# MINUTES
## Oral Health Stakeholder Work Group: Consensus Meeting
Thursday, July 31, 2014; Bismarck ND

**Attendance:** Shawnda Schroeder, Brad Gibbens, Gary Hart, Yvonne Jonk, Kristin Schuller, Bill Krivarchka, Mary Hoffman, Brad Hawk, Jan Anderson, James Podrebarac, Brittney Odberg, Jaci Seefeldt, Kimberlie Yineman, Cindy Sheldon, Rita Ozburn, Mark Schaefer

1. **Welcome *(Dr. Shawnda Schroeder)***
    a. **Top oral health needs for North Dakota**

**Minutes:** Reviewed order of events for the day. Goal is to have stakeholder consensus on recommendations/priorities for the state by end of meeting. **See attached PowerPoint for day's presentations**.

Top Oral Health needs were the same weather reviewing stakeholder conversation, input member written responses, or the data. The three oral health needs (in no particular order) are: Access and utilization among special populations; Medicaid reimbursement, access to care and Medicare (non) coverage of dental services; and Oral health literacy and prevention need across North Dakota with greater need among special populations. Special populations included: American Indian, pediatric, aging, Medicare, special physical/mental needs, Medicaid, uninsured, under-insured, homeless, new American, and/or low-income

    b. **Models – survey cuts**

**Minutes:** Stakeholders were surveyed prior to the meeting to determine if any models should be removed from the day's discussions. When asked to identify, the stakeholders were presented with a list of all possible models suggested to date (those included in the PowerPoint), and asked to identify those that did not meet particular criteria. Here is the question:

Some of the models identified may not fit as a current recommendation to meet the oral health needs in North Dakota. To better focus our discussion, identify any of the models that you do not believe should be a recommendation for the state because it either:

A) Does not meet the specific need(s) of our state
B) Is already currently funded and operational in the state, needing no further significant financial or programmatic support
C) Addresses a need that is already being met by other entities in the state
D) Conflicts with an existing oral health program; and/or
E) Has already been implemented in North Dakota and either needs no additional support, or did not effectively meet intended need(s)

Group discussion re: each model and weather to remove it from the list followed.

The models that had greater than 50% of the stakeholders vote to throw out included: New Fluoride System in West; ND AHEC Model – Dental rotations; Midlevel Provider; Dental School in ND; Apple Tree Dental Model. *Fluoride in West*: Group agreed that after having heard from the Oral Health Program, the reach of the fluoride program is already excellent and not a priority. It is the 4th leading program in the nation for reach. Not a priority for our state. Also noted that had expanded funding in past, but no community wanted it. There is not a need.

*ND AHEC Model:* Many had impression this was already in progress, or not a priority. Group discussed how this is being done in South Dakota. Discussion around dental opportunities for DDS students and new graduates. Decided to not throw out, but consider in-line with the models that outline collaboration with other dental schools, dental loan repayments, and in-state tuition.

*Midlevel Provider:* Group did not feel it was a good fit for North Dakota, though many saw positives of the model. Concerns related to high volume of RDHs (registered dental hygienists) in the state and low volume of DAs. Concern is that we have a lot of RDH, and we have a lot of DDS (with mal-distribution) so adding a new provider is not right at this time. Better to identify models or programs that better utilize existing workforce. When existing workforce is not enough, then possible to reconsider. A midlevel would not meet the DA need and would instead likely lead to greater occurrence of RDHs working below their scope of practice as a DA as is a growing trend in ND. Group did discuss expanding scope of practice for RDHs, but not to a level of needing a midlevel. Interest was to grow scope to allow a RDH to fill and extract. One concern was that we are still not getting to populations in need, and that a midlevel may be the answer to that as a DDS is not going into communities to meet those needs, and as it stands, RDHs are not doing it at a high rate either. Others agreed but felt that the RDH scope of practice was recently expanded and is just not readily being utilized. Want to make sure we use the current scope of practice at its highest capacity before adding new provider type. Did not throw out this model in its entirety, but wanted to discuss further when addressing expanding scopes of practice.

*Dental School in ND:* The market is proliferated as it is. Many DDS schools already in the nation and would be cost prohibitive in the state. Especially in such a small state where the school would complete for students with neighboring states that have very competitive DDS programs with national recognition. This is however, a great concern with students accumulating greater debt than medical students because there are no in-state options for ND students. This was viewed as a high concern and priority for the state, but a dental school was not a logical solution. Removed.

