Components and Characteristics of the Oral Health Environment – CNMI (2019)

Components of Oral Health Environment	Strengths	Weaknesses/Challenges/Gaps	Opportunities
Oral health needs/demands & how measured Example: DMFT, Basic Screening Survey; waiting lists for non-urgent care	**Basic Screening Survey:** Utilized for the Head Start/Early Head Start Programs **DMFT screening:** Done for the School Sealant Program as well as clinical exams in the dental clinic; collect data on ages 3-5 yrs, 7-8 yrs and 11-12 yrs. **FREE oral cancer screening**-visual inspection of lesions to patients attending clinics	**Serious oral health problems**: high caries prevalence among children, high prevalence of oral cancer (related to betel nut use), diabetes, cardiovascular disease, and poor diets. **No standardized data collection and surveillance,** especially for oral cancer screening	**HRSA Oral Health Workforce Grant (OHWF):** Includes support for TA to develop surveillance system; have retained a special consultant to conduct training and set up an oral health surveillance system
Delivery sites & programs **>Portable** (e.g. in schools, community centers, libraries, etc.) **>CHC** **>Hospital**	**Hospital Dental Clinic:** Through the School Sealant Program students are bused into the clinic; operating room used for pediatric cases. **HS/EHS Centers:** On site fluoride varnish applications and exams	**Maintenance of equipment:** There are no specialized dental equipment maintenance personnel available. This is an issue especially as the clinic equipment ages.	**CHC:** Currently no on site dental services. May be available in the future. **OHWF grant** enabling purchases of new equipment
Funding for Oral Health Program and Services, including impact of Compact status (if appropriate): ➢ General/local funding ➢ Medicaid and other	**MCH Block Grant: Title V program** selected National Performance Measure 13. Actions include: improving oral health in children and pregnant women by continuing school based programs; community awareness and outreach to educate the community and families on the	**No long term plan to increase and sustain workforce:** Need to explore strategies to retain and remunerate workforce. **Need to accept other private dental insurances** **Need for reimbursement for**	**Commonwealth status:** This affords opportunities for US federal aid. **Notices Of Funding Opportunities (NOFO):** Most NOFOs are being seen by higher level health administrators and often do

health insurance ➢ Patient fees & co-pays, by age-group, e.g., free for young children, co-pay for prostheses ➢ Other sources of program funding or income, e.g., grants	importance of preventive oral health for both children and pregnant women. **Medicaid Reimbursements**: Dental public health bills Medicaid for services to children and adults enrolled in Medicaid. School Oral Health Program provides sealants to ALL students participating in the program. **HRSA/OHWF Grant:** Provides financial support to expand workforce **Sliding fee instituted by the Hospital:** The sliding fee is instituted by the hospital to cover those who are socio-economically poor and who are not eligible for Medicaid. The sliding fee will include preventive services as well as curative services for ages 19 years and below AND for pregnant women, but only emergency dental treatment for others 20 years and older.	**preventive services for pregnant population:** CNMI Medicaid does NOT provide coverage for preventive dental services to pregnant women 20 years and older.	not reach the front-line dental personnel. Will explore ways to get relevant and appropriate information, e.g., NOFOs in a more timely fashion. **Appropriated money set aside to help fund dental prenatal visits.** Women's Clinic is given dental vouchers to hand to their patients for access to preventive dental care which include radiographs, complete exam, prophylaxes and oral health instructions for mom and future child.
Workforce, including types of staffing (ages/soon to retire, vacancies, etc.), onsite training and those in pipeline (e.g., at FNU)	**Current staffing** **Local Funding:** • 1 dentist • 3 expanded duty dental assistants • 1 dental hygienist • 1 oral health program preventive assistant	**STILL LACKING ADEQUATE WORKFORCE** **NEED 1 dental hygienist** (difficult to attain due to low salary, requirement to be US educated and no incentives to travel to work in CNMI)	**OHWF GRANT:** helps to support some needed dental staff. **UPDATE (July 2019):** The OH program worked with the professional licensing board to change the scope of work for dental

