

Interviews of Oral Health Stakeholders in North Dakota

Executive Summary

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Project Completed by:

The Center for Health Workforce Studies
School of Public Health, University at Albany
State University of New York
One University Place, Suite 220
Rensselaer, New York 12144-3445
(518) 402-0250
<http://chws.albany.edu>



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 2012, the Center for Health Workforce Studies (the Center) with support from the Otto Bremer Foundation and the Pew Center on the States' Children's Dental Campaign completed a study describing the oral health status of the people of North Dakota and identifying barriers to access to oral health services in that state. The research study included an extensive literature review, review and analysis of available secondary data, and interviews of stakeholders in oral health in the state.

This paper summarizes the common themes derived from personal telephone interviews with 48 oral health stakeholders in North Dakota completed between April and July 2012. The interviews were conducted and this report was written by Margaret Langelier of the Center for Health Workforce Studies at the School of Public Health, University at Albany. The author can be contacted with any questions about the content of the report at (518) 402-0250.

Special appreciation is extended to Kimberlie Yineman and Bobbie Will for their help with identifying many of the stakeholders who were interviewed. The author is especially indebted to the dentists, dental hygienists, dental assistants, education program directors, oral health program managers, facility directors, medical professionals, government officials, and policymakers in North Dakota who agreed to be interviewed. The informants provided thoughtful input to the qualitative aspects of this research study.

The Center was established in 1996. It 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>.

Background

The Center for Health Workforce Studies (the Center) at the School of Public Health, University at Albany, with support from the Otto Bremer Foundation and the Pew Center on the States' Children's Dental Campaign undertook an assessment of oral health in North Dakota. The research objectives were to understand the provision and utilization of oral health services in North Dakota and to identify gaps in oral health care throughout the state. The study included an extensive literature review, analysis of secondary data, and interviews with pertinent stakeholders. Topics of particular interest included the difficulty of providing oral health services in a sparsely populated rural state, the challenges of funding care to populations with limited access to oral health services, the adequacy of the current oral health workforce and the placement of oral health professionals in the state. This paper is a summary of the common themes identified from stakeholders who participated in the interviews.

In the period between April 3, 2012 and July 10, 2012, Center staff conducted 48 interviews with stakeholders in North Dakota who were identified with the help of key informants as interested in the issue of oral health access. Additional informants were subsequently identified by interview participants who suggested other potential informants knowledgeable about provision of oral health services or in policymaking related to oral health services in the state. Informants represented a broad cross-section of state residents including direct care providers, administrators, and policymakers. Care was taken to speak with representatives from all oral health professions and with professionals from other health disciplines or in policy or administrative positions related to oral health delivery. Informants were representative of all regions in the state.

Informants included licensed dentists, registered dental hygienists, registered dental assistants, physicians, social workers, nutritionists, oral health consultants, researchers, education program directors, oral health program managers, directors of community clinics and other safety net programs, educators, representatives of professional associations, government officials, and policymakers.

The telephone interviews lasted between 40 and 90 minutes and were arranged and conducted at the convenience of the participants. Although an interview protocol was developed and shared with informants, the protocol was used only as a guide to the discussion. This unstructured approach allowed informants to talk about topics related to their particular perspective on oral health access issues in the state.

Informants were assured that their comments were confidential with no direct attribution of remarks to individuals within the report. Informants were advised that benchmark programs might be cited by name as examples of successful strategies to meet demand for oral health services in the state. The interview protocol is included in this report as Appendix A. The organizations where informants worked are listed in Appendix B. This list was compiled to document the wide array and geographic diversity of organizations with an interest in oral health in North Dakota.

Common Themes from the Interviews:

Informants were asked to discuss their knowledge of and interest in oral health and, in many cases, their personal experiences with the oral health delivery system in North Dakota. Some informants directly provided oral health services to the state's residents as licensed oral health professionals while others were in policymaking or management positions that directly affected delivery of oral health care.

A significant outcome of the interviews was the identification of common themes that recurred throughout the discussions about oral health in the state. These themes are listed and elaborated on below.

Access to Oral Health Services

While many people in North Dakota have adequate access to oral health services, there are people in some rural and frontier areas of the state with limited access to care. There is regional variation in the ability of North Dakota residents to access oral health services. Further, there are special populations even in the more populous regions of the state with limited access to oral health services.

