South Dakota
Dental Health Strategies

“Improving Oral Health in South Dakota”

Sponsored by:
Community Health Care Association
Delta Dental Plan of South Dakota
Health Resources and Services Administration (HRSA)
South Dakota Dental Association
South Dakota Department of Health
University of South Dakota
Centers for Medicare & Medicaid Services (CMS)

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Executive Summary

Access to dental care is a growing concern for all South Dakota citizens. The status of oral health in South Dakota mirrors concerns faced by other rural states. For Native Americans in South Dakota, oral health status far exceeds documented problems found across the country. Access to oral health care and oral health disparities are recognized nationally as a serious emerging health care issue. A South Dakota Dental Health Strategies meeting was held on April 25, 2002 to bring together constituencies representing public oral health, public policy, medicine, and advocacy to identify the current status of oral health care in South Dakota, concerns with care access, and changes in oral health service resources for South Dakotans now and in the future.

More than 100 individuals were invited to participate in the one-day strategies meeting. Eighty-five leaders from all constituency areas heard presentations and participated in large-group facilitation and small-group planning sessions. The outcomes of this meeting are documented as a starting point for statewide planning. The ultimate goal of this work is dedicated to assuring access to oral health services that results in improved health and quality of life for all South Dakotans.

State, national, Indian Health Service (IHS), and dental leaders convened to present the state of oral health issues in South Dakota. They provided a framework for discussion and planning to address oral health care issues for the state. Leaders providing background for discussion and planning included:

- Scott Jones – Delta Dental Plan of South Dakota
- Paul Knecht – South Dakota Dental Association
- Ann Brunick, RDH – USD Hygiene Program
- Mel Thaler, DDS – Pediatric Dentist
- Ben Jensen, DDS – General Practice Dentist
- Joy Smolnisky – South Dakota Coalition for Children
- Bill Bailey, DDS – Aberdeen Area Indian Health Service
- Bill Schultz, DDS – Sioux River Valley Community Health Center
- Colleen Winter – South Dakota Department of Health
- Jim Sutherland, DDS – Health Resources Services Administration (HRSA)
- Dee Raisl – Centers for Medicare and Medicaid Services (CMS)
- Michael Felix – Consultant and Community Health Development Specialist

Oral health leaders agree a crisis in oral health care is emerging in the state. An expected decline in the number of dental providers, geographic realignment of providers to more populated areas of the state, continued reluctance of dentists to participate in the South Dakota Dental Medicaid & CHIP program, and the growing demand for dental care are key elements of the changing landscape. The large increases in numbers of children enrolled in Medicaid, through the Children’s Health Insurance Program’s (CHIP) expanded eligibility, further magnify the problems faced by oral health care providers and public policy leaders.
According to the South Dakota Dental Association, there are 320 dentists and dental specialists working in South Dakota, with only six dentists that are specialists in children’s dentistry or pediatric dental care. This provides a ratio of one provider to every 2,406 South Dakotans, compared to the national average of one provider for every 1,812 residents. Seventy percent of South Dakota dentists work in solo practice. Although 82% of the dentists in the state have enrolled as dental providers for Medicaid, the top 5% of those dentists delivered almost half of the care to this population. Twenty-five percent of the dentists delivered care covering 80% of the total Medicaid dental payments made.

South Dakota relies on dental schools in other states to train practitioners for the state, while the dental hygiene program at the University of South Dakota graduates 30 students annually. Approximately 72% of the graduates stay and work in South Dakota.

The oral health status of American Indians is especially troubling. According to the most recent national oral health survey, 15% of all children between the ages of two and five experience tooth decay. In the Aberdeen Area IHS - Dental Health Program (which is responsible for serving the needs of 110,000 American Indians in North Dakota, South Dakota, Nebraska and Iowa) statistics indicate that 78% of American Indian children have tooth decay and 68% of these children go untreated. A known factor in the sharp rise in oral health problems among American Indians is the loss of fluoridation in drinking water on the reservations. In 1994 there was 84% fluoridation compliance of all drinking water systems in reservation communities, compliance with fluoridation is now down to 0%. It was indicated that the compliance drop is due to the rigid testing requirements for water supplies using fluoridation with which American Indian communities fail to comply.

The lack of providers is also an ongoing problem in reservation communities. Vacancy rates in dentists is 29% in the Aberdeen area today, with little progress toward addressing the gap expected in the near future.

South Dakota’s current dental practice act is a factor that could be weighed in addressing solutions to the current and emerging oral health care issues. State statutes limit dental practice ownership to practicing dentists. Hygienists’ practice is limited to preventive and therapeutic services under the general supervision of a dentist. Hygienists may only treat patients who are patients-of-record of a licensed dentist. A recent waiver to dental practice ownership does allow dentists to be employed by federally funded community health centers. One community health center in the state currently offers services under this.

In making recommendations about the process and the direction South Dakota should take in addressing the oral health care issues of today and in the future, summit participants offered suggestions and recommendations, including:

- Form a coalition of organizations interested in improving oral health in the state.
- Gather more precise data on dental needs of South Dakotans and the views of dental practitioners.
- Expand emergency safety net services to meet current critical shortages
- Improve case management mechanisms to improve Medicaid patient access
- Educate Medicaid consumers regarding the importance of preventive care and compliance with service access
- Expand the practice of assistants and hygienists to provide more services
- Develop “mobile” clinics
- Establish links to medical care
- Develop dental student rotations in programs such as Head Start, Lutheran Social Services, Indian Health Service, etc.
- Develop strategies to recruit and retain providers through tuition reimbursement or forgiveness
- Pursue grant funding for innovative programs
- Establish web site resources as a communication and information tool for providers in all areas across the state.
- Look for funding assistance for dental students, start-up funding resources, and continuing education for providers, and other innovative programs
- Pursue exceptions to the “dentist as proprietor” law for safety-net dental services.

