

## **North Dakota Dental Summit Feedback from Interviews of Meeting Invitees**

A selection of persons invited to the “North Dakota Dental Summit” was interviewed by Felix, Burdine and Associates prior to the April 14, 2000 Dental Summit Meeting. The purpose of these interviews was for the meeting facilitators to listen to a variety of perspectives on access to dental services in the state. Persons invited but not able to attend the Summit were a priority in the process, so their issues and concerns could be represented in some way in the “Summit” process. Additionally, persons not able to schedule a phone interview were sent a fax copy of the interview questions, and offered the option of responding in writing via fax.

Approximately 30 telephone interviews have been conducted as of 4/3/00.

Comments from the phone interviews are *summarized* here; original notes from phone conversations have been kept for reference. Comments from these faxes are also incorporated. Comments are ***NOT in priority order***, and where possible, similar comments have not been repeated. Additionally, comments are organized into general categories based on a review of comments and information recorded by Felix, Burdine and Associates during telephone interviews.

### **Access to Dental Health Services: Issues and Challenges** Populations

- Financial access to dental services for low income families may be the most challenging aspect of “access to dental services.”
- The “no-show” rates among low income patients remains the biggest complaint among dentists. Project Will Show may help with this, but it is just getting started.
- If a child would be considered a “new” Medicaid patient in a practice, they will not get in unless they are in pain.
- Dentists have been wonderful in caring for children that have cleft lip/palate problems. Those who are children with other special needs may have a challenge because dentists lack the equipment and expertise to treat them.
- A survey of children with special health care needs showed that families did not have the finances to pay for dental care for several reasons, which included lack of coverage by their insurance plans. Many costs were paid for out of pocket.
- Children with special health care needs often require restraint or sedation for dental work. Dentists may not have the equipment or comfort level to handle these patients. A few dentists in the larger communities will have this capability.
- If adults have proven themselves to be reliable, dentists will often take them, even if they are uninsured or Medicaid insured.
- There is a demographic of people that have a need beyond which dentists can provide services or desire to be involved with to meet those needs; some creative strategies need to be developed to both involve dentists or other providers in getting services to these patients.

- New families moving into our communities without much money typically do not get dental services.
- It is becoming more challenging for the population at large to access dental services. When you look at lower economic classes it is even harder, and within the lower economic class, if someone has a condition or special need, they have the most difficult time accessing dental services.

Places:

- Geography and weather will always be major factors that influence how and if people can receive care of any kind in North Dakota.
- The western part of the state has fewer dentists, but is more sparsely populated.
- Cities in North Dakota may be where the actual “shortage” is...many people from surrounding towns and communities come to the cities to take care of shopping, visit with family and go to the dentist. Also, even if they move out of the city, many people keep their dentist “in town.”
- The number of dentists for the population is low to begin with, and many are reaching retirement age.
- The rural communities in the western part of the state are most affected by dentists retiring or closing their practices. Often there is only one or two dentists in town, and if another dentist closes up their practice or decreases services, people will come to the next-closest town for dental care.
- In some areas of the state, there is not even emergency dental care except through the hospital.
- Patients are referred to larger communities in the state for services, but these areas also have a shortage of dentists.
- Dentists in the rural areas who want to retire cannot find other dentists to buy their practices.

Insurance Programs or Programs that Pay for Dental Care: Medicaid, Healthy Steps (CHIP), Head Start, etc.

- Medicaid insured children and adults who are uninsured will not be accepted as new patients in many practices. Access is hardest for Medicaid insured persons age 18-21.
- Because there is a general shortage of dentists, they are very busy with patients who are able to pay their costs, and they do not need poor or uninsured patients to maintain their practice.
- Medicaid insured persons and poor persons are not reliable patients; the no-show rate is enough to keep dentists from participating in programs, or accepting these persons in their practices.
- Increases in reimbursement through the Medicaid program has helped to get kids into the dentist over the years, but it has not really helped poor adults.