*Apple Tree:* Some in group believed this to be a high priority while others had concern because model relies on use of dental therapists. In discussion, group liked idea of leaving on the list, but to discuss in relation with expanding reach or funding of safety-net clinics. Group felt that this model may be able to meet need in LTC settings – so may be worth discussing with mobile equipment model as well. One stakeholder mentioned Apple Tree comes to the state only if invited, and is willing to work with existing private practices as hubs for rural spokes. One area of need in ND that Apple Tree could help the state meet is the need for an oral surgeon that accepts Medicaid patients. Keep on list, but as a model, not an organization, and discuss in relation to other models, not on its own.

In answering this question, stakeholders also had six models that no individual wanted to remove from the list. These are likely high-priorities from the group and included:

- Increase Sealant Program – also a priority among The Health Services Interim Committee
- Expand scopes of practice
- Safety net clinics in the West
- Expand state funding of safety nets
- Medicaid reimbursement
- Expand loan programs – also a priority among The Health Services Interim Committee

2. **Presentation of Models**
   ***(Dr. Yvonne Jonk, Dr. Kristin Schuller, Dr. Shawnda Schroeder)***
   a. **Presentation of models**

**Minutes:** Went through models to answer questions. This section of the meeting was intended to review the models and offer a time for question and answer among the group. This was not a discussion of weather the group proposes/supports each, but an opportunity to gather more information before beginning said discussion. Model presentation may be reviewed in the **attached PowerPoint Presentation.**

   b. **Question and answer**

**Minutes:**
**Slide 8: Model One:** Q. How would this model meet needs of special populations? A: It is primarily for LTC and sealant programs. Would reach high need of gaining and pediatric populations. Did Bismarck pilot. Would require a lot of pieces: a coordinator, someone to review sanitation, transportation, upkeep of equipment, frequent utilization of equipment to make it worth expense, etc. Private DDS would be reimbursed when using equipment for their provided services.

**Slide 10: Model 3:** 52 schools reached, not 85. Under new funding, will reach 100 or 430 schools. 90% of schools reached are rural. Currently schools reached is predicted by the grant funder's qualifications. If state funded, could expand as wanted/needed and not need to follow current rules of qualification. Greater reach then. Currently do not bill services which makes sustainability impossible. If state funded, also work on reimbursable services. DoH cannot bill DHS for services. Working to contract out sealant program. If DoH has funds, contracts it to a third party, specifically a FQHC/CHC, the FQHC can provide the service AND bill for it, building a sustainable program.

**Slide 18: Model 9:** Include Bowbells, Minot, and Northwood in FQHC reach/location. In final report, list all of communities included in the reach of each FQHC.

**Slide 20: Model 11:** DA school in the West is a possible priority among the legislative committee as they shared great concern that current DAs can be trained chair side. Leary to expand scope of practice of a DA in ND because currently, a DA could be trained chair side, pass test taken by DAs that went to school for DA, and then under scope of practice, if expanded, could do even more services without ever going to school. Other concern is that

there may misunderstanding of DAs are providing some care (like cleaning gums) that would lead vulnerable populations to think they had received comprehensive care/cleanings. Committee would likely be in favor of schools in West, especially with online component, requiring DAs to have a degree before ever expanding scope of work.

**Slide 26: Model 15:** Dentist in Louisiana built a name for himself by going TO LTC facilities to provide necessary oral health services. Charge of $6.50/bed/month to get around family consent for care. He could present his model if interested.

**Slide 27: Model 18:** Other loans include: Slurp, Federal, Rural Loan repayment -- $80,000 over 4 years, New practices grant. The process is confusing. Many loans. Work with loan entities to create table of loan type, who funds, how much, number available, etc. and propose loan expansion and consolidation of programs.

**Slide 28: Model 19:** There is also a billing issue with colocations when a patient sees a dentists and primary care provider on same day at same location. Currently, both cannot bill for the visits – one bills for visit, other can only bill for services provided outside of the visit charge. Also cannot currently reimburse oral health screening – this is a barrier even for DH. A DH cannot do an oral health screen and help patients find a dental home and be reimbursed. For this to work, need new billing codes, need EHRs to include oral health component, need to train primary care professionals in oral health services, need primary care buy-in, need to work out issue of colocations.

**Slide 29; Model 20:** Do not focus only on boarder states. Include options for residency AND rotations. Similar to RPAP program for medical students – pay schools for spots, but to also have ND students return to ND – not only ND areas of high need.

