



# Closing the Gap

## Making Oral Health a Priority

By Michelle Meadows

Many adults, including some who are highly educated, can not remember the last time they went to the dentist. Somehow the dental checkup does not make it on the annual "to do" list, and when it does, it is usually ranked far below getting a physical exam.

But what many people do not know is that oral health *is* health. The condition of the mouth reflects the condition of the body and can help dental care providers identify many serious diseases. Oral health can impact our appearance, posture,

sexuality, the way we talk, sing, and whistle, according to Joseph L. Henry, DDS, PhD, ScD, Professor Emeritus and Associate Dean for Faculty Affairs at Harvard University, and

Dean Emeritus at Howard University.

Americans are bombarded with false media messages that the dentist's chair is usually a painful place and that looking good is what matters most—even if that means whitening our teeth but neglecting our cavities.

New parents are driven by immunization schedules but have no idea how they should care for their baby's gums. "We also hear much more about good nutrition as it relates to losing weight than we hear about good nutrition as it relates to cutting down on the sugar and acid that can decay our teeth," said Dr. Henry.

Sometimes people mistakenly assume they don't have to worry because dental caries has been all but eliminated by fluoridation of water supplies, said Dr. Henry. "But the fact is that almost half of the water supplies of this nation are not fluoridated, and dental caries occurs unnecessarily in 80 percent of children's mouths by the time they reach their 18th birthday."

### Oral health is our health

Even when oral health is acknowledged, many consider it separate from their general health. But with this view can come complex, expensive, and even life-threatening emergencies.

The oral cavity is involved with three of the five important basic human senses: taste, smell, and touch. It is the beginning of the digestive system and has an important physical and chemical role in the digestive process.

Just as poor oral health can lead to poor general health, poor general health can lead to poor oral health. For example, people with diabetes are more susceptible to oral health problems. In fact, more than 90 percent of systemic diseases have oral manifestations. Well known cases include Kaposi's sarcoma (cancer that is sometimes associated with AIDS), parotid swelling (mumps) and xerostomia (dry mouth after radiation for oral cancer).

"Probably less known is how poor oral health leads to poor general health," according to Dr. Henry. Infections in the mouth can enter the blood stream and impact major organs. One example is bacterial endocarditis, a condition in which the lining of the heart and the heart valves become inflamed. Poor mouth care can also contribute to oral cancer, any one of a variety of cancers on the lip or in the mouth. Dental health professionals are often the first to recognize the patches or sores that can signal cancer.

...continued on page 2

**"In many ways, our oral health affects who we are and can mean the difference between life and death."**

Visit us on the Web:  
<http://www.omhrc.gov>  
and look under  
"What's New" for a list  
of current Closing the  
Gap issues.

Inside	
Challenges and Opportunities for Oral Health.....	3
Dental Insurance.....	4
Minority Dentists.....	6
School Health Programs.....	8
Tips for New and Expectant Moms.....	9
Dental Sealants.....	10
Surgeon General's Report on Oral Health.....	10
Oral Disease Prevention.....	11
You Don't Have to Lose Your Teeth.....	11
Smokeless Tobacco Use.....	12
Chronic Diseases.....	13
Consumer Information.....	14
Organizations and Web Sites.....	15
Conferences.....	16



OFFICE OF PUBLIC HEALTH AND SCIENCE  
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Office of Minority Health Resource Center (OMH-RC) provides free information on various health issues affecting U.S. minorities including cancer, heart disease, violence, HIV/AIDS and diabetes. The center also distributes information on funding sources for minority health programs.

*Closing the Gap* is a free monthly newsletter published by the Office of Minority Health, U.S. Department of Health and Human Services.

Send all correspondence to: Editor, Closing the Gap, OMH-RC, PO Box 37337, Washington, D.C. 20013-7337. Or call OMH-RC toll-free, 1-800-444-6472.

Staff:

Blake Crawford  
**Executive Editor**

Howard Kelley, DDS, MPH  
**Contributing Editor**

Jennifer Brooks  
**Managing Editor**

Sibyl K. Bowie  
**Writer**

Jean Oxendine  
**Writer**

John I. West  
**Writer/Production Coordinator**

"In many ways, oral health affects who we are and can mean the difference between life and death," said Dr. Henry. But as with other areas of health, we can and should take steps to ensure prevention and early detection. Untreated tooth decay can lead to tooth abscess, which left untreated can result in tooth loss and serious destruction of bone in the jaw.

Gum disease, an infection of tissues that support our teeth, is a major cause of tooth loss in adults. But daily brushing and flossing can prevent it and often reverse the early stages. After age 35, three out of four adults are affected by some form of gum disease, according to the American Dental Association. Research also shows that racial and ethnic minorities and groups with low levels of education have the least knowledge of the preventive power of fluorides, dental sealants for cavities, and gum disease symptoms.

**Dr. Henry's Tips for Making Oral Health a Priority:**

- **Take the truth about oral health to parents and K-12 teachers.** "Who we are and what we believe begins in childhood. To end misconceptions about oral health, we must raise our children to view oral health as an integral part of their overall health."
- **Stop leaving dentistry on a rung behind medicine.** "A good colleague of mine had to fight on behalf of army dental corps professionals to make pay and benefits comparable to that of medical corps health professionals. Every time a bill comes up about raising pay or benefits for health professionals, we've had to add dentistry on because it's always left out. These are two parallel professions and should be treated as such, whether it comes to funding programs or improving insurance coverage. Most health insurance programs provide little to no dental coverage."
- **Improve education about the importance and scope of the dental profession.** "Bright students across the country turn away from dental careers because they have no idea about the lifesaving power they could hold. We need to tell them about the range of specialties, from oral and maxillofacial surgery to orthodontics. When I took general sciences classes alongside medical students, I had professors who asked why I chose dentistry. Unfortunately, they assumed all the

bright students belonged on the medical track."

- **Let us renew our commitment to the oral health profession.** "During the last 20 years, seven dental schools have closed their doors including Georgetown, Emory, and Northwestern Universities. We have learned that in order to survive, dental school faculties must show significant contributions to parent universities and surrounding communities. This lesson requires looking at the mission of the school and leading the way with cutting-edge research and technological advances in oral health."
- **Help underserved people improve self-esteem.** "Look at the mouths of 25 underserved teenagers and you will find incredible loss of teeth and poor hygiene. Ask them about their motivation to go out and get a job, and they will ask you: 'Who would hire me looking like this?' We must recognize the psychological, social, and economic impact of oral health."
- **Fund research so we can learn more about oral health.** "We do not know enough about oral health because state and federal programs are not adequately funded to study it. We especially need research on morbidity related to dentistry."
- **Make the most of recommendations from the Committee on the Future of Dental Education.** "I was privileged to be part of the Institute of Medicine's Committee on the Future of Dental Education, a group of leaders who focused on measures that can strengthen dental education. We talked with students and educators and developed 22 recommendations that should be read and responded to by every administrator, teacher, politician, regulator, and parent in this country. These recommendations, published in *Dental Education at the Crossroads: Challenges and Change* (1995), include better recruitment and retention of racial and ethnic minorities into oral health careers. When I was at Howard University, we had more than 65 percent of our students go on to practice dentistry in underserved areas. That's because in their 3rd and 4th years, we brought in mentor practitioners who had done the same."
 

Oral health is health. There's no denying this. Not in our homes and not in our policy making.

For a copy of *Dental Education at the Crossroads: Challenges and Change*, contact the National Academy Press at 1-800-624-6242.'

# Challenges and Opportunities for Oral Health in Communities of Color

By Hazel Harper, DDS, MPH

Oral health care poses special challenges to American communities of color. As never before, we need innovative and creative partnerships between oral health professionals, and the consumers and communities they serve, to transform those challenges into opportunities.

The United States continues to experience a slow but profound shift in its demographics as communities of color increase in numbers and influence. The U.S. population grew by nearly 19 million people between 1990 and 1997, according to the U.S. Census Bureau, with approximately two thirds of this growth due to racial and ethnic minority populations.

If this population trend continues, we would need to triple the number of minority dentists in our health professions workforce by the year 2050, according to Murdoch and Hoque, writing in a 1998 issue of the *Journal of the American College of Dentistry*. But there are other facts and trends that should disturb us all.

