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Report of the Survey of Dental Safety Net Providers in Maine

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Center for Health Workforce Studies
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Report of the Survey of Dental Safety Net Providers in Maine

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The Center for Health Workforce Studies is a not-for-profit research organization whose mission is to provide timely, accurate data and conduct policy-relevant research about the health workforce. The Center's work assists health, professional, and education organizations; policy makers and planners; and other stakeholders to understand issues related to the supply, demand, distribution, and use of health workers.

Preface

In recent years, oral health stakeholders in Maine, including provider organizations and policymakers have expressed concern about the oral health status of the state's population and the need to improve access to oral health services in certain geographic areas of the state. Identifying effective strategies to increase access to oral health services in Maine is complicated by the many factors that adversely affect access to care, including limited resources to pay for oral health services, lack of oral health infrastructure and workforce, and limited oral health literacy of patients. To date, Maine's strategies to increase access to care have included dental loan repayment programs, funding for a dental school in the state, and expansions in the scopes of practice for dental assistants and dental hygienists. Little is known, however, about the impact of these interventions on access to oral health services for Maine residents.

In 2011, the Maine Legislature passed Legislative Directive No. 1105 "Resolve, To Study Oral Health Care in Maine and Make Recommendations Regarding How to Address Maine's Oral Health Care Needs." The resolve called for a study of Maine's oral health care needs to include a review of public and private financial resources for oral health services, a description of limitations on oral health access in the state, a discussion of the sustainability of public financing for oral health programs, and an enumeration of the current oral health workforce in Maine. The Legislature requested that this review be completed expeditiously and that it be financed through funding other than public resources. The Center for Health Workforce at the School of Public Health, University at Albany was selected to work with Medical Care Development in Augusta to answer the questions posed by the legislature about oral health in Maine.

The comprehensive study includes a contextual assessment of historical literature and data about Maine, a survey of oral health safety net providers in the state, and an analysis of historical insurance claims data to understand utilization of dental services in the state. This report contains the summary of results from the survey of oral health safety net providers in Maine and was completed by Margaret Langelier and Tracey Continelli of the Center for Health Workforce Studies. The authors can be contacted with any questions regarding its content at (518) 402-0250. Special appreciation is extended to Margaret Gradie of Medical Care Development, Inc. for her guidance during the survey development and for her help in identifying dental safety net providers in Maine.

Established in 1996, the Center is a not-for-profit research organization whose mission is to provide timely, accurate data and conduct policy-relevant research about the health workforce. The Center's work assists health, professional, and education organizations; policy makers and planners; and other stakeholders to understand issues related to the supply, demand, distribution, and use of health workers. Today the Center is a national leader in the field of health workforce studies. It supports and improves health workforce planning and access to quality health care through its collection, tracking, analysis, interpretation, and dissemination of information about health professionals at the national, state, and local levels. Additional information about the Center can be found at http://chws.albany.edu

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Executive Summary

Background

In 2011, the Maine Legislature passed Legislative Directive #1105 requesting a study of oral health needs in Maine, a description of the oral health status of Maine's population, and an assessment of delivery of oral health services in the state. The Center for Health Workforce Studies (CHWS) at the School of Public Health, University at Albany was selected to work with Medical Care Development (MCD) of Augusta, Maine to answer the questions posed by the legislature.

The study was multifaceted including:

- a review of historical literature and oral health surveillance data about the oral health of Maine's population to understand past initiatives to improve oral health;
- interviews with a large number of oral health stakeholders to understand the context in which oral health care services are delivered in Maine;
- a review of oral health workforce initiatives across the United States to aid the legislature in understanding specific workforce models that might be useful to improve access to oral health care in Maine;
- analyses of five years (2006-2010) of medical and dental claims and eligibility data collected in the All Payer Claims Repository managed by the Maine Health Data Organization (MHDO) to understand eligibility for and utilization of oral health services; and
- a survey of dental safety net providers in the state to better understand their contributions to oral health care for Maine's people.

This report describes the results of the Survey of Dental Safety Net Providers in Maine which was conducted between August and November, 2012. The dental safety net includes programs, facilities, and professionals who provide oral health care to underserved populations who are disadvantages by medical, social, economic, or geographic circumstances.[1] The survey asked questions about delivery of services in the oral health safety net, including structural capacity, number of patients served annually, employment of oral health providers, demographics of patients served, sources of revenue for oral health services, and attitudes about impediments to care for patients and for providers. The findings are described and their implications discussed below.

[1] Edelstein B., The dental safety net, its workforce, and policy recommendations for its enhancement. *Journal of Public Health Dentistry*. 2010;70(1): 32-39.

Methods

In August 2012, invitations to complete the online survey were mailed to 116 safety net providers in Maine. The sampling frame consisted of federally qualified health centers (FQHCs); community dental clinics (CDCs), including student clinics, free clinics, government sponsored clinics, volunteer clinics, and tribal clinics; a small number of medical doctors known to be providing oral health assessment services; school-based oral health programs; and independent practice dental hygienists (IPDHs). These providers were identified from a variety of sources, including project advisors, oral health stakeholders in Maine, licensure lists from the Maine Board of Dental Examiners (MBDE), and Internet sites. The invitations explained the reasons for the research, described the survey process, and provided assurances of confidentiality to survey respondents. Each letter contained a personal Internet link to the survey instrument. Follow-up e-mails were sent every 10 to 14 days. In October 2012, a paper copy of the survey was sent to safety net providers who had not responded to prior solicitations. E-mail reminders to non-respondents continued through November 2012. Responses from the surveys were then processed, cleaned, and placed into an SPSS database for analysis.

The response rate to the survey was 32.1%.

Summary

The oral health safety net in Maine includes a wide array of programs, organizations, and providers operating in community settings in geographic areas where access to oral health care is limited. The safety net includes FQHCs; CDCs, including free clinics and student clinics linked to academic training programs for oral health professionals; school-based oral health programs; and IPDHs. The safety net also includes private practice dentists who treat large numbers of MaineCare-insured patients. Public health registered dental hygienists working under public health supervision status (RDHs working under PHS status) also provide care in the state's dental safety net. Most safety net providers (91.9%) offer both clinical oral health services and referrals to general or specialty dentists in their communities A small percentage provide no clinical services (8.1%) but do provide patients with referrals for dental services.

Survey respondents provide oral health services in over 100 locations in Maine. While many of these providers offer services to patients at a single site (53.1%), nearly one-fifth (18.8%) offered clinical dental services in 10 or more sites in Maine. FQHCs and CDCs in the state mainly served patients in three or fewer sites, while school-based oral health programs and mobile dental and dental hygiene vans operated in many different places.

Key Findings

Safety net providers in Maine are located in all areas of the state with almost half (46.7%) providing services in rural areas and small towns.
Programs and organizations providing oral health services in the safety net were dispersed across the state. Almost half of them served patients in rural areas (34.3%) or small towns (12.4%) in Maine. Twenty percent provided dental services in micropolitan areas and 33.3% provided services in the metropolitan areas of Maine.[2]

While safety net providers are located in all counties in Maine, some counties have more safety net providers than others.
Kennebec County had the highest percentage of safety net organizations serving county residents (34.4%). One-quarter of the safety net providers (28.2%) served people in Cumberland County, 28.2% served people in Penobscot County, and only 6.3% served people in Sagadahoc County.

The majority of safety net organizations offer comprehensive oral health care, including both preventive and restorative services.
The majority of safety net providers (62.5%) offered comprehensive oral health care services while 31.3% offered only preventive oral health services. The safety net providers offering only preventive oral health services included IPDHs and RDHs working under PHS status. Over 20% of survey respondents indicated that they offered specialty dental services either on-site or through community dentists.

There is a wide range of structural capacity to provide patient services among safety net organizations. While more than 40% of safety net providers report that the number of available dental or dental hygiene operatories is sufficient to meet current demand for dental or dental hygiene services, some report that current capacity is insufficient to meet demand.
Safety net organizations were asked if the current number of dental operatories in each site was sufficient to serve all patients requesting dental services from their organizations. Many indicated that current capacity was sufficient to address demand for oral health services (43.8%), but 37.5% were unsure if capacity was sufficient, and 18.8% indicated that it was insufficient.

[2] RUCA codes are a comparatively new Census tract-based classification scheme that utilizes the standard Census Bureau Urbanized Area and Urban Cluster definitions in combination with work commuting information to characterize all of the nation's Census tracts. The metropolitan classification includes areas where there is an urban cluster of 50,000 or more people. The micropolitan classification includes areas where there is a cluster of 10,000 or more people. Small towns include areas with at least 2,500 residents and rural areas comprise settlements with fewer than 2,500 residents. See USDA Economic Research Service: http://www.ers.usda.gov/topics/rural-economy-population/rural-classifications.aspx.

Most safety net providers employ one full-time dentist (42.9%), one full-time RDH (65.2%), and one full-time dental assistant (42.9%). Very few safety net providers employ specialty dentists.

One-fifth of survey respondents reported employing four or more full-time dentists (21.3%) and/or RDHs (25.2%), and/or dental assistants (24.0%). A few organizations employed more than 10 full-time dentists or RDHs. Fifty percent of safety net providers reported employing extended function dental assistants (EFDAs) with 33.4% reporting two or more full-time EFDAs. Very few safety net providers employed specialty dentists, and the organizations that did mostly employed them on a part-time basis.

Many safety net providers report difficulty referring patients to general and specialty dentists in their communities.

Most dental safety net providers (97.0%) made referrals to dentists in their communities. Almost half (48.1%) indicated that it was either difficult (29.6%) or very difficult (18.5%) to find a general dentist who accepted referrals. None of the providers found it very easy to find a specialty dentist to accept referrals and 43.6% found it either difficult (28.6%) or very difficult (25%). These providers included FQHCs, CDCs, school-based oral health programs, IPDHs, and others with primary sites in small towns and rural areas of the state.

One-quarter of survey respondents (25%) report that oral health professional vacancies in their organization cause delays in scheduling patient appointments.

Some safety net providers reported vacancies for oral health professionals, including dentists (13.8%) and dental assistants (17.2%). Very few reported vacancies for RDHs (6.5%); most reported a single vacancy in their program or organization. Safety net providers reported relative ease recruiting RDHs with only 19.3% indicating that it was difficult or very difficult to recruit these professionals. Similarly, only 21.4% reported that it was difficult to recruit dental assistants. In contrast, nearly 40% of respondents reported that it was difficult (17.9%) or very difficult (21.4%) to recruit dentists for work in the safety net. More than one-fifth of survey respondents (22.2%) indicated that the salaries offered were not sufficient to attract dentists to work for them. One-quarter of providers reported that vacancies for oral health professionals sometimes (9.4%), often (12.5%), or always (3.1%) caused delays in providing care to patients. Providers who reported these difficulties were primarily located in small towns and rural areas of the state.

Safety net providers serve all age groups. However, a smaller percentage of providers serve young children and older adults than patients in other age cohorts. School-age children are served by a variety of providers in the safety net.

More than one-third of safety net providers (34.6%) provided no oral health services to adults age 65 and older and 30.8% provided no services to very young children. Adolescents age 13 to 18 years constituted between 11% and 20% of the patient caseload in 40.7% of provider

organizations. Thirty-two percent of providers indicated that adults age 19 to 64 years constituted more than half of their patients.

There was variation in the populations served in the oral health safety net. Few organizations served elderly patients in nursing homes (61.9%), low-income older adults (age 65 and older) (47.4%), or homeless people (47.4%). Fifty percent of respondents indicated that MaineCare-insured children constituted half of their patient caseload, 35.0% of respondents indicated that low-income children constituted more than half of their caseload, and 28.6% reported treating low-income adults more than half the time. School-based oral health programs served children, including low-income children, MaineCare-insured children, and children with special needs. While more FQHCs treated MaineCare-insured children than CDCs, CDCs were more likely to treat uninsured adults.

Safety net providers receive revenue for oral health services from various sources, including MaineCare, patients (using full payments and sliding-fee/reduced-fee payments for services), commercial dental insurance carriers, and program grants and subsidies. Fifty percent of providers report that over half of their total revenue for oral health services comes from MaineCare.

All but a very small percentage of survey respondents (8.3%) received some revenues from MaineCare, with many reporting high percentages of revenue from MaineCare. More than 50% of providers reported that over half of their total revenue for oral health services was from MaineCare. Forty-six percent of safety net providers received *no* revenue from commercial insurance. Fifty percent of FQHCs, 42.9% of CDCs, and 100% of school-based oral health programs received *no* revenue from commercial insurance carriers. Most safety net organizations (81.3%) had *no* revenue from program subsidies. Half of survey respondents (54.5%) indicated *no* revenue from "other" sources, including philanthropy.

More than half of the safety net providers offer some uncompensated/free care (60.6%) or reduced-fee/sliding-fee scale oral health services (65.6%).

More than one-third of safety net organizations and programs provided more than 40 uncompensated diagnostic (33.3%), restorative (41.7%), or therapeutic (36.4%) oral health services monthly and/or more than 40 reduced-fee diagnostic (38.5%), preventive (41.2%), restorative (40%), or therapeutic (30.8%) services monthly.

