

Health Services Committee**April 13, 2016****North Dakota Dental Association****Dr Omar Chahal, President**

Chairperson Lee and members of the committee, my name is Dr. Omar Chahal and I am the President of the North Dakota Dental Association. I am an oral surgeon and I practice in Grand Forks. Thank you for the opportunity to present testimony on the topics listed on the agenda.

Dental Medicaid

Regarding Medicaid, the NDDA has had several initiatives underway to improve the system. A year ago our **“Take Five More”** program challenged dentists to see “5 more Medicaid” patients in a week, a month, or a year. 75 dentists responded. As you know, the Department of Human Services made an MMIS upgrade of their information system last October which involved all Medicaid providers. As DHS representatives testified at the last committee hearing, it is early to determine the effects of either our dentist recruitment effort or the MMIS transition on Medicaid utilization. The North Dakota Dental Association has worked hard to help dental offices navigate the administrative changes and it is hoped and expected that the challenges of this transition will dissipate over time and effects on the provider network will be minimal.

Additionally, a **Medicaid Advisory Committee** was formed last summer with dentists from across the state meeting with the Department of Human Services

quarterly to jointly discuss provider issues and provide solutions. This process has been especially important during the MMIS transition.

There are several key barriers to Medicaid recipients receiving adequate dental care. They include limited availability of dental providers, low reimbursement rates, administrative burden for providers, lack of understanding by beneficiaries about dental benefits, missed dental appointments, transportation, cultural attitudes, language competency, fear, and lack of knowledge about the importance of oral health. The interplay of these barriers determines how North Dakota measures up in Medicaid utilization, participation of dentists, and access. The job of reducing these barriers will never be complete and takes the collaboration of all stakeholders in the state working together: the dental community, state government, public health entities, and patients.

Dental Emergency Visits at Hospital Emergency Rooms

It is estimated that there are roughly 2 million visits yearly to the nation's hospital Emergency Rooms for dental pain. It is clear most of these visits are inappropriate and costly since definitive dental treatment usually cannot be provided in that setting. Evidence shows that as more patients have access to a dental home, the number of dental visits to the ER decreases. Even though In North Dakota, Sanford Health has tracked a 20% **decrease** in non-trauma dental visits to their ER Departments in the last 2 years, efforts should be relentless to continuing to seek ways to reduce these inefficient ER dental visits.

In Fargo, the Family HealthCare Dental Clinic (an FQHC non-profit public health clinic) has an agreement with Sanford ER to see any dental pain patients within the next day. The Red River Dental Access Project in Fargo serves as a backup to this coverage with a weekly walk-in clinic for free humanitarian relief of dental pain provided by 45 volunteer dentists.

In Bismarck, Dr Katie Stewart has initiated a process to set up a similar system. In Feb 2016 a meeting was held with Sanford physicians Dr. Chris Meeker and Dr. Kadon Hintz to discuss possible solutions to reduce the number of dental ER visits and how to get these patients referred to a local dentist. In April 2016, at a meeting of Bismarck area dentists, the prospect of piloting a local ER diversion plan recruitment of volunteers was discussed.

Future plan:

- Will meet with the Dental Director, Dr. Joanne Luger, at the non-profit "Bridging the Dental Gap" Clinic in the next few weeks to gauge their level of commitment to such a diversion program, similar to Family HealthCare in Fargo
- May 24, 2016 - will present the updated info to the Bismarck area dentists
- June 2016 - will present ideas to Dr. Chris Meeker and Dr. Kadon Hintz again

Indian Health Services Credentialing for Dental Professionals

As presented to the committee previously, credentialing of Indian Health Service dental professionals has been identified as a barrier to providing an adequate dental workforce for not only IHS dentists that are assigned to the Great Plains Area, but also to local dentists that wish to volunteer or contract their services with a tribe. Working with the Great Plains Regional Indian Health Service (GPAIHS) in Aberdeen, the NDDA developed a memo of understanding with that office to outsource their credentialing process with the goal of speeding it up and making it less of a barrier in recruiting workforce. This project also included a service to help match dental professionals with not only IHS clinic opportunities but also with needs that other non-profit dental clinics might have in North Dakota. Attached is an update submitted by our grantee that is supervising this project. As explained in the update, current administrative challenges within GPAIHS have delayed implementation of the credentialing project. Also attached is a map showing the distribution of the potential volunteers and potential sites. 67 dentists, 8 dental assistants, and 7 hygienists responded to the volunteer/contracted services survey.

Another request by the committee was to document the licensing requirements for dental professionals as they relate to IHS and state law. GPAIHS officials at Aberdeen confirmed that if a dentist or dental hygienist is working in an IHS clinic, they only need to be licensed in good standing in **any** state. They do not need a license from the state where the IHS clinic is located. Dentists, hygienists, or assistants working in a tribally-contracted "638" clinic, not affiliated with IHS, must

comply with state licensure requirements. Dental assistants can be hired by IHS clinics without any certification or registration. Attached is the reference from the IHS Handbook for these regulations.

Thank you for the opportunity to address the committee. I would be happy to accept any questions.