Interview participants often spoke of the challenges of North Dakota's geography commenting that it was not uncommon for residents of rural and frontier areas in the state to drive many miles to obtain oral health services. Informants also expressed particular concern about low-income children and adults; the elderly, particularly those confined to nursing homes; special-need populations including those in institutional care; and the American Indian population in the state. American Indian populations are underserved and at high risk for poor dental health. This population is young and growing in number. It is challenging to educate and provide services to American Indians due to cultural differences, transportation issues, poverty, and rurality. In addition, the oral health care delivery system on reservations does not easily interface with oral health care providers in contiguous communities, which further isolates the population on reservations from the oral health resources available in nearby towns.

North Dakota has successfully implemented some public health initiatives to improve oral health including water fluoridation but public health programs are not widely available in all geographic areas of the state.

North Dakota ranks as one of the top states in the nation on measures of water fluoridation with 96.4% of community water systems supplementing their water supplies. Fluoride is a naturally occurring mineral but it may not be present in water at sufficient levels to obtain the desired preventive effect. Because of the primarily rural geography in the state there are rural populations accessing water through private wells that may not benefit from fluoride levels that offer the desired protective outcome. Fluoride varnish programs in schools are, therefore, particularly important in rural areas to help children who do not drink fluoridated water. The Healthy Tracks program in the state has trained a variety of professionals to provide fluoride varnishes to children in those areas during health screening appointments.

Another important program in North Dakota is the school-based oral health program sponsored by the state with support from HRSA. The state employs four regional dental hygienists (DHs) who work under the standing orders of a dentist and provide services in low-income schools across the state. This new program coupled with the long established fluoride varnish program permit DHs to provide oral health education, sealants, and varnishes to children who do not have regular dental providers in their local communities. These programs could be further expanded to include more schools and offer more preventive services including prophylaxis if more oral health professionals could be engaged to participate and if funding were available to expand the reach of these programs. If expansion efforts are to be successful, dentists would need to provide standing orders to DHs to work in the program

Access Barriers

Lack of oral health literacy in many populations is a substantial issue. People who do not appreciate the value of oral health do not use oral health services appropriately. It is challenging to help people understand the importance of oral health.

Informants were clear that a major underlying barrier to promoting appropriate use of oral health services and enhancing the oral health of the population was the lack of oral health literacy among many subpopulations in the state. The repercussions of low literacy for both patients and providers are numerous, including persistent demand for urgent care for emergent and acute oral health conditions, inappropriate use of emergency departments (EDs) for treatment of dental disease, and even missed appointments for dental and dental hygiene services. One manifestation of poor oral health literacy cited by informants was the need in some populations of young children for whole mouth or quadrant dentistry under anesthesia due to deficient oral hygiene, the absence of preventive care, and poor nutritional habits, all of which are symptomatic of poor oral healthy literacy in family systems. This is especially alarming considering that young children with such poor dentition are at risk for becoming edentulous adults. Caries must be recognized as a serious disease process with systemic long term implications and the importance of prevention and management must be emphasized. People of all ages, especially families with children, need more education about the importance of consistent oral hygiene behaviors, the systemic impacts of poor oral hygiene, and the contribution of good nutrition to oral health outcomes.

Rural and frontier counties with fewer oral health providers have higher rates of elderly and low-income residents compared to the more populous regions of the state.

The rural geography in North Dakota is an especially difficult barrier to providing accessible oral health services. Population density in some areas of the state is remarkably low. In addition, there are high rates of poverty and older populations living in the rural and frontier areas of the state. These demographic characteristics amplify the challenges of increasing access to both medical and dental care. While rural residents may be accustomed to driving long distances to service centers for health and dental services, the ability to travel is dependent on having reliable transportation and the means

to pay the substantial cost of gas. The absence of public transportation systems limits many elderly and low-income patients from seeking routine oral health services. Oral health providers must be creative in designing oral health delivery systems in these sparsely populated areas. Mobile vans, oral health programs collocated with public health units, and teledentistry were all suggested as possible strategies to increase access in rural areas.

While reimbursement rates for dental services are higher in the North Dakota Medicaid program than in many other states, providers assert that reimbursement does not cover the cost of the services provided.