The consensus among the groups was a need for continued planning that would bring together committee workgroups to the development of a strategic plan for South Dakota that would include clear time frames and priority actions.

Among all groups, several key common themes for action arose. These themes include:

- **Gather more precise information on the status of oral health resources**
- **Bring together an oral health coalition to create a strategic plan for the state**
- **Seek models that work from other rural states for consideration to meet South Dakota’s needs**

The groups working together indicated a strong desire and agreed to continue their work in this important planning effort.
I. Introduction and Purpose Statement

Access to dental care is identified as a growing concern for South Dakota citizens. This concern mirrors concerns faced by other states. The South Dakota Dental Health Strategies meeting was held on April 25, 2002 to bring together constituencies representing public oral health, public policy, medicine, and advocacy to identify the current status of oral health care access and the impact of changes in oral health service resources on South Dakotans now and in the future.

Eighty-five leaders (see Appendix C for a listing of attendees) from all constituency areas took part in the presentations, large-group facilitation and small-group planning sessions. The outcomes of this meeting are provided as a starting point for statewide planning. The ultimate goal of this work is dedicated to assuring access to oral health services and reducing oral health disparities that results in increased health and quality of life for all South Dakotans.

The day-long meeting included presentations regarding the current status of oral health services nationally and locally. The presentations were designed to provide background on the current status of oral health in South Dakota and give a framework for discussion on future strategies to address identified trends impacting the quality of life and health for South Dakotans. Goals of the meeting were described in a letter that was sent out to all participants. Small group discussion meetings were held to seek input from participants regarding approaches that oral health, medical, and public policy leaders can use to address current and emerging issues in quality oral health care access and services. An agenda for the day is provided in Appendix B of this report.
II. Large Group Facilitated Discussion: Oral Health Challenges Facing the State

Michael Felix was hired to assist in the planning and facilitation of the meeting. He provided insight he had acquired from doing similar meetings across the country. He reminded attendees that those present in the room had diverse backgrounds and may view the issue of oral health from different perspectives. He added that as questions are asked and ideas are shared there will likely be feeling of discomfort, but that if everyone is honest and polite, the end result will be productive. He reminded everyone that they were at the meeting because they have a common goal. He directed the large group to identify the key issues facing South Dakota, considering the information they received during oral health presentations (listed in section IV of this report). These issues span the gamut from workforce considerations to utilization compliance. The issue areas include:

- **The economic factor** – There is a linear relationship among income levels and access to oral health care in South Dakota and nationally. Within similar low-income levels, ethnicity can influence oral health status. Linguistic and culture values of American Indian groups, as well as cultural or biologic factors, may also be driving this disparity. Dental caries is the most chronic infectious disease of childhood, five times more prevalent than asthma. Research demonstrates that parents and caregivers can give the bacteria that causes dental caries to young children and infants. The causes of tooth decay and periodontal disease are multifactorial, but key to the widespread nature of the disease is the low utilization of dental services among high-risk populations. All of these factors must be considered, plus the impact on oral health in solving this issue.

- **Funding options** – In demonstrating the need in South Dakota, there is ample opportunity to apply for federal, state, foundation, and business support to fund effective oral health activities that increase access to dental services and reduce oral health disparities. The use of South Dakota’s tobacco settlement funds was raised as a possible source to fund oral health initiatives in the state.

- **Participation versus delivery** – Eighty percent of South Dakota’s dentists are enrolled as Medicaid providers. However, many of these dentists see only a limited number of Medicaid patients. Many dentists make a business decision not to accept large numbers of Medicaid patients because Medicaid reimbursements are approximately 70% of the average charge for dental procedures in the state, and most dentists are so busy they can barely meet the needs of their full-pay and insurance third-party pay patients. Considering the overhead of many dental practices, if a dentist accepts a Medicaid patient and the Medicaid reimbursement, the practice experiences a net loss of income. The most common examples of compliance failures are missed appointments and failure to return for custom-fitted materials ordered on their behalf. Failed appointments by Medicaid patients is a primary concern among dentists, which usually results in an opening in the practice schedule that cannot be filled, and presents a substantial loss of income for the practice.
An additional factor is the way dentists structure their fees. Because only about 4% of total fees are paid by Medicaid in a typical dental practice (much lower than in medical care settings) dentists don’t set private pay fees to cost-shift the total cost burden.

- **Legislative requirements** – Two issues were discussed by the group as barriers to access to dental care: 1) With a few minor exceptions South Dakota law limits the ownership of a dental practice to a practicing dentist; and, 2) dental hygienists and assistants have a limited scope of practice that may prohibit the maximum efficiencies within a dental office. Both laws exist to ensure that the dentist is in charge of the care and management of clinical operations, thus assuring that the highest levels of care is delivered to all patients.

  Community Health Centers have the authority, under a recent exception to the law, to employ a dentist. This model could demonstrate the positive and negative aspects of dental care provided in dental clinics that are not owned by a dentist.

- **CHIP as an extension of Medicaid** - It was questioned why South Dakota tied the State Children’s Health Insurance Program (S-CHIP) with Medicaid. Although the National Governor’s Association has proposed increased federal funding participation for Medicaid and S-CHIP, it does not appear that the proposal will progress.

