

The Minnesota Oral Health Care Solutions Project: Implications for People With Special Needs

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Abstract

Disparities in oral health status and access to dental care are major problems for people with special needs in Minnesota and across the country. The current delivery system for people with special needs is failing. Patients, community leaders, private dentists, safety net clinics, and state agencies are frustrated with the Medicaid program that funds the current system; and everyone is looking for new solutions. What would an improved oral health care system and Medicaid model look like? This paper describes Minnesota's Oral Health Care Solutions Project that seeks to answer this question and highlights the implications of a new model for people with special needs.

The low reimbursements and administrative burdens of Minnesota's Medicaid program have led many dentists to reduce or stop seeing public program patients. As a result, many people with special needs have been unable to obtain routine dental care and therefore seek treatment in emergency rooms.

To facilitate the design of a new oral health care system model to serve public program patients, including people with special needs, Minnesota's Department of Human Services awarded a planning grant, the "Oral Health Care Solutions Project," to Apple Tree Dental, a private nonprofit organization. Apple Tree facilitated the design of a new model in collaboration with more than 50 partnering organizations and individuals who had been working together for many years (Table 1). During a year-long collaborative design process, the planning partners set out to design a new model for an oral health care system, and then create a business plan for a two-year pilot project to implement the new model.

The Oral Health Care Solutions Project's planning partners received help from several national experts and developed a new oral health care system model featuring patient-centered, evidence-based strategies designed to expand access and enhance the delivery of oral health care services to people of all ages enrolled in Minnesota's health care programs, which include its medical assistance (Medicaid), Minnesota-Care, and general assistance programs.

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Table 1**Oral Health Care Solutions Project – Planning Partners List****Professional Organizations**

- Minnesota Dental Association
- Minnesota Dental Hygienists' Association
- Minnesota Dental Assistants Association
- Minnesota Association for Community Dentistry
- Minnesota Primary Care Association

Community Clinics and Safety Net Providers

- Apple Tree Dental
- Children's Dental Services
- Community University Health Care Center
- Family Health Care Center
- Peterson and Peterson Family Dental
- Red River Valley Dental Access Project
- West Side Community Health Services

Educational Programs

- Century College
- Lake Superior Community College
- Mankato State University
- Minneapolis Community and Technical College
- Normandale Community College
- University of Minnesota, Department of Pediatrics
- University of Minnesota, School of Dentistry

Head Start and Community Action Programs

- Minnesota Head Start Association
- Community Action, Duluth
- Mahube Community Action, Detroit Lakes
- Ramsey Action Programs Head Start
- Western Community Action Head Start

Health Plans

- Healthpartners
- PrimeWest Health System

Advocacy and Local Public Health

- Carver County
- Dakota County
- Legal Services Advocacy Project
- Minneapolis Department of Health and Family Support
- Minnesota Disability Law Center
- Oral Health America Foundation
- Region Nine Development Commission
- Renville County

State Agencies

- Minnesota Department of Human Services
- Minnesota Department of Health
- Minnesota Board of Dentistry
- Minnesota Center for Rural Health, Rural Health Resource Center

Others

- Cincinnatus
- MAP for Nonprofits
- Project Management Institute
- OMNII Oral Pharmaceuticals
- Mount Olivet Rolling Acres

And numerous additional local individuals and national experts.

Designing a New Oral Health Care System Model

Apple Tree Dental's role during the project was to help bring out the best in each of the partners and help them design a new system that would work well for Minnesota's health care program recipients, including those with special needs. Rather than asking the group "How can we improve access to dental care?" the group was asked "How can we create an effective new oral health care system tailored to the diverse needs of public program patients?" By posing the design challenge this way, the emphasis was shifted from a focus on "access to dental care" to a new focus on designing a new "oral health care system." It was agreed that the goal was to improve oral health outcomes by providing targeted education, prevention, early detection and treatment and that "increasing access to dental care" was a key part, but not the only goal.

Why Is This Project Important for People With Special Needs?

The current dental care delivery system simply wasn't designed to meet the needs of disabled children, adults with disabilities or the frail elderly who face a host of well-documented barriers to obtaining care in traditional settings.¹ Current health insurance programs and their underlying financial models were designed based on the service utilization patterns of commercial populations that are able to access dental care in traditional settings. Dental treatment codes used for insurance billing have evolved to describe the services provided to patients successful in obtaining dental care in traditional settings. The utilization patterns and costs associated with these patients are the basis for financial models sometimes applied to the problems facing public program patients and people with special needs. Unfortunately, people with special needs and a large number of other

public program patients are only rarely able to access the traditional delivery system, and when they do, the services offered often fail to include the unique services they need to achieve optimal oral health. The Oral Health Care Solutions Project set out to design an oral health care system with a new delivery system and a new financial model designed to provide appropriate and necessary services for people with special access needs.