The number of dental school graduates has declined between 1986 and 1997. Little has changed in numbers of African American and American Indian dental graduates in this last decade, and the number of Hispanic dental graduates peaked in 1990, then dropped significantly, according to the American Dental Association Survey Center.

Some 80 percent of Medicaid eligible children—who are disproportionately minority—do not receive preventive dental services, according to a 1996 report of the HHS Inspector General. Other measures of minority oral health continue to shout for corrective action and greater public attention.

Public and private insurance combined still cover just half of U.S. dental care expenditures, according to the National Center for Health Statistics. So increases in employment and socioeconomic economic status among minority populations—which still lag the U.S. national rates—do not automatically translate into improved dental coverage and access to care.

These factors have translated into poor oral health status among American communities of color.

Consumers deserve quality care. Providers deserve fair and equitable compensation. Patients and providers must always

have options and the right to choose. Patients should have access to managed care organizations that provide education, outreach, preventive services, quality care, and a broad scope of services. Compromises in the standards of care are unacceptable.

There is much to do. We must make a firm commitment to eliminating the health disparities caused by differences in education, employment, income, and wealth, as well as by racism and access to care. We must improve the ratio of minority dentists to minority patients by recruiting and retaining more minorities into the profession. We must encourage providers to serve in areas where they are needed most. We must measure the

success of our health delivery system in terms of health outcomes and patient satisfaction rather than merely profit margins. We must hold up high standards of care, and high goals for success. And we must focus on patients' rights, human rights, and civil rights.

The National Dental Association (NDA) is dedicated to improving the oral health of all Americans, with special emphasis on the underserved. The NDA embraces the philosophy that health care is a right, not a privilege. As such, the NDA is dedicated to serving as advocates in the legislative arena and private sector in order to increase access to care in communities of color.

The NDA's mission is to enhance the skills of its members, recruit underrepresented minorities into the profession, and create opportunities for research between its members and the communities they serve. As an organization, the NDA knows that many of today's concerns will follow us into the next century.

Members of the NDA are not just clinical practitioners; they are active members in their communities. They can give training sessions on ways to prevent oral diseases, participate in career counseling programs, and assist in regional and local efforts to recruit minorities into health careers.

*If you need help in developing and/or carrying out a dental program, contact your neighborhood dentist or the NDA, 3517 16th St, NW, Washington, DC, 20010, (202) 588-1697.*

*Dr. Harper is past president of the National Dental Association.'*



# Dental Insurance is Essential, But Not Enough

By Myron Allukian, Jr., DDS, MPH

While more than 43 million Americans lack medical insurance, there are over 150 million Americans with limited or no dental insurance, according to the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services (HHS). Unlike medical conditions, dental diseases affect almost the total population, with nearly everyone needing dental care. For example, 84 percent of 17 year-olds have had tooth decay, with an average of 8 affected tooth surfaces; and 99 percent of 40-44 year-olds have had tooth decay, with an average of 30 affected tooth surfaces.

Those most likely not to receive needed dental services are the vulnerable or high-risk population groups, such as the low income, the least educated, racial and ethnic minorities, immigrants, the developmentally and medically compromised or disabled, the elderly, persons with HIV, and the uninsured. For example, lower income children have almost five times more untreated dental disease than higher income children, according to the National Health and Nutrition Evaluation Survey III.

## How much are we spending on dental services?

Although \$50.6 billion was spent for dental care in the U.S. in 1997, a majority of Americans don't have dental insurance. According to the Health Care Financing Administration (HCFA), 47 percent of dental services are paid for out-of-pocket. (See Table 1.) Only 4.4 percent of dental care expenditures were from public funds, with most it (roughly 4 percent or \$2 billion) being from Medicaid.

Lack of dental insurance affects dental utilization and oral health status. For example, 48.2 percent of people without private dental insurance did not have a dental visit in the last year, compared to 28 percent with insurance, according to data from *Dental Services and Oral Health: United States, 1989*. Of people who had dental visits, those without private dental insurance had 1.7 visits a year, compared to 2.8 for those with insurance; and 27 percent of persons over 65 without dental insurance had no teeth at all, compared to 18.3 percent with dental insurance.

## Dental Medicaid

Even when high risk groups have dental Medicaid, they may not receive needed dental care. For example, according to a 1996

study done by the U.S. Inspector General, more than 80 percent of the 21.1 million Medicaid-eligible children did not receive preventive dental services.

The six states with the *highest* proportion of Medicaid-eligible children who did not receive preventive dental services were Arizona (99.7 percent), Hawaii (99.3 percent), New Mexico (93.8 percent), North Dakota (92 percent), Montana (91 percent), and Kentucky (90.6 percent).

The six states with the *lowest* proportion of Medicaid-eligible children who did not receive preventive dental services were New Hampshire (55.2 percent), Wyoming (56.7 percent), Indiana (59 percent), Kansas (64.6 percent), Oregon (65.3 percent), and Nebraska (66.5 percent).

Unfortunately, too many low income children, over 16 million, are not receiving dental care even though they have dental insurance coverage through Medicaid. Even for the state with the highest dental utilization of Medicaid in our country, New Hampshire, 55.2 percent of Medicaid-eligible children did not receive required preventive dental services. Some studies have even shown that children with dental Medicaid have worse oral health status than low income children without dental insurance.

The Inspector General's report states that the reasons few children received dental care were complex, but there were three major reasons: 1) few dentists serve Medicaid children; 2) Medicaid families give dental services a low priority; and 3) the youngest children are the most difficult to serve and frequently are not screened at all. (See Table 2.)

The American Academy of Pediatric Dentists recommends that dentists examine all children before their first birthday. However, 99.6 percent of these children did not receive these services even though 20 states have adopted this standard, 12 states recommend screening at age 2 years, and the rest at age 3 years.

Unfortunately, dental care is an optional service for adults in the Medicaid program. Vulnerable adult population groups like the homeless, homebound, elderly, minorities, uninsured, low income, persons with HIV, and medically compromised or disabled have even greater difficulty accessing dental services.

The reasons given for dentists not participating in Medicaid, according to this report were low fees, slow payment, arbitrary

...continued on page 5

**Table 1. U.S. Dental Care Expenditures, 1997**

<b>Total</b>	<b>\$50.64 billion</b>	
<b>Private Funds</b>	\$48.37 billion	(95.5%)
Private Insurance	24.25 billion	(47.9%)
Out-of-Pocket	23.86 billion	(47.1%)
<b>Public Funds</b>	\$ 2.27 billion	(4.4%)
Federal Medicaid	1.12 billion	(2.27%)
State/Local Medicaid	.87 billion	(1.7%)
Medicare	.07 billion	(0.1%)

Source: Health Care Financing Administration, 1999.

denials and requirements for prior authorization for routine care. Also, many dentists had difficulty treating Medicaid families and general dentists didn't wish to treat younger children. From the family perspective, oral health was a low priority given other needs, and families were unwilling or unable to wait, travel, or obtain child care for dental appointments.

The Medicaid dental problems have been acknowledged by some decision-makers on the state and national levels. However, progress had been slow. In some states, such as California, Connecticut, Maine, Pennsylvania, and more recently New York, legal suits have forced states to improve Medicaid programs. In other states such as Arizona, Indiana, Massachusetts, Nebraska, North Carolina, Oklahoma, Pennsylvania, and Virginia, oral health partnerships, coalitions, constituencies, and state legislative actions also have helped to improve the program.

**Children's Health Insurance Program**

There were 11 million American children who had no health insurance in 1997, of which about 3 million were eligible for Medicaid, according to the Institute of Medicine. Congress passed the Balanced Budget Act of 1997 which included provisions for the State Children's Health Insurance Programs (CHIP). The bill originally included dental services, but by the time it passed Congress, dental services were optional and could only be included at the discretion of individual states.

The nature of the CHIP program is determined by each individual state upon approval by HCFA, and it may be an expansion of the state's existing Medicaid program, a new separate program, or a combination of Medicaid expansion and a new separate program. About \$25 billion in federal money for all health services will be available to the states for this initiative over a five-year period.

