/tenncare/members-applicants/dental-services.html

2. Tennessee Department of Health, Division of Health Planning. The State of Health in Tennessee: 2024 Annual Report to the 113th Tennessee General Assembly. Nashville, TN; 2024. Accessed November 10, 2025. https://www.tn.gov/content/dam/tn/health/2024TDHOHSAnnualReport.pdf

3. Centers for Disease Control and Prevention. Oral health indicator definitions. Chronic Disease Indicators. Updated June 3, 2024. Accessed November 10, 2025. https://www.cdc.gov/cdi/indicator-definitions/oral-health.html

4. Alpert EA, Louro J, Boynes SB, Cothron AE. The Landscape of Dental Care for People with Intellectual and Developmental Disabilities in Tennessee. Chicago, IL: The American Institute of Dental Public Health and Harmony Health; July 2024.

5. Liu Y, Adeniran E, Wang K. Changes in prevalence over time and determinants of dental care visits amongst Tennessee seniors. Int Dent J. 2023;73(4):558-565. doi:10.1016/j.identj.2023.01.004

6. America's Health Rankings. 2024 Annual Report: State Summaries — Tennessee. Accessed November 10, 2025. https://assets.americashealthrankings.org/app/uploads/tennessee-senior2024.pdf

7. Kaur AJ, Shrivastava R, Feine J, Emami E. Patients' e-readiness to use e-health technologies for oral health. PLoS One. 2021;16(7):e0253922. doi:10.1371/journal.pone.0253922

8. Pisano M, Bramanti A, Di Spirito F, Di Palo MP, De Benedetto G, Amato A, Amato M. Reviewing mobile dental apps for children with cognitive and physical impairments and ideating an app tailored to special healthcare needs. J Clin Med. 2025;14(6):2105. doi:10.3390/jcm14062105

9. Väyrynen E, Hakola S, Keski-Salmi A, Jämsä H, Vainionpää R, Karki S. The use of patient-oriented mobile phone apps in oral health: scoping review. JMIR Mhealth Uhealth. 2023;11:e46143. doi:10.2196/46143

10. Pew Research Center. Americans' use of mobile technology and home broadband. Published January 31, 2024. Accessed November 10, 2025. https://www.pewresearch.org/internet/2024/01/31/americans-use-of-mobile-technology-and-home-broadband/

11. Kaiser Family Foundation. 10 things to know about Medicaid. Published February 18, 2025. Accessed November 10, 2025. https://www.kff.org/medicaid/10-things-to-know-about-medicaid/#:~:text=1.,health%20insurance%20offered%20through%20employers.

12. CareQuest Institute for Oral Health. Recent Trends in Hospital Emergency Department Visits for Non-Traumatic Dental Conditions. Boston, MA: CareQuest Institute for Oral Health; May 2022.

13. Tennessee Department of Health. Become a credentialed provider. Accessed November 10, 2025. https://www.tn.gov/disability-and-aging/provider-information/become-a-credentialed-provider.html

14. Harmony Health and The American Institute of Dental Public Health. The Power of Prevention: Using Novel Technology to Facilitate Oral Health and Hygiene Habits for People with IDD. Chicago, IL: The American Institute of Dental Public Health and Harmony Health; July 2025. doi:10.58677/GYCH8489

Demographics

Level of Education		
Indicator	**Frequency**	**Percent**
Less than high school	29	2.8
High school diploma or GED	331	31.7
Some college	220	21.1
Associate's degree	126	12.1
Bachelor's degree	199	19.1
Graduate degree	138	13.2
Employment Status		
Employed full-time	464	44.5
Retired	222	21.3
Unemployed	130	12.5
Employed part-time	114	10.9
Self-employed	83	8.0
Other	30	2.9
Device Ownership		
Smart Phone	987	94.7
Mobile phone (not smart)	83	8.0
Laptop computer	685	65.7
iPad/Tablet	493	47.3
Desktop computer	352	33.8

Demographics (continued)