About Minnesota's Dental Access Problems

Less than a third of people covered by Minnesota's public programs are able to access even a single dental appointment each year.² With about 600,000 public program enrollees in the state, that means more than 400,000 people are not accessing dental services despite having a dental care "benefit." Ironically, this same group of people has the highest rate of dental diseases in the state, the greatest need for dental care, and the least access to it. Only about one-third of the dentists in Minnesota provide more than \$10,000 in dental care services to public program patients annually and one-fourth provide no services at all.² Why? The No. 1 reason, according to a recent survey of Minnesota's dentists, is that payments for their services average less than 50 percent of billed charges, while the amount dentists pay for their staff, supplies and other expenses range from 60 to 70 percent of billed charges.³ A typical dentist providing \$100 of billed services actually pays about \$10 to \$20 on behalf of each public program patient they treat while also donating their own professional services. As a result of the lack of available dental appointments, the majority of patient complaints about the inability to access any type of health care service at the state's ombudsman office involve dental access, even though dental care is less than 2 percent of the health care budget.³

What's a Medicaid Agency to Do?

To gain broad-based input from a variety of stakeholders, Minnesota's Department of Human Services impaneled a dental access advisory committee in December 1999.⁴ The committee studied the state's dental access problems, leading to the preparation of several dental access reports with recommendations to the Legislature.² The dental access advisory committee identified leading strategies and practices locally, nationally and internationally, and over the years, recommended multiple comprehensive strategies to improve access to care. The Department of Human Services and the Legislature made incremental changes over the next few years.

To increase the participation of dentists in the program, the Dental Practices Act was changed to make it easier for foreign dentists and those who had completed general practice residencies to obtain dental licenses.⁵ A new student loan repayment program was designed to reward dental students who agreed to serve public program patients.⁶ Funding was appropriated to establish a donated dental services program, and targeted higher reimbursements for "critical access dental providers" was established to help stabilize the state's struggling dental safety net.^{7,8}

To help make oral health education, prevention, and screening services more widely available, changes were made to the Dental Practices Act, which permitted dentists to engage in "collaborative agreements" with dental hygienists.⁹ By working together to establish on-site oral health programs in schools, Head Start centers, nursing homes and other sites, the roles of both dentists and hygienists were expanded to permit them to function like physicians and nurses outside their offices in community settings. Dentists are now able to authorize hygienists to educate, provide

prevention services, and screen patients without the old requirements that the dentist see the patient first or be present on site. Collaborating dentists and hygienists can now work together to identify patients needing care, assess risk factors, and to triage prompt follow-up care.

Unfortunately, these incremental changes within the current failing Medicaid system have not been enough to reverse the downward spiral of access to dental care. In December 2002, the assistant commissioner of the Department of Human Services stated in a presentation that the system was broken. In early 2003, the department held several informal meetings with key stakeholders and decided to issue a planning grant for the design and pilot testing of a new model based on the strategies recommended by the dental access advisory committee.

"Everything Is on the Table"

The Department of Human Services announced in its request for proposals that it would consider alternatives to:¹⁰

- How they purchase dental care,
- From whom they purchase it,
- What services are purchased and how they are delivered; and
- How they pay dentists and other providers.

In addition, the department stated that it was willing to:

- Change internal administrative strategies and policies;
- Seek necessary federal Medicaid waivers; and
- Seek necessary statutory or regulatory changes.

With this open invitation for a creative design process, the Oral Health Care Solutions Project was launched in January 2004. The project's goals were to prepare a business plan for a pilot project, and secure commitments from local partners who were ready, willing, and able to carry it out.

How Was the New System Designed?

Apple Tree established a management group to manage the project within the requirements established by the department. The management team was led by a project executive and project coordinator with expertise in community oral health and included professional facilitators from Cincinnatus, project managers from the Project Management Institute, and a business planning expert from MAP for Nonprofits. A contract admin-

istrator from the Department of Human Services worked very closely with the management group and the governance committee throughout the entire project, and played an invaluable role.

