



Health Care for the Homeless

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Bibliography #3

Oral Health Needs of Individuals Experiencing Homelessness

April 2004

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Policy Research Associates, Inc. • 345 Delaware Avenue, Delmar, New York 12054

Under contract to the Health Resources and Services Administration, Bureau of Primary Health Care

2003

Doty H, Weech-Maldonado R. **Racial/ethnic disparities in adult preventive dental care use.** *Journal of Health Care for the Poor and Underserved* 14(4): 516-534, 2003.

This study examines whether adult preventive dental care utilization differs by ethnicity/race. According to the authors, logistic regression results find that controlling only for predisposing characteristics (gender, age, education, and health status), African Americans, Mexican Americans, and Other race/ethnicity are less likely than whites to utilize dental services. The article states that the effects are no longer significant when enabling resource variables are included in the model (income level, insurance, census region, and metropolitan statistical area). Interactions between race/ethnicity and insurance status show that privately insured racial/ethnic minority groups do not differ from privately insured whites in their utilization of dental services. Similarly, the preventive dental care utilization of publicly African Americans and Other Hispanics does not differ significantly from privately insured whites. However, publicly insured whites, Mexican Americans, and individuals of Other race/ethnicity have significantly lower odds of utilizing dental services relative to whites with private insurance (authors).

Gibson G, Rosenheck R, Tullner JB, Grimes RM, Seibyl CL, Rivera-Torres A, Goodman HS, Nunn ME. **A national survey of the oral health status of homeless veterans.** *J Public Health Dent* 63(1):30-7, 2003.

OBJECTIVES: This study reports results from a survey designed to (1) assess the oral health needs of a national sample of homeless veterans and (2) compare the dental needs of homeless veterans participating in VA-sponsored rehabilitation programs with domiciled veterans in VA substance addiction programs. **METHODS:** Homeless veterans enrolled in a nationwide rehabilitation program completed a survey including questions concerning patients' perceptions of their oral health, dental service needs and use, and alcohol and tobacco use. A sample of these veterans subsequently received dental exams. A comparison group of domiciled veterans enrolled in VA substance abuse programs completed a similar survey. A sample of these veterans also received dental exams. **RESULTS:** Sociodemographic variables, patient-reported oral health information and risk behaviors, and findings from dental exams described two remarkably similar populations. **CONCLUSIONS:** As expected, the homeless veterans exhibited poor oral health, but it was not different from domiciled veterans enrolled in substance addiction programs. Lifestyle choices, such as heavy drinking and smoking, may contribute more to poor oral health than living conditions.

Glecos S. **Water Street Rescue Mission Dental Clinic: Filling the void for Lancaster community.** *Pa Dent J (Harrisb)* 70(5):39-40, 2003.

Han B, Wells BL, Taylor AM. **Use of the Health Care for the Homeless Program services and other health care services by homeless adults.** *J Health Care Poor Underserved* 14(1):87-99, 2003.

This study examined factors associated with the use of the Health Care for the Homeless Program and other health care services by homeless adults. A total of 941 homeless adults were identified in 52 soup kitchens in U.S. communities. Descriptive statistics and logistic regression models were applied. Among homeless adults, having dental problems was the most robust factor associated with their use of Health Care for the Homeless Program services. Among homeless adults who did not visit Health Care for the Homeless Program services during last six months, the number of emergency room visits was the most powerful factor associated with their use of other health care services. The results of the study can help health care providers better serve homeless adults to meet their health needs.

Health Care for the Homeless Clinicians' Network. **Filling the gaps in dental care.** *Healing Hands* 7(3): 1-

4, 2003.

Limited access to dental care increases homeless people's high risk for oral pathologies, often resulting in loss of function, self-esteem and well-being. Health Care for the Homeless (HCH) projects are endeavoring to fill the gaps in dental services for this vulnerable, hard to reach population. Over two-hundred HCH grantees and their subcontractors currently provide dental care, either directly or through partnerships with other agencies. The articles contained in this issue spotlight a few of these programs, representing a variety of service models, and describe the complex oral health problems their homeless health clients experience (authors). Available From: Health Care for the Homeless Clinicians' Network P.O. Box 60427, Nashville, TN 37206, (615) 226 - 2292, www.nhchc.org.

King TB, Gibson G. **Oral health needs and access to dental care of homeless adults in the United States: A review.** Spec Care Dentist 23(4):143-7, 2003.