**Dental Services in CHIP**

As of April 1999, 48 states have submitted CHIP proposals to HCFA and

all but three, Delaware, Colorado, and Montana, have some dental services. Florida's plan only provides dental services for children up to age 5 years. Of the 48 state proposals, 18 (plus Washington, D.C. and Puerto Rico) include dental in an expanded Medicaid program under CHIP, 8 include dental in a separate CHIP program, and 18 states include dental in a combination of both.

The scope of dental services varies and dental partnerships, constituencies, coalitions, and legislation on the state level can help improve the dental benefit package in the CHIP program. CHIP dental programs built upon the Medicaid program can only be successful if the Medicaid programs are expanded, upgraded, and improved.

Justice regulation assuring families that immigration status will not be affected for those who enroll in Medicaid or CHIP and/or who receive other benefits such as school lunch or child care. This will help reduce a potential barrier to dental care for some cultural and linguistic minorities.

**Recommendations**

Studies have shown that the financing of dental care by itself does not ensure that the oral health of a population will improve. Unfortunately, the dental Medicaid program is a prime example of this failure. Although improving the financing of dental care is essential, the following must also be done to improve oral health status in our country.

**Table 2. Percent of Medicaid-Eligible Children Who Did Not Receive Preventive Dental Services, by Age, 1993**

All ages	<1 year	1-5 years	6-14 years	15-20 years
80.3%	99.6%	84%	70%	80.5%

Source: 1996 Report of the Office of Inspector General, U.S. Department of Health and Human Services.

**Other Initiatives**

HHS's Healthy People 2010 has national objectives to help close disparities in oral health status among high-risk populations. Two federal agencies, HCFA and the Health Resources and Services Administration (HRSA), have an oral health initiative to improve access to the underserved by stimulating statewide planning and providing technical assistance and some modest funding.

HCFA and HRSA also sponsored a dental workshop for state Medicaid directors and other interested parties in 1998 to help improve the dental Medicaid programs, and a number of strategies and recommendations are included in their report. They are also trying to provide guidance to the states through their regional offices so more high-risk populations groups will be served.

On May 25, 1999, Vice President Gore approved a new Department of

1. Oral health must be a much higher priority on the local, state, and national levels.
2. The dental component of Medicaid and CHIP must be upgraded, expanded, and improved.
3. Special initiatives must be promoted and implemented for vulnerable and high-risk populations including adults, to improve their access to dental care.
4. Individual- and population-based prevention services and programs must be promoted and implemented, especially for children and high-risk populations.
5. All communities with a central water supply must be fluoridated.

To close the gap for a healthier America, we must all work together to respond to the neglected epidemic of oral diseases and its neglected financing system.

*Dr. Myron Allukian, Jr. is the director of Community Dental Programs for the Boston Public Health Commission.'*

# Minority Dentists: Why Do We Need Them?

By L. Jackson Brown, DDS, PhD, and Vickie Lazar, MA, MS

The current status of the minority dentist workforce is an important issue for the profession and the nation it serves. While some minorities have entered the profession in increasing numbers, other minorities are not as well represented, either among current dental students or practicing dentists.

### Who are the dentists?

#### Racial and ethnic distribution.

African American, Hispanic, and American Indian dentists are well underrepresented in dentistry when compared to the general U.S. population. Data from the American Dental Association's (ADA) periodic census of dentists, called, *Distribution of Dentists in the United States by Region and State*, show in 1996, 87.9 percent of professionally active dentists were White, 2.2 percent were African American, 2.8 percent Hispanic, 0.2 percent American Indian, and 5.9 percent Asian American. (See Figure 1).

**Age.** The average age of professionally active dentists in 1996 was 46.8 years. White and African American dentists were on average older (47.8 years and 47.5 years, respectively). Hispanic, Asian American, and American Indian dentists averaged 42.1, 42.2, and 43.9 years of age, respectively.

**Practice.** More than 70 percent of professionally active dentists across the five race categories indicated they practiced general dentistry, research, or administration area in 1996. Among active private practitioners of all five races, more than 70 percent practiced full-time. Similarly, more than 70 percent of active private practitioners across the five race categories were owners of their practices.

### Where are the dentists?

Data from the ADA's annual *Survey of Predoctoral Dental Educational Institutions*, show growth and distribution of minority dental students and practicing dentists.

**Dental school enrollments.** Overall U.S. dental school enrollments decreased 11.3 percent, from 18,673 in academic year 1986-1987, to 16,570 in 1996-1997. During the same period, enrollment of White students decreased 25.2 percent, Hispanic students decreased 24.7 percent, and African American student enrollment decreased 13.7 percent.

In contrast, Asian American student enrollment increased 103.4 percent during the same period, from 1,805 to 3,672. American Indian student enrollment also increased 48.2 percent, from 56 in 1986-1987, to 83 in 1996-1997.

In 1986-1987, Whites represented 78.6 percent of all dental school enrollees, but their representation decreased in 1996-1997 to 66.3 percent. While enrollee representation remained constant for African Americans, Hispanics and American Indians, it changed dramatically for Asian Americans: in 1996-1997, they were 22.2 percent of all enrollees—up from 9.7

...continued on page 7

Table 1: Dental School Enrollments and Graduates, by Race, 1986/87-1996/97

Year	DENTAL SCHOOL ENROLLMENTS						DENTAL SCHOOL GRADUATES					
	Total	White	African American	Hispanic	American Indian	Asian	Total	White	African American	Hispanic	American Indian	Asian
1986/87	18,673	14,686	1,032	1,094	56	1,805	4,957	4,162	195	208	10	382
1987/88	17,885	13,531	994	1,201	60	2,099	4,717	3,869	210	231	11	396
1988/89	17,094	12,445	984	1,276	63	2,326	4,581	3,660	227	221	14	459
1989/90	16,412	11,701	983	1,278	57	2,393	4,312	3,288	193	296	14	521
1990/91	15,951	11,185	940	1,254	53	2,519	4,233	3,165	216	320	8	524
1991/92	15,882	11,152	907	1,187	51	2,585	3,995	2,854	204	348	12	577
1992/93	15,980	11,187	943	1,152	48	2,650	3,918	2,796	174	296	12	640
1993/94	16,250	11,241	972	1,141	50	2,846	3,778	2,699	171	288	12	607
1994/95	16,353	11,326	928	967	56	3,076	3,875	2,766	194	292	13	603
1995/96	16,552	11,028	951	966	73	3,433	3,908	2,724	201	300	8	660
1996/97	16,570	10,984	891	824	83	3,672	3,810	2,674	205	209	9	693

Source: American Dental Association, Survey Center, 1996/97 Survey of Predoctoral Dental Educational Institutions: Academic Programs, Enrollment, and Graduates, Volume 1.

percent in 1986-1987. (See Table 1.)

**Dental school graduates.** From academic years 1986-1987 to 1996-1997, the overall number of dental school graduates in the U.S. decreased 23.1 percent, from 4,957 to 3,810 respectively. During the same period, the number of White graduates decreased 35.8 percent, and the number of American Indian graduates dropped slightly, from 10 to 9. The number of African American graduates increased 5.1 percent, from 195 to 205; and the number of Asian American graduates increased 81.4 percent, from 382 to 693 during that period.

The number of Hispanic graduates increased slightly from 208 to 209. However, Hispanic graduate numbers peaked at 348 in 1991-1992, then fell sharply from 300 in 1995-1996 to 209 in 1996-1997.

In 1996-1997, African Americans represented 5.4 percent of all dental school graduates, up from 3.9 percent in 1986-1987. The distribution of Hispanic and American Indian graduates remained stable, but increased from 7.7 percent to 18.2 percent for Asian Americans. (See Table 1.)

**Regional distribution.** In 1996, there were 152,205 professionally active dentists in the U.S. While the largest percentage distribution of the resident population was in the South Atlantic region (17.9 percent), the largest percentage distributions of dentists were in the Middle Atlantic and Pacific regions (18 percent in both regions). The smallest percentage was in the East South Central region (4.9 percent).

Most White professionally active dentists were found in the East North Central and Middle Atlantic regions (17.7

percent and 17.4 percent, respectively). For African American professionally active dentists, the largest percentage distribution was in the South Atlantic region (31.1 percent). Roughly one quarter of Hispanic dentists worked in the Pacific and South

Specifically, they found that 18.0 percent of children 6-14 years of age, and 36.1 percent of children ages 15-18, had one or more decayed permanent teeth. Among White, non-Hispanic children of the same age groups, the rates were 8.5 percent and 17.8 percent, respectively.

