NEVADA HEAD START ORAL HEALTH SURVEY 2017

Division of Public and Behavioral Health
Department of Health and Human Services

Brian Sandoval
Governor

Julie Kotchevar PhD.
Administrator

Richard Whitley, MS
Director, DHHS

Ihsan Azzam PhD., MD
Chief Medical Officer

2017 NEVADA HEAD START ORAL HEALTH SURVEY

Oral Health Program

Antonina Capurro DMD, MPH, MBA
Chief Dental Health Officer

Judy A. White RDH, MPH
State Public Health Dental Hygienist

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Project Direction

Judy A. White, RDH, MPH
State Public Health Dental Hygienist
Oral Health Program
Division of Public and Behavioral Health

Michael C. Manz DDS, DrPH
University of Michigan – Ann Arbor
Association of State and Territorial Dental Directors

Data Analyst and Report Writer

Michael C. Manz DDS, DrPH
University of Michigan – Ann Arbor
Association of State and Territorial Dental Directors

Report Editor

Judy A. White RDH, MPH
State Public Health Dental Hygienist
Oral Health Program
Division of Public and Behavioral Health

Dental Screeners

Antonina Capurro DMD, MPH, MBA
State Dental Health Officer
Oral Health Program
Division of Public and Behavioral Health

Judy A. White RDH, MPH
State Public Health Dental Hygienist
Oral Health Program
Division of Public and Behavioral Health

Dental Recorders

Kristen deBraga
Oral Health Program
Division of Public and Behavioral Health

Patti Oya, Director
Office of Early Learning and Development
Nevada Department of Education

Screening Coordinator and Data Enterer

Kristen DeBraga
Oral Health Program
Division of Public and Behavioral Health

Office of Early Learning and Development

Patti Oya
Director
Office of Early Learning and Development
Nevada Department of Education

Head Start Grantees

Community Services Agency
Head Start Northeastern Nevada
Inter-Tribal Council of Nevada
Little People's Head Start
Washoe Tribe of Nevada and California

Head Start Directors and Coordinators

Jody Allen	Lekeisha Crutcher	Tahnaya Sampson
Joy Asher	Ashley Henry	Debbie Smith-Carrillo
Cheryl Arrington	Brenda Hicks	Maria Sosa
Kenya Beaudoin	Cammie Jones	Tamela Street
Bobbi Bradley	Sarah Lamkin	Frances Sullivan
Kim Conklin	Julie Munson	Lisa Townsend
Misty Crank	Theresa Rowe	Randi Whiterock

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Cody L. Phinney MPH
Division of Health Care Finance and Policy

Deborah S. Aquino
Division of Public and Behavioral Health

John M. DiMuro DO, MBA

Tammy Williams
Department of Education Office of Early Learning and Development

This report will be made available on the Oral Health Program website at http://dpbh.nv.gov/Programs/OH/OH-Home/

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Table of Contents

List of Maps and Figures

Introduction

In 2003, a dental screening was conducted by what was then the Nevada State Health Division Oral Health Program to review oral health data on children enrolled in Nevada's Head Start programs. The protocol used for the screening was the Association of State and Territorial Dental Directors (ASTDD) Basic Screening Survey (BSS). All 44 Head Start sites were screened and a report was issued on the results[1].

In 2007, Nevada's Oral Health Program completed a second dental screening, and all 44 Head Start sites were again screened using the BSS protocol. A report from that survey summarized the findings of the 2007 screening, compared the findings with *Federal Healthy People 2010* objectives, and provided high-level comparison between the 2003 and 2007 screening results[2].

In 2017, the Nevada Division of Public and Behavioral Health (DPBH), Oral Health Program partnered with the Department of Education's Office of Early Learning and Development, Head Start State Collaboration Office to conduct another dental screening to collect oral health data on Nevada's rural Head Start children. The BSS protocol was again used to assess for caries, caries experience, untreated decay, and the need for urgent dental treatment. All 16 Head Start Centers located in 11 of Nevada's 17 counties were screened (see Map 1 below). Las Vegas and Reno were not included in this survey because the Head Starts in these greater metropolitan areas were already screened regularly through dental hygiene programs at the College of Southern Nevada and Truckee Meadows Community College, through Community Health Alliance, and through a research project conducted by the University of Nevada Las Vegas School of Dental Medicine (UNLV-SDM). Overlap of these similar projects in these regions was deemed undesirable.

Though all Head Start centers were not included in this survey, these data are important in that they focus on oral health in Nevada's rural population, and they document the extent of oral health needs in young children in these rural areas. According to *Oral Health in America: A Report of the Surgeon General*[3], children from "low-income" families have more tooth decay, more extensive tooth decay, and suffer more pain than children from families with higher incomes. Screening results are expected to aid in targeted interventions to prevent oral disease so that growth, development, and overall quality of life for all of Nevada's children is enhanced.

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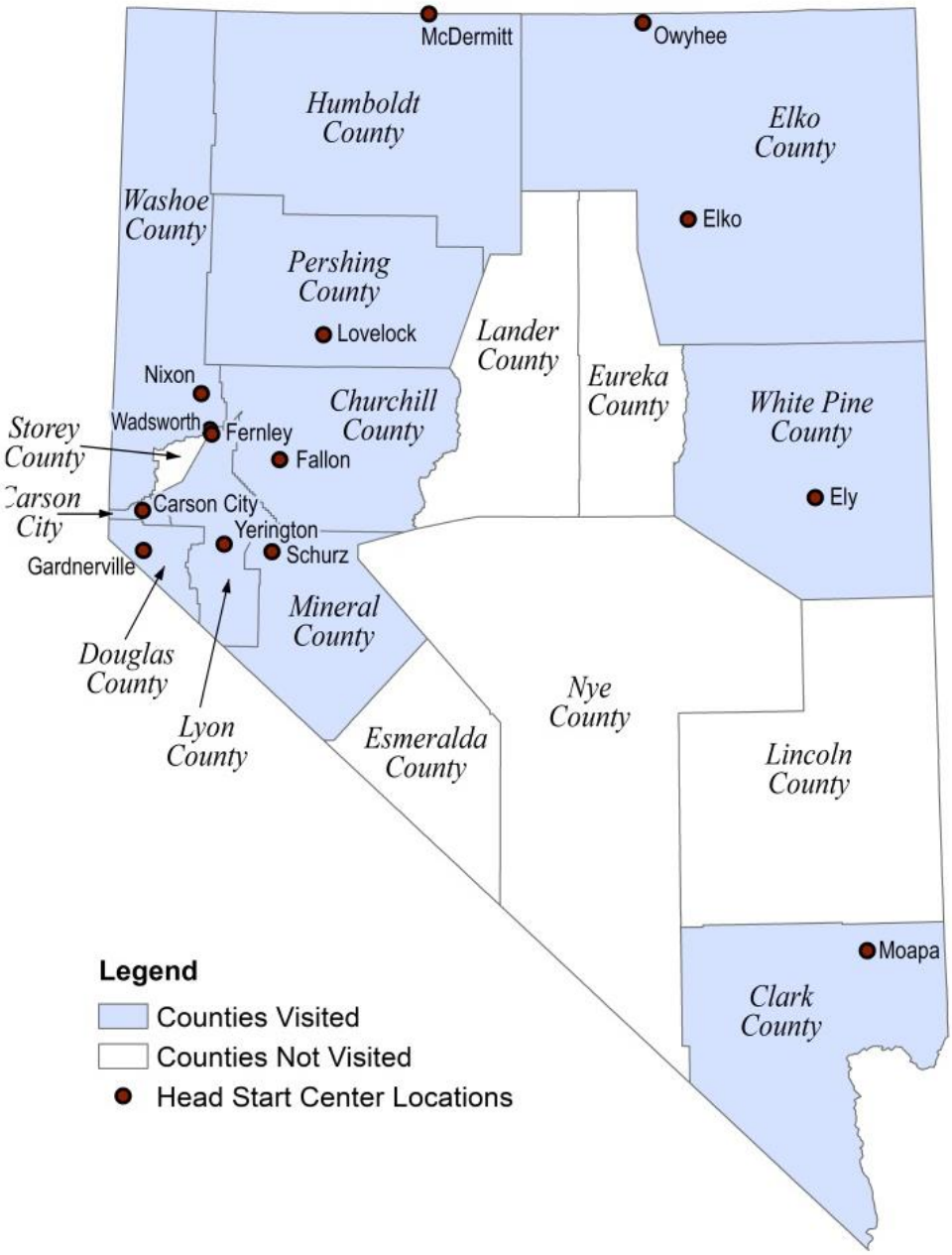
[1] *http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/OH/Oral_Health_Program_Reports/healthysmilehappychildsurvey2003.pdf*

[2] *http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/OH/Oral_Health_Program_Reports/BSSheadstart2007final73007.pdf*

[3] *U.S. Dept. of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Dept. of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of health, 2000.*

Map 1: 2017 Head Start Oral Health Survey Locations



Key Findings – 2017

- 26% of rural Head Start children in this survey had ***untreated decay,*** making dental decay more than five times more prevalent than the parent-reported prevalence of child asthma (which was about 5%) for children in this survey. While this finding exceeds the Healthy People 2020 objective for untreated decay (21%), it does represent a steady decline in untreated decay from Nevada's 2003 and 2007 Head Start surveys. Please see an explanation of Healthy People 2020 below.

- 31% of these rural Head Start children had ***treated decay***. Types of restorations are noted later in this report.

- 50% of rural Head Start children in this survey had untreated cavities and/or fillings (***caries experience***). While exceeding the Healthy People 2020 objective of 30%, this finding represents a decline in caries experience in Nevada's 2003 and 2007 Head Start surveys.

- 76% of teeth with caries experience in these rural Head Start children were **treated;** 24% were **untreated**.

- 29% of these rural Head Start children ***needed either restorative or urgent dental care.*** This represents a decline in restorative and *urgent* dental need from Nevada's 2003 and 2007 Head Start surveys.

Other key findings

- About 10% (43) reported that in the last 12 months ***their child could not get care*** when they needed it. About 23% reported "other reason" as to why they could not care; the next most reported reason was no insurance (11%).

- Almost 72% (298) reported that the **reason for their last dental visit** was a "routine check-up, examination or cleaning". Just over 2% (9) reported that the child was taken in because "something was wrong, bothering, or hurting".

- About two thirds of the parents of survey children provided a name for their ***dental provider***, while 15% of the parents stated that they had no dental provider.

- A higher proportion of **American Indian children** in rural Head Start programs had caries experience (62%) than did White (40%), Hispanic (49%) children, or those children where Race/Ethnicity was stated as "Other" (45%).

- A higher proportion of **American Indian children** in rural Head Start programs had untreated decay (27%) than did White or Hispanic (23%) children.

Methodology

Since all 16 rural Head Start locations were screened, the results of this screening are reported as a “census.” It was determined that, rather than research, this dental screening was considered an oral health surveillance effort to continue to monitor the oral health status of this population.

Letters went out first to the Head Start Administrators, and after their approval, to Head Start Coordinators at each site (see appendices). Follow-up calls were made to secure participation, answer questions, and schedule a screening visit using a Scheduling Sheet (see appendices). Packets for each child were then sent to each center with a letter to parents, a fluoride varnish brochure, a consent form, and a questionnaire (see appendices). All documents distributed to parents were available in English and Spanish. Follow-up confirmation/reminder calls were made to the centers a week before the visit date, and then the day before the visit.

The screening portion was based on the ASTDD *Basic Screening Survey (BSS)* protocol. All children with a signed positive consent form who were present the day of screening were screened in an area designated by the Head Start Center. The dental screenings were completed by the Nevada-licensed State Dental Health Officer and State Public Health Dental Hygienist, who standardized together on the BSS protocol beforehand. Screenings were conducted with a headlamp, disposable gloves, a disposable mirror, and a cotton tip applicator (as needed to remove debris). A fluoride varnish application was provided to those children with separate consent for the fluoride varnish, no contraindications listed on the consent form, and willingness to cooperate with the procedure. A recorder entered screening results for each child on paper screening forms on-site and filled out “Take Home Findings” to be sent home with the child that included post-fluoride varnish application instructions and dental tips. A list of low-cost community dental clinics in Nevada was also attached (see appendices). Children received a sticker and an oral health supply bag with a toothbrush, tooth paste, floss, and a timer for use with brushing.

A Microsoft Access database was created and tested, and decision rules were written for data entry. The recorder who entered the data on the hard copies in the field was trained to enter all information into the database.

Conditions were recorded as follows:

1. ***Non-Cavitated White Spots*** (y/n) were marked yes if at least one tooth had decalcification with no break in the enamel. Included were the number of teeth fitting the description.

2. ***Untreated Decay*** (y/n) was marked if a*t least one tooth* had a break in the enamel, and included the number of teeth fitting the description.

3. ***Treated Decay*** (y/n) was marked if at least one tooth was extracted due to decay or had amalgam (silver) or composite (white) fillings, stainless steel crowns, white-faced crowns, or "other". Included was the number of teeth fitting the description.