The homeless population in the United States is one of great diversity that continues to increase in number. Although data on the oral health status of individuals who are homeless is limited, studies consistently report both the perception and clinical evidence of dental needs among this population as well as a low utilization rate for dental services. This article reviews the oral health needs of people who are homeless as reported in literature, barriers to receiving dental care, and methods used to deliver dental care to this population. Many rehabilitation centers for adults who are homeless consider the establishment and maintenance of a state of good general and oral health as a priority and a key factor in helping homeless adults to return to the workforce and mainstream society.

2002

Beetstra, S, Derksen, D, Ro, M, Powell, W, Fry, DE, Kaufman, A. **A "Health Commons" approach to oral health for low-income populations in a rural state.** American Journal of Public Health 92(1): 12-13, 2002.

Oral health needs are urgent in rural states. Creative, broad-based, and collaborative solutions can alleviate these needs. "Health commons" sites are enhanced, community-based primary care safety net practices that include medical, behavioral, social, public, and oral health services. Successful intervention requires a comprehensive approach, including attention to enhancing dental service capacity, broadening the scope of the dental providers, creating new interdisciplinary teams in enhanced community-based sites, and developing more comprehensive oral health policy. By incorporating oral health services into the health commons primary care model, access for uninsured and underserved populations is increased. A coalition of motivated stakeholders includes community leaders, safety net providers, legislators, insurers, and medical, dental and public health providers (authors).

Byck GR, Walton SM, Cooksey JA. **Access to dental care services for Medicaid children: Variations by urban/rural categories in Illinois.** J Rural Health 18(4):512-20, 2002.

Poor oral health status and limited access to dental care have been recognized as problems for children from Medicaid and low-income families. However, little is known about dental access for Medicaid-enrolled children in rural areas. This study examines differences between rural and urban counties in dental utilization rates of Illinois children enrolled in either Medicaid or the Children's Health Insurance Program. How the overall dentist supply, the dentist Medicaid participation rate, and county level sociodemographic factors relate to Medicaid dental utilization are examined. Illinois counties were aggregated into four urban/rural categories. Descriptive analysis showed lower utilization rates in the rural categories compared with the metropolitan categories. Rural areas had a substantially lower supply of dentists, and consequently a lower

supply of dentists participating in Medicaid, despite the substantially higher Medicaid participation rate of dentists in the rural categories than in the metropolitan categories. However, regression results indicated no significant relationship between the rate of utilization of Medicaid-enrolled children and rural status after controlling for several dental supply and population factors. The most important factors relating to Medicaid-enrolled children's dental utilization, regardless of urban or rural status, were the proportion of children enrolled in Medicaid and the participating dentist to population ratio. Without the high participation rate of dentists in rural areas, access to oral health care for rural children enrolled in Medicaid would have been worse. Policy makers should focus on maintaining high rural dentist participation rates as well as addressing future supply problems that may exacerbate difficulties with access in rural areas.

Chavers LS, Gilbert GH, Shelton BJ. **Racial and socioeconomic disparities in oral disadvantage, a measure of oral health-related quality of life: 24-month incidence.** J Public Hlth Dent 62(3):140-7, 2002.

OBJECTIVES: This paper estimates the incidence of oral disadvantage based on the subject's approach to dental care, sex, race, and financial status; identifies demographic and socioeconomic characteristics that were associated with oral disadvantage; and determines if these characteristics were differentially associated with the three domains of oral disadvantage. **METHODS:** The Florida Dental Care Study was a longitudinal study of oral health in diverse groups of persons who at baseline had at least one tooth, were 45 years or older, and were either African American or non-Hispanic white. Incidence rates, odds ratios, and 95 percent confidence intervals were used to describe oral disadvantage and its relation to race, income, and other key sociodemographic characteristics. **RESULTS:** The strongest independent predictors of oral disadvantage were approach to dental care (problem-oriented attenders or regular), and situation if faced with an unexpected \$500 dental bill. Demographic and socioeconomic characteristics were differentially associated with each disadvantage domain. **CONCLUSIONS:** African Americans, females, rural residents, individuals who did not graduate from high school, individuals with limited financial resources, and problem-oriented dental attenders had significantly higher occurrences of oral disadvantage. Racial and sex disparities in oral disadvantage were largely explained by differences in approach to dental care and financial resources between these groups.

Edelstein BL. **Disparities in oral health and access to care: Findings of national surveys.** Ambul Pediatr 2(2 Suppl):141-7, 2002 Mar-Apr.

