Components and Characteristics of the Oral Health Environment–FSM/Kosrae State (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, including citing some available data, e.g., XX# of DMFT for 8-9 year olds.	**BSS:** Currently collecting these data on ECE, 1st, 2nd and 3rd grades; will continue in 2019-20 school year **Patient Wait Times:** Currently conducting a survey on patient wait times.	**Serious oral health problems**: High prevalence of pre-cancerous and oral cancer lesions (many related to betel nut/tobacco use). No dental specialist for oral surgery. High prevalence of Early Childhood Caries (ECC)	**Moving forward:** Will seek obtaining specialist for oral surgery cases.
Delivery sites & programs **>Portable** (e.g. in schools, community centers, libraries, etc.) **>CHC** **>Hospital**	**School Dental Program:** Good collaboration between public health and Department of Education. Ongoing and use portable dental units. Consistent and available transportation for these clinical efforts remain a challenge. **Department of Health & CHC**: The CHC dental clinic is still under construction. Thus, the CHC dentist provides care at the hospital until the CHC is operational.	**CHC:** Although the CHC dental clinic equipment is "on site", the clinic is still under construction and equipment not installed. Limited space for storage	**Moving forward:** Will seek more adequate storage area for dental equipment and supplies.
Funding for Oral Health Program and Services, including impact of Compact	**Compact Funding:** Covers all dental operations and staffing **Patient Fees:** Free dental services	**Local funding:** Current funding from Compact resources and Federal programs is insufficient to support needed oral health	

status (if appropriate): ➢ General/local funding ➢ Medicaid and other health insurance ➢ Patient fees & copays, by age-group, e.g., free for young children, co-pay for prostheses ➢ Other sources of program funding or income, e.g., grants	for children, including fluoride varnish, silver diamine fluoride and fissure sealants. **MiCare:** This is FSM's health insurance that all National and State government employees are encouraged to enroll in. In turn, MiCare sends quarterly payments (capitation) for all services provided to enrolled individuals including dental services. **MCH Program**: Provides some funding for equipment and dental supplies **HRSA CHC:** Supports personnel, equipment and supplies	services **Under- and Uninsured:** • Limited oral health coverage for unemployed individuals • Uninsured individuals pay "out of pocket" **Maintenance and Supplies** Annually, $20,000 is allocated only for dental equipment and supplies for a fiscal year and has been proven to be consistently exhausted before year's end. Also, there are extended long waits for repairs to and replacement of equipment.	
Workforce, including types of staffing (ages/soon to retire, vacancies, etc.), onsite training and those in pipeline (e.g., at FNU)	**Current staffing** **Kosrae State Hospital:** • 2 local dentists (45 yrs/41 yrs) • 4 dental auxiliaries (27, 28, 35 & 42 yrs)	**STILL LACKING ADEQUATE WORKFORCE** **Pipeline:** No Kosrae trainees currently in training programs	**Moving Forward:** Need more training for dental auxiliaries
Policy-mandate ➢ HRSA:CHC dental component, MCH-NPM13; local school oral health mandate for children	**MCH Title V NPM13:** This is especially important because NPM 13 was chosen and the upcoming (in FY2020) five-year needs assessment will include oral health. The findings from this will form a component of the five year MCH Title V plan	**Betel Nut and Tobacco Policies:** Enforcement of the current betel nut and tobacco laws is weak. **Lack of a National Dental Director:** Currently, although	**Moving Forward:** Need to strategically and effectively advocate for the appointment of an FSM National Dental Director.

➢ Oral health care guidelines and protocols, e.g., for pregnant women, for diabetic patients, etc.	(FY2021-2025). Activities include: providing services at MCH prenatal and well-baby clinics. **Betel Nut and Tobacco Policies**: These laws have been in place since 2017 for all FSM states. However, although health education and promotion efforts are ongoing, enforcement and penalties by Public Safety are not widely administered.	there are a national FSM Medical Director and national FSM NCD Director, there is no national FSM Dental Director.	
Partnerships-collaborations with other disciplines e.g., WIC, NCD, Early 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)	**Collaborations/Working Partnerships** • Department of Education: School based program for Early Childhood Education and Elementary Schools; and, for Child Find Survey • Maternal and Child Health: dental services provided to patients at prenatal and well-baby clinics • NCD: dental services provided to patients in diabetes clinic	**Program Logistics and Coordination:** Coordination between other health care partner programs continues to be a challenge, e.g., ensuring that schools are prepared for our clinical visits and at times, even if a visit is scheduled available transportation falls through.	**Moving Forward:** Need to explore ways for more effective coordination, communication and collaboration. Need to explore means of accessing more consistent and reliable source of transportation for the extramural dental program, e.g., supplemental funding from HRSA primary care to enhance access to care.