Most safety net providers are able to provide patients with an appointment for emergency care within one to two days of the request for services, but there are much longer waits for restorative care.

Most safety net providers (73.7%) were able to provide emergency care within one to two days of the request for services. Almost one-half of providers (48.1%) were able to see a new patient within one to five days of the request for an appointment and 51.8% provided a preventive visit

within one to five days. The wait for restorative services was longer with 47.4% of providers indicating a two- to four-week wait for restorative care. Wait times for appointments were a bit longer on average at FQHCs and CDCs than for other dental safety net providers.

FQHCs and CDCs report higher numbers of missed appointments by patients than other provider types.

All respondents indicated some missed appointments by patients each month. Most safety net providers (83.7%) reported some missed dental hygiene appointments, with 20.8% reporting more than 30 missed appointments for dental hygiene services every month. Three-quarters of survey respondents (72.7%) reported some missed appointments for dental services monthly, with more than one-third (36.4%) reporting between one and five missed dental appointments monthly.

FQHCs and CDCs reported higher numbers of missed appointments than other providers. The higher number of missed appointments in clinics may have been due to higher patient volumes in settings like FQHCs and CDCs where multiple providers were offering services. The most common reasons cited by survey respondents for patients missing appointments included lack of transportation and lack of resources to pay for oral health services.

Many safety net providers report expansion plans in the next one to three years, such as providing services in additional satellite locations, upgrading facilities, and increasing staffing in the organization.

More than half of survey respondents (57.6%) indicated plans for expansion, 27.3% reported no plans for expansion, and 15.2% were unsure of plans for expansion.

Safety net providers report that some of the most significant barriers to oral health access for patients are financial, including a limited ability to pay for services and a lack of dental insurance.

Survey respondents were asked to rank barriers to oral health access for patients.[3] Safety net providers ranked limited ability to pay for services (mean ranked score of 3.8) and lack of dental insurance (mean ranked score of 3.5) as significant barriers to oral health access for patients.

Providers indicate that low reimbursement rates for dental services are a barrier to providing oral health services.

Safety net providers were asked to rank the most significant barriers that impeded the ability of their organization to provide oral health services.[4] Survey respondents identified reimbursement rates for dental services (mean ranked score 4.0), a limited number of operatories (mean ranked

[3] A mean ranked score of 5 indicated the most significant barriers for the patient.
[4] A mean ranked score of 5 indicated the most significant barriers for the provider.

score 3.9), and their ability to successfully refer to community dentists (mean score 3.8) as the most significant organizational barriers to patient services.

When asked to rank possible solutions to address dental professional shortages in Maine, providers identify use of other oral health professionals and loan repayment opportunities as important strategies to address shortages.

Safety net providers ranked[5] increased scope of services for RDHs (mean ranked score 3.6) and loan repayment opportunities (mean ranked score 3.5) as the most important solutions to professional shortages in certain geographic areas of the state. Respondents also selected use of new types of dental providers (mean score 3.4) and tax or salary incentives (mean score 3.3) as important solutions to access concerns.

Discussion

There is an impressive array of programs and organizations providing oral health care in the safety net in Maine. Maine's past efforts to increase access to oral health services in areas of the state have resulted in expansions in the safety net. The oral health safety net includes facilities such as FQHCs and CDCs. Expansions in scope of practice for RDHs and dental assistants have given rise to IPDHs, EFDAs, and school-based oral health programs, all of which enhance the capacity of the safety net to provide services in more settings and to more people who lack access to traditional dental practices.

While the oral health safety net in Maine appears to be firmly established and serving patients throughout the state, it is apparent from survey results that there remain barriers to care for patients accessing services and for safety net organizations and programs providing care. Patients are limited from accessing care by insufficient financial resources, lack of transportation, and poor oral health literacy. Safety net providers experience financial, structural, and workforce problems that limit their capacity to meet current demand for oral health services. Past initiatives in Maine have improved access but more are needed to fully address the needs of the state's residents for oral health services.

The financial viability of organizations and programs in the dental safety net is dependent upon sufficient revenues to support the cost of providing oral health services. FQHCs and CDCs are providing large volumes of uncompensated or reduced-fee services to patients. In addition, many safety net providers depend heavily on MaineCare reimbursement to support the cost of providing services. More than 45% of safety net providers reported receiving no revenue from commercial insurance carriers and more than 80% received no subsidies for care to indigent patients. Additionally, there were limited numbers of organizations receiving revenue from philanthropy to support uncompensated care. Strategies to increase financial support for the

[5] A mean ranked score of 5 indicated the most important solutions to dental professional shortages.

safety net might include dental subsidies and/or improved reimbursement rates for services to MaineCare patients.

Providers reported difficulty recruiting dentists to work in safety net programs. Forty percent of survey respondents indicated that recruitment of dentists was either difficult or very difficult, especially in Maine's rural areas and small towns. One-quarter of survey respondents reported that oral health professional vacancies contributed to delays in scheduling patient appointments. While the average wait time for an emergency dental service from a safety net provider was only one or two days, the wait time for scheduled restorative services averaged more than two weeks for well over half of survey respondents.

Loan forgiveness or repayment programs provided incentives for dentists to work in the safety net. While 27.3% of safety net providers indicated that a professional in their organization was working under a service obligation through a government program, more than 60% reported no staff on these programs and the remainder was unsure if any staff member had a service obligation. Increased funding for dental loan repayment programs and expansion in eligibility criteria could provide an incentive for more dentists to work in the oral health safety net in Maine. The new dental school at UNE, which will educate students in a curriculum with a community health and public service orientation, may increase the number of dentists in Maine with an interest in working in the safety net or in rural communities and small towns where oral health services are not widely available.

The oral health safety net in Maine is a diverse mix of providers with a common mission to increase access to oral health services. However, the oral health safety net is not a coordinated system of care so each provider, organization, or program operates independently. Safety net providers expressed concern about both their ability to link with traditional dental providers and to interface with other providers in the safety net. Many also expressed concern about the difficulty in finding general or specialty dentists within their communities to accept patient referrals. In addition, there were concerns within the safety net about how to integrate new models of care delivery, such as school-based oral health programs, into a seamless system of care for patients who may be receiving preventive care in one setting and restorative dental services in another. Nevertheless, safety net providers felt that further expansions in scope of practice for RDHs or use of new types of oral health providers might be useful to address dental shortages in certain areas of the state.

Despite clear fiscal challenges for safety net providers operating in Maine, there is determination among safety net providers to continue to offer oral health services to patients. Fifty-eight percent of survey respondents anticipated expansions in dental services within the next one to three years. Their plans included facility and program expansions, increasing the number of oral health professionals in the organization, and updating equipment to support the quality of services provided. These plans suggest that safety net providers had identified more need for oral health services in their communities than current capacity can address. It also suggests continued

resolve to serve populations in need of care. Maine is fortunate to have so many organizations and programs working to expand access to oral health services. Future oral health policy initiatives should continue to support these efforts.

Technical Report of the Survey of Dental Safety Net Providers in Maine

Background

In recent years, oral health stakeholders in Maine, including provider organizations and policymakers have expressed concern about the oral health status of the state's population and the need to improve access to oral health services in certain geographic areas of the state. Identifying effective strategies to increase access to oral health services in Maine is complicated by the many factors that adversely affect access to care, including limited resources to pay for oral health services, lack of oral health infrastructure and workforce, and limited oral health literacy of many residents. To date, Maine's strategies to increase access to care have included dental loan repayment programs, funding for a dental school in the state, and expansions in the scopes of practice for dental assistants and dental hygienists. Little is known, however, about the impact of these interventions on access to oral health services for Maine residents.

In 2011, the Maine Legislature passed LD 1105 "Resolve, To Study Oral Health Care in Maine and Make Recommendations Regarding How to Address Maine's Oral Health Care Needs." The resolve called for a study of Maine's oral health care needs to include a review of public and private financial resources for oral health services, a description of limitations on oral health access in the state, a discussion of the sustainability of public financing for oral health programs, and an enumeration of the current oral health workforce in Maine. The Legislature requested that this review be completed expeditiously and that it be financed through funding other than public resources.

This report presents the results of a survey of dental safety net providers in Maine, which was conducted in 2012, as well as tables and figures that display the tabulations and findings from the survey.

Methodology

The online survey was initially fielded electronically in August 2012 to 116 safety net providers, which were compiled from a variety of sources, including project advisers, oral health stakeholders in Maine, licensure lists from the Maine Board of Dental Examiners (MBDE), and Internet sites. The survey was designed on the Inquisite Platform. Respondents were able to complete the survey via a standard Internet browser. Communication with potential respondents was mainly electronic, but there was also paper communication.

In August, each oral safety net provider received a letter by mail containing a personalized link to the survey. An administrator or executive director of each FQHC or CDC was identified to receive the solicitation. Other letters were addressed to individual professionals working in the safety net as dentists, IPDHs, or RDHs working under PHS status. The letter explained the reasons for the research, described the survey process, and provided assurances of confidentiality

to survey respondents. During the following weeks, oral health professionals received e-mail reminders approximately every 10 to 14 days. E-mail reminders were sent only to non-respondents. There were some professionals for whom no e-mail address was available.

In October 2012, a paper copy of the survey was sent to all safety net providers who had not responded to prior solicitations. Subsequent to the mailing of the paper survey, e-mail reminders were continuously sent to non-respondents until November 2012. At that time, survey data from the paper and electronic responses were aggregated and cleaned and placed into SPSS databases for analyses.

Results

Solicitation letters were sent to 116 FQHCs; CDCs, including student clinics, free clinics, government-sponsored clinics, volunteer clinics, and tribal clinics; medical doctors known to be providing oral health assessment services; school-based oral health programs; and IPDHs, all of which comprise the dental safety net in Maine. The response rate was 32.1%. Respondents included FQHCs, CDCs, IPDHs, school-based oral health programs, and medical practices.

Limitations

The sampling frame was deliberately broad in order to insure that all segments of the oral health safety net in the state were represented. IPDHs represented about 30% of the providers approached to participate. At the same time that the Survey of Dental Safety Net Providers was in the field, a separate survey of IPDHs was also being conducted. There was some confusion among IPDHs about the two surveys. Some IPDHs contacted CHWS staff indicating that they had already completed the survey. In reminder emails to IPDHs, they were advised that this was a different survey. This problem may have reduced the response rate to the Survey of Dental Safety Net Providers in Maine.

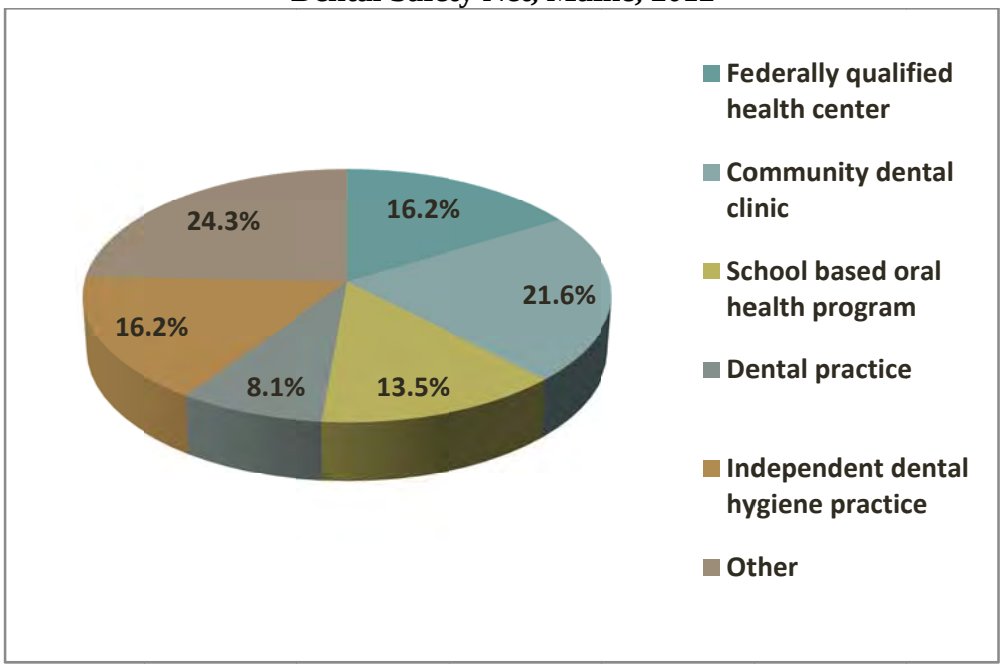
While the response rate to this survey was sufficient to present aggregate data, the small number of responses limited analysis. The report contains some tabulation describing particular characteristics of FQHCs and CDCs in Maine, but data were not sufficient for other provider types.

The following describes the findings from the survey in narrative and tabular format.