North Dakota is one of only a few states in the U.S. that still offers a dental benefit to both children and adults who qualify for Medicaid. The adult dental benefit is more limited than the dental benefit available to children in the state and the reimbursement for adult dental services is lower than that for services to children. There are dentists in North Dakota who will not participate in the Medicaid program or who restrict the number of Medicaid insured patients they serve. This is a limiting factor for Medicaid eligible patients who need dental care. Dentists and others in the state assert there is a need to raise reimbursement rates to more adequately meet the cost of providing services. There is a widespread belief among dental professionals that increasing Medicaid reimbursement rates would result in greater participation by dentists in the Medicaid program. While the North Dakota legislature has authorized incremental increases in Medicaid reimbursement over the last several legislative sessions, the current fee schedule is still viewed by some as less than needed to induce dentists to participate more fully with the program.

Even dentists willing to treat Medicaid insured children in North Dakota express reluctance to treat adults on Medicaid. The limited coverage and the low reimbursement rates negatively affect access for Medicaid insured adults to private dental practices. Interviewed stakeholders frequently commented on the lack of coverage for final restorative services (i.e., crowns) and that the high cost of crowns encouraged patients to choose extraction over restoration of diseased teeth. While extraction of a tooth solves the acute problem of pain and infection, the long term impacts of extractions on nutrition and on the integrity of other teeth in the mouth are substantial.

Unconstrained growth and shifting demographics in areas of the Baaken oil reserve are creating new barriers to oral health care for residents. People in northern and western North Dakota who are most affected by the oil boom are competing for more expensive and less readily available oral health care with the well paid and mainly itinerant oil industry workforce.

The oil boom in northern and western North Dakota has created special challenges for oral health providers and other community members in those geographic areas. Many North Dakota residents in oil boom areas are not benefitting financially from the drilling and are being negatively affected by the sudden growth in population. Dentists are a limited resource in high demand in most oil boom towns.

The delivery of oral health services has changed in those areas with dentists experiencing increased demand for urgent and emergent dental services from the largely transient population. Dentists commented that oil workers seek episodic services but do not become established patients. Many dentists will now only accept cash for dental services since oil industry workers may leave the area before bills are fully paid. If a transient worker ends employment, their dental insurance also terminates. Dentists may be left with outstanding bills and no payment recourse for the services provided. This situation challenges residents indigenous to oil boom areas who now must pay cash for oral health services and also compete with oil workers for appointments with a limited number of oral health providers in the local area.

The oil boom in North Dakota is having widespread impacts on demand for oral health care. Government resources are being diverted from programs like oral health to build new roads and services in areas where drilling and pumping oil are now the main industry.

While the oil boom obviously impacts particular areas of northern and western North Dakota, its effects are reverberating throughout the state. State government, while benefitting from substantially increased tax revenues, is struggling with rebuilding roads and enhancing public infrastructure, such as water delivery systems and sewage treatment plants, to meet the ever-growing demand for those resources in the areas of the Baaken oil reserve. This has resulted in more state funds being directed to public works projects and has diverted dollars from health and oral health care.

There is such considerable demand for housing in western North Dakota that new workers are living in trailers and recreational vehicles parked in any available space including residential roads and parking lots. Some longtime residents in oil boom towns are selling their homes and moving further afield. Workers who are unable to find adequate housing and schooling for their children near the oil fields are settling in other areas of the state and commuting distances to work. As a result, outlying towns, services centers, and cities at some distance from the oil fields are also seeing increased demand for oral health services. The impact of this shifting population on demand for oral health services is not yet fully understood.

Providers of Oral Health Services

There is a network of safety net providers and safety net programs in North Dakota but there are areas of the state where there are no safety net providers. Further, the existing oral health safety net is not able to meet demand for services in the areas where they operate and many are struggling to assure sustainability.

The array of safety net oral health providers in North Dakota is impressive. Many of the existing programs in North Dakota grew from grassroots community initiatives that recognized the need for more oral health services in a particular region, built local coalitions focused on oral health objectives, and found supportive funding for clinic infrastructure. These safety net providers are offering needed services as evidenced by the high demand in their geographic regions.

