Oral Health Needs Survey

* Michigan Oral Health Coalition*
Michigan Department of Community Health

Thank you for taking the time to complete this survey for us!
Please answer all questions from your perspective as an INDIVIDUAL practitioner

1. **In addition to your Primary Clinic, do you practice/ consult at an additional clinic?**
   ☐ Yes ☐ No

2. **Please tell us in which county your Clinic(s) is located:**

   Primary Clinic _____

   Additional Clinic _____

3. **Please tell us about the type of primary / additional clinic you practice in**

Description	Primary Clinic	Additional Clinic
A privately operated clinic (individual or group)	☐	☐
Hospital-based or other institutionally-based	☐	☐
Community Health Center	☐	☐
Health Department Dental Clinic	☐	☐

Other (please specify) : _____

4. **Please tell us about your dental school training, certifications, and any current hospital or dental school affiliations.**
   - Dental school attended _____
   - Year Graduated _____
   - Post-graduate training (AEGD, GPR, specialty) _____
   - Hospital affiliation _____
   - Dental school affiliation _____
   - Licensure status: active or inactive? _____

5. **What types of payments are accepted at your primary / additional clinic?**

Payment Type	Primary Clinic	Additional Clinic
Medicaid	☐	☐
Healthy Kids Dental	☐	☐
MI Child	☐	☐
Sliding Scale	☐	☐

Private Insurance: _____

6. **Please indicate specialty:**

   ☐ Endodontics ☐ Orthodontics
   ☐ Pediatric Dentistry ☐ Prosthodontics
   ☐ Oral Surgery ☐ Public Health
   ☐ Periodontics ☐ Other_____

7a. How many children (under 21) with disabilities would you say you treat per year?

- ☐ 0
- ☐ < 5
- ☐ 5 – 10
- ☐ 10 - 20
- ☐ 20 - 30
- ☐ > 30

7b. How many adults (21 and over) with disabilities would you say you treat per year?

- ☐ 0
- ☐ < 5
- ☐ 5 – 10
- ☐ 10 - 20
- ☐ 20 - 30
- ☐ > 30

7c. Have you had any special training for treating persons with disabilities?

- ☐ Yes
- ☐ No

7d. Have you ever treated a patient in a hospital setting?

- ☐ Yes
- ☐ No

7e. If you have treated patients in a hospital setting please tell us the age range of the patient you have treated.

- ☐ < 11 yrs
- ☐ 11 – 17 yrs
- ☐ 18 – 64 yrs
- ☐ 65+ yrs

7f. How long would you say the waiting period is for treating patients in a hospital setting?

- ☐ Immediate
- ☐ 1 month
- ☐ 2 – 3 months
- ☐ > 4 months

8. Please select the types of disabilities that you have experience with and the types of disabilities you are willing to accommodate.

Disability Condition	Experience with	Willing to treat
ADHD	☐	☐
Autistic Spectrum Disorder	☐	☐
Acquired Neuromuscular Disorder	☐	☐
Cerebral palsy	☐	☐
Down Syndrome	☐	☐
Blindness/Visual Impairment	☐	☐
Deafness/Hearing Impairment	☐	☐
Developmental Delay	☐	☐
Epilepsy/Seizure Disorder	☐	☐
Head/Brain Injury	☐	☐
Speech and/or Language Impairment	☐	☐
Mental Illness	☐	☐
Cognitive Impairment	☐	☐
Dementia	☐	☐
Multiple Disabilities	☐	☐
Oral/Touch Defensive	☐	☐

Other (please specify) _____

9. Which of the following accessibility features does your practice have to help persons with disabilities? (Select all that apply)

Features	Primary Clinic	Additional Clinic
Building and office is wheelchair accessible	☐	☐
Parking for people with special needs	☐	☐
Designated hours or days for personas with disabilities	☐	☐
Allow guardian observation	☐	☐
Convenient location for public transportation	☐	☐
Easy transfer dental chair	☐	☐
Panorex X-Ray	☐	☐
Mobile equipment	☐	☐
American Sign Language	☐	☐

Languages other than English (please specify): _____

10. Do you provide on-site services to people who reside in nursing homes?

☐ Yes

☐ No

11. Do you provide services to people with disabilities in their own homes?

☐ Yes

☐ No

12. Do you work with a hygienist(s) or assistant(s) who have had special training and / or experience treating persons with disabilities?

Clinic	Yes	No
Primary	☐	☐
Additional	☐	☐

13. Which of the following behavioral and pharmacological techniques for pain and anxiety control do you use?

☐ None

☐ Relaxation management (TV, music, massage chair)

☐ Modified communication (including tell-show-do)

☐ Desensitization (office orientation visits)

☐ Facial massage

☐ Hypnotherapy

☐ Oral sedation

☐ Nitrous oxide-oxygen inhalation sedation

☐ Protective support (papoose board)

☐ IV (Intravenous sedation

☐ IM (Intramuscular) sedation

☐ General anesthesia

14. Do you do anything different for pain and anxiety control? Please explain:

_____

_____

_____

15. Please indicate the age ranges of the patients with disabilities that you have served. (Select all that apply)

☐ < 11 yrs

☐ 11 – 17 yrs

☐ 18 – 64 yrs

☐ 65+ yrs

16. Do you feel there is a lack of dentists who treat patients with disabilities in a hospital setting?

☐ Yes

☐ No

17. Have the recent changes in Medicaid reimbursement changed your willingness to practice within a hospital setting?

☐ Yes

☐ No

18. **Please provide any other comments about the need for hospital dentistry including barriers that may prevent your clinic from offering care for persons with disabilities.**

_____

_____

_____

_____

_____

19. **Do you have an interest in furthering your education on treating patients with special needs?**

☐ No

☐ Yes (Please provide your name and contact info below)

Name: _____

Professional Degrees (DDS, DMD, MD, MBA, etc): _____

_____

Phone: _____

Email: _____

20. **Are you interested in being in a resource book as an oral health provider who treats persons with disabilities?**

☐ Yes (Please go to question 21. Only information provided about clinic will be used in the resource book)

☐ No (No information provided by you will be disclosed)

21. **Please provide the following information about your clinic(s).**

Primary Clinic:

Group or Practice Name:

_____

Address 1_____

Address 2_____

City/Town_____

Zip Code_____

Phone_____

Email_____

Website_____

Office hours_____

Additional Clinic:

Group or Practice Name:

_____

Address 1_____

Address 2_____

City/Town_____

Zip Code_____

Phone_____

Email_____

Website_____

Office hours_____

Thank you!