



Oral Health 2001



A strategic plan for oral health in Hawai'i

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Oral Health Task Force

Participating Organizations

AlohaCare
American Academy of Pediatrics - Hawaii Chapter
The ARC in Hawai'i
Bay Clinic & Pāhoa Family Health Center
Big Island Dental Task Force
Community Clinic of Maui
State Planning Council on Developmental Disabilities
Denticare
Hāmākua Health Center
Hāna Community Health Center
Hawai'i Dental Association
Hawai'i Primary Care Association
HMSA
Ho'ōla Lāhui Hawai'i
Kalihi-Pālama Health Center
Kaua'i Dental Health Task Force
Kōkua Kalihi Valley
Ke Ola Mamo
Maui County Dental Health Alliance
Office for Social Ministry - Catholic Church in Hawai'i:
Mobile Care Health Project – Hawai'i and Maui
Papa Ola Lōkahi
Saint Francis Health Care System
State Health Planning Development Agency
State Department of Human Services, Med-QUEST Division
State Department of Health, Personal Health Services Division
State Department of Health, Dental Health Division
State Department of Health, Family Health Services Division
State Department of Health, Hawai'i District Health Office
State Department of Health, Maui District Health Office
State Department of Health, Kaua'i District Health Office
State House Committee on Health
State Office of Rural Health
State Senate Committee on Health & Human Services
Wai'anae Coast Comprehensive Health Center
Waikīkī Health Center
Waimānalo Health Center

Key Findings & Recommendations

Five key challenges to oral health emerged from comprehensive data gathered on oral health in Hawai'i. These findings were the basis for recommendations from a diverse group of stakeholders for actions to achieve better oral health in Hawai'i.

Hawai'i's Five Key Oral Health Challenges:

1. **Children's Oral Health Needs.** Our children's oral health is among the worst in the nation. Studies of common oral health indicators for children, such as untreated dental caries and baby bottle tooth decay, show Hawai'i with rates up to four times worse than national averages.

Children in vulnerable populations fare even worse than the already poor state average. Vulnerable children include those from certain geographic areas and from specific ethnic and economic groups.

Solutions for children's oral health woes include fluoridating community water supplies, ensuring that dental services are accessible, and public health education about self-care and nutrition that can improve oral health status.

2. **Vulnerable Adult Population Needs.** Some of our most vulnerable adults are those who live in areas without accessible dental services, individuals with disabilities, low-income uninsured adults or those enrolled in Medicaid or QUEST, homeless adults, and individuals with HIV infections.

Solutions for vulnerable adults include restoring Medicaid and QUEST benefits and supporting safety-net providers that care for all (regardless of ability to pay) and that offer language, transportation, and case management services, which enhance accessibility.

3. **Inadequate Dentist Participation in Medicaid/QUEST.** An extremely low number of Hawai'i dentists care for patients covered by QUEST and Medicaid. Hawai'i is ranked among the last in the nation for proportion of dentists offering service to Medicaid/QUEST participants.¹

Solutions include involving dentists in the discussion of our oral health problems. Safety-net providers, which would serve Medicaid and QUEST patients, need help in recruiting dentists. Such assistance includes: changing licensure provisions and training new dentists in community-oriented dentistry; increasing Hawai'i's markedly low fees for Medicaid/QUEST services; and restoring cost-based reimbursement for QUEST services provided by federally qualified health centers.

4. **Neighbor Island Disparities and Access.** Certain geographic areas in the state have acute shortages of dentists.² It is no surprise that these same areas have populations with the highest rates of poverty, lack of insurance, and Medicaid/QUEST coverage.

Lack of access and other factors contribute to oral health indicators that are worse than average among Neighbor Island children.

Solutions include those identified to improve children's oral health, encouraging greater dentist participation in Medicaid/QUEST, and supporting development and on-going operation of dental safety-net providers.

5. **Practicing Prevention.** Data show that cost and lack of knowledge about preventive practices contribute to poor oral health.

Solutions include public health education about oral health self care; proper nutrition to reduce dental caries, baby bottle tooth decay, and gum disease; and the importance of regular preventive dental care, including dental sealants and topical fluoride treatments for children. In order to address the cost factor, we need to ensure the availability of safety-net dental providers in undeserved communities that provide service regardless of ability to pay.

To recapitulate, Hawai'i's **Five Key Oral Health Challenges** are:

1. **Children's Oral Health Needs.**
2. **Vulnerable Adult Population Needs.**
3. **Inadequate Dentist Participation in Medicaid/QUEST.**
4. **Neighbor Island Disparities and Access.**
5. **Practicing Prevention.**

The **Key Solutions** are:

1. **Fluoridating community water systems.**
2. **Restoring Medicaid/QUEST dental benefits to adults.**
3. **Developing and supporting dental safety-net providers.**
4. **Increasing the supply of dentists participating with Medicaid/QUEST.**
5. **Carrying out a campaign to educate the public about oral health self-care, nutrition, and regular preventive dental care.**

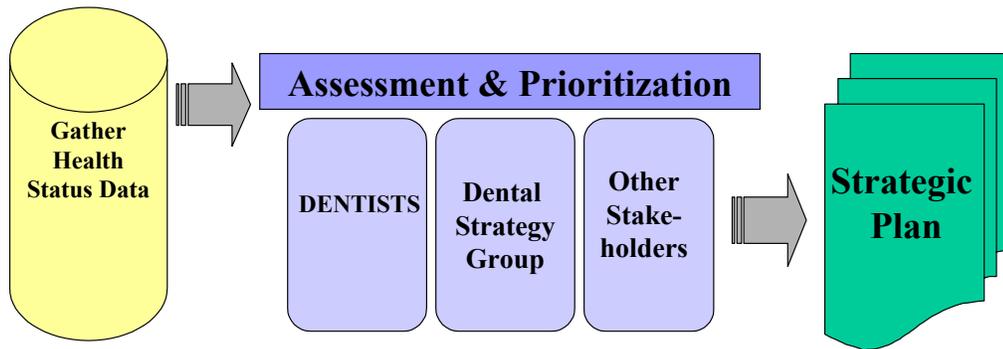
Process

Under the leadership of the Hawai‘i Primary Care Association (HPCA) and in collaboration with the Department of Health, Dental Health Division and Family Health Services Division, a community-based initiative was started to address issues relating to oral health. An Oral Health Task Force was formed in 1999 to identify and address oral health concerns. The Task Force membership includes diverse private and public entities interested in improving oral health conditions. Over 30 organizations across the state participate in the Task Force’s on-going efforts. In addition, Kaua‘i, Maui, and Hawai‘i formed island Oral Health Task Forces to focus on unique issues and solutions for neighbor island communities.