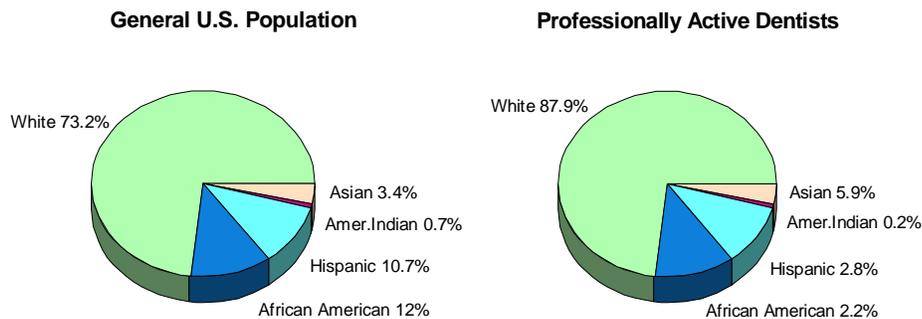
Furthermore, data from a recent ADA survey, *1996 Dentist Profile Survey*, showed that underrepresented minority dentists are likely to provide oral health care to minority populations. Over three quarters (76.6 percent) of White dentists' patients were White, while African American dentists reported that approximately three out of five of their patients (61.8

percent) were African American. Among Hispanic dentists, 45.4 percent of their patients were Hispanic and 43.6 percent were White. Almost one third (62.7 percent) of the patient base of American Indian dentists was White, while 10.1 percent were American Indian. Asian American dentists indicated that about one quarter (25.1 percent) of their patients were Asian American and 47.5 percent were White.

African American and Hispanic dentists may be more culturally attuned to the needs of patients from their own subcultures. The outreach to a growing minority patient base is an important reason why the dental workforce should reflect the Nation's diversity.

*Dr. Brown is associate executive director for health policy, and Ms. Lazar is manager of health policy analysis for the American Dental Association.'*

**Figure 1. Racial Distribution of General U.S. Population and Professionally Active Dentists, 1996**



Source: U.S. Bureau of the Census, 1998; and *Distribution of Dentists in the United States by Region and State, 1996*, American Dental Association, Survey Center.

Atlantic regions (25.2 percent and 24.9 percent, respectively). And 30.4 percent of American Indian dentists were in the Pacific region. The majority of Asian American dentists were located in the Pacific region (60.9 percent).

***Why do we need more minority dentists?***

Aside from the social issue of reaching parity—having the same proportion of minority dentists as their representation in the general population—the underrepresentation of minority dentists may be an underlying factor when considering the unmet needs of minority patients.

Oral health problems disproportionately affect minority populations in the U.S. A September 1998 article in the *Journal of the American Dental Association*, reported that African American and Mexican American children were about twice as likely to experience caries and had higher levels of untreated caries than their non-Hispanic White counterparts.

# Making School Health Programs What They Used to Be

By Phyllis A. Lambert, RDH

**T**eeth should last a life time. Yet even with fluoridated water, fluoride dental products, and a bountiful food supply, dental caries is the most common nutritional-related disease of childhood. Should dental health be practiced daily in our school health programs? We used to think so.

As early as 1880, most states had laws requiring the teaching of hygiene and physiology. In 1903, the first school dentist served in Reading, Pennsylvania, and in 1910, the first school lunch program was implemented in New York City.

In subsequent years, school health programs included a dental component that was expected by parents, teachers, and the



community to monitor the dental health of all school aged children. Students were evaluated and given health records that contained the results of their dental survey, vision and hearing screenings, immunization records, and other pertinent health information. These documents remained part of

students' records of dental and general health activity from kindergarten through 12th grade.

But these dental indicators are no longer in use. Budgetary and staff limitations and decreased parental involvement place the responsibility of dental health education on individual teachers. In general, dental health is emphasized only during National Children's Dental Health Month in February, but demands on teachers' time exceed their ability to get out needed dental messages.

According to Child Health USA, differences in the prevalence of cavities were found among racial and ethnic populations, and differences also existed in patterns of cavities for primary and permanent teeth. From 1988 to 1991, children 2-4 years of age had 1.2 decayed and filled primary surfaces. Roughly 80 percent of all filled permanent teeth were found in only 25 percent of children ages 5-17 with at least one permanent tooth.

Early exposure to dental health education, treatment, and care has proven to be effective in establishing the building blocks of oral health for children. Continued support for preventive dental care services for all children is not only the responsibility of the parent and the school health program, but the community at large.

Our goal should be to inform non-dentists—parents and

community leaders—of the importance of oral health services to minorities. The Department of Health and Human Services has set goals for oral health. The Department's Healthy People 2000 objective is to increase, to at least 90 percent, the proportion of all children entering school programs for the first time who have received an oral health screening, referral, and follow-up for necessary diagnostic, preventive, and treatment services.

Efforts to reach their objectives should include nontraditional approaches in existing school health programs. Community-based organizations and corporations can fund parent/youth focus groups to define dental health issues and activities for a comprehensive school program that can be integrated into the existing curriculum.

Parent and student organizations can enlist dental schools and associations to develop programs that promote oral health activities. For instance, the Washington, DC, Chapter of the Continentals Society funds and participates in the Annual YMCA's Healthy Kids Day. The event offers a dental fair as well as an array of health screenings. The Howard University College of Dentistry provides follow-up treatment to dental fair attendees who need it.

Parental and student participation ensures that unique cultural and linguistic issues are addressed in spoken and written education materials. Parental involvement is effective in encouraging the establishment of dental activities in school health programs. For example, parents can be trained as dental advocates by dental schools and dental societies. Parents employed at partner corporations can ask for sponsorship of program materials.

School health programs and dental health can be translated into successful partnerships using students, schools, and parents. Decision-makers can support school linked community efforts with legislation, directives, and proclamations to increase budgetary allocations for comprehensive and preventive dental health care for school health programs. The strength and resiliency of students, families, and partner agencies play a major role in optimal health for all children in the next century.

*Ms. Lambert is assistant outreach coordinator/health educator for the United Planning Organization, a Community Action Agency for the Nation's Capital.*

**Percent of children ages 2-4 with dental caries in primary teeth: 1988-1991**

White	Black	Mexican-American
13.0%	22.0%	32.3%

**Percent of children ages 5-17 with dental caries in permanent teeth: 1988-1991**

White	Black	Mexican-American
44.3%	39.4%	48.6%

Source: Child Health USA.

# 10 Things You Should Know About Oral Health

## *Information for New and Expectant Mothers*

By John P. Rossetti, DMD and Amy Seif

The old adage, “For every baby, a tooth” addresses the notion that pregnancy causes tooth loss. There is no justification for tooth loss due to a decline in a mother’s oral health. With reasonable and proper care prior to and during pregnancy, new mothers can avoid oral health problems while protecting the oral health of her child.

Dental disease is an infectious disease. Transmission of cavity-causing bacteria can occur between a mother and her baby. Therefore, mothers play an important role in preventing dental disease.

The following are 10 things every expectant or new mother should know:

1. **Visit the dentist.** An expectant mother should visit her dentist soon after learning she is pregnant. Reducing the mother’s cavity-causing bacteria will reduce the amount of cavity-causing bacteria passed to the baby.

2. **Take vitamins.** The baby’s developing teeth depend on the mother’s proper intake of important minerals and vitamins. Eat balanced meals and remember to take the vitamins prescribed by a doctor daily.

3. **Check the status of community drinking water.** Parents should find out about the fluoride status of their drinking water. If the water supply is not fluoridated, parents should ask their dental provider about fluoride supplementation.

4. **Clean baby’s mouth.** Even before the first tooth erupts, clean baby’s gums with a cloth after every meal. Beginning with the first tooth, clean baby’s teeth with a soft brush. Teeth should be brushed with a pea-sized amount of fluoridated toothpaste starting at 12 months. Cleaning the gums and brushing the teeth early encourage children to develop good oral hygiene habits and can be useful in preventing early childhood caries.

