

SUMMARY OF STRATEGIC PLANNING FOR DENTAL ACCESS



“Red River Valley communities uniting to improve oral health for all”

Red River Valley Dental Access Committee
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Funded by
Dakota Medical Foundation

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EXECUTIVE SUMMARY

BACKGROUND:

The Red River Region Community Dental Access Committee (Appendix A) was formed in 1997 to address a critical and growing problem of access to oral health care in a 25 county region, primarily by low-income families, children and the elderly.

The goal of the Committee “is to improve access to basic and urgent dental care for families and children in the Red River Valley who are living below 200% of the poverty level, the uninsured, the homeless population, Native Americans, seasonal farm workers and recent refugees.”

The Committee is composed of health and dental professionals; representatives from Minnesota and North Dakota Departments of Health and Departments of Human Services; representatives from local human service programs; county health departments; Dakota Medical Foundation; Managed Care representation from Minnesota; Northwest Technical College; University of Minnesota Dental School and non-profit community dental service providers.

The Red River Valley Community Dental Access Committee and invited participants met at the Expressway Inn in Fargo, ND On November 11 and 12, 1999 to develop a strategic plan to improve access to oral health. Jan Gabriel with Gabriel and Associates, and Mark Bourdon from FirstLINK facilitated the meetings. The Committee developed a vision statement, identified five main critical issues and developed goals and objectives around each critical issue.

VISION STATEMENT: *Red River Valley communities uniting to improve oral health for all.*

CRITICAL ISSUES:

1. Project Coordinator/Coordination
2. Education/Prevention
3. Reimbursement/Funding
4. Recruitment
5. Emergency Services

GOALS AND OBJECTIVES FOR EACH CRITICAL ISSUE:

A. Project Coordinator/Coordination

Goal: To facilitate/direct the implementation of the strategic plan to improve access to dental care.

Objectives:

1. To gather data and community input on oral health access issues on an on-going basis
2. To schedule and facilitate meetings of the steering committee and associated subcommittees
3. To prepare agendas and record meeting minutes
4. To work with community stakeholders to develop systems of care which address access barriers
5. To develop projections of resources needed for short and long term objectives
6. To prepare and submit grant proposals to obtain funding for the implementation of the plan
7. To prepare and submit progress and final reports
8. To gather and report data for on-going evaluation of the project
9. Develop a public relations campaign
10. Develop parameters to support individual and community efforts that advance the goals of the coalition

B. Education/Prevention

Goal: To increase understanding and awareness of oral health and access issues.

Objectives:

1. Develop strategies to develop public education messages to improve oral health
2. Educate the low-income public on how to access services
3. Educate the public on the importance of early and ongoing oral health
4. Develop strategies to educate professionals on dental issues
5. Develop a plan to keep policy makers informed on oral health issues

C. Reimbursement/Funding

Goal: To ensure adequate funding for dental public programs and identify and obtain public and/or private funding to support the efforts of the RR valley Community Dental Care Access Committee.

Objectives:

1. To ensure an adequate level of reimbursement to providers for dental services
 - a. Maximize federal funding through primary health and other available resources and through federal matches of state Medicaid programs

- b. Increase reimbursement rates to 75-85% of UCR, and then assess effects on provider participation
 - c. Develop tiered reimbursement rates to assist providers with more extensive public program patient populations
2. To reduce overhead expenses of providers by decreasing administrative expenses in public dental programs
 - a. Work with state health and human service agencies in ND and MN
 - b. Work with health plans to reduce administrative burdens on dental providers in MN
 3. To fund overall expenses for coordinating the Dental Care Access Committee and its work groups (explore tobacco settlement funding)
 4. To identify funding streams in both public and private sectors at the local, state and national levels to support the above

D. Recruitment

Goal: To provide an adequate supply of dental professionals in the RR valley now and in the future.