The *Oral Health 2001* strategic planning effort began in late 1999. The Task Force sought to first develop a solid understanding of the present oral health status in Hawai‘i and second, to set forth priorities and recommendations to improve areas of critical concern.

This strategic planning process involved many key stakeholders, including public and private organizations, dental providers, and other concerned individuals and groups. A planning process was established, as outlined in Figure 1. Background information on Hawai‘i’s oral health status was shared with key stakeholder groups. Subsequently, assessment, prioritization and recommendations were developed through round-table discussions, surveys and comprehensive evaluation.

Figure 1: *Oral Health 2001* Strategic Planning Process



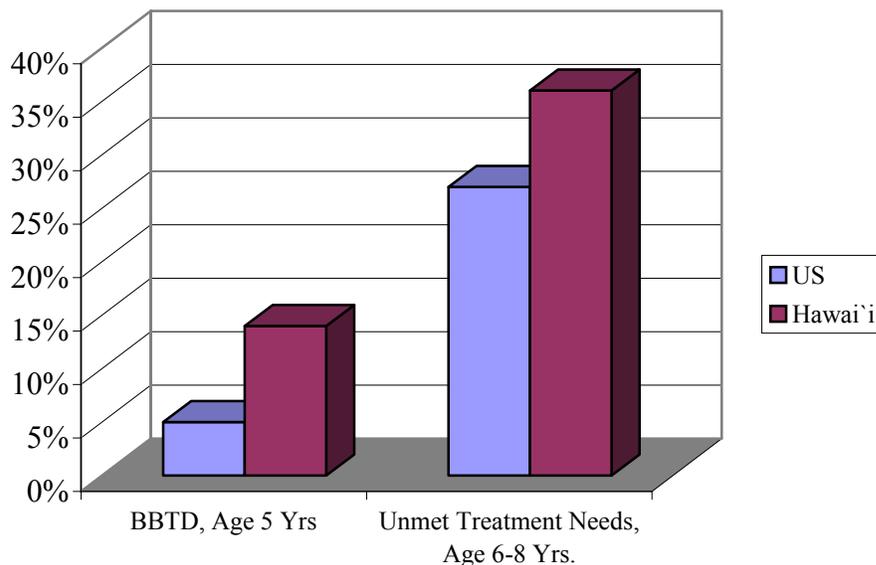
Hawai'i's Oral Health Status

Information was gathered from a wide range of sources including oral health provider surveys, national comparative reports, Centers for Disease Control studies, Behavioral Risk Factor Surveillance System (BRFSS) surveys, and informant interviews with providers, health insurers, and public and private agencies. Through this process a picture of the current oral health status of Hawai'i residents emerged. The Department of Health, Dental Health Division was an important source of information and provided significant assistance in the gathering of oral health status information.

A. Children

Children in Hawai'i have some of the worst oral health conditions in the nation. Key oral health indicators reveal rates up to four times higher than national averages. An important indicator is dental caries, which is the most common childhood chronic disease. As seen in Figure 2, Hawai'i's rate of baby bottle tooth decay (BBTD) is nearly three times higher than the national average, with 14% in Hawai'i versus the US rate of 5%.³

Figure 2: Dental Conditions in Children, U.S. and Hawai'i, 1999



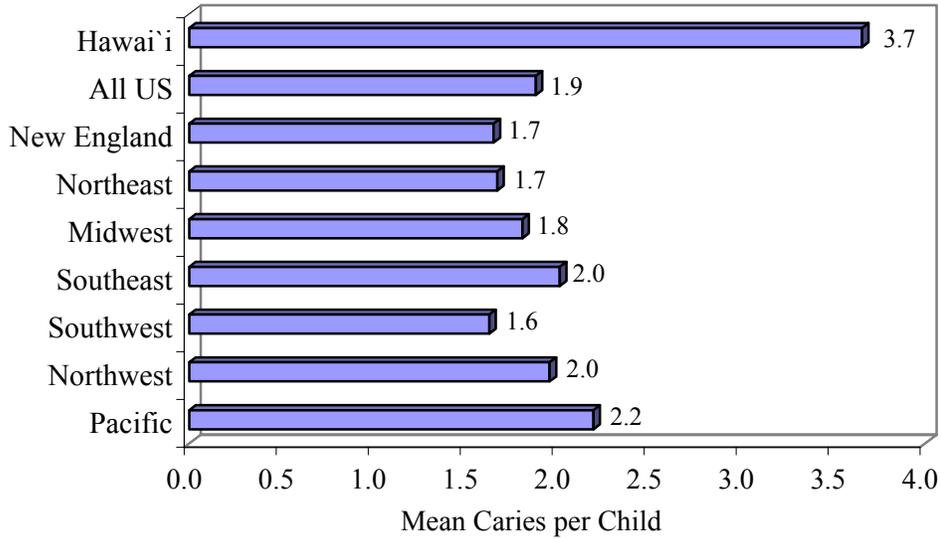
Source: Greer, M. & Louie, R., DOH Dental Health Division, 2000

When comparing mean numbers of dental caries for Hawai'i children (ages five to nine) to regional U.S. numbers, the data show that Hawai'i's rates are almost twice the average elsewhere in the nation (Figure 3).⁴

Certain children have increased vulnerability related to poor oral health conditions. Neighbor island children exhibit higher rates of dental disease. Children on Lana'i and