The sequence of steps used in the Oral Health Care Solutions Project included:

- Recruiting key stakeholders as design partners (see partners list);
- Establishing a governance committee and project ground rules;
- Retreat No. 1: Consensus on the project's design goals;

■ Retreat No. 2: Consensus on the oral health care system design framework;

■ Meetings of design teams, with leaders and project managers;

■ Designing synthesis and consensus on the new oral health care system model;

■ Drafting and approval of the business plan for a pilot project;

■ Recruiting ready, willing and able pilot project partners; and

■ Submitting the business plan to the Department of Human Services.

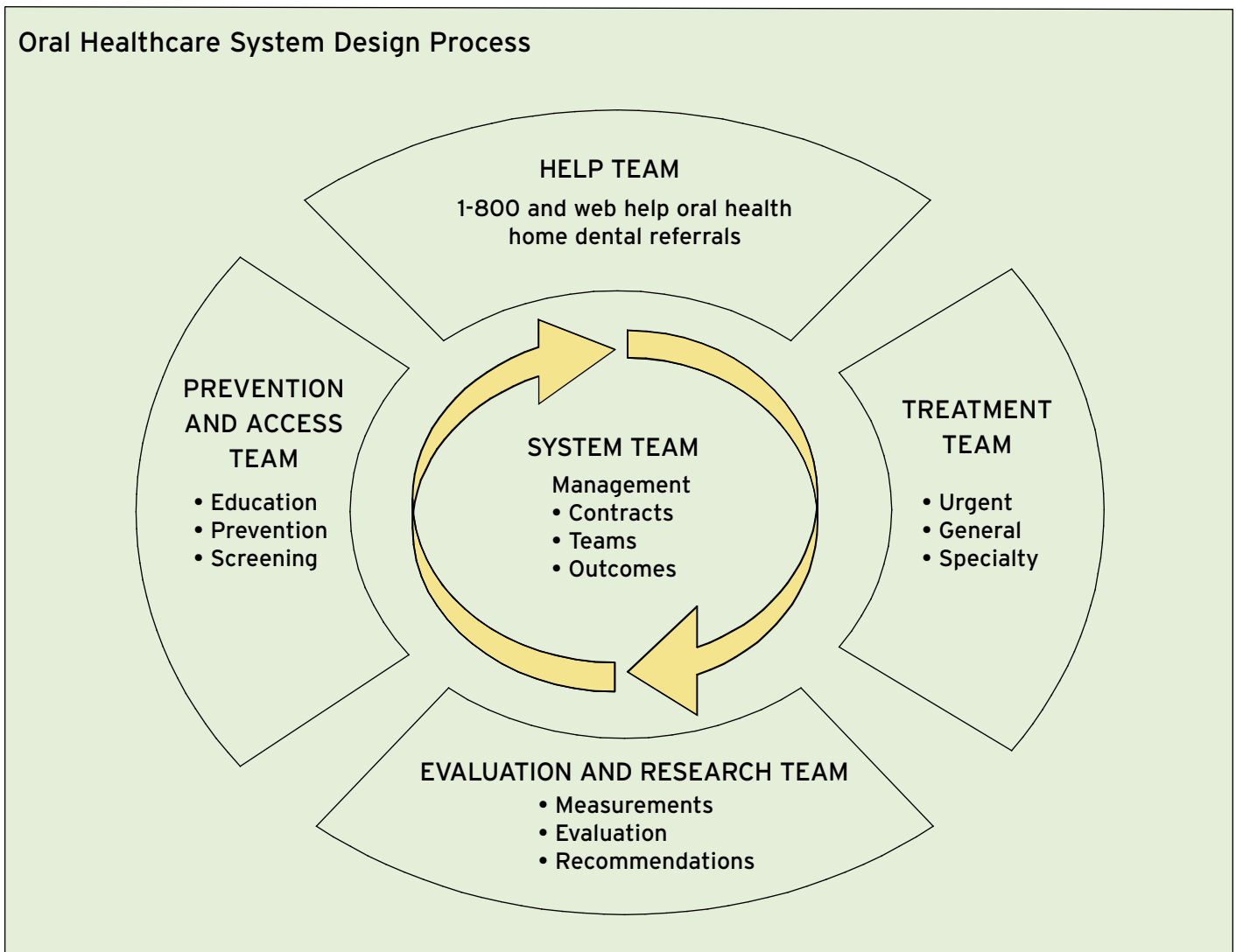


Figure 1. The oral health care system's design process.

