

# **Current Status and Strategies to Improve Oral Health Program Infrastructure and Capacity in the US Affiliated Pacific Islands: A Needs Assessment and Technical Assistance Project**

## **EXECUTIVE SUMMARY**

Association of State and Territorial Dental Directors (ASTDD) in collaboration with the Pacific Island Health Officers Association (PIHOA), November 2019



### **PURPOSE**

Through funding from CDC Division of Oral Health Cooperative Agreement 6 NU58DP006573-01-00, Partner Actions to Improve Oral Health, ASTDD conducted a project to meet the following Objective: “By 8/31/19, assess and report on oral health program infrastructure and capacity, identifying strengths, gaps and needs for the US Affiliated Pacific Islands including the US Flag Territories of Guam, the Commonwealth of the Northern Mariana Islands and American Samoa); the three Freely Associated States (the Republic of the Marshall Islands, the Republic of Palau, and the Federated States of Micronesia-- Chuuk, Kosrae, Pohnpei and Yap) and the Caribbean islands of Puerto Rico and the US Virgin Islands.

### **APPROACHES AND METHODS**

- ASTDD provided direct program support, management, coordination and technical expertise through five consultants and ASTDD staff.
- ASTDD initiated a contract with PIHOA for major coordination, logistical and travel support for Pacific Basin Dental Association (PBDA) meetings and onsite technical assistance, as well as liaisons with Pacific Islands Primary Care Association (PIPCA), Association of State and Territorial Health Officials (ASTHO), National Association of Chronic Disease Directors (NACDD) and Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB).
- Numerous existing reports from HRSA, ASTHO, NACDD and other groups were reviewed for information that would inform the needs assessment.

- ASTDD briefed and solicited support for the project from USAPI Directors and Ministers of Health at their PIHOA meeting in Honolulu in September 2018.
- ASTDD established distance communications via a new ASTDD email-listserv and video conferencing links via Zoom for individuals identified as key USAPI contacts, mostly the dental chiefs.
- ASTDD consultants developed assessment tools and table templates to collect information from each USAPI, i.e., *Priority Oral Health Topics and Components and Characteristics of the Oral Health Environment*.
- ASTDD, PIHOA, PBDA and PIPCA planned and convened PBDA and the Needs Assessment meetings in Honolulu in February 2019 to discuss their priorities and the needs assessment process to gain local input, assuring a grassroots approach that would result in culturally relevant and realistic information.
- Each USAPI completed the *Characteristics of the Oral Health Environment* tables, which were the basis for a summary report of findings.
- The draft report consisting of three sections and appendices of their tables was sent to each USAPI for review as well as to representatives of key national organizations and federal agency partners. The final reports of both the USAPI and Caribbean Islands will be submitted to CDC with some recommendations for next steps.

## **SELECTED FINDINGS**

### Oral Health Needs

- In almost all USAPI, serious oral health problems exist, including high dental caries prevalence among children, high prevalence of diabetes, cardiovascular disease, and obesity/poor diets. In certain USAPI, there is a high prevalence of oral cancer, frequently associated with betel nut use.
- Community water fluoridation is not realistic for most USAPI for several reasons. Storage of fluoride products may also be a challenge.
- There is consensus among the USAPI dental leaders about the need to establish a common oral health surveillance system using tools such as the *ASTDD Basic Screening Survey (BSS)* that serves as the basis for the US National Oral Health Surveillance System. Community health centers should continue to collect and report clinical services data to HRSA Bureau of Primary Health Care (BPHC).

### Public Oral Health Care Delivery Sites

- Public oral health care delivery sites range from fixed facilities in main hospitals or in community health centers, to extramural/community sites, e.g., community dispensaries, schools and Head Start centers, most using portable dental equipment. In most locales, services are provided by culturally appropriate staff and in appropriate settings. On occasion,

outreach/off-site care is provided in conjunction with other health disciplines, e.g., nurses. In some locations, capacity for telehealth and distance training/learning is increasing. A few of the islands such as Guam and Saipan have private practitioners.

- The USAPI have large geographic expanses and diffuse populations spread over vast areas of ocean. All USAPI experience limitations of modest economies and limited funding for oral health.
- Many dental clinical locations have limited clinical facilities and equipment, some in need of renovation or replacement, and there is limited local expertise for equipment maintenance. Because of their remote locations from vendors, products and other resources, importing equipment and supplies is expensive with long waits or delays, causing issues with “use by date” products and those needing refrigeration.

#### Funding for Public Health Oral Health Programs and Services

- All USAPI have established public health infrastructures with oral health components. Oral health program funding comes primarily from general government funds. Each USAPI receives HRSA Community Health Center funding; almost all have a dental component. Some USAPI have Medicaid and other health insurance/financing programs that cover dental services for certain age groups. Providers bill for services but typically the reimbursements go back to the general hospital/health center funds rather than being earmarked for the oral health programs. Patients may receive free care or are billed on a sliding fee scale. In most USAPI, preventive care is provided to children at extramural sites, e.g., schools.
- All USAPI oral health programs are faced with insufficient funding to meet the oral health needs of all age groups in their populations, especially in isolated communities, and to sustain programs. The status of the formal political relationships of each USAPI with the US may change in the upcoming years and the impacts on funding and services are unknown.
- Unlike states, the USAPI have not been eligible for CDC Division of Oral Health funding to support infrastructure development, surveillance or population-based preventive services.