Disability Status		
Indicator	**Frequency**	**Percent**
I have a disability	252	24.2
Someone in my family has a disability	377	36.2
I have a close friend with a disability	199	19.1
I do not know anyone personally with a disability	367	35.2
Has a close family relative, friend, or partner with IDD		
No	666	63.9
Yes	377	36.2
(If Yes)		
Caregiver	36	3.5
Close Friend	99	9.5
Family Member	256	24.5
Partner	38	3.6
Other	14	1.3
Dental Insurance Type		
Private insurance through an employer	382	36.3
No dental insurance	258	24.7
Medicare/MA	170	16.3
Medicaid/TennCare	161	15.4
Subscription/Membership plan	35	3.4
VA or DoD Dentist	31	3.0
Other	6	0.5

Demographics (continued)

Dental Insurance Type		
Indicator	**Frequency**	**Percent**
Private insurance through an employer	382	36.3
No dental insurance	258	24.7
Medicare/MA	170	16.3
Medicaid/TennCare	161	15.4
Subscription/Membership plan	35	3.4
VA or DoD Dentist	31	3.0
Other	6	0.5

Dental Insurance and Dental Care Experiences

Dental Insurance x Dental Visit Locations					
Indicator	**Medicaid**	**Medicare**	**None**	**Other**	**Private**
Private dental office	77 (47.8%)	117 (68.8%)	107 (41.5%)	42 (58.3%)	338 (88.5%)
Do not typically go to the dentist	24 (14.9%)	21 (12.4%)	104 (40.3%)	9 (12.5%)	15 (3.9%)
Free dental clinic/event	25 (15.5%)	5 (2.9%)	18 (7.0%)	5 (6.9%)	7 (1.8%)
Community Health Center	15 (9.3%)	10 (5.9%)	11 (4.3%)	5 (6.9%)	8 (2.1%)
Specialty Care facility	9 (5.6%)	8 (4.7%)	4 (1.6)	6 (8.3%)	8 (2.1%)
Dental school	10 (6.2%)	7 (4.1%)	4 (1.6%)	3 (4.2%)	4 (1.0%)
Mobile van/visit	1 (0.6%)	2 (1.2%)	10 (3.9%)	2 (2.8%)	2 (0.5%)

It is easy for me to find a dentist that accepts my insurance plan				
Insurance	Agree		Disagree	
	Num	%	Num	%
Medicaid	54	33.8	106	66.2
Medicare	120	72.3	46	27.7
None	54	38.3	87	61.7
Other	50	73.5	18	26.5
Private/Employer Paid	320	84.2	60	15.8
It is easy for me to get an appointment with my dentist when I need it				
Medicaid	49	31.0	109	69.0
Medicare	117	70.9	48	29.1
None	98	45.4	118	54.6
Other	43	63.2	25	36.8
Private/Employer Paid	312	81.9	69	18.1
I can manage the out of pocket costs with my dental insurance				
Medicaid	70	45.5	84	54.5
Medicare	102	63.4	59	36.6
None	73	34.9	136	65.1
Other	45	64.3	25	35.7
Private/Employer Paid	287	75.9	91	24.1
I am able to implement oral care and hygiene between visits that my dentist recommends				
Medicaid	106	66.7	53	33.3
Medicare	148	88.6	19	11.4
None	152	67.9	72	32.1
Other	52	76.5	16	23.5
Private/Employer Paid	349	92.8	27	7.2

I feel empowered to address my own oral healthcare needs				
Medicaid	101	63.5	58	36.5
Medicare	132	78.1	37	21.9
None	155	66.8	77	33.2
Other	53	77.9	15	22.1
Private/Employer Paid	328	87.9	45	12.1
I frequently use technology to understand or improve my healthcare				
Medicaid	129	82.7	27	17.3
Medicare	111	70.3	47	29.7
None	158	69.0	71	31.0
Other	52	74.3	18	25.7
Private/Employer Paid	289	79.0	77	21.0
I want more technology options that improve my dental care at home				
Medicaid	140	89.7	16	10.3
Medicare	97	65.1	52	34.9
None	166	76.5	51	23.5
Other	49	72.1	19	27.9
Private/Employer Paid	279	78.2	78	21.8
If I had feedback from an app or other personal healthcare device, I would be able to improve my own dental health				
Medicaid	129	84.3	24	15.7
Medicare	92	61.3	58	38.7
None	142	64.8	77	35.2
Other	46	66.7	23	33.3
Private/Employer Paid	266	75.4	87	24.6