In this background paper, sociodemographic variables, including age, race, family income, sex, parental education, and geographic location, have been used to characterize the dental status of US children and their access to dental services. Because tooth decay, or dental caries, remains the preeminent oral disease of childhood and national data is available on dental office visits, tooth decay has been used as the primary marker for children's oral health, and visits to the dentist is the marker for care. In general, children from low-income families experience the greatest amount of oral disease, the most extensive disease, and the most frequent use of dental services for pain relief. Yet these children have the fewest overall dental visits. Paradoxically, children in poverty-those living in households with annual gross incomes under \$16 500 for a family of 4-or near poverty-those in family households with incomes between \$16 500 and \$33 000-also have the highest rates of dental insurance coverage, primarily through Medicaid and SCHIP. For those most affected, dental disease is consequential for their growth, function, behavior, and comfort. The twin disparities of poor oral health and lack of dental care are most evident among low-income preschool children, who are twice as likely to have cavities as are higher income children. Medicaid-eligible children who have cavities have twice the numbers of decayed teeth and twice the number of visits for pain relief but fewer total dental visits, compared to children coming from families with higher incomes. Fewer preventive visits for services

such as sealants increase the burden of disease in low-income children. These disparities continue into adolescence and young adulthood, but to a lesser degree. Disparities in oral health status and access to dental care are also evident when comparing black, Hispanic, and Native American children to white children and when comparing children of parents with low educational attainment to children of parents with higher educational attainment. The fastest growing populations of children are those that currently have the highest disease rates and the lowest amount of dental care. If the strong correlation between these subpopulations and dental diseases continues, caries rates are likely to rebound after longstanding declines, and the stress on publicly financed dental care will likely increase.

Mofidi, M, Rozier, G, King, RS. **Problems with access to dental care for Medicaid-insured children: What caregivers think.** American Journal of Public Health 92(1): 53-58, 2002.

This study aimed to gain insight into the experiences, attitudes, and perceptions of a racially and ethnically diverse group of caregivers regarding barriers to dental care for their Medicaid-insured children. Criterion-purposive sampling was used to select participants for 11 focus groups, which were conducted in North Carolina. Seventy-seven caregivers of diverse ethnic and racial backgrounds participated. Full recordings of sessions were obtained and transcribed. A comprehensive content review of all data, including line-by-line analysis, was conducted. Negative experiences with the dental care system discouraged many caregivers in the focus groups from obtaining dental services for their Medicaid-insured children. Searching for providers, arranging an appointment where choices were severely limited, and finding transportation left caregivers describing themselves as discouraged and exhausted. Caregivers who successfully negotiated these barriers felt that they encountered additional barriers in the dental care setting, including long waiting times and judgmental, disrespectful, and discriminatory behavior from staff and providers because of their race and public assistance status. Current proposals to solve the dental access problem probably will be insufficient until barriers identified by caregivers are addressed (authors).

Northridge ME, Jean-Louis B, Shoemaker K, Nicholas S. **Advancing population health in the Harlem Children's Zone Project.** Soz Praventivmed 47(4):201-2, 2002.

Ottley C. **Improving children's dental health.** J Fam Health Care 12(5):122-5, 2002.

Surveys show that tooth decay in young children is becoming concentrated in more deprived sectors of the population. Only by targeting families with young children in underprivileged areas will dental health be improved further. An analysis of dental health promotion advice has shown that simple, direct advice to "brush teeth twice a day with fluoride toothpaste" is just as effective as complicated health promoting activities. Questions about the development of the teeth and oral structures are common among new parents but they rarely turn to the dental team for answers. Nurses, health visitors and midwives are very much in the front line because of their work with young families. Dental health advice for families with young children, delivered by community health professionals including health visitors and midwives, may be the key to tackling inequalities in oral health in young children.

Zabos, G, Northridge, M, Ro, M, Trinh, C, Vaughan, R, Howard, J, Lamster, I, Bassett, M, Cohall, A. **Lack of oral health care for adults in Harlem: A hidden crisis.** Amer J of Pub Health 92(1): 49-52, 2002.

