



SASKATCHEWAN POPULATION HEALTH AND EVALUATION RESEARCH UNIT

Northern Health Strategy Dentist Access Initiative Evaluation

Part 1: Interviews with Key Informants

Summary Report

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Healthy
Children

Rural Health

Northern and
Aboriginal Health

List of Abbreviations:

AHA = Athabasca Health Authority

CCOH = Centre for Community Oral Health

FNHI = First Nations and Inuit Health Branch

KYRHA = Keewatin Yatthé Regional Health Authority

MCCRHA = Mamawetan Churchill River Health Authority

MoH = Saskatchewan Ministry of Health (Formerly Saskatchewan Health)

NHS = Northern Health Strategy

NHSWG = Northern Health Strategy Working Group

NITHA = Northern Inter-Tribal Health Authority

NOHWG = Northern Oral Health Working Group

PAGC = Prince Albert Grand Council

RFP = Request for Proposal

U of M = University of Manitoba

U of S = University of Saskatchewan

INTRODUCTION

The evaluation of the Dentist Access Initiative being conducted by the Northern Health Strategy (NHS) includes four components: 1) interviews with key stakeholders/informants on the implementation process of the initiative, 2) client satisfaction interviews, 3) a review of the dentist services provided (from CCOH and the health jurisdictions), and 4) an assessment of the quality of services provided.

In December 2009, the Northern Health Strategy asked Saskatchewan Population Health and Evaluation Research Unit (SPHERU) researchers to conduct Part 1, the key informant interviews. A full report of findings from the interviews was presented to the NHS in March 2010. This report provides a summary of these findings.

BACKGROUND

Since 2003, the Northern Oral Health Working Group (NOHWG) has sought to promote oral health across northern Saskatchewan, which has included the provision of opportunities for networking and continuing education to dental professionals in the north. Other activities include: standardizing treatment, prevention and oral health promotion programs based on best practices. One of the larger initiatives of the NOHWG is the Dentist Access Initiative, an adult dental program that expands access to dentist care for adults in several northern communities. Meetings to discuss structure, coordination and logistics of dentist services in northern communities were held and in April 2005 a Request for Proposals (RFP) to provide dentist services in the north was issued by NHS. In 2007, the contract was awarded to the Community Centre for Oral Health (CCOH) at the University of Manitoba.

METHODS

The NHS provided the research team with a list of ten key informants to be interviewed for the Dental Access Initiative evaluation. NHS initially informed these ten individuals via email of the evaluation and that they would be contacted shortly by SPHERU researchers with a request for an interview. An e-mail regarding participation in a telephone interview was then sent by SPHERU, along with the interview questions, developed by the NHS, and a consent form. Nine of ten individuals agreed to participate and returned a completed consent form via fax at which point an interview was scheduled. Interviews were conducted in February and March 2010. Interview questions focused on respondents' involvement in the process of implementing dentist services, and open-ended questions

related to the identification of: 1) challenges encountered in the implementation process and the way in which these challenges were addressed, 2) successes of the program as perceived by those who were involved in its inception, and 3) information on the impacts of the initiative at the community level.

INTERVIEW ANALYSIS

Interviews with nine key informants were 30 to 45 minutes in length duration. Responses to the interview questions were thoughtful and detailed, with interview discussions yielding rich descriptions of the challenges and successes. The main themes are summarized below.

1. Level of Involvement

The level of involvement of interview respondents in the initiative varied, ranging from extensive involvement in dental services in the province and the development of the initiative, to participation in the delivery of the program in the communities. The majority of the respondents, however, were involved at some level in the development of the initiative.

2. Program Structure

Interviews with key informants, along with a summary document¹ provided by the NHS, contributed to the following description of the structure of the Dentist Access Initiative. The initiative is a collection of strategies that combine to allow for the delivery of dentist services in northern and remote² communities which previously experienced a complete lack of service or inconsistent service, frequently accompanied by quality of service issues. Most significantly, the program addresses the lack of adult oral health services, which could only be accessed locally on an emergency basis prior to this initiative. The program delivery strategies include:

- Contracts between participating health organizations and the CCOH who provide dental teams to visit communities on a regular rotational basis³.
- Provision of two-chair community dental clinics, community-level support services, and accommodation for dental teams by participating health organizations.

¹ *Dentist Services Background for SPHERU*, February 9, 2010.

² For the purposes of this document, northern communities are considered to be those located north of Prince Albert; communities considered remote are those accessible only by air and/or seasonal road.

³ Dental teams visit for approximately 3 weeks at a time, every 6-8 weeks, over an 11 month period (no service in July)

- Funding from Saskatchewan Ministry of Health to participating health organizations to offset transportation costs to bring dental teams to communities.
- Funding from Health Canada (FNIH) by way of contribution agreements to cover shortfalls experienced by participating First Nation communities when per diem charges levied by CCOH exceed invoiced recoveries from FNIH.

Although each element makes a positive contribution, it was evident from the interviews that the central component is the provision of dentists through the agreement with the CCOH. Respondents were unanimous in identifying the inability to attract dentists to work in the north as the primary barrier to providing services in the region. It should be noted that the initiative does not provide for increased coverage of dental services, but rather addresses the issue of lack of services available in the region. Currently, agreements are in place with the AHA, PAGC, KYRHA, and MCRRHA.