- Medicaid eligibility is a month to month process. When families go on and off the program it is very hard to maintain continuity of care and to convince dentists to keep these patients in their practices.
- Most dentists are Medicaid providers, but they do limit their practice to the number of persons that they can take with this kind of insurance.
- There is a lack of trust between dentists and the programs that pay for dental services.
- There is no problem with getting children insured by Healthy Steps (the state CHIP program) into the dentist: the payment is acceptable, and it is not perceived as a social services or welfare program.
- Field trips with Head Start children to dental offices for a screening have been very successful and the dentists are very good about providing this service. Follow-up with children who need advanced dental work does not always happen because dentists are not accepting new Medicaid patients into their practices.
- Medicaid insured persons often come to the cities for dental care, thinking that their chances might be better at getting into a dental practice.
- Families are now “negotiating” with dental practices based on what their insurance can cover: they discuss how often they can come in, what procedures can/should be done based on the money they have to pay.
- Head Start programs require screening of children within 45 days; sometimes there is a challenge in meeting our Federal guidelines because dental practices have longer waiting lists than this, and/or patients miss the window of time to call them and make an appointment for the month (e.g., call the first day of the month for the slots open to the Medicaid insured).
- Changes in the Medicaid reimbursement helped to maintain the number of dentists participating in the program; without it there would have been a decrease.
- Persons enrolled in Medicaid may not value the dental care they receive because it is free to them. Some type of cost sharing or payment on the part of patients will create value for the service, and maybe help remedy the no-show situation.
- Even if Medicaid were paying for 100% of fees charged or if reimbursement were increased, there would still be an access problem for these patients, both because of the general shortage, and because dentists do not feel they value dental care.
- Many dentists take 1-2 new Medicaid patients per month, and maintain all other Medicaid insured persons that have accumulated in their practice over the years. There is a great deal of satisfaction that comes from seeing these patients get to a place where their oral health is good, and where they value the dental care they are receiving.
- If forced to choose, many dentists would rather accept a new uninsured/self-paying patient over a Medicaid insured patient.

### Providers of Dental Services

- There is both a “distribution problem” as well as a “shortage” of dentists in the state.
- The dental manpower shortage is isolated to certain areas in the state right now (such as Fargo), but in 5-10 years the entire state will not have enough dentists.
- There are not enough dentists taking new Medicaid insured patients, or any new patients, into their practices.

It is important to recognize that dentists often don't target one group or another to exclude from their practices. If dentists are not taking new Medicaid patients, they may not be taking *ANY* new patients.

- Most practices are now scheduling into June or even September. This may be due to a shortage of dentists.
- Greater use of dental hygienists would appear to solve a lot of the problems, but there seems to be resistance to that in the state.
- Each time practice has been “expanded” for dental hygienists, it has made (my) office operations flow more smoothly, and we see more patients.
- The ebb and flow of dentists on the Indian reservations makes things busier in communities near reservations in North Dakota: when there are fewer dentists, practices off the reservation have an increase in patient volume. Some reservation waiting lists for dental services are as long as 700 people.
- Dentists would appreciate being recognized for their participation in caring for low income or uninsured patients, whether from the state or other programs.
- As the shortage of dentists increases across the county, it will be harder for students from our state to secure a spot in other states' dental schools. We will have to compete harder for those spots to stay guaranteed for our students. This will make our overall recruitment efforts much more difficult in the future.
- Dentists are sensitive to the public perception of their profession + be sensitive to that and recognize that many do have a public health perspective and are ambassadors for public health.

### Other issues and challenges related to access to dental health services

- There is a challenge in trying to provide continuity in dental services for low income families and children, because they see dentists or any provider when they can, and because their Medicaid eligibility can change from month to month.
- People are just treated badly because they are poor; these families don't complain about it, they will just switch providers.
- The primary challenge is that this problem has been building for years...it won't be fixed in one year.
- The bottom line is that at the point of service or where people have to discuss payment, the relationships are awkward or negative, and in general, people are not treated with respect. They are belittled or abused, and have a hard time being “appreciative” themselves in that environment.

- The unmet need in the state may well turn into a public health problem + so the public health sector must be involved now to both understand and potentially prevent the problem.
- Dental schools need to make their students aware of the many types of patients they will be treating, and to see the patients as a person. Students need to appreciate that the trend is toward community-based services + is the dental profession preparing students for the real world?

