MINUTES
Oral Health Stakeholder Work Group – Conference Call/Webinar
Monday, July 21, 2014; 1:00 pm – 4:00 pm

Attendance: Shawnda Schroeder, Brad Gibbens, Gary Hart, Yvonne Jonk, Kristin Schuller, Bill Krivarchka, Michael Helgeson, Ron Seeley, Rachelle Gustafson; Rae Ann Hansen, Jan Anderson, Rhonda Anderson, Kimberlie Yineman, Jaci Seefeldt, James Podrebarac, Jodi Hulm, Brittney Odberg, Brad Hawk

1. **Welcome *(Dr. Shawnda Schroeder)***
    a. **Order of consensus for July 31**

Minutes:
On July 31, at the final stakeholder meeting, stakeholders will be expected to come prepared for discussion. Prior to the meeting date, Shawnda Schroeder will send information regarding the proposed models, along with questions for the group to think about. The meeting will be in Bismarck at the Job Services Building, 11-2:30. Lunch will be served and travel will be covered. More information to come later this week. At that final meeting, the CRH will walk away with a list of proposed recommendations made by the stakeholder group. We will review each model for its feasibility, plausibility and need.

2. **Presentation of Models *(Bill Krivarchka, DDS)***
    a. **Presentation of models currently in report**

Minutes:
(1) One time Purchase of Mobile Dental Equipment: This model would require a one-time purchase of dental equipment to be stored in central locations and "checked-out" like library items to be used in various community settings. Conversation has begun among Bobbie Will (Oral Health Program) and Marcia Olson (Bridging the Dental Gap and the Oral Health Coalition).

- No formal plan yet developed
- Initial thought would be to store equipment in larger long term care settings because they have the space AND a population in need – also geographically dispersed
- Store in eight regions of the state
- Maintenance checks would be addressed by the users
- Still need to develop guidelines
- Need an entity to spearhead the project (i.e. organize schedules and check-outs)
- This would minimize access issues
- Marcia is working on dental commitments in the professional community – who would use and access this resources if they were available?
- Eight sites – equipment at each -- $25,000 per mobile unit = $200,000 ask – could look for match funding

(2) Fluoride in the State: There is no ND requirement for fluoridation levels in the drinking water. 266 communities receive water fluoridated by the state; 78 communities are not having their water fluoridated – this is because there are already high enough levels in their water, or they are purchasing fluoride elsewhere –some are not covered.

- ND is national example for fluoride – around 96% of population has fluoridated water in ND
- Pros: safe, prevents tooth decay, benefits all populations
- Cons: "involuntary mass medication," most other countries do not have fluoride and do fine, too much fluoride can change your tooth enamel – bones too?

(3) Expand Seal! ND: Seal ND is a sealant program in schools. Was once covering 85 schools, but last year, only 2 because of drop in funding. Funded by federal grants, needs an oral health prevention coordinator and need more money to target schools. Benefits kids in need with positive outcomes.

(4) ND Dental Outreach Model (EAHEC): The goal of the North Dakota Area Health Education Center (AHEC) Dental Outreach Model is to provide dental students with clinical experiences that reinforce their knowledge of the principles of delivering dental health care, while providing needed dental services to a variety of patients, including underserved patient populations, in contemporary off-site clinical settings in ND. Such experiences also enable students to participate in community dental health education, as well as dental career promotion and inter-professional education activities. North Dakota not having a School of Dentistry, relies on a return import to sustain the dental workforce, from regional Schools of Dentistry (University of Minnesota, Creighton University, University of Nebraska, University of Iowa and other institutions). Dental workforce maldistribution creates critical shortages in rural, underserved and Native American communities. Non-existent dental clinical rotation experiences challenges the opportunity to recruit the dental workforce.

The ND AHEC Dental Outreach Model would establish clinical sites (North Dakota State College of Science, Northland Community Health Center, Quentin Burdick Health Center, FQHC's), adjunct faculty and financial support for the 4 week dental clinical rotation (2 dental students) for a four year project model. The model would then be partnered to the ND Dental Association, ND Oral Health Coalition, ND Health Department and other appropriate partners for formalization, as a state of North Dakota legislatively appropriated program.

b. Stakeholder feedback on missing pro/con regarding models

Minutes:

Q: Under model number 4: Could we expand this idea and also buy slots with those schools to accept ND students?
Discussion: Legislature could pay to hold spots and require these students to then come back to ND to practice. This is an issue because UofM no longer does in-state tuition for ND students so it is a large investment for students, but also large investment for ND to buy those slots.

Q. Could we combine idea number 1 and 4? Have those students not only come back to ND but have them practice in remote areas using the mobile equipment meeting the greatest needs in ND?
A. This is part of the discussion among the EAHEC as well. Yes. We are working on what type of implementation would need to happen for this idea.

Q. Where would the eight sites be located for idea #1? Rural areas of need?
A. It would need to be in locations where there is a LTC facility large enough to store the equipment and geographically dispersed. This is all that is known now.