4. ***Treatment Urgency*** was *considered the whole mouth, with* **"Urgent"** marked for signs or symptoms that included pain, or infection, swelling or soft tissue ulceration of more than two-weeks' duration as determined by questioning were present. **"Early"** was marked if visible caries without accompanying signs or symptoms were present, or there was spontaneous bleeding of the gums or suspicious white or red soft tissue areas. **"None"** was marked if the child was without any of the problems listed above.

Summary of BSS Protocol Changes Across Surveys from 2003 – 2017

- The 1999 version had one data element for race and another for ethnicity. Field-testing found two problems with the 1999 method – missing data, and the inability to code multi-racial children. The 2003 version of BSS updated the method for collecting race and ethnicity information by combining them into one question (to reduce the amount of missing data), and included a code for multi-racial children.

- The 1999 version of *Basic Screening Surveys: An Approach to Monitoring Community Oral Health* included "untreated decay" and "caries experience" as two of the screening indicators. Combining these two indicators, however, did not allow states to determine which children had received previous treatment for caries. In 2007, the ASTDD Executive Committee approved changing the "caries experience" indicator to "treated decay".
  After that point it has been recommended that caries experience, which is still an indicator for the National Oral Health Surveillance System (NOHSS), be calculated from untreated decay and treated decay.

- As states developed their oral health surveillance infrastructure, some indicated interest in collecting information on disease severity in addition to prevalence data. The 2008 version of *Basic Screening Surveys* added a set of options for each indicator, ranging from a simple "no/yes" prevalence measure to more complex measures indicating severity of disease. If a severity option is selected, prevalence can still be calculated as one of the NOHSS indicators.

- In 2015, the early childhood caries (ECC) indicator – decay experience on maxillary anterior teeth – was deleted because the generally accepted definition of ECC is decay on *any* tooth rather than *only* on the maxillary anterior teeth. The optional questions were updated to align with national surveys.

- In 2017, optional indicators for dental sealants on primary molars and potentially arrested decay were added for states wishing to monitor the use of primary molar sealants and caries arresting agents such as silver diamine fluoride. The optional questions were again updated to align with current national surveys. (Note: "sealants on primary teeth" and "potentially arrested decay" were not recorded in the 2017 Nevada Head Start Survey.)

Head Start Response Rates and Demographics

Sixteen Head Starts in 11 counties were screened (see Map 1). Out of the 472 children enrolled and receiving a consent form, 417 returned signed consent forms (88%), much higher than response rates for the 2003 and 2007 surveys. High consent return for this survey may be attributed, at least in part, to the incentive offered. Head Start schools were offered a $100 gift card to an online educational supply house if at least a 70% consent return rate was met for the school as a whole. Of the 16 schools, 15 met or exceeded the 70% rate. Gift cards were distributed at the time of the dental screening.

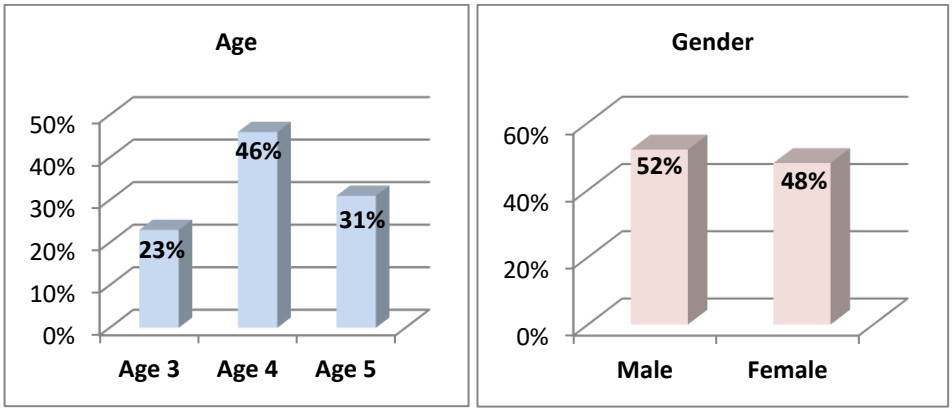
Consent return rate	Number of schools
100%	2
90-99%	6
80-89%	6
70-79%	1
Below 70%	1

Due to negative responses, absences, and some participation/cooperation issues, the final number for the 2017 rural Nevada Head Start population with completed oral screenings was 336 (71%).

A fluoride varnish application was offered along with the screening. Many parents chose not to participate in this free fluoride varnish application for their children, with 192 children (41%) receiving fluoride varnish. While some refusals could be due to allergies, medical issues, and/or recent fluoride application, this result may also reflect continuing attitudes of mistrust related to fluoride and fluoride preventive regimens.

The demographic characteristics of age, gender, and race/ethnicity for the 2017 Head Start survey participants can be seen in Figures 1 and 2.

Figure 1: Age and Gender Distribution of Children in Nevada Head Start Programs Screened in 2017



Race/Ethnicity – On the consent form, the parent/guardian could select one or more choices from the following list: White, Black/African American, Asian, Hispanic/Latino, Native Hawaiian/Pacific Islander, American Indian/Alaska Native, Multi-Racial and Other. For summary purposes the responses were organized into mutually exclusive groups using the following logic.

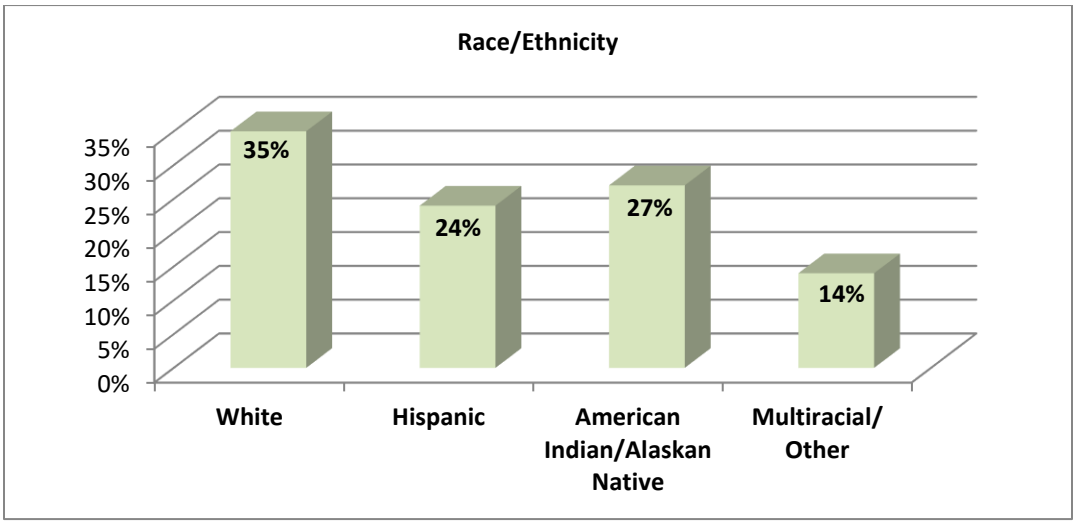
If Hispanic was selected as one of the choices, then the child was categorized as Hispanic.

If only White was selected, then the child was categorized as White.

If only American Indian/Alaska Native was selected, then the child was categorized as American Indian.

Because of small numbers in the other categories (Black/African American, Asian, Native Hawaiian/Pacific Islander, Multi-Racial, Other, and any child with multiple selections (not including Hispanic) were categorized as Multi Racial/Other.

Figure 2: Race/Ethnicity Distribution of Children in Nevada Head Start Programs Screened in 2017



Healthy People 2020

Healthy People 2020 is a set of health objectives for the nation to achieve by the year 2020[4]. There are 17 specific oral health objectives to prevent and control oral diseases and reduce oral health disparities. Three oral health indices are included for children three to five years of age. They are:

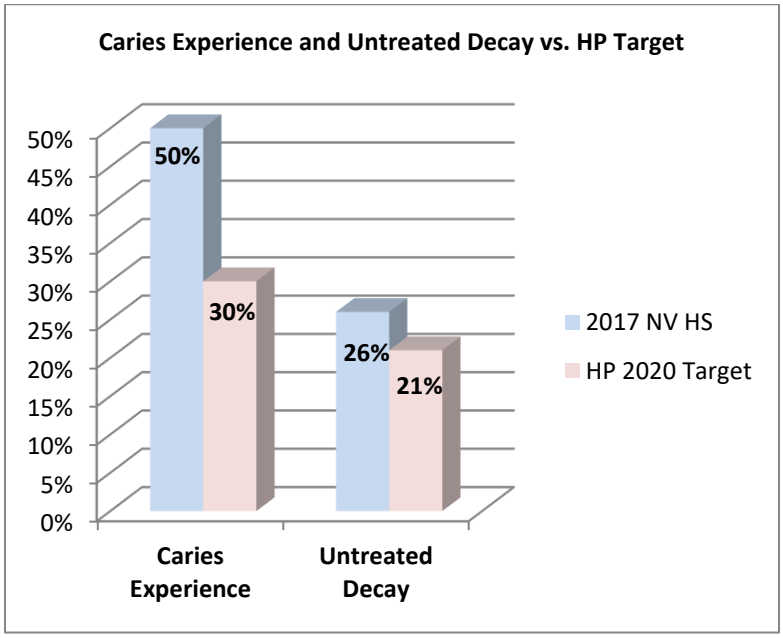
OH 1.1 Reduce the proportion of children aged 3 to 5 years with dental caries experience in their primary teeth (target – 30%)

OH 2.1 Reduce the proportion of children aged 3 to 5 years with untreated dental decay in their primary teeth (target 21.4%)

OH 12.1 Increase the proportion of children aged 3 to 5 years who have received dental sealants on one or more of their primary molar teeth (target 1.5%)

Figure 3 compares 2017 caries experience and untreated decay for children in Nevada's Head Start programs (age three to five) to *Healthy People 2020* objectives 1.1 and 2.1. This clearly demonstrates the gap in achieving the *Healthy People 2020* objectives for children of families with low incomes.
The 2017 Nevada Head Start Survey did not assess dental sealants on primary teeth.

Figure 3: 2017 Nevada Head Start Children's Oral Health Compared to *Healthy People 2020* Objectives - Caries Experience and Untreated Decay

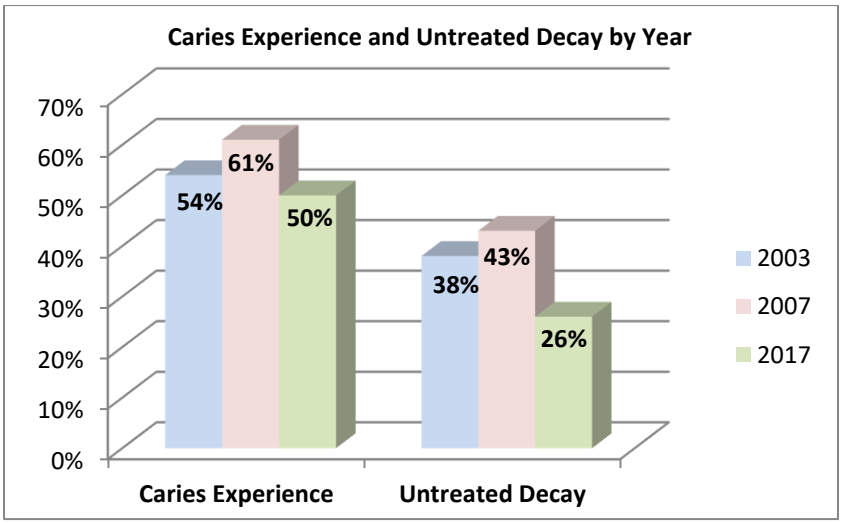


[4] *https://www.healthypeople.gov/*

Comparison of 2003, 2007, and 2017 Screening Results

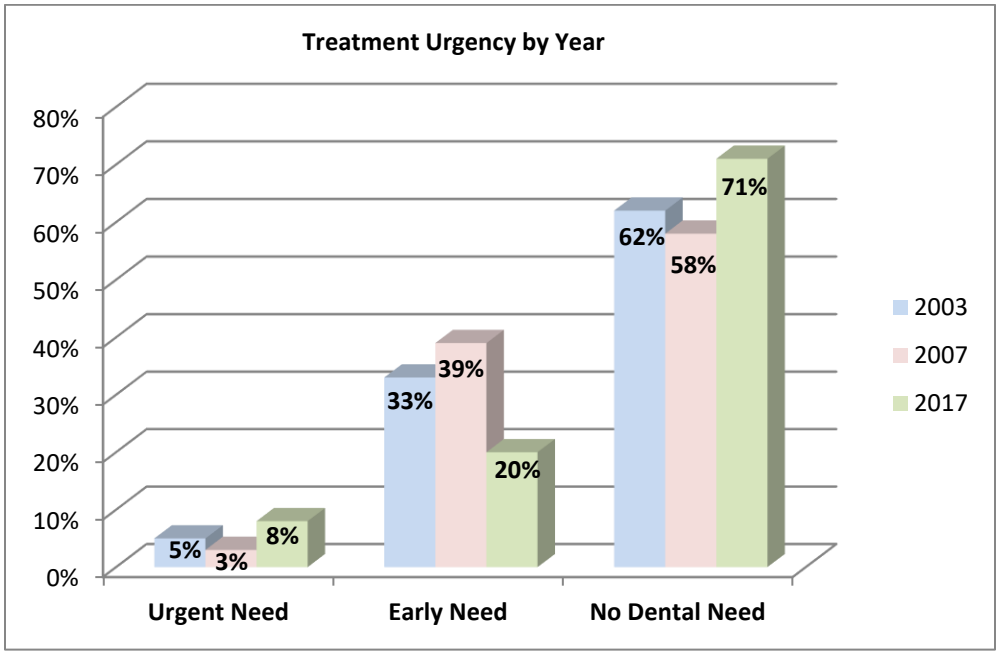
A comparison of 2017 to the 2003 and 2007 screening results of children in Nevada's rural Head Start programs indicates that oral health status has improved (see Figure 4), at least for these rural Head Start children. Caries experience, untreated decay, and need for treatment were all lower in the 2017 survey compared to results for rural Head Start children in 2003 and 2007. The overall caries experience prevalence of 50%, is lower than the 54% prevalence for rural children in 2003, and the 61% for rural children in 2007. Untreated decay shows a remarkably larger improvement at a prevalence of 26% compared to rural Head Start children prevalence 38% in 2003 and 43% in 2007.
Though improvement has been made, rural Nevada Head Start Children are still short of the *Healthy People 2020* goals of 30% for caries experience and 21% for untreated decay.

