

# **Oral Health Forums Summary and Conclusions**

Iowa Department of Public Health  
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Prepared by  
Janan Wunsch –Smith

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## **Process**

Twelve Oral Health Community Forums were held over a two-month period representing urban and rural communities in all geographic regions of Iowa. The sites scheduled for forums were Ottumwa, Mt. Pleasant, Corning, Atlantic, Marshalltown, Boone, Davenport, LeMars, Storm Lake, New Hampton, Mason City and Cedar Rapids.

The Iowa Department of Public Health, Oral Health Bureau, extended the invitation to attend to the local public health professionals and other partners in the regions around the forum sites. Partners invited included oral health professionals, hospital administrators, Head Start, Title V contract agencies, other medical professionals, non-profit agencies and other related community programs.

A PowerPoint presentation along with an Oral Health Facts sheet was shared with the attendees at the beginning of the forum for stimulation of thought and discussion.

All forums were one and one half hours long with information gathered using an open forum format. Attendance numbers ranged between 7 and 30 with a wide representation from oral health and community organizations.

The following questions and statements were used to stimulate discussion.

- What are the barriers, if any, preventing optimal oral health for families in your community?
- What is currently being done in your community to promote good oral health for families?
- What are the assets available in the community to promote good oral health?
- Based on barriers and assets discussed, what are possible strategies/interventions to address optimal oral health for families in the community?
- What do you need from the state?
- What can your community do to assist with a statewide plan?

The information gathered at each site contained some similar issues, while other components were remarkably different across the geographic regions. There was also a significant difference in responses between urban and rural.

The following section summarizes the responses from all 12 forums. These responses have been organized into four sections; barriers, current activities, possible strategies, and suggestions for state activities. Each section is divided into eight categories; lack of perceived need, lack of providers and/or hours of service, lack of providers with specialized education, transportation, financial issues, lack of system integration, ethnic, cultural, and environmental barriers, education and availability of data.

## **Barriers**

1. Perceived need
  - Oral health is frequently not viewed as a part of overall health
  - Oral health is often treated only when there is an acute problem and pain
  - Prevention is often not a priority for people especially when they are un- or under-insured
2. Availability of providers and/or hours of service
  - Use of dental hygienists providing screenings and other preventive services varies across the state. It is dependent on funding for programs
  - Many dentists, especially in rural areas, are nearing retirement age and cannot find other providers to buy their practice or have not actively pursued anyone to begin taking over their practice
  - Many dental offices are open 8-5:00, which are hours that are not convenient for many clients
  - Many rural areas are lacking adequate numbers of providers (uneven distribution of dentists)
  - There is a perception that the University of Iowa does not promote placement of dentists in the west half of the state and does not promote rural practice
3. Availability of providers with specialized education
  - There are too few pediatric dentists
  - Too few dentists take children prior to 3 years of age
  - Many dentists do not do anything beyond general practice dentistry
4. Transportation
  - There are varied transportation issues across the state--some clients have to find transportation to another community to have access to general dental services while others need transportation to have specialty care
  - Our aging population often has transportation issues, especially in rural areas
5. Financial issues
  - Dentists resist taking new or any Title XIX patients due to low reimbursement
  - Few people have adequate dental insurance
  - Dentists often require up front pay, which many clients do not have
  - Dentists often require up front pay and expect clients to file insurance and wait to be reimbursed from the insurance company
  - Retired citizens have no dental coverage with Medicare and many live on limited resources
  - The poor cannot afford care unless it is an emergency and they go to the emergency room
  - In some areas there has been loss of insurance due to loss of jobs
  - There is a need for funding dental hygienists for all WIC clinics
6. System integration
  - Medical professionals do not routinely refer patients with oral health issues to dentists
  - It is not clear how to integrate registered nurses into the oral screening
  - There is a lack of integration of oral health education in prenatal visits with medical doctors
7. Ethnic, cultural and environmental factors
  - Language barriers are a problem in both urban and rural areas
  - Pop machines in school provides easy access to high sugar content drinks
  - There is a great deal of poor nutrition
  - Baby bottle tooth decay is a serious problem with some ethnic groups

- Dentists who take Title XIX often only give one chance and if patients do not show up they do not offer an appointment time to that client again
  - There is a huge increase in “Meth Mouth”
8. Education and availability of data
- There is a lack of instructors for dental schools which limits expansion of programs
  - There is currently a limited number of slots for dental students
  - More pediatric education and hands on experience needs to be incorporated into curriculum
  - Medical and dental curriculums need to incorporate education on the integration of the two systems

### **Current Community Activities**

Despite local and state barriers, there are many current activities that promote oral health care in the community. Examples of the type of activities in the state are listed below.