There are areas of the state, notably the south, the west, and some areas of the north that do not have safety net providers that offer oral health services. While dentists throughout the state provide services to populations who might be considered safety net patients, the absence of structured safety net clinics in some areas is detrimental to access. Community clinics and federally qualified health centers (FQHCs) may have more flexible payment options for patients with limited resources. In addition health centers with dental clinics are able to transition patients between health care and dental care more seamlessly than private delivery systems where the established siloes of care often obstruct interface between health and oral health. This segmentation across health and oral health is a barrier for patients in North Dakota and elsewhere. It is an especially significant barrier for people who do not regularly access care and who may not have an understanding of how to obtain services. A medical provider in a FQHC can complete an oral health assessment and then refer a patient for dental services within the same building, providing a nearly seamless transition for the patient.

Financial fortification of the safety net would assure sustainability for these providers. The strengthening of the safety net depends on funding strategies that foster efficiency and encourage quality but still adequately support the cost of care. Reimbursement methodologies should be designed with the objective of both maintaining and enhancing safety net resources and services.

Reauthorization of the state dental loan repayment program would be an incentive to new dentists to work in underserved areas and in safety net settings.

Informants commented often on the importance of a state dental loan repayment program as an incentive for a dentist to work in the safety net serving populations with difficulty accessing oral health care in private dental offices. The state loan repayment program was viewed as a critical incentive to enable safety net organizations to recruit dentists to work in their dental clinics. Stakeholders were optimistic that the legislature would reconsider and reauthorize this program in the next legislative session and permit not-for-profit community clinics along with FQHCs to be eligible placement sites for the loan repayment program.

While the supply of oral health workers in North Dakota appears sufficient on a per population basis, it is not well distributed. In addition there is some excess capacity within the dental hygiene workforce that could be tapped to increase oral health literacy and provide more preventive services.

As is true in many states, the oral health workforce supply in North Dakota might be described as sufficient based on current dentist-to-population ratios but it is not well distributed to meet population need. Typically across the U.S., the majority of dental professionals are found in population centers where there is sufficient demand for services and an adequate income base to support the cost of providing care. This is true in North Dakota where about 30% of dentists are located in Cass County home to the most

populous city, Fargo. There are 16 counties in the state with no dentist and an additional eight counties with a single dentist.

While there appears to be an adequate supply of dentists statewide, there is apparently an oversupply of DHs in the state. Informants remarked consistently on the lack of employment opportunities for DHs. Newly graduated DHs are experiencing significant difficulty in finding any work, even part time. In the licensure database examined as part of the study, there were over 80 DHs maintaining licenses that did not have a current practice address. While not practicing may be elective for some, these numbers may indicate a weak job market for DH professionals in North Dakota. Informants repeatedly commented on this oversupply and regretted there was unused capacity among educated and credentialed oral health professionals that was not being tapped to improve the oral health of state residents.

Paradoxically, informants also discussed a shortage of dental assistants (DAs) in the state. North Dakota is somewhat unique among states in that it severely limits the tasks permitted to chairside-trained DAs, while providing much greater latitude in scope of practice to registered (formally educated and credentialed) DAs. In many states, the tasks permitted to DAs are standard for chairside or formally educated professionals, with expanded duties reserved only for experienced or certified professionals. Dentists in North Dakota prefer to hire formally educated and/or certified DAs who are registered with the Board of Dental Examiners in the state. The supply of these professionals is low. Some licensed DHs in the state are even training as DAs in order to find work in oral health. A DH's work is considerably different from that performed by DAs so there is a learning curve to master restorative skills. These dually trained individuals provide advantages and flexibility in dental practice.

There are very few public health and school-based oral health programs employing dental hygienists in community settings.

There is obvious need for preventive oral health services for children in the state. School oral health programs were viewed as ideal vehicles for delivery of education and prevention services because they can provide seamless routine care for children in their daily setting. The excess number of licensed DHs in the state was often cited as well-trained capacity that could potentially be engaged in expanded efforts to deliver regular preventive services to children. While the current school-based program depends on time-limited federal grant money, school-based programs in North Dakota may have to transition to a payment model that permits DHs to bill for the services they provide to Medicaid or CHIP eligible students. This is the payment model that is operational in other states that has enabled school-based programs to attain relative permanency and sustainability.

A more collaborative team-based approach to providing oral health care services could improve patient's access to care. There is a particular need for improved interprofessional referral systems to connect patients to appropriate providers in the oral health care system.