- **Concerns within the dental profession** – It was acknowledged that any strategies developed regarding oral health issues must take into consideration the concerns of the dentists and auxiliaries providing the care as well as the patients needing the care. Consideration should be made for:
  - The history of legislation and other initiatives that have tried and failed
  - The capacity of the dentists to provide care
  - The need for practice standards to change – expanded roles for hygienists and assistants
  - Small business sustainability
  - The needs of the working poor must be considered
  - Geographical areas where lack of access is driven by sparsity of the population
  - Coordination and collaboration (integration issues could be improved)
  - Education and awareness issues must be addressed in the context of change
  - Financing issues must be addressed to assure the success of the entire service system

- **Restorative and cosmetic dentistry in South Dakota** – There are no statistics, nationally or at the state level, regarding how much dental care delivered fits into these two general categories. According to panel members, South Dakota has very limited cosmetic practice, with an estimate of fewer than 5% of procedures being cosmetic. This could indicate that, because the number of dentists in South Dakota is lower than the national average, less work is done in cosmetic areas and more work is done in restorative procedures.

- **Collaboration between the State and IHS** – The expected addition of a State Oral Health Specialist could enhance collaboration between the South Dakota Department of Health and other state agencies, federal agencies, private insurance companies and public and private practice dentists. Presently, IHS statistics are used by the state to describe the oral health
concerns and emerging issues needing to be addressed. It was acknowledged that this is often lost when it gets to access and service delivery.

- **Attracting new dentists** – Most often, students go to large metropolitan areas, marry and stay there. Even students coming from rural communities are not adequate enough to draw new dentists back to South Dakota. They are looking for quality of life, the ability to retire large amounts of debt, and stable income. Ownership of a practice is a consideration, but may not be the most important consideration at the time the dentist enters the profession. IHS is aggressively going after dentists who are retiring – looking at creative uses of this group of practitioners. There are no financial incentives to bring people to rural areas, which are greatly needed, according to dental association leaders. New graduates don’t want to come into a practice with old, poor equipment, which often happens when practices in rural parts of the state are sold. The National Health Service Corps has a loan repayment program; however, the number of dentists they are able to assist is low, and requirements placed on the practitioners utilizing the program deters some from seeking this option.

As a final large group activity, Michael Felix identified the following key themes, which must be a part of the overall planning structures:

- The cost of doing business – Reimbursement
- “Defining the workforce” – Expanding the scope of practice for hygienists and assistants
- Integrating case management – Assuring efficiencies
- Capacity building – Assuring accesses
- Preceptorship program strategy – Leveraging service while encouraging permanent placement
- Demonstration projects – Seeking resources available for innovative programs
- Delta Dental - Leverage a $2.5 million fund to implement a statewide strategy
- The military as a source – Getting training and resources through military retirees
- Home-grown strategies – Developing strategies from cradle to grave unique to South Dakota
- Dental and hygienist programs – Expanding training options in state and through consortium with other rural states

Based on the outcomes of the large-group facilitation, small groups were formed to address the structure for an action plan for the future.
III. Small Group Facilitated Discussion: Issues and Recommendations for Action

Mr. Felix identified three key areas for small group discussions. These areas included Education and Health Promotion, Best Oral Practices, and Policy and Financing. Each randomly selected group was asked to discuss their area. The outcomes of the three groups were then reported to the large group, along with a request for commitment to continue planning efforts. Following are the outcomes of each small work group:

Education and Health Promotion

Members: Nance Orsbon  Greg Tuttle, DDS
         Audrey Ticknor  Shirley Lund
         Representative Larry Frost  Naomi Ortmeier-Ottnoff
         Representative Phyllis Heineman  Renee Foos
         Donal Scheidel, DDS  Bill Bailey
         Mary O’Meara Metz  Rick LaBrie
         Stephanie Leuthold  Lona Jones
         Mendy Herke  Colleen Winter
         Rhonda Bradberry  Julie Larson

The issues identified by this group include the following (in no prioritized order):

- **Education**
  - Workforce
  - Lack of dental educators
  - Lack of public health education in dental schools
  - More education from more professionals
  - Focus on community education
  - Campaign for getting pop machines out of schools
  - Pre-natal training
  - Insurance companies currently not paying for dental education
  - Diversity of education/training
  - Patient and family
  - Understanding their responsibilities
  - Need for multilingual literature
  - Across the lifespan education
  - Bottled water/drinking systems and fluoride access in general
  - Funding for adult dental care

- **Oral Health Promotion**
  - Effects of nutrition on oral health
  - Oral hygiene
  - Resources to fund oral health promotion
- Lack of current relevant materials or where to attain them
- Comprehensive school health efforts lacking
- Strategies to make oral health promotion “cool”
- Soda studies and understanding of the impact of soda
- Strategies to identify tooth decay as an “infection”
- Interrelationship of oral health and its effect on overall health

The group identified many important resources that South Dakota has in its favor as it works to address the oral health education and promotion:

- County health nurses
- Ability to rally communities for local initiatives
- Telephones
- Current programs that could be replicated in oral health
- School nurses

The group also identified in this exercise the resources that are lacking in the state:

- Community health nurses
- Transportation programs that are operational
- Possible coverage of situations in terms of sharing (i.e., Martin/Pine Ridge)
- Child care health consultant network statewide
- Grants

The advice they would provide to the planning process includes the following strategies:

- Survey public on dental services
- Develop legislation to increase resources to oral health issues
- Establish and/or leverage case management mechanisms to support oral health
- Educate dentists to facilitate change in the “perception” of Medicaid patients
- Expand the practice of assistants and hygienists to provide more services
- Develop mobile/portable clinics
- Track dental-related medical costs as a means of showing savings on the medical side of the Medicaid program
- Assess how models for oral health coordination such as Head Start, child care, and Medicaid could be leveraged for new populations in need
- Build strategies to assure that health screenings in all programs include oral health
- Develop partnerships to promote oral health education and prevention
- Find strategies to ease transition from emergent care to preventative regular care
- Develop dental student rotations in programs such as Head Start, Lutheran Social Services, IHS, etc.
- Provide parent education regarding oral health advocacy for their children
- Develop ongoing funding for oral health education
- Develop strategies to support providers through tuition reduction and forgiveness
- Build education curriculum in oral health and capacity-building for auxiliary dental programs
• Establish web site resources as a communication and information tool for providers in all areas across the state
• Consider legislation to provide funding assistance for dental students, start-up funding resources, and continuing education for providers