Figure 4: Comparison of 2003, 2007 and 2017 NV Head Start Screening Results – Caries Experience and Untreated Decay



Treatment urgency also shows improvement. Figure 5 displays the distributional findings of treatment need for rural Nevada Head Start children from the 2017 survey. In comparing to rural results for the 2007 survey and combining “urgent” and “early” dental needs, 2017 results reveal that 28% of rural Head Start children have need for dental care, compared to 42% of rural children in 2007. However, the 8% of children with “urgent” need for dental care is higher than the overall 5% in 2003 and the 3% in 2007, and represents many children with dental pain or infection at the time of the screenings. This “urgent” category may be less reliable though, if screeners in the different surveys had slightly different interpretations of the difference between “early” and “urgent” needs. Even though there appears to be improvement since 2007, one in four children is still a very high proportion of children having need for dental care.

Figure 5: Treatment Urgency Distribution for 2017 Nevada Head Start Children

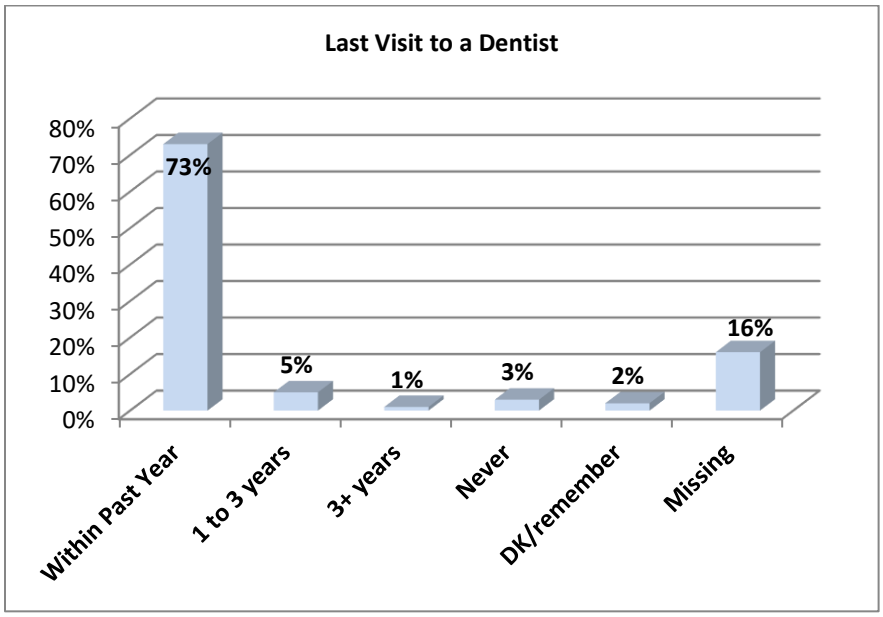


Consent Form/Parent Questionnaire Results

Standard questions were included on the parent consent form to obtain further information from parents that could be related to the oral health status of the children. General health questions asked parents whether their child had asthma, allergies, medical conditions, current medications, current fluoride tablets or drops, and fluoride varnish treatment in the past three months. There were relatively few positive responses to these questions, with 5% reporting their children had asthma, about 11% reporting allergies, about 3% reporting medical conditions, less than 5% reporting that the child was currently taking medications, about 8% reporting that the child was currently getting fluoride tablets or drops, and about 13% of the children having received a fluoride varnish application in the past three months.

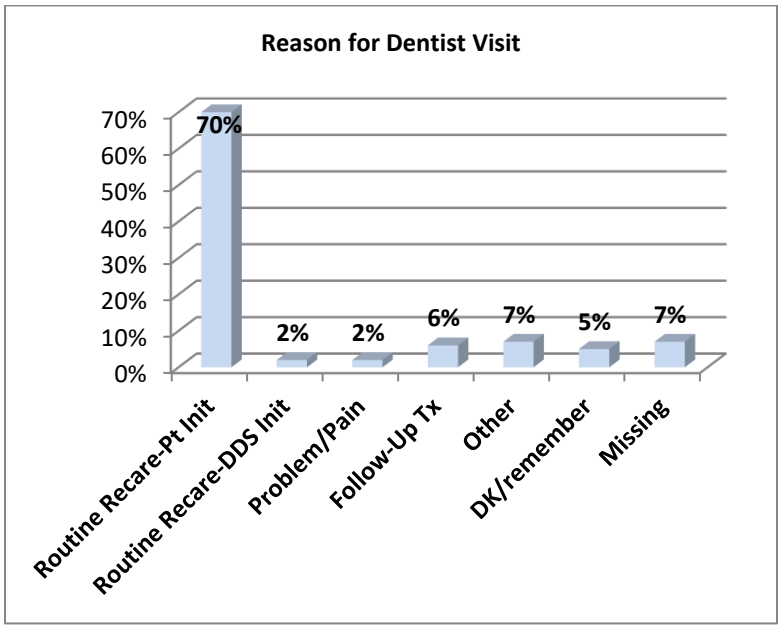
The consent form also included questions directly related to the dental care and oral health of the child. When asked about time since the child last visited a dentist, most parents reported that child has seen a dentist within the last year. The full results for this question are shown in Figure 6.

Figure 6: Time Since Child's Last Visit to a Dentist



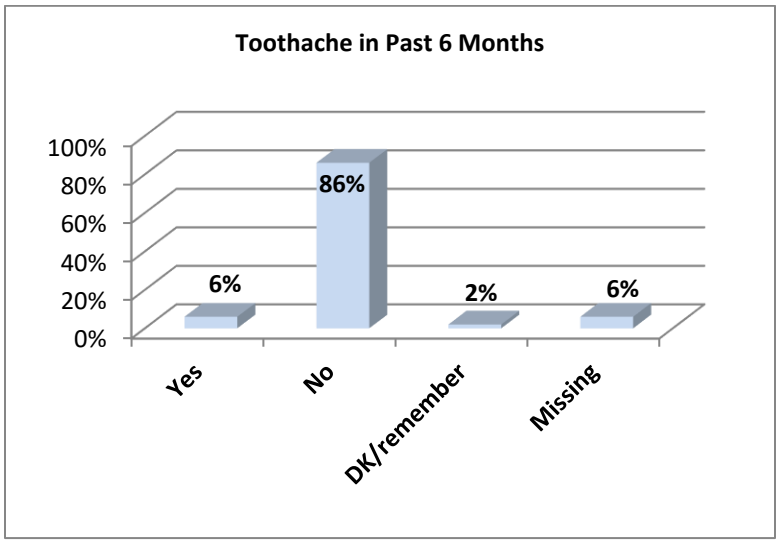
Most children (72%) had visited the dentist for a routine recall, either initiated by the parent or by the dentist. Only 2% of the dentist visits were related to a dental problem or dental pain. The distribution of reasons for a dental visit are shown in Figure 7.

Figure 7: Reason for Child's Last Visit to a Dentist



When asked specifically if their child had experienced a toothache when biting or chewing in the past six months, few parents responded positively. See Figure 8.

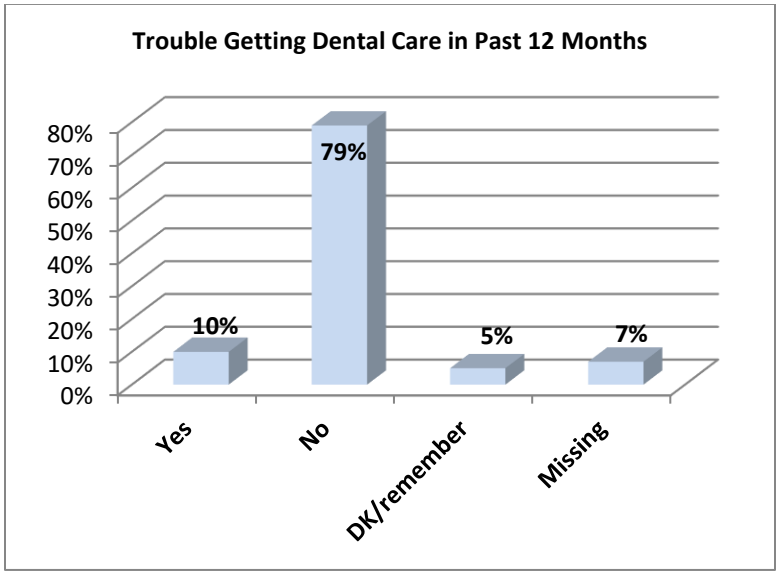
Figure 8: Child Experienced Toothache in the Past 6 Months When Biting or Chewing



When asked if the dentist seen for the last dental visit was also providing follow-up care for the child, only 21% gave a positive response. There are different possible explanations for this result. Though it is possible that the last dental visit involved an oral health screening indicating that this visit did not indicate a “dental home” for the child, it is very likely that many of the children had a routine recall appointment and simply didn’t require any follow-up care.

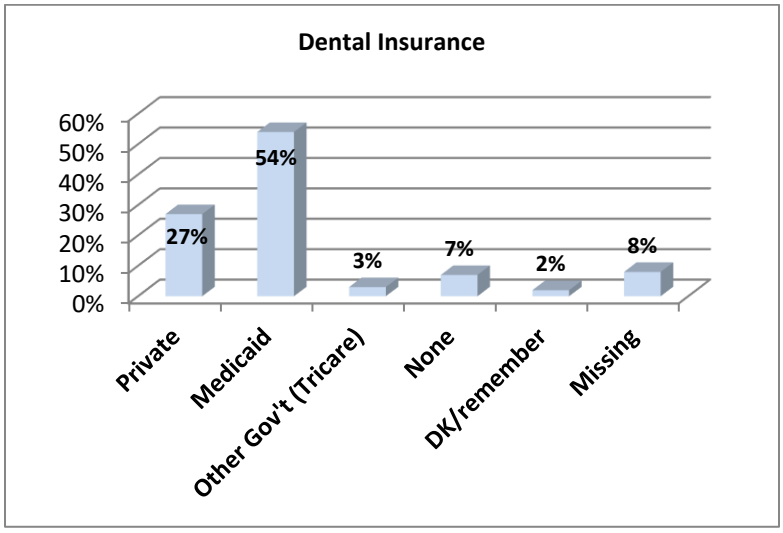
A further indication of dental care access was addressed by a question asking parents if they had experienced trouble getting their child needed dental care in the past 12 months. Ten percent of parents indicated that they had problems getting care. The results for this question are seen in Figure 9.

Figure 9: Child Needed Care in Past 12 Months and Couldn’t Get It



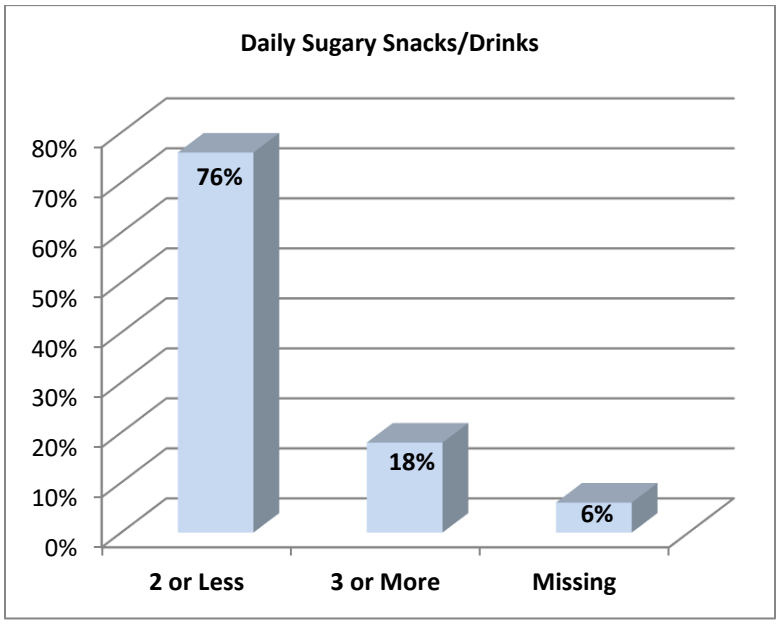
Asked specifically about dental insurance, the most frequent response was Medicaid. See Figure 10.