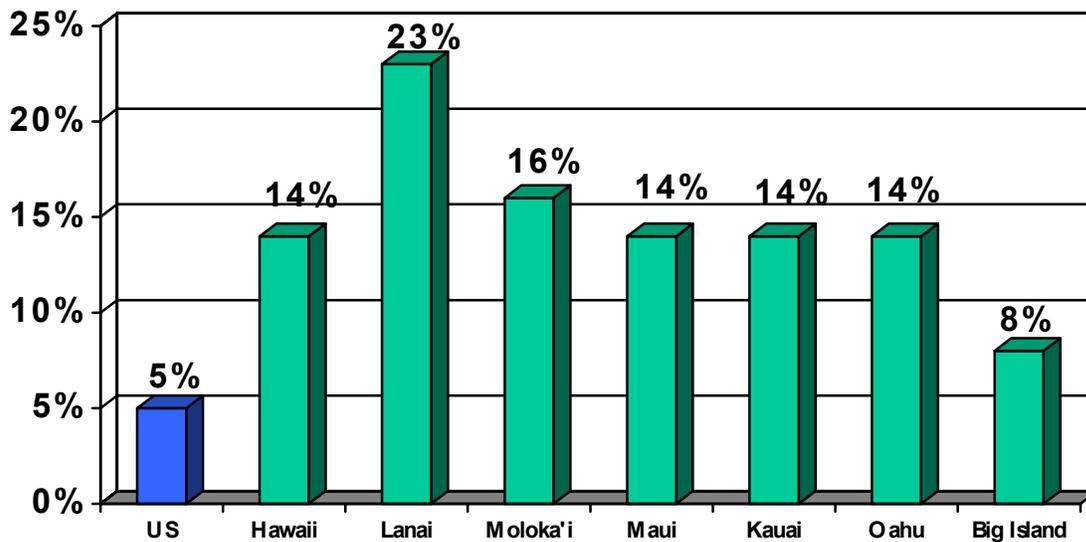
Moloka'i are especially vulnerable, as seen in Figure 4. Baby bottle tooth decay on these islands was up to four times higher than the national rate.⁵

Figure 3: Mean DFT Among Children Ages 5-9: Hawai'i vs. Continental US



Source: Greer, M. & Tengan, S. "Dental caries in early childhood among Native Hawaiians: Pacific Health Dialog, 1998, 5(2) 332-336.

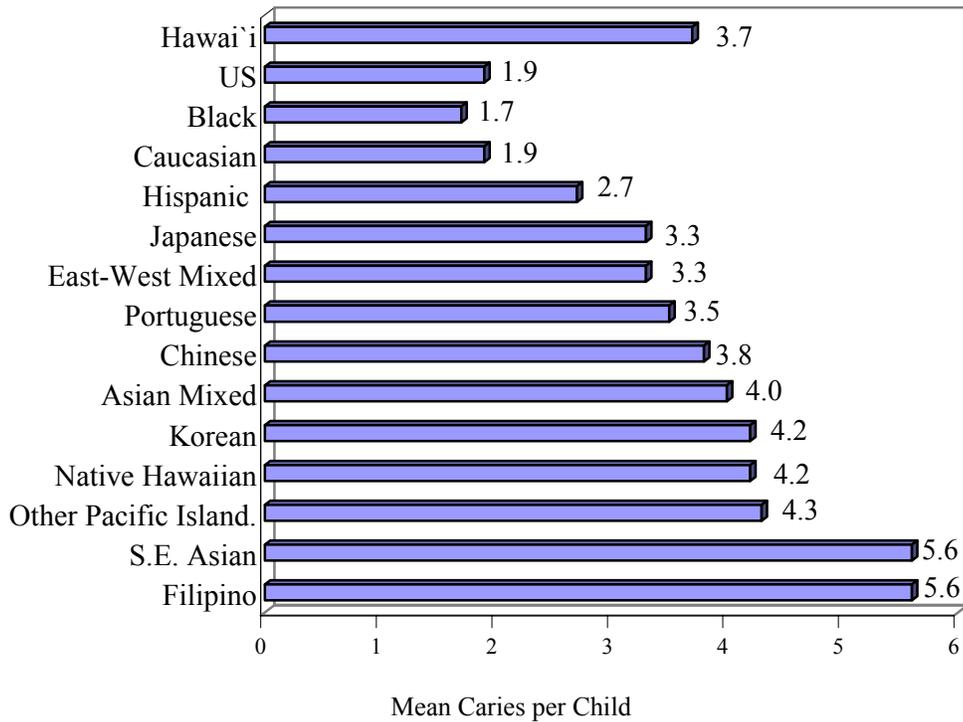
Figure 4: Proportion of five year-olds with Baby Bottle Tooth Decay, 1999



Source: Greer, M. & Louie, R., DOH Dental Health Division, 2000

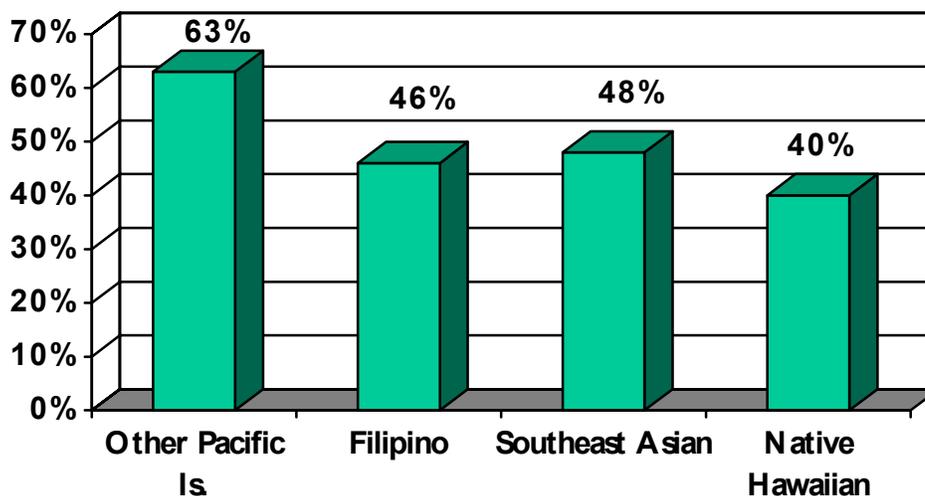
Also at higher risk are Native Hawaiians and ethnic groups with large immigrant populations. Filipino and Southeast Asian children have over 60% more decayed or filled primary teeth than the national rate. Figure 5 supports this estimate, showing how dental caries rates among ethnic groups in Hawai'i compare to the dental caries national average.⁶ Although Southeast Asian and Filipino children stand out as having the highest rates, most of the other ethnic groups are also well above the national average. Many of these ethnic groups also have extremely high rates of unmet treatment needs. As seen in Figure 6, nearly half the Native Hawaiians, Southeast Asian, Filipino and other Pacific Islander children age 6-8 years have unmet dental treatment needs.⁷ Together this high-risk group composes about one-fourth of the children in our state.