Q. For idea #1 would there be a clause or requirement that the mobile equipment could only be used to meet oral health needs of special populations? i.e. LTC, children, disabled, low income, homeless, etc.
A. Yes – that is the intent

Q. For #1 – if you had the one time funding, how would you support maintenance, repairs, travel, etc. of all the equipment over time?
A. Could work with the large retailers of equipment/supplies in the state to work on partnerships and donated services. Reduced fee or charitable giving for a program like this. Could also then look for match funding for the charitable service through DentaQuest or other funding options.

Q. What about a ND dental school?
Discussion:

- Out of state tuition is too high to ask legislature to pay for student spots
- Some private colleges pay students to do their internship/externship elsewhere – look into this model and how we could promote those students to come to ND
- Costs about $14,000 per student for a school to send them to ND for externship (4 weeks of lodging, food, travel, and 4 weeks of loss productivity for the home school's dental clinic)
- Why did MN change to out-of state for ND students? No knowledge of this
- Maybe an idea would be to increase our loan repayments – have various models in the state but it might not be enough of an incentive – increase it?
- We have no instate option for dental education – no dental school gives an in-state option and we have no clinicals here – hard to recruit
- Beyond just buying seats to admit ND students – it should be rural ND students first if possible – better chance they will return to community to practice
- WICHE is also one of the loans that does not require the ND student to practice in ND
- Also need to consider creative partnerships between communities to recruit and incentivize placement of dentists. I.e. involve economic development – give student means to open a practice, give start up funds, community and state, etc.

Q. Model #3, what is reach of Fluoride now and what would need to happen to expand?
A. No need to expand – huge cover already – leading the nation. It is covering the west as well. Studies finding that water in west has naturally high levels of fluoride in water. We have a community water fluoridation program and a FTE and the needs are being met.

3. **North Dakota Dental Hygienists' Association**
   (Rachel Gustafson, President Elect)
   a. **Presentation of current/future projects**

Minutes: See several attached resources shared by the NDDHA.
Spoke to collaboration and working together. Huge push for oral health literacy and prevention. Currently DH is under a dentist and this is sometimes a barrier to getting a DH into a community where there are no practicing dentists. A DH could do more with more relaxed supervision rules.

- ND is one of the last few states that does not have without direct access – this means that a DH cannot provide many services without the DDS present. If this were to change, then ND DHs could provide care in the communities under a DDS order, but without him or her present during care/education.
- Working on an advanced dental hygiene professional – similar to dental therapy. This is similar to the Advanced Dental Therapist.... not the dental therapist. The ADHP/ADT must have been a Registered Dental Hygienist. This is often referred to as dual licensure. Where the provider is licensed to provide preventative hygiene services and diagnostic and restorative services.
- This model would still need a practicing DDS to collaborate with, but would not need them to order the work. The ADHP/ADT would be trained and educated to diagnose and treat the patient within their scope of practice off site from the dentist, but the collaborative DDS would be there to consult if needed. It is a collaborative team approach.
- Currently board of dental examiners are looking at how to use DH to bring sealant programs to the schools

   b. **Question and answer**

Minutes:
Q. How is an ADT different than an ADHP?
Discussion: Not very different. Just a different name. However, an advanced dental therapist and an ADHP both have experience or already have a dental degree (DH) as opposed to a DT. Currently in MN, Metropolitan State and Normandale both offer education for an ADHP. The NDDA does not support this model. The advantage of being a DH first then becoming an ADHP as opposed to a DT is the clinical experience of DH.

Q. What needs to happen to change the direct access designation in ND?
Discussion: Kimberlie shared that ND is about there. ND is working with the American Dental Hygienists' Association to have the ND designation changed soon. Just a little wording issue. DH in ND can perform services without direct supervision. They can go to a LPHU for example and provide care within scope if under orders of a DDS.

Q. How does a DDS with direct access end up in a community setting providing care?
A. A DDS has to contact or be contacted by the community center (LTC, school, LPHU, etc.) and then write orders for a DH to provide the care. The DH can then go into the setting without the DDS to provide the services specified in the orders. The DDS is then reimbursed for the care in the community. Even a retired DDS can write the orders for these services if he/she is still licensed in the state.

Q. Does there need to be a change to the Century Code for addition of ADT or ADHP?
A. Yes for both

Q. Does expanding the current scope of work require a Century Code change?
A. possibly – not sure
Discussion: In MN it did require century code change and legislative change because they need to have their licensed recognized in the state.

Q. What is the general perspective of ND DHs regarding the ADHP model?
A. the NDDHA did a survey to assess this and it is preliminary now but it looks like general support of the model or just no real understanding yet.

Q. Any providers show interest in the state to employ an ADHP?
A. no real ask yet but think that community health centers would be welcoming to this professional

Q. Does the NDDHA have a legislative ask?
A. no – just looking to what others are doing and if room for collaboration or support?