Figure 10: Type of Child's Dental Insurance



Finally, most parents reported a low daily frequency of sugary snacks/drinks for their children. The results for this question are displayed in Figure 11.

Figure 11: Average Daily Sugary Snacks for Child



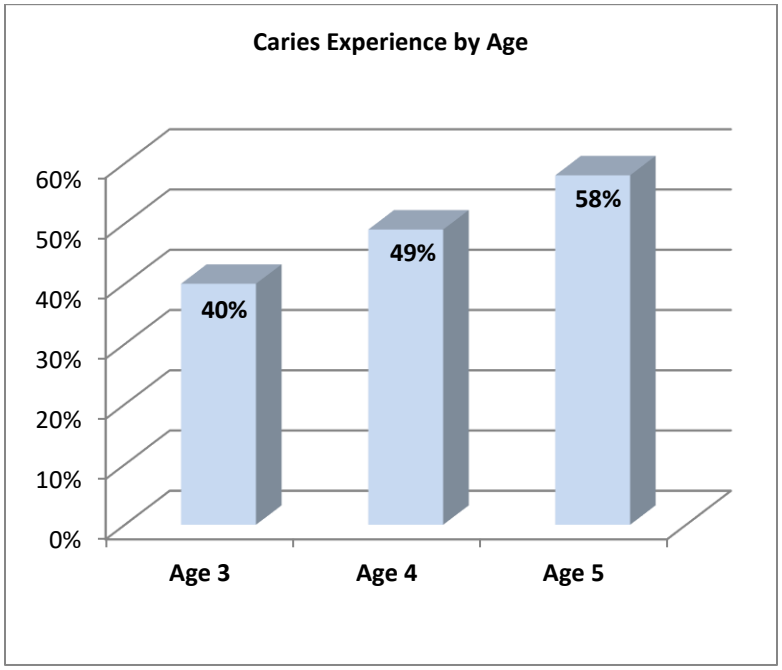
2017 Summary - Caries Experience

Caries experience includes the presence of fillings and untreated decay in primary (baby) teeth, and primary teeth missing due to caries. Half of Nevada's rural Head Start three to five-year-old children have decay experience. There was no important difference in caries experience by gender. The following results show caries experience for these children by age, race/ethnicity and other potentially associated variables from the parent questionnaire.

As expected, caries experience increases with age, increasing in prevalence by 18% between ages 3 and 5 (Figure 12), with 50% of rural Nevada 3 to 5-year-old Head Start children having caries experience. For reference, the National Health and Nutrition Examination Survey (NHANES) for 2015-16 found an estimated 21% of all 2 to 5-year-olds (not just Head Start rural children) had caries experience. NHANES results did show higher caries experience with lower family income level.

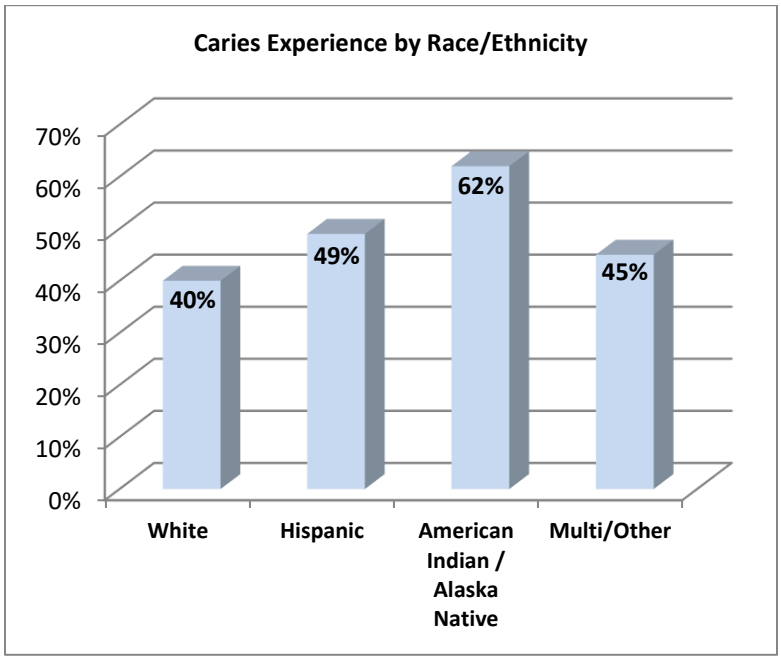
Twelve other states and the Indian Health Service have submitted Head Start BSS data for the CDC Oral Health Data website. The submitted estimates are for all Head Start children in the state and are not stratified by urban/rural status. Estimates for caries experience in Head Start children range from 19% for Connecticut to 46% for Nebraska. The Indian Health Service Head Start caries experience estimate is 67%.

Figure 12: Caries Experience of Rural Nevada Head Start Children – by Age



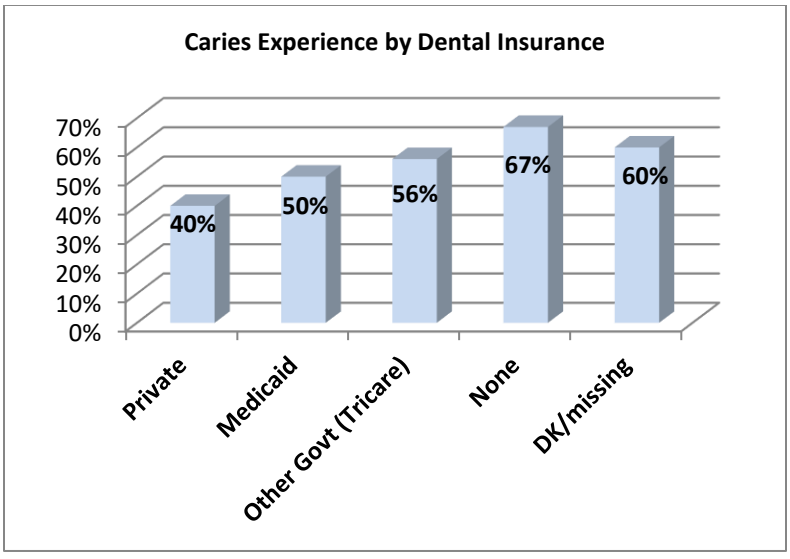
American Indian children in Head Start programs had higher rates of caries experience than all other racial/ethnic groups, followed by children in the Hispanic and Multi-Racial/ Other categories. White children had the lowest caries experience. See Figure 13.

Figure 13: Caries Experience of Children in Rural Nevada Head Start Programs – by Race/Ethnicity



Caries experience is lowest for Nevada Head Start children with private dental insurance and highest for those without dental insurance. See Figure 14.

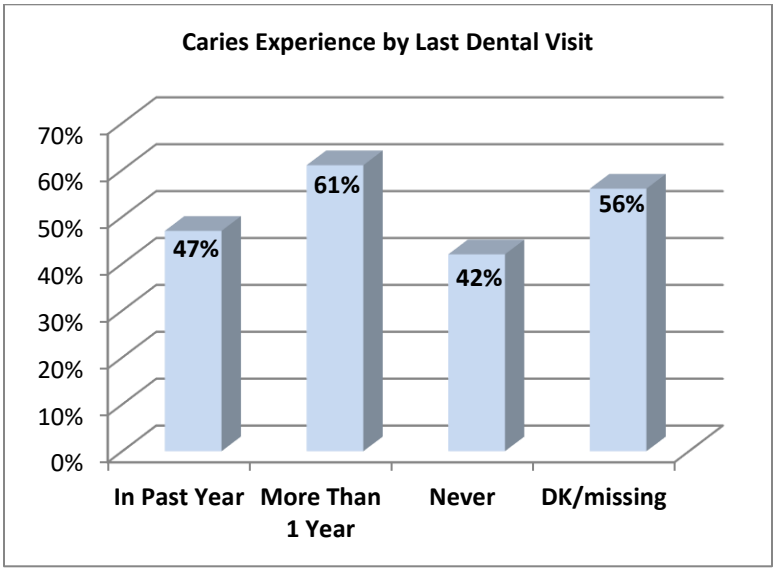
Figure 14: Caries Experience of Rural Nevada Head Start Children – by Dental Insurance



Lower caries experience was seen in children with a dental visit in the past year, and children having never been to the dentist (Figure 15). The lower caries experience in

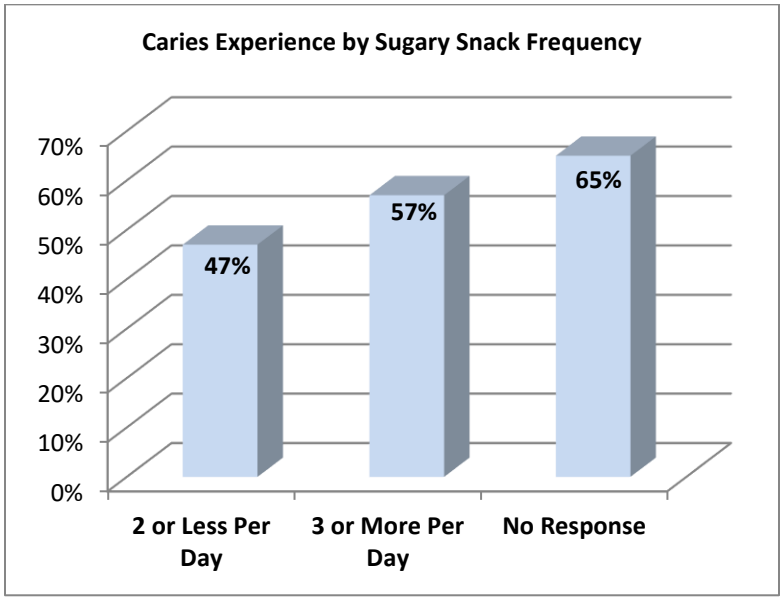
children who haven't seen a dentist may reflect in part children who hadn't experienced dental symptoms and the parents hadn't perceived a need for a dental visit.

Figure 15: Caries Experience of Rural Nevada Head Start Children – by Last Dental Visit



Lower caries experience was seen in children with lower frequency of sugary snacks. See Figure 16.

Figure 16: Caries Experience of Rural Nevada Head Start Children – by Sugary Snack Frequency



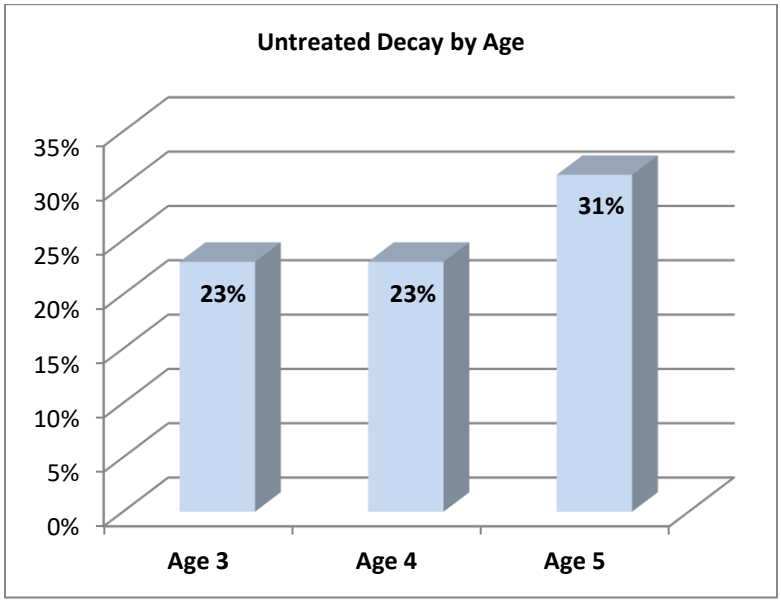
2017 Summary - Untreated Decay

Untreated decay refers to caries experience (a cavity) that is visible but has not been filled or treated. More than one in four (26%) of Nevada's Head Start children have untreated decay. There was no important difference in untreated experience by gender. The following results show caries experience for these children by age, race/ethnicity and other potentially associated variables from the parent questionnaire.

Though untreated decay prevalence is unchanged between ages 3 and 4, an increase is seen by age 5 (Figure 17), with 26% of rural Nevada 3 to 5-year-old Head Start children overall having untreated cavities. The National Health and Nutrition Examination Survey (NHANES) for 2015-16 found an estimated 9% of all 2 to 5-year-olds (not just Head Start rural children) had untreated decay. And as with NHANES results for caries experience, results showed higher prevalence of untreated decay with lower family income level.