Figure 5: Mean DFT in Hawai'i by Ethnic Group for Ages 5-9 Years



Source: Greer, M. & Tengan, S. "Dental caries in early childhood among Native Hawaiians: Pacific Health Dialog, 1998, 5(2) 332-336.

Figure 6: Percent of Children Ages 6-8 Years with Unmet Treatment Needs, 1999



Source: Greer, M. & Louie, R., DOH Dental Health Division, 2000

The reasons for the extreme disparity in dental disease among children of various ethnic groups are complex and not entirely understood. Dental providers and researchers identify an array of factors that include:

- Lack of community water fluoridation.
- Certain foods and cultural customs common in Hawai'i that promote tooth decay.
- A high percentage of recent immigrants have limited understanding of good oral health practices, place less priority on oral health, and have few resources to pay for care.
- Socio-economic factors among the diverse ethnic groups.

B. Specific Vulnerable Populations

In addition to recent immigrants and those with low incomes, certain other populations are at higher risk for poor oral health than the general population. These include individuals with mental and physical disabilities, the homeless, people with HIV/AIDS, those in nursing homes, and those who are homebound. The few studies assessing the oral health needs of these groups confirm their high rate of unmet oral health needs. For example, approximately 76% of Hawai'i's homeless residents have dental care needs. Of those, only 36% are successfully referred. Much of the difficulty for these populations in maintaining good oral

health is associated with access to care issues that will be discussed in the following section of this report.

The link between health and wealth is well established in public health research and is in evidence in the oral health findings in Hawai‘i. For key indicators such as visits to dentists and loss of teeth, there is a clear correlation of better oral health for those with financial resources.⁸ For example, 61% of persons with income over \$50,000 retained all their teeth while this was true of only 40% of persons with income below \$15,000. The low-income population in our state remains significantly vulnerable to poor oral health conditions.

Access to Dental Care

The prelude to access is understanding that good oral health is dependent on primary prevention and regular preventive dental care. Lack of timely dental care can result in escalating oral problems, which may be costly and difficult to treat.

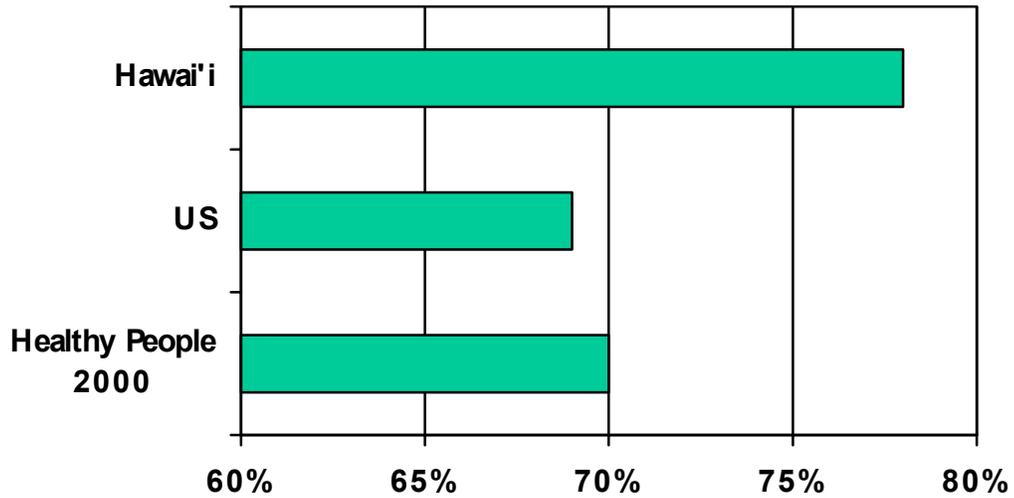
Hawaii has several factors, however, that limit access to dental care for many who seek it. One factor is economic: dental care is relatively expensive so insurance coverage (or lack thereof) and limitation of benefits can keep families with limited incomes from getting dental care. Another factor to access concerns provider availability. Availability issues include the total number of dentists who are actively practicing, geographic areas with dental provider shortages, and providers’ willingness and ability to serve segments of the population with special needs. Lastly, there are cultural barriers. The understanding, priority, and practice of good oral health behaviors are influenced by cultural background and expectations.

On the whole, Hawai‘i’s adult residents lead the nation in regular dental visits. This is a strong indicator of availability of access for the general population. As seen in Figure 7, 78% of Hawai‘i’s adult population visited the dentist in the past year. The national median is 69%. Hawai‘i is well above the Healthy People 2000 goal of 70%.⁹ Of course, more frequent use of dental services does not necessarily indicate excellent oral health. The fact that Hawai‘i leads the nation in adult dental usage may reflect that the poor oral health indicators found among our children also prevail among our adult population.

As a whole, Hawai‘i does better than the nation in private dental insurance coverage for its residents. In our islands, 67% of residents have private dental insurance compared to only 44% nationally.

