

Resources



Chapter 3

- ✓ Examples of Oral Health Objectives from State HP 2010 Plans
- ✓ Worksheet: Writing Objectives
- ✓ Summary of Needs Assessment Methods
- ✓ Catalogue of Surveys Related to Oral Health: Oral Health Variables
(not included, see Web site http://drc.nidcr.nih.gov/Catalog/catalog_instruction.asp)
- ✓ Setting Target Levels for Objectives
- ✓ IHS Tracking Health Indicators
- ✓ Characteristics of High-Quality and Effective Data for Policy Making
- ✓ Oral Health of North Dakota's Youth: 2001 Youth Risk Behavior Survey Results
(<http://www.health.state.nd.us/ndhd/prevent/mch/dental/OralHealthYRBS2001.pdf>)
- ✓ Texas Risk Factor Report; Oral Cancer Risk Behaviors (www.tdh.state.tx.us/dental)
- ✓ ASTHO Health Care Safety Net Amendments of 2002
- ✓ Legislative Updates: Health Safety Net Amendments
- ✓ References

Examples of Oral Health Objectives from State HP 2010 Plans

District of Columbia

- ⊕ Increase to at least 85% the proportion of all children entering school programs for the first time who have received an oral health screening.
 - Of those children screened and needing referral, increase to at least 25% the proportion receiving a referral for necessary diagnosis, preventive and treatment services.
 - Of those children being referred for treatment, increase to at least 30% the proportion beginning treatment within 90 days.
- (No baseline data)

West Virginia

- ⊕ Reduce dental caries (cavities) in primary and permanent teeth (mixed dentition) so that the proportion of children who have one or more cavities (filled or unfilled) is no more than 60% among children aged 8 and 60% among adolescents aged 15.
(Baseline: age 8, 65.6%; age 15, 66%)
- ⊕ Increase to 50% the proportion of school-based health centers (pre-kindergarten through grade 12) with an oral health component.
(Baseline: 40% in 1998)

Alaska

- ⊕ Increase the proportion of children and adolescents under age 19 at or below 200% of federal poverty level who received only preventive dental services during the past year to 50%.
(Baseline: 24%)

North Carolina

- ⊕ Increase the proportion of adults who visited a dentist within the past year to 73.9%.
(Baseline: 67.2% in 1999—based on 10% improvement)

Iowa

- ⊕ Increase to at least 70% by the year 2010 the proportion of seniors aged 75 and over who have had a dental examination in the previous year.
(Baseline: 50% of rural elders in 1992)
- ⊕ Increase use of topical fluorides in schools to at least 75% of people not receiving optimally fluoridated public water by the year 2010.
(Baseline not yet available)

Kentucky

- ⊕ Increase to at least 70% the proportion of 8 year-olds, 12 year-olds and 15 year-olds who have received protective sealants in permanent molar teeth.
(Baseline: 10% of 5-9 year-olds; 7% of 14-17 year-olds)

WORKSHEET Writing Objectives

Priority

Area: _____

Goal	
Available Data Sources	
Potential Objectives	A.
	B.
	C.
Potential Strategies	

Summary of Needs Assessment Methods

METHOD	PURPOSE	COST	TIME INVOLVED	ADVANTAGES
A. Secondary Data From National or Regional Oral Health Surveys	Needs or problem analysis	Very Inexpensive	Extremely Fast	Data readily available
B. Other Secondary Data	Needs or problem analysis	Inexpensive	Fast to Moderate	Data available (self-reported and other fiscal or regulatory information)
C. Demographic Indicators	Needs or problem analysis	Inexpensive	Very Fast	Data available from public documents
D. Analyzing Non-clinical Data	Resources analysis	Inexpensive to Moderate	Fast	Can also use for annual reports; trend analysis of activities
E. Analyzing Clinical Program Data	Resources analysis	Inexpensive to Moderate	Moderate	Can also use for annual reports; understand extent of services provided
F. Public Comment	Needs or problem analysis	Inexpensive	Moderate	Invitation of public input and exchange
G. Informant Groups	Needs or problem analysis	Inexpensive to Moderate	Fast to Moderate	Minimal preparation time; facilitates communication from providers and consumers
H. Questionnaire/ Interview Survey	Needs or problem analysis	Moderate	Moderate	Relatively good way to obtain information about knowledge and behavior
I. Basic Screening Survey	Needs or problem analysis	Moderate to Expensive	Moderate to Slow	Assesses individuals; good estimate of population if probability sampling is used

Source: ASTDD Seven-Step Model; Step 3, Table 3: Assessing oral health needs.

Setting Target Levels for Objectives

Population Objectives

To support the national goal of eliminating health disparities, a single national target that is applicable to all select populations has been set for each measurable, population-based objective. Three guiding principles were used in setting targets for the measurable, population-based objectives:

- ⊕ For objectives that address health services and protection (for example, access to prenatal care, health insurance coverage) the targets have been set so that there is an improvement for all racial/ethnic segments of the population (that is, the targets are set “better than the best” racial/ethnic subgroup shown for the objective). Data points for at least two population groups under the race and ethnicity category are needed to use “better than the best” as the target-setting method.
- ⊕ For objectives that can be influenced in the short term by policy decisions, lifestyle choices, and behaviors (for example, physical activity, diet, smoking, suicide, alcohol-related motor vehicle deaths), the target setting method is also “better than the best” group.
- ⊕ For objectives that are unlikely to achieve an equal health outcome in the next decade, regardless of the level of investment (for example, occupational exposure and resultant lung cancer), the target represents an improvement for a substantial proportion of the population and is regarded as a minimum acceptable level. Implicit in setting targets for these objectives is the recognition that population groups with baseline rates already better than the identified target should continue to improve.

