

Research Article

Oral Health and Dental Care in Older Korean Immigrants in the United States: A Qualitative Study

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Abstract

Many segments of the U.S. population experience a disproportionate burden of oral disease and inequities in dental care, and older Asian immigrant populations are among those at high risk. To attend to ethnic variations among older Asian Americans and to better understand contextual factors that shape their experiences of oral health and dental care, we conducted in-depth interviews with 18 older Korean immigrants in Los Angeles.

The qualitative inquiries were theoretically guided by the three core categories of the Andersen (1968, 1995) health service model: oral health needs, service barriers, and service outcomes. Using the constant comparison method, we derived eight themes across the three categories: (1) oral health problems, (2) perceived needs, (3) insurance and finance, (4) language barriers, (5) social support, (6) knowledge and beliefs, (7) satisfaction with service, and (8) areas for improvement.

The study findings demonstrated that older Korean immigrants have varied experiences associated with oral health and dental care and informed the development of services and programs responsive to the identified needs and barriers.

Keywords: Oral Health; Dental Care; Health Services Accessibility; Culturally Competent Care; Immigrants; Asian Americans; Qualitative Research

1. Introduction

With more than 16 million people in the United States unable to access dental care, oral health presents a high rate of unmet needs [1]. A window to health, oral health has direct and indirect impacts on health and well-being, including increased disease susceptibility and mortality [2, 3] Although oral health has become a national and global public health priority [4], many segments of the U.S. population continue to experience a disproportionate burden of oral disease and inequities in dental care; these disparities are now considered a matter of social justice [5]. Immigrant populations are at high risk of poor oral health and inadequate dental care. Using the 2008–2012 Medical Expenditure Panel Survey, Wilson and colleagues [6] showed that those who were foreign-born were 17% less likely than their U.S.-born counterparts to have dental visits. Studies of older Asian Americans with diverse ethnic backgrounds in various geographic locations have identified barriers to oral health and dental care, highlighting the influence of such factors as dental insurance, socioeconomic status, English proficiency, acculturation, and oral health knowledge and beliefs [7-10]. To explore ethnic variations and to better understand contextual factors that shape the experiences of oral health and dental care,

we conducted in-depth interviews with older Korean immigrants in Los Angeles. Korean Americans are the fifth largest Asian American subgroup [11]. About a third of all Korean immigrants in the United States reside in California, and 67% of the Korean immigrants in California are concentrated in the greater Los Angeles area [12]. Jang et al. [9] conducted a survey on the oral health and dental care vulnerabilities of older Korean immigrants and found that more than 70% of the sample did not have dental health insurance and about 40% did not have any dental visits in the previous year. The present study aimed to contextualize the experiences and challenges associated with oral health and dental care of the target population, which would inform the development of effective services and programs. The Andersen [13, 14] behavioral model of health service use established the framework for our inquiry. The model categorizes individual factors that determine health services, including predisposing, needs, enabling, and service use variables. It has been widely used in health services research and has contributed to our understanding of the factors associated with the use of various types of health services. The model has also been applied to dental care service use [15] and has guided many quantitative studies on the topic [8, 9, 16]. For our study, we used the Andersen model's core constructs-oral health needs, service barriers, and service outcomes-as major areas of qualitative inquiries. We also considered characteristics of the target population in terms of contextual factors in relation to immigration, culture, and geographic location.

2. Methods

We conducted individual interviews with Korean

immigrants aged 60 or older living in Los Angeles during the spring of 2019. Using a volunteer-based purposive sampling method, we recruited 18 participants. Interviews consisted of a short survey of background information (e.g., demographic characteristics, oral health status, dental care use) and semi-structured interview questions guided by the core categories of the Andersen's health service model [13, 14]. Major questions included the following: "Do you have any oral health issues? If so, what are the symptoms?" "Regarding your current oral health status, what are the biggest challenges or difficulties you are experiencing?" "In the past 12 months, have you visited any dental clinic for oral health issues? If yes, how satisfied were you with the service you received? If you were not satisfied, why not?" "What are the challenges you have experienced in seeking dental care?" The interviewers asked questions and prompted follow-up explanations to collect rich data that elaborate theoretical domains. All interviews were conducted in Korean at a place that protected participant privacy. Each interview lasted about an hour. The sessions were audio-recorded with consent, and participants were each paid U.S. \$50 at the end of the interview.

