Washington State Department of Health

Health Systems Quality Assurance, Office of Community Health Systems

GUIDE: Dental Provider Survey

To complete this Survey online: http://www.doh.wa.gov/hsqa/ocrh

Thank you for participating in this Dental Care Provider Survey. Your information will help us understand the healthcare needs in your area. We will use the results to determine if your service area qualifies for designation as a Health Professional Shortage Area (HPSA). The HPSA designation will help eligible providers qualify for over 30 federal programs.

Information collected will also be used by the Department of Health and your local health department to study other dental care access concerns. Results from any studies will be presented in aggregate form and will not identify individual providers. This guide will provide explanation to the questions.

We request that a survey be completed for each individual Dental Care Provider at the practice site. For questions regarding survey information requested please contact Phi.Ly@doh.wa.gov or (360) 236-2825.

I - PROVIDER INFORMATION

1.-5.	Please provide the **complete, full name** of the dental care provider, including the **birth year** and **gender**.
6.	Check the appropriate provider **credentials**: ▪ D.D.S. (Doctorate of Dental Surgery) ▪ D.M.D. (Doctorate of Dental Medicine)
7.-12.	A) List the primary **practice site name** for this provider. Include the complete **street address, city, zip code, county**, as well as the site's **phone number**. Provide the **mailing address** if it is different than the physical street address. (9a.-12a.)
	B) If this provider has a **secondary practice site** include the name, street address, phone number and county. Additional information about the secondary practice should only be completed if known (Questions 18-30)
13.	Select the provider's primary dental care.
14.	Select the provider's **specialty**. ▪ Periodontics (prevention, diagnosis, and treatment of periodontal disease) ▪ Oral Surgery (surgical treatment of diseases, injuries, and defects of the mouth-head areas) ▪ Endodontics (treatment dealing with tooth pulp and root of tooth) ▪ Prosthodontics (dental prosthetics) ▪ Orthodontics (treatment of malocclusions) ▪ Other (please describe) Specialty hours worked will reflected in Question 20 under "Specialty Care".
15.	a. Mark if the provider is a **US citizen**. If no, then answer 15b. b. For non-citizens identify what the provider's current visa status is.
16.	Mark the program or status that applies to the provider, otherwise mark "None Listed".
17.	If the provider intends **to leave practice within the next six months**, please explain the reason(s).

II - PRACTICE INFORMATION

18.	a. Please list the number of **dental hygienists** that work at this provider's practice, include contract employees. b. List the combined **total hours** worked by all of the dental hygienists in a given week.
19.	a. Please list the number of **dental assistants** that work at this provider's practice, include contract employees. b. List the combined **total hours** worked by all of the dental assistants in a given week.
20.	Please list in whole numbers the best **estimate of weekly hours** the provider spends on each of the following: ▪ Primary Dental Care: includes time spent preventative and routine, non-urgent dental health, and Pediatric Dentistry. ▪ Specialty Care: clinical care that includes Periodontics, Oral Surgery, Endodontics, Prosthodontics, Orthodontics. ▪ Non-Clinical Care: Clinic administration; continuing education, lecturing, hospital meetings, etc.

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21.	Provide a best estimate **average number of patients** seen in a typical week at this practice site. Also list for the secondary practice site if known.
22.	Provide the **number of days or weeks** it takes to schedule **a routine, non-urgent appointment** for: ▪ Current patients ▪ New patients
23.	Please indicate whether an **alternative language** is spoken at the practice site(s). Please list all non-English languages spoken with patients.
24.	Please indicate any **interpretative services** offered at the practice site(s) and how it these services are provided. This may include non-English translation, sign language, etc.
25.	Identify what percentage of the provider's dental patients is: a) **Transitory agricultural migrant farm workers** are defined as no having a permanent local address in the same area as the Practice. Please include dependents in the average number. b) **Homeless persons** are defined as those living in unstable, nonpermanent locations, such as in shelters, transitional housing, in tents, in cars or on the streets. Please include dependents in the average number.
III - PAYER INFORMATION	
26. – 30.	For each of the payee type(s) provide the **best percentage estimate**. In determining the percentage estimate please consider how much of the identified payee type accounts for the business. Also mark whether or not the provider is **accepting new patients** and if there are restrictions. This information will be used to identify need in your area. ▪ 26. Private Insurance: Dental insurance through work or self-purchased; include Basic Health, military. ▪ 27. Medicaid: Federal and state administered payment for low income persons; include Fee for Service and Healthy Options. ▪ 28. Self Pay Patients: No dental insurance; patient pays full fees. ▪ 29a. Sliding Fee Schedule (SFS): No dental insurance or subsidies; fees discounted according to income level; charity. 29b. Identify whether or not the SFS is visibly posted and available to all patients. ▪ 30. Labor and Industries: Worker's compensation. ▪ 31. Other: please identify payee type not already listed. *The sum percentages of Question 26-31 should total 100% for each practice. *For purposes of this survey and HPSA the Payer descriptions are prescriptive and may not reflect the provider's actual distribution. Please provide estimates if necessary.
ADDITIONAL INFORMATION	
	Comments: Share any questions or concerns you, the provider or staff, may have about access to primary care and information which will help us understand the needs in your area. Please feel free to attach additional documentation. These comments may be shared with your county health department.
	Please provide ***contact information*** should our office have any questions regarding information on this survey.
Please return completed surveys to: DOH, P.O. Box 47853, Olympia, WA 98504-7853, or fax (360) 236-2830	

Survey Questions
Rural Health Research and Analysis
Ms. Phi Ly
(360) 236-2825
Phi.Ly@doh.wa.gov

Health Professional Shortage Area (HPSA);
Medically Underserved Areas
Ms. Laura Olexa
(360) 236-2811
Laura.Olexa@doh.wa.gov