Providers in the Dental Safety Net

Providers of oral health services in the oral health safety net in Maine included federally qualified health centers (FQHCs) (16.2%), community dental clinics (CDCs) (21.6%), independent practice dental hygienists (IPDHs) (16.2%), and "other" types of providers (24.3%), such as community action agencies and registered dental hygienists (RDHs) working in school-based oral health programs under public health supervision (PHS) status. For a list of "other" types of organizations, see Appendix A of this report, Question 1.

Figure 1. Types of Organizations and Providers Offering Oral Health Services in the Dental Safety Net, Maine, 2012

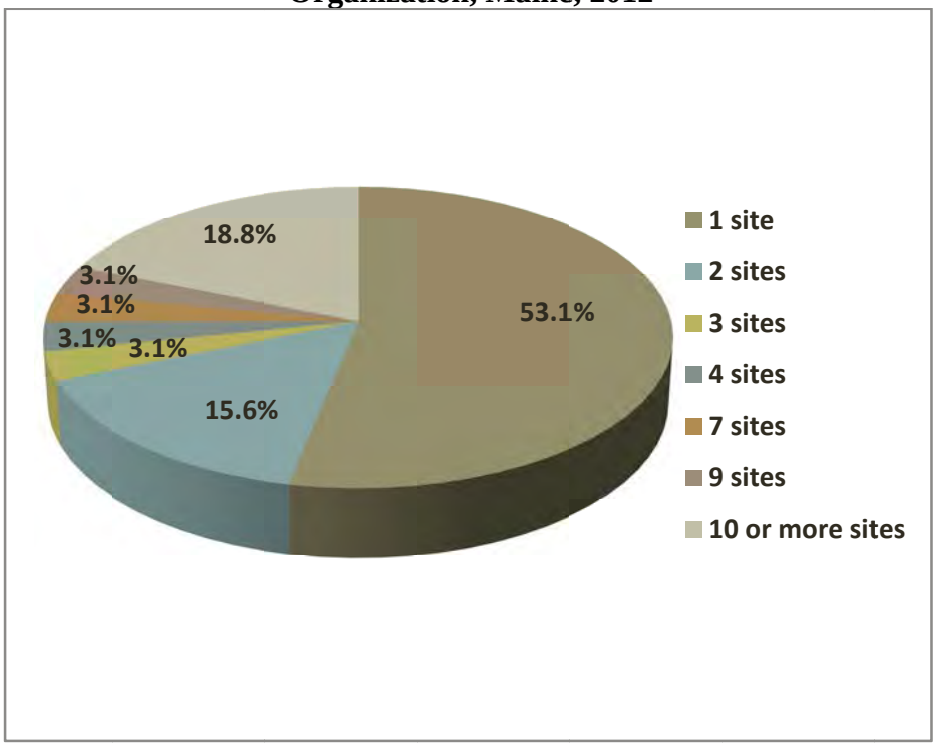


Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, 2012, Question 1.

Most providers in the dental safety net offered both clinical dental services and referrals for dental services (91.9%) with the remainder (8.1%) only providing referrals for dental services.

While more than half of the provider organizations (53.1%) operating in the safety net offered clinical services in a single site, 18.8% of providers offered clinical services in 10 or more sites in Maine. Providers who offered services in 10 or more sites were mainly school-based oral health programs or providers working in mobile programs and dental vans in the state, one of which provided services in 34 schools. FQHCs and community dental clinics (CDCs) mainly offered services in one, two, or three sites. One CDC offered services in seven sites.

Figure 2. Percent of Organizations by Number of Clinical Sites Managed by the Safety Net Organization, Maine, 2012



Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, 2012, Question 2.

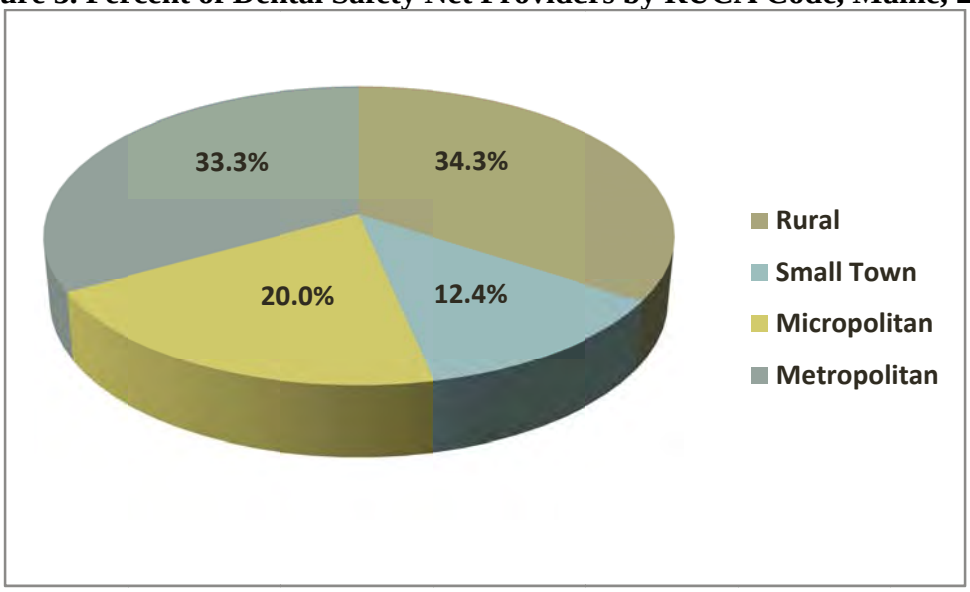
Those who responded to the survey on behalf of their organizations were asked to describe their roles. One-quarter (25.0%) of the respondents held administrative positions, 40.6% were clinical/dental personnel, 6.3% had educational roles, and 28.1% reported "other" roles mainly described as dual administrative and clinical roles. For a description of "other" responses see Appendix A of this report, Question 4.

Geographic Locations Served by the Oral Health Safety Net in Maine

To accomplish a geographic analysis of the locations of safety net providers in Maine, the zip codes of the 105 locations where organizations provided oral health services were compiled along with rural urban continuum area (RUCA) codes of the U.S. Census Bureau[6] to identify the location as either metropolitan, micropolitan, small town, or rural. More than one-third of safety net providers (34.3%) operated in rural areas of Maine and an additional 12.4% provided services in small towns in the state.

[6] RUCA codes are a comparatively new Census tract-based classification scheme that utilizes the standard Census Bureau Urbanized Area and Urban Cluster definitions in combination with work commuting information to characterize all of the nation's Census tracts. The metropolitan classification includes areas where there is an urban cluster of 50,000 or more people. The micropolitan classification includes areas where there is a cluster of 10,000 or more people. Small towns include areas with at least 2,500 residents and rural areas comprise settlements with fewer than 2,500 residents. See USDA Economic Research Service: http://www.ers.usda.gov/topics/rural-economy-population/rural-classifications.aspx.

Figure 3. Percent of Dental Safety Net Providers by RUCA Code, Maine, 2012



Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, 2012, Question 3.

Survey respondents were asked to describe the geographic catchment area for their program or organization by county in Maine. They were asked to indicate if the organization served all areas of a county or only part of a county.

One-fifth of the safety net organizations that responded to the survey (21.9%) served all of Cumberland County and 18.8% served all of Penobscot County. Only 6.3% served all of Sagadahoc County and no organizations partially served patients living in that county. Kennebec County had the highest percentage of safety net organizations either wholly or partly serving county residents (34.4%).

Table 1. Percent of Safety Net Organizations by Whole or Partial Geographic Catchment Area, Maine, 2012

County	All	Part	Not in Catchment Area
Androscoggin	15.6%	12.5%	71.9%
Aroostook	12.5%	9.4%	78.1%
Cumberland	21.9%	6.3%	71.9%
Franklin	15.6%	6.3%	78.1%
Hancock	6.3%	12.5%	81.3%
Kennebec	9.4%	25.0%	65.6%
Knox	9.4%	3.1%	87.5%
Lincoln	9.4%	3.1%	87.5%
Oxford	9.4%	9.4%	81.3%
Penobscot	18.8%	9.4%	71.9%
Piscataquis	12.5%	9.4%	78.1%
Sagadahoc	6.3%	0.0%	93.8%
Somerset	12.5%	12.5%	75.0%
Waldo	6.3%	9.4%	84.4%
Washington	12.5%	6.3%	81.3%
York	15.6%	3.1%	81.3%

Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, 2012, Question 5.

Patient Services

Safety net providers described the types of oral health services that were provided to patients in each of their sites. About two-thirds of the safety net organizations (62.5%) provided comprehensive oral health services including both preventive and restorative services for patients and 31.3% provided only preventive oral health services.

Table 2. Percent of Safety Net Organizations by Type of Oral Health Services Provided for Patients, Maine, 2012

Services Provided to Patients	Yes	No	Unsure	All Sites	Some Sites
Preventive oral health services only	31.3%	68.7%	0.0%	31.3%	0.0%
Restorative oral heal services only	0.0%	100.0%	0.0%	0.0%	3.1%
Comprehensive oral health services	62.5%	37.5%	0.0%	59.4%	3.1%
Specialty dental services	21.9%	75.0%	3.1%	18.8%	3.1%
Referral only to community dental providers	2.7%	97.3%	0.0%	0 .0%	3.1%
Other	12.5%	81.5%	0.0%	9.4%	3.1%

Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 6. Totals exceed 100% because survey respondents were permitted to select multiple response options. Percents may vary from other tables due to differences in response rates to individual questions. Percents may vary from other tables and figures due to differences in numbers of responses to each of the questions used in the cross-tabulation.

Providers were asked to describe the number of dental and dental hygiene operatories in each of the sites in which they provided oral health services to patients. Safety net organizations were more likely to have two or more dental operatories in a site than to have two or more dental hygiene operatories. Dental operatories are somewhat flexible and may be used by RDHs if and when needed to handle overflow patients.

Some safety net organizations had large numbers of dental or dental hygiene chairs in multiple sites. A cross tabulation of the survey data revealed that organizations with large numbers of operatories were generally FQHCs and CDCs. The cross tabulation also revealed that most of the providers offering services in more than three sites were school-based oral health programs.

Table 3. Percent of Safety Net Organizations by Number of Dental or Dental Hygiene Operatories by Site Location, Maine, 2012

Program Site	Number of Dental Operatories									
	1	2	3	4	5	6	7	8	9	10
Site 1	29.2%	33.3%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	12.5%
Site 2	8.1%	23.5%	2.7%	0.0%	0.0%	0.0%	0.0%	2.7%	0.0%	2.7%
Site 3	5.4%	2.7%	0.0%	0.0%	0.0%	0.0%	2.7%	0.0%	0.0%	2.7%
Site 4	5.4%	2.7%	0.0%	0.0%	0.0%	2.7%	0.0%	0.0%	0.0%	2.7%
Site 5	5.4%	2.7%	0.0%	0.0%	0.0%	2.7%	0.0%	0.0%	0.0%	0.0%
Site 6	5.4%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Site 7	5.4%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Site 8	5.4%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Site 9	5.4%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Site 10	5.4%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Program Site	Number of Dental Hygiene Operatories									
	1	2	3	4	5	6	7	8	9	10
Site 1	51.7%	24.1%	6.9%	0.0%	0.0%	6.9%	3.4%	0.0%	0.0%	6.9%
Site 2	21.5%	2.7%	5.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Site 3	13.5%	5.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.7%
Site 4	13.5%	5.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Site 5	13.5%	5.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Site 6	16.2%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Site 7	16.7%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Site 8	13.5%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Site 9	13.5%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Site 10	10.8%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Questions 7 and 8a.

Safety net organizations were asked if the current number of dental operatories in each site was sufficient to serve all patients requesting dental services from their organization. Many indicated that current capacity was sufficient to address demand for oral health services (43.8%), but 37.5% were unsure if capacity was sufficient, and 18.8% indicated that it was insufficient. These providers were asked how many additional dental operatories would be useful to meet demand for dental services. One in 10 respondents (10.8%) indicated that an additional dental operatory in one or another site would be helpful. A very small percent indicated that an additional two operatories (2.7% of respondents) or three operatories (5.4%) would be helpful.

Safety net providers were also asked if the number of dental hygiene operatories in programs sites was currently sufficient to meet demand. The majority of respondents (59.4%) indicated that current capacity was sufficient, but 21.9% were unsure, and 18.8% indicated that current capacity was insufficient to meet current demand. One in 10 respondents (13.5%) indicated that

one additional dental hygiene operatory in a primary, secondary, or tertiary site would help to address demand for dental hygiene services. Again, a small percentage felt that an additional two operatories (2.7% of respondents) or three operatories (5.4% of respondents) would be helpful.

Oral Health Workforce in the Safety Net

Most safety net organizations employed one full-time dentist (42.9%), one full-time RDH (65.2%), and one full-time dental assistant (DA) (42.9%). A few organizations employed large numbers of dentists; one organization employed 14 full-time dentists, another employed 20 full-time dentists, and still another employed 32 full-time dentists. Similarly a few respondents reported employing large numbers of RDHs; one provider employed 14 full-time RDHs, another employed 15 full-time RDHs, and still another employed 32 full-time RDHs. Some safety net providers also reported employing large numbers of DAs; one employed 18 full-time DAs, another employed 30 full-time DAs, and another employed 32 full-time DAs. A few organizations reported employing extended function dental assistants (EFDAs), with one organization employing 10 EFDAs. Some respondents indicated that the number of part-time employees in their organizations varied.