2.1 Analytic strategy

The audio-recorded interviews were transcribed verbatim in Korean. Using the constant comparison method [17], we independently coded each transcript, compared and discussed each code and meaning, and developed and modified the codes. The coding procedure began with open coding. The codes were refined and then clustered into larger categories in order to yield emerging themes [18]. During analysis and interpretation, we used several strategies-such as

intensive engagement, triangulation, and record keeping-to ensure the trustworthiness and rigor of the study [19]. The interviewers and coders have expertise in aging and health services research and have worked with older Korean immigrants. Such knowledge and skills facilitated participant rapport and engagement. We conducted multiple cross-coding to bring various perspectives into data analyses. We also kept our memos, such as process recordings and reflections on the codes and discrepancies; we discussed those record trails and reflected them in coding and interpreting themes as they emerged. The first five authors participated in the interviews, read all of the transcripts in Korean, and immersed themselves in the data. Then they independently developed a preliminary code list in English. Using the preliminary code lists, each coder independently coded the initial two interviews line-by-line; as they did so, they were free to add codes to their own preliminary list. Then they compared the coded transcriptions, discussed discrepancies, and recoded the interviews using a set of consensus codes. The coders then independently coded additional two transcripts and compared codes. Through this iterative process, the coders agreed that the transcripts could be reliably coded, guided by the main codes and definitions. Then two coders (YJ and MKR) coded the transcripts through the consensus approach (coding separately followed by discussions of all areas of disagreement), and three other coders (CHJ, EYC, and JP) reviewed all coded transcripts and discussed any discrepancies. For an additional reliability check, three co-authors (YJ, MKR, and NP) independently reviewed the codes and checked their accuracy. A qualitative data analysis program, Atlas.ti (Scientific Software Development, Berlin), was used for organizing and analyzing codes. Translation of

the selected quotes into English was conducted as a final step to minimize the loss of content and meaning in the original language [20].

3. Results

3.1 Sample description

The sample included 18 participants. Their mean age was 75.1 (*SD* = 8.9), with a range from 60 to 93 years old. About 56% were women, and half were married. About 67% had a high school education or lower, and 61% rated their financial status as “below average.” All participants were born in Korea and used Korean as

their primary language. The number of years lived in the United States ranged from one to 54 years, with a mean of 30.5 years (*SD* = 12.8).

3.2 Interview findings

As a result of the data immersion and consensus coding described above, we identified eight interview themes and nineteen subthemes, which we grouped into the three core categories. The categories, themes, and subthemes are presented in Table 1 and discussed below, along with exemplary quotes from the participants.

Categories	Themes	Subthemes	
1. Oral health needs	1. Oral health problems	1. Problem severity	
		2. Type of the problem	
		3. Areas impacted by the problem	
	2. Perceived needs	1. Awareness/unawareness	
		2. Attention/neglect	
2. Service barriers	1. Insurance and finance	1. Lack of insurance as a challenge	
		2. Limited knowledge about dental coverage	
		3. Financial burden	
	2. Language barriers	1. Linguistic concordance with providers	
		2. Limitation in information seeking	
	3. Social support	1. Source and type of social support	
		2. Sense of burden	
	4. Knowledge and beliefs	1. Oral health knowledge	
		2. Beliefs on personal care	
	3. Service outcomes	1. Satisfaction with service	1. Perceived experience
			2. Lowered expectation
		2. Areas of improvement	1. Affordability and accessibility
2. Informational and relational needs			
3. Education on oral health and dental care			

Table 1: Categories, Themes, and Subthemes of Oral Health and Dental Care.