Best Oral Health Practices

Members: Kathy Hayes Joy Smolnisky
Nicole Glines Tessia Johnston
Ivy Allard Jill Franken
John McDaniel Marti Pollard
John Zimmer, DDS Cindy Myers
Damian Prunty Sheila Riggs, DDS
Sandi Durick Jim Sutherland, DDS
Ben Jensen, DDS Michael Houk, DDS
Bill Schultz, DDS Allison Simcox
Paul Knecht Amy Reil
Brent Barker, DDS Jane Bruggeman

The first task that the small group undertook was to define “best practices”. The definition included these three key areas:

• **Patient Outcomes** (prevention, early intervention, emergency intervention, and patient perception of service quality and access)
• **State of the Art Practice** (progressive science-based services, services designed to avoid increased risk of future oral health problems)
• **Cost Effectiveness** (care decisions that balance quality, prevention, intervention, and health with cost)

The desired outcomes (not identified in any priority order) were:

• Functional teeth and a pain free mouth
• Accessible dental care for all (prevention)
• Early and frequent culturally-relevant prevention education in oral health
• No disparities in dental outcomes based on ethnicity, income, or rural setting
• Non-traditional providers empowered to carry out work
• Expanded functions for auxiliary staff
• Non-refusal of medically necessary emergency services
• Incentives for dental providers to treat Medicaid patients

The group identified many important **resources** that South Dakota has in its favor as it works to address the oral health concerns and emerging issues of our people. These important benefits, which can be leveraged, include:

• Access to federal grants (Tom Daschle as an advocate in Washington)
• Diverse collaboration at the table and willingness to work together (local leadership, dental association, USD, rural health)
• Maternal and child health structures in place within the state
• Good quality of life already in the state
• Proximity to four dental schools
• Already planned dental school outreach clinic in Watertown (good model)
• WIC doing more prevention education and providing information
• Number of dentists who are signed up to accept Medicaid
• Presence of Medicaid and CHIP making more children eligible for coverage
• Community health services expanding to meet critical shortage needs
• Presence of a referral center
• Retired dentists in the state who would be willing to help
• Federal community health model in the state that could be expanded/replicated
• University dental hygiene outreach programs in place as a model
• Tobacco settlement funding for dental education and prevention services
• Options to coordinate with schools, elderly programs, Bright Start, child care and others

The advice this group would give to oral health and public policy leaders in the state included the following items (in no particular order), with the exception of the first item:

• Expand emergency safety net
• Pursue grant funding for innovative programs (e.g. mobile dental units)
• Change laws to better utilize auxiliaries and expand training and education
• Build strong workforce development initiatives
• Develop communication strategy with the Department of Health to maximize the benefit of the new staff position being structured to address this issue
• Build a strong collaborative public education component
• Increase motivation for Medicaid patients to keep appointments and demonstrate responsibility for ongoing oral health care
• Increase providers in the state through expanded residency placement, outreach dental school clinics, and other workforce development initiatives
• Create an exception to dentist-owned state requirement for safety-net dental services

Policy and Financing

Members: Ann Brunick, RDH
         John Ahlechwede, DDS
         Steve Stunes
         Rhonda Eidet
         Dee Raisl
         Secretary Jim Ellenbecker
         Stacie Roddis
         Jim Byrne, DDS
         Bernie Osberg
         Bernie Schuurmans, DDS
         Barb Holzworth
         Larry Iversen
         Chris Jesch
         David Quissell, DDS
         Jonell Bly, RDH
         July Brooks
         Ranee Dosch
         Wanona Goetz
         Pat Martinmaas
         Steve Buechler, DDS
         Scott Jones
         Kodi Kannan, DDS
Mel Thaler, DDS   Judy Buseman

The issues identified by this group include the following, in no prioritized order:

- Define the workforce and seek specific information regarding:
  - Distribution
  - Geography
  - Specialty
  - Licensure
- Reimbursements (incentive reimbursements for providing care; independent reimbursement for dental hygienist care)
- We can’t just focus on treatment – we must address total wellness, including oral health
- We must leverage other health care providers who can be delegated to provide oral health prevention, monitoring, and education, including:
  - School nurses
  - Head Start – Early Head Start
  - Community health center personal
  - Doctors
  - WIC
  - Community health nurses/educators
- Apply science to education – better use of science in developing strategies and outcome
- Need to educate legislators on the issues

The group identified many important resources that South Dakota has in its favor as it works to address the public policy issues related to oral health concerns and emerging issues of our people. These important resources, that can be leveraged, include:

- Nebraska “no-show” policy that could act as a model for the state
- ABCD Program operational in Washington and South Dakota
- Case management systems in place in numerous programs
  - Head Start
  - Community Health
  - Mental Health
  - Social Services
  - Hospitals
  - Home Health
  - Parishes
  - Turning Point
  - Lutheran Social Services
  - Missions and shelters
- School nurses
- Federal and State government commitment
- South Dakota Health Department coordination efforts
- Hygienists/assistance groups and training
- Community transportation models
- Faith County Transport
- Non-profits
- Volunteer operated programs
- Church operated programs

- Mobile oral health van as a model
- Tobacco settlement money (available for education)
- Cement Plant Fund (available to the General Fund)
- Inter-governmental Transfer (IGT) (available for health care)
- Colorado models for capacity building grants
- Preceptorship programs
- Strong Congressional Delegation
- Federal grant resources accessible
- WellMark Foundation
- Delta Dental Philanthropic Fund

The advice this group would give includes:

- Create cost projections for a South Dakota initiative
- Survey current providers
- Analyze population trends
- Establish clear goals and a work plan for oral health development
  - Workforce development goals, strategies, tactics
- Maintain focus on prevention
- Develop local case management approaches as models for access
- Consider use of trust funds for loan repayment and tuition reduction
- Develop a coordination plan among all the partners
- Develop a consumer education strategy statewide
- Develop incentives for patient compliance
- Develop home-grown strategies
  - Dental school visits for interested South Dakota students
  - Purchase slots in dental schools
  - Create preceptorships
  - Expand hygienist and dental assistant role
- Identify stakeholders who are not a part of this initial planning process – get them involved
- Create an oral health coalition
  - Delta Dental
  - Dental Association
  - Community health centers
  - State Health Department
  - IHS
- Identify who is not at the table and seek their involvement
  - Hospital Association legislative committees
  - Medical Society
  - Long-term care associations
  - Consumers
IV. Next Steps

The consensus among all groups was a need for additional planning, bringing together constituency groups toward the development of a strategic plan for South Dakota. The key themes to be addressed should include the need for more precise information, the importance of comprehensive planning, strategy and timeline development, and the need to look for models that are working in rural states across the country that could be replicated to meet the unique needs of the state. These common themes are described and were further defined as follows:

- **Gather more precise information on the status of oral health resources.**
  - Dental providers must be surveyed to determine their views on service and reaction to possible changes in service approaches and practice in the state
  - Models from other rural states must be gathered and analyzed for their replication value within the state
  - Population trends must be studied to determine geographic changes in the need for services and resources
  - Costs must be analyzed to determine budgetary impact of possible strategies that might be implemented as part of the master plan for the state

- **Bring together an oral health coalition to create a strategic plan for the state.**
  - Build on the important leadership of the South Dakota Dental Association as a partner in the coalition effort
  - Assure that constituencies not yet at the table are invited and encouraged to participate at all levels of planning
  - Build a strategic plan that includes clear goals, strategies, timelines and assignments of responsibility for partners and includes all elements of the process:
    - Workforce development, expansion, and continuing education
    - Meaningful collaboration of State and Federal tribal directed resources in all areas of prevention and service
    - Consumer education
    - Public awareness and education
    - Legislative action for funding and practice authority

- **Seek models that work from other rural states for consideration to meet South Dakota’s needs.**
  - Seek out additional information on models from across the country making these models available to planning participants for assessment and recommendation
V. Keynote Presentations Summary –
The State of the Issue in South Dakota

State, national, Indian Health Service (IHS), and local leaders presented the state of oral health issues in South Dakota, providing a framework for discussion and planning.

Accessing to Dental Care – A Payer’s Perspective – (See Appendix D for detailed charts of this presentation) Scott Jones, President and CEO of Delta Dental of South Dakota, provided a perspective on the status of payer systems in the state. He indicated that prior to 1954 there was no dental insurance anywhere in the country. The first dental insurance benefit was developed as part of employee collective bargaining and was primarily targeted at preventive services for children. This resource substantially changed the behavior of users toward much higher utilization of preventive services.

Mr. Jones indicated that having insurance is the single largest determining factor for people going to the dentist. With the growth of insurance coverage, dental care utilization has increased for all age groups. There continues to be a strong emphasis on the importance of preventive and early intervention care. In all age categories, approximately 20% more people who were insured had a dental visit in the past year than those who were uninsured. The demographic information on patient utilization indicates that the largest users of dental care are adolescents 12 to 17 years of age with over 80% of insured individuals and 60% of uninsured youth seeking care. In contrasting care utilization over time, the percentage of persons seeking dental care has risen from an average of 52% in 1980 to 66% in 1998 (the latest year that statistics have been compiled).

There have also been significant changes in the types of treatment provided to patients over the past 20 years. For example, typical 19 to 24 year-old patients in 1980 averaged 2.2 restorations, while in 1995 restorations per user dropped to .9 per user. Simple extractions for this same age group averaged .23 per user in 1980, dropping to less than .1 per user by 1995. Endodontic procedures and cast crowns have seen very similar drops in utilization over this time frame. However, for older users from age 35 to 65, endodontic and cast crown procedures have stayed the same or gone up, as more patients are opting to save teeth as an alternative to extraction. This is borne out in the data on full denture fittings, which have gone down dramatically in the past 20 years for persons older than age 35.

The pressures in the industry are coming from higher expectations, fewer missing teeth, growing utilization rates among all age groups, and the impact of baby boomers needing more comprehensive care to save their teeth. This, added with a declining dentist-to-population ratio and other factors, have led us to a shortage in practitioners today and projected shortages into the future.

Mr. Jones went on to describe the status of oral health care access for those individuals served under Medicaid. The data indicates that South Dakota has a high number of dentists registered to deliver services for patients covered by Medicaid (over double of all other areas of the country). These practitioners delivered over 46,000 visits in fiscal year 2001 and are projected
to deliver almost 50,000 service visits in fiscal year 2002. The fastest growing is children, making up 29,886 of the total of 46,000 visits in fiscal year 2001.

Although 82% of the dentists in the state are Medicaid providers, 5% of those dentists delivered almost half of the care to this population, and 25% delivered 80% of the dental care. The disparity is even more apparent in services for children using Medicaid where half of dentists delivered 95% of the care.

Nationally, the top reasons given by dentists for not treating Medicaid patients are low reimbursement rates, too much paperwork, delays in getting reimbursement, patient behavior of missing appointments, not taking dental care seriously, demonstrating disruptive behavior, and dentists’ lack of training to meet the unique needs of varied Medicaid populations.