Beyond this general guidance, the exact target levels were determined by the lead agency workgroups that developed the objectives. The workgroups used various methods for arriving at the target levels, including:

- ⊕ “Better than the best” (described above)
- ⊕ “Best of the best”, benchmarking against the top 10% in any area of the U.S.
- ⊕ ____ percent improvement
- ⊕ “Total coverage” or “Total elimination” (for targets like 100 percent, 0 percent, all States, etc.)
- ⊕ Consistent with _____ (another national program, for example, national education goals)
- ⊕ Retain year 2000 target (the Healthy People 2000 target has been retained).

Health Outcomes and Performance Objectives

The following guidance focuses primarily on setting targets for health outcomes and performance. Formulas and technical examples are given in the Healthy People 2010 Toolkit referenced in Chapter 1.

⊕ *Using an absolute percent decline*

Some Healthy People objectives use an absolute percent decline based on "best guesses"/expert opinion to indicate a "reasonable" change over time. Calculations can be made based on the percent of the target population reached and change expected. For example, an absolute decline of 1% of the current level adds to 10% over the decade. Be careful to calculate the percentage for the numbers from the beginning of the decade or it will be a compounded percentage achieved.

⊕ *Using peer communities*

You can set targets by comparing your community to others like it. Age and poverty distribution and population size and diversity may define peer communities. The following may be used to describe one's peers: typical values for a specific objective, means or medians, or the variation among peers.

⊕ *Using the pared-mean method to set data driven benchmarks*

The pared-mean method determines "top performance." This is defined as the best outcome accomplished for at least 10 percent of the population. Data sources to use for the pared-mean method include vital statistics and the Behavioral Risk Factor Surveillance System. This method is not feasible for all Healthy People objectives. Data may not be available for some objectives, or the nature of the objective may not lend itself to using the pared-mean method. For example, access to preventive care should be available for 100 percent of the population, regardless of what the data show.

Source: Allison J., Kiefe C.I., Weissman N.W. "Can Data-Driven Benchmarks be Used to Set the Goals of Healthy People 2010?" American Journal of Public Health, 89(1):61-5, 1999.

⊕ *What if areas in the state have already achieved or surpassed the national Healthy People target for an objective?*

You can calculate a new, higher state target that will be challenging for local areas that have achieved or surpassed the national target. You also may wish to note in your plan the jurisdictions that have not achieved your previous targets and redouble your efforts in these areas as well as set equally ambitious targets for year 2010.

Process Objectives

Many process objectives, particularly those that pertain to infrastructure (e.g., data systems, workforce) are new for Healthy People 2010. These should be examined carefully to determine their applicability to the state or community plan. Setting measurable targets for process objectives requires judgment and is not an exact science. To set process targets, planners should consider the current status (baseline) of the state/community's public health infrastructure, seek stakeholder input on the desired level of improvement, and make a realistic assessment of what can be accomplished given past experience and current resources, political opportunities, and partner commitment.

⊕ *Annual percentage change*

This measure can be used to track whether progress is on course and to determine if the HP 2010 objectives will be reached. It provides the amount of decline each year that is needed to reach the target.

⊕ *Using performance measures*

"Performance measurement responds to the need to ensure efficient and effective use of resources, particularly financial resources. It links the use of resources with health improvements and the accountability of individual partners." (*Prevention Report*, Winter 1997) This is of particular importance since the inception of the Government Performance and Results Act of 1993, which aims at holding federal agencies accountable for spending public dollars. This extends to states, local jurisdictions, and other organizations that receive federal funding. Performance measures can be incorporated into or based upon Healthy People objectives.

Source: Adapted from Setting Targets and Measuring Progress. Healthy People 2010 Toolkit. pages 93-94.

Indian Health Service Tracking Health Indicators

INDICATOR	DATA SOURCE	LOGIC	Consistent with GPRA+?
<i>Oral Health</i>			
<u>Indicator 11</u> : During FY 2002, increase the proportion of AI/AN population receiving optimally fluoridated water by 5% over the FY 2001 levels for all IHS Areas.	WFRS (CDC) and reports from Area Fluoridation Coordinators		
<u>Indicator 12</u> : During FY 2002, increase the proportion of the AI/AN population who obtain access to dental services by 1% over the FY 2001 level.	Numerator – NPIRS data Denominator – official user population count		
<u>Indicator 13</u> : During FY 2002, increase the number of sealants placed per year in AI/AN children by 2.5% over the FY 2001 level.	NPIRS data		
<u>Indicator 14</u> : During FY 2002, increase the proportion of the AI/AN population diagnosed with diabetes who obtain access to dental services by 2% over the FY 2001 level.	IHS Diabetes Care and Outcomes Audit		