Objectives:

1. To increase awareness of oral health professionals among high school and college students
 - a. Develop career educational materials and fact sheets for high school counselors, etc.
 - b. Attend career fairs
 - c. Develop and distribute list of local dental providers serving as mentors to colleges
2. Provide opportunities for dental students to experience community based dentistry
 - a. Develop dental mentorship program for Red River Valley
 - b. Develop dental externship programs
 - c. Explore the development of Red River Valley dental residency program
3. Develop incentives to attract dental providers to underserved areas
 - a. Secure appropriate designation status
 - b. Work with state legislators to develop and expand scholarship and loan repayment programs
 - c. Raise awareness of federal incentives for candidates
4. Distribute community dental profiles to prospective candidates
 - a. Gather information on local dental practices and incorporate into booklet form for distribution
 - b. Conduct vacancy and turnover rate surveys and track trends
 - c. Conduct dental school program visits annually to disseminate practice information
 - d. Develop recruitment and retention committees
 - a. Identify practice vacancies and conduct a recruitment/retention workshop
 - b. Track personnel turnover rates

E. Emergency Services

Goal: To provide necessary emergency dental services for all.

Objectives:

1. To develop and implement a dental call list and achieve call participation from 100% of dentists
 - a. Hire a Project Coordinator responsible for dental call schedule
 - b. Establish knowledge of the need for and necessity of participation in a dental call program with area dentists
2. To establish protocols for accessible dental referrals
 - a. Work with dentists to improve processes for scheduling for urgent needs
 - b. Develop emergency dental access protocols for area healthcare facilities
3. To provide dental emergency care education for area emergency department and urgent care physicians
 - a. Develop a consumer education tool for access to emergency services
 - b. Provide education to handle minor dental issues

In 2000 and beyond the Committee will further develop strategies to accomplish these goals and objectives, with primary emphasis on the Fargo-Moorhead area. Grant funds have been applied for.

REPORT ON THE STRATEGIC PLAN FOR IMPROVED DENTAL ACCESS IN THE RED RIVER VALLEY

BACKGROUND

The Red River Region Community Dental Access Committee (herein, called the Committee) was formed in 1997 to address a critical and growing problem of access to oral health care in a 25 county region, primarily by low-income families, children and the elderly. The goal of the Committee “is to improve access to basic and urgent dental care for families and children in the Red River Valley who are living below 200% of the poverty level, the uninsured, the homeless population, Native Americans, seasonal farm workers and recent refugees.”

The Committee is composed of health and dental professionals; representatives from Minnesota and North Dakota Departments of Health and Departments of Human Services; representatives from local human service programs; county health departments; Dakota Medical Foundation; Managed Care

representation from Minnesota; Northwest Technical College, University of Minnesota Dental School; and non-profit community dental service providers.

TARGET POPULATION

The catchment area for the Dental Access Committee and dental access improvements is a 14 county area in North Dakota and a 11 county area in Minnesota within an 80-mile radius of the Fargo-Moorhead area. The catchment area encompasses the Red River, which runs on the border between North Dakota and Minnesota. The region encompasses North Dakota's most populous areas and Minnesota's more rural areas. (Appendix B)

Just under one-half (45%) of North Dakota's population resides in the catchment area while 5.1% of Minnesota's population resides in the area. Of the state Medicaid population, 38 percent (24,000) of North Dakota's eligibles reside in the catchment area, while in Minnesota 7.1 percent (53,000) of the Medicaid eligibles reside in the area. Of the Minnesota eligibles, 51 percent are enrolled in a managed care program. North Dakota currently does not have a managed care program for dental services.

The Committee is concerned about dental access for the 77,000 Medicaid eligibles in the region along with the uninsured working poor and special populations. Special populations include Native Americans, migrant workers, the disabled, the elderly, and refugees settling in the region. These populations may have difficulty with mobility, transportation, use of the English language, and a lack of basic education about dental care.

Children are of major concern. It has been proven that early dental screenings and preventive procedures can prevent most dental diseases. The American Dental Association recommends that children first see a dentist by the age of one. Head Start programs that serve children from 0-5 are required to provide dental screenings, but have difficulty finding a dentist to do the screenings and any subsequent follow-up procedures.