3.3 Oral health needs

3.3.1 Oral health problems: Participant reports of oral health status reflected a varying range, from no or minor oral health issues to extreme oral health issues. On a quantitative question, 72.2% rated their overall oral health status as “fair” or “poor,” and only 27.8% rated their status as “good,” “very good,” or “excellent.” In the qualitative interviews, some participants reported that their teeth are in excellent condition without any particular difficulties or complaints, whereas other participants reported substantial problems with their oral health. For example, a 93-year-old female participant who had lost all of her teeth while she was giving birth in her early 20s said:

- Through my whole life, I have been suffering a lot from my dental problems. Having good teeth is a blessing, but I didn't have that blessing. [female, 93]

The reported oral health concerns included missing or broken teeth, bleeding in the gums, intense pain at night, damage in their dentures, and unpleasant feelings due to an extremely dry mouth.

Participants also reported negative impacts of oral health problems on various aspects of their life. The primary area of concern was eating; many participants reported restrictions in eating due to their oral health issues and described how the restrictions affect the enjoyment of food and life:

- I always have a funny taste in my mouth because of the dentures. Everything tastes like a chemical glue in my mouth, and I cannot fully appreciate food that I eat. [male, 79]

- I have to avoid food with hard textures and always eat soft food. I used to love almond, but now I cannot even try to have a bite of it. I shouldn't even think about Kakdoogi [Korean cubed radish kimchi]. Sometimes I try it after chopping it finely, but as you know it is not the same..... There is no fun if you cannot eat what you want. [female, 74]

Participants were self-conscious about their appearance and feared interpersonal interactions due to oral health problems. Negative experiences or anticipation of them in social contexts seem to further diminish their self-image and confidence:

- One time, my dentures fell out while I was talking at a church meeting. It was horribly embarrassing. Since then, I get worried when I have to speak in front of other people. I pray not to have such a thing happen to me again. [female, 74]

Other areas of concern involved sleep, cognition, and mood. Participants experienced poor sleep quality because they had to wake up in the middle of the night either to drink water due to dry mouth or to go to the restroom because of the amount of water they drank during the day to prevent dry mouth. Also, oral health issues such as pain and poorly fitted dentures had both physical and mental health effects.

3.3.2 Perceived needs: Participants expressed varying levels of awareness and recognition of oral health needs. While a few participants clearly indicated that they needed to see a dentist due to oral health problems-such as damaged dentures, tooth pain, and need for implants-many seemed to find it difficult to identify the problems

that they had. It was also interesting that many participants with dentures were unaware of dental care needs. One participant stated: “When you don’t have your own teeth, there is no point of doing dental care.” [male, 77].

Another subtheme was the level of attention to oral health needs. Some participants seemed to neglect or downplay their oral health problems:

- I lost three molars, but that doesn’t bother me much. I can still eat. I don’t think I need to see a dentist for that. [male, 71]
- It is not a big deal. If I have severe pain or bleeding, I would see a doctor, but I am fine. I can deal with it on my own. [male, 65]

3.4 Service barriers

3.4.1 Insurance and finance: All participants noted the importance of dental insurance in their deciding whether to use dental care services. About 65% of the participants reported that they had no dental insurance coverage, and 60% reported that there was a time in the past 12 months that they were not able to use needed dental care services due to high costs. Many participants reported the challenges with dental service use in the absence of dental insurance:

- People without dental insurance cannot easily see a dentist. It is too expensive. They usually endure their pain until it gets unbearable. [female, 81]
- When I was working, I had great dental coverage provided by my company. After retirement, I lost all those benefits and I have to pay for dental expense out of my own pocket. I am not rich but not poor enough to be

eligible for Medi-Cal. It is really hard to pay my dental bills.... I used to visit dental clinics for check-ups ... but now I only go when I really have to. [male, 79]

About 80% of the participants were covered by Medi-Cal, but their level of awareness of covered benefits (e.g., preventive dental care) and their use of them varied substantially. Some participants did not even know what kind of dental insurance they had, much less their entitled dental benefits. Moreover, even when they had some knowledge about their dental benefits, it was mostly limited or inaccurate. Independent of dental insurance coverage, all participants expressed a high level of concern about finances:

- My dental insurance doesn’t cover implants. I had to pay cash for that. [male, 71]
- There were many occasions that I needed dental care but couldn’t get it because of the high cost. A simple treatment can easily cost a few hundred dollars. [male, 66]
- Who wouldn’t want to have implants? It is all because of money. [male, 73]

3.4.2 Language barriers: All of the study participants were born in Korea and used Korean as their primary language; therefore, it was no surprise that many participants mentioned the challenges that language barriers posed to using professional dental health services. Participant statements also reflected the geographic characteristics of Los Angeles where there are many Korean or Korean-speaking medical providers:

- It is very uncomfortable to see American doctors because I don’t speak English at all. I

live in Granada Hills and used to see a Korean doctor in my neighborhood. He is Korean but didn't speak Korean at all, and all the nurses in the clinic were Americans. There was no one that I could communicate in Korean there.... That was why I switched to a clinic in Koreatown where all the doctors and nurses are Koreans who speak Korean. I had to drive about an hour to see my new doctor, but I don't mind. [female, 81]

One notable behavior affected by language barriers is information seeking. In general, the sources of information that participants use regarding their oral health and dental care were limited to local media or informal sources.

3.4.3 Social support: In seeking oral health and dental care, participants noted support from various sources. The primary source of support was adult children. Participants also mentioned using informal support sources such as friends and members of religious organizations. It was interesting that many participants who received support from their adult children expressed not only their appreciation for the help but also a sense of burden or a desire for independence:

- When the treatment requires a big payment, I have to talk to my son. He willingly pays the bill for me. I am always grateful but also feel sorry. When my son was growing up, I didn't do much for him as a parent. I was just busy working like all other immigrant workers. Now he is doing a lot of things for me. Because I cannot speak English well, he takes care of important matters for me and the whole family.

He also helps me pay medical bills. ...He is busy with his work and has his own family, but he has to help me as well. I am just thankful and sorry for him. [male, 79]

- When I needed new dentures, I didn't tell my daughter for several months. Somehow, she found out, and that was how I got to have my new dentures. I wish I could take care of the payment on my own. I don't want to add anything on my daughter's shoulder. She is already doing a lot for me. [female, 93]

3.4.4 Knowledge and beliefs about oral health and dental care: Participants showed varying levels of knowledge and differing beliefs about oral health and dental care. Some knowledge and beliefs were conflicting among participants. For example, a few participants reported using salt for preventive oral care and even for emergency treatment:

- When I had oral pain, I wasn't able to see a dentist. I searched on the Internet and learned that salt, especially bamboo salt, would be helpful. So, I was holding salty water in my mouth all day long. The pain seemed to go away, but I felt like my mouth was being marinated. [male, 66]
- If you use salt for brushing and mouth washing, you would never have a problem with your teeth, gums, and throat. Salt prevents and cures all problems. [female, 81]

Another participant held a different belief:

- Many people think salt is good for oral care, but that is not true. I told my family and friends not to use salt for oral care. [male, 76]

While participants generally agreed that oral health care is important, many participants did not seem to place a priority on oral health and dental care. One participant working on getting dental implants was an exception:

- Teeth are the most important part of your body. Dental care is costly, but I put priority in dental care. I would rather save on other things than delaying the dental treatment necessary. [male, 79]

Many participants associated their symptoms with aging and held a pessimistic view of oral health and dental care:

- Until last year, my teeth were in a good condition. Now, many problems are beginning to occur. I realize I am getting old and there is not much that I can do against of my age. [male, 71]
- I don't particularly look for information on health. I am too old, and there is no point in doing dental care. It is too late. [female, 81]

3.5 Service outcome

3.5.1 Satisfaction with service: Participants reported varying levels of satisfaction with dental service. On a quantitative question, about 30% rated their satisfaction level as either "very dissatisfied" or "dissatisfied." One participant with Medi-Cal expressed a high level of satisfaction with dental services:

- I really like my dentist. She is like an angel. Her office is one of the few accepting patients with Medi-Cal in Koreatown. You don't know how embarrassing it is to see a doctor with Medi-Cal, but she makes me feel comfortable. It is always a big concern to poor people like

me if there is any extra cost for treatment. My dentist always checks the coverage before I ask. She makes sure that there is no unexpected cost at the end. God bless her! [female, 60]