### **Advice for Addressing Issues**

- In our practice, each person has a treatment plan, regardless of how, if or when they are paying for their services. We try to stick to that treatment plan, and our office staff work with people to keep them from getting uncomfortable with the fact that they need help, or cannot pay for everything front, and a payment plan is arranged as well.
- It takes a special kind of person to work with people who are proud and cannot pay their bills, especially to do this in a way that keeps them coming back for the care they need, and paying for services a little at a time.
- Programs to increase access will be successful if they work with the many existing efforts already in place addressing this issue, such as the Pre-K to 16 Partnership Council in Grand Forks, which is focusing on community issues that impact youth in the areas of physical and mental health.
- Have consistent guidelines for the age that children should begin to receive dental screening: for WIC/Head Start it is age 1, but dentists may not recommend screening for children under 4.
- The state and state dental society need to allow dental graduates to practice here; there needs to be mentoring and internship opportunities for students to work in the state while they are still in dental school.
- Dental care seems to be more a priority when it is included as part of a whole realm of specialty services “needed” by a child, when the child is treated by a team of specialists and practitioners in a concentrated period of time. This model works for children with cleft lip/palate, and might work for other children as well.
- Public health should be considered an integral part of screening families and children who need dental care (as well as a lot of other services) and getting them connected to services.
- In a small state with a small staff (for any program!), we balance between being “parochial” with our programs and stretching to work together. Often, having programs work boils down to money and that we can only do what we are paid to do.
- Would a dental van that travels around the state be a possibility?
- Keep supporting those programs that inform high school students and counselors about the options and benefits of dentistry! Recruit kids younger to be interested in the profession.

- Do more to build relationships with students from North Dakota who are in dental school+the challenge is in getting students to return to the state, not necessarily in getting them into school. One strategy is to establish mentors for dental students who are established practitioners in the state, or to have them become sponsored members of the North Dakota Dental Association when they are in school.
- Send strategies developed to the Summit to John Warford, Jr., a dental student at the University of Minnesota. He will organize a discussion with dental students in the school from North Dakota in follow up to the Summit, and gather their feedback on how or if the strategies recommended would work.
- Completely do away with the Medicaid program, and start over with a program that would have a chance at a positive history and some accountability for both providers and patients.
- There may be more creative strategies that can be put in place that are more oriented to the private sector, which is where dental practices really operate.
- Programs that would allow graduates to be in the state for at least one year in return for support during dental school, whether through a small stipend or supporting their cost of living, might allow them to establish some roots and relationships that would retain them in the state. A year is a manageable time frame for students to consider and long enough for them to get established, and be exposed to our way of life, which increases the chance that they will stay.
- Look at how other professions handle treating low income people: law, for example. How do they manage the pro bono system?
- Mandate that receptions cannot ask “what kind of insurance do you have” before they make the appointment.
- Teach dental office staffs what it means to be a patient advocate, and the creative ways that people can do that to help people get services.

**What would you really like to see come out of this meeting? What would make it worth it for you (whether attending or not)?**

- To understand the perspective of dentists and private providers better than we do+what do they think are the problems? How do we help them reach more people and expand their practices in a helpful, reasonable way?
- A raised consciousness about the issues surrounding access to dental services, particularly for our legislators.
- Keep everything “above board” and all the issues on the table.
- Consensus on the issues and a reasonable plan to address them.
- Hear what other ideas are and what has worked across the state and nation.
- Dental access is a state-wide problem that we will have to work on, and the legislators need to recognize this, hopefully through this meeting.
- The meeting should result in a partnership with the Dental Association; if we don’t have this, we won’t have a whole lot of possibilities.

- For those who make policy and decisions about resources to hear about the problems that are out there directly from those families or persons who have the problem.
- Strategies that will result in more dental services for kids, especially for routine services like cleaning.
- Awareness on the part of legislators of the need for North Dakota to have and preserve its positions in dental schools, and the need for low interest loans for dental students.
- Make it known that people who cannot get access to dental care exist in the state.
- A coalition that will support legislative efforts to increase dollars for dental positions or dental school slots.
- A chance for lots of people to see the issue from multiple perspectives.
- A unification of goals for improving access.
- Answers to some questions about exactly what the needs of our state are, maybe through some data or other presentations.
- Would like to hear the North Dakota Dental Association describe what they reasonably can and cannot do to address the access problems for low income people.