Profound and growing disparities exist in oral health among certain US populations. We sought here to determine the prevalence of oral health complaints among Harlem adults by measures of social class, as well as their access to oral health care. A population-based survey of adults in Central Harlem was conducted from 1992-1994. Two questions on oral health were included: whether participants had experienced problems with their teeth or gums during the past 12 months and, if so, whether they had seen a dentist. Of 50 health conditions queried about, problems with teeth or gums were the chief complaint among participants. Those more likely to report oral health problems than other participants had annual household incomes of less than \$9000, were unemployed, and lacked health insurance. The privately insured were almost twice likely to have seen a dentist for oral health problems than were the uninsured. There is a need to provide oral health services for adults in Harlem. Integrating oral health into comprehensive primary care is one promising mechanism (authors).

2001

DeAngelis S, Warren C. **Establishing community partnerships: Providing better oral health care to underserved children.** J Dent Hyg 75(4):310-5, 2001.

A community partnership between a dental hygiene school and a social service program was designed to improve oral health outcomes and reduce disparities among children. This resulted in a preventive oral hygiene care project that complimented the dental hygiene program's didactic curriculum. The children received much needed oral health care and education, while the experiences enhanced dental hygiene student learning by applying the principles for planning, implementing, and evaluating dental health programs; establishing a context for understanding the prevalence of oral disease as well the disparity among population subsets; and developing a variety of clinical skills. Oral health professionals and dental hygiene programs may find this partnership a prototype of a highly productive and beneficial community health experience that could be incorporated, in part or in its entirety, into their own community health projects.

Macek MD, Edelstein BL, Manski RJ. **An analysis of dental visits in U.S. children, by category of service and sociodemographic factors, 1996.** Pediatr Dent 23(5):383-9, 2001.

Data from the 1996 Medical Expenditure Panel Survey were analyzed to determine the distribution of diagnostic and preventive, surgical, and other dental visit types received by U.S. children, aged 0-18 years. Weighted point estimates and standard errors were generated using SUDAAN and stratified by age, sex, race/ethnicity, and poverty status. Overall, 39.3% of children had a diagnostic or preventive visit, 4.1% had a surgical visit, and 16.2% had a visit for a restorative/other service. Diagnostic and preventive services were most common, across age categories. For all types of service, utilization was higher among white and non-poor children, but there were no differences by gender. Age-specific associations were mixed, with diagnostic and preventive service and surgical service utilization having a different distribution than other service type. Poverty status was generally not associated with service-specific utilization among African-American children. There are profound disparities in the level of dental services obtained by children, especially among minority and poor youth. Findings suggest that Medicaid fails to assure comprehensive dental services for eligible children. Improvements in oral health care for minority and poor children are necessary if national health objectives for 2010 are to be met successfully.

Manski RJ, Edelstein BL, Moeller JF. **The impact of insurance coverage on children's dental visits and expenditures, 1996.** J Am Dent Assoc 132(8):1137-45, 2001.

BACKGROUND: Health insurance coverage has been shown to relate positively with the use of dental services. The purpose of the authors' study was to describe the level of dental coverage among U.S. children and to assess the impact of dental coverage on children's use of dental services and expenditures for dental care. **METHODS:** The focus of these analyses is on dental care coverage, use and expenditures for U.S. children during 1996. National estimates are provided for the population with dental coverage, the population with a dental visit, and mean total expenditure for each of several socioeconomic and demographic categories during 1996 using data from the Medical Expenditure Panel Survey. **RESULTS:** Fifty-two percent of children younger than 18 years of age had private dental coverage during 1996. Approximately 56 percent of children in families with a poverty status level of 133 percent of the federal poverty level or below were covered by Medicaid during 1996. Fifty-six percent of children with private coverage had made at least one dental visit, compared with 28 percent of noncovered children. Twenty-eight percent of children covered by Medicaid had made at least one dental visit compared with 19 percent of noncovered children. **CONCLUSION:** Medicaid dental coverage seems to have had a lesser effect on the likelihood of a child's having a dental visit than had private coverage. Improving oral health for poorer children may depend partly on improving the design of Medicaid dental coverage programs. **PRACTICE IMPLICATIONS:** By understanding these analyses, practitioners, advocates and policymakers will be better positioned to provide care, improve access and better meet the needs of all American children.

Marcus, M, Maida, CA, Guzman-Becerra, N, Bellosso, R, Fidell, L. **Policy implications of access to dental care for immigrant communities.** Berkeley, CA: California Program on Access to Care, 2001.

This study was designed to provide the California Program on Access to Care with information on the barriers to accessible dental care for working poor and indigent residents of Spanish-speaking immigrant communities. The authors assert that while California is seeking to increase the number of insured families through the expansion of Medi-Cal, Transitional Medi-Cal, Healthy Families, and the 1931(b) program, a consistently large number of children of Latino immigrants statewide remain uninsured, especially for dental services. This study sought information on access issues as they pertain to dental health and care of residents of recent immigrant communities, with special emphasis on the development of a policy-relevant model that would enhance access, outreach and cost-effective use of dental care (authors).