Table 4. Percent of Safety Net Providers that Employ Full-Time or Part-Time Dentists, RDHs, DAs, or EFDAs, Maine 2012

Type of Oral Health Professional	Number of Full-Time or Part-Time Oral Health Professionals								
	1 FT	1 PT	2 FT	2 PT	3 FT	3 PT	4 or More FT	4 or More PT	None
Dentists	42.9%	15.6%	21.4%	6.3%	7.1%	3.1%	21.3%	0.0%	7.1%
Dental Hygienists	65.2%	21.9%	4.3%	25.0%	4.3%	0.0%	25.2%	3.1%	0.0%
Dental Assistants	42.9%	15.6%	19.0%	6.3%	9.5%	0.0%	24.0%	0.0%	4.8%
Extended Function Dental Assistants	16.7%	0.0%	16.7%	3.1%	0.0%	0.0%	16.7%	0.0%	50.0%

Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 11a.

Safety net organizations mainly employed general dentists although some employed part-time specialty dentists to treat patients. One organization employed 10 or more pedodontists full time.

Table 5. Percent of Safety Net Providers that Employ General or Specialty Dentists Full Time or Part Time, Maine, 2012

Specialty of Employed Dentists	Number of Full-Time or Part-Time Oral Health Professionals							
	1 FT	1 PT	2 FT	2 PT	3 FT	3 PT	4 or More FT	4 or More PT
General dentist	46.2%	15.6%	23.1%	3.1%	7.7%	3.1%	15.4%	0.0%
Pedodontist	0.0%	0.0%	0.0%	3.1%	0.0%	0.0%	3.1%	0.0%
Periodontist	0.0%	3.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Prosthodontist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Orthodontist	0.0%	3.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Endodontist	0.0%	3.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Oral Surgeon	0.0%	3.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

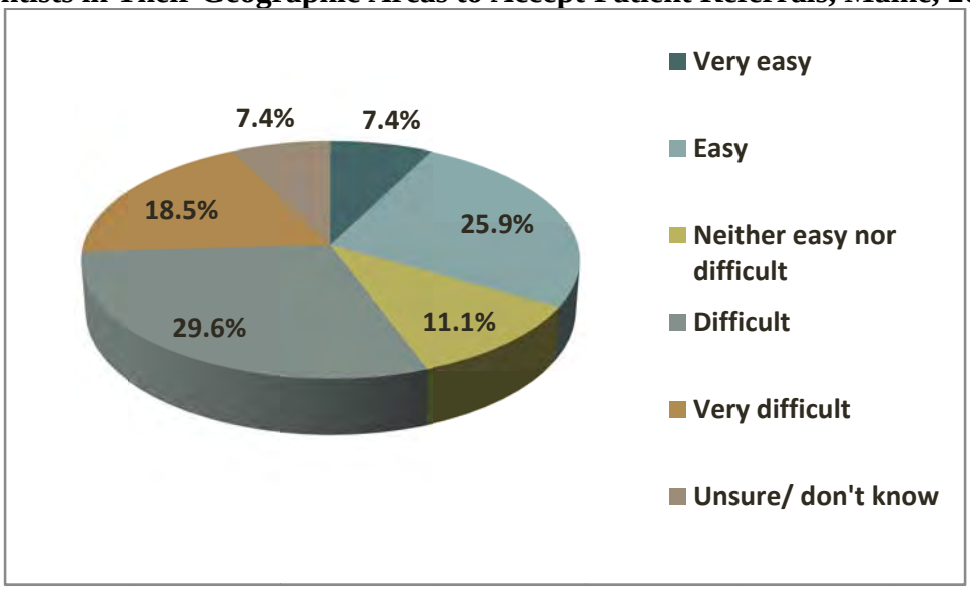
Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 11b.

Dental Referrals

Most dental safety net providers (97.0%) made dental referrals to dentists in their communities. Survey respondents assessed the overall level of difficulty the organization or provider experienced with finding a dentist to accept a patient referral in their geographic areas.

Survey respondents were asked to assess the degree of difficulty with finding general dentists to whom they could refer patients in their geographic areas. Almost half (48.1%) indicated that it was either difficult (29.6%) or very difficult (18.5%) to find a general dentist to accept a referral. Providers who experienced referral difficulties were mainly FQHCs, CDCs, school-based oral health programs, IPDHs, and others with primary sites in small towns and rural areas of the state.

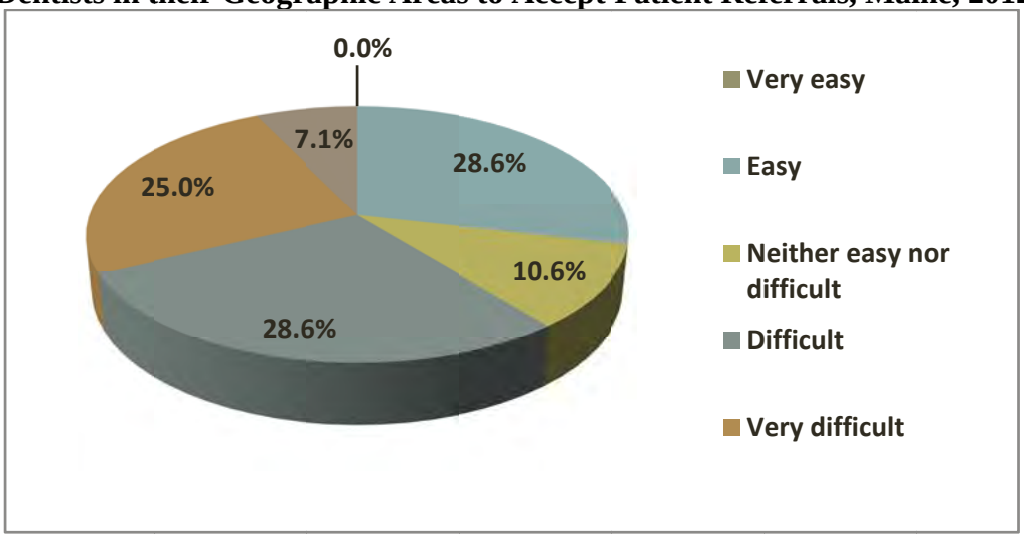
Figure 4. Percent of Safety Net Providers by Degree of Difficulty with Finding General Dentists in Their Geographic Areas to Accept Patient Referrals, Maine, 2012



Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 12a.

Survey respondents expressed similar levels of difficulty with finding specialty dentists in their geographic areas to accept patient referrals. No provider (0.0%) found it very easy to find a specialty dentist and 43.6% found it either difficult (28.6%) or very difficult (25%) to find a specialty dentist to accept patient referrals in their communities. Again, providers who experienced difficulty finding specialty dentists to accept referrals were FQHCs, CDCs, school-based oral health programs, IPDHs, and others who were mainly located in small towns and rural areas of Maine.

Figure 5. Percent of Safety Net Providers by Degree of Difficulty with Finding Specialty Dentists in their Geographic Areas to Accept Patient Referrals, Maine, 2012



Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 12a.

Vacancies for Oral Health Professionals

Safety net providers were asked to report if there were vacancies in their programs or organizations for oral health professionals. Providers reported some vacancies for oral health professionals with 17.2% indicating at least one vacancy for a DA and 13.8% indicating at least one vacancy for a dentist. Very few providers (6.5%) reported any vacancies for RDHs.

Table 6. Percent of Safety Net Providers with Vacancies for Oral Health Professionals by Number and Type of Vacancies, Maine, 2012

Type of Oral Health Professional Needed	% of Providers with Vacancies	% Unsure if Vacancies	% with 1 Vacancy	% with 2 Vacancies	% with 3 Vacancies	% with 4 Vacancies
Dentists	13.8%	6.9%	6.9%	6.9%	0.0%	0.0%
Registered Dental Hygienists	6.5%	0.0%	6.5%	0.0%	0.0%	0.0%
Dental Assistants	17.2%	3.4%	8.1%	0.0%	2.7%	2.7%
Extended Function Dental Assistants	11.5%	7.7%	5.4%	0.0%	0.0%	2.7%

Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 13.

Survey respondents were asked to describe the overall level of difficulty with finding oral health professionals to hire in their geographic areas. There were differences in the level of difficulty recruiting new hires by profession. Most respondents (61.3%) indicated that it was very easy (9.7%), easy (16.1%), or neither easy nor difficult (35.5%) to recruit RDHs. Providers also reported relative ease with recruiting DAs with 60.7% indicating that it was very easy (3.6%), easy (10.7%), or neither easy nor difficult (46.4%) to hire a DA. However, only 32.3% of organizations indicated relative ease with recruitment of dentists and 39.3% indicated that recruiting dentists to their organization was either difficult (17.9%) or very difficult (21.4%) in their geographic areas.

Table 7. Percent of Safety Net Providers by Level of Difficulty Recruiting Oral Health Professionals, by Type of Professional, Maine, 2012

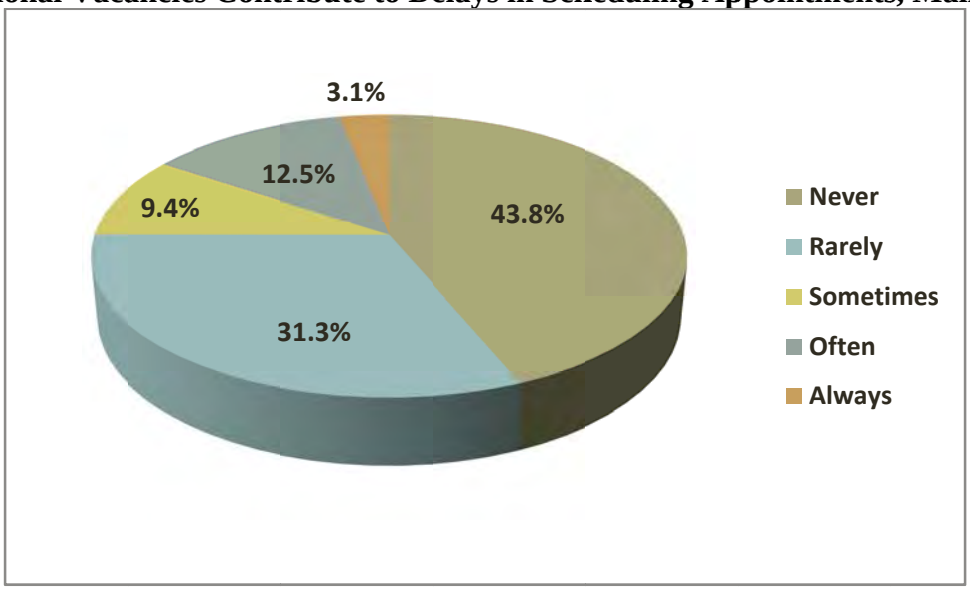
Type of Oral Health Professional Needed	Very Easy	Easy	Neither Easy Nor Difficult	Difficult	Very Difficult	Unsure/ Don't Know
Dentists	0.0%	3.6%	28.6%	17.9%	21.4%	28.6%
Dental Hygienists	9.7%	16.1%	35.5%	16.1%	3.2%	19.4%
Dental Assistants	3.6%	10.7%	46.4%	21.4%	0.0%	17.9%
Extended Function Dental Assistants	0.0%	3.8%	23.1%	15.4%	7.7%	50.0%

Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 14.

Survey respondents were asked to report if vacancies of oral health professionals in their organizations contributed to delays in scheduling patients for appointments and, if so, how often vacancies affected wait times or appointments. Many survey respondents indicated that professional vacancies never affected wait times (43.8%) and 31.3% reported that vacancies rarely delayed patient scheduling. However, 25% of survey respondents reported that oral health professional vacancies sometimes (9.4%), often (12.5%), or always (3.1%) caused delays in scheduling patient appointments.

Providers who reported that vacancies sometimes, often, or always contributed to delays in appointments included FQHCs, CDCs, school-based oral health programs, IPDHs, and others. Providers who reported delays in scheduling appointments due to professional vacancies were primarily in small towns and rural areas of the state.

