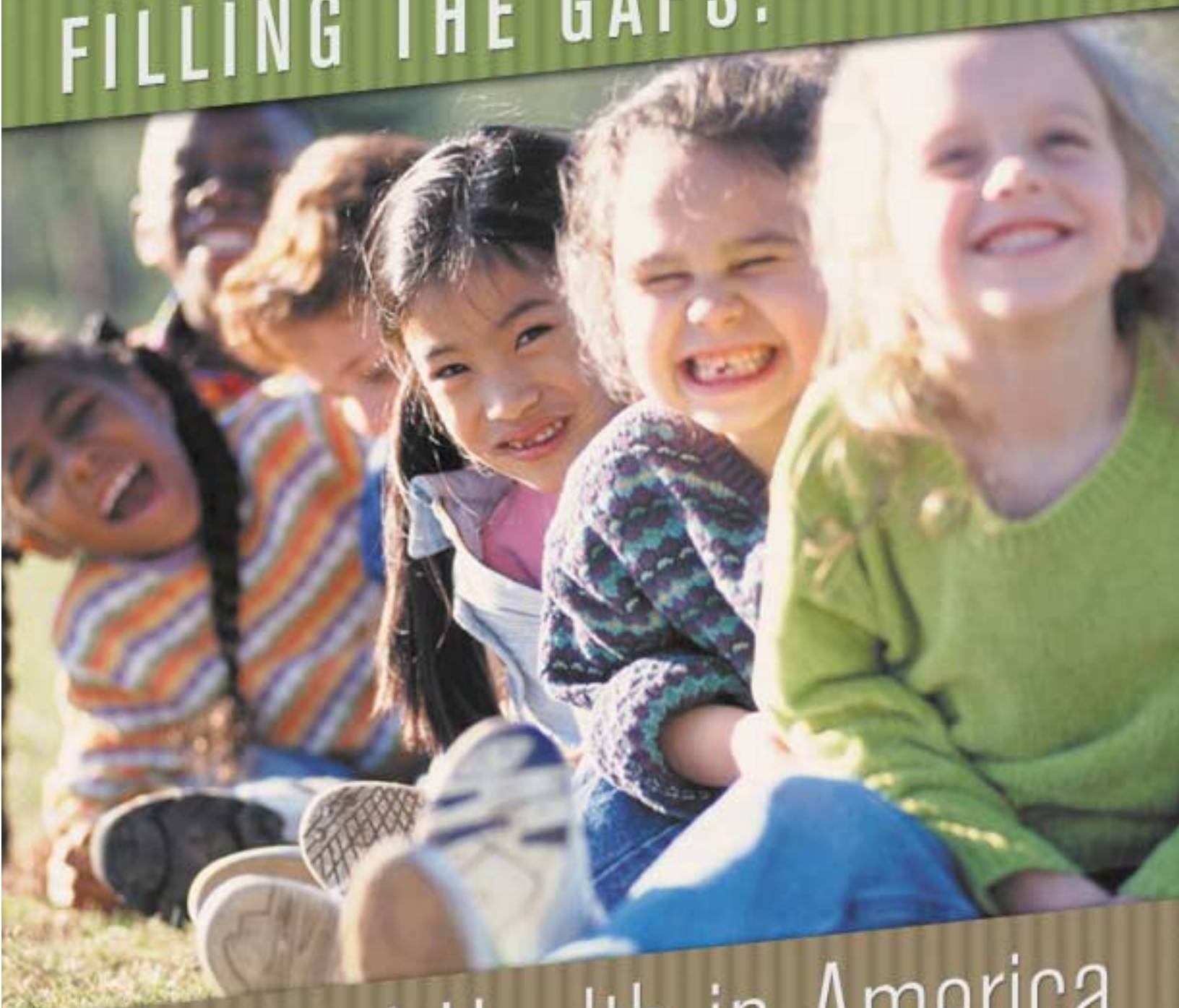
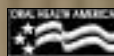


FILLING THE GAPS:



Oral Health in America

THE ORAL HEALTH AMERICA
NATIONAL GRADING PROJECT
2001-2002
NATIONAL GRADE: C



Campaign for Oral Health Parity

Funded in part by The Robert Wood Johnson Foundation

2001 Oral Health Report Card

PREVENTION: C

Fluoridation

Sealants

ACCESS TO CARE: C-

Availability of Dentists

Children's Medicaid Dental Program

Visits to Dentists

Dental Insurance Status of Adults and Elderly

ORAL HEALTH LEADERSHIP: B+

Dental Director

Oral Health Coalition

ORAL HEALTH STATUS: C+

Oral Health of Children

Use of Spit Tobacco

Edentulous Elderly

Oral Cancer Mortality Rates



Comments

ORAL HEALTH OVERVIEW

The nation's grade of a C in oral health for 2001 signifies new possibilities for the future as well as widespread unmet needs. On one hand, there is new energy to improve the nation's oral health. Surgeon General David Satcher's call for attention to the "silent epidemic" of oral diseases in his 2000 report, *Oral Health in America*, is starting to be heard. A number of states have hired dental directors in the past year. This signifies an important step toward supplying vital leadership at the state level. However, much more progress is needed. Too many low-income people lack access to care, and too few communities have taken advantage of cost-effective prevention measures. Many of our children and our older Americans have gone too long without adequate dental care. Improving the nation's oral health grade will require additional leadership and resources. There is much more work to be done.

- Over 108 million U.S. adults and children have no dental insurance.
- For every child without medical insurance, there are 2.6 without dental insurance.
- Poor individuals (66%) are less likely to visit a dentist than the non-poor (46%) in any given year.
- Tooth decay is the most common chronic childhood disease, affecting 50 percent of first graders and 80 percent of 17-year-olds.

- Every year, over 30,000 people develop oral and pharyngeal (throat) cancer.
- Oral/pharyngeal cancer is the 6th most common cancer in U.S. males and the 4th most common cancer in Black men.
- Almost 2.5 million days of work are lost each year due to dental problems.

As the states and the nation as a whole work to improve the health care system, it is important to remember that good oral health is a major contributor to good overall health. Dental disease can threaten a child's health, well-being, and achievement. Children with oral health problems can have difficulty eating and sleeping, and paying attention in school. In addition, researchers are exploring links between adult oral disease and diabetes, heart disease, stroke, and pre-term, low birth weight babies.



ABOUT THIS REPORT CARD

This report card provides a snapshot of oral health in America, using data available at the state level. The grading categories are intended to call greater policy attention to areas of need in prevention, access to care, oral health leadership, and oral health status across the country. They are not intended to grade any one national, state, or local program. The reasons for poor oral health are many, including under-supported prevention measures, lack of insurance, regional shortages of oral health practitioners, and population behavior.

Fortunately, safe and effective oral disease prevention measures do exist, such as community water fluoridation and dental sealants. Many of these measures are cost effective. Individuals, communities, and the health professions must work together to create successful policies and programs that will make oral health care an integral part of overall health care.

PREVENTION: C

Americans cannot underestimate the importance of prevention and preventive services in maintaining a lifetime of good oral health. Tremendous variances exist throughout the states and the District of Columbia when it comes to prevention. Basic, cost-effective preventive measures, such as the fluoridation of public water supplies, have not been implemented in many parts of the country. However, it should be noted that some states are making significant improvements. Even though the state received an F in this category, currently almost 30% of Californians drink fluoridated water, an increase from 17% in two years.

The use of dental sealants remains low, even as a proven means of caries prevention among high-risk children. According to the Centers for Disease Control and Prevention's Synopsis of State and Territorial Dental Programs, three states stand out



in their efforts to reach children through public health sealant programs: Ohio (28,575 children reached in 2001); New York (26,000 children reached in 2001); and Illinois (22,362 children reached in 2001). Other states are working hard to expand their services. Maine, for example, increased its school-based dental sealant program from 38 schools to 91 schools .