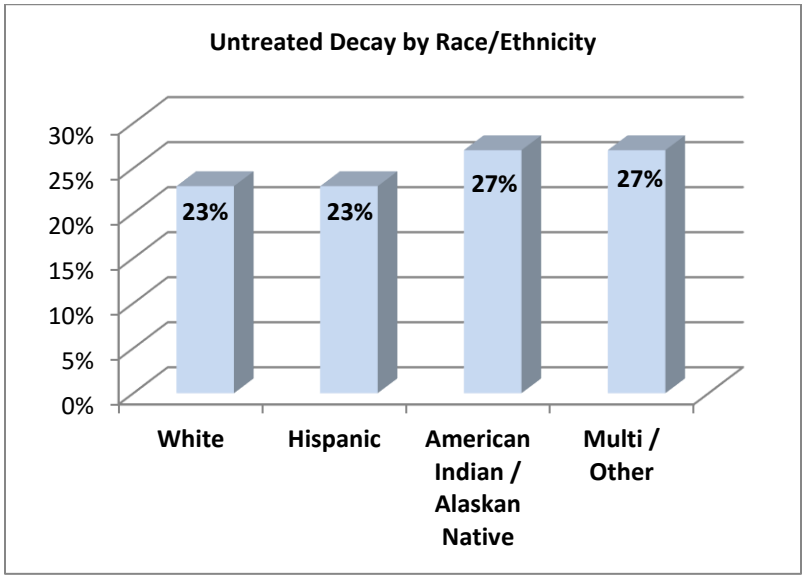
Of the twelve other states and the Indian Health Service that have submitted Head Start BSS data for the CDC Oral Health Data website, state estimates for all Head Start children in the state (not stratified by urban/rural status) for untreated cavities range from 10% for Connecticut to 30% for Nebraska. The Indian Health Service Head Start untreated cavities estimate is 39%.

Figure 17: Untreated Decay of Children in rural Nevada Head Start Programs – by Age



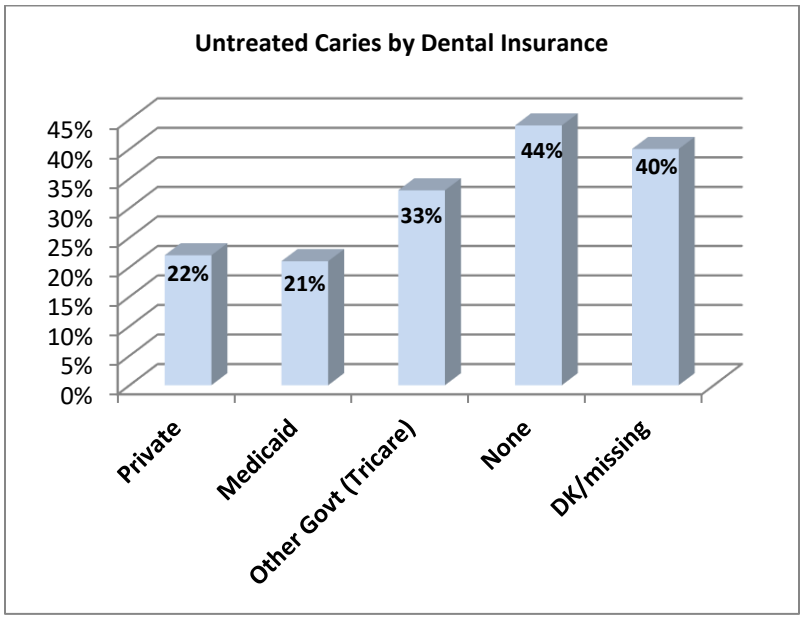
American Indian and children in the multi-racial/other category in rural Nevada Head Start programs had a higher rate of untreated decay than the white and Hispanic groups. See Figure 18.

Figure 18: Untreated Decay in Rural Nevada Head Start Children – by Race/Ethnicity



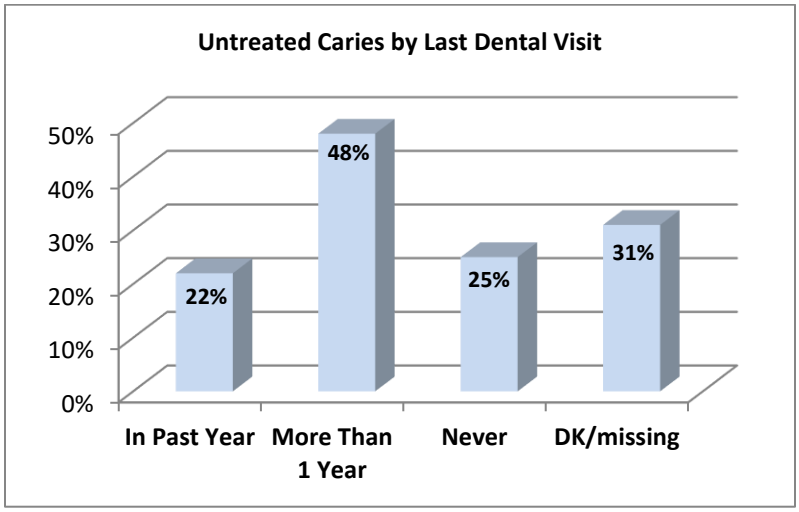
Untreated caries prevalence is lowest for Nevada Head Start children with private dental insurance or Medicaid, and highest for those without dental insurance. See Figure 19.

Figure 19: Untreated Caries Prevalence of Rural Nevada Head Start Children – by Dental Insurance



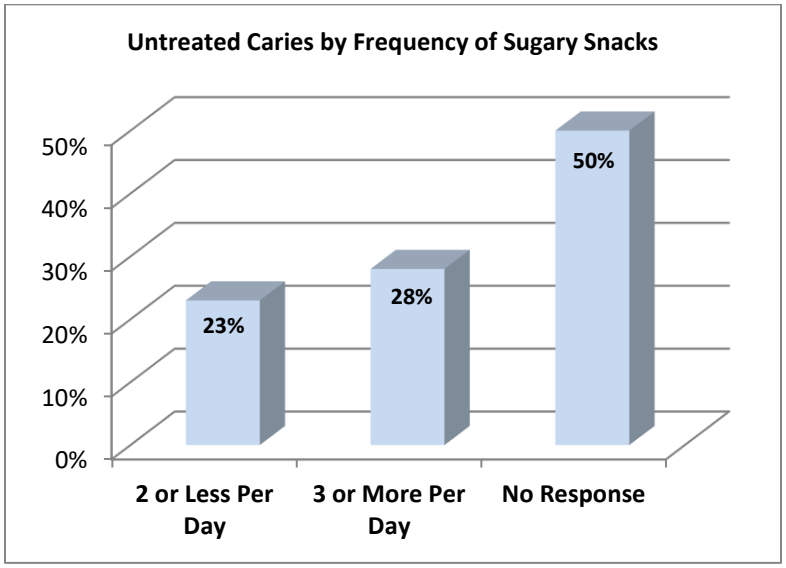
Lower untreated caries was seen in children with a dental visit in the past year and children having never been to the dentist (Figure 20). The lower caries experience in children who haven't seen a dentist may reflect in part children who hadn't experienced dental symptoms and the parents hadn't perceived a need for a dental visit.

Figure 20: Untreated Caries of Rural Nevada Head Start Children – by Last Dental Visit



Similar to caries experience, children with a lower frequency of sugary snacks had a lower prevalence of untreated decay. See Figure 21.

Figure 21: Untreated Caries of Rural Nevada Head Start Children – by Frequency of Sugary Snacks



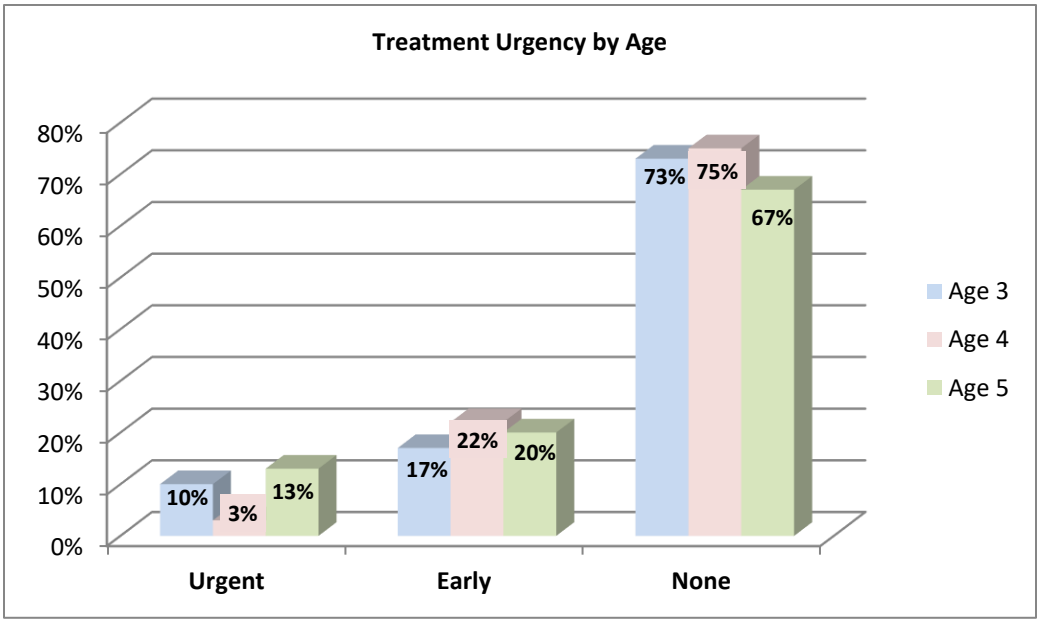
In addition to untreated cavitated lesions, the children were screened for white spots that may indicate initiation of a carious lesion. Standardization of screeners for identifying white spots is more difficult than standardization for cavitated carious lesions, but we were interested in assessing children who may have developing caries even if there are no frank cavitated lesions yet. Screenings revealed that 44% of these rural Nevada Head Start children had one or more teeth with white spots, indicating a large proportion of these children have teeth in the early stages of future tooth decay, and should be targeted for preventive measures.

2017 Summary - Treatment Urgency

After screening was completed for each child, the screener assigned the child to one of three treatment urgency categories. The categories were “No obvious problem/needs-routine preventive care (None)”; “Needs restorative care (Early)”; or “Needs immediate care-pain or swelling present (Urgent)”. The following results summarize the overall treatment urgency for children in rural Nevada’s Head Start programs.

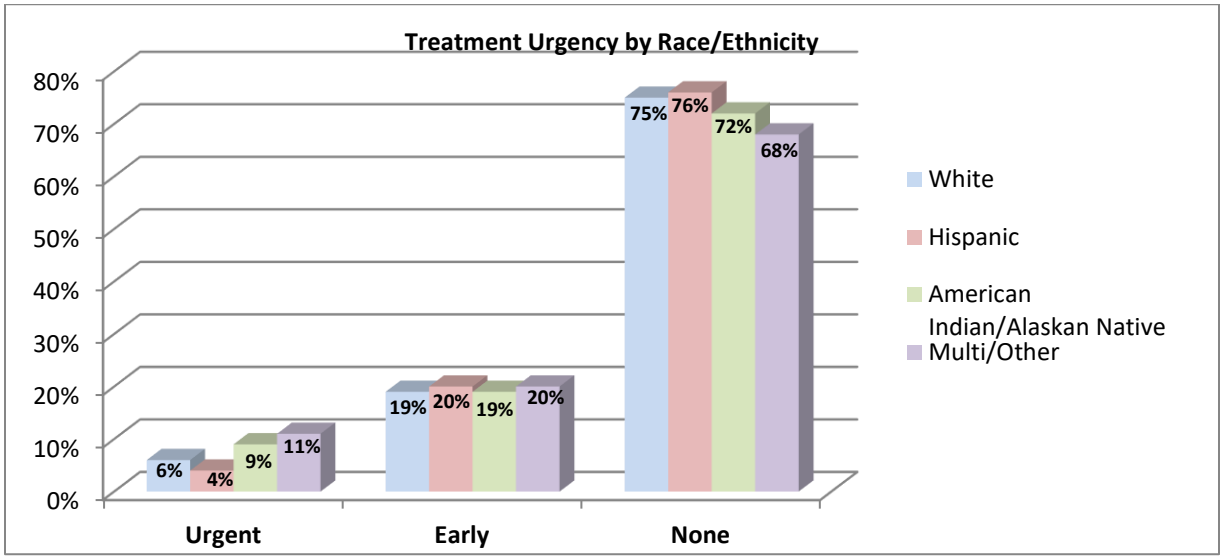
The only difference seen in by gender results was a slightly higher percentage of females perceived as having urgent treatment needs by the screeners. Treatment urgency by age is displayed in Figure 22. There was some variation in treatment urgency by age, with a slight decrease in five-year-old children with no treatment need.