Understanding what segments of the population are not getting care and why, is important. Data show that there are two general reasons for poor oral health practices. One is that about 34% of the population does not understand the importance of regular check-ups. The second leading reason was the cost of dental care.¹⁰

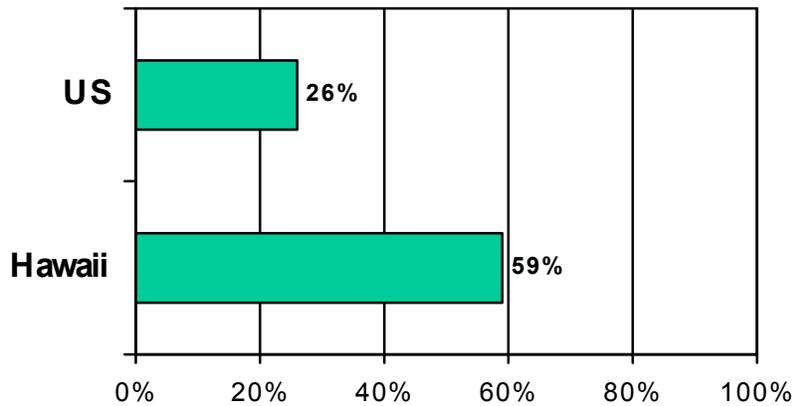
Figure 7: Percentage of Adults that Visited a Dentist in the Past Year, 1996



Source: "Hawai'i 2000, State Health Profile," CDC, DHHS

Hawai'i has the highest rate of dental insurance coverage in the nation for older adults. In the US only 26% of senior citizens have private dental insurance (Fig. 8), in comparison to 59% of Hawai'i seniors.¹¹ Coverage is particularly critical for older adults because Medicare dental benefits are limited to catastrophic pathological emergencies requiring oral surgeries. Basic prevention, routine and restorative dental care, such as dentures and health visits, are not Medicare benefits.

Figure 8: Percent of Older Adults with Dental Insurance, 1996



Even with the extent of insurance coverage in Hawai'i, there is a very sizeable portion of the population with no dental insurance. Almost 300,000 Hawai'i residents, or 24% of the population, are uninsured for dental care. This would include adult participants of QUEST

and Medicaid dental plans. Essentially, in those plans, adults receive only emergency care coverage. Finally, a large proportion of the dentally uninsured are employees of small businesses, which do not offer dental insurance as part of their benefit plans.

Hawai‘i is among the top states in having a favorable dentist-to-population ratio. According to the US Department of Health and Human Services, with 81 dentists per 100,000 residents, Hawai‘i was second highest in the nation.¹² The Department of Health Dental Health Division’s most recent assessment indicates there are 1,026 practicing dentists in Hawai‘i. Comparison by island shows that O‘ahu and Kaua‘i have the highest concentration of dentists and Moloka‘i and Lana‘i have the lowest.

The impressive number of dentists belies the fact that there are severe shortage areas in the state. Certain geographic areas, particularly rural communities, have critical shortages of dentists. Other areas that have ample numbers of dentists in practice do not have any that serve low income uninsured individuals or Medicaid/QUEST enrollees. In fact, Hawai‘i has ten federally designated dental “Health Provider Shortage Areas” (HPSA). The entire island of Hawai‘i is composed of eight shortage areas. On the island of Maui, the Hāna-Ha‘ikū area is a HPSA. On O‘ahu, the Kalihi area has recently received a HPSA designation. The Department of Health expects an increase in dental HPSA designations.

The following chart shows Hawai‘i’s population by island who are most at risk for being unable to get needed oral health services:

	Uninsured (No Coverage)	Medicaid Adults (No Coverage)	Medicaid Children (Limited Access)	TOTAL Underserved	Island Population
Kaua‘i	14,200 26.0%	4,010 7.3%	3,620 6.6%	21,830 39.9%	54,650 100.0%
O‘ahu	176,100 21.0%	54,960 6.6%	49,830 5.9%	280,890 33.5%	838,486 100.0%
Maui	33,500 30.3%	5,350 4.8%	5,090 4.6%	43,940 39.8%	110,500 100.0%
Moloka‘i	2,121 30.3%	1,002 14.3%	940 13.4%	4,063 58.0%	7,000 100.0%
Lana‘i	758 30.3%	91 3.6%	85 3.4%	934 37.3%	2,500 100.0%
Hawai‘i	46,000 33.1%	14,600 10.5%	15,475 11.1%	76,075 54.7%	139,165 100.0%
TOTAL	272,679 23.7%	80,013 6.9%	75,040 6.5%	427,732 37.1%	1,152,301 100.0%

A. Access to Care for QUEST and Medicaid Members

For participants of public dental insurance programs (QUEST for the low-income population and Medicaid for the low income population that is aged, blind and disabled) issues of access are significant. These groups face the most frustrating and overwhelming barriers to care. These are:

1. Small Number of Actively Participating Dentists

Only 30% of Hawai‘i’s practicing dentists serve QUEST and Medicaid beneficiaries.¹³ This is among the lowest percentage of participation in the nation. It is particularly troubling that our children, with such serious oral health needs, may be entitled to comprehensive Medicaid/QUEST benefits but remain uncared for because of the paucity of dentists available to them.

2. Limitation of Benefits

The QUEST and Medicaid programs provide full dental coverage for children but adults are limited to emergency dental benefits only.

3. Neighbor Island disparity in need and providers

The neighbor islands have a higher percentage of their population participating in QUEST and Medicaid, and they generally have lower dentist-to-population ratios, especially of dentists who participate with Medicaid/QUEST.

