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Center for Rural Health
University of North Dakota
School of Medicine & Health Sciences

Fact Sheet

# Dental Practice Setting Influences Dentists' Attitudes toward Oral Health Access Solutions

*This fact sheet is Number 13 in a series of analyses regarding oral health in North Dakota.*

During 2015, the North Dakota Legislature considered the licensure of a new dental provider, a dental therapist (DT). Legislation did not pass, though Senate Concurrent Resolution #4004 called for additional study of oral health workforce solutions. During 2017, House Bill 1256 proposed licensing DTs, but failed in the House by a 32-59 vote. In response to legislation, the Center for Rural Health developed a survey to assess North Dakota dentists' knowledge of, support for, and the willingness to participate in nine proposed dental care access solutions. See the full data brief for more information.[1]

**Table 1. Proposed Access Models /Survey Variables**

| Workforce Model | Abbreviation |
|---|---|
| Funding and implementation of case management, including as a reimbursable service | Case Management |
| Increasing opportunities for dental students to complete residencies in North Dakota | Residencies |
| Additional locations and funding for dental safety-nets | Safety-nets |
| Increasing Medicaid reimbursement for dental services | Medicaid |
| Expanding the service area (funding) of Seal!ND2 | Seal! ND |
| Utilizing dental hygienists at their expanded scope of practice (once certified), including limited restoration procedures under direct supervision of a dentist | DH Current |
| Further expansion of the scope of practice for dental hygienists including expanded restorative procedures | Expand DH |
| Expanding the scope of practice for dental assistants including preventative and restorative services | Expand DA |
| Develop and utilize a CODA certified dental mid-level provider | DT |

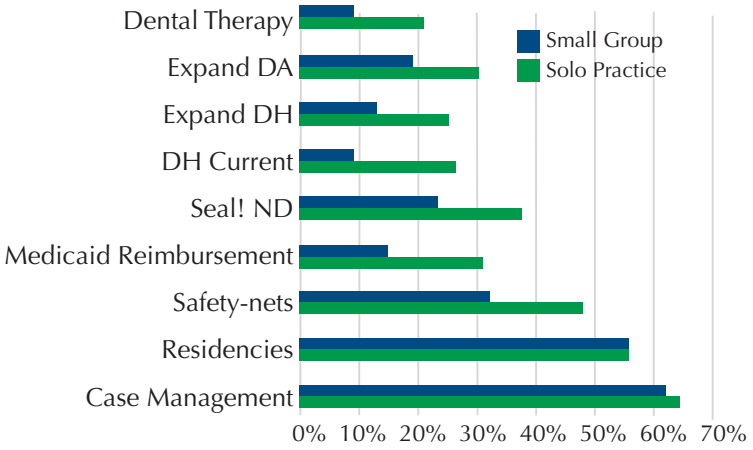
## Survey Responses

Approximately 421 North Dakota dentists received the survey; analyses included 187 completed surveys for a response rate of 44%. Roughly 58% of respondents served urban communities while 42% provided care primarily to rural residents. A large majority (77%) practiced general family dentistry. A majority of dentists served in a solo private practice (50%); 38% served small group private practices with 12% identified as other.

## Dentists' Knowledge of Access Models

Dentists employed in a solo private practice were as likely, or more likely, than those in small group practices to report no knowledge for all nine proposed access solutions, though not statistically significant. See Figure 1.

**Figure 1. Percent of Dentists with No Knowledge of Model by Practice Type**




## Dental Support & Participation

Dentists working in solo practices were more likely than those in small group settings to support implementing DT, and expanding the scope of practice for dental hygiene (DH). Small group practices were more likely to support all other models. See Table 2. There is slight variability in a dentist's willingness to participate based on practice setting, but the difference is significant ($p<0.05$) only with regard to participation in care for Medicaid enrollees.

Nearly 86% of dentists serving in other practice settings would participate and serve Medicaid enrollees compared to 62% of small group dentists, and 47% of those in solo private practice.