Primosch RE, Balsewich CM, Thomas CW. **Outcomes assessment an intervention strategy to improve parental compliance to follow-up evaluations after treatment of early childhood caries using general anesthesia in a Medicaid population.** ASDC J Dent Child 68(2):102-8, 80, 2001.

Young children from low-income families are at risk for the development of early childhood caries (ECC) that can progress to severe oral disease. Treatment of this condition often requires extensive rehabilitation using general anesthesia in an ambulatory care facility. These children, presenting with neglected oral health, frequently face major obstacles to accessing dental care in a timely manner. Recently, several retrospective studies reported poor follow-up compliance (return for recall evaluations) in children treated for ECC using general anesthesia (GA). The purpose of this study was to provide a prospective analysis of an intervention strategy aimed at improving follow-up compliance in this population. Results of the analysis suggested that the insertion of an additional pre-operative consultation appointment failed to improve significantly compliance to follow-up evaluations or change parental dental health knowledge and preventive practices. Patient variables studied also failed to discriminate influences on predicting compliant behavior. Although retreatment (relapse) was prevalent among those patients who complied with follow-up evaluations, a statistically significant improvement in plaque, gingival, and mutans streptococci scores were demonstrated, following the degree of aggressive restorative treatment typically provided using general anesthesia. These

findings are contrary to those reported from conventional restorative therapy and might reflect a beneficial outcome of an aggressive restorative approach. Further investigation is required to identify an intervention strategy that improves follow-up compliance and reduces the costly ravages of dental neglect in young children from low-income families.

Rule JT, Bebeau MJ. **The good practitioner: The story of Brent L. Benkelman.** Quintessence Int 32(6): 483-494, 2001.

Dr Brent Benkelman has practiced oral surgery in Manhattan, Kansas, since 1971. Having grown up in a tiny farming town in western Kansas, he opted for the lifestyle of a smaller community after graduating from the University of Missouri at Kansas City School of Dentistry in 1966 and completing his training in oral and maxillofacial surgery in 1969. His experiences since then have revolved around family, practice, and community. With his family as his first priority, he has participated in various community activities, including a church-operated food pantry, an emergency shelter for the homeless, and Habitat for Humanity. He was nominated as a moral exemplar in dentistry for his dedicated commitment to his patients and because he understands and cares about the complexities of his patients as human beings, placing his own financial gain secondary to the interests of his patients.

Skaret E, Milgrom P, Raadal M, Grembowski D. **Factors influencing whether low-income mothers have a usual source of dental care.** ASDC J Dent Child 68(2):136-9, 142, 2001.

Mothers are both the source of dental caries and the managers of children's use of dental care. This is particularly important for the low-income population. The objective of this research was to explore predictors of having a usual source of dental care among low-income women. Eight-hundred-ten mothers (82 percent white, mean age twenty-seven years), drawn from among participants in an ABCD program in one Washington State County completed a study questionnaire. The study examined predisposing, enabling and illness level variables in relation to whether the mother reported a usual source of dental care for herself. Fifty-two percent of the subjects gave positive answers to the dependent variable Do you now have a dentist you can go to if you have a problem? The analysis suggests that mothers that report good oral health and believe in care for their children are five times as likely to have a usual source of care for themselves than mothers who report both poor oral health and more negative attitudes about dental care for children. The results suggest that interventions aimed at child health that ignore the welfare of the mother are likely to be less successful than those that also address the mothers' needs.

Wilbanks DS. **Reaching out: TDA dentists strive to meet the access challenge.** Tex Dent J, 118(2) 154-63, March 2001.

Zabos GP, Trinh C. **Bringing the mountain to Mohammed: A mobile dental team serving a community-based program for people with HIV/AIDS.** Am J Public Health, 91(8): 1187-9, August 2001.

In spite of the direct referral system and family-centered model of primary health care linking medical and dental care providers, most HIV-positive patients at the Columbia Presbyterian Medical Center received only emergency and episodic dental care between 1993 and 1998. To improve access to dental care for HIV/AIDS patients, a mobile program, called WE CARE, was developed and collocated in community-based organizations serving HIV-infected people. WE CARE provided preventive, early intervention, and comprehensive oral health services to minorities, low-income women and children, homeless youths, gays and

lesbians, transgender individuals, and victims of abuse. More efforts to collocate dental services with HIV/AIDS care at community-based organizations are urgently needed.