Characteristics of High-Quality and Effective Data for Policy Making

Technical Characteristics	
Content	Cover one or more major health policy or program concerns with sufficient detail to clarify the implications of alternative policy choices.
Currency (Timeliness)	Appear on a sufficiently timely basis and with the appropriate frequencies that they provide a relatively current profile and can be credibly used.
Completeness	Achieve sufficiently high submissions, reporting, or response rates and item completion, to limit biases leading to distorted conclusions.
Reliability	Provide classification and coding consistency to enhance interpretability and reduce confusion.
Analytical Flexibility	Support both routine and special analyses, particularly on an interactive or real-time basis.
Strategic Characteristics	
Cross-System Flexibility	Allow users to merge, compare, or jointly use data from complementary systems; include compatible and consistent variable definitions, coding categories, and a linkage mechanism.
Adaptability	Allow data content and/or reporting to be readily modified to address changing needs.
Accessibility	Provide clear reports to a non-technical audience; make available diverse reports or information tailored to different decision needs or users, and provide access to public-use data sets at a reasonable cost so they can be independently analyzed.
Translation and Policy Applicability	Effectively translate technical data to policy-relevant information.
Dissemination	Accurately and fully inform potential users or decision-makers about the resources and how to access it effectively.

Source: Feldman P., Gold M., Chu K. "Enhancing Information for State Health Policy." Health Affairs, 13(3):238, 1994.

Oral Health of North Dakota's Youth 2001 Youth Risk Behavior Survey Results



The fifth biennial Youth Risk Behavior Survey conducted during the spring of 2001 shows that the oral health of North Dakota's children needs improvement. Weighted data were obtained from 1,377 seventh and eighth students and 1,599 students in grades nine through 12. Seventh and eighth students were asked about dental visits, while students in grades nine through 12 were asked about dental visits, daily brushing habits and cavities in their permanent teeth.

Daily Brushing

- ⊕ While three-fourths (75.9%) of students brushed their teeth daily, one-fourth (24.1%) did not.
- ⊕ Female students (86.1%) were more likely to brush daily than were male students (66.6%).
- ⊕ Only 70.5 percent of students in grade nine reported brushing daily, while 81.2 percent of students in grade 12 brushed daily.

Dental Visits

- ⊕ While 75.5 percent of students in grades nine through 12 had visited the dentist within the past year, 16.4 percent had not.
- ⊕ Of these students, 1.6 percent have never visited the dentist.
- ⊕ Females (78.9%) were more likely to visit the dentist in the past year than were males (72.5%).
- ⊕ During the past year, 81.8 percent of students in grades seven and eight visited the dentist.
- ⊕ Cavities in Permanent Teeth
- ⊕ More than one-half (57.5%) of students reported one or more cavities in their permanent teeth.
- ⊕ One-third (34.1%) of students reported no cavities.
- ⊕ More than 8 percent of students were not sure if they have cavities or have not visited the dentist.

North Dakota Department of Health
Oral Health Program
600 E. Boulevard Ave.
Bismarck, N.D. 58505
701.328.2493

04/02



Texas Risk Factor Report

Behavioral Risk Factor Surveillance System

Texas Department of Health

February 1997

Volume 4 No. 1

ORAL CANCER RISK BEHAVIORS 1995-1996 Survey Data

Highlights of this Issue

- * **About 4.5 million (33%) Texas adults report at least one risk behavior for oral cancer.** Risks assessed in 1995 and 1996 included cigarette smoking, smokeless tobacco use, and risky alcohol behaviors.
- * **It is estimated that one million Texans with at least one oral cancer risk behavior had no dental or routine medical visit in the past year.** Dental and medical visits provide important opportunities for early detection of oral cancers.
- * **Over 900 thousand Texans are estimated to have combined smoking and risky drinking behaviors.** These behaviors in combination represent the greatest behavioral risk factor for developing oral cancer.

Introduction: Tobacco, alcohol and their combined use are major behavioral risk factors for developing oral and pharyngeal cancers (referred to collectively as oral cancer in this report).^{*} Smokers are 3 to 13 times more likely to develop oral cancer than non smokers and the risk tends to rise with the amount of tobacco smoked.¹ Smoking cessation, however, sharply reduces these risks.² Smokeless tobacco (ST) also called spit tobacco, chew or snuff, is not a safe alternative to smoking. The risk of developing oral cancer for ST users ranges from 2 to 11 times that of nonusers.^{2,4} Alcohol also presents a risk for oral cancer. After accounting for the risks from smoking, those who drink 15-29 alcoholic beverages per week have about 6 times the risk of developing oral cancer than nondrinkers. Combine smoking and drinking and the risk multiplies: those who combine heavy smoking and heavy drinking have up to 35 times the risk of developing oral cancer of nonsmoker, nondrinkers.²

Older adults are at higher risk for developing oral cancer than their younger counterparts, and this may be attributed to longer exposure to carcinogens. The average age at diagnosis is 60 years, with about 95% of oral cancer striking those over 40 years of age.⁵ Although oral cancer patients are predominantly men, women may be increasing their risk. A Connecticut study found that the male to female ratio for oral cancer

has decreased from 5:1 to about 2:1 since 1950, and may be attributed to an increase in smoking and alcohol use among women.⁶ National cancer incidence data show that African American males have the highest incidence of oral cancer, followed by white then Hispanic males.^{7,8} Additionally, among women, white females have the highest incidence, followed by African American and Hispanic females.