Figure 22: Treatment Urgency Distribution of Children in Rural Nevada Head Start Programs – By Age



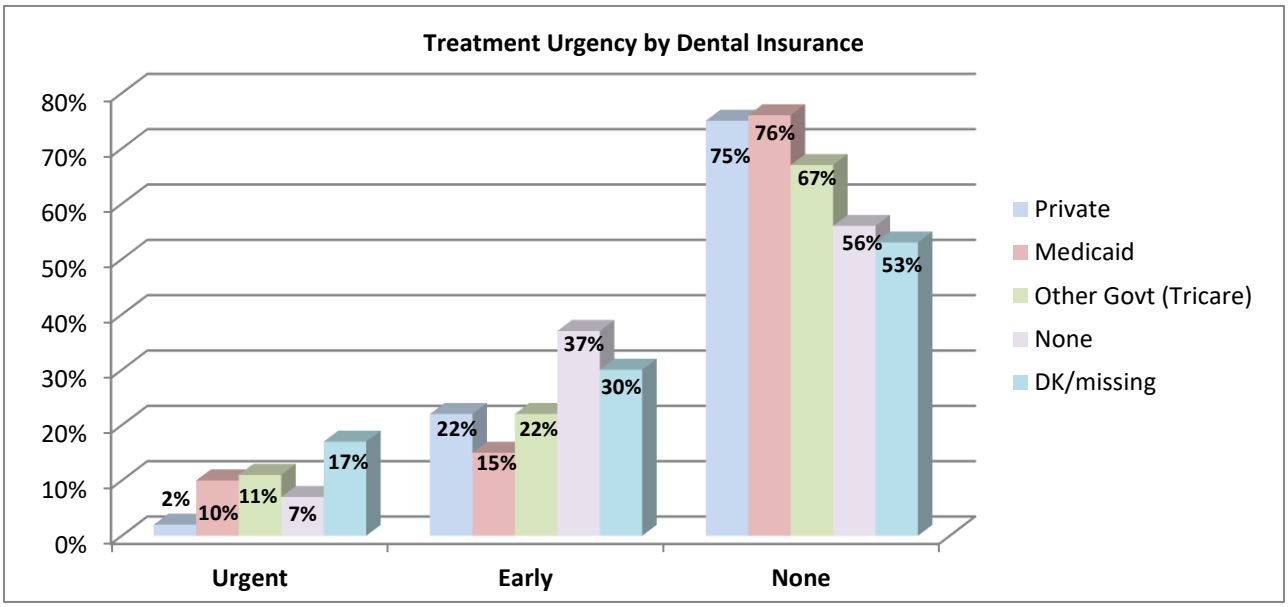
In the 2017 survey, rural Head Start American Indian children, and children in the multi-racial/other category had slightly higher prevalence of urgent needs and slightly lower prevalence of no need compared to White and Hispanic children. See Figure 23.

Figure 23: Treatment Urgency Distribution of Children in Rural Nevada Head Start Programs – By Race/Ethnicity



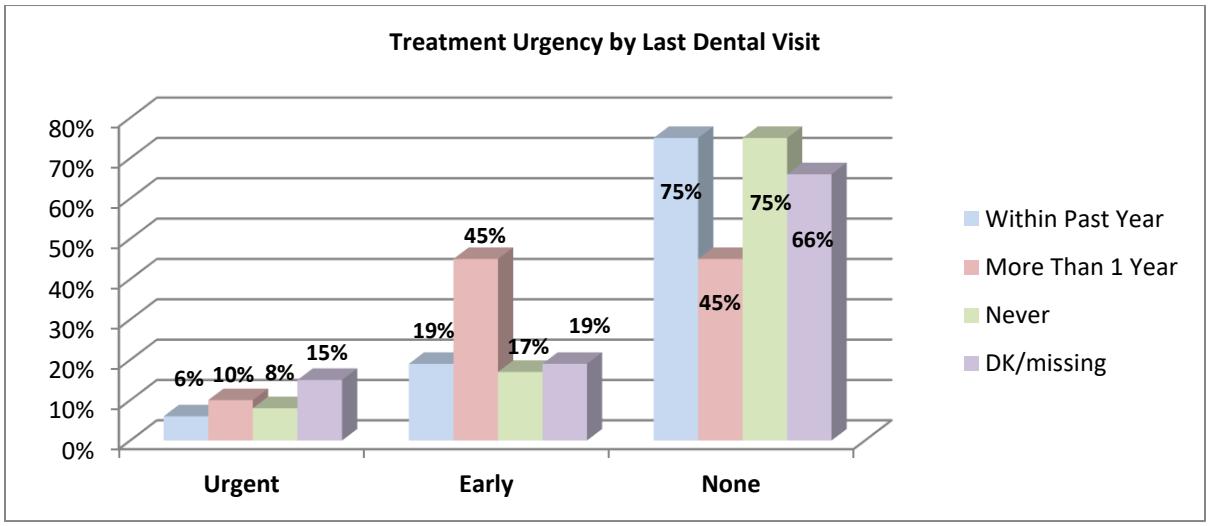
Rural Nevada Head Start children with private dental insurance had the lowest prevalence of urgent dental needs (Figure 24). Though a higher percentage of Medicaid children had urgent needs, overall percentage of Medicaid children with *any* dental needs was about the same as children with private dental insurance. A higher percentage of children without private or Medicaid dental coverage needed dental care.

Figure 24: Treatment Urgency Distribution of Rural Nevada Head Start Children By Dental Insurance



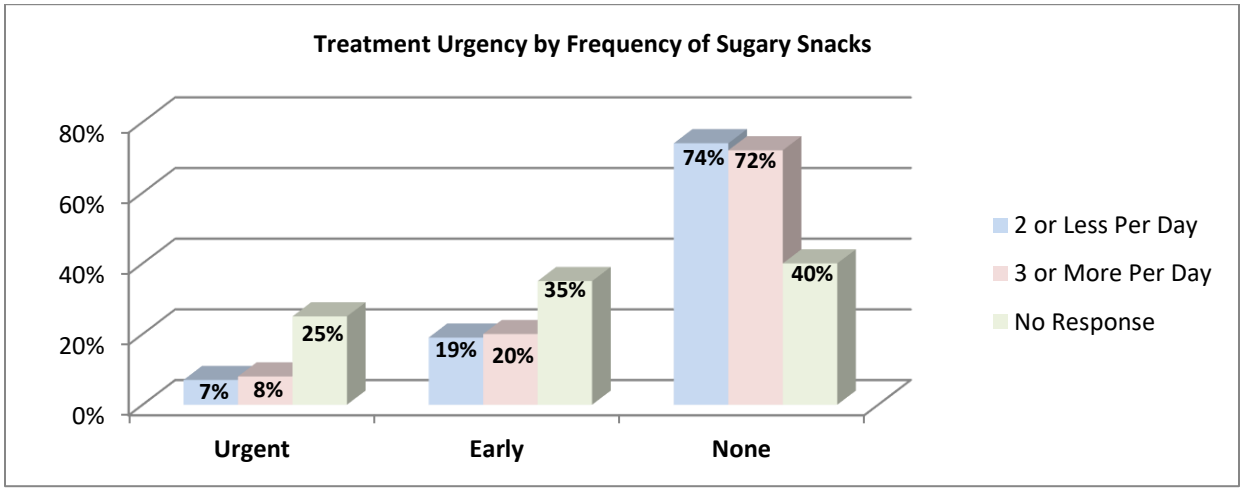
Treatment urgency results by last dental visit correspond with results seen for caries experience and untreated decay–children with better access to dental care generally have less dental disease and treatment needs. Children with a dental visit within the past year and those having never been to a dentist had the lowest dental needs. See Figure 25.

Figure 25: Treatment Urgency Distribution of Rural Nevada Head Start Children – By Last Dental Visit



Treatment urgency results by frequency of sugary snacks reflect results for caries experience and untreated decay showing more oral problems with higher frequency of sugary snacks (Figure 26). The lowest percentage of urgent and total dental treatment needs were seen in those children with the lowest frequency of sugary snacks, although the differences between two or less and three or more per day were not very large. Interestingly, the highest treatment needs were seen in children whose parents did not respond to this question.

Figure 26: Treatment Urgency Distribution of Rural Nevada Head Start Children – By Frequency of Sugary Snacks



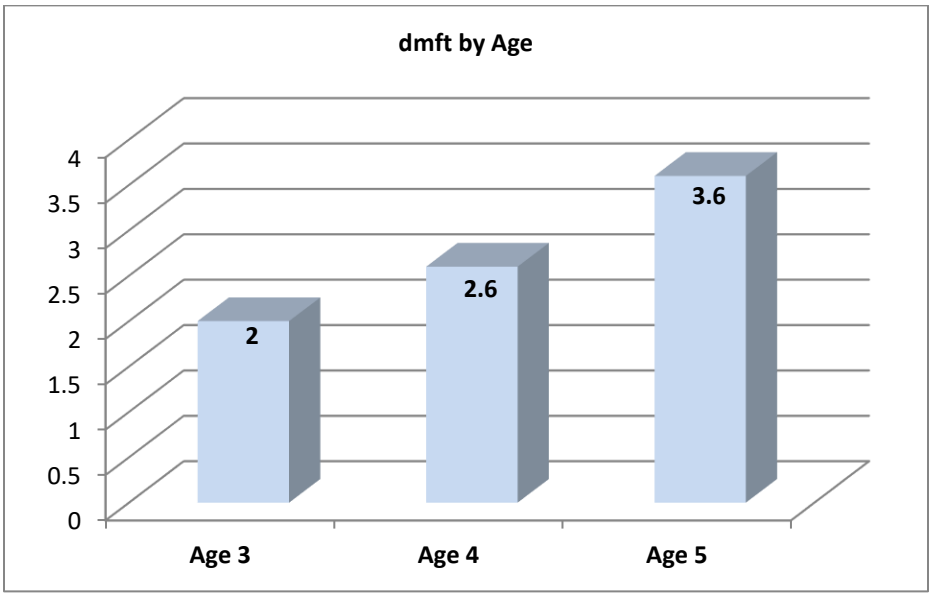
2017 Summary - Decayed, Missing or Filled Primary Teeth (dmft)

Each child present, whose parent/guardian gave permission, was screened for decay, fillings or missing primary teeth per the BSS criteria. Teeth in the following categories were counted: non-cavitated carious lesions, cavitated carious lesions, treated, filled, stainless steel crowns, extractions, and white-faced crowns (a type of esthetic crown for front teeth).

Of the children screened, 31% had treated teeth. Of those children with any type of treated teeth, 72% had one or more stainless steel crowns, 23% had one or more white-faced crowns, 19% had one or more extractions due to caries, and 50% had one or more dental fillings of some type.

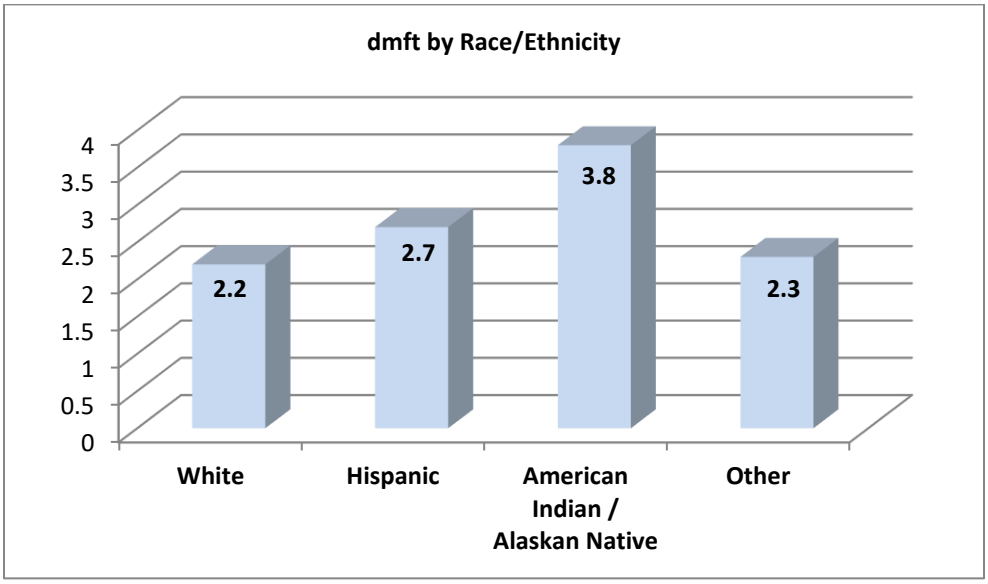
A count of combined cavitated carious teeth, missing teeth due to caries, and filled teeth is considered equivalent to a dmft score. The average dmft for rural Nevada Head Start children was 2.8 teeth, which is slightly lower than the 3.0 dmft found for rural Nevada Head Start children in the 2007 survey. This is slightly lower than the rural Head Start children average dmft of 3.0 found in the 2007 survey. Females had a slightly higher average dmft (3.0) than males (2.6). Further cross tabulations for dmft by other variables are displayed in Figures 26-30.
As expected, average dmft of children in rural Head Start programs increases with age. See Figure 27.