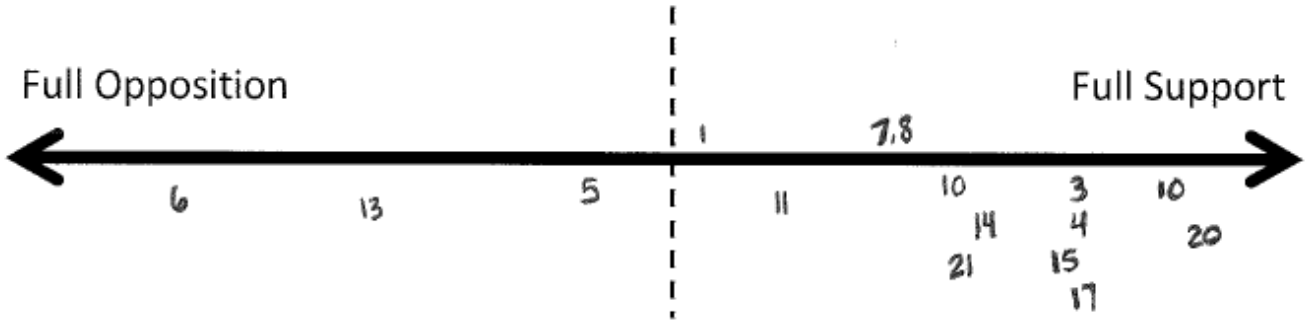
**Slide 30; Model 21:** Transportation also a huge issue for HIS patients. Use CRH services now – would think this would alleviate one of the significant barriers but people would still prefer the care come to them. More comfortable than going out for care.

3. **Working Lunch/Break (*Lunch is provided)***
    a. **Stakeholder open discussion**

4. **Activity: Get Ideas Moving**

**Minutes:** Group was asked - What level of support would there be in the state for each given model? * Not based on your organization or personal position, but the state collectively to include consumers, providers, organizations, legislature, hospital systems, FQHCs, etc.

Room was spilt and individuals moved across the room – no one could stand in the middle. The larger consensus for each model is presented below.




**a. Present survey findings on model need/effectiveness**

**Minutes:** Stakeholders were asked two questions about each model prior to the meeting. Their results were presented and the group was encouraged to discuss what they saw and what this meant for their recommendations. See PowerPoint for graph of results (slide 34), but questions and results included here as well:

How great of an impact would each of the proposed models have on its intended population/focus in North Dakota?
No impact (1); Fair impact (2); Good impact (3); Great impact (4)

How likely is it, given the current oral health environment (political, economic, social, demand) that each of the proposed models could be implemented in North Dakota?
Very unlikely (1); Unlikely (2); Somewhat unlikely (3); Somewhat likely (4); Likely (5); Very likely (6)

*Tier One: Impact 3+, Likelihood 4+*

- Increased Sealant Program
- Expand Scope of Practice
- Expand Safety Nets
- NDDA Case Management
- Expand Loan Repayment

*Tier Two: Impact 2+, Likelihood 4+*

- Purchase of Mobile Equipment
- Fluoride in West
- Collaborate with Boarder Dental Schools

**b. Discussion of each model**

**Minutes:**

Stakeholder asked to identify their one significant priority/model and any they think should not be considered.