What Should the New Oral Health Care System Provide?

The governance committee, which included key stakeholders and functioned like a board of directors for the project, determined the broad goals and vision for the project. The project's partners agreed that the new oral health care system should provide:

- The earliest possible education, prevention, screening, diagnosis, and treatment;

- New or expanded points of entry in community-based settings;

- Expanded community health roles for allied health professionals and dentists;

- A "Respectful Referral" system that matches patients with dentists;

- Evidence-based care that leads to better outcomes and accountability; and

- Flexibility to adapt to changes in workforce, technologies, and resources.

Oral Health Care System Design Teams

Four design teams were established to design the functional elements of the new model. A fifth team, called the "system team" was established to manage the other teams and to design the central management functions for the pilot project (Figure 1).

The "prevention and access team" designed new ways to provide expanded access to education, prevention and screening services at community sites

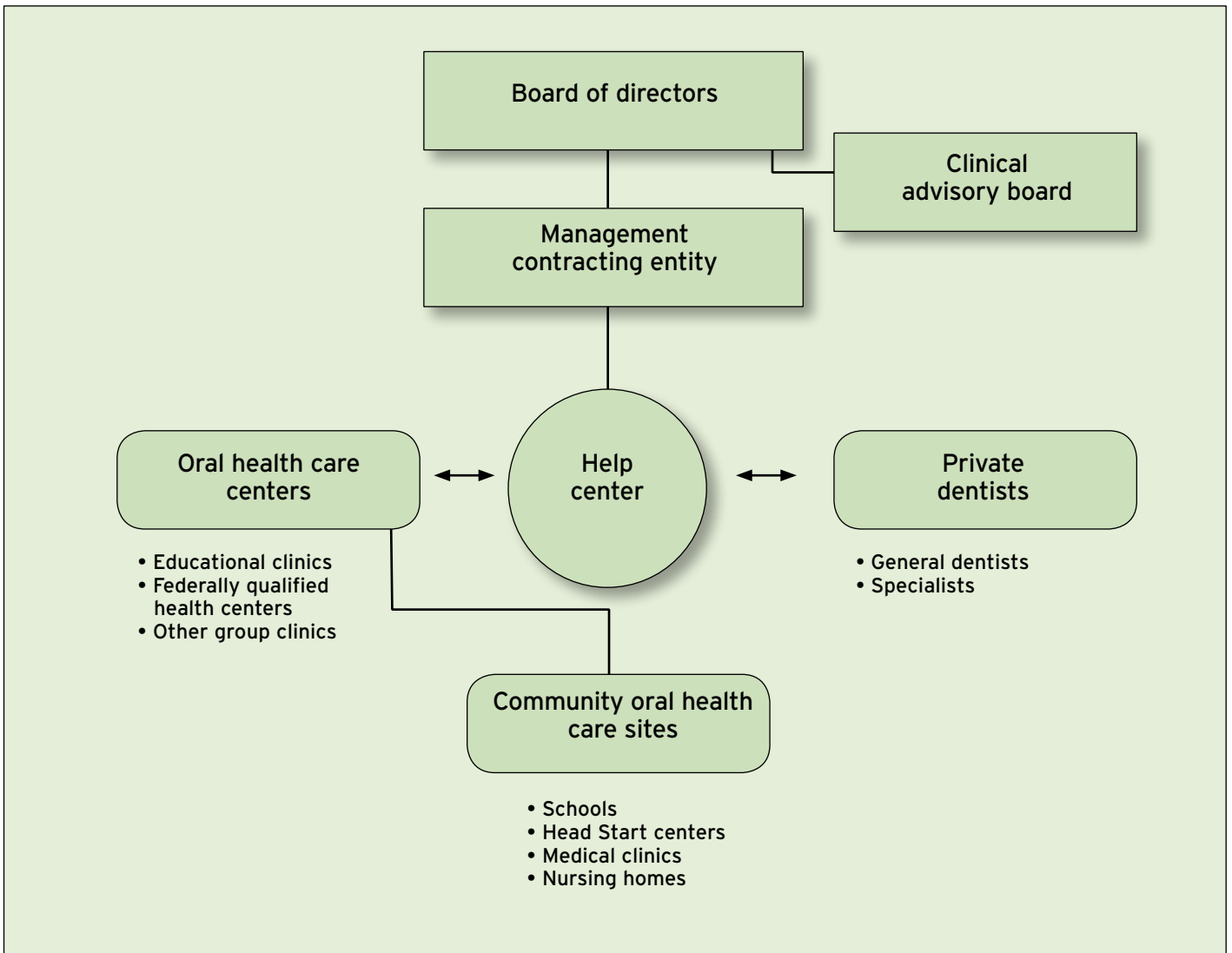


Figure 2. Oral health care system diagram in the next system.