Some state dental health programs are leading the way by expanding clinics, developing school-based programs, supporting oral health legislation, and initiating innovative partnerships to improve oral health. For example, North Dakota's state oral health program developed and implemented an oral health component for home health visits to all new mothers to promote good oral health and its impact on overall health throughout life. In other states, community, government, and business leaders are coming together to form oral health coalitions to help address these issues.

ACCESS TO CARE: C-

Access to oral health care is a problem for millions of Americans, particularly for children, elderly adults, minorities, and people with disabilities. Many regions of the country have a maldistribution of dentists, and community-based dental clinics, even where they exist, are not sufficient to fill the gap. Private health insurance, designed to

be the cornerstone of the American health care system, is hardly universal and often does not provide dental coverage. The Medicaid dental program and State Children's Health Insurance Program are unable to meet the oral health needs of the more than 108 million Americans who do not have dental insurance. Income plays a major role in who receives services and who does not. If we fail to fill this gap, the U.S. will pay a high and long-term cost for failing to prevent illnesses and treat all of its citizens.

A number of states are leading the way in finding solutions to access problems. In Alabama, the governor increased Medicaid reimbursement rates to 100% of insurance rates, and the state oral health program is educating dental providers and recipients about Medicaid through a grant from The Robert Wood Johnson Foundation. In 2001, Georgia provided \$1 million for expanding the Georgia Oral Health Prevention Program statewide to help improve access to dental prevention services for poor children. The Dental Health Division of the Hawaii State Department of Health secured funds to open a comprehensive care dental clinic on the Island of Maui to assure access to care for Medicaid eligible children and adults, including those with disabilities.

ORAL HEALTH LEADERSHIP: B+

The nation has made significant progress in boost-

ing the leadership necessary to improve oral health. Only six states are without a dental director. The formation of dental coalitions in states across the country can be seen as a result of the U.S. Surgeon General's call to action on oral health in 2000. Now that many states have leadership in place to direct and develop innovative programs, it is time to ensure they have the human and financial resources to get the job done.

ORAL HEALTH STATUS: C+

The oral health status of the nation indicates areas of need and oral health conditions, rather than programs and prevention measures designed to address those needs. For example, tooth decay is the single most common childhood disease in the U.S.—five times more common than asthma and seven times more common than hay fever. Poor oral health during childhood can cause health and social problems throughout life. Oral cancer is more common than leukemia, ovarian, thyroid, kidney, pancreatic, and esophageal cancer, and it is rarely diagnosed in the early stages of the disease, thereby leading to higher mortality rates.

Preventive services and access programs developed at the community, regional, and state level can help to reverse these trends. For instance, Maryland is launching an oral cancer mortality prevention initiative including oral cancer screenings and training for dentists, dental hygienists and other health care providers who are the first line of defense in spotting oral cancer.

Increased efforts to track state-specific data will help track progress and provide clearer pictures of areas in need. As we identify policy and educational changes, and develop public-private partnerships to address oral health problems, America must recognize that oral health is a key part of overall health in order to make the grade.



Grading Scale

METHODOLOGY

For the 2001 grading project, Oral Health America gathered public health information available from a variety of sources to develop a state-by-state database. The most recent primary data sources possible were used, including centralized data sources from the Centers for Disease Control and Prevention. In particular, data were collected from the oral health modules of the National Oral Health Surveillance System (www.cdc.gov/nohss) and the Behavioral Risk Factor Surveillance System (www.cdc.gov/nccdphp/brfss/).

Additional state data were obtained from state dental health programs, the American Academy of Pediatrics, Campaign for Tobacco-Free Kids, Health Care Financing Administration/Centers for Medicare and Medicaid Services (CMS), Health Resources and Services Administration (Bureau of Maternal and Child Health), and the National Cancer Institute. Data sources are listed for each grading category.

Grades for each of the categories are based on obtainable data, as well as desired levels of oral health status and use of oral health services. In most categories, grades are based on a national mean or bell curve, by establishing the mean as a “C” grade and assigning other grade ranges based on standard deviations above and below the mean. Some of Oral Health America’s grading scales exceed or are more rigid than the

Healthy People 2010 standards. For example, given the health risks, Oral Health America could not condone any use of spit tobacco. In this category, “A” equals 0% use.