Figure 6. Percent of Safety Net Providers by Frequency with which Oral Health Professional Vacancies Contribute to Delays in Scheduling Appointments, Maine, 2012

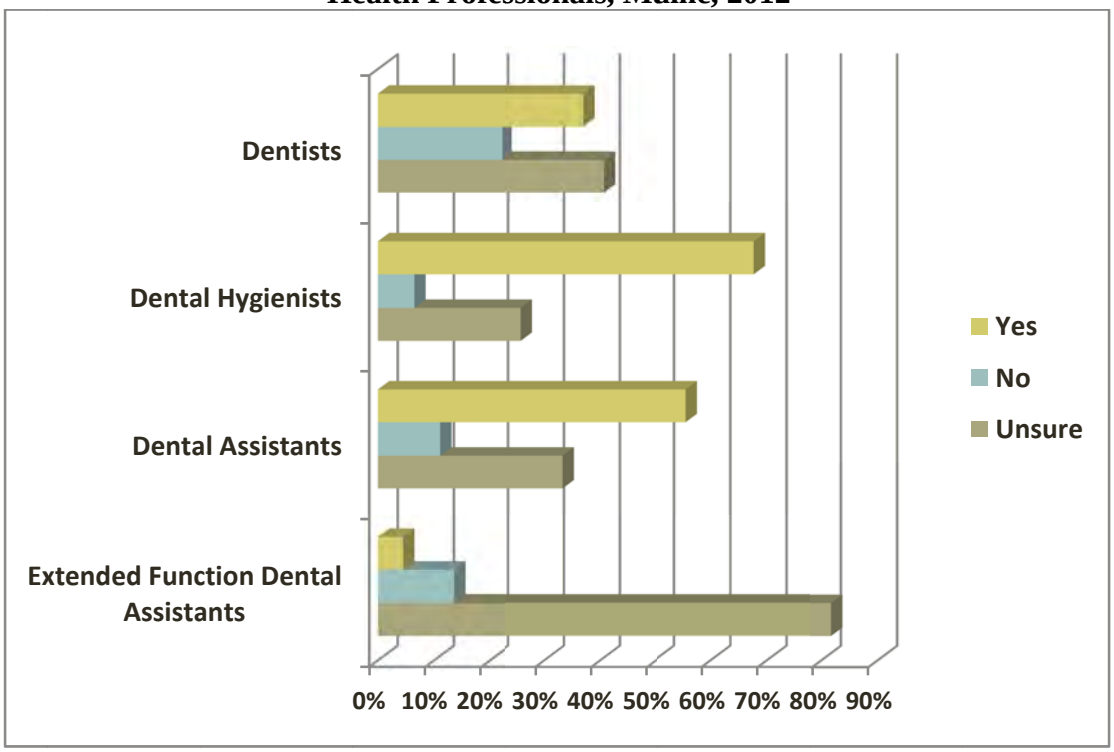


Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 15.

Survey respondents were asked if any of the oral health professionals in the organization or program had a service obligation through a state or federal loan repayment program or through the federal scholar program. More than one-quarter of providers (27.3%) reported that a professional in the organization was working under a service obligation through a government program. Most providers reported no professionals on staff with service obligations (60.6%) but some were unsure (12.1%).

Safety net providers were asked if the salaries or compensation they were able to offer to oral health professionals were sufficient to attract quality oral health professionals to their geographic areas. More than one-fifth of respondents (22.2%) indicated that the salaries they were able to offer were *not* sufficient to attract quality dentists. More than two-thirds of respondents (67.7%) indicated that the salaries offered to RDHs were sufficient to attract quality professionals, and more than half (55.5%) felt that salaries for DAs were sufficient to attract quality DAs.

Figure 7. Percent of Safety Net Providers by Their Appraisal of Whether the Salaries Offered by Their Organizations or Programs Were Sufficient to Attract Quality Oral Health Professionals, Maine, 2012



Source: CHWS, 2012, Survey of Dental Safety Net Provider s in Maine, Question 17.

Patients Served

Safety net providers were asked about the patients served in their organizations. There was significant variation in the number of unique patients receiving dental services in organizations each year.

Some survey respondents provided only preventive care services (e.g., IPDH practices) and therefore, no dental services were provided to patients in those practices. Other organizations, especially CDCs and FQHCs, saw large numbers of patients for both dental and dental hygiene visits annually.

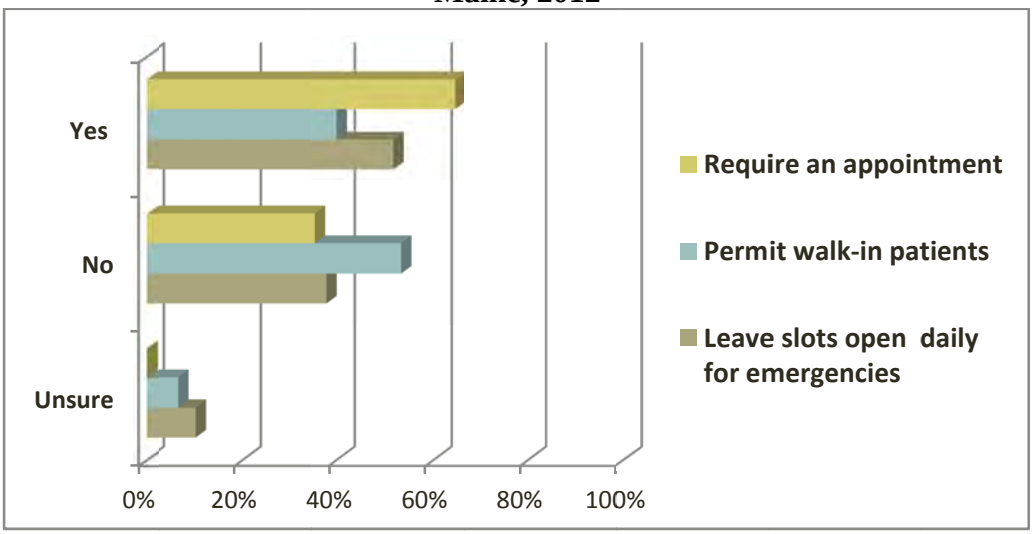
Table 8. Mean Number of Annual Patient Visits for Dental or Dental Hygiene Services for All Providers, for FQHCs, and for CDCs, Maine, 2012

Annual Patient Visits	All Respondents		FQHCs		CDCs	
	# of Unique Patients With a Dental Visit	# of Unique Patients With a Dental Hygiene Visit	# of Unique Patients With a Dental Visit	# of Unique Patients With a Dental Hygiene Visit	# of Unique Patients With a Dental Visit	# of Unique Patients With a Dental Hygiene Visit
Mean # of Visits	1,613	1,664	1,959	4,109	4,267	2,788
Minimum	0	28	1,700	2,217	60	60
Maximum	20,292	11,723	3,917	6,000	20,292	11,723

Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 19.

Providers were asked about the need for appointments and the availability of walk-in services or emergency services in their organizations. Almost two-thirds of survey respondents (64.5%) required patients to have appointments for dental or dental hygiene services. Half of the survey respondents (51.7%) had slots available each day for emergency appointments and 40% permitted walk-ins.

Figure 8. Percent of Safety Net Providers by Appointment Policies in Their Organizations, Maine, 2012



Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 18.

Survey respondents were asked to describe the age groups of the patients that received oral health services in their organization or program. Safety net providers served all age groups. However, more than one-third of safety net providers (34.6%) provided no oral health services to adults age 65 years and older and 30.8% provided no services to very young children. Adolescents age 13 to 18 years constituted between 11% and 20% of the patient caseload in 40.7% of provider organizations.

Table 9. Percent of Safety Net Providers Providing Oral Health Services to Patients by Age Cohort of Patients, Maine, 2012

Percent of Patient Caseload	Infants birth to 3 years	Children 4 to 12 years	Adolescents 13 to 18 years	Adults 19 to 64 years	Older adults 65 years and older
0%	30.8%	14.3%	7.4%	20.0%	34.6%
1% to 10%	30.8%	10.7%	18.5%	12.0%	30.8%
11% to 20%	30.8%	14.3%	40.7%	12.0%	7.7%
21% to 30%	0.0%	14.3%	3.7%	4.0%	11.5%
31% to 40%	3.8%	7.1%	7.4%	4.0%	3.8%
41% to 50%	0.0%	10.7%	7.4%	16.0%	0.0%
51% to 60%	0.0%	7.1%	7.4%	8.0%	0.0%
61% to 70%	0.0%	10.7%	3.7%	8.0%	3.8%
71% to 80%	0.0%	7.1%	0.0%	0.0%	0.0%
81% to 90%	0.0%	3.6%	0.0%	4.0%	0.0%
91% to 100%	3.8%	0.0%	3.7%	12.0%	7.7%

Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 20.

Survey respondents described some characteristics of the patients receiving oral health services in their organizations. There was variation in the populations served. Many organizations served no confined elderly patients (61.9%), no low-income older adults age 65 and older (47.4%), or homeless people (47.4%). However, some IPDHs (33.3% of IPDH respondents) indicated that more than half their caseload was confined elderly. These IPDHs likely provided services in nursing homes.

Some respondents indicated that certain types of patients constituted more than half of their patient caseloads, including MaineCare-insured children (50% of safety net providers), low-income children (35.0%) and low-income adults (28.6%). School-based oral health programs mainly served only children, including low-income children, MaineCare-insured children and children with special needs.

Table 10. Percent of Safety Net Providers by Characteristics of Patients Served, Maine, 2012

Characteristics of Patients	0%	1% to 10%	11% to 20%	21% to 30%	31% to 40%	41% to 50%	More than 50%
Uninsured children (0 to 18 years)	14.3%	42.9%	23.8%	9.5%	4.8%	0.0%	4.8%
Uninsured adults (19 to 64 years)	33.3%	4.8%	23.8%	14.3%	0.0%	4.8%	19.0%
MaineCare- insured children	8.3%	12.5%	4.2%	4.2%	8.3%	12.5%	50.0%
MaineCare-insured adults	34.8%	17.4%	17.4%	13.0%	0.0%	4.3%	13.0%
Low-income children	15.0%	20.0%	10.0%	10.0%	5.0%	5.0%	35.0%
Low-Income adults	33.3%	4.8%	9.5%	19.0%	4.8%	0.0%	28.6%
Low-income older adults (age 65 and older)	47.4%	15.8%	21.1%	10.5%	0.0%	0.0%	5.3%
People with special needs	23.6%	54.5%	22.7%	0.0%	4.5%	0.0%	4.5%
Homeless	47.4%	42.1%	5.3%	0.0%	0.0%	0.0%	5.3%
Confined elderly	61.9%	23.8%	0.0%	0.0%	0.0%	4.8%	9.5%
Other	58.3%	16.7%	0.0%	0.0%	0.0%	0.0%	25.0%

Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 21.

The following table provides data about patients served by FQHCs and CDCs in Maine. The numbers of other provider types who responded to the survey were too small to permit meaningful comparisons. FQHCs and CDCs treated a variety of patients although there were differences in the types and percentages of patients treated. CDCs were more likely to treat uninsured adults than FQHCs (25.0% of FQHCs treated no uninsured adults), while more FQHCs treated MaineCare-insured children than CDCs (28.6% of CDCs treated no MaineCare-insured children). Some FQHCs and CDCs treated no MaineCare-insured adults.

Table 11. Percent of FQHCs and CDCs Providing Services in the Dental Safety Net by Characteristics of Patients Served, Maine, 2012

FQHCs	0%	1% to 10%	11% to 20%	21% to 30%	31% to 40%	41% to 50%	More than 50%
Uninsured children (0 to 18 years)	0.0%	50.0%	25.0%	25.0%	0.0%	0.0%	0.0%
Uninsured adults (19 to 64 years)	25.0%	0.0%	50.0%	0.0%	0.0%	0.0%	25.0%
MaineCare-insured children	0.0%	25.0%	25.0%	25.0%	0.0%	0.0%	25.0%
MaineCare-insured adults	25.0%	0.0%	25.0%	50.0%	0.0%	0.0%	0.0%
Low-income children	0.0%	25.0%	25.0%	25.0%	0.0%	0.0%	25.0%
Low-Income adults	25.0%	0.0%	0.0%	25.0%	0.0%	0.0%	50.0%
Low-income older adults (age 65 and older)	50.0%	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%
People with special needs	0.0%	33.3%	33.3%	0.0%	33.3%	0.0%	0.0%
Homeless	0.0%	66.7%	0.0%	0.0%	0.0%	0.0%	33.3%
Confined elderly	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Community Dental Clinics	**0%**	**1% to 10%**	**11% to 20%**	**21% to 30%**	**31% to 40%**	**41% to 50%**	**More than 50%**
Uninsured children (0 to 18 years)	33.3%	50.0%	16.7%	0.0%	0.0%	0.0%	0.0%
Uninsured adults (19 to 64 years)	0.0%	0.0%	33.3%	26.7%	0.0%	0.0%	50.0%
MaineCare-insured children	28.6%	14.3%	0.0%	0.0%	14.3%	14.3%	28.6%
MaineCare-insured adults	14.3%	14.3%	28.6%	14.3%	0.0%	14.3%	14.3%
Low-income children	33.3%	16.7%	0.0%	0.0%	16.7%	16.7%	16.7%
Low-Income adults	0.0%	0.0%	16.7%	16.7%	0.0%	16.7%	50.0%
Low-income older adults (age 65 and older)	33.3%	33.3%	16.7%	16.7%	0.0%	0.0%	0.0%
People with special needs	33.3%	50.0%	16.7%	0.0%	0.0%	0.0%	0.0%
Homeless	16.7%	66.7%	16.7%	0.0%	0.0%	0.0%	0.0%
Confined elderly	66.7%	33.3%	0.0%	0.0%	0.0%	0.0%	0.0%
Other	33.3%	66.7%	0.0%	0.0%	0.0%	0.0%	0.0%

Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Questions 2 and 21.

