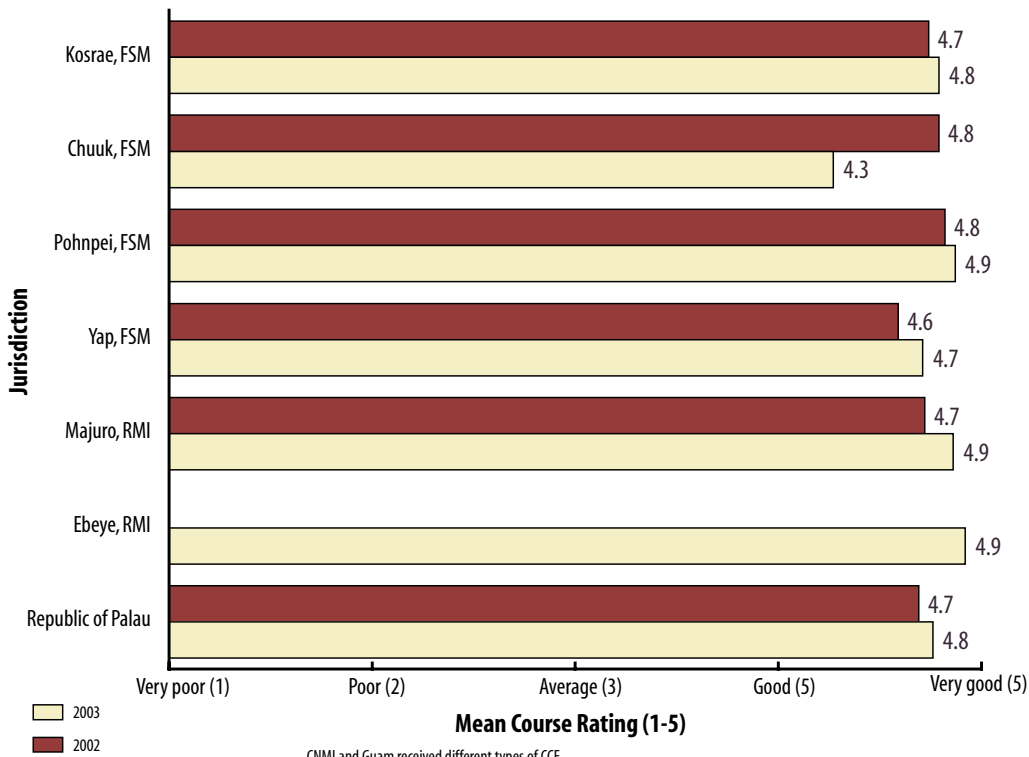


EVALUATION OF PICCEP CME COURSES (BEHAVIORAL HEALTH TOPICS): 2002-2003



CNMI and Guam received different types of CCE.
 PICCEP partner U of HI provided CCE to American Samoa with different evaluation protocol, with same general results.

curriculum that focused on provider-patient communication. The interactive instruction and small groups workshops led participants through techniques for recognizing and prioritizing problem behaviors with patients, identification of where patients fall on the “stages of change” continuum, and techniques to help patients to change problem behaviors. In addition, the curriculum addressed mental health and psychiatric topics of particular importance to primary care providers, including diagnosis and management of acute psychosis, recognition and management of depression and anxiety and panic disorders, and substance abuse and dependence. The program consisted of a total of 12 hours (four hours in 2002 and eight hours in 2003) of on-site workshops in all PICCEP sites except Guam and CNMI (where PICCEP

provided specific CCE courses requested by those jurisdictions).

Participants evaluated all of the behavioral health courses, which were consistently well-attended and received (see box above).

SAMPLE PICCEP BEHAVIORAL HEALTH COURSE TOPICS

- Alcohol problems: screening and brief interventions
- Enhancing patient motivation: Managing chronic health and substance abuse problems
- Enhancing motivation with diabetes patients (exercise)
- Smoking cessation
- Definitions: Substance abuse and dependence
- Alcohol and tobacco problems: Assessing, intervening and managing patients

“Much-needed training and guidance.
 This will definitely facilitate my clinical life.”
 —course participant

ORAL HEALTH PROGRAMS

In part because some of their faculty had worked previously in the Pacific Islands, the PICCEP team knew at the outset of the PICCEP that early childhood dental disease was highly prevalent in the region. It affects more than 90% of the children, a rate more than double that of the mainland United States. A survey conducted on Kosrae by a local dentist in 2002 found only 1 of 123 first-grade children to be free of dental decay. The IOM report, a review of research literature, and PICCEP site visits identified a general shortage of dentists and dental health workers in many parts of the region.

But poor oral health has been evident even in areas with highly developed health systems and large health workforces. The problem is closely linked to changes in lifestyle that have occurred with the shift to cash economies, and by extension, to a diet rich in such “cariogenic” foods as soft drinks and sugary cereals and snacks. Bottle-feeding behaviors, particularly using sugar-containing substances, have further contributed to an outbreak of caries in young children. When children contract the infection—often from their mothers and before their first birthdays—it spreads rapidly to deciduous and then permanent teeth, causing pain, dysfunction, and demand for expensive (and often inaccessible) dental health services.

