



Introduction and background

Oral health is integral to overall health. However, over the past three decades, oral health has diminished as a public health priority, leading to large numbers of people going without necessary dental care. Children who lack dental care may have long-term oral health problems, miss school days due to dental decay and pain, and dental carries can lead to delayed growth and behavior problems. Good oral health care is critical to a child's success.

In 2000, Surgeon General Dr. David Satcher led an effort to raise the awareness of oral health as a public health priority. In the first ever **Oral Health in America: a Report of the Surgeon General**, Dr. Satcher outlined children's oral health as a national issue, integral to children's health and well being. In the same year, *The Face of the Child: Surgeon General's Conference on Children and Oral Health*, gathered more than 700 people from an interdisciplinary, national constituency to consider children's oral health and the report's recommendations from a broader perspective.

Some of the KEY FINDINGS from the conference

- Dental caries is the most common chronic disease of childhood, affecting half of children by middle childhood, and 80% by late adolescence. Tooth decay (or dental caries) is **5 times more common than asthma** and 7 times more common than hay fever.
- Severe periodontal disease in a pregnant woman may lead to a seven-fold increase in that woman's risk of delivering a premature baby of low birth weight. This risk may be even greater for a woman with diabetes and severe gum disease.
- Dental caries are infectious and can be passed from parent to child through activities like sharing utensils. Baby bottle tooth decay is a problem resulting from frequent exposure to sugar and bacteria when drinking something other than water out of a bottle for prolonged unsupervised periods of time.
- Dental caries can be prevented if intervention starts early. The process can be prevented by a combination of community, professional, and individual measures including water fluoridation, preventive dental visits, application of topical fluorides and dental sealants, use of fluoride toothpastes, proper infant feeding practices, and diet.
- Research shows that oral and dental diseases have a significant impact on children and families. Children lose an estimated 52 million hours a year from school due to dental problems and related care.
- Untreated caries can be associated with delayed growth, serious behavior and attention problems in children, and may result in costly emergency room visits and hospitalizations.
- Dental care is the most frequent unmet health need of children. For every child without medical insurance there are 2.6 without dental insurance. Dental health care costs account for approximately 30% of family out of pocket expenditures for children's health care.
- Low-income and minority children and those with special health needs have greater access problems and poorer oral health outcomes. Fewer than 1 in 5 Medicaid-eligible children received preventive dental care in one year reviewed (1993). Hispanic, African American, and American Indian children have high levels of severity and untreated disease.



The situation in Minnesota

Some summary data on Minnesota's children's oral health situation is below

- Poor people, including people covered by Minnesota Health Care Programs (MA, MNCare, GAMC), have declining access to dental care.¹ Between 1997 and 1999, the percent of MHCP beneficiaries receiving dental services decreased from 37% to 34% for managed care clients, and from 26% to 20% for fee-for-service clients.

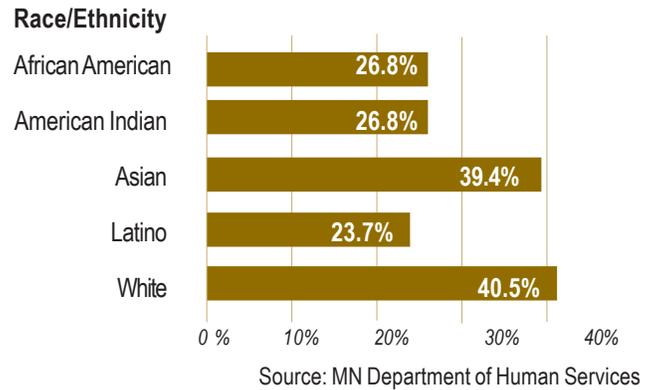
- People on public health programs have less access to dental care than private-pay individuals. In 1995, 70% of commercially insured Americans accessed dental care. The comparable number for MHCP beneficiaries was 30.5% in 1997.¹