Delta Dental Plan of South Dakota is working to encourage increased access for Medicaid patients through a variety of strategies:
- increased fees for certain services for both children and adults in 2000 and 2001
- significant improvements in administrative paperwork
- training programs in serving individuals with developmental disabilities
- provided continuing education vouchers for dentists seeing a large number of Medicaid/CHIP patients.
- staff gift boxes and appreciation dinners for high volume providers
- a referral center and language line translation services paid for by Delta Dental Philanthropic Fund
- assist and support both patients and providers
- coordinate the Donated Dental Services Program
- implement the ABCD (Access to Baby and Child Dentistry) Program in July, 2002 to further promote access to care.

Mr. Jones provided a listing of important things to do to increase access to dental care services for Medicaid families. He recommended that South Dakota seek to increase the dental workforce, increase reimbursement for direct services, provide other incentives for dentists to serve Medicaid patients, consider patient education and case management initiatives, expand safety net services systems, and increase preventive efforts.

**South Dakota Dental Workforce** (See Appendix D for detailed charts of this presentation) Paul Knecht, Executive Director, South Dakota Dental Association, provided a description of the current dental workforce in South Dakota. According to the Association, there are 320 dentists and specialists working in South Dakota. This provides a ratio of one provider to every 2,406 South Dakotans, compared to the national average of dentists to population as one provider for every 1,812 individuals. Seventy percent of dentists work in solo practice. Six to eight retirements occur annually in the state, replaced with an equal number of new providers. There are expected to be twice the number of retirees than graduates each year in South Dakota, beginning in approximately 10 years and lasting for another 10 years, dropping the total dentist pool in South Dakota to 250 within the next 15 to 20 years. An important shift is occurring as new providers generally come into more urban areas, leaving more rural areas of the state even more sparsely covered. A significantly large number of dentists are between the ages of 45 and 54,
closely tracking with a spike in enrollment in dental schools in the 1970s. Enrollment dropped off dramatically in the 1980s after the elimination of programs to entice dentists to rural areas of the state.

A typical student coming out of dental school has school loans of $127,000, compared with $91,000 less than ten years ago.

The South Dakota Dental Association is working on several initiatives:

- recruitment of South Dakota students into dental school
- recruitment efforts to get dental students to practice in the state
- development of a placement service for dentists interested in locating in South Dakota
- partnering with universities to provide dental training to give dental students opportunities to experience South Dakota’s work
- scholarships for dental students
- development of loan forgiveness options for practicing in the state

These efforts, coupled with greater emphasis on prevention, actively work toward funding for Medicaid reimbursement and encouraging greater efficiencies in practice, are directed at the overall goal for the association to assure a dental home for all South Dakotans.

**Dental Hygiene Workforce in South Dakota** – *(See Appendix D for detailed charts of this presentation)*  Ann Brunick, RDH, representing the University of South Dakota Hygiene Program and South Dakota Dental Hygienists’ Association, provided the perspective of licensed preventive oral healthcare professionals. She indicated that the Dental Practice Act 36-6A-40 regulates the work of dental hygienists within the state, allowing them to provide primarily preventive and therapeutic services under the general supervision of a dentist and treat only patients who are patients-of-record of a licensed dentist. Under supervision, these professionals may administer local anesthetics and nitrous oxide/oxygen sedation.

There are 331 licensed dental hygienists currently in the state, with almost half working in Sioux Falls or Rapid City. Vast areas of western South Dakota have no practicing hygienist. The majority of hygienists work in private practice settings. In addition, hygienists are employed by the IHS, South Dakota Department of Corrections, and those involved in training personnel at the University of South Dakota. A survey completed in 1999 and updated in 2001 indicates that there is a maldistribution of hygienists in the state, with some areas demonstrating more pressing need for personnel. There are fewer job opportunities than perceived, and most positions open are for part time versus full time positions.

Seventy-two percent of all hygienists in the state are graduates of the state’s only hygienist training program located at USD. Approximately 30 students graduate from this program annually.

The USD Hygienist Program actively promotes the profession through recruitment in schools across the state. Dentists in South Dakota support this effort by allowing job shadowing and other observation to meet admission requirements. In addition, the USD program provides materials for
all dental offices in the state and has actively targeted promotion initiatives to recruit American Indian students.

The outreach activity of the hygienist’s program at USD actively promotes working with traditionally underserved populations. Agreements with Head Start allow between 50 and 100 children to receive dental hygiene services and examinations. Collaborative efforts with Early Head Start will increase this number and address the training and service needs for very young patients. Students receive rotation at the Sioux River Valley Community Health Center to better understand the needs of lower income patients. The state’s prison system also offers training and service sites for program students. Adjustment training centers and the state’s developmental center offer experience with developmentally disabled populations. The USD program staff provide elementary and middle school classroom student presentations, and tours of day care centers and preschools are completed to give students expanded knowledge of early dental needs. Special initiatives are underway to offer students training experiences on Native American reservations as well.

In addition to children’s outreach, outreach to elderly populations are also targeted as training and service activities. Weekly visits to area nursing homes provide assistance and staff in-service. Under agreement with Sioux Valley Hospital, hygiene services are offered as part of the Geriatric Health Institute, and oral health assessments are offered at nursing homes in Sioux Falls and Dell Rapids.

Regulatory constraints are the single largest barrier to getting hygienist services to individuals most in need. Dental hygienists are not recognized as “providers” within the reimbursement system, making it unrealistic for them to provide services within group settings. The Dental Hygiene Association has supported regulatory changes and continues to work toward prevention solutions including fluoride education, water fluoride testing, and oral health seminars.

**Dental Care Providers’ Perspectives** – Dr. Mel Thaler, Pediatric Dentistry, and Dr. Ben Jensen, General Dentistry, provided perspectives of full time practicing dentists. Dr. Thaler is involved in a large pediatric practice in Sioux Falls. Dr. Jensen provides general dentistry in a practice in Yankton, SD.