### Table 2. Dentists' Support by Practice Setting

| | No Support | | Support/Support Depends | |
|---|---|---|---|---|
| | Solo Private | Small Group | Solo Private | Small Group |
| Case Management | 14% | 7% | 86% | 93% |
| Residencies | 3% | 3% | 97% | 97% |
| Safety-nets | 20% | 7% | 80% | 93% |
| Increase Medicaid | 3% | 0% | 97% | 100% |
| Seal! ND2 | 14% | 7% | 86% | 93% |
| Current DH | 42% | 38% | 58% | 62% |
| Expand DH | 48% | 54% | 52% | 46% |
| Expand DA | 35% | 30% | 65% | 70% |
| Dental Therapy | 85% | 91% | 15% | 9% |

Though the "other" category only represents 23 practicing dentists in the State, they represent dentists serving in safety-net clinics, public health, Indian Health Services, the veterans' administration, and corporate practices; many of which already serve Medicaid enrollees.

Support for proposed models did not translate to participation regardless of practice setting. See Figure 2. For example, on average dentists indicated support for increasing Medicaid reimbursement (2.9 on a 3-point scale). However, average participation regarding Medicaid was 2.0 on a 3-point scale.

### Figure 2. Average Knowledge, Support, and Willingness to Participate by Practice Setting

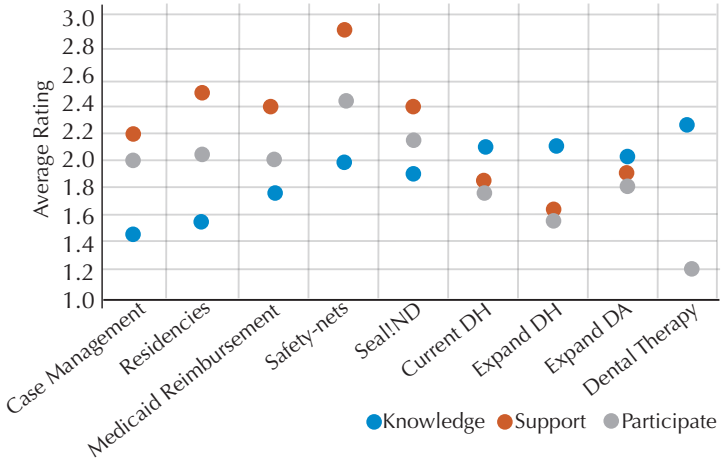



Figure 2 also illustrates greater support and participation for programmatic interventions (case management, residencies, increased Medicaid reimbursement, increasing reach of Seal! ND[2], and expanding reach of dental safety-net clinics), than for those models focused on increasing scopes of practice for current or new dental providers.

## Conclusions

Dentists serving in solo private practice made up a majority of all dentists in the State. Solo practice dentists had less knowledge regarding access solutions than did dentists working in small group settings. In fact, 31% and 65% of solo practice dentists reported no knowledge of increasing Medicaid reimbursement and case management, respectively. However, there was near majority support for both models.

Regardless of practice setting, dentists indicated more support for those models involving programmatic intervention than those focused on increasing scopes of practice for current or new dental providers. Additionally, support did not necessarily translate to willingness to participate as evident in Figure 2.

While willingness to participate was low overall, solo private practice dentists were more willing than small group dentists to participate and utilize DHs, DAs, and DTs at current and/or expanded scopes of practice. This is likely due to the nature of their practice, and their reliance on all members of the dental team to serve patients. It is also likely that small group practices have more resources to participate in programmatic initiatives (e.g., Seal! ND, dental student residencies) than do solo providers. Solo providers' inability to participate may also explain why they have less knowledge on programmatic solutions.

As organizations in the State look to partner with dental providers on access solutions, programmatic initiatives should look to partner with small group practices, while initiatives exploring current and potential services provided by other members of the dental team look to private practice dentists.

## Data

*Two rounds of the survey were mailed in December 2016, and January 2017 to all dentists in the State with a practice address on record with the Board of Dental Examiners. Responses were anonymous.*


1. Schroeder, S. & Fix, N. (2017). Dentists' knowledge, support, and participation in proposed dental care access solutions. Center for Rural Health. Available at: ruralhealth.und.edu/what-we-do/oral-health.
2. Seal! ND is managed by the State Department of Health, Oral Health Program. The initiative looks to place dental sealants while in school-based settings. For more information: www.ndhealth.gov/oralhealth/programs.htm.


### For More Information

Visit the CRH webpage for additional oral health publications and information. ruralhealth.und.edu/what-we-do/oral-health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