5. **Take baby to the dentist.** A baby’s teeth usually come in between six and

twelve months of age. This is an excellent time to bring baby in for its first dental visit. A good dentist wants to see baby teeth early and regularly.

6. **Take care of baby teeth.** A common misconception among parents is that a child’s baby teeth are not important. Baby teeth serve as “placeholders” for permanent teeth, help a child to chew properly, develop proper speech and a beautiful smile.

7. **Prevent early childhood caries.** Early childhood caries, or baby bottle tooth decay, is caused by frequent and prolonged exposure of a child’s teeth to sugar and *Streptococcus mutans*—a cavity-causing bacteria. This exposure is often the result of putting a child to bed with a bottle containing sugary liquid (including milk, formula, or fruit juice) or allowing a child to drink “at will” from a bottle during the day. The most important way to reduce the risk of early childhood caries is to never put a baby to bed with a bottle and encourage baby to drink water. Wean a baby from a bottle as early as possible to promote good oral health. Most children are ready to begin using a cup between six and nine months of age.

8. **Special considerations for children with special health care needs.** Some children born with special health care needs, such as cleft lip and cleft palate, have their own special concerns. For example, an increased intake of sweetened medications may make these children more susceptible to dental decay. Parents can ask their oral health provider for suggestions for alternative medication or preventive intervention to minimize effects.

9. **Prevent oral/facial injuries.** Parents should not allow their babies to use walkers due to considerable risk of injuries to the head and face, and should request that family members not give them as gifts. In addition, the use of car seats and safe use of shopping carts can prevent many situations

that place a child’s oral health at risk.

10. **Encourage healthy eating habits.** It is never too early to encourage healthy eating habits that will also benefit good oral health. Introduce baby to healthy and unsweetened snacks that do not promote tooth decay.

*Bright Futures in Practice: Oral Health* is a guide that addresses the oral health needs of children ages 0-21 by presenting guidelines on oral health promotion and disease prevention and other preventive strategies and tools.

The guide is designed for many health and education professionals, including dental professionals, physicians, nurses, nutritionists, educators, and child care providers. The information in this guide can also be adapted for use with families.

For more information on *Bright Futures*, visit the Web site at <http://www.brightfutures.org>

*Dr. Rossetti is chief dental officer of HRSA’s Maternal and Child Health Bureau. Amy Seif works for the National Maternal and Child Oral Health Resource Center.’*

### Some people should see a dentist more often than others

People who should see a dentist every six months are:

- children who are one year old and still using a bottle;
- children age six or seven years who have not had sealants placed on their teeth;
- children age 12 or 13 years who have not had sealants placed on their teeth;
- pregnant women;
- people who have diabetes; and
- people who have heart disease.

# “Immunizing” Our Children’s Teeth

By G.M. Nana Lopez, DDS, MPH

The top surfaces of molars (back teeth) have grooves and fissures where tooth decay (caries) usually forms. If a cavity does not get filled early in the disease process, it progresses to become a larger hole and eventually can kill the nerve of the tooth causing a painful abscess.

**How do we prevent tooth decay?** It is possible to stop dental grooves and fissures from getting caries if teeth are exposed to dental sealants and fluoride at the right time. Sealants are clear plastic coverings that are painted on teeth to protect them from new decay. They can even be placed on early decay, arresting its progression.

Sealants are a powerful preventive tool. Like immunizations, sealants are relatively inexpensive, easy to administer, and save patients the pain, suffering, and health service costs associated with dental disease.

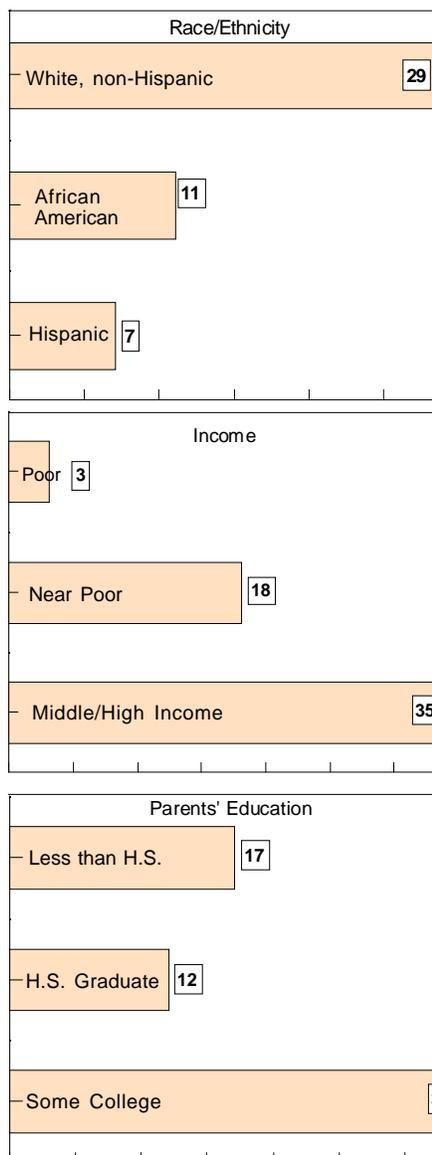
**When should children get sealants?** The “window of opportunity” when children should get sealants is when they lose their front teeth. At that time, their first permanent molars usually show up (around 6-7 years of age). Another good time is when children’s second permanent molars come in (at 12 or 13 years of age). Teachers and health care providers working with children of these ages should alert parents about this opportune time for placing sealants.

**Who needs sealants most?** Needy and vulnerable children could benefit the most from sealants, yet they have been the ones least treated with this intervention. One of the Healthy People objectives for oral health is that 50 percent of all children would have sealants on their teeth by the year 2000. However, the most recent National Health and Nutrition Evaluation Survey (NHANES), found huge disparities in the proportions of children who had sealants (see Table).

One of the most effective ways to get sealants on children is to take the sealants to kids through school-based programs. Since sealant placement is relatively simple, it does not require much to put together

portable, mobile systems to deliver treatment. Typically, a dentist will evaluate and select the teeth for sealants. This is also an excellent opportunity for the dentist to examine other oral structures and make referrals as needed. Once the teeth are evaluated and selected, a dental hygienist can place the sealants. Many states also allow dental assistants with special training to place sealants.

Percent of Children with Dental Sealants



Source: 1988-1993 data from NHANES III.

In conclusion, sealants on back teeth are excellent tools for preventing a large proportion of dental disease. They should be an integral part of any primary health care system for children. Application needs to occur before decay sets in, thus it is important to have children’s teeth evaluated and sealed during the appropriate “windows of opportunity.”

For information on starting a school-based sealant program, contact Larry Hill at (513) 357-7380; [larry.hill@cinhlthe.rcc.org](mailto:larry.hill@cinhlthe.rcc.org).

Dr. Lopez is program services director, the National Center for Farmworker Health.

## Surgeon General’s Report

### Report on Oral Health

The first Surgeon General’s Report to focus on oral health will define, describe, and evaluate the interaction between oral health and general health throughout the life span and in the context of changes in society. Caswell Evans, DDS, MPH, executive editor of the *Surgeon General’s Report on Oral Health*, said, “This connection is not fully appreciated by the public and some professionals.”

Intended for broad readership, the report will provide an overview of the status of oral health in the U.S., along with goals and recommendations. The report will also explore what’s on the horizon with oral health promotion at the community level, education for home care, delivery systems, financing, and dental technology. The needs of disadvantaged populations, people with disabilities, and children’s oral health will also be covered.

The report is expected to be released by late Spring of year 2000. Companion activities will include a workshop planned for March 2000 and a larger conference to be held in June 2000. Both meetings will be held in Washington, D.C.

For more information, call 301-594-5498, or browse the Web site: <http://www.nidr.nih.gov/>

# Oral Disease Prevention that Works

By Kay Mescher, RDH, MS

**A**lthough caries is the most widespread oral disease, there has been a decline in the number of children with cavities in the United States over the past 20 years. Studies show that nearly 50 percent of children under age 12 have no dental caries or fillings. This decline is attributed to fluoride in the diet, primarily fluoridated water, as well as the use of dental sealants, and limitations on sugar intake.