	OHWF Grant: • 1 dentist • 3 dental assistants-in training (1 on Saipan, 1 on Rota, 1 on Tinian) • 1 dental therapist/hygienist • 1 OHP coordinator	**Dental Therapists can NOT be utilized** due to restrictions from Board of Dentistry to supra-gingival scale only. Dental therapist current scope of work is similar to an expanded duty dental assistant (EDDA).	therapists. Moving forward they will be able to function similar to a dental nurse, e.g., fillings, administer local anesthetics, fillings, simple extractions, scaling, and diagnoses.
Policy-mandates ➢ HRSA:CHC dental component, MCH-NPM13; local school oral health mandate for children ➢ Oral health care guidelines and protocols, e.g., for pregnant women, for diabetic patients, etc.	**MCH Title V NPM13:** This is especially important because NPM 13 was chosen and the upcoming five-year needs assessment will include oral health. The findings from this NA will form a component of the five year MCH Title V plan (FY2021-2025). **OHWF grant**: The oral health plan is to have the local government fund the salaries of the additional workforce that the grant is currently supporting. The increase in workforce results in the increase of revenue that should sustain the expanded workforce.	**Oral health** often an afterthought; other medical and public health programs take precedent **Culturally** oral health is not a priority **Policy Driven:** Oral health is limited by certain policies, e.g., limited by the scope of the dental practice acts and the board of licensure. For example, it would be good to integrate oral health practices with other healthcare professionals, such as to apply fluoride varnish or have dental assistants imbedded in "sister programs" like WIC to apply FV. The practice acts do NOT allow these practice models.	**NOFO** to disseminated down to Oral Health Program **Resolution of Support:** obtain from PIHOA, PIPCA and ASTDD **Explore changes in Dental Practice Acts:** In some states, changes to dental practice acts have been obtained by public health entities. This might be in the form of "waivers" or the like. (Also see **UPDATE** above.)
Partnerships-collaborations with other disciplines e.g., WIC, NCD, Early	**PBDA:** OH support among the USAPI may be increasing as evidenced by the revitalizing of the PBDA. **Public School System:** MOU for	**NO effective collaboration with NCD**: Better collaboration could result in enhanced approaches or outcomes for the community, such as better oral	**Better Oral Health/NCD integration:** There are opportunities to better integrate oral health/NCD. For example, oral health

Education/Head Start, including: kind of collaboration, e.g., informal, MOU, co-funding (oral health receives some funding from other programs or co-located services, like dental hygienist placed in prenatal clinic)	busing, scheduling students in the school sealant program **HS/EHS:** MOU to visit centers for fluoride application **NCD:** Some partnering for oral cancer outreach/screening and fluoride varnish applications as well as Oral Health Awareness promotion efforts **MCH Centering Program:** Collaborative efforts to provide prenatal dental visits. This program is takes a holistic approach to prenatal care which has a dental component which includes dental voucher **"Wrap Around Care:"** a "wrap around program" for Rota and Tinian in which dental assistants will be partnering with immunization in the well baby clinics to provide FV to the babies and oral health education to the mothers.	cancer awareness and outreach; and, enhanced screening for diabetes in dental clinical settings. **Lack of Support from HS/EHS on FV application for the EHS students.** In the EHS program management prohibited the OHP to apply FV to children on site. A compromise was reached (at an increased overall cost) to have the parents of the EHS bring their children into the dental clinic for application of the FV. (Compliance continues to be a challenge.) A positive dividend of this approach was that the parents received health education and oral care instructions for their child and themselves.	has collaborated with NCD on its school oral health cancer outreach program. OHP and NCD can build upon this and enhance integration within tobacco and cancer prevention programs. Also recently, the OHP has collaborated with NCD's diabetes program to implement glucose screening in the dental office primarily for patients who have periodontal disease.