Figure 27: Average dmft of Children in Nevada Head Start Programs – by Age



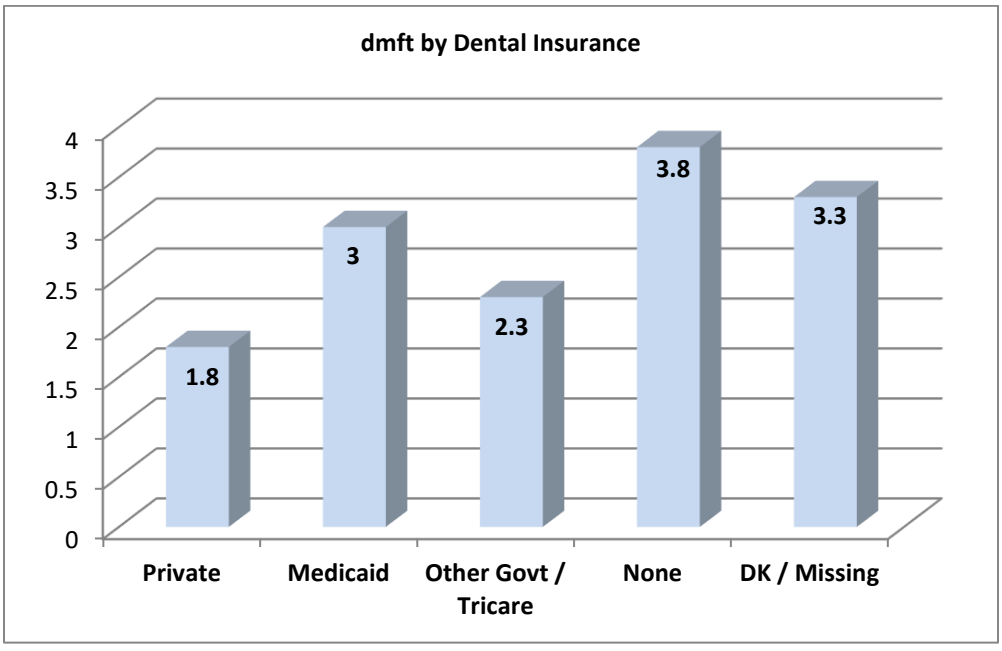
As with other caries results, the lowest average dmft was found in the white and "other" race/ethnicity categories. American Indian/Alaskan Natives had the highest average dmft. See Figure 28.

Figure 28: Average dmft of Children in Rural Nevada Head Start Programs – by Race/Ethnicity



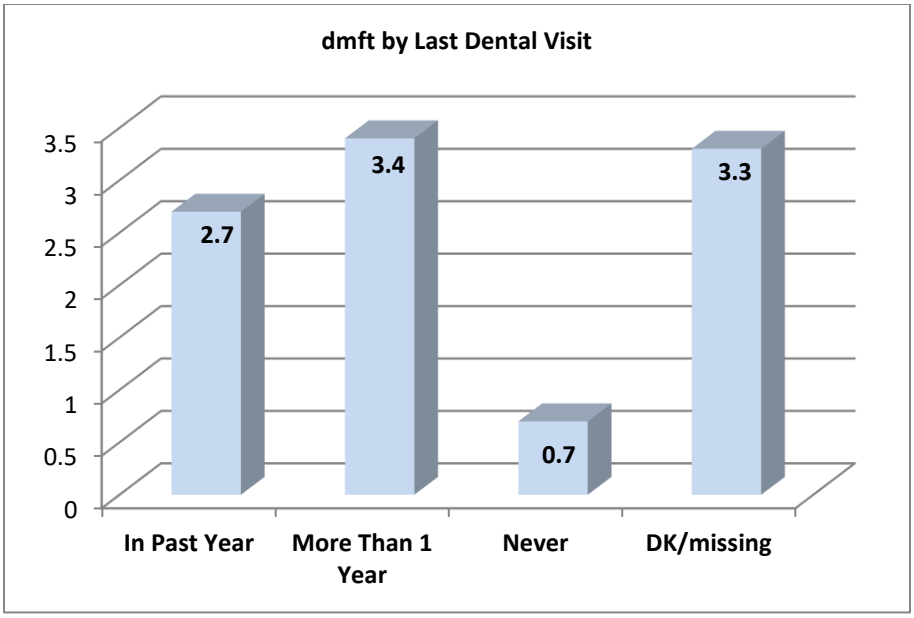
Rural Nevada Head Start children with private dental insurance have the lowest average dmft score, while those with no insurance have the highest average dmft. See Figure 29.

Figure 29: Average dmft of Children in Rural Nevada Head Start Programs – by Dental Insurance



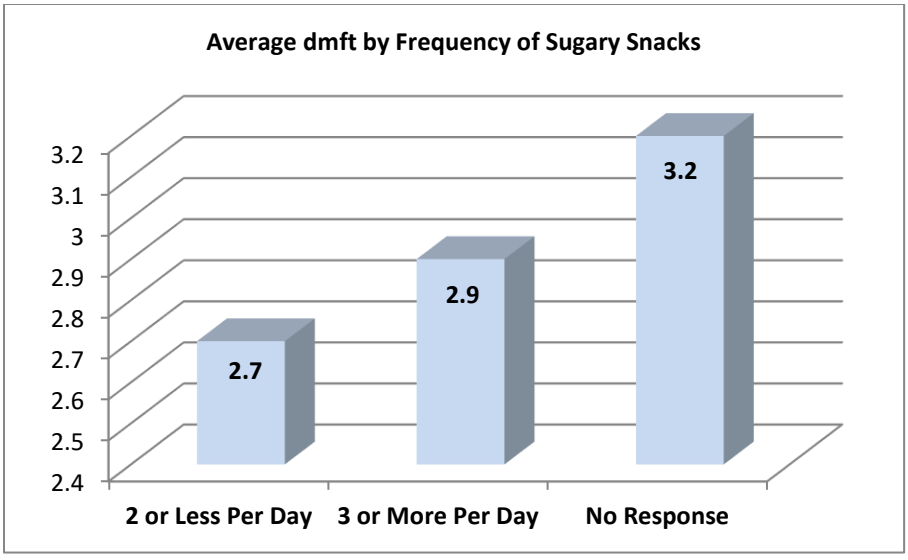
The lowest average dmft was seen in children who have never been to the dentist, followed by children with a dental visit in the past year (Figure 30). The lower dmft in children who haven't seen a dentist may again reflect parents having accurately perceived no dental issues in their children and based on this, not taking their children for a dental visit.

Figure 30: Average dmft of Rural Nevada Head Start Children – by Last Dental Visit



Like caries experience, children with a lower frequency of sugary snacks had a lower average dmft. See Figure 31.

Figure 31: Average dmft of Rural Nevada Head Start Children – by Frequency of Sugary Snacks



Appendices

- **Letter to Head Start Administrator**
- **Letter to Head Start Site Coordinator**
- **Scheduling Sheet**
- **Survey Letter to Parents**
- **Brochure on Fluoride Varnish - English**
- **Brochure on Fluoride Varnish - Spanish**
- **Consent Form and Questionnaire**
- **Survey Screening Form**
- **Oral Health Indicator Summary Form for Screeners**
- **Take-Home Findings Letter to Parents**
- **Nevada Dental Services Directory**

STATE OF NEVADA

BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS

CODY L. PHINNEY, MPH
Administrator, DPBH

JOHN DIMURO, DO MBA
Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

January 25, 2017

Dear Head Start Administrator,

The Nevada Division of Public and Behavioral Health (DPBH) has partnered with the Department of Education's Office of Early Learning and Development, Head Start State Collaboration Office to assess children's oral health at Head Start Centers across the state. Our goal is to increase the number of young children with dental "homes", and to decrease the number of children with untreated tooth decay. This information will help determine the extent of children's dental needs and where to allocate resources. But it all starts with dental screenings of this population.

DPBH is offering a dental screening to all Head Start children with signed parental consent. This year, parents can also consent to a fluoride varnish application for their child. We will conduct the services from January – June 2017. All services are completely free.

Past surveys completed by Head Start site personnel have shown that these dental screenings are well received! In 2007, 95% said that the screening was important for measuring children's oral health and 91% said that the screening was valuable to their programs. Ninety-one percent said that the screening was well organized. Other previously written-in comments:

- "The screening enabled us to convince parents how important oral health is. Many parents took their children to the dentist after the survey."
- "It helps to identify children who are in need of dental treatment who may not have access or have not visited a dentist to receive routine care."
- "Good feedback from staff about identifying children with emergency needs which might have gone unmet without the screening team visit."
- "We had two different teams come out to our center and they were very child friendly, courteous and professional".

We will call each site to schedule the screening at a time that's convenient, and mail the forms in advance for distribution (please see enclosed samples, which will also be available in Spanish). The screening and application of fluoride varnish will be conducted by a licensed dental professional. The process should take about two minutes per child. Following the screening, children will receive a toothbrush, toothpaste, floss, written take-home findings for the parents, and contact information for clinics where treatment can be rendered for issues identified during the screening.

While the name of a child may be shared with the Head Start center coordinator for follow-up, no individual child will be identified in any reports. Only aggregated results will be reported (e.g., from centers or counties). The information will be used to inform policy makers and others on what is needed to improve oral health for young children. Participating Head Start Centers and Administrators will be the first to receive these reports.

Your center's participation is very important even if the children regularly visit a dentist! Your site may be representative of a geographic section of Nevada that may not otherwise be characterized. Participating in the screening can help the children currently attending your center; the aggregated reports can help design programs to help young children in years to come.

We sincerely hope that you will accept this opportunity, and let your site staff know of your support. The Oral Health Program will contact you for your response within the week.

Thank you for your attention in this matter.

Respectfully,

Cody Phinney

Administrator, Public and Behavioral Health

Patti Oya

Director, Office of Early Learning and Development

STATE OF NEVADA

BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS

CODY L. PHINNEY, MPH
Administrator, DPBH

JOHN DIMURO, DO MBA
Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

Nevada Department of Education

February 15, 2017

Dear Head Start Site,

The Nevada Division of Public and Behavioral Health (DPBH) has partnered with the Department of Education's Office of Early Learning and Development, Head Start State Collaboration Office to assess children's oral health at Head Start Centers across the state. Our goal is to increase the number of young children with dental "homes", and to decrease the number of children with untreated tooth decay. This information will help determine the extent of children's dental needs, and where to allocate resources. But it all starts with dental screenings of this population. We have reached out to your parent grantee administration with a request to do this assessment at their Head Start Centers, and they have agreed. We are writing to explain the process.

DPBH is offering a dental screening to all Head Start children with signed parental consent. This year, parents can also consent to a fluoride varnish application for their child. We will conduct the services from January – June 2017. All services are completely free.

Past surveys completed by Head Start site personnel have shown that these dental screenings are well received! In 2007, 95% said that the screening was important for measuring children's oral health, and 91% said that the screening was valuable to their programs. Ninety-one percent said that the screening was well organized. Previously written-in comments include:

- "The screening enabled us to convince parents how important oral health is. Many parents took their children to the dentist after the survey."
- "It helps to identify children who are in need of dental treatment who may not have access or have not visited a dentist to receive routine care."
- "Good feedback from staff about identifying children with emergency needs which might have gone unmet without the screening team visit."
- "We had two different teams come out to our center and they were very child friendly, courteous and professional".

We will call you to schedule the screening at a time that's convenient for your site, and mail the consent forms in advance for distribution (please see enclosed samples, which will also be available in Spanish). The dental screening and application of fluoride varnish will be conducted by a licensed dental professional. The process should take about two minutes per child. Following the screening, children will receive a toothbrush, toothpaste, floss, written take-home findings for the parents, and contact information for clinics where treatment can be rendered for issues identified during the screening.

While the name of a child may be shared with your site for follow-up, no individual child will be identified in any reports. Only aggregated results will be reported (e.g., from centers or counties). The information will be used to inform policy makers and others about what is needed to improve oral health for young children. Participating Head Start Centers and Administrators will be the first to receive these reports.

Your center's participation is very important, even if the children regularly visit a dentist! Your site may be representative of a geographic section of Nevada that may not otherwise be characterized. Participating in the screening can help the children currently attending your center; the aggregated reports can help design programs to help young children in years to come.

We sincerely hope that you will accept this opportunity. The Oral Health Program will contact you within the week.

Thank you for your attention in this matter.

Respectfully,

Cody Phinney

Administrator, Public and Behavioral Health

Patti Oya

Director, Office of Early Learning and Development

Head Start Site Scheduling Sheet
Spring 2017

Name of Center
Physical Address of where children will be screened:

Special Driving Directions:

Primary Contact Name:
Phone #:
Email Address:

Secondary Contact Name:
Phone #:
Email Address:

Dates that School is not in session through the end of the school year:
(e.g., spring break, parent-teacher meetings, etc.)

Last Date of School:

Normal hours: M T W Th Fr

	AM	PM	Full Day	Extended Day	Totals
Hours					
Enrollment					
# of Eng/Span forms needed per class					

	Date
Confirmed program needs at site (3 chairs, table, waste basket; teacher, parent, or volunteer to distribute consents, walk children back to class, etc.)	
Scheduled visit	
Mailed Eng/Span parent letter/consent forms	
Follow-up call one week after sending consent forms	
Reconfirm three days before visit	
Screener confirmed	
Recorder confirmed	
Packed supplies	
Sent thank you, stats, and eval after visit	

VISIT SCHEDULED FOR (Date, time):

Comments:

March 15, 2017

Dear Parent;

The 2017 Nevada Head Start Oral Health Survey is about to take place! We will be screening children across Nevada to help us learn about children's oral health. A healthy mouth is an important part of total health, and helps a child to be ready to learn. Combined results of dental screenings at Head Starts will help us find out what community needs are so that we can plan dental programs for Nevada's children. For this reason, your participation is important! We hope that you will consent to having your child participate in the screening even if s/he already visits a dentist.

With your consent, a dentist or dental hygienist will look at your child's teeth using a small mouth mirror and a light. We will send a report home to you that describes any findings, along with a list of clinics in your area. Please note that this screening does not take the place of a complete dental exam.