**Fluoride.** Fluoride in the water at the level of one part per million makes the surface of teeth more resistant to dental cavities. In addition to the fluoridation of water supplies, fluoride has been added to toothpastes and mouth rinses. No single measure has proved more effective in preventing dental cavities than fluoride in drinking water.

**Sealants.** In addition to fluoride, dentists are placing small amounts of plastic on chewing surfaces of teeth and sealing pits and fissures from decay caused by acid and bacteria on the tooth. Dental sealants

have been used increasingly over the past 20 years to prevent cavities on primary and permanent teeth, but they are most effective in preventing cavities on chewing surfaces of permanent teeth, when placed shortly after the tooth is seen in the mouth.

**Reduce sugar intake.** A low sugar diet or limiting the number of times a day that sugar is eaten is helpful in preventing cavities. The bacteria that lives in the mouth thrives on sugar and produces the acid that attacks the tooth and starts the cavity process. Therefore, reducing the amount of sugar in your diet and the number of times that sugar is eaten reduces the amount of time sugar is available for the bacterial to produce its destructive acids.

The easiest way to reduce sugar exposure is to eat three regular meals a day and limit snacks to foods with little amounts of sugar, and drink more water than soda or fruit juice.

Although early gum disease is present in almost every mouth with adult teeth,

advanced stages of gum disease can be prevented with good oral hygiene. In most cases inflammation of the gums is caused by irritation from deposits on the teeth. The more food deposits are allowed to harden on teeth, the more irritated and inflamed the gums become. Minor gum disease progresses to major gum disease with bone loss, gum pockets, bad breath, abscesses, and tooth loss.

Good oral hygiene should include brushing after every meal, flossing once a day before bedtime, rinsing with an astringent mouth wash, and having regular professional teeth cleanings once every six months. This includes mechanical or ultrasonic cleaning of teeth and fine polishing of exposed tooth surfaces to prevent most gum diseases and to prevent rapid destruction of gums caused by certain diseases of the body.

*Kay Mescher works in the Department of Preventive and Community Dentistry, College of Dentistry, University of Iowa.'*

## Minority Health Perspective

# You Don't Have to Lose Your Teeth!

By Ronald Romero, DDS

**T**hroughout the 20th century, the oral health status of the American population has improved significantly. According to the American Dental Association, a majority of adults 65 years and older have better oral health than their parents. As this century draws to an end, most people can look forward to keeping their teeth a lifetime, but this may not be true for all Americans—especially minorities and poor children. These two groups suffer disproportionately from tooth decay and other oral diseases, making them vulnerable to tooth loss as they age.

My grandparent's generation grew up thinking that complete tooth loss was

inevitable. Three of my grandparents lost all their natural teeth by the time they were 70 years old. My parent's generation believed that if they accessed dental care on a regular basis, they might not suffer the same fate as their parents.

My generation benefited from many of the advances in dentistry that were taking place during the latter half of this century. Community water fluoridation was introduced as well as other types of fluoride use. Tooth decay began a downward trend. Treatment recommendations shifted from extractions to restorations. Edentulism (loss of all permanent natural teeth) and dentures were no longer the norm.

Today we know that tooth decay is a preventable infectious disease. All segments of society must understand that you don't have to lose your teeth in this day and age because of the numerous preventive measures available to us.

If the standard for optimal health in the 21st century is to be met, then oral health should be regarded as an integral part of overall health. Health professionals, policymakers, administrators, and organizations are challenged to integrate oral health into a comprehensive health care system in order to eliminate disparities in health.

*Dr. Romero works for the Dental Health Program of the New Mexico Department of Health.'*

# Tobacco Prevention: Looking Beyond the Statistics

By Sibyl K. Bowie

What is the harm in a little pinch of snuff or chewing tobacco a few times a day? According to the National Institutes of Health's National Cancer Institute (NCI), the Surgeon General concluded as early as 1986 that the use of smokeless tobacco "is not a safe substitute for smoking cigarettes."

Smokeless tobacco can cause cancer of the throat, larynx, and esophagus, as well as the lip, tongue, cheeks, gum, and the floor and roof of the mouth. Chewing tobacco and snuff can lead to nicotine addiction and dependence, and can cause a number of noncancerous conditions such as high blood pressure, gum disease, loss of bone in the jaw, and tooth decay.

Chewing tobacco and snuff contain 28 cancer-causing agents, including formaldehyde, used in embalming fluid, polonium, which gives off radiation, and the highly addictive nicotine. One can of snuff delivers about as much nicotine as 60 cigarettes.

Despite the warnings, smokeless tobacco use was extensive among American Indian adolescents on the Blackfeet Reservation in northwestern Montana. That is, until the Indian Health Service's (IHS) Blackfeet Dental Department (BDD) intervened in 1988 to raise awareness about the dangers of smokeless tobacco.

"Students as young as six years old were found purchasing and using smokeless tobacco products. They would bring tobacco to Head Start to share with their friends," according to Julie Rattler, a registered dental hygienist at the Browning clinic—one of two BDD clinics operated by the IHS in Montana. "Much of the smokeless tobacco used by the adolescents was without their parents' or guardians' consent."

In January 1988, the Blackfeet Tribal Council was the first in the U.S. to pass a resolution banning the sale of tobacco products to minors and limiting the public utilization of these products to traditional use. Six months later, the BDD surveyed 11-19-year-olds through the Reservation school systems and found that almost 94 percent used smokeless tobacco products.

The BDD targeted sixth and eleventh graders in the fall of 1988 as a part of a community-wide health education program on the hazards of smokeless tobacco. Methods used to reach students:

- As part of Montana's *Tobacco Free by the Year 2000* educational program, students are being followed over the course of 12 years and given special tobacco prevention educational material.
- Presentations were made at all of the Blackfeet Reservation schools

(grades K-12). Each grade received age-specific information in the form of videos, handouts and verbal reinforcements. By the end of the first year nearly 100 percent of the students had received educational material.

- Literature and posters on the hazards of tobacco usage and second-hand smoke were placed in strategic locations on the reservation. Public service announcements were aired on the local radio station.
- Various tribal, federal and state government departments, and the local school and community college systems distributed pamphlets and showed tobacco education videos.
- The *Spitting Image Smokeless Tobacco Teaching Guide* was developed by the Indian State Board of Health for use as a permanent part of the middle school curriculum.

By 1995, when the BDD added smoking prevention objectives to its program, the percentage of sixth graders who had experimented with and used smokeless tobacco had decreased, but those who had either tried smoking or were smokers had increased.

In 1999, data indicated the number of students who tried smokeless tobacco products decreased by almost 20 percent since the study's inception. The percentage of students who were smokeless tobacco users remained about the same. However, those who experimented with smoking or smoked rose between 1989-99.

"We may be witnessing an increase in cigarette smoking because it's easier for young people to access cigarettes since the passage of the Tribal resolutions and state laws regulating the sale and possession of smokeless tobacco products to and by minors," Rattler said.

There have been some small victories for the BDD. "We've experienced some frustrations too," said Rattler. "But we must constantly look at our community to see anything positive which helps us to be more optimistic."

Ten years ago, according to Rattler, teachers were smoking in classrooms with students present. Now, that is never done. In fact, many have quit smoking. Ten years ago you could go into the Tribal Offices and the majority of adults, including employees, were smoking or using smokeless tobacco right inside the buildings. Now there are just a few standing outside in the back.

"You need to look continually at the small improvements for gratification. And, we must continue to provide the education needed to precipitate change", Rattler concluded.

For more information on tobacco and cancer, contact the NCI's Cancer Information Service at 1-800-422-6237. You can access NCI's Web site at <http://www.nci.nih.gov/>

## Surgeon General's Report on Tobacco

The 1998 Surgeon General's Report, *Tobacco Use Among U.S. Racial and Ethnic Minority Groups*, published by the Centers for Disease Control and Prevention, indicates that rates of tobacco-related cancers other than lung cancer vary widely among members or racial and ethnic groups, and are particularly high among African American men.

This is the first report in the 34-year history of Surgeon General's studies on tobacco use to focus on the impact on African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics.

To view a copy of the report, browse the CDC's Web site at: <http://www.cdc.gov/nccdphp/osh/sgr-minorities.htm>.