where public program patients live, work, attend school, or receive other health and social services. The “treatment team” designed new ways to expand access to dental treatment in private dental offices and at safety net clinics while reducing the use of emergency rooms. The “help team” designed new ways to meet the unique needs of patients on the one hand, and dental offices and safety net clinics on the other, seeking to maximize successful referrals while serving as a centralized source of information. The “evaluation and research team” designed an evaluation plan to measure the performance of the new model, and helped other teams identify leading practices and sources of information needed for planning. It also designed methods for incorporating evidence-based decision-making processes into the management of the pilot project.

The New Oral Health Care System

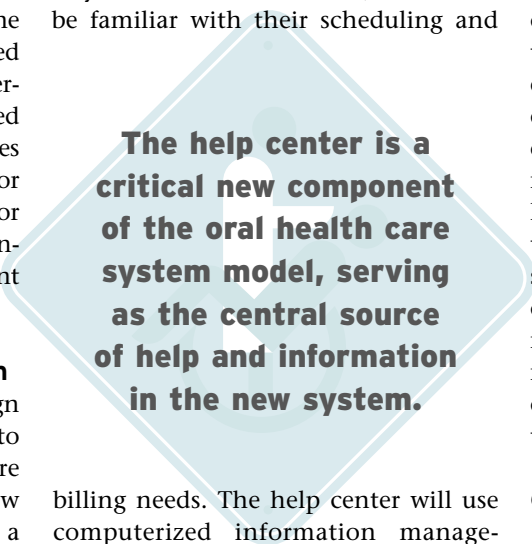
Based on the work of the design teams, a pilot project was designed to implement the new oral health care system. The new system features a new community-based delivery system, a centralized source of help and information, a new governance and management model, and a new financial model. The oral health care system diagram illustrates key roles played in the new system (Figure 2).

To carry out the oral health care system pilot project, the Department of Human Services plans to issue a request for proposals and award a contract to a management contracting entity. This entity will be governed by a board of directors representing key stakeholders and will establish a clinical advisory board to provide advice on leading practices, evidence-based care, and other clinical issues.

The Help Center

The help center is a critical new component of the oral health care

system model, serving as the central source of help and information in the new system. The help center will be staffed by care coordinators skilled at helping Minnesota’s health care programs’ patients coordinate transportation, language, and other social services needed to obtain dental care successfully. In addition to assisting patients, the help center also serves dentists, oral health care centers, and community oral health care sites, and must be familiar with their scheduling and



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billing needs. The help center will use computerized information management technologies and a call center to create a single point of contact via a 1-(800) service and also provides a website for patients and providers. This single source of system-wide information will also provide data needed for quality assurance and evaluation.

Private Dentists

Increasing the participation of private dentists is essential in the new system, and will be voluntary. Private dentists will have enhanced flexibility and control over how they participate and will receive higher reimbursements from a single administrator. Private dentists can choose whether to provide comprehensive dental services for public program patients or to deliver specific treatments recommended by a referring oral health care center or via a help cen-

ter referral. Private dentists will be able to control the type and number of public program patients referred to them on a monthly basis by updating their own dental practice’s “referral preferences form” stored at the help center.

Oral Health Care Centers

Existing safety net clinics such as federally qualified health centers, the school of dentistry, and critical access dental providers may become oral health care centers in the new model. In addition to providing their current safety net dental services, the new oral health care centers will expand or establish new on-site services agreements with community oral health sites and employ hygienists in collaborative agreements to provide education, prevention, and screening services. The oral health care centers will also provide diagnosis and referral services, collect diagnostic information, develop treatment plans, and collaborate with private dental practices to provide necessary treatments.

Community Oral Health Care Sites

Community oral health care sites play a critical role in expanding access to services by providing convenient new points of entry for public program patients. These sites will offer oral health education, prevention and screening services without the need for transportation to private dental offices, and offer the help of teachers, nurses, and translators to overcome a number of access barriers. Community oral health care sites establish contracts with oral health care centers that employ dental hygienists to provide services on site.