2000

Craft-Rosenberg M, Powell SR, Culp K. **Health status and resources of rural homeless women and children.** West J Nurs Res 22(8): 863-878, 2000.

The purpose of this research is to describe the health status and health resources for homeless women and children in a Midwestern rural community. A group of 31 rural homeless women in a shelter participated in the study by answering questions on the Rural Homeless Interview developed by the investigators. The findings revealed higher than expected rates of illness, accidents, and adverse life events, with the incidence of substance abuse and mental illness being comparable to data from other homeless populations. The data on children were limited by lack of knowledge on the part of their mothers. Some mothers reported that their children were in foster care, had been adopted, or were being cared for by others. The inability to access health and dental care was reported by half of the participants.

Hoag, S, Woolridge, J, Thorton, C. **Setting rates for Medicaid managed behavioral health care: Lessons learned.** Health Affairs 19(4): 121-133, 2000.

This article reviews Tennessee's experience setting, monitoring, and updating capitation rates for Medicaid managed behavioral health care, and draws lessons from those experiences for other states. The review of assumptions about four components of Tennessee's rate-setting process -- data, benefit design, savings expectations, and processes for monitoring and updating rates -- suggests that the initial rate established by Tennessee was inadequate, and its inadequacy resulted primarily from the way available information was used to set the rate, rather than from the method of rate setting selected. Tennessee's experiences illustrate how difficult rate setting is and illuminate several key lessons about the rate-setting process (authors).

Locker D. **Deprivation and oral health: A review.** Community Dent Oral Epidemiol, 28(3):169, June 2000.

The link between socioeconomic status and health, including oral health, is well established. The conventional measures of socioeconomic status used in these studies, such as social class and household income, have a number of weaknesses so that alternatives, in the form of area-based measures of deprivation, are increasingly being used. This paper reviews epidemiological research linking deprivation and oral health. Four types of study are identified and described: simple descriptive, comparative, analytic, and explanatory. These studies confirm that deprivation indices are sensitive to variations in oral health and oral health behaviors and can be used to identify small areas with high levels of need for dental treatment and oral health promotion services. As such, they are likely to provide a useful administrative tool. In terms of research, the studies demonstrate that these measures provide a ready way of controlling for socioeconomic status in studies examining the association between oral health and other variables. However, this research, in largely replicating previous studies using social class, does not address fundamental issues concerning the mechanisms which link social inequality and health. Deprivation measures have a major role to play in research that examines features of people and places, and how they promote and/or damage both oral and general health.

Murphy D, Klinghoffer I, Fernandez-Wilson J, Rosenburg L. **Mobile health units: Design and implementation considerations.** AAOHN Journal 48(11): 526-532, 2000.

This article discusses the New York University College of Dentistry's (NYUCD) proposal for a mobile unit. This mobile unit would be created in response to the critical need for oral health among underserved urban and rural pediatric populations. According to the authors, the mobile dental clinic targets low income populations with a special emphasis on pediatric populations, and would provide an increased range of services, ease and timeliness of care delivery. The article also attributes overall efficiency in providing comprehensive care, which indicates that this mode of treatment to be well suited to the needs of many target populations. The planning, staffing, process, problems, and legal considerations faced by the authors are discussed (authors).

Oral health in America: A report of the Surgeon General. U.S. Dept. of Health and Human Svcs, 2000.

The first-ever Surgeon General's report on oral health identifies a "silent epidemic" of dental and oral diseases that burdens some population groups and calls for a national effort to improve oral health among all Americans. The report also focuses on the relationship between oral health and overall good health throughout life, the mouth as a "mirror for general health and well-being and the association between oral health problems and other health problems." Major barriers to oral health include socioeconomic factors, such as lack of dental insurance or the inability to pay out of pocket, or problems of access that involve transportation and the need to take time off from work for health needs. While 44 million Americans lack medical insurance, about 108 million lack dental insurance. Meanwhile, uninsured children are 2.5 times less likely to receive dental care than insured children, and children from families without dental insurance are 3 times as likely to have dental needs as compared to their insured peers. This report charts a broad course of action including: enhancing the public's understanding of the meaning of oral health and the relationship of the mouth to the rest of the body; raising the awareness of the importance of oral health among government policy makers to create effective public policy that will improve America's oral health; and educating non-dental health professionals about oral health and disease topics and their role in assuring that patients receive good oral health care.

