



## Dental Public Health Activities & Practices

**Practice Number:** 26001  
**Submitted By:** Dental Health Program, Minnesota Department of Health  
**Submission Date:** April 2002  
**Last Updated:** April 2002

### SECTION I: PRACTICE OVERVIEW

**Name of the Practice:**

National Governors Association (NGA) Policy Academy on Oral Health Care for Children

**Public Health Functions:**

Policy Development – Collaboration & Partnership for Planning and Integration  
 Assurance – Building Linkages & Partnership for Interventions  
 Assurance – Access to Care and Health System Interventions

**HP 2010 Objectives:**

- 21-1 Reduce dental caries experience in children.
- 21-2 Reduce untreated dental decay in children and adults.
- 21-10 Increase utilization of oral health system.
- 21-11 Increase preventive dental services for low-income children and adolescents.

**State:**

Minnesota

**Region:**

Midwest  
Region V

**Key Words:**

Collaborative planning, policy, access to care, legislation, Medicaid reimbursement, community dental clinics, access grants

**Abstract:**

Minnesota was one of seven states to participate in the first National Governors Association (NGA) Policy Academy on Oral Health Care for Children, held December 13-15, 2000. The Academy required Minnesota to assemble a state team, the Minnesota NGA Oral Health Policy Academy Team. The Minnesota NGA team represented major stakeholders of oral health including the following members: a representative from the Governor's Office, a legislator, the state dental director, a representative from the Department of Human Resources, a representative from the state dental association, representatives for community programs, a practicing pediatric dentist, and a representative from a major HMO health plan. Outcomes observed from the work of the Academy and the Minnesota NGA team included: (1) gaining strong and influential support from the team's participating state legislator to address oral health issues, (2) development of a vision statement and a strategic action plan to improve children's oral health in the state, (3) passage of the 2001 dental access legislation that included improving the dental workforce by licensing foreign trained dentists and expanding the duties of dental auxiliaries, (4) providing enhanced reimbursement rates for "critical access providers" who delivered more than \$50,000 of dental services for public dental program recipients, (5) developing/expanding community-based dental clinics, and (6) establishing dental access grants.

**Contact Persons for Inquiries:**

Mildred H. Roesch, RDH, MPH, Consultant, Dental Health Program, Minnesota Department of Health, 85 East Seventh Place, St. Paul, MN 55164-0882, Phone: 651-281-9900, Fax: 651-215-8953, Email: [mildred.roesch@health.state.mn.us](mailto:mildred.roesch@health.state.mn.us)

Tom Fields, Minnesota Department of Human Services, 444 Lafayette Road, St. Paul, MN 55155, Phone: 651-297-7303, Email: [tom.fields@state.mn.us](mailto:tom.fields@state.mn.us)

## SECTION II: PRACTICE DESCRIPTION

### **History of the Practice:**

The National Governors Association (NGA), founded in 1908, is the instrument through which the nation's Governors collectively influence the development and implementation of national policy and apply creative leadership to state issues. Its members are the fifty state Governors, three territories and two commonwealths. In 2000, the NGA Center for Best Practices selected seven states (Alabama, Colorado, Minnesota, Ohio, Oregon, South Carolina, and Virginia) to participate in the first NGA Policy Academy on Oral Health Care for Children, held December 13-15, 2000. The Academy was designed to help formulate and implement policies and programs to address the oral health care of children. Due to the overwhelming number of states that applied for the first Academy, additional Academies have been conducted. A second Academy was held May 7-9, 2001 and was attended by Arkansas, Delaware, Georgia, Kentucky, Tennessee, Utah, West Virginia, and Wyoming. A third Academy was held in October 29-31, 2001 and involved Florida, Maine, Massachusetts, Mississippi, Missouri, and Pennsylvania. The selection process requires states to clearly define existing challenges in providing oral health services for low-income children, explain current thinking on how to address those challenges, and provide compelling evidence that they would dedicate staff time and the necessary resources to participate in, and benefit from, the project.

### **Justification of the Practice:**

Oral health care is needed for children from low-income families in Minnesota. The percent of children (grades K-12) on the free/reduced school lunch program totaled 30% for the school year 1999-2000. In FY 2000, more than 206,000 children in Minnesota were eligible and were enrolled in Medicaid. Utilization of dental services is low among the Minnesota Health Care Programs' (MHCP) beneficiaries despite good coverage – MHCP includes the Medicaid program and other state/federally funded programs for health care coverage. Only 30 percent of MHCP beneficiaries visited a dentist in the mid-1990s compared to 70% Americans with commercial insurance. Access to dental care is critically limited in Minnesota. Demand for dental services exceeds the dental workforce supply. There is low provider participation in MHCP, and patients are unable to get dental appointments. Medicaid dental payment rates are considerably lower than average fees charged by dentists.