#### Workforce (Current Staffing and Pipeline)

- There is an established pipeline for training oral health clinical providers for many of the USAPI. USAPI have a limited ability to hire contract “expatriate” dental providers from other countries. Some dental US federal “loan repayment” opportunities exist.
- Almost all USAPI are faced with workforce issues, e.g., number of providers, levels/types of expertise, low salaries, insufficient funding to fill vacancies including challenges in funding National Health Service Corps required salary match) and to train additional workforce, finding culturally appropriate providers. In addition, there is no formal, regular continuing education opportunities and training for all levels of staff.

## Policy Mandates

- USAPI have US Territory/Commonwealth status that affords some opportunities for US federal aid. Two MCH programs (CNMI and the FSM) have retained the oral health related MCH Title V-National Performance Measure (NPM) 13 (oral health for pregnant women and for children) and American Samoa has adopted an oral health related State Performance Measure (SPM). As a result, oral health will be part of their upcoming MCH five-year needs assessment.
- Some USAPI have local oral health mandates for children, e.g., dental exam prior to entry for school year and dental services to young children. States in the FSM have local laws regarding the sale and use of betel nut and tobacco that have been in place since 2017.
- Each USAPI oral health program continues to be challenged to actualize policy mandates into public health practice, e.g., enforcement and penalties by Public Safety are not widely nor effectively administered for the betel nut and tobacco laws.
- In some USAPI, oral health efforts are limited by certain policies, e.g., scope of the dental practice acts and the boards of licensure
- Each FSM state has a chief dental officer. Although there is a national FSM Medical Director and a national FSM Non-communicable Diseases (NCD) Director, there is no national FSM Dental Director to provide leadership and professional/clinical representation and input.

## Partnerships and Collaborations

- All USAPI collaborate or partner to some degree with selected “sister programs”, e.g., Head Start and the Education agency for school-based services, NCD and MCH for services to their respective patients or populations, but communication and collaboration are not optimal.
- There is consensus about the benefits of revitalizing the PBDA and creating a plan for sustainability. PBDA and the USAPI oral health collective are still in the early stages of revitalization and thus, need common organizational components. All USAPI have participated in the ASTDD Strategy-3 listserv and ZOOM calls to facilitate communication. Two members presented an overview of USAPI on a panel at the National Oral Health Conference (NOHC) in April 2019.

## **SOME OPPORTUNITIES AND TEN NEXT STEPS**

1. CDC and HRSA should continue to provide funding to ASTDD for TA or to the USAPI directly to fund BSS training and development/maintenance of an oral health surveillance system. ASTDD already is assisting FSM, Guam, American Samoa and CNMI in using the BSS.

2. Use the oral health data collected to continue to make compelling cases for 1) hiring more oral health workforce, 2) targeting priority populations, and 3) integrating oral health with other health programs.
3. PBDA, PIHOA and PIPCA can work with ASTDD and its national and federal partners as well as other USAPI international partners and dental equipment and product distributors to explore future funding opportunities for equipment upgrades, expansion of portable or mobile options as well as feasibility of telehealth in some areas, and establishing a regional system for training local community members in equipment maintenance; inventory, storage and loan of equipment or parts or products; and strategize approaches for timely shipping, storage and online support.
4. CDC should issue more NOFOs for support of USAPI oral health programs and integration with other health programs. NOFOs should be culturally relevant and realistic given the unique geographic, economic, workforce and other challenges, e.g., since CWF is unrealistic for most islands, focus on other fluoride delivery methods.
5. Each USAPI can establish closer relationships with NCD and MCH colleagues to explore more formal and enhanced integration of oral health with other health care and education programs and services, especially inclusion in grant applications.
6. Promote NCD Collaboration re: oral health protocols for clinical patients, such as, diabetes, obesity, cardiovascular diseases. NACDD Pacific Chronic Disease Council and PIHOA might assist in this regard.
7. Build upon the revitalization of the PBDA and explore establishing a Community of Practice for the USAPI oral health programs. This could be a vehicle for sharing program and clinical information and best practices, continuing education and collegial/professional support.
8. Determine if existing policies interfere with eligibility to pursue or receive funding or other types of assistance for oral health. Continue to build upon the beneficial policy mandates that promote oral health and actively promote practical and realistic oral health program efforts. Explore ways that dental practice acts could be changed or modified to increase the oral health workforce and increase access to oral health services.
9. If there are advocacy groups in the islands that have not been involved in promoting oral health or asking the government to comply with current laws and regulations, they might be contacted to educate them about the oral health/dental care needs and determine if there are mutually beneficial ways to collaborate. Advocacy also is needed to establish an FSM Dental Director position.
10. Promote USAPI oral health by presenting findings and recommendations to ASTDD, PIHOA, PIPCA and others at future meetings and through other information dissemination pathways. USAPI need to better “market” themselves, including their strengths and needs. Another panel based on this report will be presented at the 2020 NOHC.