Providers in the safety net and traditional medical practices report a great need for an accessible referral network of dentists. While the systemic implications of oral disease are often discussed and the integration of health and oral health touted as a desired objective, there are structural barriers that impede realization of this goal.

Primary care medical providers need to refer patients for general and specialty dental services. ED personnel need to refer patients for urgent and emergent dental needs. Safety net clinics need to refer dental patients for specialty dental services. DHs working in school-based programs need to refer children for restorative services. Establishing collaborative networks of providers would be beneficial to patients, especially those in the safety net who do not regularly receive oral health care and, therefore, do not enjoy an established dental home.

The need for community dentists to engage with other providers, particularly medical providers, in addressing demand for urgent and emergent dental problems was a recurrent theme. There are no effective mechanisms currently to refer patients from EDs to community dental providers. Informants discussed the need to network professionals so that patients with dental complaints or conditions can be transitioned to appropriate care.

Discussion

An important benefit of North Dakota's small population is its strong sense of common identity. One obvious asset in the state is an engaged group of oral health professionals and advocates that have formed active coalitions and collaborations to address gaps in oral health services. While this networking has been ongoing and productive for many years, the need for oral health services appears to have outpaced the incremental approaches to expanding access that have effectively addressed gaps in oral health care in the past. Historically, the state experienced only minor shifts in population so incremental change in the delivery of oral health services had greater impacts. The pace of change currently suggests the need for more available oral health services in public health programs and public health infrastructure than is currently available in the state.

For example the school-based oral health programs, which are more limited in North Dakota than in many other states, have the potential to increase the number of children who receive oral health education and preventive services. Oral health literacy, which is identified as a major issue, begins with teaching children about the importance of positive oral health behaviors and nutritional habits that become routine. One barrier to increasing the number of school oral health programs is finding dentists willing to provide standing orders to DHs working in schools. Another barrier is the lack of school nurses in many of the public schools in the state. School nurses often serve as advocates for children and provide linkages to parents that would be valuable to school oral health programs. Another major barrier to expansion of these programs is funding. While the state currently has a federal grant to support the costs of supplies and salaries for the sealant and varnish program for the next two years, unless that funding is renewed the existing school-based programs will be in jeopardy.

While North Dakota experiences many of the same challenges in delivery of oral health services that other states with similar population demographics and geography also encounter, North

Dakota also experiences unique challenges and opportunities. North Dakota's rurality is a substantial barrier to improved access to oral health care. There are also demographic shifts occurring in the state with more ethnic and cultural diversity in North Dakota today than in the past. The oral health needs of the growing and relatively young American Indian population present a major challenge to the current oral health care delivery system as well. Demand for restorative care is high in this population.

While the recent oil boom has had many positive economic impacts, it has also created challenges. Population centers in western North Dakota, which have been most affected by the boom, lack infrastructure to meet ever-growing demand for housing and health services. The continuing influx of migrating workers looking for jobs is taxing both local and state governments. In addition, the oil boom has impacted the local population in western North Dakota who are dealing with inflation and inordinate population growth. The cost of oral health services has risen and these services are more difficult to obtain than in the past. While there has been an increase in the number of oral health providers in areas most affected by the boom, that increase has been insufficient to meet demand for oral health services.

There is a need for more community-based dental services for low-income and uninsured populations in the safety net and for more secure financing for safety net providers. While there are several well-established safety net clinics in the state, they are not geographically accessible to all populations. A financially secure safety net is essential to increase access to oral health services in North Dakota. Economic viability in the safety net depends on state and federal subsidies, philanthropy, and sufficient public reimbursement to cover the cost of providing care to low-income populations.

As a result of the maldistribution of dentists in North Dakota, there are places in the state where demand exceeds the capacity of the oral health delivery system to provide care. This is problematic since these are generally areas where it may not be feasible for dentists to establish a dental practice. A viable practice must treat enough patients and generate enough revenue to cover the high cost of delivering dental services. Creative ideas about addressing need in low density areas will be important as North Dakota stakeholders consider the problems of rural underserved populations.