Renson T. **Reducing inequalities in oral health.** Prim Dent Care 7(4):131, 2000.

Silberman P, Wicker DA, Smith SH Jr., DeFriese GH. **Assuring access to dental care for low-income families in North Carolina. The NC Institute of Medicine Task Force Study.** NC Med J, 61(2):95-8, March-April 2000. Comment in: NC Med J, 61(3):135, May-June 2000.

Following publication of the Task Force's recommendations for improving dental care access among low-income populations, North Carolina has taken several steps forward. The Division of Medical Assistance and the NC Dental Society are forming an advisory committee (comprising Medicaid patients, providers, and representatives from all elements of organized dentistry in the state) to review dental coverage and reimbursement rates. Using existing state funds, the NC Office of Research, Demonstrations and Rural Health Development has recruited 15 additional dentists and 1 dental hygienist to practice in community facilities serving low-income and uninsured patients. In 1999, the NC General Assembly revised the NC Dental Practice Act.

U.S. Surgeon General report reveals profound disparities in oral health of Americans. J Can Dent

Waplinton J, Morris J, Bradnock G. **The dental needs, demands and attitudes of a group of homeless people with mental health problems.** *Comm Dent Health*, 17(3):134-7, Sep 2000.

This study investigated the dental needs, demands and attitudes of a group of homeless people living in a hostel in Birmingham, many of whom had mental health problems. Seventy subjects underwent a dental examination. The clinical criteria for the examination were especially selected to be simple and cause minimal discomfort to the subject, but be reproducible and cover the wide range of conditions expected to be found. Five of the subjects were selected to take part in semi-structured interviews. Thirty-one per cent of the subjects were found to be edentulous, with only 32% wearing dentures. The dentate subjects had a mean DMFT of 15.9. High levels of dental need were found amongst the dentate subjects who had an average of 3.6 decayed teeth and 54% had one or more teeth with obvious pulpal involvement. Eighty-five per cent of the dentate subjects had some dental wear leading to exposed dentine. The periodontal condition was generally poor, 50% of dentate subjects having excessively mobile teeth. The interviews revealed a low level of perceived need and indicated that difficulties would be encountered in tailoring services to meet this client group's requirements. High levels of normative need were found in this group of people, however it is concluded that providing dental services to meet this need would prove difficult.

1999

McManus J, Davis M, Albert D. **Accessible dental care for children.** *NY State Dent J.* 65(3):24-6, 1999.

The development of a school-based comprehensive and cost-efficient oral health care program requires careful planning centered on the needs expressed by the community. Gaining the support and the cooperation of school officials and parents creates an environment that has a significantly greater opportunity for success. Location, appropriate design of the facility and support from a local charitable organization further insure excellent access and expeditions care.

Office of Minority Health, U.S. Dept. of Health and Human Services. **Oral Health.** *Closing the Gap*, 1999.

This issue of the Office of Minority Health's monthly newsletter focuses on oral health. Topics include: challenges and opportunities for oral health; dental insurance; minority dentists; school health programs; tips for new/expectant moms; dental sealants; Surgeon General's report; oral disease prevention; preventing tooth decay; smokeless tobacco use; chronic diseases; consumer information; and oral health organizations and web sites. AVAILABLE FROM: DHHS, Public Health Service, Office of Minority Health Resource Center, PO Box 37337, Washington, DC 20013-7337.

1998

Dental public health: The past, present, and future. American Association of Public Health Dentistry. American Board of Dental Public Health. J Am Dent Assoc, 117(1):171-6, July 1998.

The continued recognition process of dental public health as a specialty of dentistry served as an opportunity for the specialty to rediscover and reevaluate itself. What it found was a discipline that has evolved for 38 years to address the issues of a dynamic society. Dr. Abraham Kobren, ADA past-president has stated that public health dentistry stands as the dental conscience of the nation. The changes in dental public health mirror both changes in society and the technical changes occurring in dentistry. Identifying diseases in children is giving way to identifying diseases in adults. Access to dental care for the poor and homeless is as much a problem as is access to care for people with infectious diseases. Infection control, technology transfer, national oral health objectives, and a myriad of new financing mechanisms are some areas of change. What has remained constant is the specialty's goal to improve the oral health of the public, and its commitment to work through "organized community efforts" to achieve this goal.