1. Perceived need
  - Some education programs target prevention, i.e. Healthy Smiles
  - Some schools have oral health education via the fluoride mouth rinse program
2. Availability of providers/services and/or hours of service
  - Two communities have or are attempting to get a mobile dental van
  - Most dentists will continue to see existing patients if patient’s payment status changes to Title XIX
  - Dental hygienists provide screenings in some communities at WIC clinics, Head Start, lead screenings and immunization clinics
  - Hospital foundation provides support for the school nurse to provide case management relating to dental and other services.
  - Additional Community Health Centers (CHC’s) have been approved for Iowa
  - Free dental clinics in some areas of the state
  - “Give Kids a Smile Day” where dentists open slots for taking kids for free exams
  - Sealant and Fluoride vanish programs
  - Broadlawn doing oral assessment in long term care facilities
3. Availability of providers with specialized education
  - IDPH and U of I College of Dentistry are expanding relationships in order to share information and needs identified.
  - Existing pediatric dentists are highly sought for service and highly thought of in their communities
  - Increased number of pediatric dentists around the state in the past few years
4. Transportation
  - Provided locally in some communities
  - Some communities provide transportation to larger urban areas for care, i.e. A few South-west Iowa communities provide transportation to Des Moines and Omaha
5. Financial issues
  - Small rural community partnered with their local economic development to get a dentist to their community
  - Title XIX will pay for transportation
  - Title V may provide limited funding for dental care for un- and under-insured children
  - Story County/United Way established reimbursement program for dentists
6. System integration
  - Medical personnel and dental staff at CHCs work more collaboratively; there is increased awareness of the value of the integration within the CHC system
7. Ethnic, cultural and environmental factors
  - Local respite care provided so spouses can meet appointments for oral health care

- Interpreters in CHCs
  - Polk County interpreters
  - Local schools are pushing for healthy snacks in school vending machines
  - Education regarding baby bottle tooth decay
  - Local community provided 15,000 dental kits to area residents
8. Education and availability of data
- Many communities have various forms of community education campaigns
  - Local programs have gathered data over the duration of their programs

## **Possible Local Strategies**

1. Perceived need
  - Educate families in showing up at appointments, empower not enable
  - Educate families on value of prevention vs. intervention
2. Availability of providers/services and/or hours of service
  - Mobile dental vans, using medical and dental students
  - Start a “Give Kids a Smile” Day and grow the program
  - Retired dentists pool
  - Loan repayment programs
  - Develop relationship with Creighton University if on the west side of state
3. Availability of providers with specialized education, i.e. Arizona model
  - Educate medical healthcare students in good oral health practices, i.e. first dental visit by the age of one
  - Include a public health rotation for all healthcare students
  - Educate dental students on need for and how to see one-year-olds
4. Transportation
5. Financial issues
  - *hawk-i* carve out for dental so that families who already have medical insurance but no dental can apply for *hawk-i* dental
  - Provide funding for more consistent program coverage statewide, i.e. sealant, fluoride varnish, WIC hygienist etc.
  - Educate legislators regarding the plight of working poor
  - Have oral health coverage included for retired persons on Medicare
6. System integration
  - Train medical professions to make oral health referrals at appropriate ages
  - Train medical professionals to include oral health education at prenatal exams
  - Involve Farm Bureau when looking into educating physicians
  - Emergency Room (ER) doctors collaborate and communicate with dentists
  - Have dentists take ER call like medical doctors
  - Develop method for sharing follow up records for use in total case management
7. Ethnic, cultural and environmental factors
  - Formal interpreter system
  - Use Delta Dental’s interpretation phone service when possible
  - Have required oral health exam prior to school enrollment (just passed in Illinois)
8. Education and availability of data
  - Educate dentists on the benefits of preventive care
  - Work closer with WIC to provide education regarding baby bottle mouth and other oral health issues
  - Educate entire population in the benefits of prevention
  - Educate Boards of Health and Boards of Supervisors regarding prevention and severity of the oral health situation in local communities

