

A Conversation with Dental Health Leader Frank Courts, DDS, PhD

Interview conducted by Crystal Adams and Steve Cline

Frank Courts, DDS, PhD, is a pediatric dentist who has had a varied career in education and has practiced in North Carolina for the last two decades. He was heavily involved in Medicaid at the University of Florida before moving to North Carolina and becoming a Physicians Advisory Group (PAG) member. Courts is also a member of the North Carolina Dental Society (NCDS) and serves as chairman of its Council on Oral Health and Prevention.

Courts led North Carolina's first school-based dental health program, with the primary goal of providing sealants in a school-based environment. He recently co-chaired the North Carolina Institute of Medicine (NCIOM) Oral Health Transformation Task Force [1], which envisioned a patient-centered future for oral health in North Carolina. Courts was also a member of the 2012–2013 Task Force on Children's Preventative Oral Health Services [2], which recommended policy changes that helped lead to legislation allowing dental hygienists to work in certain environments without direct supervision and to work with dental assistants in those environments [3].

"I think that really kind of opened the door to school-based and community-based oral health programs for the underserved in North Carolina," said Courts.

Crystal Adams, MA, CDA, RDH, Director of the North Carolina Oral Health Collaborative, conducted the following interview with Dr. Courts, alongside **Steve Cline**, DDS, MPH, Vice President of the Foundation for Health Leadership & Innovation (FHLI).

This interview has been condensed and edited for clarity.

Crystal Adams, NCOHC: What is your "why" for expanding dental care access?

Frank Courts: *I grew up in rural North Carolina, and I had friends and neighbors, kids I played with, who had oral health problems, and there wasn't a lot of access to care for them. My experience with a dentist as a child was that I saw the dentist every six months. I don't think I ever got my teeth cleaned; I just got a different filling every visit. I really didn't know how to brush my teeth correctly until I went to dental school. I realized that many people don't have the basic understanding of diet and oral hygiene that is necessary to prevent oral disease. As I got into dentistry and gravitated toward pediatrics, I saw real problems with access to care and oral health equity. As an educator, that was one of my passions, and it is something that I've gotten a lot*

of satisfaction out of working for change. There is still a long way to go, and I am enthusiastic about making a difference.

Adams: As you've worked on these policy changes, how have you decided which partners are essential to making them happen?

Courts: *The North Carolina Dental Society is a powerful advocate for oral health in the state. They have the resources to promote meaningful change in North Carolina. So, getting them behind an initiative is a critical factor in implementing policy changes. Additionally, the North Carolina State Board of Dental Examiners, which regulates the practice of dentistry, needs to*

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— Frank Courts, DDS, PhD

be informed and subsequently approve any proposed policy changes. The North Carolina Oral Health Collaborative has been critical in terms of identifying the problems and potential solutions. Lastly, the funders, especially The Duke Endowment and Blue Cross and Blue Shield of North Carolina Foundation, are important partners in the process. These funders often see there's a problem and are willing to make investments to help improve oral health care for patients in our state. These are the

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four critical groups in terms of making policy changes and moving oral health care forward in North Carolina.

Adams: In the last couple of years, we have seen several oral health policy and legislative changes. What opened the door for these changes?

Courts: Dr. Mark Scheiderich, then President of the NCDS, and Dr. Alec Parker, the NCDS Executive Director, were crucial to these changes. These leaders formed the NCDS Council on Oral Health and Prevention. Once that Council was formed, we had a forum of a diverse group of oral health advocates who could get together and discuss the problems, exchange ideas, and educate members of the NCDS and the public about the benefits and disadvantages of different oral health strategies.

Adams: How do we keep that momentum going?

Courts: The first thing we need to address is the workforce. Oral health equity and access to care are dependent on a vibrant workforce, and all the parties involved are really concerned about ensuring that the workforce is viable and growing and able to provide the care that North Carolinians need.

Adams: How can we increase the dental workforce in North Carolina, especially in our rural communities?

Courts: We don't have the workforce to solve all the oral health problems. At this point, we don't have enough dentists. We don't have enough hygienists. We don't have enough dental assistants. As we move into the future, we must consider increasing the dental workforce. We also need to look at different ways to make the workforce more efficient, such as enhancing education and implementing evidence-based technology and procedures. Even with an increased workforce, access to oral health care will continue to be a problem in the rural areas of Eastern and Western North Carolina.

We have spent a lot of effort trying to fix oral disease; in the future, we need to invest more heavily in population oral health, preventing oral disease, and providing more early nonsurgical treatments.

Steve Cline, FHLI: You co-chaired the NCIOM Oral Health Transformation Task Force. Can you talk about your experience with that?

Courts: The NCIOM's task force significantly broadened the discussions of oral health issues that were already occurring at the Council on Oral Health and Prevention. With the participation of state leaders in medicine, dentistry, nursing, education, and health policy, a vision of the future of oral health in North Carolina was brought into focus. Additionally, input from experts from other states gave the task force insight into what best practices were happening elsewhere. The importance of the NCIOM providing a forum for everyone to get together, understand the problems, and identify solutions was critical. We looked at value-based care, dental therapy, care coordination, and Medicaid reimbursement. We also explored how other Medicaid programs throughout the country provide care and

the successes and challenges they face. These interactions were a significant step toward understanding the oral health issues we face in North Carolina. We still have a lot of work to do, but our understanding of the problem and our ability to look at different solutions has been greatly enhanced.

Cline: Can you say more about dental therapy and where it stands in North Carolina?

Courts: Dental therapy is in its infancy in terms of its educational process and how it operates in the United States. The last I saw, there were 158 dental therapy practitioners in the entire country. We don't have the resources to invest in something that's just getting started. We need to improve the efficiency of the existing dental team and invest in oral health prevention in North Carolina. Dental therapy doesn't seem to be a viable option for our state at this time, but we should continue to monitor its evolution.

Cline: What do you think the future of dental managed care is in North Carolina?

Courts: Most states that I've been able to look at that have adopted managed care did not have a well-run Medicaid dental program. It was understaffed and underfunded, and the states didn't know what to do. In North Carolina, that has not been the case. We've had an incredible steward of our Medicaid dental program in Dr. Mark Casey. Historically, North Carolina has had a strong oral health program, but recently, providers have become concerned that our program has fallen behind due to low reimbursement rates. We have a lot of expertise in North Carolina that is very interested in ensuring that quality oral health care, access, and equity are vital components of the Medicaid program. Because of that, managed care may not be the best option at this time. The task force did, however, give a strong recommendation that increased reimbursement in the current state-administered program should be funded.

Adams: There is a national interest in moving toward medical-dental integration. How do you see oral health in North Carolina fitting into this model?

Courts: Dentistry has been siloed in many different ways. The electronic medical record is something that dentistry needs to get on board with and share with medicine. As we learn how oral health interacts with general health, we need to understand that dentistry needs the information that medicine has, and medicine needs the information from dentistry. Unfortunately, the technology to accomplish this is a work in progress. However, with electronic health records, we can take the first big step by ensuring our patients receive quality care and that oral health providers can access up-to-date information about the patient's overall general health.

Adams: As we wrap up the interview, do you have any other thoughts you would like to share?

Courts: For dentistry to continue to advance, it needs to become more flexible in delivering oral health care. We need to

modify care delivery and provide oral health prevention based on evidence-based research. In addition, we need to utilize the existing dental team most efficiently to serve patients' needs. NCMJ

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