This participant also shared her negative experience related to Medi-Cal in another clinic:

- I am diabetic. It was diagnosed about two years ago. When I went to see a cardiac doctor, the nurse who saw my chart said that I should be tested for blood sugar. Then the other nurse said, 'No, she is Medi-Cal.' I was badly hurt when I heard that. I don't deserve having that simple strip test because I am Medi-Cal? I felt devalued and degraded. I hate going to clinics and showing my Medi-Cal card. [female, 60]

On a quantitative question, more than 36% of the participants reported having negative experiences in dental clinics (e.g., discrimination, unfriendliness, mistreatment, overtreatment), which seemed to contribute to their dissatisfaction with services. Participants particularly expressed a high level of dissatisfaction with cost and care quality. Some participants receiving medical benefits from social insurance programs seemed to have lowered their expectations:

- I have no complaint. Everything is fine. I am very grateful for what they offer to me. How can I ask for more? [female, 93]

3.5.2 Areas for improvement: The main improvement that participants wanted related to affordability and accessibility:

- I wish there are options for dental care that seniors can easily use without worrying about cost. It would be wonderful if basic dental service is covered. [female, 74]
- There are only a few Korean dentists who accept patients with Medi-Cal, and the option is becoming more limited every year. I don't know what to do if my current doctor says she doesn't receive Medi-Cal patients any longer. [female, 60]

Another area for improvement relates to patients' informational and relational needs. Participants wanted to better understand their conditions and be able to make informed decisions:

- I have never seen a dentist who is kind enough to explain the conditions and treatment options to patients. Doctors and nurses speak their medical jargons like special codes and ignore me. Even when I ask a question, they don't respond well. They should respect their patients. [male, 82]

Also, participants noted the need for oral health education:

- I realized the importance of oral health when I became old. I should have known it earlier. People should get educated when they are young, so that they can build good lifelong habits. I have two grand kids. Every time I see them, I talk about the importance of brushing well. [male, 79]

4. Discussion

This qualitative study explored the oral health and dent-

-al care experiences among older Korean immigrants and identified contextual factors influencing their dental service use. Older Korean immigrants reported many oral health problems such as missing or broken teeth, gum problems, pain, poorly fitted dentures, and dry mouth. These problems negatively impacted various aspects of life, ranging from eating restrictions to low self-confidence. This finding is in line with previous research reporting poor oral health status among older immigrants [8-10]. However, despite their poor oral health, there was a lack of perceived need for dental care. The fact that older ethnic minority adults tend to consider oral health care less important than other health care [10] and tend to seek dental care only when urgently needed [21] may explain this discrepancy. Given that perceived need for dental care is one of the major driving forces of dental care service use [9,10], it is important to understand the potential mechanisms of the discrepancy and to identify ways to promote awareness of the importance of preventive dental care.

The study findings also identified four specific barriers to dental care services: (1) insurance and finance, (2) language, (3) social support, and (4) knowledge and beliefs. Many participants did not have dental insurance and had a high level of financial burden, and thus were not able to use dental care services despite the needs. These findings are consistent with previous research which identified lack of dental insurance and financial strain as significant barriers to the use and unmet needs of dental care services for older adults [7-10]. Moreover, a considerable number of the study participants with Medi-Cal were not aware of its dental coverage. Such lack of knowledge about insurance

benefits serves as a barrier by discouraging individuals from using health services [22, 23].

Limited English proficiency was a barrier because it limited the available service options. Korean immigrants experienced difficulty in communicating with health professionals, and thus preferred Korean dentists who shared language and culture. All study participants had, in fact, visited Korean-speaking dentists within the Korean community. Korean-speaking dentists are more available to older Korean immigrants in Los Angeles than in many communities; however, the options for dental care services and the sources for oral health information are still primarily limited to the Korean enclave and not readily available in the broader Los Angeles area. Due to financial burdens and limited English proficiency, many older Korean immigrants depend on their adult children for support in seeking dental care. However, the older adults' deep sense of burden and desire for independence served as barriers to care. For example, fear that they would cause concern and impose financial obligations on their adult children prevented many older Korean immigrants from using dental care services. This finding highlights the significant roles of social support and family network for older Korean immigrants relative to dental care. It also provides further insight into the impact of social support mechanisms on the use of dental services and calls for the need to enhance access to formal support (e.g., community organizations and agencies) to reduce family burden and older individuals' sense of dependency.