Management Contracting Entity


A single organization, called the management contracting entity, will be responsible for implementing the oral health care system pilot project. The management contracting entity will establish a board of directors, which

will include key stakeholders such as the school of dentistry, the Minnesota Dental Association, the Minnesota Primary Care Association, the Minnesota Dental Hygienists' Association, and patient representatives. The purpose of the board of directors is to provide governance oversight for the pilot project. The board of directors will receive clinical decision-making advice from a clinical advisory board that will apply evidence-based care principles. The clinical advisory board's members will include both local and national experts in clinical oral health care. The management contracting entity will consist of management partners and staff with expertise in the areas needed to manage the pilot project. The management contracting entity will be responsible for pilot project enrollment, finance, information systems, help center management, quality assurance, marketing, communications, and evaluation.

How Does the New Model Serve Patients With Special Needs?

Patients with special needs have a single point of contact and a virtual dental home in the new model provided by the help center. The center provides a new way for people with special needs to receive ongoing care coordination services, no matter where they live or work. Specially trained staff at the help center will assist people by assessing their unique needs and then linking them to participating community oral health care sites, oral health care centers, or area private dental practices ready, willing, and able to serve patients with their particular needs. The help center serves as the virtual dental home for patients throughout their lifetime, and is a single source of information about their health and social service needs, oral health assessments, risk factors and treatment history, oral health providers, and other information.

In the new model, patients with special needs have multiple points of entry and/or treatment. Oral health care centers establish contracts with community oral health care sites, including group homes for people with disabilities, nursing homes, senior assisted living centers, work sites for people with disabilities, medical offices serving people with special needs, and other locations where people with special needs live, work, or receive other services. These "oral health services contracts" facilitate the provision of ongoing oral health services under the



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direction of an oral health care center dentist and staffed by a combination of dental hygienists, dental assistants, and dentists. Designed to avoid sporadic and episodic care that arises when prevention has failed, the new oral health services contracts will provide a mechanism to assure that ongoing preventive services and comprehensive care are available year round.

Like the old model, the new model respects dentist-patient relationships. So enrollment of dentists and patients into the new model is carried out by first enrolling participating dentists and dental clinics and then assigning all their existing patients to the new pilot project. Existing relationships are unaffected, and patients without a dentist relationship can seek care through any of the new points of entry offered by the new model, the help center, private

dental office, a group home, school, oral health care center, etc.

Providing oral health services at community sites adds the skills of group home staff, social workers, nurses and physical therapists, physicians, and other caregivers to those of the oral health care team, and with their help, it becomes possible to overcome a host of well-documented barriers that arises when patients with special needs are transported to traditional dental offices. For example, patients with developmental disabilities frequently become fearful and uncooperative when transported to traditional dental offices. In the new model, a dental hygienist will visit the patient at their own group home during periodic on-site visits throughout the year. During those visits, the hygienist becomes a familiar face to the patient and their caregivers, and is able to observe and assist with toothbrushing in the patient's own bathroom. Under these circumstances, it becomes possible to provide a whole new level of education and prevention. After repeated visits that include one-on-one caregiver coaching and supervision, many disabled patients are able to cooperate sufficiently to accomplish an examination and receive preventive services while reducing the use of physical or chemical restraints. In this example, the new model can reduce hospitalizations for general anesthesia, reduce the use of oral sedatives and physical restraints, reduce the risk of injury to patients or dental office staff during dental appointments, and reduce the time and resources spent attempting unsuccessful referrals to dental offices not adequately prepared to meet the patient's needs.

The pilot project also provides a new financial model for special care clinics, dental school clinics and other oral health care centers so that they can provide a range of new services for people with special needs. In the new model, oral health care centers are not simply

reimbursed based on existing dental treatment codes, but can be reimbursed for providing the new on-site education and prevention services previously described. The new model provides reimbursement for follow-up treatment

provided on site using mobile equipment, at oral health center clinics or through targeted referrals made through the help center to specific participating private dentists who are ready, willing, and able to meet the needs of individual

patients. Oral health care centers will create specific program budgets tailored to the mix of old and new services they deliver, and will be paid on a monthly basis based on their budgets and their performance. Inappropriate financial

