Survey of Dentists in Delaware

To determine the current capacity and needs of dentists in Delaware to address the oral health needs of Delawareans with disabilities

Complete the questions on the pages that follow
and submit the completed survey
in the self-addressed stamped envelope

University of Delaware | Center for Disabilities Studies

Delaware Health and Social Services
Division of Public Health
Bureau of Oral Health and Dental Services

Please note that you must currently hold an active dental license issued by Delaware to complete this survey.

Thank you for agreeing to complete this survey.

The information you provide is likely to improve access to dental care and oral health services for Delawareans with disabilities. It will be used to develop training for the dental workforce in Delaware to enhance their responsiveness to the needs and preferences of people with disabilities.

All responses will be aggregated, and individual responses will remain anonymous.

Your participation is voluntary. You may skip any questions that you would prefer not to answer. Please note, however, that by answering all of the questions, you will contribute tremendously to this effort.

Many questions can be answered by placing an (x) in the box (☐) in front of your response. Some questions may not apply to you, and you will be instructed to skip them. When this occurs, you will find relevant instructions right after your response. When no instruction is given for your response choice, please continue with the next question.

If you have any questions about the survey or need assistance in completing the survey, please contact Katie Rosch Hegedus (302) 831-3206 (khegedus@udel.edu) or Jae Chul Lee (302) 831-8186 (jaelee@udel.edu).

By completing and returning the survey, you will be considered to have consented to participate in the survey.

Thank you for your time and effort in completing the questions.

1. Do you currently hold an active dental license issued by Delaware?
   - ☐ Yes
   - ☐ No **[STOP the survey]**

2. Do you currently provide dental care to patients in Delaware?
   - ☐ Yes
   - ☐ No **[STOP the survey]**

3. What is your age?

   _____ years

Practice

4. Please indicate your primary type of practice.
   - ☐ General Practice
   - ☐ Specialty Practice

5. Please select the type(s) of specialty services that you routinely perform. (Check **ALL** that apply.)
   - ☐ Dental Public Health
   - ☐ Endodontics
   - ☐ Oral and Maxillofacial Pathology
   - ☐ Oral and Maxillofacial Radiology
   - ☐ Oral and Maxillofacial Surgery
   - ☐ Orthodontics and Dentofacial Orthopedics
   - ☐ Pediatric Dentistry
   - ☐ Periodontics
   - ☐ Prosthodontics
   - ☐ None of the Above

6. What is the ZIP Code for each of your practice locations?
   - ☐ Primary location: _____
   - ☐ Secondary location: _____
   - ☐ Tertiary location: _____

7. Which of the following best describes the setting of your current dental practices? (Circle **ONE** answer for each practice, if you practice in more than one location in **Delaware**.)

Primary Practice in Delaware	**Secondary** Practice in Delaware	**Tertiary** Practice in Delaware
Practitioner's Office (solo or group practice)	Practitioner's Office (solo or group practice)	Practitioner's Office (solo or group practice)
Hospital (except federal)	Hospital (except federal)	Hospital (except federal)
Federally Qualified Health Center (FQHC)	Federally Qualified Health Center (FQHC)	Federally Qualified Health Center (FQHC)
Public Health Dental Clinic	Public Health Dental Clinic	Public Health Dental Clinic
Nursing Home	Nursing Home	Nursing Home
Facility for People with Disabilities	Facility for People with Disabilities	Facility for People with Disabilities
Federal Health Facility including Veteran's Administration Center/Clinic	Federal Health Facility including Veteran's Administration Center/Clinic	Federal Health Facility including Veteran's Administration Center/Clinic
Correctional Facility Clinic	Correctional Facility Clinic	Correctional Facility Clinic
Other	Other	Other

8. Are you currently enrolled as a Medicaid provider?
   - ☐ Yes
   - ☐ No [**Go to Question 10**]

9. Are you currently accepting new Medicaid patients?
   - ☐ Yes
   - ☐ No

10. Which of the following best describes your patient care practice capacity?
    - ☐ My practice is full: I cannot accept new patients.
    - ☐ My practice is nearly full: I can accept a few new patients.
    - ☐ My practice is partially full: I can accept some new patients.
    - ☐ My practice is far from full: I can accept many new patients.

11. Please estimate the proportion of your time in a typical month that you spend with patients from the following categories. (Circle ONE answer for <u>each</u> category.)