Progress Update: Credentialing/Contracting/Volunteer Project in North Dakota IHS and Non-Profit Clinics

North Dakota Dental Association

April 1, 2016

NDDA conducted surveys in late 2015 to assess interest that dentists, dental assistants and dental hygienists had in serving at any of the non-profit dental facilities and tribal dental facilities within North Dakota. The surveys were sent out to members of the North Dakota Dental Association (NDDA), the North Dakota Dental Hygienists Association (NDDHA) and the North Dakota Dental Assistants Association (NDDAA). The NDDA survey was launched giving dental professionals the opportunity to respond via paper or online survey. In summary, a total of 67 dentists, 8 dental assistants and 7 hygienists responded to the survey. In addition, they were given the opportunity to identify dental facilities they were interested in serving. Attached is a map that reflects the interest. It is very evenly represented and holds good opportunity for our next steps in creating the liaison bridge for aligning dental professionals and assisting with the credentialing/privileging process. It is the goal of NDDA to build this process and do outreach to dental professionals quarterly.

With the level of interest from our first survey our efforts turned to presenting NDDA's credentialing/privileging liaison process with the goal of increasing dental professionals in all the areas identified. The next step was the creation of a call program to the dental facilities to assess needs and create memorandums of understanding for volunteer services. The Indian Health Service dental clinics within North Dakota fall under the direction of the Great Plains Area Indian Health Service (GPAIHS) administration. The first focus was the connection with the GPAIHS administration for a formal agreement to work with them to reflect the initial discussions held with GPAIHS leadership in mid-2014. The initial concept of the credentialing project was presented to the GPAIHS Area Director Ron Cornelius and members of GPAIHS executive team. It was in that meeting there was mutual consensus the NDDA's credentialing/privileging liaison project had merit and would have GPAIHS leadership support. Shortly after that initial discussion, GPAIHS experienced a dramatic increase in the number of issues with the delivery of critical care services within their service units. These critical issues continued to mount reaching national attention in late 2015 (<http://www.indian.senate.gov/hearing/oversight-hearing-reexamining->

substandard-quality-indian-health-care-great-plains). As the attention of delivery issues reached the national landscape, the ability to secure critical development time with GPAIHS leadership for next steps became extremely difficult. However, through persistent outreach efforts, progress was made with the GPAIHS Chief Dental Officer. In early January 2016, The Chief Dental Officer indicated that there would be meetings to move the process forward. However, due to increased activity within the GPAIHS administration to address the problems with critical care service delivery, progress on the credentialing project stalled. Shortly thereafter executive leadership changed and Rear Admiral (RADM) Kevin Meeks was appointed to the position of Area Director. In addition, a team from the national IHS office and Department of Health and Human Services was assigned and deployed to begin the work of identifying the critical service issues and restructuring GPAIHS in order to bring the Area to a higher level of service delivery. The impact to the credentialing project has been significant, as it will not progress without RADM Meeks signoff. To date it has not been presented to him as other critical care issues take precedence. Given that GPAIHS is dealing the critical service issues as well as the transition into the new executive leadership, the dental credentialing project is not a priority. NDDA respects the current challenges facing the new leadership of GPAIHS and its priority and as a result we will be proceeding more slowly to accommodate their more critical initiatives. We will be focusing our efforts this next quarter on the other non-profit dental facilities throughout the state.

NDDA Survey Results

Assessment of interest in serving Dentists, Dental Hygienists, Dental Assistants

Fall 2015

IHS, Trenton, Trenton Service Area

1 - Assistant
4 - Hygienists
3 - Dentists

IHS, Belcourt, Turtle Mountain Reservation

1 - Assistant
4 - Hygienists
4 - Dentists

Valley Community Health Centers

Dental Clinic, Grand Forks
2 - Assistant
2 - Hygienists
8 - Dentists

IHS, Fort Totten, Fort Totten Reservation

1 - Assistant
4 - Hygienists
8 - Dentists

Tribal Clinic, New Town, Fort Berthold Reservation

1 - Assistant
2 - Hygienists
8 - Dentists

Northland Community Health Center, Turtle Lake

1 - Assistant
3 - Hygienists
4 - Dentists

Bridging the Dental Gap, Bismarck

2 - Hygienists
9 - Dentists

IHS, Fort Yates, Standing Rock Reservation

2 - Assistant
4 - Hygienists
6 - Dentists

Family HealthCare, Fargo

3 - Assistant
1 - Hygienists
11 - Dentists

Red River Valley Dental Access
Project Walk-In Clinic, Fargo

20 - Dentists

Dental Assistants
Dental Hygienists
Dentist

Others:
1 - Assistant
2 - Hygienists
2 - Dentists

Indian Health Service Staff Credentialing and Privileging Guide

United States Public Health Service Indian Health Service

September, 2005

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VII Licensure Requirements

Licensure requirements in the IHS are established in Federal personnel regulations and IHS policy circulars:

- A** PHS Commissioned Corps Personnel Manual, Personnel Instruction 4, Subchapter CC23.3, "Appointment Standards and Appointment Boards". (<http://dcp.psc.gov/INDEX-B.asp>)
- B** Licensure requirements for Civil Service employees can be found at www.opm.gov and searching by discipline, i.e., "physician licensure requirements"
- C** IHS Circular 95-16, Credentials and Privileges Review Process for the Medical Staff, 12/8/95, revised by Circular No. 96-06, date June 5, 1996.

Tribal programs require caution in interpreting applicability of the federal authority to allow clinicians to practice with out-of-state licenses. If the provider is a federal employee assigned to a tribal program, there is no question: the federal rules apply. For clinicians employed by the tribe, however, experience has shown that attitudes vary between professional licensing boards and from state to state. The best practice for tribal sites is to obtain the view of the appropriate licensing board in writing if there is a desire to use a provider licensed in another state. While a tribe may eventually prevail in a legal dispute over licensing jurisdiction, meanwhile the provider may be placed in an awkward or risky position. Urban programs, with rare exceptions where a federal employee may be assigned to them, must have clinicians licensed in the local state.