In recent years, the dental access problem for low and moderate income Minnesotans has gained increasing attention at the state legislature. In 1998, the legislature mandated that the Department of Human Services complete two studies of the dental access problems. Subsequently, the "Dental Services Reimbursement Study" and the "Dental Services Access Report" were completed and submitted to the legislature. In 1999, based in part on the findings of these reports, the legislature mandated that the Minnesota Department of Human Services (DHS) convene a Dental Access Advisory Committee to develop strategies for increasing dental access for Minnesota citizens. The Committee provided the legislature with a report in January 2001, entitled, "Dental Access for Minnesota Health Care Programs Beneficiaries" reporting their findings and recommendations.

### **Administration, Operations, Services, Personnel, Expertise and Resources of the Practice:**

DHS applied for the NGA Policy Academy on Oral Health Care for Children. In October 2000, Minnesota was selected to participate in the NGA Academy. A staff member from the NGA Center for Best Practices conducted a site visit to Minnesota beforehand to facilitate discussion and prepare state teams for the Academy. Minnesota had the discretion in choosing the size and scope of its state team. The Minnesota NGA Oral Health Policy Academy team comprised of representatives from the academic, non-profit and private sector dental provider communities included members of the following:

- A representative from the Governor's Office
- A state legislator
- The state dental director (as a representative from the Department of Health)
- A representative from the Department of Human Resources
- A representative from the state dental association
- Representatives for community programs
- A practicing pediatric dentist
- A representative from a major HMO health plan

In developing the team, it was recognized that consumers, the Department of Education and other partners were not represented. However, it was important to keep the team small in order for members to efficiently work together. Being part of a national process led the team members to place a higher obligation in improving oral health for the state.

The Academy required substantial preparation from the Minnesota NGA team. For example, prior to the Academy, the Minnesota NGA team developed a vision statement which was: To optimize and maintain oral health as a key component of the general health of all Minnesota children through a coordinated public-private effort where government supports the safety-net and fosters solutions that engage the private sector and, to the pursuit of these outcomes: 1) absence of active disease; 2) reduced disparities among all populations; 3) individual practice of behaviors that support oral health; and 4) absence of compromised dental function due to dental disfigurement or pathology. In addition, the team identified oral health priority areas and the appropriate target population for the focus of the Academy process.

The Minnesota NGA team joined the teams of six other states in Charleston, South Carolina for the Policy Academy, which was conducted over a two and a half days. The Policy Academy was not a conference, but an interactive policy-making process. The Academy required active team participation and strong commitment from the team toward implementing the ideas that were generated. State teams were provided with the opportunity to work with peers and leading national experts to develop strategic plans in addressing oral health care coverage and services for children in their state.

As a result of the Academy, the Minnesota NGA team developed goals, objectives and an action plan to improve oral health care for children. The Minnesota strategies to improve dental access included recommendations for increasing the non-dental providers' role in oral health screening and prevention, increasing the workforce, developing and expanding dental clinics for treatment, implementing an oral health campaign, and providing administrative simplification for health plans' enrollment, coverage, payment and authorizations.

The team had much energy and momentum for the first 6-month period following the Policy Academy. This interactive process resulted in a strong cohesiveness among the team members, bringing a stronger collaboration with their agencies and organizations. In addition, the process provided an opportunity for a state legislator to learn the oral health issues in the state and resulted in gaining a strong oral health advocate in the legislature. Furthermore, the collaboration and working relationships between the Dental Access Advisory Committee and the Minnesota NGA Oral Health Policy Academy team have led to many legislative recommendations.

The *Minnesota Dental Access 2001 Legislation* was proposed and passed as a result of the action plan and the collaborative efforts of the Minnesota NGA team. The legislation included measures to: (1) provide enhanced reimbursement rates for "critical access providers," identified as having delivered at least \$50,000 of dental services for public program recipients in the previous year, (2) provide dental access grants, (3) provide community clinic expansion grants, (4) license foreign trained dentists, (5) establish expanded functions dental auxiliaries, (6) establish a dental student loan forgiveness program, (7) increase provider enrollment and retention in state health care programs, and (8) establish a retired dentist program to reimburse a retired dentist's costs of license fee and malpractice insurance for services provided at a community dental clinic.