Approximately 10 percent of young children in North Dakota age 3-5 suffer from a severe form of dental caries called baby bottle tooth decay. Among Native American children, the baby bottle tooth decay rate is three times greater at 29 percent. Twenty-five percent of 6-8 year olds and 22 percent of 15 year olds have untreated caries and the rate for Native American children is twice as high. A North Dakota statewide survey of low-income families indicated the major reasons for not seeking dental care was cost and an inability to find providers to treat them, as well as a lack of awareness of preventive dental care.

SUMMARY OF NEED

In the past few years, State, local, and private agencies have begun initiatives to improve the participation of dentists in Medicaid and to encourage children and families to use dental services. State initiatives include: (1) increased reimbursement rates, (2) managed care arrangements, and (3) streamlined claims processing, (4) outreach and beneficiary education, (5) mandated provider

participation, (6) training general dentists and non-dental health providers, (public and private non-profit clinics for dental care), and (8) donated voluntary efforts by dentists. (Source: Children's Dental Services Under Medicaid Access and Utilization, Office of Inspector General, Department of Health and Human Services April 1996).

In North Dakota, a federally designated community health clinic has been established (the Family Health Care Center) that began offering dental services during the fall of 1995. An expansion of dental services to the Moorhead site of the Family Health Care Center is planned for the fall of 1999. Funding has been secured.

Reimbursement rates were increased in late 1997 in North Dakota to 87.4% of billed charges for children and adults at 74.4% of billed charges. Minnesota recently increased its reimbursement rates by 3% to 56% of usual and customary charges. Minnesota has also implemented incremental increases in reimbursement rates over the past 10 years and included a rural health care access fee under managed care plans for Medicaid populations. All health care providers pay these access fee funds, but dental professionals complain that little comes back for dental services.

Although the need for dental services is increasing in eastern North Dakota, especially for Medicaid eligible persons, the need in northwest and northcentral Minnesota is even more critical. A report completed by the Department of Human Services in 1998 includes utilization data encompassing all 87 counties that measures receipt of at least one dental service per 1,000 member months. It showed for recipients enrolled in managed care, all six of the counties in the lowest usage rate are in the Red River area and for non-managed care (fee-for-service) recipients, three of the seven counties in the lowest usage rate are in the Red River area. Clay County is one of the two counties in Minnesota with the lowest utilization rate of 9 percent or less of eligible recipients. This means that less than 10 per cent of all Medicaid eligible recipients in Clay County are able to access dental care.

Dental manpower is also of significant concern for the future. In a survey done by the North Dakota Department of Health, over 40 percent of dentists plan to retire or sell their practice within the next 10 years. Over 25 percent of Minnesota dentists plan to retire or sell within the next ten years. With no dental school in ND, and enrollment dropped to 86 students at the University of Minnesota Dental School, attracting adequate numbers of providers to both states will be a major challenge.

The number of general dentists being trained nationwide is also on the decline. Dental schools are closing and the availability of loan repayment and scholarship funds has greatly decreased since the 1980's. Seven dental schools have closed, one has opened, and another has recently been approved in Nevada. As all states face dentist shortages, the need for more slots in dental schools will grow along with competition to attract dentists to individual locations, primarily in rural states like North Dakota and Minnesota.

The population to dentist ratio for North Dakota in the Red River Region is 2155:1 and the ratio for the Red River Region in Minnesota is 2419:1. Both regions have ratios more than the US average of

1859:1. To make matters worse, only 3 percent of the dental providers in the state of Minnesota practice in west central Minnesota (an eleven county area of eighty-seven counties in Minnesota).

Findings from a 1996 needs assessment survey, conducted by Southeastern North Dakota Community Action Agency ranked access for dental care among the top three unmet needs of low-income families in southeastern ND. Less than 24 percent of the dentists in the region accept Medicaid patients on a regular basis. Anecdotal evidence shows that many families covered under Medicaid or a managed care program have to spend several hours on the phone to locate a dentist who will provide dental services. Many families have to travel 20-60 miles to access dental care, and this can be very difficult if follow-up appointments are needed.