Suggested strategies to address unmet need for oral health services might include:

- Enabling remote supervision for DHs or alternative oral health workforce to offer more preventive services, like prophylaxis, in schools and other settings;
- Initiating the use of teledentistry;
- Supporting more extensive use of medical professionals to provide screening, basic prevention, and referral services;
- Permitting employment of DHs in medical settings;
- Increasing the number of oral health programs available in public health units across the state;
- Introducing mobile dental programs using portable equipment such as the demonstration project in two nursing homes in Bismarck;
- Using mobile dental vans like the Ronald McDonald Care Mobile; and

- Engaging critical access hospitals to provide structural resources (i.e., a dental chair) for satellite dental clinics.

Several current conditions in North Dakota present opportunities to increase access to oral health services: There is:

- A definite need for increased oral health literacy in the population;
- Limited access to regular/routine oral health services in some areas of the state; and
- Excess dental hygiene capacity in the state.

DHs are widely available to work in programs that promote oral health literacy while also offering preventive and prophylactic services to the public. Using a team-based approach to care in which a DH works remotely from the supervising or cooperating dentist could increase access and substantially improve the overall oral health delivery system in a particular area.

As stakeholders develop new strategies to advance an oral health agenda for the state, there will be greater need for current data on the oral health workforce and the oral health status of the population. It is an especially critical time for states to have an accurate inventory and a comprehensive understanding of their oral health care workforce, providers, and utilization patterns. While North Dakota has some oral health data, they are not widely available or current enough to effectively assist in the design of new oral health programs or to guide changes in policies to increase access to oral health services. For instance, there are gaps in hospital data that limit understanding of patient utilization of dental services in EDs. These are costly services that could be obtained less expensively and more appropriately in other settings. The effective date for the Affordable Care Act is fast approaching and its expected impacts on oral health care delivery and financing suggest the immediate need for robust data collection and analyses related to oral health at the local, regional, and state levels.

According to many key informants, North Dakota prides itself on its ability to build community collaboration to address issues of concern. Informants talked about the importance of self-reliance, determination, and the benefits of having an engaged network of concerned professionals and policymakers capable of assembling resources and working cooperatively. These assets combined with innovative programs would increase access to oral health services and improve oral health outcomes for North Dakota's population.

Appendix A.

Interview Questions for Stakeholders in Oral Health in North Dakota

**Conducted by: The Center for Health Workforce Studies
School of Public Health, University at Albany, State University of New York
One University Place, Suite 220
Rensselaer, NY 12144**

Contact: Margaret Langelier (MHL02@health.state.ny.us)

This interview is being conducted to inform a review of oral health workforce in North Dakota, to describe barriers to access to oral health services, and to recommend pathways to increased access to dental care. The research is conducted by the Center for Health Workforce Studies at the University at Albany with support from a grant by the Otto Bremer Foundation secured by the Pew Center on the States. This interview is voluntary and will take approximately 30 minutes to 45 minutes to complete. Please tell me at any point if you wish to or must discontinue this interview.

Although the following questions are meant to guide the interview process, only some of the questions may be asked depending on the time allotted. Any information provided during the interview will be confidential.

Do you have any questions or concerns about this interview before we begin to talk?

Questions:

1. Describe your personal or professional interest in oral health in North Dakota.
2. What do you perceive to be the major barriers to universal access to oral health care in North Dakota?
3. Do you have concerns about lack of access to oral health care for certain populations? Who is at risk for not receiving dental care? What geographic areas in the state experience limited access to oral health care?
4. Are you aware of any successful initiatives or collaborations that have addressed the need for increased access to oral health services in the state? What strategies were employed by those initiatives to improve access to care?
5. Can you describe the coalitions who implemented these projects, their funding sources, and the patients served by these initiatives? What kinds of oral health workforce were employed to achieve the project objectives?

6. What could be done by government stakeholders from a policy perspective to encourage increased access to oral health care in the state? How does funding for oral health care affect access to dental services in North Dakota?
7. How do current regulatory limitations on scope of practice for dental hygiene and dental assisting professionals impede access to care for those at risk for not receiving oral health services? Are there particular examples of regulatory barriers to care?
8. Have there been any past initiatives in North Dakota to expand the scope of practice of dental hygienists and/or dental assistants or to decrease incumbent levels of supervision for these auxiliaries? Were these initiatives implemented and if so, have they had any appreciable impacts on increasing access to oral health care? If not, why not?
9. Describe your perceptions of stakeholders' concerns about efforts to expand access to oral health care through workforce initiatives? How have oral health professionals historically responded to proposed legislation to elevate scope of practice for either dental hygienists or dental assistants or to decrease supervision requirements for these personnel? What are the main concerns expressed by oral health professionals about such regulatory change?
10. What is your perception of the sufficiency of supply of oral health workforce in the state? Is there a need to recruit more dentists, dental hygienists, or dental assistants to work in specific locations in the state?
11. What educational programs in the state or out of state might be engaged to train new oral health professionals? Are partnerships among educational programs easily achieved?
12. Are there any issues that we have not discussed today that you feel are relevant to this discussion?

