DEPARTMENT OF HEALTH

Oral Health in Rural Minnesota

SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS FROM THE RURAL HEALTH ADVISORY COMMITTEE

Background

As rural Minnesota begins experiencing the full effects of a population that is both aging and diversifying rapidly, many questions arise regarding the sustainability and sufficiency of the state's current oral health delivery system.

The Rural Health Advisory Committee (RHAC), a 15-member group appointed by the governor to advise the commissioner of health and other policymakers on rural health issues, convened a workgroup of key stakeholders to explore this increasingly important issue and develop recommendations.

Over approximately one year, the workgroup studied the current landscape of Minnesota's rural oral health system and needs, including:

- The oral health status of rural Minnesotans
- Utilization and access trends
- The oral health workforce
- Emerging models

The following is a summary of the workgroup's final recommendations and key findings.

A full report will be published in July 2017 on the Rural Health Advisory Committee website (http://www.health.state.mn.us/divs/orhpc/rhac/index.html).

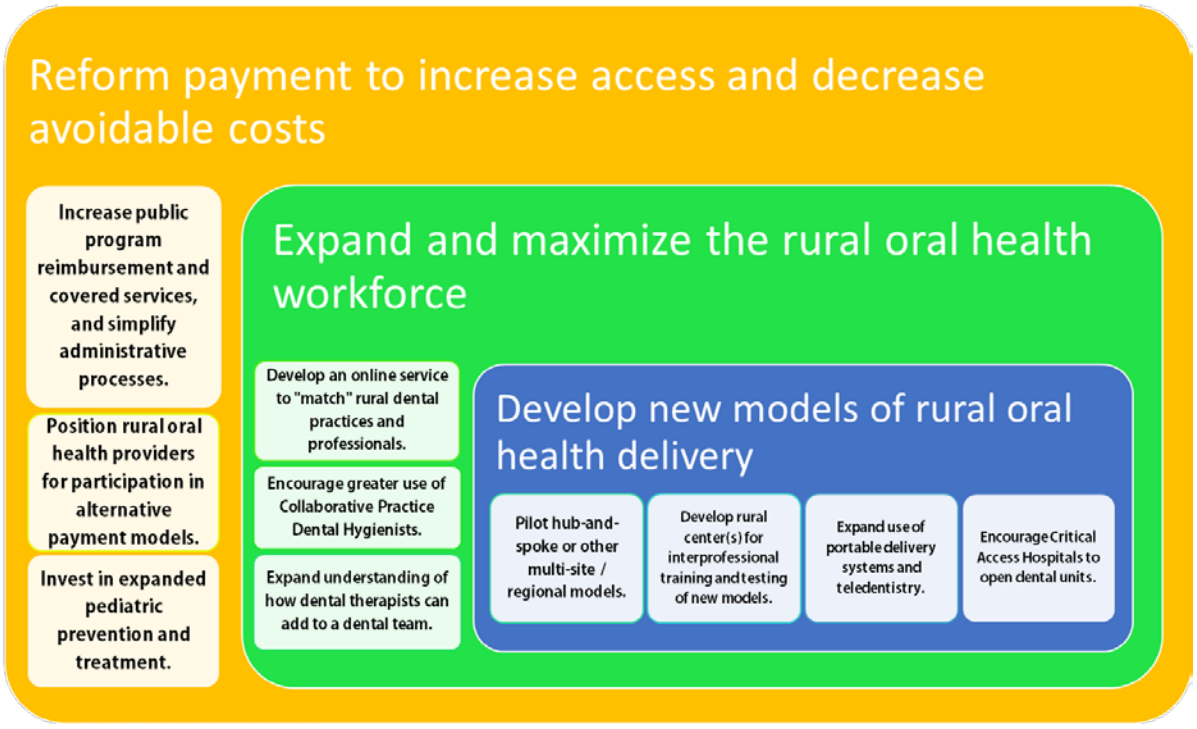
Key Findings

- Rural Minnesotans face a variety of **barriers** to accessing dental care, including geographic isolation, lack of transportation, higher poverty rates, and difficulty finding providers willing to treat publicly insured patients.
- Residents of rural Minnesota **visit emergency rooms for oral health conditions** at disproportionate rates: Between 2007 and 2010, over one third of patients visiting hospitals with traumatic oral health emergencies were from rural areas.
- Compared to their urban counterparts, rural Minnesotans have **lower rates of dental insurance** and slightly higher rates of foregone care, with the worst rates of both in isolated rural areas.
- Minnesota has some of the lowest Medicaid dental **reimbursement rates** in the U.S.
- Minnesota's **oral health workforce**, with the exception of dental therapists, is disproportionately urban.
- Nearly half of rural Minnesota's dentists **plan to stop practicing** in the next 10 years, yet 56 percent of the state's rural counties have no dentists aged 35 or younger to replace them.
- **Dental hygienists and dental therapists** could provide more preventive and basic restorative care in community settings, but are underutilized outside traditional dental clinics.
- **New models** of rural oral health practice are needed, including those able to provide more extended geographic reach, integration with medical services, and more emphasis on prevention and addressing social and cultural barriers to good oral health.

Recommendations

1. Increase public program **reimbursement rates** and covered services, and simplify program processes.
2. Develop a central online service to facilitate **recruitment and retention** for the rural Minnesota oral health workforce.
3. Pilot regional **Center(s) for Rural Oral Health** that would provide both oral health training and service clinics in underserved rural areas of the state.
4. Pilot hub-and-spoke or other regional model(s) for **multi-site dental practices**.
5. Encourage greater use of **Collaborative Practice Dental Hygienists**.
6. Expand awareness and understanding of how **dental therapists** can be incorporated into rural practice.
7. Invest in expanded **pediatric prevention** and treatment.
8. Facilitate use and expansion of **portable delivery systems and teledentistry**.
9. Encourage **Critical Access Hospitals** to open dental units.
10. Position rural oral health providers for participation in **alternative payment models** (developmental recommendation).
11. Add an oral health professional representative to the **Rural Health Advisory Committee**.

Figure 1. Overview of proposed recommendations



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