Q. Are there programs you are supporting in ND?
A. We support a lot of efforts in the state: Sealants in the schools, Elder care, NDDA collaboration model and others

Q. The two MN schools that have ADHP degrees – are they in-state or out of state for ND residents?
A. do not know about tuition but they have spots open for ND students

4. **Oral Health in West *(Ron Seeley, DDS)***
    c. **Presentation of Oral Health Needs in Western ND**

Minutes: Been a practicing DDS in Williston for 34 years

- Sees patients ages 2-102
- Huge growth in the last 3 years for the practice
- Average day believes they field 10-20 emergency calls from new patients – they may have significant oral decay, most are oil workers with low oral health IQ. Try to treat the emergency patients as soon as possible

and have them return for routine care. Usually significant extractions in need of an oral surgeon. Doing a LOT of surgical treatment now.

d. Question and answer

Minutes:

Q. Is there a longer wait or issues for those with a dental home because of the number of traumas?
A. Not at his practice. Dental homes have a priority and are seen as needed but they do have a different model for setting up appointments. If an appointment is needed in 6 months, they will make it then.

Q. What insurance are you seeing? Increase in Medicaid?
A. Increase in Medicaid only because increase in overall patient numbers. Those that are coming in are coming in with money because of oil work and are generally able to pay. Not covered by Medicaid because employed.

Q. Trouble recruiting or keeping staff? Higher wage than in the rest of the state?
A. Some trouble recruiting but pay is much higher. Need to make sure you keep around good people. Starting salary used to be $12/hour for front desk and instead it is $20/hr now. Hygienists are not as hard to recruit as assistants. Certified assistants are very hard to find.

Q. Is there emergency protocol at the hospital?
A. No – there should be and there used to be. Dr. Seeley and his partner trade off a cell phone for emergency calls when out of the office.

Q. Reimbursement problems at your practice? Accounts receivable?
A. We used to mail bills and wait for payment, but we can't do that anymore. It is now a cash business. Patients pay at time of care. Some payment plans may be made, but not typical.

Q. Your position on ADT?
A. Worry that most of what we see in the West cannot be taken care of by an ADT – it is primarily surgical – it needs an oral surgeon. Need to not only know what you can do, but what you cannot do. We have had five new DDS come into Williston.

Q. What do you see for dental insurance?
A. Volume has increased overall – no one particular type.

Q. See use of mobile clinics?
A. Yes. But for surgical care mobile units could not meet that need. Need good follow up care for those services.

Q. How could we meet need?
A. Young dental professionals. Need dental schools and to bring the DDS back into ND. Get ND kids back to ND and get ND kids into DDS schools. Dean at Creighton said they would be interested in having more ND students come and even do their last year back in ND communities – could follow up on this. Need opportunity to make this happen.

Q. How do we make the above happen?
A. Legislation would need to give money to hold spots for those ND students .Need a legislative approach. Creighton would also be interested in American Indian students.

End of the day – it needs to be about the patients.

5. Apple Tree Dental *(Dr. Michael Helgeson, CEO)*

e. **Presentation of current/future projects**

Minutes: See attached presentation

- Slide 9: Apple Tree looking to how they can help us meet these goals
- Slide 14: Need access to keep up with age wave
- Slide 38: $1/2 million with Fergus Falls included

f. **Question and answer**

Minutes:

Q. How do you finance the model?
A. Generate revenue from Medicaid payments, grants for capital, state federal grants, raising funds as well

Q. Are salaries completive with private practices?
A. They are within the range – not below

6. **Valley Community Health Center *(Rae Ann Hansen, Family Services)***

g. **Presentation of current/future projects**

Minutes:

- No Specialty care
- Started doing partials now but require upfront payment
- Help clients fine other assistance in the state to pay for their dental care
- Employ four DDS, 3 DH and one sub DDS for Fridays
- In May – roughly 370 exams and 100 new patients
- Most new patients have 10 cavities and 1 extraction at first visits
- Majority are Medicaid or uninsured
- Also help uninsured apply for insurance
- Most do come as a dental home
- Book about 3 weeks out, any more and no-show rate is higher
- For those in pain with swelling/bleeding, only 1-2 day wait
- Other wait time about 1-3 weeks

h. **Question and answer**

Minutes:

Q. Why create the clinic?
A. Need – huge access issue for Medicaid and uninsured in Grand Forks and surrounding area

Q. Origination of clinic?
A. Bremer was startup funds and some federal grant monies – now Medicaid reimbursement

Q. Sliding fee?
A. Yes and no free care. Even those eligible will still pay at least a small fee.

Q. Do you get a lot of Medicare patients?
A. Medicare does not cover routine dental but we get requests from those with Medicare and have to inform them of this. We try to turn them to our healthy neighbors program.

7. **Adjourn – Future Meeting Dates**

Thursday, July 31, 20014 11:00 AM – 2:30 PM In-Person; Bismarck