Table 2	
Cost-Savings Strategies	
1. Provide less costly education, prevention and screening services	Community oral health care sites can deliver education, prevention and screening services on site at a lower cost than private dental offices. Data shows that between 55 percent and 90 percent of children below poverty are healthy and do not need to see a dentist. Screening larger numbers of patients early, and doing so at a much lower cost at community oral health care sites, reallocates existing funding to permit higher payments to dentists for examinations and restorative services.
2. Optimize the roles of all the providers: <ul style="list-style-type: none"> ■ Private practices ■ Oral health centers ■ Community sites ■ Emergency rooms 	The roles of private practices are optimized by triaging patients after they have been educated, screened and have received a "respectful referral" for a successful dental visit, reducing appointment failures. The roles of the old "safety net" clinics change from providing high levels of expensive care for people with uncontrolled dental disease, to the coordinators of a public health approach that targets preventive care to at-risk people through community site partnerships. Emergency room use for urgent dental care needs can be virtually eliminated in the new model by using the help center to coordinate effective and timely dental visits.
3. Optimize the frequency of preventive care, based on risk assessment	Substantial costs can be saved in the new model by tailoring the frequency of oral screenings and dental examinations to the needs of each patient. Patients who have been disease-free for one or more years, and are at low risk for disease can be seen annually rather than every six months. Conversely, patients who are actively experiencing disease, or who have moderate or high-risk factors should be seen more frequently for preventive services and screenings.
4. Reduce the use of infective treatments	The new model will reduce the use of ineffective treatments by collecting centralized data and using a clinical advisory board to apply principles of evidence-based care and disease management to optimize the use of the most effective treatments and minimize the use of ineffective treatments.
5. Reduce indirect costs	Indirect costs include those for claims processing as well as costs incurred by the general health care system due to failures of the oral health system. Administrative costs are reduced in the new model by eliminating multiple redundant administrative systems. General health care savings can be obtained by reducing the consequences of untreated dental diseases which include low birth weight pre-term babies, pneumonia, heart disease, oral cancer, and complications of diabetes.

incentives in the current system will be reduced and new incentives will be created that reward the expanded use of leading practices that demonstrably improve oral health outcomes.

To continually improve the content and delivery of oral health services, the new model establishes a clinical advisory board and internal evaluation management system that works together to evaluate the pilot project and its outcomes. The clinical advisory board's composition will include one or more oral health professionals with expertise in special care dentistry. To assure that patients' satisfaction levels continue to improve, patient satisfaction surveys will become an ongoing and integral part of all aspects of service delivery. Patient representatives on the board of directors, alongside dental professionals and other stakeholders, will further assure that the new system is accountable for meeting the needs of patients and dentists alike.

How Does the New Model Work for Private Dentists?

The new model was designed with continuous input from private dentists and the Minnesota Dental Association. The new model for care delivery emphasizes community-based education, prevention and screening, and carefully coordinated referrals for treatment by private dentists. The new financial model obtains cost savings in the areas of prevention, and transfers those savings into higher reimbursements to private dentists. The new model addresses each of the top complaints about the current public program system as reported by Minnesota's dentists in a recent survey.³

The new model provides:

- Higher reimbursements, ranging from 65 percent to 85 percent of usual and customary reimbursement levels;
- Help preventing "no shows" from the help center;
- Freedom to control the number and type of patient referrals;

■ A single source of prompt payments with reduced administrative barriers; and

■ Freedom to offer appropriate alternative treatment options.

Where Will the Pilot Project Be Carried Out?

The pilot project is designed to be carried out in three regions of Minnesota that include urban and rural areas. These specific regions were selected by the governance committee based on several factors, including the documented need for improved dental access in the region, the numbers and types of community organizations in the region interested in participating in a pilot project, and a survey of dentists conducted by the Minnesota Dental Association indicating where dentists felt the needs were greatest. The Twin Cities metropolitan area, the Red River Valley area in the northwest, and the St. Louis County region, including Duluth, in the northeast, were selected.

What Are the Cost-Saving Strategies?

The financial goal for the new model is to contain costs to the levels currently being expended per person treated per year. This new financial model is a variation of "contact capitation" models and is different than traditional capitation models that charge "per member per month" fees for people who did not receive any services. The total amount expended will rise as the number of people receiving treatment rises. Cost savings are obtained in the new model using the following strategies (Table 2).

What's Next?

Following the 2005 legislative session, the Department of Human Services will decide whether or not to issue a request for proposals to launch the pilot project. The pilot project was designed to include a six-month startup period followed by two years of operation.

Periodic evaluations and reports will be generated during the pilot project, and if successful, it will be expanded in future years. **CDA**

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