Oral Cancer Risk Behaviors

- **Tobacco use**
- **Alcohol use**
- **Combined alcohol and tobacco use**

Only half of oral cancer patients are alive five years after diagnosis, and the death rates are higher in low income, low educated, under-insured persons, minorities and the elderly.⁷⁻⁹ This may be attributed to late detection, which allows considerable growth of the cancer. Early diagnosis, however, dramatically improves survival: five-year survival rates for early detected oral cancers are about 76%, compared to 18% for advanced, late detected cases.¹¹ Routine mouth examinations provide valuable opportunities for early detection. Though traditionally considered the responsibility of dentists, all clinical health care providers are encouraged to provide oral cancer examinations during routine check-ups.¹²

* Other behaviors also may contribute to oral cancer risks, however data were not available to adequately explore these risk factors.

Methods: The Texas Behavioral Risk Factor Surveillance System (BRFSS) is a monthly telephone survey sponsored by the Texas Department of Health, Bureau of Chronic Disease Prevention and Control. Non-institutionalized adult Texas residents with a telephone were interviewed by the University of Texas' Office of Survey Research using a truncated list-assisted sample design for random digit dialing.

Information about alcohol use was collected in 1995 and smokeless tobacco use was assessed in 1996, while smoking behavior was collected during both years. Current smokers were defined as those who ever smoked 100 cigarettes and now smoke every day or most days. Heavy smokers were defined as those who smoke ≥ 25 cigarettes/day. Smokeless tobacco users were defined as those who currently use smokeless tobacco products. Risky alcohol behavior was defined as having ≥ 60 alcoholic beverages in the past month, and/or ≥ 5 drinks on a single occasion in the past 30 days. Heavy smoking/alcohol users were defined as those who reported smoking ≥ 25 cigarettes/day and having risky alcohol behavior.

Statistical analyses were performed using SUDAAN¹² and EpiInfo version 6.¹³ Data were weighted to reflect the age, sex, and race distribution of Texas as well as the probability of being drawn into the sample. Weighting ensures that each respondent effectively represents a specific number of Texas residents within his or her given socio-demographic group. This method of analysis allows the results of the survey to be generalized to the population represented in the sample frame.

Results:

*** Smoking:** The 1996 Texas BRFSS data indicate that 23% of Texans were current smokers and that 19% of those were heavy smokers. Among 35-44 year olds and 45-54 year olds, about 26% reported were current smokers. (Figure 1) Males were significantly more likely to report smoking than females, with 28% of males versus 19% of females currently smoking ($p < .05$). Smoking prevalence was 18% for Hispanics, 25% for African Americans, and 25% for whites. These differences did not reach statistical significance, perhaps due to the small numbers in each of the race/ethnic subgroups. For more about smoking in Texas, see *Texas Risk Factor Report, Vol3, No2, Tobacco Use*.

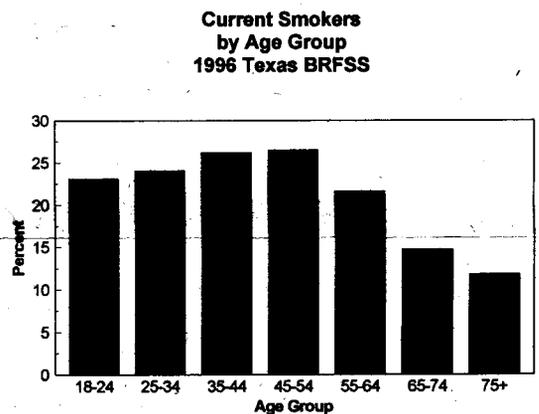


Figure 1

Did you know....?

- * About 75% of oral cancers hit smokers who drink heavily.
- * Oral cancer incidence peaks in persons aged 65-74, and 10 years earlier in African Americans.
- * A mouth examination for oral cancer takes only 2-5 minutes to complete.

* **Smokeless Tobacco (ST):** These data were collected during the 1996 survey year. The largest proportion of ST users were 25-34 year old men. (Figure 2) Only 0.4% of Texas women report its use compared to 8% of men. Of white men, 11% reported current smokeless tobacco use compared to 5% of Hispanic men, however, this difference was not statistically significant. No African Americans in our sample reported ST use.

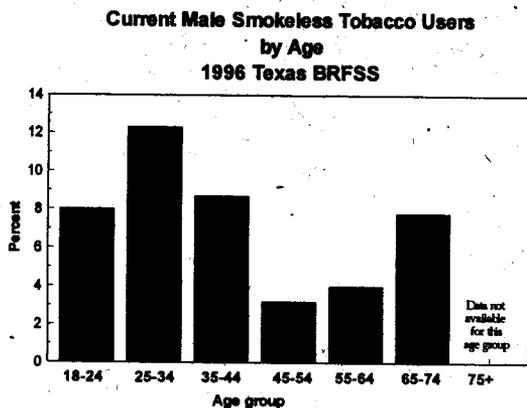


Figure 2

The bulk of ST use was reported by those men in the lowest and highest income strata. (Figure 3) Though this finding did not reach statistical significance, it may suggest a rising trend in ST use among those in higher income groups. While 73% of male ST users reported using only smokeless tobacco, 27% reported combining ST use with smoking.