- There are **disparities in dental access among different ethnic groups** (see chart). For example, approximately 40% of Caucasian and Asian children on Minnesota Health Care Programs received dental services in 1999. This compares to 26% of American Indian and African American children, and 24% of Hispanic children.¹

- In 1999, the Minnesota Department of Human Services published utilization statistics (for 1997) showing that Hennepin and Ramsey county Medical Assistance (MA) enrollees consistently rank at or near the bottom of Minnesota counties in terms of MA eligibles receiving dental services. This was true for most age categories and, most significantly, in the 0-20 year age range.² In the same report, DHS identified both Hennepin and Ramsey Counties as the lowest dental utilization for the MA population in the metro area. Other low-income children without dental coverage are even less likely to visit a dentist.

The Minnesota Association of Community Dentistry, the Minnesota Department of Human Services, and the Minnesota Primary Care Association have worked to identify and correct many policy and reimbursement issues related to oral health in general. The Department of Human Services has issued several in-depth reports related to oral health in Minnesota, providing substantial information and recommendations for new policy and program interventions.^{1,2,5}

Percent of MHCP children by race/ethnicity receiving one or more dental services 1999



The City of Minneapolis

Approximately 22% (18,517) of Minneapolis children ages 0-17 years lack dental insurance, which is comparable to the 23% statewide figure. However, 30% (19,695) of insured Minneapolis children are covered by public health programs, compared to only 12% statewide.³

The City of Minneapolis, through its Department of Health and Family Support, subsidizes dental visits to children through its contracts with Children's Dental Services and the Neighborhood Health Care Network (through CUHC, Southside, and Fremont clinics.). Hennepin County also supports community clinic programs to provide dental care. Children's Dental Services has a close affiliation with four Head Start sites, maintains a presence in four elementary schools in Minneapolis, provides services at one site in St. Paul, and maintains a clinic at its downtown location at Metro Community and Technical College.

Children's Dental Services clients⁴

- 93% are children of color, with the largest population being African Americans at 37%.
- 76% (5,185) have public insurance
- 16% (1,092) have private insurance
- 8% (564) have no insurance
- 46% (2,864) age 0-5
- 53% (3,253) age 6-17

Dental health workforce needs and issues

- Dental practitioners strongly assert that the DHS payment rates are insufficient. In 1999, the Minnesota Health Care Programs paid 54.5% of dental charges statewide.⁵ This payment rate is not enough to cover the costs of providing services.
- Access to dental providers is an issue for low-income people. A recent DHS survey of the State's dentists revealed that about 60% of dentists currently accept new MHCP participant patients. However, while 74% of dentists describe themselves as having enough time to grant appointments to all who request them, only 14% of dentists grant appointments to all MHCP enrollees who request them.⁶
- The system of paying for care is overly complicated. Providers face administrative complexities in treating MHCP participants because MHCP prepaid programs involve multiple payers and varying administrative requirements.¹
- The dental workforce is aging and facing future shortages. The average age for dentists in Minnesota is 47 years. More dentists are retiring than are graduating from dental schools, and more are working fewer hours a week than in previous years.¹
- State and local oral health surveillance data is lacking. Without better data, the extent and significance of children's oral health issues is difficult to assess. Data from such a surveillance system would help accurately assess the problem, help design and drive policy interventions, and measure improvements after the interventions.
- Schools of dentistry lack a population health focus, leading to few dentists understanding oral health as a community health issue.¹

POLICY GOALS

Building Minnesota's oral health safety net will require adherence to three overarching policy goals

1. Maintain broadest possible range of dental services for underserved populations.
2. Develop new purchasing, administrative and delivery models to increase access for underserved populations.
3. Increase the dental workforce.