Children insured by Medicaid or CHIP	> 20%	11-20%	6-10%	1-5%	0%
Uninsured children	> 20%	11-20%	6-10%	1-5%	0%
Uninsured adults	> 20%	11-20%	6-10%	1-5%	0%
Nursing home residents	> 20%	11-20%	6-10%	1-5%	0%
Individuals with substance use disorder	> 20%	11-20%	6-10%	1-5%	0%
Children ages up to 21 who have disabilities	> 20%	11-20%	6-10%	1-5%	0%
Adults ages more than 21 who have disabilities	> 20%	11-20%	6-10%	1-5%	0%

[Note: The patient categories are NOT mutually exclusive.]

12. How many years have you actively practiced dentistry?
    - ☐ Less than 5 years
    - ☐ 6-10 years
    - ☐ 11-15 years
    - ☐ 16-20 years
    - ☐ 20-30 years
    - ☐ More than 30 years

13. Which of the following best describes your plan for your dental practice in the next five years? (Check **ALL** that apply.)
    - ☐ I plan to maintain the practice as is.
    - ☐ I plan to increase patient care hours.
    - ☐ I plan to reduce patient care hours.
    - ☐ I plan to move the practice to another location in Delaware.
    - ☐ I plan to move the practice out of state.
    - ☐ I plan to retire.

14. Which type of anesthesia or sedation services does your practice offer? (Check **ALL** that apply.)
    - ☐ None
    - ☐ Local anesthesia
    - ☐ Nitrous oxide inhalation analgesia
    - ☐ General anesthesia
    - ☐ Conscious sedation

Dental Care for Underserved Populations

15. About how many hours of direct patient care for which you receive no payment / reimbursement do you deliver in a year? This would include caring for patients inside your own practice and volunteer activities in which you see patients outside your own practice.
    - ☐ 0 hours
    - ☐ 1−10 hours
    - ☐ 11−20 hours
    - ☐ 21−40 hours
    - ☐ More than 40 hours

16. Please indicate the extent to which you agree with the following statements. (Circle ONE answer for each statement.)

I feel comfortable providing dental care to young children (0-3 years).	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel comfortable providing dental care to elderly individuals.	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel comfortable providing dental care to children with sensory disabilities (e.g., blind/low vision or deaf/hard of hearing).	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel comfortable providing dental care to adults with sensory disabilities.	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel comfortable providing dental care to children with physical disabilities.	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel comfortable providing dental care to adults with physical disabilities.	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel comfortable providing dental care to children with developmental disabilities.	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel comfortable providing dental care to adults with developmental disabilities.	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel comfortable providing dental care to patients with substance use disorder.	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel comfortable providing dental care to medically compromised individuals.	Strongly Agree	Agree	Disagree	Strongly Disagree

[Note: Developmental disabilities can include but are not limited to the following: intellectual disability, autism spectrum disorder (ASD), attention deficit and hyperactivity disorder (ADHD), cerebral palsy, and Down syndrome.]

17. What experience have you had related to special care dentistry? (Check **ALL** that apply.)

    [Note: According to the Special Care Dentistry Association, special care dentistry is the branch of dentistry that provides oral care services for people with physical, medical, developmental, or cognitive conditions which limit their ability to receive routine dental care.]

    - ☐ Academic training
    - ☐ Continuing education [**Go to Question 19**]
    - ☐ Clinical practice [**Go to Question 20**]
    - ☐ Other [**Go to Question 20**]
    - ☐ No related exposure [**Go to Question 20**]

18. If academic training provided exposure to special care dentistry, how much time was devoted to this topic? (Check ONE box.)

    - ☐ Minimal emphasis during a course
    - ☐ A few lectures during a course
    - ☐ An entire course
    - ☐ More than one entire course

19. Has your education/training experience helped you effectively interact with patients with disabilities? (Check ONE box.)

    - ☐ Yes
    - ☐ No
    - ☐ Not seeing patients with disabilities in practice

20. Approximately how many patients with disabilities did you see **in the last 12 months**? (Do **NOT** include your volunteer dental service.)