An “I” represents “incomplete,” where there were no data available to provide any measurement of status. In working to improve oral health and oral health care in America, it is particularly important that state-specific measurements of prevention, access, and oral health status are gathered in order to provide baselines for improvement and/or achievement. In several cases, states did not respond to our requests for information, indicated by a “DNR” or “did not respond.”

It is our hope that opinion leaders, public advocates, policy makers, and the media will take note of our nation’s shortfalls and will work to support existing infrastructure and programs to improve and promote oral health across the country.

REPORT CARD CATEGORIES AND DATA SOURCES, 2001

The following scale was used to assign point values for letter grades in the oral health report card grading:

A	4.00	D+	1.33
B+	3.33	D	1.00
B	3.00	D-	0.67
B-	2.67	F	0.00
C+	2.33	I	Data not available/ no score
C	2.00		
C-	1.67	DNR	Did not respond/no score

PREVENTION

Fluoridation

Grades are based on the percentage of population in each state on public water supplies receiving fluoridated water.

SOURCE: Fluoridation Census 2000, Centers for Disease Control and Prevention, Division of Oral Health.

Fluoridation Grading Scale

Percentage of Population on Public Water Supplies Receiving Fluoridated Water

A	90% - 100%	D	50% - 64%
B	80% - 89%	F	0% - 49%
C	65% - 79%		

Sealants

Dental sealants are among the most cost-effective (and under-utilized) means of protecting children's teeth from tooth decay. Grades are based on the percentage of third-grade children (or 8-year-olds) estimated to have one or more dental sealants on permanent molars. The grading scale is based on the Healthy People 2010 target for increasing the number of children receiving dental sealants on their molar teeth to 50%. This category is difficult to grade because sealant data were derived from different sources for submis-

sion to the Maternal and Child Health Block Grant Applications. For example, some states use data derived from dental health clinics, while others use data from needs assessment surveys. The data also do not measure high-risk children specifically. However, despite the flaws in the data, it is too important a category to overlook. For the future, Oral Health America recommends that states adopt a single tool with standardized sampling methodology to gather data on the percentage of high-risk children with one or more sealants on permanent molars.

SOURCE: Health Resources and Services Administration (Bureau of Maternal and Child Health)—Form 11, Title 5 Block Grant Annual Report, 1999.

Sealants Grading Scale

Percentage of Third-graders (or 8-year-olds) with One or More Dental Sealants on Permanent Molars

A	50% - 100%	D	12% - 22%
B	34% - 49%	F	0% - 11%
C	23% - 33%		

ACCESS TO CARE

Availability of Dentists

An adequate supply of dentists is one key to ensuring that the population can access oral health care. Grades are based on the number of professionally active, licensed dentists in each state compared to the state population. Unfortunately, available data do not address the distribution of dentists in rural versus urban/suburban areas, nor do they address the extent to which dentists serve Medicaid or other underserved populations, and the number or type of services they are providing. These factors have a direct impact on access to care, and the availability of such data is critical to determining and prioritizing areas of need.

SOURCE: American Dental Association, Distribution of Dentists in the United States by Region and State: Total No. of

Professionally Active Dentists, 1998; Population information taken from the U.S. Census Bureau web site (www.census.gov) estimate surveys, 2001.

Availability of Dentists Grading Scale

Number of Professionally Active, Licensed Dentists in Each State Compared to the State Population

A	1: 1 - 1,000	D	1: 2,001 - 2,500
B	1: 1,001 - 1,500	F	1: 2,501 +
C	1: 1,501 - 2,000		

Children's Medicaid Dental Program

Historically, publicly funded dental coverage for poor children has not assured their oral health. Medicaid has provided broad dental coverage, but only limited access to care and services, though numbers have improved in the last couple of years. If Medicaid is the way to reach children with oral health services, we need to systematically improve Medicaid services for enrollees.

Grades are based on the percentage of Medicaid enrolled children, ages 0-20, with at least one dental visit in 1999.