B. Provider Participation

The most serious access barrier is the limited availability of dentists for QUEST and Medicaid participants. Although Hawai‘i has many qualified dentists, and most are qualified and enrolled as QUEST and Medicaid providers, only 30% actively participate. In a national survey of all states, Hawai‘i was at the bottom, ranked 49th, with the second lowest percentage of active providers.¹⁴

Reasons for Hawai‘i’s poor dentist participation are consistent with national studies that find that low reimbursement rates are a primary reason for non-participation. Hawai‘i’s Medicaid and QUEST reimbursement rates are comparatively lower than regional and national public insurance dental reimbursements. One reason is that the fee schedule used by QUEST and Medicaid insurers is based on rate sheets that are nearly a decade old. The basic Medicaid reimbursement rate has not been changed since 1990 when the Hawai‘i State Legislature modified the rate to 60% of the 75th percentile of the 1991 fee profile. Hawai‘i’s Medicaid reimbursement rates are as much as 60% lower than the amount dentists would collect for serving commercially insured patients.¹⁵ Dentists assert that their “break-even rates” are 65-75% of average commercial insurance collection, including the patients’ portion. A national report found states that instituted rate increases but remained below 35% of regional rates showed little sign of increased participation. Participation did improve in states that instituted increases at or above this level.¹⁶

Dentists are further discouraged from serving the Medicaid and QUEST population by the heavy administrative burden or “red tape” required for participating providers. Dentists cite unique claim forms and codes, difficulties with claims handling, preauthorization requirements, and slow payments as disincentives to participation.¹⁷ The staff training and business commitment required to handling QUEST and Medicaid administration discourages providers from taking “just a few” patients. The option of taking capitated payment for patients has a significant benefit of reducing red tape, yet this option is not well accepted in

the local dental community. As most dental practices are comprised of only one or two dentists, they are, as businesses, apprehensive of taking on the potential financial risks of managed care dentistry. While there are several successful private practices using the capitation approach, most dentists are not aware of how to successfully incorporate capitation into their practices.

Nationally and locally, private practice dental providers have little experience in working with the low-income population and therefore are often frustrated when dealing with this population group. For the low-income population, the higher rate of broken appointments is a major concern among dentists. Provider education to effectively decrease broken appointments could go a long ways to mitigate this problem. Education of patients is also needed. Some states have undertaken efforts to educate patients about the importance of oral health and keeping dental appointments. A national report cited Washington state's *Access to Baby and Child Dentistry* program as having a positive impact. The program provides parents with basic education on oral health practices for their children, training about proper dental office behavior, and the importance of keeping scheduled appointments.¹⁸

**Five Ways to Increase
Dental Provider Participation in QUEST and Medicaid**

- 1. Increase reimbursement rates**
- 2. Reduce administrative burden (“Red Tape”)**
- 3. Educate patients about appropriate office conduct, particularly keeping appointment times**
- 4. Educate dentists about the severe oral health conditions of Hawai‘i’s children**
- 5. Educate dentists and staff about successful strategies in working with program and population**

Source: GAO, “Oral Health, Factors Contributing to Low Use of Dental Services by Low-Income Populations,” September 2000, Round-table discussions with Private Practice Dentists, Honolulu, October, 2000

Hawai‘i dentists give a significant amount of free or discounted care each year. A recent Department of Health survey reports that on average, dental practices “write-off” \$29,000 in free or discounted care. This is about 8% of gross revenues for each practice. Pedodontists, dentists specializing in the care of children, give the greatest proportion - approximately 16% - of gross revenue each year.¹⁹ Given low public program participation rates, this implies that many dentists are perhaps working outside the public insurance system in their provision of care to the under-served populations in the state.

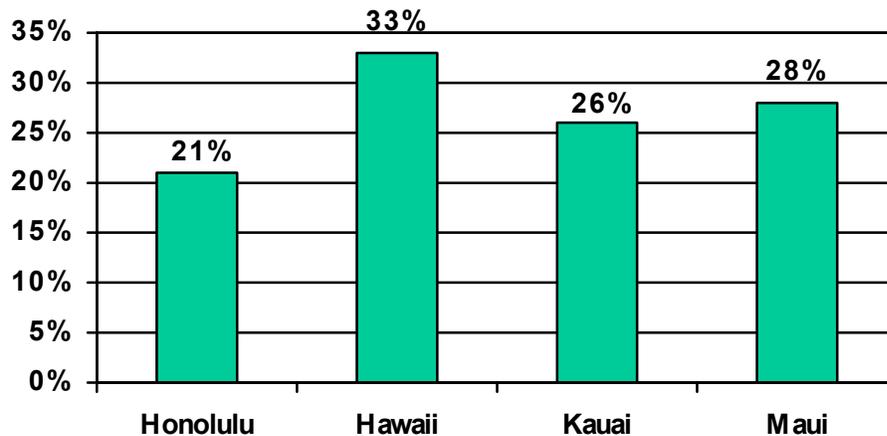
C. Limitation of Benefits

The exclusion of comprehensive dental benefits for adults from the QUEST and Medicaid program has created several significant problems. Nearly half of all QUEST and Medicaid beneficiaries - over 79,000 people - are adults. Their lack of coverage for basic dental care results in untreated oral disease. Not getting timely dental care can result in escalating complex medical and dental problems that may become very costly and difficult to treat. Additionally, this difference in benefit structure between adults and children in QUEST and Medicaid confuses and frustrates families and creates misunderstanding between patients and providers. It also appears to result in reduced use of available benefits by QUEST and Medicaid recipients.

D. Neighbor Island Disparity

The neighbor islands carry the double burden of a high proportion of uninsured residents and a low proportion of dentists. Figure 9 shows that, while 21% of the residents of the county of Honolulu are uninsured for dental services or are covered by Medicaid or QUEST, neighbor island counties' rates range from 26% to 33%.²⁰ The lower concentration of dentists, combined with proportionately higher numbers of uninsured exacerbates the neighbor island access issues. Further study is needed to understand the proportion of dentists actively participating in QUEST and Medicaid outside of O'ahu. Presently, anecdotal reports indicate a critical shortage of participating providers.

Figure 9: Percent of Dental Uninsured by County, 1996



Source: DOH BRFSS, 1996

1. Neighbor Island Oral Task Force Initiatives

The islands of Kaua‘i, Hawai‘i and Maui have formed oral health task forces which have been actively addressing oral health issues unique to their needs. The following are summaries of each task force’s recent activities.

a) KAUA‘I

The children of Kaua‘i have among the highest rates of tooth decay in the nation. The Kaua‘i Dental Health Task Force was formed in response to this problem, with the goal of developing a comprehensive five-year prevention strategy. The task force focused its efforts in the areas of school dental health, community education, dental care, and fluoridation.