I feel comfortable using healthcare technology at my home				
Medicaid	135	85.4	23	14.6
Medicare	126	79.7	32	20.3
None	195	85.2	34	14.8
Other	53	76.8	16	23.2
Private/Employer Paid	321	87.0	48	13.0
In the past year: Routine Visit with my Dental Provider				
Medicaid	60	37.3	101	62.7
Medicare	64	37.6	106	62.4
None	169	65.5	89	34.5
Other	27	37.5	45	62.5
Private/Employer Paid	65	17.0	317	83.0
In the past year: Emergency or Urgent Care for Dental Pain/Infection				
Medicaid	133	82.6	28	17.4
Medicare	155	91.2	15	8.8
None	224	86.8	34	13.2
Other	58	80.6	14	19.4
Private/Employer Paid	346	90.6	36	9.4
In the past year: Self-medicated because of dental issue				
Medicaid	110	68.3	51	31.7
Medicare	152	89.4	18	10.6
None	193	74.8	65	25.2
Other	58	80.6	14	19.4
Private/Employer Paid	334	87.4	48	12.6

In the past year: Dental pain or infection				
Medicaid	114	70.8	47	29.2
Medicare	149	87.6	21	12.4
None	196	76.0	62	24.0
Other	55	76.4	17	23.6
Private/Employer Paid	310	81.2	72	18.8
In the past year: Difficulty affording dental hygiene products (toothbrush, toothpaste, floss, etc.)				
Medicaid	141	87.6	20	12.4
Medicare	161	94.7	9	5.3
None	228	88.4	30	11.6
Other	63	87.5	9	12.5
Private/Employer Paid	365	95.5	17	4.5

Disability Status and Dental Care Experiences

Insurance Status: Responses for People who Indicated they have a Disability				
Insurance	No		Yes	
	Num	%	Num	%
Medicaid	205	81.3	47	18.7
Medicare	198	78.6	54	21.4
None	187	74.2	65	25.8
Other	229	90.9	23	9.1
Private/Employer Paid	192	76.2	60	23.8

Disability Status and Dental Care Experiences (continued)

Access to Care: Responses for People who Indicated they have a Disability				
It is easy for me to find a dentist who accepts my insurance plan.	119	54.8	98	45.2
It is easy for me to get an appointment with my dentist when I need it	130	54.9	107	45.1
I can manage the out-of-pocket costs with my dental insurance.	107	47.6	118	52.4
I am able to implement oral care and hygiene between visits that my dentist recommends.	173	73.0	64	27.0
I feel empowered to address my own oral healthcare needs.	164	68.3	76	31.7
Technology Attitudes: Responses for People who Indicated they have a Disability				
I frequently use technology to understand or improve my healthcare.	172	74.5	59	25.5
I want more technology options that improve my dental care at home.	176	79.6	45	20.4
If I had feedback from an app or other personal healthcare device, I would be able to improve my own dental health.	159	71.8	62	28.2
I feel comfortable using healthcare technology at my home.	196	84.5	36	15.5
Dental Experiences in the Past Year: Responses for People who Indicated they have a Disability				
Routine visit with a dental provider	144	57.1	108	42.9
Emergency department or urgent care	33	13.1	219	86.9
Self-medicated because of a dental issue	62	24.6	190	75.4
Self-extraction to relieve dental pain	20	7.9	232	92.1
Dental pain or infection	72	28.6	180	71.4
Difficulty affording dental hygiene products	30	11.9	222	88.1
None of the above	56	22.2	196	77.8