POLICY STRATEGIES

Specific strategies toward reaching these goals are

- Expand the role of allied dental professionals (dental hygienists and dental assistants) through legislative action. A mid-level practitioner model, similar to a nurse practitioner, is an effective and relatively inexpensive way to increase the dental workforce and its capacity.
- Increase primary care involvement in oral health. Promote the understanding of oral health as an integral part of overall health among many health disciplines and with the public at large. Encourage the medical profession to do more primary prevention during the course of well child exams in the first five years of life.
- Work with the Department of Human Services and the Minnesota Legislature to increase reimbursement and/or other incentives for providers willing to serve high volumes of public program patients.
- Expand the use of dental screening and dental sealants in day cares, schools and community settings.
- Incorporate a community health approach in schools of dentistry. Teach dental professionals in-training about access barriers for low-income patients, and addressing racial and ethnic disparities in dental care.
- Support culturally specific approaches to oral health education and oral health care, and cultural competency among dental health professionals.
- Work with the Minnesota Department of Health to develop a statewide and local surveillance system for oral health to inform policy change and measure intervention success.
- Work with the Local Public Health Association to maximize the impact of their dental health legislative positions, and to incorporate dental health into local public health officials' overall health priorities.

*Partners advocating
for an oral health safety net*

Many organizations are working to improve the oral health safety net in Minnesota. The list below is not exhaustive, but represents several organizations actively involved in the issue. If you are interested in being added to the list, and receiving updates on activities to build the oral health safety net, contact Megan Ellingson at 612-673-3817.

Apple Tree Dental

Dr. Michael Helgeson, 763-784-7993 x34

Children's Defense Fund

Jim Koppel, 651-227-6121

Children's Dental Services

Sara Wovcha, 612-359-1544

Community-University Health Care Center

Dr. Karl Self, 612-638-0655

Minneapolis Department of Health and Family Support

David Doth, 612-673-3798

Megan Ellingson, 612-673-3817

Minnesota Association of Community Dentistry

Dr. Carl Ebert, 763-784-7993 x35

Minnesota Community Action Association

Tarryl Clark, 651-210-4143

Minnesota Dental Access Advisory Committee

Tom Fields, 651-297-7303

Minnesota Dental Hygienists' Association

Candy Hazen, 952-835-5183

Minnesota Department of Health

Mildred Roesch, mildred.roesch@state.mn.us

Minnesota Department of Human Services

Tom Fields, 651-297-7303

Minnesota Head Start Association

Gayle Kelly, 218-728-1091

Minnesota Local Public Health Association

Laura LaCroix, 651-224-3344

Minnesota Primary Care Association

Rhonda Degelau, 612-253-4715

Otter Tail County Public Health

Diane Thorson, 218-739-7117

Pilot City Health Center

Gary Cunningham, 612-302-4762

University of Minnesota Department of Pediatrics

Dr. Amos Deinard, 612-638-0700 x212

University of Minnesota School of Dentistry

Dr. Tom Boeckman, 612-624-9480

Uptown Community Clinic

Deborah Jacobi, dajacobi@earthlink.net

Individuals

Dr. Denis Zack, 612-382-6636

REFERENCES

¹ MN Department of Human Services, "Dental Access for Minnesota Health Care Program Beneficiaries: Report to the 2001 Minnesota Legislature."

² MN Department of Human Services, "Dental Services Access Report," March, 1999.

³ MN Department of Health, Health Economics Program, 2001 Health Access Survey.

⁴ 2001 Children's Dental Services statistical report.

⁵ MN Department of Human Services, claims payment data, 2000.

⁶ Wilder Research Center, Survey of Minnesota Dentists, November, 2000, preliminary results.



For more information about this policy brief, contact
**Minneapolis Department of Health and Family Support
Policy Division**

250 South 4th Street – Room 510
Minneapolis, MN 55415-1384

or visit our website www.ci.minneapolis.mn.us/dhfs

If you need this document in an alternative format,
please call 612-673-2301 or
TTY 612-673-2157 (General City Information).

PREPARED BY

Megan Ellingson • (612) 673-3817 •
megan.ellingson@ci.minneapolis.mn.us
Janet Howard • (612) 673-3735 •
janet.howard@ci.minneapolis.mn.us