## Suggestions for State Activities

1. Availability of providers/services and/or hours of service
  - Assist Council Bluff's CHC to restart their dental clinic
  - Request that Iowa Board of Dental Examiners provide Continuing Education credit for volunteer hours
  - Have it be mandatory that all dentists see a certain percentage of Title XIX clients
  - Limit programs available to children to only those that qualify (e.g. school-based sealant program would only see children with no regular source of dental care)
2. Availability of providers with specialized education
  - Provide Public Health curriculum for all oral health students
3. Financial issues
  - Clarify billing procedures for dental hygienist services through Title V contractor
  - Promote local and state Economic Development working with all communities to attract dentists to their area
  - Increase Medicaid rates
  - Work with insurance to at a minimum cover the cost of care
  - Sustained funding for essential prevention programs
  - Simplify *hawk-i* and carve out
  - Make grants more flexible
  - Provide supplemental grants
  - 5% of all health dollars designated to oral health
  - Eliminate 100% reimbursement for *hawk-i*
4. System integration
  - Bring medical and dental providers together
  - Create a task force to develop strategies to address oral health issues
5. Ethnic, cultural and environmental factors
  - Share information about Delta Dental's interpretation phone service and other related information that may help local communities adapt to a more diverse population
6. Education and availability of data
  - Start campaign to education the general population that dental work is not as painful as in the past
  - Market oral health care where kids and people will see it, i.e. MTV, Wiggles etc.
  - Use oral health students to go into schools to provide education
  - Produce education piece for legislature
  - Provide funding to collect and analyze the data already available at the community level
  - Work with the Department of Education to assure health classes include oral health
  - Require mandatory public health education for school administrators
  - Educate volunteers regarding state volunteer programs
  - Provide educational material statewide to all dentist and the community
  - Do a study to determine if Title XIX "no show rates" are higher than self-pay patients
  - Provide education on relationship between oral health and general health

## **Conclusion**

Oral health is a serious issue across the entire state of Iowa. However the barriers and issues vary based on geographic region. The following is a summation of the most common issues:

- Dentists are hesitant to take new Title XIX patients due to the low reimbursement rates and the increased likelihood of those patients to not show up for appointments. This was the most frequently identified barrier in all the forums.
- Many rural communities see an aging provider population with few new and/or younger dentists coming into their communities. The reason for this was described as younger families not wanting to locate in the more rural communities because of lack of services and resources.
- There is a perception that the University of Iowa, College of Dentistry may promote the eastern ½ of the state for establishing practices with the exception of a few of the more urban areas in the western part of the state.
- Dentists with specialty practices such as pediatrics are limited and again the rural areas have very few and have to travel much farther to access these services.
- Dental, as well as medical students need to have more community and public health education to understand the needs of the population.
- The integration of the medical health care system and the oral health care system has begun in a few areas and in the CHCs. This is a strategy that most communities feel is essential to the overall health and well being of the citizens.
- Some rural communities cited “perception of need” and the lack of importance placed on oral health services as the greatest barrier to care.
- Transportation, though provided by some communities is still an issue especially in some of the more rural communities.
- Uninsured and underinsured citizens as well as those on Title XIX have a very difficult time accessing care. Finding a provider is the first hurdle, and for the working poor, the cost of preventive care is prohibitive so they often wait until they are in crisis before attempting to access services. The wait time, even when they are in severe pain, may be weeks.
- Education is needed for the general population, dentists, and medical professionals regarding the value of prevention, integration of services, and types of more pain free intervention.
- Overall the most prevalent issue of all the forums involved education at the university, provider and consumer level.
- It is critical that more data is collected and analyzed to provide verification of the need and the value of oral health prevention and timely intervention.

## Appendix 1

### **Iowa Department of Public Health Oral Health Community Forum**

#### AGENDA

##### **Welcome and Introductions**

- Background and purpose
- Objectives for forum – to gather input from local stakeholders about oral health needs and community capacity to meet those needs, to hear recommendations on how to best build local capacity, and to raise awareness about oral health issues.

##### **Small Group Discussion**

- What are the barriers, if any, preventing optimal oral health for families in your community (family/cultural, school, dental providers, financial, transportation)?
- What is currently being done in your community to promote good oral health for families?
- What are the assets available in the community to promote good oral health?