Dr. Jensen pointed out that the total number of dentists in the state is small. With reimbursement levels for Medicaid covered care being so low that dentists must make an economic decision and often choose to fill their appointments with patients who are more compliant with appointments and who, generally, demonstrate a higher commitment to oral health maintenance. He indicated that the solutions offered in planning must: 1) have immediate impact to address the overwhelming burden on current providers who have more patients than they can now successfully serve; 2) a system which must improve the access to care for all individuals in all areas of the state; and, 3) the solutions must assure equity for dental service providers.

Dr. Jensen indicated that the laws of the state act to exaggerate the problem of access. He offered Colorado’s laws as a possible solution to the overburden of providers. Their laws allow for mid-level practitioners to do more procedures. These open practice options could address
some of the backlog now faced in dental practice. He was clear in pointing out that the dentist maintains overall supervision and oversight of work performed by mid-level providers.

In conclusion, Dr. Jensen reiterated that the need for changes in Medicaid reimbursement must be included in the mix of solutions offered to address the emerging crisis.

Dr. Mel Thaler indicated that his clinic is the largest provider of Medicaid services in South Dakota. He believes that South Dakota is only one provider away from a catastrophe in the state and that solutions must be addressed immediately to address the problems of access to care. He offered examples of the over 6,000 Medicaid eligible children that his practice saw last year. They have built in significant efficiencies but still have a 61 to 62% overhead in their practice, meaning that they lost money on every Medicaid patient’s services.

Dr. Thaler was complimentary of the Medicaid system set up in the state, with prompt reimbursement and no second-guessing on the type and quality of care decisions he makes. His concerns include: the no-show rate, which cost his office $368,000 in empty chair time, burnout of staff and drastic wait times for all of his patients.

The national initiative regarding oral health care, according to Dr. Thaler, is actually hurting the efforts for South Dakota. Dentists don’t want to come to South Dakota unless they are from the state, and, because dental schools are becoming harder to access by South Dakota students, fewer dentists are coming to replace the aging dentists in the state. Dr. Thaler offered that one goal to address the immediate problem and lessen the impact on planning solutions is for all dentists to take at least some Medicaid patients instead of a small minority of practitioners taking large numbers of these patients.

Under-Served Children — Joy Smolnisky, South Dakota Coalition for Children, provided a perspective on the oral health status of children in poverty. She stated that low-income children have more tooth decay, see a dentist less frequently, and are at higher risk of compromised health as a result of poor oral health care access. She further indicated that low-income families suffer significant bias when they attempt to access dental health services.

Nationally, 63% of all children see a dentist at least annually. For children who are in the CHIP program, 25% have seen a dentist only once in the past three years. Understanding that low-income children have more tooth decay, significant oral health issues are going untreated. She indicated that, in South Dakota, American Indian children residing on reservations are even more at risk with access numbers far lower than non-reservation children in the CHIP program.

School nurses are on the front line of seeing the effects of untreated dental issues. Nationally kids miss 51 million days of school because of dental pain. School districts have stopped doing dental screenings because they find that children identified as in need of dental care are not getting to the dentist after parents are alerted to the need. When parents are asked, they indicate that even with cash they can’t get their CHIP kids into dentists.
Families who are considering CHIP often believe that the dental access barriers go to all services. According to Smolnisky, parents often will reject making application for CHIP, believing that the program will not benefit in access to dental or medical benefits. The bias in treatment of families receiving CHIP often discourages them from seeing the program as a benefit for their children. Many families report as well that denial of services once they are on CHIP is a rejection of their children—a rejection they are not willing to see their children face.

Transportation is a critical issue for families in the CHIP program. Many families report that the lack of transportation is often the reason they are noncompliant in getting to scheduled appointments. Smolnisky described that families, when confronted on the no-show compliance issue, are willing to be educated to strategies in order to take more responsibility for care.

**Public Health Perspective** – *(See Appendix D for detailed charts of the IHS presentation)*

Dr. Bill Bailey, IHS, and Dr. Bill Schultz, Sioux River Valley Community Health Center, offered a perspective of public health and its efforts to address oral health issues.

Dr. Bailey heads the Aberdeen Area Indian Dental Health Program, which is responsible for serving the needs of 110,000 American Indians in North Dakota, South Dakota, Nebraska and Iowa. In South Dakota the IHS has 11 clinics, with 30 dentists serving the needs of American Indians.

According to the national oral health survey, 15% of children between the ages of two and five experience tooth decay. In the Aberdeen Area IHS, statistics indicate that 78% of children have tooth decay and 68% of these children go untreated for their tooth disease. One factor in the sharp rise in oral health problems among American Indians is the loss of fluoridation in drinking water on the reservations.

The lack of providers is also a continuing problem in reservation communities. Vacancy rates in dentists are 29% in the Aberdeen Area today, with little progress expected toward addressing the gap in provider resources. The loss of dental public health infrastructure at the federal level has much to do with this gap in personnel, according to Dr. Bailey.

The IHS is focusing on several key initiatives to attempt to address this growing health concern:

- Hired a full time coordinator to carry out a “Paint to Prevent” program. This program will target young children getting teeth sealed to prevent decay.
- A full time Water Fluoridation Coordinator has been secured to attempt to regain compliance with fluoridation recommendations. His target will be the top 13 of the 57 different water systems serving reservations. These top 13 systems serve over 70% of the people and will make great strides toward their goal of full compliance. Use of new water testing technologies that allow remote site monitoring will also assist to remedy this problem.
- Targeting dental schools with a program to offer financial incentives to dentists coming to the IHS system. A $20,000 annual loan forgiveness program is hoped to have a significant impact in filling the 90 current dentist vacancies nationwide and 14 vacancies in the
Aberdeen Area IHS. They are also seeking to offer a fourth year dental school in South Dakota as an option for dentists to serve while they finish their learning.