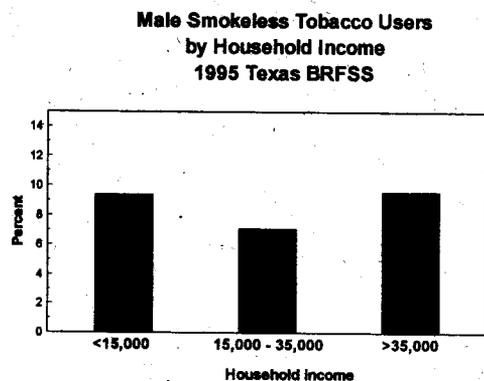


Figure 3

* **Alcohol use:** In 1995, 16% of Texans reported risky drinking behaviors, with 24% of males and 9% of females comprising this high risk group. Of Hispanics, 22% reported risky drinking behavior, while 15% of whites and 13% of African Americans reported similar risk. Hispanics had a significantly higher prevalence of risky drinking behavior than did whites ($p < .05$). Risky drinking behavior showed an inverse relationship with age. (Figure 4)

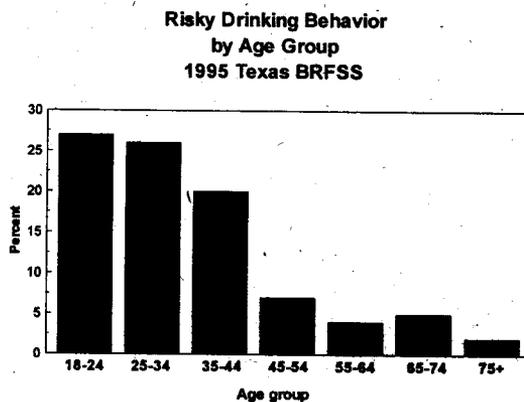


Figure 4

* **Smoking and Drinking:** Data from the 1995 BRFSS indicate that overall 7% of Texans both smoke and drink alcohol, while Texans aged less than 45 most often report these risk behaviors in combination. (Figure 5) Ten percent of males and 4% of females reported combined smoking and risky drinking behaviors. Additionally, 7% of whites, 9% of Hispanics, and 6% of African Americans reported this combination of risk behaviors, however these differences did not reach statistical significance.

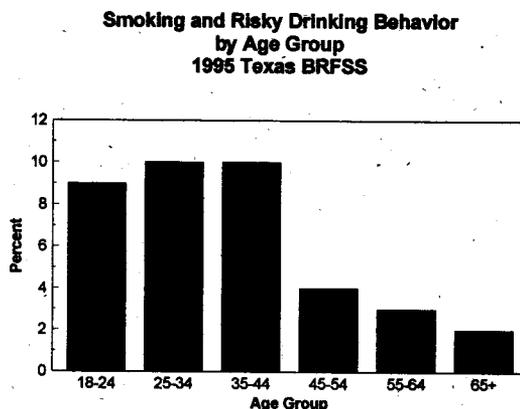


Figure 5

Dental and Medical Care Utilization

*** Smokers:** Of 1996 current smokers, 42% reported not having a dental visit during the past year and 41% reported no routine medical visit. Twenty percent of smokers reported seeing neither health care provider in the past year compared to 13% of nonsmokers. (Figure 6) Of those who reported heavy smoking, 32% reported no dental or routine medical visit in the past year. Among male smokers, there were no significant differences in recent health care utilization by race/ethnicity.

No Dental or Medical Visit in Past Year by Smoking Status

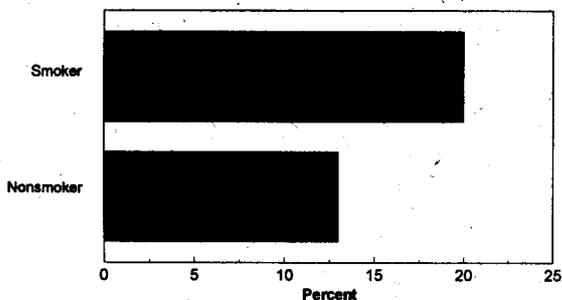


Figure 6

*** Smokeless Tobacco Users:** Of male ST users surveyed in 1996, 48% did not have a dental visit and 46% did not have a routine medical visit in the past year. (Figure 7) However, 23% percent indicated seeing neither a dentist nor physician compared to 17% of nonusers reporting the same. Seventeen percent of male smokeless tobacco users reported their last dental or medical visit was 2 or more years ago. (Table 1)

Male Smokeless Tobacco Users by Past Year Dental or Medical Care Utilization

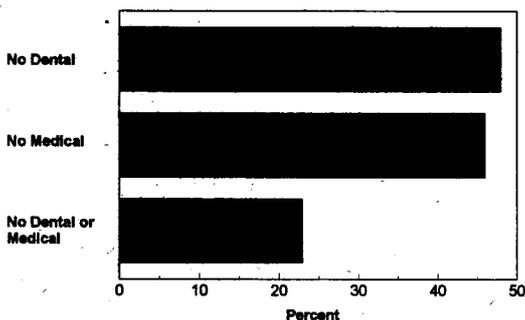


Figure 7

*** Alcohol Use:** In 1995, of those reporting risky drinking behaviors, 23% reported no dental or routine medical visit during the past year, 13% of those not at risk reported the same ($p < .05$). Additionally, 11% of those at risk reported no dental or medical visit in 2 or more years, compared to 6% of those not at risk ($p = .056$). (Table 1)

*** Combined Smoking and Drinking:** Fifty-one percent of smoker/risky drinkers reported no routine medical visit during the past year, and 48% reported no dental visit. (Figure 8) Additionally, 27% of smoker/risky drinkers reported seeing neither a dentist nor physician compared to 13% of those who did not report these behaviors in combination ($p < .05$). Additionally, 52% of heavy smoker/drinkers saw neither a dentist nor a physician in the past year.