Source: Health Care Financing Administration/Centers for Medicare and Medicaid Services (CMS), Lines 1 and 12a of HCFA Form 416 Reports for the Federal fiscal year 1999.

Children's Medicaid Grading Scale

Percentage of Medicaid Enrolled Children, Ages 0-20, With at Least One Dental Visit in 1999

A	50% - 100%	D	5% - 19%
B	35% - 49%	F	0% - 4%
C	20% - 34%		

Visits to Dentists

Although dental visits are vital to maintaining good oral health, many people do not even visit a dentist once a year. Three grades are given for this category:

- 1 The percentage of all adults, ages 18 and older, with an annual income of less than \$15,000, reporting a visit to a dentist or dental clinic;

- 2 The percentage of all adults, ages 18 and older, with an annual income of \$15,000 or more, reporting a visit to a dentist or dental clinic; and
- 3 The percentage of all adults, ages 18 and older, reporting a visit to a dentist or dental clinic in the past year.

Source: Behavioral Risk Factor Surveillance System (BRFSS), 1999, <http://www.cdc.gov/nccdphp/brfss/>.

Visits to the Dentist Grading Scale

Percentage of Adults, Ages 18 and Older, With an Annual Income of Less Than \$15,000, Reporting a Visit to a Dentist or Dental Clinic; Percentage of Adults, Ages 18 and Older, With an Annual Income of \$15,000 or More Reporting a Visit to a Dentist or Dental Clinic; Percentage of All Adults, Ages 18 and Older, Reporting a Visit to a Dentist or Dental Clinic in the Past Year

A	79% - 100%	D	43% - 54%
B	67% - 78%	F	0% - 42%
C	55% - 66%		

Dental Insurance Status of Adults and Dental Insurance Status of Elderly

Private medical insurance is the gateway to medical care for most Americans. This category measures the percentage of adults, 18 and older, in each state without dental insurance coverage. Grades are based on the percentage of self-reported adults without dental insurance.

Source: Behavioral Risk Factor Surveillance System (BRFSS), 1998, <http://www.cdc.gov/nccdphp/brfss/>.

Older people often have special oral health needs. As Medicare provides minimum adult dental coverage, this measure examines the percentage of people age 65 and over without dental insurance. Grades are based on the percentage of self-reported elderly without dental insurance.

Source: Behavioral Risk Factor Surveillance System (BRFSS), 1998, <http://www.cdc.gov/nccdphp/brfss/>.

Dental Insurance for Adults and the Elderly Grading Scale

Percentage of Self-Reported Adults Without Dental Insurance;
Percentage of Self-Reported Elderly Without Dental Insurance

A	0% - 37%	D	54% - 61%
B	38% - 45%	F	62% - 100%
C	46% - 53%		

ORAL HEALTH LEADERSHIP

Dental Director

The presence of a full-time state dental director, especially one who is a dental professional, can indicate the state government's commitment to addressing oral health needs and its understanding that oral health is a critical part of overall health. Grades are based on the presence of a dental professional (dentist or dental hygienist) serving as state dental director, and whether he/she is full-time.

Source: Association of State and Territorial Dental Directors Membership Listing, www.astdd.org.

Dental Director Grading Scale

A	Full-Time Dental Director—must be a dental professional
C	Part-Time Dental Director/or a full-time, non-dental professional
F	No Dental Director

Oral Health Coalition

Grades are based on the presence of an oral health coalition in the state. A coalition is defined as a group of individuals/organizations, including dental and non-dental professionals, seeking to improve oral health through advocacy, public awareness, and education. Factors that affect grades are the size and scope of the coalition, and how recently it met.

Source: State Dental Health Programs.

Oral Health Coalition Grading Scale

An independent panel assigned grades based on the presence and scope of the oral health coalition. Scores are given for the presence of a coalition, whether or not there is non-dental representation, how recently the coalition met, and how often the coalition meets.