To address the problem, PICCEP developed an oral health CCE component to train providers in caries prevention strategies that can be performed in the usual scope of work of primary care providers. The education and training engaged both dental and medical providers in achieving a common goal of recognizing oral health as an integral part of general health, and dental care as an important component of primary health care. To



PICCEP oral health demonstration, Chuuk, FSM

promote awareness of the problem and encourage basic preventive behaviors, the team looked not only to non-dental providers such as physicians, nurses, and community health workers but also to such “auxiliary” providers as directors of Head Start and of public health and maternal and child health programs. PICCEP dental faculty from the University of Washington School of Dentistry developed a series of CCE lectures and workshops on dental health issues—combining didactic and hands-on methods—that was presented in conjunction with the CME provided by the project’s medical team. The program focused on interventions for pregnant women and very young children.

The PICCEP team assembled a packet of oral health information and protocols to be distributed in the Pacific jurisdictions. The PICCEP oral health team emphasized the integration of preventive oral health strategies into primary medical care, shared preventive techniques such as the application of fluoride varnishes, and provided instruction in diagnosis of dental disease, identification of referral and treatment options, and consultation with dental providers, physicians, and others working with children. In response to requests, PICCEP provided translations of University of Washington published materials (including the “Lift the Lip” flip chart), in Marshallese and Kosraen.

The program has raised the region’s awareness of the integration of oral health strategies into primary care, and some of the jurisdictions have continued the work. Palau, for example, developed a model oral health program that includes an oral health nurse who works with MCH providers. The RMI has initiated new oral

“Very practical information/application which are simple but can take care of a very serious and prevalent problem with children.

Thank you very much for sharing with us.”

—course participant

“Eye-opening remarks on practical things that can be done with very low financing; very practical—maybe we need to implement urgently.”

—course participant

health surveillance methods for young children. PICCEP also identified regional individuals who could be involved in providing oral health CCE to encourage regional sustainability, and it helped revitalize the Pacific Basin Dental Association as an active subgroup under the PIHOA. PICCEP oral health faculty helped several jurisdictions prepare successful grants to CDC for oral health programs in the region. Several dentists from the region have attended the University of Washington Dental School Summer Institute.

The PICCEP oral health program faculty participated in many regional planning and policy forums, including the Oral Health Summit held by the South Pacific Commission, WHO, and a meeting with the dental program leadership of the Fiji School of Medicine (where many of the region’s dentists are trained) in early 2001.

The program stressed the importance of integrating oral health into the larger system of primary care and involving medical personnel in anticipatory guidance and preventive services.

HEALTH ASSISTANT PROGRAMS

Members of the PICCEP team who had worked in developing countries knew that much of the health services provided in the remote locations of the Pacific jurisdictions do not occur in the central hospitals but in more remote clinics and dispensaries staffed by non-physicians. In many locations, these staff are health assistants or health aides who have had minimal clinical training. Some Pacific states have adopted the health assistant or health aide model, in which villages or remote communities select lay members to receive basic clinical protocol training to handle emergencies, provide basic preventive and prenatal care, and treat common infections. This often occurs under radio or telephone supervision by centrally located physicians or other clinicians. The Alaska Health Aide Program, which began in the 1950s, is one example of the successful application of the health assistant model. The University of Washington physician assistant training program (MEDEX Northwest) has a strong relationship with the Alaska program, including the training of more than 30 health aides as physician assistants.

Drawing from its Alaska experience, MEDEX developed and implemented a health worker program in FSM during the 1970s. Health worker programs are in place in Yap, Chuuk, and the RMI, operating with varying resource, infrastructure, and training needs.

As part of the program needs assessment, MEDEX staff during 2002 visited the RMI and FSM (Chuuk and Yap) to assess continuing education for the health assistants. They found, to different degrees, a poorly maintained primary care system, one further undermined by factionalism and nepotism. The over-riding problems

appeared to be deteriorating infrastructure, the lack of even radio communication in many areas, and a dearth of resources to transport both clinicians and supplies to remote islands.

PICCEP sought new resources to mobilize MEDEX to create and implement CCE and additional training for health assistants in the region, a proposal that generated strong interest in several jurisdictions. It called for application of a “train the trainer” model, through which MEDEX staff would train physicians in Chuuk, considered the most challenging and needy environment



PICCEP course, Ebeye, RMI

in the region. The physicians would become familiar with the health worker system, engage in curriculum development, and deliver month-long CCE to health assistants. These activities could be duplicated and delivered in other jurisdictions over time.

To prepare for this effort, PICCEP in 2002 brought health assistant program educators from Chuuk to Alaska to observe training and operations of the Alaska

Health Aide program, which trains lay community members to provide, under physician direction, basic health services in remote sites. But 2003 was to be the final year of the PICCEP program because HRSA decided to have a new competitive cycle to award CCE funds for the Pacific jurisdictions. The health assistant “train the trainer” program requests were not funded by HRSA or others.



Pohnpei, FSM