Combined Smoking and Risky Drinking Behaviors by Past Year Dental or Medical Utilization

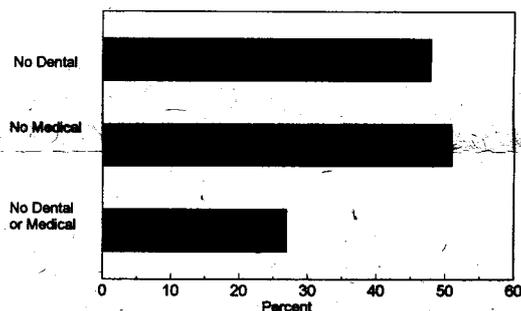


Figure 8

Dental and medical care utilization: Smokers and Male Smokeless Tobacco Users 1996 and 1995 Texas BRFSS

	S 1996	STm 1996	D 1995	S/D 1995
No dental visit past year	.42	.48	.41	.48
No medical visit past year	.41	.46	.43	.51
No dent or med visit past year	.20	.23	.23	.27
No dent or med visit 2 +years	.12	.17	.25	.18

S: smoker STm: male smokeless tobacco user
D: alcohol drinker S/D: combined smoking and alcohol use

Table 1

Conclusions:

- * Thirty-two percent of heavy smokers reported no past year dental or routine medical visit where they might have received oral cancer preventive services.
- * Although typical ST users are described as young white or American Indian/Alaska Native males of low socioeconomic status from the South or rural areas, ST use may be rising among higher income Texans.
- * Smokeless tobacco users were more likely than nonusers to report no past year dental or routine medical visits that may have provided an oral cancer examination.
- * Risky drinking behavior showed an inverse relationship with age. Twenty-five to 44 year old Texans most often reported combining risky drinking behaviors with smoking.
- * Texas respondents who reported combined smoking and risky drinking behaviors reported in smaller proportions a routine medical or dental visit during the past year than those who did not report this combined behavior.
- * Over half of those who combined heavy smoking with risky drinking behaviors reported no past year dental or routine medical utilization where that may have received an examination to oral cancer.

Recommendations:

- * Public awareness and education efforts should be increased with emphasis on the oral cancer risks associated with tobacco and alcohol use. Although oral cancer typically strikes older adults, interventions targeting younger persons may discourage long-term alcohol and tobacco exposure.
- * Increased efforts should be made to encourage those at risk for developing oral cancer to visit a health care provider yearly and receive an oral cancer examination.
- * Health professions education curricula should include oral cancer education and intraoral examination techniques.
- * Clinical health care professionals should assess oral cancer risk behaviors for their patients and provide oral cavity examinations as recommended. The *Clinician's Guide to Preventive Services, Put Prevention Into Practice*, provides guidelines and instructions for oral cavity examinations.

Early detection dramatically improves the chance of survival from oral cancer. The US Public Health Service and US Preventive Services Task Force recommend early diagnosis for reducing oral cancer deaths. Similarly, the year 2000 national health objectives aim to increase the numbers of adults who receive yearly oral examinations from primary care providers.^{15,16}

If you believe you are at risk for oral cancer, ask for an oral cancer check during your next dental or medical visit.

References:

1. US Department of Health and Human Services. The Health Consequences of Smoking: Cancer. DHHS Pub No. (PHS)82-50179, 1982.
2. Blot WJ, McLaughlin JK, Winn DM, et al. Smoking and drinking in relation to oral and pharyngeal cancer. *Cancer Res* 48:3282, 1988.
3. Winn DM et al. *Snuff dipping and oral cancer among women in the Southwestern United States*. *New England Journal of Medicine*: 304: 745-9; 1981.
4. Stockwell HG, Lyman GH. *Impact of smoking and smokeless tobacco in the risk of cancer of the head and neck*. *Head and Neck Surg.*; 9(2): 104-110; 1986.
5. Silverman S. *Oral Cancer*, ed 3. American Cancer Society, Atlanta, 1990.
6. Chen J, Katz RV, Lyman GH, Krutchkoff DJ. *Intraoral squamous cell carcinoma*. *Cancer* 66: 1288-1296, 1990.
7. Miller BA, et al. (eds.). *Racial/Ethnic Patterns of Cancer in the United States, 1988-1992*. National Cancer Institute. NIH Pub No 96-4104. Bethesda, DM, 1996.
8. Centers for Disease Control and Prevention. *Current Trend: Deaths from oral cavity and pharyngeal cancer - United States 1987*. *MMWR* 39:457-460(1990).
9. Bloom B, Gift HC, Jack SS. *Dental services and oral health: US, 1989*. Washington DC: government printing office, 1992; DHHS pub no (PHS) 93-1511 *Vital and Health Statistics series 10*, no 183.
10. Greenberg RS, Haber MJ, Clark WS et al. The relation of socioeconomic status to oral and pharyngeal cancer. *Epidemiology* 2:194-200;1991.
11. Garfinkel L. Cancer statistics and trends. In: Holleb AL, Fink DJ, Murphy GP. *American Cancer Society Textbook of Clinical Oncology*. Atlanta, GA. American Cancer Society 1991.
12. US Preventive Services Task Force. *Guide to Clinical Preventive Services*. Baltimore MD: Williams and Wilkins, 1989.
13. Shah, Babubhai V, et al. (1991). *SUDAAN User's Manual*, 5.50. Research Triangle Institute, Research Triangle Park, NC, 27709.
14. Dean AG et al. *Epi Info 6*: Centers for Disease Control and Prevention, Atlanta, GA, 1994.
15. USDHHS, PHS. *Clinician's Handbook of Preventive Services, Put Prevention Into Practice*. US Government Printing Office, 1994.
16. US Department of Health and Human Services, Public Health Service. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. Washington, DC: DHHS pub no. (PHS) 91-50212, 1991.