Revenue for Services Provided in the Safety Net

Safety net providers received revenue for oral health services from various sources, including commercial dental insurance carriers, MaineCare, patients (including full payments and sliding-fee/reduced-fee payments for services), and program grants and subsidies. There was variation among safety net providers in the percentage of revenues received from each source. All but a very small percentage of survey respondents (8.3%) received some revenues from MaineCare. However, 81.3% of organizations had no revenues from program subsidies and 45.8% had no revenue from commercial insurance. More than half of survey respondents (54.5%) indicated no

revenue from "other" sources including philanthropy. (See Appendix A, Question 22 for a description of other.)

Some organizations received high percentages of their revenues from MaineCare with half of all survey respondents (50.1%) reporting that MaineCare revenues were more than 50% of total revenues for oral health services. These organizations included FQHCs, CDCs, school-based oral health programs, and other providers such as a mobile dental van. (See Appendix A, Question 2 for a description of other.) Half of organizations (50.0%) indicated between 1% and 30% of revenues were from patient payments. While 47.4% of safety net providers received no revenue from payments on a sliding fee scale, 52.7% of providers received between 1% and 30% of their revenues from patient payments on a sliding fee scale.

Table 12. Percent of Safety Net Providers by Percent of Revenue for Oral Health Services, by Source, Maine, 2012

Percent of Revenues	Commercial Insurance	MaineCare	Self-pay	Sliding fee	Program subsidies	Other
0%	45.8%	8.3%	16.0%	47.4%	81.3%	54.5%
1% to 10%	16.7%	16.7%	20.0%	15.8%	6.3%	0.0%
11% to 20%	12.5%	4.2%	24.0%	31.6%	6.3%	0.0%
21% to 30%	12.5%	4.2%	16.0%	5.3%	0.0%	0.0%
31% to 40%	4.2%	0.0%	8.0%	0.0%	0.0%	0.0%
41% to 50%	0.0%	16.7%	0.0%	0.0%	0.0%	0.0%
51% to 60%	0.0%	8.3%	4.0%	0.0%	0.0%	0.0%
61% to 70%	0.0%	4.2%	4.0%	0.0%	0.0%	9.1%
71% to 80%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%
81% to 90%	8.3%	8.3%	0.0%	0.0%	6.3%	9.1%
91% to 100%	0.0%	16.7%	8.0%	0.0%	0.0%	27.3%

Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 22.

While the number of survey respondents was too small to do an extensive analysis of revenue sources and apportionment by organization type, it was possible to describe the types of organizations who received *no* revenue from the various sources listed in the survey. The following table shows that 50% of FQHCs, 42.9% of CDCs, and 100% of school-based oral health programs received *no* revenue from commercial insurance carriers. Commercial insurance payments are important to safety net providers because reimbursement rates from commercial carriers are generally higher than from other sources and help to subsidize care in the safety net. Another interesting finding was that 28.6% of CDCs received no revenue from MaineCare. These organizations, including free clinics and others, relied mainly on donations and subsidies to support the cost of care. Some provided services to patients under special circumstances such as clinics serving psychiatric patients under a state consent decree.

No FQHCs or IPDHs received subsidies to provide oral health services, but 40% of CDCs and 25% of school-based oral health programs received some subsidies to support the cost of providing services. Most CDCs (80%), FQHCs (75%), and school-based oral health programs (60%) received some revenue from patients paying directly for services.

Table 13. Percent of Safety Net Providers Receiving *No* Revenue for Oral Health Services, by Source, Maine, 2012

Type	FQHCs	CDCs	School-based	Dental Practice	IPDH	Other
Commercial insurance	50.0%	42.9%	100.0%	0.0%	0.0%	50.0%
MaineCare	0.0%	28.6%	0.0%	0.0%	0.0%	0.0%
Self-pay	25.0%	20.0%	40.0%	0.0%	0.0%	0.0%
Sliding-fee scale	25.0%	16.7%	75.0%	100.0%	100.0%	66.7%
Program subsidies	100.0%	60.0%	75.0%	100.0%	100.0%	100.0%
Other	100.0%	33.3%	50.0%	100.0%	100.0%	66.7%

Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Questions 2 and 26.

More than half of the safety net organizations provided some uncompensated/free care (60.6%) or reduced-fee/sliding-fee scale oral health services (65.6%) for patients. A few respondents were unsure if the organization provided free (12.1%) or reduced fee (3.1%) services. More than one-third of safety net organizations and programs provided more than 40 *uncompensated* diagnostic (33.3%), restorative (41.7%), or therapeutic (36.4%) oral health services monthly and/or more than 40 *reduce-fee* diagnostic (38.5%), preventive (41.2%), restorative (40%), or therapeutic (30.8%) services monthly.

Table 14. Percent of Safety Net Providers by the Number of Uncompensated or Reduced Fee Services Provided to Patients Monthly by Type of Oral Health Service, Maine, 2012

Number of Uncompensated Services	Diagnostic	Preventive	Restorative	Therapeutic
None	33.3%	16.7%	33.3%	36.4%
1 to 4 services	0.0%	11.1%	8.3%	9.1%
5 to 10 services	0.0%	5.6%	0.0%	0.0%
11 to 15 services	16.7%	16.7%	8.3%	0.0%
16 to 20 services	8.3%	11.1%	8.3%	0.0%
21 to 25 services	0.0%	11.1%	0.0%	9.1%
26 to 30 services	0.0%	0.0%	0.0%	0.0%
31 to 35 services	0.0%	0.0%	0.0%	0.0%
36 to 40 services	8.3%	5.6%	0.0%	9.1%
More than 40 services	33.3%	22.2%	41.7%	36.4%
Total	99.9%	100.1%	99.9%	100.1%
Number of Reduced Fee/ Sliding Fee Scale Services	**Diagnostic**	**Preventive**	**Restorative**	**Therapeutic**
None	30.8%	5.9%	26.7%	38.5%
1 to 10 services	7.7%	23.5%	20.0%	15.4%
11 to 20 services	7.7%	11.8%	6.7%	7.7%
21 to 40 services	15.4%	17.6%	6.7%	7.7%
41 to 60 services	23.1%	23.5%	33.3%	23.1%
61 to 80 services	7.7%	0.0%	0.0%	0.0%
81 to 100 services	0.0%	5.9%	0.0%	0.0%
More than 100 services	7.7%	11.8%	6.7%	7.7%
Total	100.1%	100.0%	100.1%	100.1%

Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Questions 23b and 23c. Note: Totals do not equal 100% due to rounding error.

The number of survey respondents was too small to do an extensive analysis of uncompensated or reduced-fee services by provider type. However, the data from FQHCs and CDCs permitted some cross tabulations. More than half of the FQHCs and CDCs that responded to the survey provided large numbers of uncompensated or reduced-fee services (defined as 40 services or more) on a monthly basis.

Table 15. Percent of All Safety Net Providers, FQHCs, and CDCs Offering More Than 40 Uncompensated or Reduced-Fee Services to Patients, Maine, 2012

Type of Provider	Diagnostic	Preventive	Restorative	Therapeutic
More than 40 uncompensated services				
All safety net providers	33.3%	22.2%	41.7%	36.4%
FQHCs	100.0%	50.0%	100.0%	100.0%
CDCs	60.0%	20.0%	40.0%	50.0%
More than 40 reduced-fee services				
All safety net providers	38.5%	41.2%	40.0%	30.8%
FQHCs	50.0%	50.0%	50.0%	50.0%
CDCs	50.0%	50.0%	50.0%	40.0%

Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Questions 2, 23b, and 23c.

Safety net providers were asked to report approximate wait times for appointments in their organization or programs for different types of oral health services, including a new patient appointment or an appointment for a preventive or restorative or emergency care visit. Most providers (73.7%) were able to offer emergency care within one to two days. Almost half of providers (48.1%) were able to see a new patient within one to five days of the request for an appointment and 51.8% could provide a preventive visit within one to five days. The wait for restorative services was longer with 47.4% of providers indicating a two- to four-week wait for restorative care and 21.1% indicating a wait of more than four weeks.

Table 16. Percent of Safety Net Providers by Wait Time for Appointments for New Patient, Preventive, Restorative, or Emergency Oral Health Services, Maine, 2012

Wait Time for Appointment	New Patients	Preventive	Restorative	Emergency
1 to 2 days	25.9%	33.3%	10.5%	73.7%
3 to 5 days	22.2%	18.5%	10.5%	15.8%
1 week	7.4%	3.7%	10.5%	0.0%
2 to 4 weeks	33.3%	40.7%	47.4%	5.3%
More than 4 weeks	11.1%	3.7%	21.1%	5.3%

Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 24.

Wait time in some safety net organizations and programs exceeded two weeks for all but emergency services. On average, wait times for appointments were a bit longer in FQHCs and CDCs than for other dental safety net providers

Safety net providers reported information about missed appointments for oral health services on a monthly basis. All respondents indicated some missed appointments monthly. Most safety net providers (83.7%) reported some missed dental hygiene appointments monthly with 20.8% reporting more than 30 missed appointments for dental hygiene services every month. Three-quarters of survey respondents (72.7%) reported some missed appointments for dental services monthly. More than one-third (36.4%) reported between one and five missed dental appointments monthly. More than half of survey respondents (52.9%) reported no missed appointments monthly for emergency dental services.

Table 17. Percent of Safety Net Providers by Number of Missed Appointments Monthly for Dental, Emergency, and Dental Hygiene Services, Maine, 2012

Number of Missed Appointments Monthly	Scheduled dental services	Emergency dental services	Dental hygiene services
0 missed appointments	27.3%	52.9%	16.7%
1 to 5 missed appointments	36.4%	29.4%	29.2%
6 to 10 missed appointments	9.1%	5.9%	16.7%
11 to 15 missed appointments	0.0%	11.8%	12.5%
16 to 20 missed appointments	9.1%	0.0%	4.2%
21 to 30 missed appointments	4.5%	0.0%	0.0%
More than 30 missed appointments	13.6%	0.0%	20.8%

Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 26.

Again, FQHCs and CDCs had higher numbers of missed appointments than other providers responding to the survey. Some of the higher rates of missed appointments may be due to higher volumes of patients in settings like FQHCs and CDCs where multiple providers are offering services. The following table compares the percentage of *all* safety net survey respondents indicating more than 20 missed appointments monthly for each type of service to FQHCs and CDCs that responded to the survey.

Table 18. Percent of All Safety Net Survey Respondents, FQHCs, and CDCs with More than 20 Missed Appointments Monthly, by Type of Service Missed, Maine, 2012

Type of Provider	Scheduled dental services	Emergency dental services	Dental hygiene services
All safety net providers	18.1%	0.0%	20.8%
FQHCs	33.3%	0.0%	100.0%
CDCs	42.9%	0.0%	42.9%

Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Questions 2 and 26.

Survey respondents were asked to indicate the five most common reasons why patients missed appointments. They were asked to rank the reasons on a five-point Likert scale with 1 being the most common reason. Safety net providers were provided with some defined response options but were also permitted to select "other" and to describe "other."

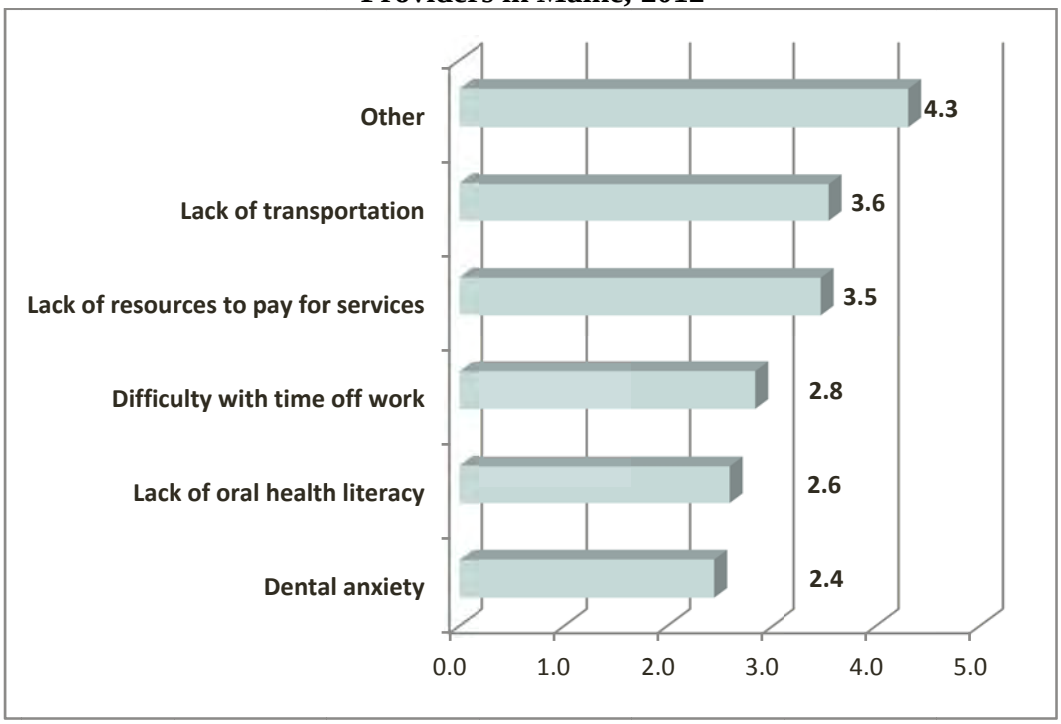
The responses on the Likert scale were weighted by multiplying the number of responses at each point on the scale (1 or 2 or 3, etc.) times a designated weight. Those weights were as follows:

- The number of most common responses at point 1 was multiplied by 5;
- The number of very common responses at point 2 was multiplied by 4;
- The number of common responses at point 3 was multiplied by 3;
- The number of somewhat common responses at point 4 was multiplied by 2; and
- The number of least common responses at point 5 was multiplied by 1.