The Minnesota NGA Oral Health Policy Academy team still continues to meet monthly but after two years, the Minnesota NGA team has lost some of its initial momentum. The team has decided to continue with a new focus in devoting efforts to monitor the impact of the 2001 legislation.

#### **Budget Estimates and Formulas of the Practice:**

- The Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) funded the NGA Policy Academies, which covered travel expenses for up to seven members of the Minnesota team.
- Time and effort of the NGA team members devoted to the preparation, attending the Academy and subsequent meetings were donated as in-kind contributions from the individuals and their agencies/organizations.
- Additional team members' travel, beyond the seven members covered by NGA Academy, was financially supported by their agencies.

#### **Lessons Learned and/or Plans for Improvement:**

Selection of individuals for the NGA team should include agencies, organizations, groups or individuals with significant commitment to improving oral health in the state. Try to keep the size of

the team manageable in the number of members to allow efficient planning and decision-making processes. A strong legislative presence in the team is critical as well as a committed representative from the Governor's office.

**Available Resources - Models, Tools and Guidelines Relevant to the Practice:**

- Minnesota's NGA Application
- Minnesota NGA Oral Health Policy Team Report (includes the goals, objectives and action plan)
- A synopsis of *Minnesota Dental Access 2001 Legislation*
- *Dental Access for Minnesota Health Care Programs Beneficiaries* – a report by the Minnesota Department of Human Services to the 2001 Minnesota Legislature

## SECTION III: PRACTICE EVALUATION INFORMATION

### **Impact/Effectiveness**

*Does the practice demonstrate impact, applicability, and benefits to the oral health care and well-being of certain populations or communities (i.e., reference scientific evidence and outcomes of the practice)?*

The NGA Policy Academy process resulted in strong, influential support from a state legislator for oral health issues in Minnesota. Efforts of the NGA team and their action plan helped the passage of 2001 legislation that improved access to care by providing enhanced reimbursement rates for “critical access providers” who have delivered at least \$50,000 of dental services for Minnesota Health Care Programs’ recipients in the previous year, establishing a dental student loan forgiveness program, providing dental access grants, expanding community-based dental clinics, and increasing the dental workforce with expanded functions dental auxiliaries and licensing foreign trained dentists.

### **Efficiency**

*Does the practice demonstrate cost and resource efficiency where expenses are appropriate to benefits? Are staffing and time requirements realistic and reasonable?*

The Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) funded the NGA Policy Academies, which covered travel expenses for up to seven members of the Minnesota team. Time and efforts of the NGA team members devoted to the preparation, attending the Academy and subsequent work meetings were donated as in-kind contributions from the individuals and their agencies/organizations. There was no formal budget for the NGA team.

### **Demonstrated Sustainability**

*Does the practice show sustainable benefits and/or is the practice sustainable within populations/communities and between states/territories?*

The Minnesota NGA team continued to meet monthly for two years following the Policy Academy. The NGA team currently has chosen to continue with the next effort in monitoring the effects of the legislation that was passed. Legislation passed has sustainable effects on improving the dental workforce for the state and maintaining providers for public dental programs.

### **Collaboration/Integration**

*Does the practice build effective partnerships/coalitions among various organizations and integrate oral health with other health projects and issues?*

The NGA Policy Academy assembled a state team consisting of a representative from the Governor’s Office, a legislator, the state dental director, a representative from the Department of Human Resources, a representative from the state dental association, a representative for community programs, a practicing pediatric dentist, and a representative from a major HMO health plan. The team members became a cohesive group and members worked very well together to bring their agencies and organizations to a higher level of collaboration.

### **Objectives/Rationale**

*Does the practice address HP 2010 objectives, the Surgeon General’s Report on Oral Health, and/or build basic infrastructure and capacity for state/territorial oral health programs?*

The Policy Academy provided a focus to develop strategic plans in addressing oral health care coverage and services for children in their state. This effort supports advances related to reducing dental caries experience in children, reducing untreated dental decay in children and adults, increasing utilization of the oral health system, and increasing preventive dental services for low-income children and adolescents. In addition, the Academy efforts support reducing disparities in oral health status and improving access to care.

### **Extent of Use Among States**

*Is the practice or aspects of the practice used in other states?*

A total of 21 states have attended the NGA Policy Academy on Oral Health care for Children. Seven states were selected for the first NGA Policy Academy: Alabama, Colorado, Minnesota, Ohio, Oregon, South Carolina and Virginia. Eight states attended the second Academy: Arkansas, Delaware, Georgia, Kentucky, Tennessee, Utah, West Virginia and Wyoming. A third Academy had six states including Florida, Maine, Massachusetts, Mississippi, Missouri, and Pennsylvania.