- Without increase in Medicaid, none of the other models would work. Cannot take less than cost to provide care regardless of who is providing the services. This is even true among CHCs, etc. Without increasing Medicaid, the state will have to continue to provide programs with state funding without full plan for sustainability
- There is a LOT of donated care in ND and cannot expect the ND oral health environment to improve with only donated care. Dentists cannot just donate services to meet all of the need in the state.
- Need to explore ideas around collaboration between non-profits and private sector.
- Many agree that without increase in Medicaid, special populations will continue to have unmet need. This is especially true with regard to oral surgeons who are not accepting Medicaid patients in ND.
- All are priorities but biggest concern is the mobile equipment model. Do not think this is best fit. Others agreed. It is expensive start up and would require a lot of steps to have it properly executed. Would also require new codes for billing to make it sustainable and encourage DDS to use it. Not a bad idea, but not a priority at this time in the state.
- Need to create a model that addresses more preventative care and results in less urgent care. This would also alleviate cost. More preventative care and better reimbursement would lead to greater revenue in IHS facilities and more revenue could lead to more provided services.
- Need to look at care for those with special needs who are encouraged to go to DDS only every three years because of how difficult they are to work with and many require sedation. Look into ideas to collaborate with medical community to meet needs of this population.
- Expand safety net clinics – see about oral health surgery for safety nets – something like expanding safety nets in partner with Apple Tree model to bring dental surgery to patients in need (Medicaid patients). Concern is it is huge process to open or originate an FQHC – group leads more to hub and spoke models discussed by Apple Tree and Children's dental to expand reach. Work with existing FQHCs to build or identify more spokes in the system to expand reach. Also look to add workforce to existing FQHCs, specifically surgeons. Noted that many tribal members live off of the reservation (40-50%) and have to utilize safety nets because they do not have the insurance and cannot utilize IHS services.
- Needs to be priority to attract new DDS students and to encourage ND students to go to DDS school. Many have heard students (American Indian students too) that want to go to dental school, but no school in ND and students say it is too expensive to go out of state so they go to medical or veterinary school instead where tuition rates are not as high. Average debt is between $300,000 and $350,000 for DDS school. Need to build system where we encourage DDS school, help students afford DDS school out of state (offering in-state tuition match, reserving spots, offering loan repayment, etc.) and focus/priority on rural and tribal students with DDS interest. Higher probability they will return to ND.
- Promote the models/programs that highlight oral health literacy and prevention. Sealants are important and a huge need among IHS students.
- There is no preventative budget for oral health among IHS.

5. **Final Consensus**
    a. **Priority ranking of recommendations for North Dakota**

**Minutes:** Group was each asked to list a top priority recommendation and it was listed on a poster board around the room. The models listed around the room included those identified as priorities from the early survey and day's discussion. Each present stakeholder was given three dots and told to place dots on their three recommended priorities for the state. They could not place all three dots on one model. The models that were listed around the room are listed below (in order or importance) with the number of dots and discussion that followed:

**1.** Expand Safety Nets – using models/ideas/support from Apple Tree and Children's Dental – Collaboration with a non-profit to expand services. (6)

- Use this model and use it to employ existing RDH workforce to their full capacity.

**2.** Increase Medicaid (4)

- See earlier discussion – same points.

**3.** Increase Sealant program: have state support for program (financial) and create a billing structure so that all sealants can be reimbursed by Medicaid or third party insurers *when* students have the insurance to cover the care provided. Utilize the current RDH workforce at their full scope of practice. They can do preventive services and oral health literacy in the schools. This would also partner with the NDDA case management model by training the existing RDHs to do case management at the time of the oral health literacy and sealants for the students, linking them to a dental home whenever possible.(4)

- Group agrees this model meets most of the identified need and has greatest impact among the current proposals.

**4.** Increase dental loans, consolidate the loan programs, and work with out of state dental schools to reserve spots/in-state tuition, develop externships/rotations in ND (3)

- Need to develop a process from high school graduation through DDS school to encourage DDS school among ND students, support them, and bring them back to ND. Not an immediate answer for the state, but once implemented, could bring a significant workforce to ND and one that would meet rural and tribal needs.
- No solution proposed really meets immediate need other than sealant program – all would take time and this could be a long term solution brining workforce and revenue to state while meeting the greatest need populations.

**5.** Expand DH Scope of Service (2)

- Those who did not support this basically shared they would rather see better use of existing scope of practice to RDHs instead of expanding scope. Others agreed.

**6.** NDDA Case Management (1)

- Good model – but works best when discussed in accord with other models. Use this idea to work alongside other priorities.
- Like that it uses the existing workforce.

**7.** Dental Residencies (0)

- More support for the idea to collaborate. This could be included in earlier discussion of creating a process of following students and supporting them through dental school and practice.

**b. Question and answer**

**Minutes:**

Final comments:

- This effort has brought together many oral health agencies/organizations and has brought the topic to the forefront
- Strong partnerships have come from this
- Prevention is key and not relying on the state's high volume of volunteer services provided by the private practice DDSs

**6. Adjourn – Thank you for your all of your participation and time!**

**a. Future efforts – draft review**

Not all stakeholders were able to make the meeting. These notes illustrate the preliminary recommendations of the group. However, a final assessment, along with the meeting minutes, will be sent to the other stakeholders and all will be encouraged to provide their final top three recommendations for the state. These results will be reviewed and analyzed and a final formal recommendation will be made at the last meeting for the Health Services Interim Committee. Final draft reports outlining current programs and proposed models will also be sent to the stakeholder group as well as the input members for review and final comments.

Thank you to all entities working on the project and for providing feedback!