The weighted values for each item were then added together and divided by the number of responses to that item to arrive at a mean value. A mean score of 5 would indicate the most common reason for missed appointments.

The most common reason for missed appointments was "other" than the listed responses with a mean score of 4.3. "Other" was described by several respondents as patients forgetting appointments (see Appendix A, Question 27 for the list of "other"). The next most common reasons for missed appointments were lack of transportation (mean score 3.6) and lack of resources to pay for oral health services (mean score 3.5).

Figure 9. Ranked Reasons for Missed Appointments Reported by Oral Health Safety Net Providers in Maine, 2012



Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 27.

Expansion of the Oral Health Safety Net in Maine

Safety net providers were asked if their organization or program anticipated expansion of dental services in the next one to three years. More than half of survey respondents (57.6%) indicated plans for expansion; 27.3% reported no plans for expansion; and 15.2% were unsure of any plans for expansion in their program or organization.

Respondents were asked to describe their expansion plans. A full list of expansion plans is available in Appendix A, under Question 28. Providers indicated plans to expand to additional satellite locations, diversify their programs, upgrade equipment and facilities, and increase the number of oral health professionals working in their organization.

Safety net providers were also asked if their organization had considered the possibility of becoming a training site for dental students from the University of New England Dental School. More than one-half (54.5%) indicated they had considered becoming a training site, 27.0% had not considered the possibility, and 15.2% were unsure if their organization or program was contemplating the idea.

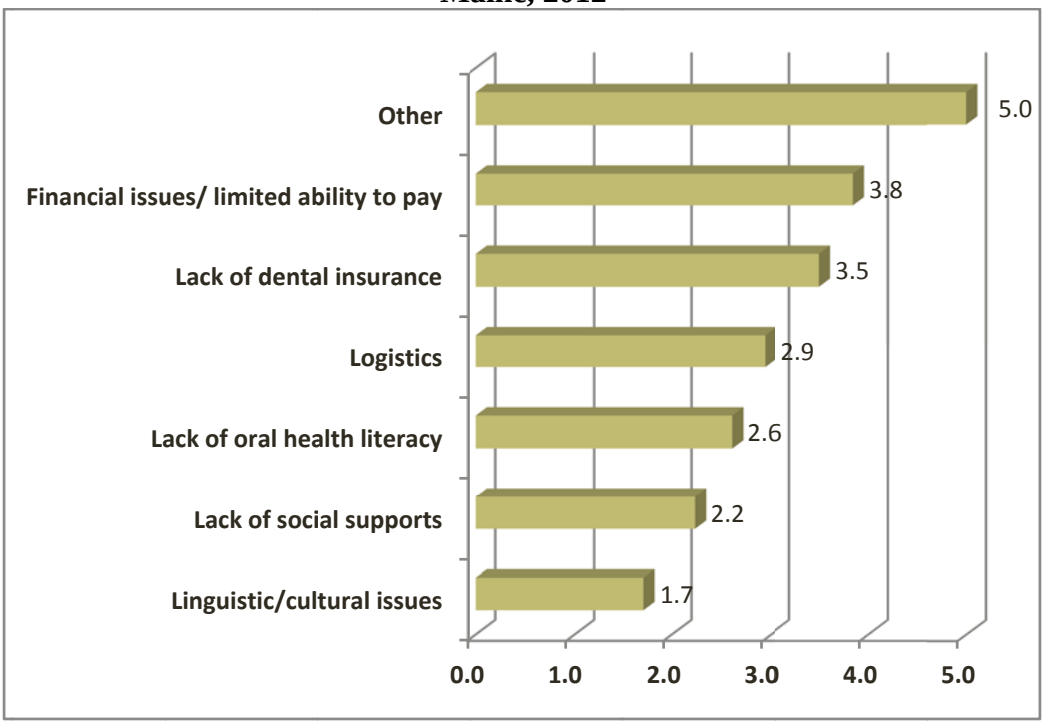
Attitudes and Opinions

Safety net providers were asked to rank the five most significant barriers that limited patients' access to oral health services in the geographic area where their safety net organization provided services. Respondents were provided with a list of defined response options including the ability to select and describe "other" than the responses listed.

Respondents were asked to rank their choices on a five-point Likert scale with 1 being the most significant barrier. Responses were weighted as described on page 40 of this report and a mean rank score was then computed. A mean score closest to 5 indicated the most significant barrier identified by respondents.

Survey respondents ranked "other" than the listed responses as the most significant barrier (mean score 5.0). "Other" was described variously, including patients not seeking care and a lack of available providers. (See Appendix A, Question 30 for a list of "other" responses.) The next most significant barriers selected by informants were financial issues and a patient's limited ability to pay for services (mean ranked score 3.8) and a lack of dental insurance (mean ranked score 3.5).

Figure 10. Barriers to Access to Oral Health Services Ranked by Safety Net Providers in Maine, 2012



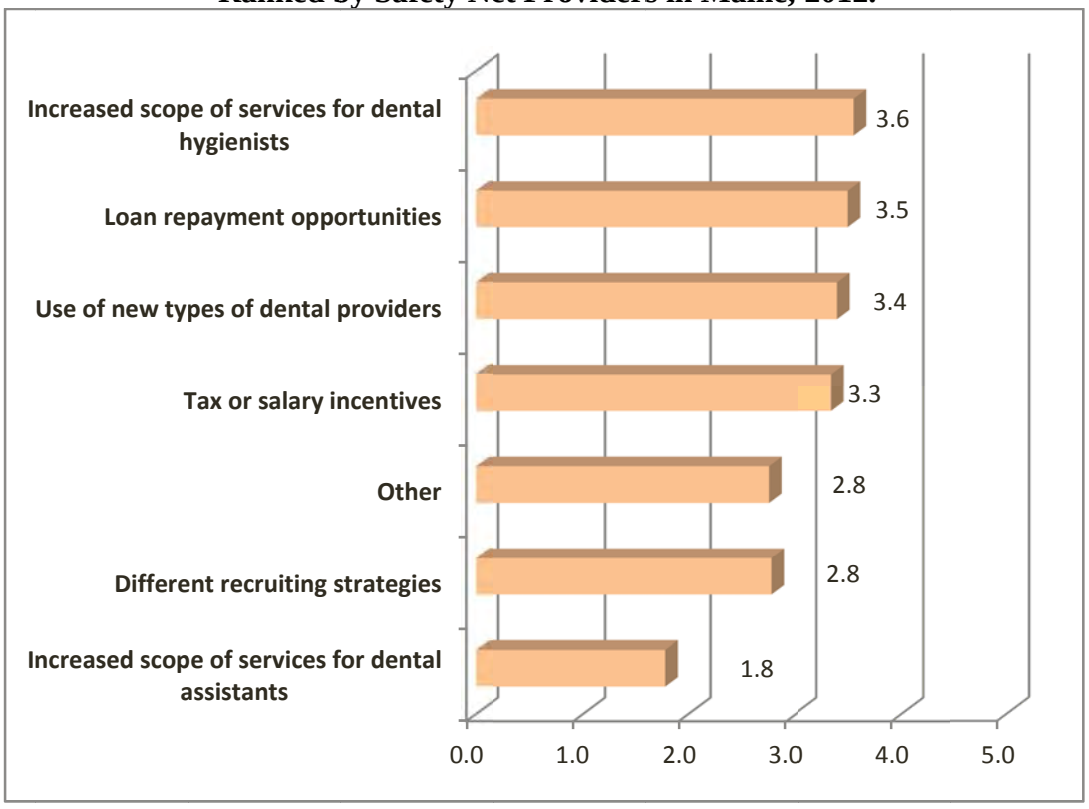
Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 30.

Safety net providers were also asked to rank a list of possible solutions to access concerns resulting from dental professional shortages in certain geographic areas of Maine. Respondents ranked a list of defined response options including "other" on a five-point Likert scale with 1

being the most important solution. Responses were weighted as previously described in this report and a mean score was computed. A mean score closest to 5 indicated the most important solution identified by survey respondents.

Safety net providers ranked increased scope of services for DHs (mean ranked score 3.6) and loan repayment opportunities (mean ranked score 3.5) as the most important solutions to professional shortages in certain geographic areas of the state. Respondents also selected use of new types of dental providers (mean score 3.4) and tax or salary incentives (mean score 3.3) as important solutions to access concerns.

Figure 11. Solutions to Access Concerns Resulting from Dental Professional Shortages Ranked by Safety Net Providers in Maine, 2012.

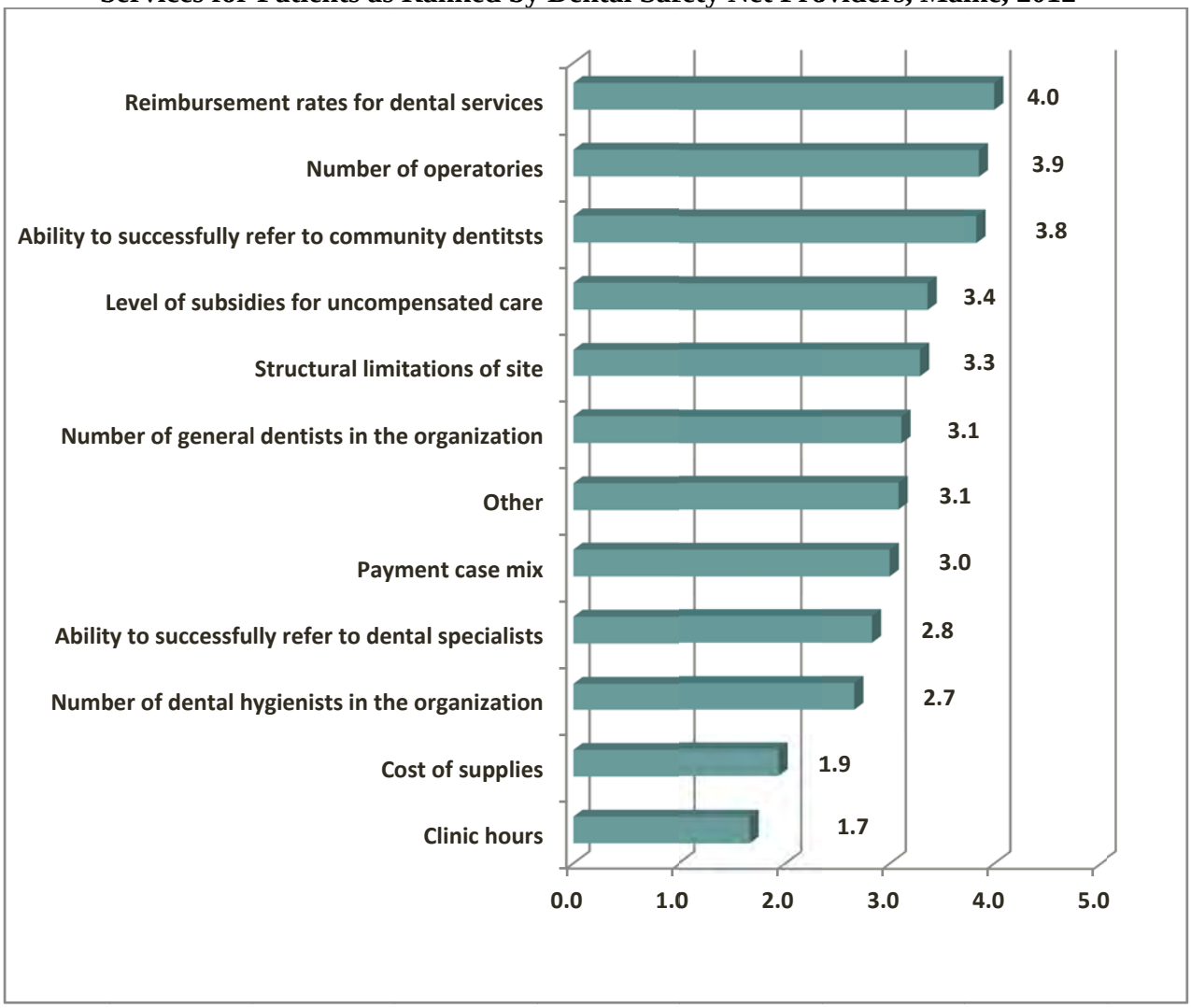


Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 31

Safety net providers were also asked to rank the five most significant barriers encountered by their program or organization that impeded the ability of the organization to provide oral health services to patients. Respondents ranked a list of response options including "other" on a five-point Likert scale with 1 being the most significant barrier. Responses were weighted as described earlier in this report and a mean score was computed. A mean score closest to 5 indicated the most significant barrier identified by survey respondents.