The CCOH operates on a fee for service basis where a per diem rate is charged for each day a dental team is present in a community to provide services. This fee is charged regardless of the number of clients who are seen. The fee is paid through invoices that CCOH submits on behalf of insured clients to their funders (Health Canada FNIH for First Nations residents; Saskatchewan Ministry of Health for clients on social assistance; private insurance companies for residents with insurance supplied privately or through their employer). If the funds received through invoicing insurers are less than the per diem fee, the participating health organization is responsible for paying the outstanding amount. According to those interviewed, FNIH covers the shortfall amount for participating First Nation health organizations, while provincial health authorities must make up the shortfall from existing funding. Participating health organizations provide the following program supports: travel to and from the communities, accommodations for the dental teams (meals and lodging), two-chair dental clinic infrastructure and equipment, and local staff who provide support services.

3. Program Challenges

Developmental Challenges - Respondents identified two challenges experienced during the program's developmental phase: the lack of in-province capacity to provide services and the limited scope of the initiative, as a small number of member organizations had signed onto the initiative. In relation to the former, respondents believed that service provision by the U of S College of Dentistry was likely in the future as experience and understanding of service provision in the North were increasing. With respect to the latter, some respondents viewed the narrow scope of the initiative as a result of the limited involvement by the NITHA at the NHS table, and

the lack of an equivalent position in NITHA to that of the provincial coordinator. Further, the varying capacity among organizations to negotiate may play a role in determining the degree of support received under the current model, as each organization is required to negotiate a contract individually. It was noted that more First Nations communities were joining the program, such as those in the PAGC. However, the addition of provincial communities remained a concern.

Implementation Challenges - Several implementation challenges were identified, some of which were one-time start up challenges while others were ongoing. For example, each contract is negotiated separately and processed through the legal departments of both CCOH and four individual health authorities, leading to administrative burdens and inefficiencies. Respondents noted that after the contract was awarded to CCOH, negotiations⁴ were required to determine a funding structure, which resulted in piecemeal implementation and delays in program start-up. Further, the integration of the new services with those already in place in the communities could be problematic and have unintended consequences. In particular, the introduction of the new dental service required adjustments in policies, procedures and staff duties across jurisdictions, a restructuring of the way in which some existing services were provided, and accommodation of existing service providers.

A persistent challenge cited by respondents was the absence of a dental health prevention and promotion component, which was identified as a major shortcoming of the program. The lack of a database to collect information to measure program impacts was also seen as a missing element. In addition, the ability to generate sufficient revenue to achieve cost recovery was identified to be of paramount importance to the sustainability of the program, particularly as it affects issues related to the capacity of local community staff.

Recruiting and retaining dentists was another critical challenge to providing the continuity of care that allows residents to build trust and continue to seek services. Retention was associated with the fulfillment of dentists' expectations that influence their ability to do their work and their desire to remain with the program, such as infrastructure, community level dental support staff, and accommodation. Further, community residents' expectations also played a part in their acceptance and use of the program in the communities, and were related to: delays in program start-up, appointment wait times, transition from an emergency to an oral health model of care, dentist acceptance, and the lack of denture services. In addition, the availability of accommodation, funding disparities between residents, the lack of a single

⁴ Negotiations included the participating health authorities, the provincial government (MoH) and Health Canada (FNIH)

organization for the service provider (CCOH) to contract with, and difficulties arising from the short duration of the contracts were also identified as barriers to smooth implementation of the program.

It was communicated that the NHS needed to continue working toward the larger vision of oral health, including: developing a data collection system, addressing funding issues for NHS member organizations, and working to have the province embrace the incorporation of oral health care into primary health care. Respondents particularly focused on the absence of a database to collect baseline oral health information so that anticipated improvements from the introduction of community-level services could be measured and the relationship between oral health and overall health demonstrated. Data on increased services would support the re-investment of transportation savings into improvements in equipment, travel support to residents in the region, and financial support to participating health organizations to offset increased administrative time required to manage the program. As well, it was indicated that the discrepancy in access to dental services for non-First Nation residents in the north in comparison to First Nation residents has not been rectified.

4. Program Successes

Several program successes were identified from the interviews, with establishing the program and increasing access to dentist services identified as foremost among these. The manner in which the NHS and the NOHWG worked across jurisdictions to bring stakeholders together to create the program was heralded as a success, as was having a key person in place at all stages. The NOHWG was mentioned as being particularly instrumental in achieving the initiative, as communication from the NOHWG back to the NHS members was seen as crucial. The level of service provided, savings on transportation costs, dentist satisfaction, and the effects of the program on the communities were also described as successes by respondents.

5. Effect on Communities

Effects on communities that respondents identified were: improved quality of care and the elimination of travel barriers resulting from expanded access to dental services, increased awareness of oral health, and a change in the level of care sought by community residents from emergency treatment to maintenance and prevention. Further, the initiative alleviated stress on existing programs. Also, residents now have higher expectations and anticipate that dentists will be there on a regular basis, and community health providers have gained awareness of what is required to run an efficient dental clinic. Overall improvements in general health as a result of improved dental health were also viewed as a real and anticipated success.

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SPHERU is a bi-university, interdisciplinary research unit committed to critical population health research. The SPHERU team consists of researchers from University of Saskatchewan and University of Regina who conduct research in three main areas: northern and aboriginal health, rural health, and healthy children.