Additional information about oral cancer is available from:

American Cancer Society
1-800-4 CANCEr
1-800-422-6237
National Cancer Institute
(301) 496-5583

For additional information regarding this report contact:

Ken Condon
Texas Department of Health
Bureau of Chronic Disease
Prevention and Control
1100 West 49th St.
Austin, TX 78756
(512) 458-7200

Prepared by:

Shellie Ann Kolavic, DMD, MPH
Medical Epidemiologist

GM Nana Lopez, DDS, MPH
State Dental Director

Kenneth W. Condon, Epidemiologist
Behavioral Risk Factor Surveillance System

Philip P. Huang, MD, MPH, Chief
Bureau of Chronic Disease Prevention and Control



ASSOCIATION OF STATE AND
TERRITORIAL HEALTH OFFICIALS

Health Care Safety Net Amendments of 2002

On Saturday, October 26, 2003, President Bush signed into law the Health Care Safety Net Amendments of 2002, which reauthorize both the consolidated Community Health Center program and the National Health Service Corps. The law also includes several additional provisions that may be of interest to state health agencies. It is important to note that most of these programs are authorizations and that funding levels, if any, will be determined through the appropriations process, which has not been completed for the current fiscal year.

Highlights of the legislation include:

- **Reauthorizes the Consolidated Community Health Center Program to Provide More Care for the Uninsured**

The bill strengthens the federal Community Health Centers program, the key federal effort to expand care for the uninsured. In signing the bill, the Administration reaffirmed its goal to create 1,200 new or expanded health centers by 2006. The law authorizes the Health Centers program through FY 2006; raises the authorization level to \$1.3 billion; and maintains the program's core principles: to target resources to high need areas, deliver health care regardless of ability to pay, and gives the community being served a voice in the governance of the health center. It also encourages initiatives to hold down costs and ensure high quality care, and authorizes grants to eligible health centers with a substantial number of clients with limited English speaking proficiency to provide translation, interpretation, and other such services.

- **Reauthorizes the National Health Service Corps to Support More Doctors, Nurses, and Dentists**

The bill revises and continues funding for the National Health Services Corps and includes a provision to automatically designate all federally qualified health centers and rural health clinics that meet specific criteria as having a shortage. The law also directs the Health Resources and Services Administration to revise the criteria used to designate dental health professional shortage areas to provide a more accurate reflection of oral health care need, particularly in rural areas. A provision directs this to be done in consultation with the Association of State and Territorial Dental Directors, dental societies, and other interested parties. The law raises the overall authorization level of the Corps to \$146 million and includes authorization of \$12 million for grants to states to support loan repayment programs.

- **Expands Availability of Dental Services**

The law authorizes a grant program to help states in the development and implementation of innovative programs to address the dental workforce needs of designated dental health professional shortage areas in a manner that is appropriate to the states' individual needs. States would be able to use funds for the development of a state dental officer position or the augmentation of a state dental office to coordinate oral health and access issues in each state.

Legislative Updates

107th Congress

Health Care Safety Net Amendments (Loan Repayment Reports)

P.L. 107-251 (H.R. 3450, S. 1533/S. Report 107-83)

Impact of Public Law

P.L. 107-251, the Health Care Safety Net Amendments, repeals the requirement for the Health Resources and Services Administration loan repayment program (LRP) reporting requirements, which also repeals the National Institutes of Health LRP reporting requirements, which were mandated under the National Health Service (NHS) authorities. Specifically, this repeals Section 338B(i) of the Public Health Service Act, which required an annual report to Congress on the NHS Corps Loan Repayment Program.

Legislative History

P.L. 107-251 reauthorizes the Community Health Center program, the National Health Service Corps (NHSC), and rural outreach grants to ensure that both the uninsured and the underinsured have access to quality health care services. The legislation increases the funding authorization for health centers to \$1.293 billion and includes language allowing health centers to provide behavioral, mental health, and substance abuse services if they choose. The legislation also reauthorizes NHSC, which serves as a pipeline for health care facilities that have trouble attracting health professionals, and strengthens the service obligation requirements of the program. By strengthening this provision, health care facilities using program graduates can be certain that health corps personnel will fulfill their entire service contract.