Dental providers state that the three primary reasons dentist will not accept Medicaid patients is:

- 1. low-reimbursement rates**
- 2. failure of clients to keep appointments, and**
- 3. Poor attitudes and lack of patient compliance with treatments.**

In North Dakota, 68 percent of the adults in the general population visit the dentist each year while only 30 percent of the Medicaid eligible recipients see the dentist each year. For children, the statistics are only slightly better. Eighty one percent of all children visit the dentist yearly, while only 34 percent of the Medicaid eligible children visit a dentist each year.

In Minnesota, 76 percent of the adults in the general population visit the dentist each year while the Medicaid utilization rate for adults is 40 percent (26.4 for the fee-for-service program and 13.6 percent in the managed care program). For children, 78 percent of all children visit the dentist yearly, while only 52.4 percent of Medicaid eligible children visit the dentist yearly (26.3 percent for the fee-for-service program and 26.1 percent for the managed care program).

NEED FOR STRATEGIC PLAN

Due to the growing interest in developing strategies to address oral health issues, Dakota Medical Foundation hosted a meeting in November 1998, facilitated by Oral Health America, to look at issues, resources, sample models, infrastructure and collaboration efforts relating to improved oral health in the

Red River Valley. Dakota Medical Foundation then asked that the Red River Valley Dental Access Committee formulate a strategic plan to address a coordinated approach to oral health. The foundation provided funds in April 1999 for a one year planning grant to develop a strategic plan.

STRATEGIC PLAN PROCESS

Members of the Red River Valley Community Dental Access Committee and invited participants (Appendix C) met at the Expressway Inn in Fargo, ND the evening of November 11, 1999, and from 8 AM until 3 PM on November 12, 1999. Facilitating the meeting were Mark Bourdon from FirstLINK, and Jan Gabriel from Gabriel and Associates. Assisting was Carol Grimm, Fargo Cass Community Health. Prior to this meeting, Jan Gabriel, the project coordinator, gathered information relating to oral health needs and possible solutions through literature reviews and interviews with Committee members and focus groups.

After some group warm-up exercises, Mark divided the participants into four groups. He asked them to write a news story five years from today that would describe the perfect Red River Valley Community Dental Access accomplishments as if the program developed was a model to be admired all over the country.

NEWS STORIES/ VISIONING

Group #1 “Look Ma, No Cavities!” Local project eliminates dental disparities. Five years ago, only 1/2 of Medical Assistance eligible children saw a dentist each year. Public and private providers joined forces to develop a unique system to meet the dental needs of children and special needs patients.

Dakota Medical Foundation fostered this regional, two-state effort by providing seed funding for the planning effort. A Board of Directors representing Minnesota and North Dakota counties oversaw implementation of the plans. Minnesota and North Dakota Health and Human Services officials, and state legislators passed policies to standardize procedures to overcome barriers, which kept providers from serving these populations in a 25 county region.

As a result, four new clinics and a system of portable delivery units staffed by paid and volunteer dental practitioners and support staff has made accessible dental care a reality for all.

Group #2 “Five Years Later – Pilot program for Dental Health Proves to be an On-going Success!” Underserved individuals and families are receiving prompt and routine dental care. There is an emphasis on prevention and early intervention. Program utilized a multi-agency approach through a partnership of community-based clinics, private dental professionals, public health agencies, schools and various other governmental and non-profit agencies as funders. The population has been empowered through education.

Group #3 “Red River Region Is All Smiles!” The Red River Region was the first in the nation to achieve 100% participation of dentists in the region including new dentists who were recruited through a new residency program bringing dental students into the region. This increase in dentists also led to the first 24-hour regional dental emergency program serving all residents.

Because of the high value of dental care in the region, tri-partisan support was gained in the two-state area as envisioned by “President Ventura.”

Educational efforts successfully increased the dental IQ: to the highest in the nation. The new technologies used in the residency training program produced painless dentistry.