# The Mouth is a Mirror of the Body

By Michael Glick, DMD

The era when we only went to the dentist to repair and replace our teeth has come to an end. We can now rely on our dentists for much more. Dental care providers have changed their identity and have taken on the responsibility of primary care providers. They are intimately involved in the overall health of their patients and provide a watchful eye to identify and control chronic diseases such as diabetes, cancer, and heart disease. Dentists may be the first health care provider to recognize signs or symptoms of diseases that we may not recognize.

Apart from taking a thorough medical history and checking blood pressure, the dentist sees signs in the mouth that mirror systemic conditions or diseases in the body.

**Immune Deficiency.** Frequent occurrence and rapid progression of severe and destructive periodontal disease, oral ulcerations, and oral thrush can be seen in advanced stages of immune destruction. These signs are particularly evident during the progression of HIV.

Oral thrush is an early sign of immune deficiency, which resembles "cottage cheese-like" small white curds that can easily be wiped away from the soft parts of the mouth. Thrush can also appear in the mouth of patients taking antibiotics for a long period of time, individuals using inhalers to treat asthma, or patients with poorly controlled diabetes.

**Viral Diseases.** Oral ulcerations, or sores in the mouth, may indicate a large number of systemic conditions. Ulcerations are often early signs of viral diseases such as herpes infections, mononucleosis, herpangina, hand-foot-mouth disease, or HIV infection. When ulcers are accompanied with malaise, fever, or a sore throat, a systemic disease is usually suspected.

**Cancer.** If an ulcer has been present for more than three weeks without any sign of healing, a thorough investigation is needed. A biopsy will often rule out a cancer. However, if a cancer is present, it needs to be taken seriously. Oral cancer kills one person in the U.S. every hour, but

early detection can reduce this number significantly.

**Leukemia.** This life threatening form of cancer of the blood may manifest first in the gums. Persons with leukemia may have large swollen gums that bleed upon the slightest touch.

**Diabetes.** It is common for rapid progressive periodontal disease, or gum disease, to indicate undiagnosed diabetes. People with controlled diabetes have healthier gums than those who do not. People with poor gums seem to have severe diabetic conditions, and people with severe diabetic conditions seem to have severe gum disease. Dry mouth, burning sensation in the mouth, diminished sense of taste and smell, and tingling, numbness, and ulcers in the oral region may be present in people with diabetes.

**Heart disease.** Recent studies have suggested that gum disease may be associated with heart disease. Patients with heart disease have increased severity of gum

disease compared to individuals without heart disease.

**Medications.** Swollen gums can be the result of certain drugs. Patients taking dilantin to control epilepsy often have swollen gums. Increased inflammation of the gums can be present in people using specific heart and hypertension drugs like calcium channel blockers.

Although signs in the mouth may represent a serious condition or systemic disease, they may also be completely harmless. Clinical signs alone are not diagnostic of systemic diseases; they must be supplemented with laboratory procedures such as biopsies or blood tests to confirm the presence of disease. However, the realization that the mouth is a mirror of the body can assist in diagnosing serious diseases and conditions early, and can help to achieve and maintain optimum health.

*Dr. Glick is director of the Program of Medically Complex Patients, University of Pennsylvania School of Dental Medicine.'*

## Warning Signs in the Mouth

By CDR Ronald Bajuscak, DMD

**Kidney disease.** Chronic renal (kidney) disease has several early oral signs. Patients often notice a metallic taste along with an ammonia-like odor in the mouth. Dry mouth, swelling glands, and frequent infection of the soft tissues are signs that raise concern about possible kidney disease.

**Anemia.** In early stages of anemia, patients will often complain about the tongue becoming smooth, glistening, and feeling like it is burning. This smoothing and burning begins at the tip and spreads to the back of the tongue. If a person's tongue becomes swollen, smooth, and bright red in color, there should be immediate concern for vitamin B12 deficiency pernicious anemia, or recurrent aphthous ulcers.

**Hemophilia and other bleeding disorders.** Unprovoked bleeding of the

gums is a warning sign of bleeding disorders such as hemophilia, von Willebrand's disease, leukemia, hodgkin's lymphoma and lymphomas.

**Adrenal gland disorders.** Brown or black splotches on the inner linings of the cheeks and lips are seen in early stages of Addison's Disease and other adrenal gland disorders.

**Inflammatory bowel diseases.** A cobblestone appearance of the soft tissue of the mouth and a generalized swelling of the linings of the cheeks and lips are early signs of inflamed bowels and Crohn's disease. Patients with ulcers often have a history of oral cold sores because tissues of the mouth and intestines are closely related.

*CDR. Bajuscak works for the Health Services Department, Federal Correctional Institution of the Federal Bureau of Prisons.'*

# FAQs on Oral Health: What Consumers Need to Know

**H**ave dental questions but don't know where to look? The American Dental Association (ADA) provides information on topics ranging from root canal therapy to cosmetic surgery. The following consumer-oriented information is from the ADA's Web site: [www.ada.org/consumer/faq](http://www.ada.org/consumer/faq), and is reprinted with permission of the ADA.

## Choosing the right dentist

### Q: How do I choose a dentist?

**A:** Consult with people whose opinions you trust—family, friends, co-workers, physician, the ADA or state dental society (available at: <http://www.ada.org/states/st-menu.html>), your local hospital or dental school—for a list of accredited dentists. An ideal dentist should explain techniques and provide instructions in a way you understand. And you should feel comfortable asking questions on things that are unclear.

### Q: Where can I go for low-cost dental care or financial assistance for dental work?

**A:** Visit your local dental school for treatment, including braces and other dental devices, at a reduced rate; or contact your state dental society for assistance.

### Q: What safety precautions should dentists follow to prevent infection in the office?

**A:** Dentists should take blood and body fluid precautions for all patients at all times. Workers should wear new protective gloves and other barriers before each patient; use chin length plastic face shields and protective eyewear, and reusable or disposable clothing such as lab coats; and practice techniques such as washing hands. Sharp items like needles or scalpel blades contaminated with patient blood should be handled with care. All dental instruments and equipment should be cleaned thoroughly before sterilization or high-level disinfection. Countertops and other unit surfaces should be cleaned with disposable towels, using appropriate cleaning agents and water as necessary.

### Q: How do I file a complaint against my dentist?

**A:** First discuss any concerns you have with your dentist. If you are not satisfied, contact your state dental association at: <http://www.ada.org/states/st-menu.html>, or your local dental society. A peer review board may help resolve the issue through mediation.

## Orthodontics

### Q: What are orthodontic problems and how are they corrected?

**A:** An orthodontic problem, or malocclusion (bad bite), occurs when there are extra teeth in the mouth, teeth are crowded or missing, or jaws are out of alignment. Most orthodontic problems can be corrected with braces—metal or plastic devices that exert gentle, constant pressure on teeth, allowing them to move. But some severe orthodontic problems may require surgery.

### Q: At what age can people have orthodontic treatment?

**A:** Both children and adults can benefit from orthodontics. ADA recommends that all children receive an orthodontic evaluation by age seven. Treatment time usually averages 24 months, but it may be a little longer for adults.

## Infants and Children

### Q: At what age should my child go to the dentist?

**A:** The ideal age your child should get its first dental checkup is by the first birthday. The earlier your child starts making dental visits, the sooner you'll help your child build a lifetime of good dental habits.

### Q: Should I clean my baby's mouth even if there are no teeth yet?

**A:** Yes. After every feeding, wipe your baby's gums with a damp washcloth or

gauze pad to remove plaque. This promotes good oral hygiene and establishes the feel of having clean teeth and gums at an early age.

### Q: Does teething cause a fever?

**A:** No. While teething can be painful or irritating to a baby's gums, it does *not* cause fever. If your baby is teething, you can soothe its sore and tender gums by rubbing them gently with a clean finger, a wet gauze, or a teething ring.

## Bridges & Dentures

### Q: What's the difference between conventional and immediate dentures?

**A:** Conventional or "complete" dentures can be inserted soon after the remaining teeth have been removed and the tissues are healed. Immediate dentures are inserted immediately after the removal of the remaining teeth, so that you don't have to be without teeth for any period of time.