In addition to poor knowledge and beliefs about insurance benefits, participant responses reflected

varying levels of knowledge and beliefs about appropriate preventive dental care measures and pessimistic views on dental care based on the belief that poor oral health is a natural process of aging. Consistent with previous research [10, 21], they also placed a lower priority on dental care than on other health care and sought dental care services only for curative purposes, rather than preventive purposes. Although these findings warrant further exploration, knowledge and beliefs about oral health and dental care among older Korean immigrants seem culturally embedded and also closely interconnected with the language barrier. That is, older Korean immigrants obtain health information from informal and ethnically homogenous networks due to their limited English proficiency, and such information can be misleading, reinforce cultural norms and beliefs in specific health behaviors, and ultimately lead to inadequate health decisions [22, 23]. The structural and cultural barriers may also be associated with compromised care quality and patient safety. In fact, about 30% of study participants were dissatisfied with the dental service they had received, and over 36% reported that they had had negative experiences in dental clinics, such as mistreatment or overtreatment. The study identified several approaches for improving dental care use, including affordability, accessibility, and enhancement of oral health literacy through education. Multilateral efforts from diverse stakeholders-such as health policy makers, oral health service providers, and local ethnic community agencies-would be required to proactively address these areas for improvement.

One of the unique study findings was the interconnected nature of the three core categories: oral health needs,

service barriers, and service outcomes. Challenges in each category exacerbated challenges in the other two, creating a vicious circle of poor dental care. For example, older Korean immigrants who experience multiple service barriers may experience poor service outcomes due to (1) limited service options, or (2) compromised care quality and aggravated oral health, or (3) a lower level of perceived needs for dental care because they are discouraged about using dental care services. Poor service outcomes and a lower level of perceived needs for dental care caused by multiple service barriers may then serve as subsequent barrier to service use. Service outcomes and oral health needs are also interconnected in that continued unsatisfactory service outcomes may discourage individuals and lower the level of their perceived needs for dental care, which may lead to aggravated oral health status. Thus, it is critical to understand the mechanisms through which the challenges of the three categories influence one another and to take a comprehensive approach to better address the varied challenges facing older Korean immigrants.

The study has several limitations. First, restricting the sample to older Korean immigrants who live in Los Angeles may limit generalizability of the study findings. Older Korean immigrants who live in other, smaller Korean communities or who live outside of Korean enclaves may have different experiences than the study participants. Thus, future research should expand the scope of the target population to include diverse geographic locations. Second, the small purposive-based sample may not represent the larger population of older Korean immigrants. Third, despite our research team's effort to ensure the trustworthiness of the study,

each member's biases and perceptions may have influenced the interpretation of data to some extent.

Despite the limitations, this study has several significant implications for policy and practice to promote optimal oral health and dental care. The discrepancy between the perceived and actual needs for dental care calls for action to raise older Korean immigrants' awareness and understanding about the significance of preventive dental care. Also, a variety of services and programs that respond to the needs and barriers identified in the study need to be developed. For example, financial burden, lack of awareness of benefits covered by Medi-Cal, and language are major service barriers for some older Korean immigrants; therefore, developing a culturally and linguistically tailored education program about the dental care services covered by Medi-Cal would promote their use of dental care services. Taking a comprehensive and multilateral approach that includes policy-, community-, and individual-level efforts is also critical to better address the interconnected oral health and dental care challenges. By identifying oral health and dental care challenges in the areas of oral health needs, service barriers, and service outcomes, our study not only sheds light on the varied experiences of oral health and dental care among older Korean immigrants, but also informs the development of services and programs responsive to the identified needs and barriers.

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