Since its creation in 1972, NHSC operates two programs to help meet the needs of underserved communities: the scholarship program, which provides funds to students for educational living expenses during health care practitioner training, and the LRP, which provides financial assistance to help newly graduated practitioners repay their educational loans. For each year that the NHSC scholarship program or LRP provides support, participants are obligated to provide 1 year of medical care in underserved communities.

S. 1533, the Health Care Safety Net Amendments, was introduced on October 11, 2001, by Senator Edward M. Kennedy (D-MA) and was referred to the Senate Health, Education, Labor and Pensions Committee. The bill was reported out of that Committee on the same day and passed in the Senate on April 16, 2002, by unanimous consent.

H.R. 3450, the Health Care Safety Net Improvement Act, was introduced on December 11, 2001, by Representative Michael Bilirakis (R-FL) and was referred to the House Energy and Commerce Subcommittee on Health. On October 1, 2002, the bill passed the House by a voice vote. The bill, as amended, passed the House on October 16, and the Senate concurred with the House-amended bill on October 17. The legislation was signed by the President on October 26 as P.L. 107-251.

Source: <http://olpa.od.nih.gov/legislation/107/publiclaws/healthcare.asp>

References: Setting Health Priorities, Establishing Oral Health Objectives and Obtaining Baseline Information

Arizona Department of Health Services. *Guidelines for Oral Health Screening*. Phoenix, AZ: ADHS. 1999. (AZ Oral Health Program 602-542-1866)

Association of State and Territorial Dental Directors. *Assessing Oral Health Needs. ASTDD Seven-Step Model*. Columbus, OH: ASTDD. 1995. www.astdd.org

Association of State and Territorial Dental Directors. *Basic Screening Surveys: An Approach to Monitoring Community Oral Health* (manual and video). Columbus, Ohio: ASTDD. 1999. (same Web site as above)

Beltrán-Aguilar ED, Goldstein, JW, Lockwood, SA. Fluoride Varnishes: A Review of Their Clinical Mechanism, Efficacy, and Safety. *J Am Dent Assn* (131):589-596, 2000.

Centers for Disease Control and Prevention. *Health, United States, 2002*. Atlanta, GA: CDC. 2002. www.cdc.gov/nchs/hus.htm.

Centers for Disease Control and Prevention. *Investment in Tobacco Control: State Highlights 2001* Atlanta, GA: CDC. 2001. www.cdc.gov/tobacco

Centers for Disease Control and Prevention. The national tobacco control program. *Chronic Disease Notes & Reports*. 14(3):whole issue, 2001. www.cdc.gov/nccdphp

Folse GJ. National MDS and dental deficiency data reported by the US Health Care Financing Administration. *Special Care Dentistry*. 21(1):37-8, 2001.

Gaffield ML, Colley Gilbert BJ, Malvitz DM, Romaguera R. Oral health during pregnancy: An analysis of information collected by the Pregnancy Risk Assessment Monitoring System. *J Am Dent Assn* (132):1009-1016, 2001.

Geurink KV. *Community Oral Health Practice for the Dental Hygienist*. Philadelphia, PA: W B Saunders. 2002.

Health Division. Oregon Department of Human Resources. *1992-93 Oral Health Needs Assessment*. Portland, OR: 1993.

Indian Health Service. *Regional Differences in Indian Health 1998-99*. Rockville, MD: Indian Health Service. 2000.

Manski RJ and Moeller JF. Use of dental services. An analysis of visits, procedures and providers, 1996. *J Am Dent Assn*. 133(2):167-75, 2002.

NCCDPHP. Searchable Internet based databases enhance accessibility and usefulness of NCCDPHP data. *Chronic Disease Notes & Reports*. 14(2):whole issue, 2001.

Pan American Health Organization. *Oral Health Bibliography*. No. 1. Washington, DC: PAHO. 2001. www.paho.org.

Populations Receiving Optimally Fluoridated Public Drinking Water — United States, 2000. *MMWR*, February 22, 2002;51(7):144-147.

[Proceedings: NIH Consensus Development Conference on Diagnosis and Management of Dental Caries Throughout Life](#). *Journal of Dental Education*, October 2001. Also available online at www.nidr.nih.gov/news/consensus.asp.

Promoting Oral Health: Interventions for Preventing Dental Caries, Oral and Pharyngeal Cancers, and Sports-related Craniofacial Injuries: A Report on the Recommendations of the Task Force on Community Preventive Services. *MMWR*. 50(RR-21):1–13, November 30, 2001. www.cdc.gov/OralHealth/guidelines.htm.

Recommendations for Using Fluoride to Prevent and Control Dental Caries in the United States. *MMWR*, August 17, 2001;50(RR-14):1–42. Also available as a PDF file (PDF-373K). www.cdc.gov/OralHealth/guidelines.htm.

Surveillance for Use of Preventive Health-Care Services by Older Adults, 1995-1997. *MMWR*. 48(SS08):51-88. December 17, 1999.

Vargas CM, Kramarow EA and Yellowitz JA. The oral health of older Americans. *Aging Trends*. No. 3. CDC, NHHS. March 2001.