    - ☐ None [**Go to Question 22**]
    - ☐ 1-5
    - ☐ 6-10
    - ☐ 11-20
    - ☐ 21-50
    - ☐ 51-100
    - ☐ More than 100

21. When providing care to people with disabilities, how often do you find it difficult to interact with them?
    - ☐ Always
    - ☐ Usually
    - ☐ Sometimes
    - ☐ Rarely
    - ☐ Never

22. What issues create the greatest barrier to your provision of dental care to individuals with disabilities? (Choose up to **THREE** answers.)
    - ☐ Patient behavior
    - ☐ Type of disability [Please specify:_____]
    - ☐ Severity of disability
    - ☐ Co-occurring medical conditions [Please specify:_____]
    - ☐ My level of training
    - ☐ Office staff training
    - ☐ Low reimbursement rate
    - ☐ Too much paperwork
    - ☐ Concern about liability issues
    - ☐ Care is more time consuming
    - ☐ Accommodations for communication [Please specify:_____]
    - ☐ Other [Please specify:_____]
    - ☐ I encounter no barriers in the provision of care.

23. Regarding patients with disabilities, which of the following are most important for dental professionals to know? [Choose up to **THREE** answers.]
    - ☐ Specialized techniques and equipment
    - ☐ How to implement a preventive program tailored to the patients
    - ☐ How to reduce patients' anxiety
    - ☐ Behavior management
    - ☐ Effective strategies for communicating with patients
    - ☐ Positioning techniques appropriate to providing oral hygiene procedures
    - ☐ Proper body mechanics for performing a wheelchair transfer
    - ☐ General information about people with disabilities including their oral health needs
    - ☐ Other [Please specify:_____]

24. Are you interested in learning about how to provide effective and respectful care and services to people with disabilities?
    - ☐ Yes
    - ☐ No

25. If training were available to help you treat patients with disabilities more effectively, would you participate in such training?

    □ Yes
    □ No

26. Is your facility physically accessible regarding the following? (Circle ONE answer for <u>each</u> statement.)

Parking spaces (For example, is wheelchair accessible parking available?)	Yes	No
Office space (For example, is there sufficient clear floor space for people using a wheelchair or other mobility device to transfer to an exam chair?)	Yes	No

27. Please indicate which type of anesthesia or sedation services your practice offers for the following types of patients. (Circle **ALL** answers that apply for <u>each</u> statement.)

Young children (0-3 years)	None	Local anesthesia	Nitrous Oxide	General sedation	Conscious sedation
Children with sensory disabilities (e.g., blind/low vision or deaf/hard of hearing)	None	Local anesthesia	Nitrous Oxide	General sedation	Conscious sedation
Adults with sensory disabilities	None	Local anesthesia	Nitrous Oxide	General sedation	Conscious sedation
Children with physical disabilities	None	Local anesthesia	Nitrous Oxide	General sedation	Conscious sedation
Adults with physical disabilities	None	Local anesthesia	Nitrous Oxide	General sedation	Conscious sedation
Children with developmental disabilities	None	Local anesthesia	Nitrous Oxide	General sedation	Conscious sedation
Adults with developmental disabilities	None	Local anesthesia	Nitrous Oxide	General sedation	Conscious sedation
Individuals with substance use disorders	None	Local anesthesia	Nitrous Oxide	General sedation	Conscious sedation
Medically compromised individuals	None	Local anesthesia	Nitrous Oxide	General sedation	Conscious sedation

28. Does your facility provide multiple language interpretation methods for communicating with patients who have limited English proficiency?
    - ☐ Yes
    - ☐ No
    - ☐ No patients require such accommodations.

29. Does your facility use a certified American Sign Language interpreter for communicating with deaf patients?
    - ☐ Yes
    - ☐ No
    - ☐ No patients require such accommodation.

30. Does your facility provide accommodations (e.g., communication devices, large print, and braille) for communication with patients with disabilities, if needed? (Check ONE box.)
    - ☐ Yes
    - ☐ No
    - ☐ No patients require such accommodations.

Demographic Information

31. Are you male or female? (Check ONE box.)
    - ☐ Male
    - ☐ Female

32. Are you of Hispanic, Latino/a, or Spanish origin?
    - ☐ Yes
    - ☐ No

33. Which one or more of the following would you say is your race? (Check **ALL** that apply.)
    - ☐ White
    - ☐ Black or African American
    - ☐ Asian
    - ☐ American Indian or Alaska Native
    - ☐ Native Hawaiian or Pacific Islander
    - ☐ Other [Please specify: _____]

Thank you for taking the time to complete this survey.

Use this space below to provide any comments about providing dental care and oral health services to people with disabilities in Delaware.

If you have any further questions about this survey, please contact Katie Rosch Hegedus (302) 831-3206 (khegedus@udel.edu) or Jae Chul Lee (302) 831-8186 (jaelee@udel.edu).

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