Safety net providers ranked reimbursement rates for dental services (mean ranked score 4.0) as the most significant barrier that impeded the ability of the organization to provide oral health services to patients. The next most significant barriers were the number of operatories in the organization or program (mean ranked score 3.9) and the ability of the program or organization to successfully refer to community dentists (mean ranked score 3.8). Levels of subsidies for uncompensated care (mean ranked score 3.4) and the structural limitations of the site (mean ranked score 3.3) were also identified as significant impediments to the organization's ability to provide oral health services.

Figure 12. Impediments to the Organization's or Program's Ability to Provide Oral Health Services for Patients as Ranked by Dental Safety Net Providers, Maine, 2012



Source: CHWS, 2012, Survey of Dental Safety Net Providers in Maine, Question 32.

Safety net providers were also asked to provide comments about access to oral health services in Maine. These comments are contained in Appendix A of this report under Narrative Comments. Providers discussed different concerns about the lack of available dental homes and difficulties with dental referrals, patients not seeking dental services, reimbursement for oral health services, and scopes of practice for oral health professionals, among others.

Appendix A: Description of "Other" and Narrative Comments from the Dental Safety Net Surveys

The survey that was fielded for this research contained predefined response options but many questions also permitted the respondent to select "other" as a response. Survey participants were then asked to describe "other." This appendix contains a list of "other" responses and is organized by survey and question number.

The survey also asked respondents to provide narrative comments. These comments are also listed in this appendix.

1a. Describe your organization or program that provides oral health services to patients. "Other"

I am also an independent hygienist
I work for a university but we provide care in an FQHC
Mobile van with two operatories - Public Health Dental Hygiene program going to 34 schools
Nursing home
Outreach public health through community action agency
Patients with cognitive disabilities and mental health issues
Public health supervision status dental hygienists working at schools in dental hygiene van
School-based and private dental practice
University providing care in FQHC
Not in business since 2009, MaineCare out of funds to reimburse our services.

4. Describe your position in the organization/program. "Other"

Administrative and clinical dental (3)
Administrative AND Clinical Dental AND Educational (2)
Dental hygienist
I am a DMD and the Executive Director of the clinic, occasionally providing clinical services.
Only person here - IPDH, no other staff at this time! Hopefully soon!
Owner

6. Does the organization or program provide any of the following? If so, at which sites? "Other"

Comprehensive oral health services for hygiene only, hygiene specialty
Oral health case management for all sites and comprehensive oral exams by a dentist at one site
Our clinic site provides preventive care; we refer to local volunteer dentists for restorative, extractions, and dentures.
Referrals to dentists who will see our kids on a one-time basis to get their mouths back to health but not to take them on as permanent patients

21. Approximately what percentage of dental patients in your organization/program are: (Totals may exceed 100% due to overlapping categories. Please include those under 200% federal poverty level as low-income patients). "Other"

Currently seeing patients under 21 years old; plan to expand programs for adults in the future, including veterans
Insurance status of patients is unknown
Nursing home residents with Alzheimer's
Patients with mental health and cognitive disabilities

22. Indicate the percentage of revenue from dental services in your program by source. "Other"

City-run mobile unit, dental hygiene services are provided by employee
Donations
Donations from community members and foundations, we receive no state or federal funding
Exploring other possibilities for reimbursements
No money taken, state consent decree pays for many patients. MaineCare pays to our billing agency.
Private foundation/grant dollars (2)

27. Rank the 5 most common reasons for missed appointments with 1 being the most common reason. "Other"

Forgot appointment (5)
Multiple reasons but often not told to me, often better/fun things to do-beach, ski, friends, etc.
Neglect
Not in school
Personal issues: apathy/irresponsibility
Patient claims they "forgot" or "overslept"
Schedule mix-up
Social problems
We don't have missed appointments, they are all walk-ins

28. Does your organization/program anticipate expansion of dental services in the next one to three years? Describe.

1. Additional satellite locations
2. Additional providers (dentists, EFDA, RDH, CDA)
3. Expansion of mobile and portable dental programs
4. Expansion of school-based programs

We expect to acquire an additional dental van to have a dentist following us from school to school to treat students who are identified with need. This however is dependent on a dental grant for funding.

Hope to offer dental hygiene services for youth, 18 years of age and younger, at some of our health centers that don't have dental access.

Facility upgrades and 100% conversion to EDR and digital radiography.

Hopefully another IPDH or denturist or dentist or hygiene mid-level!

I am a mobile dental hygienist who travels into the homes of people who are unable to get out - also do many assisted and nursing care patients.

One site would like to become a part of the UNE dental school and create actual operatories. As of right now, we provide care with portable equipment (please note that on the question about dental operatories, I entered 10+ hoping to flag that for you because the true answer is ZERO but I couldn't unclick once I had clicked something. We have NO true operatories; we operate with portable equipment.

Possible addition of an orthodontics residency

Possible increase in residencies

Taking in a student from the new dental school

To go to other school systems that will allow a public health hygienist to go into their school and establish a preventative program. We may also start going into nursing homes.

Unsure as of now

We are assisting in plans for a possible federally qualified health clinic being built in our county, with the opportunity to hire a dentist. If this does not come through our clinic will explore hiring a dentist, money is the largest barrier to this.

We are exploring building expansion in order to expand our operatories and hours of operation.

We are planning to create mobile units to go into nursing home facilities to provide preventative services to clients.

We currently have one fully equipped operatory and one partially equipped operatory. Once we have the funds, we want to expand to three fully equipped operatories.

We hope to expand and add 1/2 to 1 FTE dentist

We will be writing a grant for another van and if received, we will be able to treat twice as many kids.

Will be working with more public schools to provide on-site preventive oral health services.

30. With 1 being the most significant barrier, rank the 5 most significant barriers that patients encounter that limit their access to oral health services in your geographic area. "Other"

Apathy/do not seek care
1- Cost, 2- Dentist's office policies, 3- restorative, x-ray and 2 yearly exams
Lack of providers
Most are wheelchair bound. Many have cognitive and physical limitations
Unknown

31. With 1 being the most important solution, rank the 5 most important solutions to access concerns resulting from dental professional shortages in certain geo areas. "Other"

Adequate reimbursement and subsidies
Hygiene mid-levels, loan repayment for all providers
Improve business climate in the state
Others unknown

32. With 1 being the most significant barrier, rank the 5 most significant barriers encountered by your program that impede the ability of the organization to provide oral health services for patients. "Other"

Broken appointments and cancellation rate
High no-show rate
Many MaineCare patients do not thinking hygiene/prevention is important
MDBE is disallowing IPDHs to work within their scope of practice and educational training
Other items do not relate to our organization
Patients desire to seek care
Restrictions on public health hygienists by the Maine Board of Dental Examiners
Support from other dental professionals
The control that the dentists have over the rules and regulations for dental hygienist to practice,
The number of volunteers – period.
Transportation; logistics to make it all happen outside of facility
We are open 40 hours per week with one operatory and have openings most every week

33. Please provide us with any comments about subjects related to access to oral health services not covered in this survey.

The low reimbursement rate that the state of Maine pays for dental services for MaineCare patients is by far the largest impediment for these patients to receive care. There are many children in our area who do not have a dental home because of it. The general dentists cannot afford to take them as they are losing money when they treat them. Also, this population has a tendency to not show up for appointments, which also makes offices unwilling to schedule them.

It would be nice if dentists had some sort of incentive to work with public health hygienists and independent hygienists.

There seems to be a distinct lack of desire for many people to seek dental care. Even among private (employer) insurance holders, a large percentage choose not to have comprehensive care. Because of the difficulty to get people to make and keep appointments, dentistry should follow the lead of the medical community and strive to create a "dental home" where comprehensive care is available at one location, fragmentation of care is minimized, and resources are used efficiently with good communication. Medicine is seeing the wisdom/effectiveness of minimizing the number of different places a patient has to go for all their care. We have experienced quite a number of patients who go elsewhere for a singular hygiene visit (school or independent RDH) and do not return for proper diagnostic, restorative/comprehensive care. We have had tremendous success in providing a full range of services to our patients and encouraging them to make use of their dental home.

My IPDH practice has been open for 1-1/2 years, working many hours there and also 16 for a dentist most weeks to keep the home and office above water. Have 2nd mortgage and equipment loans with dental company - would like to be paid by my business, getting closer to that and most months can pay office bills. At this time it is a balancing act to cover home and work expenses. Sure hope the economy gets better and hygiene mid-level licensure passes into legislation to work in the IPDH office for the patients that are not able to make it to a dentist.

Perhaps a system that encourages experienced dentists to mentor new graduates would go a long way in improving the profession's ability to reach the "underserved" and ultimately significantly improve the oral health of Americans in general. Also, the emphasis on PREVENTION needs to be there, but it's not as glamorous as esthetic dentistry and it isn't high tech.

The average Maine citizen cannot afford the cost of seeing a dentist unless they have insurance. The 2nd biggest barrier is dental literacy. The key is to teach and provide prevention at an early age. Go to where the children are and that is in the schools. I see every day what a difference I make.

We are a public health dental hygiene program that does not employ a dentist as we do not have the resources to do that. We rely on a dentist in the area seeing our referrals on a one-time basis, which has worked out very well. As I said it would be nice to have a dentist follow us around to provide the additional care that is needed. Having said that, I do know that there are other states where dentists in vans go to schools and from what I have read depending on the program depends on the QUALITY of care. Some organizations are only in for the dollar and that frightens me. I want a dentist with a conscience working with our program.

Restrictions by Board of Dental Examiners placed on independent dental hygienists.

General restriction of trade placed on public health hygienists and IPDH hygienists by the Board of Dental Examiners.

Not all questions relate to our organization. Therefore, some items were intentionally left blank.

We have an all-volunteer dentist staff.

As a public health hygienist it seems that we have many rules and regulations that are one sided. A public health hygienist has to contact any dentist listed on the permission form, but dental offices are not required to contact us to see which services were provided. Also, if a parent wants to have a child seen at school and the child has seen a dentist in the past year (regularly), we are not allowed to see that child. I think that one thing people are forgetting is that in these hard economic times between time off from work, gas, and all the other inflation we are enduring, it may be easier for a child to be seen at school than the parent having to take time off from work and traveling to receive preventive care.

After 3 years of practice as an independent dental hygienist, it would be imperative to our profession to become self-regulated so that we could provide more complete care to our patients- no more "thumbs" holding us down- we need our own system in place (much like nurse practitioners do) in order to be successful providers and business owners.

The rules set forth by Maine Dental Board are transparently NOT in place to "protect the citizens of Maine," but to simply control hygienists' scope of practice- to the detriment of our patients RIGHT to choose a provider that best suits their needs!

We operate a mobile van with two operatories and visit 34 schools. Students are prequalified prior to our arrival at school so we have a list of patients we see.

With the exception of 1 paid assistant, we are entirely volunteers under the auspices of a free medical clinic. Our dental clinic is completely free and accepts adults, 21-64 who are not on any

type of 3rd party insurance. We work 2 nights per month for 3 hours each night. We provide diagnostic, preventative, restoration services as well as complete dentures and acrylic partial dentures.

The most significant barriers I am told by my patients are: 1-cost, 2- dentist's office policies, 3- restorative, radiographs and exam mongering, 4- the inability of IPDH to work or provide services that they were educated to do, 5- per service or care, 6- dentists availability, that is reference to they are not working 40 hours a week and their weekends are not covered by another dentist when they will not be available.

I think raising awareness of prevention should be a priority. Not being educated is a big barrier for oral health. I would say nearly everyone I have seen was not shown, told, or explained how to take care of their oral cavity. These are people who have been to a dentist and to hygienists.

Dental schools need to educate the profession of dentistry about providing dental treatment for the purpose of obtaining disease free health and well-being, not margins, profits, and sales.

Difficulty finding a dentist to accept a patient referral depends on specialty. Hiring difficulty also depends on location. Salaries and compensation depends on years of experience. It is easier to attract "new" or "senior" professionals. The hardest to attract are "mid-career" dentists. Also very disappointed/angry with the governor's decision to withhold promised BMD funds- will impact decision about offering training sites. Survey too late, it really is not about workforce--access and sustainability require adequate reimbursement.

The two biggest challenges facing our clinic are:
1) Low rate of reimbursement from MaineCare
2) Broken appointments and no-shows combined run about 15-20% /month**.**