Over the past five years the Task Force has achieved much through collaboration and the significant efforts of Task Force member organizations. Accomplishments include:

- Passage of legislation that strongly recommended dental check-ups and treatment for Kaua‘i children entering school for the first time. Though not mandated, there was a 50% compliance rate.
- Coordinated four successful dental health conferences with statewide attendance.
- Assisted in a Kaua‘i community water fluoridation demonstration project and strongly supported the statewide fluoridation initiative during the past legislative session.
- Collaborated with Kaua‘i Electric Company to include Children’s Dental Health Promotion inserts into electricity bills.
- Developed and distributed dental health flipcharts to 110 preschools, early childcare providers, and health/social service agencies in collaboration with AHEC- Na Wiliwili.

b) HAWAI‘I

Hawai‘i County has the highest percentage of Medicaid and QUEST enrollees as well as uninsured individuals in the state, with one third of its population in one of these categories. The island’s large land mass and inadequate public transportation system limits access to dental services. Many residents must travel long distances to see their dentists, and for Medicaid/QUEST patients, finding and traveling to a participating dentist may require several hours of driving time. In addition, access for Medicaid-eligible adults requiring oral surgery or hospital admission on O‘ahu is even more difficult.

The Office for Social Ministry of the Catholic Church in Hawai‘i and St. Francis Healthcare System started the Mobile Care Health Project, which provides direct medical and dental services at nine clinic sites throughout the island, using two fully equipped mobile units. These units, called Mobile Care vans, have provided dental care to the indigent for several

years. Since 1997, approximately 4800 patient visits have been made to these vans for dental services.

c) MAUI

Twenty-eight percent of Maui County's 120,000 residents have no dental insurance or have only Medicaid/QUEST. The Maui County Dental Health Alliance is a task force developed from the State Health Planning and Development Agency's (SHPDA) Tri-Isle SAC in May 2000. Its mission is "improving oral health of the citizens of Maui County." This alliance continues to stay in the forefront of public health dentistry, and advocates for improved access to oral health services. Areas in which the alliance has been focusing its efforts are fluoridation, sealants, education, and prevention.

A dental project that addresses the needs of dental services on Maui is the Mobile Care Health Project's Maui Dental Clinic. This project began a year ago in response to community groups such as the Salvation Army and Homeless Resource Center expressing the serious lack of dental services for their clients. The mobile dental van began operation in July 2000, and is open one day a week. The program is operated by a part-time staff that provides urgent dental services.

E. Access Issues for Individuals with Disabilities

Within Medicaid, individuals with disabilities face significant challenges in getting dental care. The severely disabled who need full sedation for dental treatment have few treatment options. Most dentists do not have surgical privileges at hospitals and poor reimbursement rates increase reluctance to serve this population. However, the majority of individuals with disabilities do not need full sedation or special access services. For example, on Kaua'i, approximately 107 people with developmental disabilities are in need of dental services, but are unable to access care. Of these 107 people, only seven would require sedation or hospitalization. Similarly, on Maui an estimated 197 people with developmental disabilities are in need of dental services. Of these, 150 can receive services at a dental office, while 47 would need sedation or hospitalization.

Most adults with disabilities in Hawai'i are covered by Medicaid and therefore have no basic dental benefits. A state-funded pilot project has been initiated to evaluate the benefit it an increased reimbursement strategy for individuals with disabilities. This effort is expected to yield important information regarding increasing participation, education of dentists and their staff, and appropriate reimbursement rates. Even with the pilot project, services for individuals with disabilities are limited on neighbor islands.

F. Safety Net Providers

An assortment of public and private agencies offers dental services to those unable to get care at private dental offices. In Hawai'i, these programs are:

- The Department of Health Dental Health Division, which offers dental care to low-income individuals and families. It has specific abilities to serve individuals with mental and physical disabilities. Those services are provided at Department dental clinics in four areas of O‘ahu: Kalihi, Pearl City, Kāne‘ohe and Kaimukī. Over the past two fiscal years, the Hospital and Community Dental Services Branch program averaged 2,370 patients, 19,820 dental procedures performed, and 9,173 patient visits, per year.
- Kalihi-Pālama Health Center in urban Honolulu provides general dentistry services to about 2,600 individuals.
- Kōkua Kalihi Valley in urban Honolulu provides general dentistry services to about 2,240 individuals.
- Wai‘anae Coast Comprehensive Health Center in leeward O‘ahu provides general dentistry services to about 2,230 individuals.
- Ho‘ōla Lāhui Hawai‘i on Kaua‘i serves about 500 patients per year.
- Hāna Community Health Center in remote Hāna, Maui provides general dentistry services to about 230 individuals.
- The Mobile Care Program serves about 1,500 dental patients on the island of Hawai‘i and 1,000 on the island of Maui.

A number of these safety net providers report that their capacity to serve patients in need is hampered by difficulties in recruiting dentists.

Recent legislation appropriated start-up funds for establishing two to three dental clinics in underserved areas of the state. The Department of Health is in the process of identifying high need areas and qualified providers to participate in the application process for the funds.

Clearly, with nearly 400,000 Hawai‘i residents without dental insurance or enrolled in Medicaid or QUEST, there remains a big gap in availability of dental services for the underserved. Safety net providers are invaluable resources that fill gaps in care and should be expanded and given greater resources to do their job. While private dental practitioners remain the primary source of dental care for the public it is important to recognize that they can meet only some of the needs of the underserved population. Safety net providers, such as community health centers, are critically important to meeting the dental needs of Hawai‘i’s underserved groups.

G. General Practice Dental Residency Program

The Queen’s Medical Center has operated an accredited post-graduate advanced training program in general dentistry for the past 40 years. This Residency Program provides training for special patient care and serves as the primary resource for hospital-based dentistry. The program produces two graduates each year and provides sedation and special patient management services for persons in need of dental treatment in a hospital setting. Due to the hospital’s declining resources, a transfer to the University of Hawai‘i John A. Burns School of Medicine is being planned to preserve and expand the residency program’s capabilities.