### Q: Will my dentures need to be replaced?

**A:** Over time, dentures do need to be relined or rebased due to normal wear. Dentures need to be replaced due to changes in the mouth such as receding gums which can cause dentures to slip, making chewing and talking difficult.

### Q: What is a "bridge"?

**A:** Bridges are devices used to replace gaps caused by missing teeth. Among the most common are "fixed" bridges which are attached permanently to surrounding teeth.

### Q: What other tooth replacements are there?

**A:** Dental implants are artificial teeth that look and feel natural. Through a series of surgeries, implants are attached directly into the jaw bone or under the gum and are more secure.'

### **American Academy of Pediatric Dentistry.**

This site for families and oral health professionals includes information on subjects ranging from caring for your baby's teeth to early orthodontic treatment. A directory of advanced education programs, continuing education resources, and information on the annual session is provided for health professionals. **Web:** [www.aapd.org](http://www.aapd.org)

### **American Association of Dental Schools**

(AADS). The AADS seeks to lead the dental education community in addressing issues of education, research, and the health of the public. This site contains news and updates, subscription information for publications, a schedule of conferences and meetings, and a directory of dental education programs. **Web:** [www.aads.jhu.edu](http://www.aads.jhu.edu).

**American Dental Association.** This one-stop shopping site for oral health information for health professionals and consumers includes position statements, fact sheets, product information, and a directory of dentists. Dental sealants and baby bottle tooth decay are among the Maternal and Child Health-related topics discussed. **Web:** [www.ada.org](http://www.ada.org).

### **American Dental Hygienists Association.**

This site features a Consumer Information Center on topics that include oral cancer screening and tips for brushing and flossing. A special section for kids has educational games and suggestions for healthy snacks. Its Career Information Portfolio covers issues in public health and licensing. **Web:** [www.adha.org](http://www.adha.org).

### **American Association of Public Health**

**Dentistry (AAPHD).** The AAPHD is committed to educating the public and health professionals in order to advance disease prevention and health promotion. This site provides links to other sites pertaining to federal agencies and other organizations, patient information, databases, and journals. **Web:** [www.pitt.edu/~aaphd/index.html](http://www.pitt.edu/~aaphd/index.html).

### **Association of Managed Care Dentists**

(AMCD). The AMCD is a nonprofit

organization dedicated to educating dentists and other oral health professionals about the emerging managed care delivery systems. This site contains an electronic copy of the association's newsletter and links to other related sites.

**Web:** [www.dentalgroup.com/amcp](http://www.dentalgroup.com/amcp).

**Bright Futures.** The Bright Futures Web site is designed to provide both health professionals and families a greater understanding of the diagnostic process and what can be expected in health supervision visits. Publications, including the *Bright Futures in Practice: Oral Health*, can be ordered from this site. **Web:** [www.brightfutures.org](http://www.brightfutures.org).

### **Bureau of Primary Health Care, Models**

**That Work.** This site features innovative community-based models for delivering primary health care to underserved and vulnerable populations. It includes an overview of the Models That Work campaign, information-sharing resources, and a database of primary care programs. **Web:** [www.bphc.hrsa.dhhs.gov/mtw/mtw.htm](http://www.bphc.hrsa.dhhs.gov/mtw/mtw.htm).

### **Health Systems Research (HSR) Technical Assistance Project.**

The HSR Technical Assistance Project provides support to Title V agencies in efforts to develop comprehensive systems of care for children and families. The Web site has reports from technical assistance projects, such as serving vulnerable populations under managed care, training communities in systems development, and developing quality assurance standards for children with special health care needs. **Web:** [www.ichp.edu/mchb/hsr](http://www.ichp.edu/mchb/hsr).

### **Hispanic Dental Association (HDA).**

The HDA is a national organization with membership that includes Hispanic dentists and hygienists, dental assistants, technologists, academics, and students. Site provides scholarship information and details its New Professionals/Student Program. **Web:** [www.hdassoc.org](http://www.hdassoc.org).

### **National Center for Tobacco-Free Kids.**

This Web site highlights the activities of the National Campaign for Tobacco-Free

Kids. The Campaign works to alter the nation's social, political, and economic environment regarding tobacco; change public policies at federal, state, and local levels; and increase the number of organizations and individuals involved. The site includes fact sheets on topics such as smokeless (chewing) tobacco and children, and tobacco use by ethnicity. **Web:** [www.tobaccofreekids.org](http://www.tobaccofreekids.org).

**National Dental Association (NDA).** The largest and oldest organization of minority oral health professionals in the world, NDA represents over 7,000 African American dentists in the U.S. and abroad. Its membership includes dentists from Canada and several countries in the Caribbean, Africa, and Latin America. **Web:** [www.howard.edu/collealliedhealth/ndamain.htm](http://www.howard.edu/collealliedhealth/ndamain.htm).

### **National Maternal and Child Oral Health Resource Center.**

This site proves online access to current oral health information and materials, including an extensive database of Maternal and Child Health (MCH) organizations, oral health publications, and links to other MCH and oral health Web sites. **Web:** [www.ncemch.org/oralhealth](http://www.ncemch.org/oralhealth).

### **National Oral Health Information**

**Clearinghouse.** This site provides resources to assist health professionals in meeting the special care needs of patients. Special care publications, an online oral health database, and resource links are accessible from this site. **Web:** [www.aerie.com/nohicweb](http://www.aerie.com/nohicweb).

### **Surgeon General's Report on Oral Health.**

The site will post the report, when released, as well as information on the background and charge of the report. **Web:** [www.nidr.nih.gov/sgr/sgr.htm](http://www.nidr.nih.gov/sgr/sgr.htm).

### **Synopses of State Dental Public Health**

**Programs.** Produced in collaboration with the Association of State and Territorial Dental Directors, this site provides a synopsis of state dental public health programs by year and state. **Web:** [www2.cdc.gov/nccdphp/doh/synopses/index.asp](http://www2.cdc.gov/nccdphp/doh/synopses/index.asp).

## DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service  
Office of Minority Health Resource Center  
P.O. Box 37337  
Washington DC 20013-7337

Official Business  
Penalty for Private Use \$300

PRSR STD  
POSTAGE AND FEES PAID  
DHHS/OPHS  
PERMIT NO. G-280



# *Closing the Gap*

## Conferences: 1999-2000

**July 30-Aug. 5:** National Dental Association Annual Meeting held in Atlanta, GA. Contact: (202) 588-1697.

**Aug. 8-13:** National Medical Association Annual Scientific Assembly and Exposition, held in Las Vegas, NV. Contact: (202) 347-1895; fax (202) 842-3293

**Aug. 19:** Chronic Disease in Minority Populations Forum, held in Milwaukee, WI. Sponsored by the Office of Minority Health (OMH) (Region V), and the Wisconsin Department of Health and Family Services. Contact: (608) 266-9708; fax (608) 266-8925.

**Aug. 29-Sep. 1:** National HIV Prevention Conference in Atlanta, GA, sponsored by the Centers for Disease Control and Prevention. Contact: (404) 639-1942.

**Sep. 22-24:** Hispanic Dental Association Seventh Annual Meeting in San Antonio, TX. Contact: 1-800-852-7921.

**Sep. 25:** Chronic Disease in Minority Populations Forum, held in St. Paul, MN. Sponsored by OMH (Region V) and the Office of Minority Health, Minnesota Department of Health. Contact: (651) 297-3006.

**Nov. 4-5:** Dental, Oral, and Craniofacial Health Technology Forum sponsored by National Institute of Dental and Craniofacial Research (NIDCR). Event held at Lister Hill Auditorium, Bethesda, MD. Contact: NIDCR (301) 496-4261.

**April 5-9, 2000:** NIDCR's 78th Meeting of International Association of Dental Research, held in Washington, DC. Contact: (301) 496-4261.

October 9-13, 1999

### **ADA's 140th Annual Session, in Hawaii!**

Say "Aloha" to your colleagues from throughout the U.S. and around the world at the American Dental Association's 140th Annual Session in beautiful Honolulu, Hawaii. Say "Aloha" to the future of dentistry by taking advantage of the meeting's extensive program and more than 1,100 technical exhibits.

Browse ADA's Web site to find descriptions of programs and activities, as well as registration forms: <http://www.ada.org/session/index2.html>.

