GUEST EDITORIAL

Is Our Nation Fully Prepared to Provide Disaster Relief to Victims Needing Dental Care?

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When Hurricane Katrina devastated New Orleans and other communities along the Gulf Coast, the evacuation displaced hundreds of thousands of people, distributing them throughout 48 states without medical charts or prescription medications, extending the impact beyond the strike zone. Disasters have a way of magnifying community preparedness and the need for leadership to ensure that communication, coordination, and collaboration are actualized on ground zero. "Evacuee receiver communities" must know the mission and primary objectives in order to cope with the fluidity of the relief effort. For evacuees, the primary objectives of protection and security, moving from shelters into more "temporary permanent" housing, and employment and access to health care are paramount. These objectives have implications for planning and implementing triage, emergency care, and primary health care services for large, fluctuating numbers of people.

For dental relief efforts, planning and assessment of readiness are crucial. Do we have national, statewide, and regional and local plans with a clearly defined mission and specific objectives that can be activated and sustained? Are communication networks in place? What are the roles of public health dentistry, local health departments, community clinics, hospitals and the private sector? What about communities having military and veterans administration dental facilities and dental schools – what should be their contribution? Will treatment be provided at shelters using mobile and/or portable equipment? Is there a workable transportation system to take shelter evacuees to the dentist? Who will be treated – just those living in shelters? How do we identify and verify evacuee status? Should we provide dental emergency care, primary care, rehabilitative care on a sustained basis for a determined period of time? What do we do with the evacuees who lost their dentures while being air lifted to safety, or whose dentures fell out when they jumped off rooftops into 15-foot deep fetid water to swim to dry ground? Do we have the resources, including laboratory support? Have priorities been established? Is there a perception that host community dental treatment needs are being put on hold to accommodate those of evacuees? Who will make critical decisions? Is there a viable local dental public health infrastructure to coordinate the relief effort?

What happens if the majority of evacuees are adults with chronic recurring dental care needs who are not covered by Medicaid, no longer have a source of income or have lost employer-provided dental benefits? How relevant is "presumptive eligibility" if it applies to children only and parents are reluctant to let "strangers" take their children to the dentist? How do we mobilize the dental workforce for a disaster relief effort? Do we have an up-to-date volunteer bank of dentists and auxiliaries who are willing to serve when disaster strikes? Can normal licensing requirements be waived for licensed dentists crossing state lines to provide dental care in stricken areas or "evacuee host states"?

When the federal government called Katrina a national disaster, the interpretation at ground zero in host states was that federal authority would supercede state laws. The disaster wiped out health care infrastructures, destroying dental practices, medical and dental records, and displacing providers to states in which these providers were not licensed to practice. It was assumed that licensed public health dentists/commissioned corps officers detailed (on orders) to the Katrina relief effort and/or volunteer dentists from around the country and the world wanting to volunteer for the relief effort could provide dental care to hurricane evacuees. This assumption presumes that Boards of Dental Examiners have been briefed on the "federalization" in declared national emergencies such as Katrina, when in fact they may not have been and are themselves stretched beyond capacity, providing provisional licensure for dentists displaced by the disaster. When such planning vacuums transpire at ground zero, relief efforts are compromised as precious time is lost resolving discrepancies in state and federal laws.

Over time, after media coverage fades and evacuees are broadly dispersed in the community, it is easy to move on and to assume that the tragedy no longer exists for evacuees. It is important to remember, however, that evacuees have lost homes, vehicles, jobs, and employer-based health care coverage as well as their roots, culture, families, friends and networks for the daily interactions that we all take for granted. And while dental care needs may not be the highest priority, they are reflective of the oral health disparities and poverty in America. A man waiting in line to be triaged for dental care said in frustration: "I just want somebody, anybody to do something, anything for me" as he wept silently. Another man expressed his gratitude for being referred to get his "teeth fixed" so he could find a job and begin to put his life back together.

Our most recent disasters, such as Hurricanes Katrina and Rita, should cause us to re-think about preparedness at all levels as well as short-term and long-term strategies for responding to the dental needs of evacuees. Logistical challenges are greater than those related to providing dental care. To be effective dental workforce relief providers, we need knowledge of and access to community assets. If we don't have a well-crafted and coordinated preparedness plan, field readiness may be unattainable. In the end, we have to determine whether or not we have the trained provider networks, the will, and the staying power needed to provide dental relief.

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