1997

Eisen R. **The Shout Clinic: helping street kids build self-esteem. Shout Clinic Dental Program, Toronto, Ontario.** Ont Dent, 74(9):39-40, Nov 1997.

Waldman HB. **Homeless children.** ASDC J Dent Child, 64(6):391-394, Nov 1997.

Homeless children are an "invisible" population within our community. A review is provided of the economic, social, medical and dental conditions of these children.

1996

Clarke M, Locker D, Murray H, Payne B. **The oral health of disadvantaged adolescents in North York, Ontario.** Can J Public Health, 87:261-3, July-Aug 1996.

Disadvantaged youth, such as the homeless, the unemployed or recent immigrants, are thought to be at high risk for dental problems. Using interviews and clinical examinations, this study measured the oral health status and treatment needs of a convenience sample of 478 disadvantaged adolescents aged 14 and older in North York, Ontario. The data suggest that disadvantaged youth have high rates of oral disease. The adolescents reported a variety of symptoms, including oral pain and low rates of dental visiting. Clinically, high rates of periodontal disease, dental decay and urgent treatment needs were detected. Efforts should be made to identify high-risk groups that may be overlooked in general surveys. Prevention, detection and treatment programs should be considered for high-risk adolescents.

Crosson FB. **Mobile oral hygiene services.** Probe, 30(2):72-3, March 1996

Valla ME, Westcott RC. **Mobile dental unit brings services to the young and needy.** N Y State Dent J, 62(4):32-5, April 1996.

1995

Allukian M Jr. **Oral health: An essential service for the homeless.** J Public Health Dent, 55:8-9, 1995.

Bolden AJ, Kaste LM. **Considerations in establishing a dental program for the homeless.** J Pub Health Dent, 55:28-33, Winter 1995.

This study reviewed program-planning issues, focusing on the unique aspects of establishing dental programs for shelter-based persons, based on experiences of a dental program for homeless persons in Boston. The establishment of a portable dental program in 1988 involved many considerations, including determination of needs and barriers to dental care, resource identification and development, program planning and implementation, evaluation, and the development of constituency support. The diversity of the homeless population in combination with the variation of space and medical resources at different shelter sites dictates flexibility in the development of programs to address the oral health needs of the homeless.

Gaetz S, Lee J. **Developing dental services for street youth.** Ont Dent, 72(9):34-7, Nov 1995.

Kaste LM, Bolden AJ. **Dental caries in homeless adults in Boston.** J Public Health Dent, 55:34-6, 1995.

This study characterizes the dental caries status among users of a dental treatment and referral program at homeless shelters in Boston, MA. Persons attending the program during a one-year period were assessed for dental caries. Decayed, missing and filled teeth (DMFT) counts were abstracted from patient records. The population examined was 66% male with a mean age of 36 years. The racial composition was 51% African-American, 34% white, and 14% Hispanic. The 70 dentate people examined had a mean DFT of 11.1. The mean percent of DFT that was DT per person was 55.7%. Untreated caries were detected in 91.4% of those examined. There is evidence of previous dental services utilization by these individuals and a high need for preventive and restorative dental therapy.

1994

Pizem P, Massicotte P, Vincent JR, Barolet RY. **The state of oral and dental health of the homeless and vagrant population of Montreal.** J Can Dent Assoc, 60:1061-5, Dec 1994.

A study conducted in Montreal in April 1993 has made it possible to better evaluate the oral health status of homeless persons and to identify ways of making dental treatment available. Once the oral health status of this population is known, the official body responsible for homeless and vagrant individuals can be given recommendations for treatment and care. Most of the homeless are welfare recipients and have access to some benefits, including free access to basic dental services, which are available after a six-month waiting period and are provided by a dentist of the person's choice. It was hypothesized that homeless people would prefer to be treated in the shelters where they sleep, but in 65% of cases, their responses to a questionnaire indicated they preferred to visit a private dentist of their choice. Another important group wished to receive dental treatment in the hostels they frequented.

1993

Giangregio E. **Homeless find dentistry's doors open.** CDS Review, 86(5):28-30, June 1993.

Groark CM. **Serving the underserved.** RDH, 13(4):13, April 1993.

Harmon RG. **Oral health care for the underserved in the 1990s: the HRSA perspective.** J Public Health Dent, 53(1):46-9; discussion 50-3, Winter 1993.

Purtell EP. **Indigent dental care in New Mexico.** N M Dent J, 44:14-5, Winter 1993.