Dr. Bailey indicated that the development of a “Physician Assistant” for dental care is a strategy that should be considered. It is his belief that this approach would significantly expand the ability of dentists to meet the needs of patients. He also stated that recruitment and retention of providers must be a part of the strategies to get oral health care access across rural communities. Many providers leave the community because of poor quality of life and poor schools for their children. The overall quality of life must be considered as strategies are put in place.

Dr. Bill Schultz provided a perspective of public health issues related to his work as a dental provider for the Sioux River Valley Community Health Center in Sioux Falls. Sioux River Valley Community Health Center is the only South Dakota community health center site to offer dental care services. Dr. Schultz indicated that 75% of his practice is adults and 25% is children. His entire practice is emergency care. He addresses his no-show rate, which is relatively high, with walk-ins who are seeking emergency care.

Dr. Schultz said that there is a desperate need to increase the number of providers directing their care at low-income patients. In addition, he recommended the expanded utilization of dental assistants to expand the capacity of dentists in delivery of care. He also recommended that there must be a strong emphasis on informing the public of the public health problem of poor oral health care access. The development of a national rural health plan that includes oral health care as a key component would move this effort forward in a positive way to get care to the people who have the greatest need.

South Dakota Department of Health Update – Colleen Winter represented the South Dakota Department of Health providing an update on the state’s efforts to address oral health care needs. Ms. Winter related information regarding a new position within the Department of Health whose job will be to look at oral health and be a liaison with oral health partners in South Dakota to address current and emerging needs. The staff person for this position has not yet been named.

Ms. Winter indicated that the addition of this staff position would allow the Department to carry out more efforts in education of the public and key constituencies on the oral health needs of the state, and work with a multi-state task force currently forming with a goal to address the needs of underserved populations in the region.

Ms. Winter also relayed the efforts of the Department of Health to utilize the Women, Infant and Children (WIC) Program as a focal point for oral health education and early intervention. There are WIC clinics using oral hygiene students from the University of South Dakota to carry out oral health screenings. It is hoped that this could be expanded, along with fixed clinical opportunities for dentists, to carry out clinical activities in concert with WIC program activities.

The National Perspective – (See Appendix D for detailed charts of this presentation) Dr. James Sutherland, Denver Field Office Regional Dental Consultant for Health Resources and Services Administration, and Dee Raisl, Maternal and Child Health Coordinator for the Centers
for Medicare and Medicaid Services, provided a perspective of the national issues relating to oral health care.

Dr. Sutherland described the efforts of the policy leaders to identify the oral health issues affecting the nation. He recommended that all participants seek out the report of this first meeting, “Building Partnerships to Improve Children’s Access to Medicaid Oral Health Services,” which is available at http://www.mchoralhealth.org/PDFs/Ohproceedings.pdf. This report describes very clear failures in the area of oral health care nationwide. The reality is that only one in five children is getting routine oral health care. About 1% of all Medicaid expenditures in states are for dental care. The linkage of poor oral health care to overall health status is compelling and should drive the system toward development of clear oral health prevention and early intervention strategies, according to Dr. Sutherland. This concern is further spelled out in the Oral Health in America: A Report of the Surgeon General released in May 2000, http://www.nidcr.nih.gov/news/052500.htm, which defines the impact of poor oral health on general health.

Dr. Sutherland described an emerging crisis in the decline of the dentistry’s workforce, which must be addressed if oral health care problems are to be lessened. According to national projections, the nation will lose between 250 and 1,800 dentists per year more than dental schools can produce between 2014 and 2031. Five dental schools have closed in recent years and many more have reduced their enrollment size, further stressing the oral health care system.

It was described by Dr. Sutherland that tooth decay disease is observed disproportionately with populations of poverty. Much work has begun at the national and regional level through a variety of workgroups and to develop the “best practice programs” designed to address this issue. But, he stressed, there cannot be enough emphasis placed on educating the public on the connection of oral health problems and general health status. If the country does not address these issues, there will be increased health care costs in the long run.

Dee Raisl provided a perspective on the roles Medicaid and the Regional Office Oral Health Team (ROCT) play. At the federal level, there is a requirement that all expansions of community health centers nationwide must have a dental plan as part of their service delivery model. Medicaid programs were encouraged to develop a plan for improving access to oral health services to 50%. The ROCT works through staff in CMS and HRSA to monitor these activities.

There are two noteworthy demonstrations funded by the federal government, which may have an impact on how Federal policy addresses oral health issues. A California model program will significantly expand children’s services and services for pregnant women, with children under the age of three. The North Carolina program trains physicians to carry out dental screenings and provide fluoride applications. These, and the regional forum on oral health practices within Head Start, are seeking to target young children as a starting point for changed oral health emphasis as a part of overall health care resources. Oral health care summits and policy academies in North Dakota, Montana, Colorado, Utah, and Wyoming in Region VIII have also developed strategies to address oral health issues. These activities have prompted legislative actions, changes in coding approval requirements for Medicaid, and a linkage of dental application to the Medicaid application in at least one state.
Appendix B

Meeting Agenda
Appendix C

Listing of Summit Attendees
Appendix A

Listing of Planning Committee Members
Appendix D

Presentation Slides

- Access to Dental Care – A Payer’s Perspective – Scott Jones
- South Dakota Workforce – Paul Knecht
- Dental Hygiene Workforce – Ann Brunick
- Overview of Aberdeen Area IHS Dental Program – Dr. Bill Bailey
- National/Regional Perspective – Dr. Jim Sutherland

Presentation Handouts

- South Dakota Oral Health Issues Background
Appendix E

South Dakota Oral Health Care
A Fact Sheet