

Oral Health



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Colorado

Reducing the Burden of Oral Diseases by Tracking Diseases and Targeting Programs

Public Health Problem

Cavities have declined in the United States because of preventive strategies such as community water fluoridation, use of fluoride toothpaste and mouth rinses, and application of dental sealants. Despite this progress, dental decay remains a significant problem among all age-groups and is particularly a problem among people with low incomes and some racial and ethnic groups. In Colorado, 62% of third grade children have already had a cavity, and 26% have untreated dental decay.

Program Example

The Colorado Department of Public Health and Environment's Oral Health Program is establishing a surveillance system that will track oral health information on people of all ages in the state. The system is being developed through a cooperative agreement with the CDC. The state has developed a surveillance plan to identify which oral diseases, conditions, and age-groups to track and how often the data will be collected. By collecting data on people's oral health and access to care, Colorado will be able to monitor trends over time and document improvements in oral health among state residents. These data also will allow the state to target the populations most in need of oral health services and direct funds to programs that will reduce disparities and the burden of oral disease in the state. Because much of the data will be represented in the National Oral Health Surveillance System, Colorado will be able to compare state data with national findings. In addition, the Oral Health Program enhanced its Web site to make data on disease levels available to state and local policy makers as well as the public. The program also is producing a document that will describe the status of oral health in Colorado and the economic impact of oral health disparities in the state.

Implications and Impact

The new surveillance system will provide Colorado's Oral Health Program with data to help plan and evaluate the state's primary and secondary prevention programs. This information can be used to engage policy makers, communities, and other stakeholders interested in addressing oral health disparities in the state. These data also will be essential when the state sets priorities for programs to further address the burden of oral disease.

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Promoting Better Oral Health Through a Statewide Coalition

Public Health Problem

Although prevention and treatment for oral disease have improved significantly over the past 50 years, thousands of people in Illinois continue to experience dental pain and dysfunction. Illinois mirrors the nation in that oral disease remains pervasive among some populations, and cavities continue to be a major problem for some children. The Project Smile statewide survey, conducted in 1994, revealed that 38% of children aged 6–8 years in the state had untreated cavities, and the figure was even higher in the Chicago area, where 54% of children had untreated decay. Only 29% of Hispanic and 40% of black children aged 8–12 years were free of obvious decay, compared with 52% of white children.

Program Example

Illinois communities have been assessing their oral health needs since the late 1990s and have used this information in local planning efforts. These community assessments have provided a growing database of information about disparities in oral health, challenges that block access to care, and actions that could improve oral health at the community level. One direct outcome of these efforts was the formation of the IFLOSS Coalition, a community collaborative with more than 50 member organizations whose mission is to improve oral health for Illinois residents. Since its formation in 1998, this grassroots coalition has continued to flourish. The IFLOSS Coalition has played a key role in the 2001 Illinois Oral Health Summit and the subsequent development of the state oral health plan, *Roadmap to the Future: Oral Health in Illinois*. Town hall meetings about the plan were held in 7 communities across the state, and the plan incorporates input from more than 300 stakeholders. The Roadmap addresses the five policy goals contained in the Surgeon General's 2000 report, *Oral Health in America*, as well as state priorities for improving oral health. A 5-year cooperative agreement with CDC is allowing Illinois to conduct some of the activities called for in the oral health plan.

Implications and Impact

A broad-based, state coalition such as the IFLOSS Coalition can support and strengthen statewide planning efforts to promote oral health. The oral health plan developed for Illinois can be used as a framework for eliminating oral health disparities and improving oral health. A strong planning process can attract other related state and community coalitions to incorporate a focus on oral health (e.g., diabetes or tobacco control coalitions). With key partners and an oral health plan now in place, the Illinois Division of Oral Health is prepared to lead efforts to develop oral health infrastructure in the state and provide a model for other states and territories.



Preventing Tooth Decay Through Water Fluoridation

Public Health Problem

Cavities have declined dramatically in the U.S. population because of preventive strategies such as community water fluoridation, the use of fluoride toothpastes and mouth rinses, and the application of dental sealants (plastic coatings placed in the pits and grooves of molar teeth to prevent decay). Despite these gains, dental decay remains a significant problem for all age-groups, particularly for poor people and those of some racial and ethnic groups. Water fluoridation is the most cost-effective way to use fluoride to protect people from dental decay, with the average annual cost ranging from \$0.50 per person in communities with populations of 20,000 or more to \$3.17 in communities with fewer than 5,000 residents. The *Healthy People 2010* goal is for 75% of the U.S. population to receive fluoridated water. Currently, water fluoridation reaches about 66% of the U.S. population on community water supplies, or about 162 million Americans. About 100 million people in the United States were not receiving optimally fluoridated water as of 2000. In 1992, only 2% of Nevada's population on public water supplies received fluoridated water.

Program Example

Nevada has made significant progress in increasing the level of fluoride in drinking water to a level effective in preventing tooth decay. Clark County, which includes Las Vegas and Henderson and has a population of about 1 million people, began water fluoridation in 2000. This measure increased the fluoridation coverage in Nevada from about 28,000 to approximately 1 million residents, or two-thirds of the population on public water. Nevada is also strengthening its capacity to monitor oral diseases, extend water fluoridation, and provide school-based dental sealants.

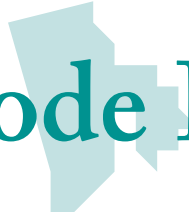
Implications and Impact

Nevada's water fluoridation program demonstrates the importance of increasing people's access to fluoridated water as an effective means of decreasing tooth decay and its related pain and suffering, costs for treatment, and lost school and work days.

Contact Information

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Rhode Island



Improving Oral Health by Building Infrastructure and Developing School and Community Partnerships

Public Health Problem

In 1998, Rhode Island did not have an oral health program within the state department of health. Without a state dental director or program, Rhode Island had limited capacity to plan, conduct, and evaluate oral disease prevention programs for at-risk children or gather surveillance information. In 1996, only 28% of children under age 14 years in Rhode Island's Medicaid program had received dental sealants (plastic coatings placed in the pits and grooves of molar teeth to prevent cavities). In 1998, 35% of children screened in 10 Providence inner-city elementary schools had unmet oral health needs.

Program Example

The Healthy Schools! Healthy Kids! Oral Health Initiative is a statewide effort supported by CDC to improve the oral health of Rhode Island children through school and community partnerships. The program is a collaborative effort by the Rhode Island Department of Education and the Rhode Island Department of Health. Activities have included the formation of the statewide Healthy Schools! Healthy Kids! Steering Committee, made up of members from more than 30 state, public, and private agencies, foundations, and organizations. The state also has hired a dental director, a health promotion specialist, and an oral health program coordinator. The oral health staff, in conjunction with the Rhode Island Department of Education, worked to change state regulations and to carry out these changes beginning with the 2000–2001 school year. Schools are now required to provide standardized oral health screenings each year for children in grades K–5 and once for those in the grades 7–12. Parents of children requiring follow-up treatment are notified and given a list of community-based oral health providers. A standardized screening form is used to collect data on children's oral health to define current needs and guide future oral health programs.

Implications and Impact

Rhode Island has been successful in expanding and enhancing its state oral health programs because it has in place the three components of oral health infrastructure mentioned in the Association of State and Territorial Dental Directors report, *Building Infrastructure and Capacity in State and Territorial Oral Health Programs*: leadership to address oral health problems, development and promotion of policies for better oral health, and improvement of oral health systems.