##### **Large Group Discussion**

- Each group reports current barriers and/or assets identified regarding good oral health in the community.

##### **Small Group Discussion**

- Based on barriers and assets discussed, what are possible strategies/interventions to address optimal oral health for families in the community?
- What do you need from the state?
- What can your community do to assist with a statewide plan?

##### **Large Group Discussion**

Each group report strategies/interventions

##### **Prioritization of Key Interventions**

##### **Summary**

Appendix 2

# ***Improving Oral Health in Iowa***

**A Public Discussion Sponsored by the Iowa Department of Public Health**

## **OTTUMWA**

**Tuesday, April 12**

**11:00-12:30**

**Area Education Agency 15**

**Conference Room B**

**2814 N. Court Street**

## **MOUNT PLEASANT**

**Wednesday, April 13**

**11:00-12:30**

**Henry County Health Center**

**Health Education Room**

**407 South White Street**

## **CORNING**

**Monday, April 18**

**3:00-4:30**

**Alegent Health Mercy Hospital**

**Conference Room**

**603 Rosary Drive**

## **ATLANTIC**

**Tuesday, April 19**

**11:00-12:30**

**Cass County Hospital**

**Conference Room 1**

**1501 E. 10<sup>th</sup> Street**

## **MARSHALLTOWN**

**Wednesday, April 20**

**10:30-12:00**

**Marshalltown Medical and Surgical Center**

**Conference Room D**

**3 S. 4<sup>th</sup> Street**

## **BOONE**

**Wednesday, April 20**

**2:30-4:00**

**Boone County Hospital**

**Conference Room West**

**1015 Union**

## **DAVENPORT**

**Monday, May 16**

**3:30-5:00**

**Community Health Care**

**Conference Room**

**500 W. River Drive**

## **LEMARS**

**Thursday, May 19**

**3:00-4:30**

**Floyd Valley Hospital**

**Conference Room 1**

**714 Lincoln Street, NE**

## **STORM LAKE**

**Friday, May 20**

**10:30-12:00**

**Area Education Agency 8**

**Conference Room**

**824 Flindt Drive**

## **NEW HAMPTON**

**Tuesday, May 24**

**3:30-5:00**

**Community Services Building**

**Meeting Room**

**260 E. Prospect**

## **MASON CITY**

**Wednesday, May 25**

**11:00-12:30**

**Department of Human Services**

**Liberty Room**

**22 N. Georgia**

## **CEDAR RAPIDS**

**Thursday, May 26**

**11:00-12:30**

**St. Luke's Hospital Nassif Heart Center**

**Classrooms 2 and 3**

**1026 A Avenue, NE**

## Appendix 3

### **Iowa Oral Health Facts**

- Seventy-two of Iowa's 99 counties are designated as Dental Health Professional Shortage Areas (HPSA's).
- According to the 2000 Iowa Child and Family Household Health Survey:
  - About 25 percent of Iowa's children did not have a dental visit in the previous year.
  - Fifteen percent of children had never been to the dentist.
- While the large majority of children without a dental visit were under age four, three percent of those ages five to nine had never been to the dentist. Almost half of children (46%) were thought to need dental care in the previous year.
- According to the IDPH 1999 Oral Health Survey of 2<sup>nd</sup>- 4<sup>th</sup> graders, 57 percent of the children surveyed had a history of decay. This rate was even higher, 68 percent, for low-income children. Thirty-three percent of all the children surveyed had untreated decay, while 47 percent of the low-income children had untreated decay. Twenty percent of low-income children had untreated decay in permanent teeth, twice that of the higher-income children, and approximately 30 percent of the low-income children had more than one decayed tooth.
- The IDPH 2004 Sealant Prevalence Survey found that 40 percent of third graders had a sealant on a molar, but just 33 percent of children with no dental insurance and 32 percent of children on the free/reduced lunch program had a sealant. Of children participating in the free/reduced lunch program, 17 percent did not have a dentist of record compared to only 5 percent of children not on the lunch program without a dentist of record.
- An IDPH survey in 2001 found that over 31 percent of immigrants reported never having seen a dentist. Almost 33 percent of the immigrant families with children did not take them for an annual dental exam.
- In FY03, only 42 percent of Medicaid-enrolled children, ages 1-20 received any dental services.