Thank you for talking with me today. If you have any questions about this interview at any time please contact me (Margaret Langelier) at MHL02@health.state.ny.us or by phone at (518) 402-0250.

Appendix B.

Work Locations of Interview Participants

The following list is provided to demonstrate the diversity of organizations in which informants worked. In all, 48 people participated in the interviews. In some cases, there was more than one interview participant from an organization. In the case of dentists, dental hygienists, and dental assistants there were multiple informants in many of the locations listed.

Government

North Dakota Department of Health
Oral Health Program
Barnes, Benson, Cavalier, Cass,
Dickey, Eddy, Foster, Grand Forks,
Griggs, LaMoure, Nelson, Pierce,
Pembina, Ramsey, Ransom,
Richland, Rolette, Sargent, Steele,
Stutsman, Towner, Traill, Walsh,
Spirit Lake Reservation, Turtle
Mountain Reservation,
Adams, Billings, Bowman, Burleigh,
Burke, Divide, Dunn, Emmons,
Golden Valley, Hettinger, Kidder,
Logan, McIntosh, McKenzie,
McLean, Mountrail, Slope, Stark,
Williams, Fort Yates, Three
Affiliated Tribes, Grant, Mercer,
Morton, Oliver, Sioux, Sheridan,
Wells, Standing Rock Reservation

North Dakota Department of Health,
Oral Health Program
Bismarck, North Dakota

Southwestern District Health Unit
North Dakota Department of Health
Dickinson, North Dakota

North Dakota State Board of Dental
Examiners
Bismarck, North Dakota

Rolette County Public Health District
North Dakota Health Tracks
Child Health Screening Program
Rolla, North Dakota

Head Start State Collaboration
North Dakota Department of Human
Services
Bismarck, North Dakota

North Dakota Indian Affairs Commission
Bismarck, North Dakota

North Dakota Department of Human
Services
Medical Services Division
Bismarck, North Dakota

DentaQuest
North Dakota Department of Health
Division of Family Health
Bismarck, North Dakota

Burleigh County Social Services
Bismarck, North Dakota

Safety Net Providers

Valley Community Health Centers
Northwood, North Dakota

Bridging the Dental Gap

Northland Community Health Center
Turtle Lake, North Dakota

Family HealthCare Center
Fargo, North Dakota

Safety Net Providers (cont.)

Bridging the Dental Gap
Bismarck, North Dakota

Ronald McDonald House Charities of
Bismarck
Bismarck, North Dakota

Red River Valley Dental Access Project
Fargo, North Dakota

Education Programs

North Dakota State College of Science
Dental Hygiene Program
Wahpeton, North Dakota

Physicians

Medcenter One
Bismarck, North Dakota

Dentists

North Dakota Dental Association
Bismarck, North Dakota

General or Specialty Dentists in:
Ellendale, North Dakota
Grand Forks, North Dakota
Bismarck, North Dakota
Minot, North Dakota
Fargo, North Dakota
Jamestown, North Dakota
Dickinson, North Dakota

Dental Hygienists

North Dakota Dental Hygienists'
Association

Registered Dental Hygienists in:
Bismarck, North Dakota
Fargo, North Dakota
Thomson, North Dakota
Williston, North Dakota

Dental Assistants

North Dakota Dental Assistants' Association

Registered Dental Assistants in:
Bismarck, North Dakota
Mandan, North Dakota
Northwood, North Dakota
Hillsboro, North Dakota

Other Oral Health Stakeholders

Community HealthCare Association of the
Dakotas
Bismarck, North Dakota

Center for Rural Health
University of North Dakota
School of Medicine and Health Sciences
Grand Forks, North Dakota

North Dakota Head Start Association
Devils Lake, North Dakota

Early Explorers Head Start
Towner, North Dakota

North Dakota Long Term Care Association
Bismarck, North Dakota