Prevention of Oral Disease

Effective primary prevention measures for oral health are well recognized, safe and cost-effective. In Hawai‘i, implementation of proven prevention strategies, such as community water fluoridation, often lags behind that of many other states.

A. Fluoridation

Community water fluoridation is one of the major public health advances of the 20th century. Fluoride, a naturally occurring substance in water, substantially reduces tooth decay when available in appropriate concentrations. Because most water supplies do not contain the needed concentration, fluoride is adjusted at the source of the supply. National studies show that living in a fluoridated community from birth reduces tooth decay by as much as 65%.

Despite these proven benefits and the high prevalence of tooth decay among children in the state, Hawai‘i has not implemented fluoridation in any county water supply. The military bases in Hawai‘i have fluoridated their water and demonstrate significantly lower rates for tooth decay among children on base. Leading U.S. cities have well established fluoridation systems and have long records of safe and effective implementation. Community water fluoridation is one of the most cost-effective ways to reduce tooth decay in a community. State dollars devoted to fluoridation will be returned many times over in Medicaid/QUEST dental savings.

In lieu of this community-wide approach, it is important that children receive fluoride by some means. While more costly on a per-participant basis, pre-school and school based fluoride programs are effective methods to reach high-risk children. Fluoride mouth rinse programs can decrease tooth decay in children up to 35%. The Department of Health, Dental Health Division administers weekly fluoride mouth rinse programs on Kaua‘i, Ni‘ihau, Lana‘i, and in Hāna, Maui.

B. Dental Sealants

The application of dental sealants, a thin resin coating applied to the chewing surfaces of molar teeth is an important complementary prevention practice. Its effectiveness increases prevention significantly when used in conjunction with fluoridated water or rinses.

Kōkua Kalihi Valley Community Health Center, as part of a collaborative outreach effort, provides dental sealants to five elementary schools. The school-based initiative screened over 1,600 students. This clinical effort is done in conjunction with education on oral health.

Identified Strategies

Discussions and surveys with the Task Force members and dental providers identified numerous strategies to improve oral health in Hawai'i. A long-term improvement can be achieved by implementing critical factors and addressing gap areas. There are three action items that consistently received the highest priority for addressing present disparities in oral health. They are:

- 1. IMPLEMENT COMMUNITY WATER FLUORIDATION**
- 2. RESTORE MEDICAID/QUEST DENTAL BENEFITS TO ADULTS**
- 3. DEVELOP AND SUPPORT DENTAL SAFETY-NET PROVIDERS**
- 4. INCREASE DENTISTS' ACTIVE PARTICIPATION IN QUEST AND MEDICAID BY INCREASING REIMBURSEMENT RATES. In addition, reduce the administrative burden and provide education for both participants and providers.**
- 5. CARRY OUT A CAMPAIGN OF PUBLIC EDUCATION ABOUT ORAL HEALTH SELF-CARE AND PREVENTIVE DENTAL CARE.**

A more comprehensive list of proposed strategies is attached.

Conclusion & Priorities

The oral health of Hawai'i's most vulnerable residents is seriously lacking. The rate of dental decay among Hawai'i's children is an embarrassment to our state. Children's oral health deficiencies cut across ethnic, geographic and income lines. For some of Hawai'i's children tooth decay and lack of dental care has reached epidemic proportions.

Other vulnerable populations are Hawai'i's low income uninsured residents and those served by Medicaid. Adults who are disabled, have HIV/AIDS, or are homeless are other underserved, vulnerable groups.

There is a severe shortage of dentists willing to actively participate in QUEST and Medicaid. The impact of this shortage is the most devastating to neighbor island residents. Safety-net providers in Hawai'i are an invaluable resource for underserved populations but are under-supported.

An array of preventive and educational efforts pertaining to oral health is being pursued throughout the state. The most effective preventive strategy – implementing community water fluoridation – is an urgent priority. Other preventative initiatives are also needed.

Public and private collaborations are necessary to establish appropriate strategies that will balance the present health status inequities.

Hawai‘i has a good supply of dentists, and adults here are in the habit of visiting their dentists more regularly than the national average. These strengths may help us reach parity for our islands’ children and other vulnerable populations.

¹ 1998 Survey of State Medicaid Departments by the Forum for State Health Policy Leadership, National Conference of Legislatures

² Primary Care Needs Assessment Data Book, DOH Family Health Services Division, 1999

³ Greer, M. & Louie, R. DOH Dental Health Division, 2000

⁴ Greer, M. & Tengan, S. “Dental caries in early childhood among Native Hawaiians: Pacific Health Dialog, 1998, 5(2) 332-336.

⁵ Greer, M. & Louie, R. DOH Dental Health Division, 2000

⁶ Greer, M. & Tengan, S. “Dental caries in early childhood among Native Hawaiians: Pacific Health Dialog, 1998, 5(2) 332-336.

⁷ Greer, M. & Louie, R. DOH Dental Health Division, 2000

⁸ DOH, BRFSS 1996

⁹ “Hawai‘i 2000, State Health Profile,” Center for Disease Control, 1999

¹⁰ DOH, BRFSS, 1996

¹¹ Janes, Gail et al.

¹² Greer, Mark. Internal Report, Dental Health Division, DOH, September 1999

¹³ 1998 Survey of State Medicaid Departments by the Forum for State Health Policy Leadership, National Conference of Legislatures

¹⁴ 1998 Survey of State Medicaid Departments by the Forum for State Health Policy Leadership, National Conference of Legislatures

¹⁵ GAO, “Oral Health, Factors Contributing to Low Use of Dental Services by Low-Income Populations,” September 2000, Round-table discussions with Private Practice Dentists, Honolulu, October, 2000

¹⁶ GAO, “Oral Health, Factors Contributing to Low Use of Dental Services by Low-Income Populations,” September 2000

¹⁷ GAO

¹⁸ GAO

¹⁹ Department of Health, Dental Division, “1998 Hawai‘i Dental Practice Survey” June 1999

²⁰ DOH BRFSS, 1996