ORAL HEALTH STATUS

Oral Health of Children

Good oral health begins with proper prenatal care. Steps taken early on can ensure a lifetime of healthy teeth and gums. However, poor dental habits too often begin in childhood and continue to old age. It is important to regularly measure the oral health status of children, which is not uniformly done, or not done at all in some cases, across the country. Grades for this category are based on whether or not a state has collected statewide baseline data on children's oral health and how recently data were collected. State legislatures should be encouraged to support funding for periodic surveys of oral disease prevalence among different age groups to provide a reliable national data set.

Source: State Dental Health Programs.

Oral Health of Children Grading Scale

An independent panel assigned grades based on whether or not statewide baseline data on caries prevalence among children were collected and how frequently data were collected.

Use of Spit Tobacco

Spit tobacco use can lead to nicotine addiction, gum recession, tooth decay, and oral lesions, and can cause oral cancer. Grades are based on the percentage of high school males who used spit tobacco in the 30 days prior to the survey. This category, like the category for sealants, is difficult to grade because of differing practices in gather-

ing data among the states. All states should utilize the same model to track spit tobacco use on a routine basis to provide a uniform measurement of spit tobacco use across the country.

Source: Youth Risk Behavior Survey (YRBS), 1999, 1998, and 1997 (<http://www.cdc.gov/nccdphp/dash/yrbs/index.htm>); Youth State Tobacco Activities Tracking and Evaluation System, 1999; State Survey Information.

Use of Spit Tobacco Grading Scale

Percentage of High School Males Who Used Spit Tobacco in the Past 30 Days

A	0%	D	20% - 29%
B	1% - 10%	F	30% - 100%
C	11% - 19%		

Edentulous Elderly

Grades for this category are based on the percentage of people 65 and older without any natural teeth. As with the “Dental Visits” category, three grades are given to highlight the difference in status for those of lower and higher incomes and the overall status of elderly in any given state.

- 1 The percentage of people 65 and older who have no natural teeth and have an annual income of less than \$15,000;
- 2 The percentage of people 65 and older who have no natural teeth and have an annual income of \$15,000 or more; and
- 3 The percentage of all people 65 and older without any natural teeth.

Edentulous Elderly Grading Scale

Percentage of People 65 and Older who have No Natural Teeth and Have an Annual Income of Less than \$15,000; Percentage of People 65 and Older who have No Natural Teeth and an Annual Income of \$15,000 or More; Percentage of All People 65 and Older Without Any Natural Teeth

A	0% - 14%	D	39% - 50%
B	15% - 26%	F	51% - 100%
C	27% - 38%		

Source: Behavioral Risk Factor Surveillance System (BRFSS), 1999, <http://www.cdc.gov/nccdphp/brfss/>.

Oral Cancer Mortality Rates

Approximately 30,000 new cases of oral cancer are diagnosed and over 8,000 people die each year from oral cancer. If detected early, mortality rates for oral cancer can be lowered significantly. Grades for this category are based on the average annual age-adjusted mouth and throat cancer mortalities per 100,000 people, based on data from the North American Association of Central Cancer Registries. Grades are based on the mean for each gender in all 50 states and the District of Columbia.

Source: North American Association of Central Cancer Registries-Seer Cancer Statistics Review (1994-1999), http://seer.cancer.gov/Publications/CSR1973_1998/oralcav.pdf.

Oral Cancer Mortality Grading Scale (Male)

Average Mouth and Throat Cancer Mortalities per 100,000 People

A	0 - 2.5	D	5.6 - 7.0
B	2.6 - 4.0	F	7.1+
C	4.1 - 5.5		

Oral Cancer Mortality Grading Scale (Female)

Average Mouth and Throat Cancer Mortalities per 100,000 People

A	0 - 1.0	D	2.3 - 2.8
B	1.1 - 1.6	F	2.9+
C	1.7 - 2.2		

FINAL GRADES

State Grades

Final grades were assigned to each state using an average of the independent variables rated. The final numeric grade was assigned a corresponding letter grade according to the grading scale outlined in the introduction of this report card.

National Grade

The final national grade is an average of all the state grades. The final national average was assigned a corresponding letter grade according to the grading scale outlined in the introduction of this report card.

For more information and links to state oral health initiatives, visit

www.oralhealthamerica.org.