A virtual community created by the Red River region is used world wide as a site to learn about solving dental access. All kids have sealants, all the children of God receive care in a way that is accessible to them, school based programs provide preventive care, and dental professionals and their patients determine appropriate care.

Group #4 “BUY-IN FOR ALL” Improved access for everyone through a cost-effective delivery system. The system included increase reimbursement, increased participation, a cooperative emergency call system, extern and residency program (DDS, RDH), recruitment-retention program, public education of patients and physicians and managed care reform.

THEMES

Mark led the group in discussing the themes that showed up in the news stories. The following themes were identified.

- Individual and community education
- Individual and community awareness
- Improved access
- Partnerships
- Cooperation
- Quality
- Funding
- 100% dentist participation
- Red River basin
- Two states

VISION STATEMENT

Based on the themes the group identified a common vision statement:

RED RIVER VALLEY COMMUNITIES UNITING TO IMPROVE ORAL HEALTH FOR ALL

OPPORTUNITIES AND THREATS

The planning participants identified the following opportunities and threats. No prioritizing was done.

- Funding possibilities – RWJ, Medical School PCO grant, HCFA
- Healthy Steps Program
- Awareness campaigns
- National awareness HP 2010/Surgeon General report
- Varied ideas other states
- Opportunities for success/momentum

- State wide dental summit
 - Remove pain from those who hurt
 - Gain more dentists/dental professionals
 - Loss of dentists (esp. in ND)
 - Some movement addressing access
 - Slots for MA clients
 - Dental access story often buried
 - Movement toward evidence based dental care (defines uniform treatment) (seen as method of cost control)
 - Focus keeps legislators aware
 - Federal legislation pending
 - Change in the rules/regs
 - New (dental) resident program
 - Virtual dental community
 - Expand functions for dental hygienists
 - Area hospital participation
 - Dental collaboration leads to other medical issue collaboration
 - Questionable funding (State and Federal)
 - Paid staff to keep collaboration going
 - What is general public feeling/perception
 - Dental Practice Acts don't match between the states (look at statute language)
 - Concern over school programs closing (ND and MN)
 - Focus of Dental School (research vs. community)
 - Number of slots in Dental School
 - Communities need to work together to attract dentists
 - Break through the apathy of colleagues
 - Need to change attitudes (press, public relations)
 - School based dentistry
-
- Long term care focus on oral health
 - Need to communicate hope for change
 - Oral health relationship to systemic health
 - Education of public
 - New technology/change in dentistry
 - Changes in administration of public program

REVIEW OF HISTORY AND DATA

Jan Gabriel reviewed the handouts regarding the history of dental access in the Red River region along with problems and solutions identified by individual interviews, literature reviews, and focus groups. From all the problems and solutions identified, Jan divided the issues into seven categories.

- I. Dental reimbursement/payment increases
- II. Incentives to serve public assistance patients
- III. Incentive and methods to improve patient behavior
- IV. Better use of dental auxiliary services
- V. Emergency and donated services
- VI. Oral health education
- VII. Expand opportunities in dental/education

PRIORITIZING ISSUES

Mark asked each planning participant to individually list their top five key issues they felt were most important based on all the information discussed. Many issues were identified by more than one person and fourteen issues were prioritized and then grouped together into five critical issues.

Priority List of 14 Issues (not listed in priority order)

1. 100% participation of dentists (8 votes)
2. Healthy mouth = Healthy body – Education (22 votes)
3. Equalization of dental rates (1 vote)
4. Dentists/patient determines treatment (2 votes)
5. Project Coordinator (15 votes)
6. Residence program with loan repayment provisions (1 vote)
7. Reimbursement/funding (18 votes)
8. Recruitment of dental professionals (14 votes)
9. Emergency Services (13 votes)
10. Prevention (3 votes)
11. Public policy (5 votes)
12. Alternative dental auxiliary services (7 votes)
13. Coalition building (7 votes)
14. Advocacy with managed care (1 vote)