With your consent, your child can also have a thin coating of fluoride varnish painted on the teeth with a tiny brush. Fluoride varnish helps prevent new cavities, and it can help stop some cavities that have just started (please read the enclosed brochure). On rare occasions, a child will have some swelling in the mouth after fluoride varnish is applied. Sometimes children with sensitive stomachs can have some nausea. If this occurs, the thin film of fluoride varnish can be removed immediately with a toothbrush and floss, and then by rinsing with and spitting out warm water.

The screening and the fluoride varnish take about two minutes, and they are completely free. These services are voluntary and your child can leave at any time. Every child who participates will receive a free toothbrush, floss, and toothpaste. All information will be kept confidential**,** and your child's name will NOT be used in any report.

If you want your child to participate in either or both of the services, then you must sign the attached Consent Form—we cannot see any child without consent signed by the parent. It would be helpful if you would return the form even if your child does not participate. Please return the form to your child's teacher as soon as possible, so that we can plan for our visit.

For questions please call the Nevada State Dental Health Officer, Dr. Antonina Capurro, at (702) 774-2573. Thank you for your attention in this important matter.
Respectfully,

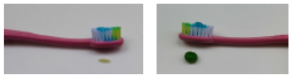
Cody Phinney
Administrator, Public and Behavioral Health

Patti Oya
Director, Office of Early Learning and Development

The 2017 Nevada Head Start Oral Health Survey is funded in part by an across-agency partnership with the
Nevada Department of Education's Office of Early Learning and Development, Head Start State Collaboration Office.

Oral Hygiene Tips

- Eat fruits and vegetables and drink plenty of water. Avoid sugar, soda pop, and juice. A healthy diet is important.
- Visit the dentist regularly starting when the first tooth erupts at about 6-12 months of age.
- Brush for two minutes twice a day with a fluoride toothpaste and floss regularly.
- Use a smear of toothpaste before age 3 and a pea size amount for older kids who can spit out the toothpaste.



Smear vs Pea size

- Remember, even baby teeth and gums are important. Never put baby to bed with a bottle and clean baby's mouth with a damp cloth after each feeding.

"You are not healthy without good oral health"
Dr. C. Everett Koop, Surgeon General of the United States, 1981-1989

Improving Dental Health in Nevada

Department of Health and Human Services

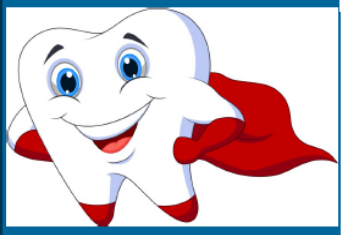
Division of Public and Behavioral Health

4150 Technology Way
Carson City, Nevada 89076

775-684-4285

http://dpbh.nv.gov/Programs/OH/OH-Home/

Fluoride Varnish

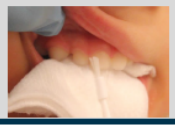


Your tooth's cavity fighter!

Saving Nevada Smiles One Tooth At A Time

How Is Fluoride Varnish Applied?

- A trained health professional will dry the teeth, mix the varnish, and paint a tiny amount on the teeth with a small disposable brush.
- The varnish application takes less than 2 minutes and may have a slightly tangy taste.
- The sticky temporary coating dries quickly and slowly releases fluoride to the tooth surface.
- Fluoride varnish is an easy way to brush on prevention and keep your teeth healthy.



Fluoride Varnish-Is It Safe?

Yes, fluoride varnish is safe. The sticky varnish dries quickly and creates a thin coating over the teeth.

Why Use Fluoride Varnish?

- Fluoride is a natural mineral found in water sources. Fluoride varnish contains 5% sodium fluoride
- Fluoride varnish helps strengthen the outer (enamel) layer of teeth and makes them more resistant to the bacteria that cause decay.
- Children as young as 12 months old can get cavities.
- Cavities in both baby and permanent teeth can cause real pain! Cavities can prevent children from eating, speaking, sleeping and learning.
- Fluoride varnish can help prevent cavities—some studies say up to 40%.

Fluoride Varnish Can Help Prevent Tooth Decay.

"Tooth decay is the single most common chronic childhood disease—5 times more common than asthma, 4 times more common than early childhood obesity, and 20 times more common than diabetes."
American Academy of Pediatric Dentistry

After The Varnish Is Applied:

- Water is safe to drink after application.
- Avoid chewy, crunchy, or hot foods. Instead, eat soft foods until the next day.
- Brush and floss your teeth the next morning. Sometimes the fluoride varnish looks yellow—this will all brush off.
- Do not take a fluoride supplement the day of application and 2 days after.

How Long Will It Last?

Fluoride varnish sticks to the teeth until it's brushed away the next day, but the benefits can last several months.

Fluoride varnish can be safely applied every 3 to 4 months

Consejos Para La Higiene Oral

- Coma frutas y vegetales y tome mucha agua. Evite el azúcar, refrescos, y jugos. Una dieta saludable es importante.
- Visite el dentista con regularidad empezando cuando el primer diente brote entre los 6-12 meses de edad.
- Cepille por dos minutos dos veces al día con pasta dental con fluoruro y use hilo dental regularmente.
- Unte un poco de pasta dental antes de los 3 años de edad y para niños mayores que puedan escupir la pasta, use una cantidad del tamaño de un chícharo.

Un poco vs Tamaño de chícharo

- Recuerde, aun los dientes de leche y las ansias son importantes. Nunca ponga su bebe a dormir con una

"No eres saludable sin una buena salud oral"
Dr. C. Everett Koop, Cirujano General de los Estados Unidos, 1981-1989

Mejorando la Salud Dental en Nevada

Departamento de Salud y Servicios Humanos

División de Comportamiento y Salud Publica

4150 Technology Way
Carson City, Nevada 89076

775-684-4285

http://dpbh.nv.gov/Programs/OH/OH-Home/

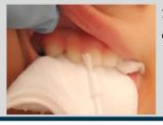
Barniz de Fluoruro

¡El Luchador Contra las Caries!

Salvando Las Sonrisas De Nevada Un Diente A La Vez

¿Como Se Aplica El Barniz de Fluoruro?

* Un profesional de salud capacitado secara los dientes, mezclara el barniz y pintara una pequeña cantidad en los dientes con un pequeño cepillo desechable.
* La aplicación de barniz toma menos de 2 minutos y puede tener un sabor un poco agrio.
* La capa temporal pegajosa se secara rápido y lentamente libera fluoruro en la superficie del diente.
* Barniz de fluoruro es una manera fácil de prevención y mantener sus dientes sanos.



Barniz de Fluoruro-¿Es Seguro?

Si, barniz de fluoruro es seguro. El barniz pegajoso se seca rápido y crea una capa fina sobre los dientes.

¿Porque Usar Barniz de Fluoruro?

- Fluoruro es un mineral natural encontrado en fuentes de agua. El barniz de fluoruro contiene 5% fluoruro de sodio.
- Barniz de fluoruro ayuda a fortalecer la capa externa (esmalte) de los dientes y los hace mas resistentes a las bacteria que causan caries.
- Los niños tan jóvenes como 12 meses de edad pueden tener caries.
- ¡Las caries en los dientes de leche y los dientes permanentes pueden causar dolores verdaderos! Las caries pueden causar que los niños no puedan comer, hablar, dormir o aprender.
- Barniz de fluoruro puede ayudar a prevenir caries—Unos estudios indican hasta el 40%.

El Barniz De Fluoruro Puede Ayudar A Prevenir Las Caries Dental.

"La caries dental es la enfermedad crónica mas común de la infancia- 5 veces mas frecuente que el asma, 4 veces mas frecuente que la obesidad infantil, y 20 veces mas común que la diabetes." La Academia Americana de Odontología Pediátrica

Después Que El barniz Sea Aplicado:

* El agua es segura para beber después de la aplicación.
* Evite las comidas pegajosas, crujientes o calientes. En lugar, coma comidas blandas hasta el día siguiente.
* Cepille y use hilo dental la mañana siguiente. A veces el barniz de fluoruro se ve amarillo– todo esto se cepillara.
* No tome suplementos de fluoruro el día de la aplicación y dos días después.

¿Cuanto Tiempo Durara?

Barniz de fluoruro se pega a los dientes hasta que se cepille el día siguiente, pero los beneficios pueden durar varios meses.

El barniz de fluoruro se puede aplicar con seguridad cada 3 a 4 meses.

For office use only:
Screening Date _____
Center Name _____
Record # _____

2017 Nevada Head Start Oral Health Survey
Consent Form

Please answer the following questions about your child. Complete a separate form for each child.

1. **Child's Name** (print) _____

2. **Child's Age** _____ **3. Name of Child's Dentist** _____ or ☐ None

4. **Gender** ☐ Male ☐ Female **5. Zip code that the child lives in** _____ **6. County** _____

7. **Note: You must answer yes or no to *all* of the questions for #7 if you want your child to have a fluoride varnish application.**
   Does your child have any of the following: (Circle **"Y"** for yes and **"N"** for no for each question)
   - **Y N Asthma**
   - **Y N Allergy to pine nuts or colophony**
   - **Y N Any other allergies** (list) _____
   - **Y N Any medical condition** (list) _____
   - **Y N Taking any medication** (list) _____
   - **Y N Takes fluoride tablets or drops at home**
   - **Y N A fluoride varnish treatment within the last three months**

Parental Permission for Services

IMPORTANT NOTE: <u>You must mark "Yes", SIGN, and return this slip</u> if you want your child to be screened and/or to have fluoride varnish. No services can be provided without marking the boxes and signing your consent.

☐ **Yes, I give permission for my child to have a dental screening. I understand** that this screening does not replace a full dental exam, and that my child should still go to a dentist. **I understand** that the results of this screening may be shared with the Nevada Department of Health and Human Services, Head Start, and with dental providers for my child.

☐ **Yes, I give permission for my child to have a fluoride varnish application.**

☐ **No, I do not want my child to have either of the services mentioned above.**

X _____

Signature of Parent/Legal Guardian **Date**

We are conducting a survey about the dental health and needs of Head Start Children across Nevada. The following information is important to help us understand access to dental care in your community. Would you help us? Please answer the following questions.

8. **About how long has it been since your child last visited a dentist?** Include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists. (Circle one)
   a) Within the last year
   b) More than 1 year, but not more than 3 years ago
   c) More than 3 years ago
   d) Never has been to a dentist
   e) Don't know/don't remember

9. **What was the main reason your child last visited a dentist?** (Circle one)
   a) Went in on own for routine check-up, examination or cleaning
   b) Was called in by the dentist for check-up, examination or cleaning
   c) Something was wrong, bothering or hurting
   d) Went for treatment of a condition that dentist discovered at earlier check-up or examination
   e) Other (Please specify) _____
   f) Don't know/don't remember

10. **Is the dentist who completed your child's last exam also providing follow-up care for your child?** (Circle one)
   a) No
   b) Yes
   c) Don't know/don't remember

11. **During the past 12 months, was there a time when your child needed dental care but could not get it at that time?** (Circle one)
   a) No
   b) Yes
   c) Don't know/don't remember

12. **The last time your child could not get the dental care he/she needed, what was the main reason he/she couldn't get care?** (Circle one)
   a) No insurance
   b) Not a serious enough problem
   c) Health of another family member
   d) Dentist hours are not convenient
   e) Speak a different language
   f) Didn't know where to go
   g) Difficulty in getting an appointment
   h) Wait is too long in clinic/office
   i) Don't like/trust believe in dentists
   j) Could not afford it
   k) No dentist available
   l) No way to get there
   m) Dentist did not take insurance/Medicaid
   n) Another dentist recommended not doing it
   o) Unable to take time off of work
   p) Did not want to spend the money
   q) Don't know
   r) Other reason: (Please specify) _____

13. **Do you have any kind of insurance that pays for some or all of your child's DENTAL CARE? (Note: NO insurance will be billed – these services are completely free).** (Check one)

   ☐ Private dental insurance (Delta Dental, BC/BS, etc.) ☐ Medicaid ☐ Other government dental insurance (TriCare, etc.) ☐ None ☐ Don't Know

14. **During the past six months, did your child have a toothache more than once when biting or chewing?** (Check one)
   ☐ No
   ☐ Yes

☐ Don't know/don't remember

15. How many times a day does your child have sugary snacks/drinks? (Check one)

☐ 2 or less ☐ 3 or more

16. Which of the following best describes your child? (Check all that apply)

☐ White ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Multiracial

☐ Asian ☐ Hispanic/Latino ☐ American Indian/Alaskan Native ☐ Other

Thank you for your participation!

Nevada 2017 Head Start Oral Health Survey
Screening Form/Treatment Record

Screening Date	_____
Center Name	_____
Record #	_____

3. Child's Name (print) _____

4. Child's Age _____

No services provided.	❑ Absent	
HH Reviewed.	❑ Yes	❑ No
Consent signed.	❑ Yes	❑ No

Basic Screening Survey – Screening Data Collection			
Non-cavitated white spots	**Untreated Decay**	**Treated Decay**	**Treatment Urgency**
❑ Yes	❑ Yes # Teeth _____	❑ Yes # Teeth _____	❑ Urgent ❑ Early ❑ None
❑ No	❑ No	❑ No	Comment:

Screening Completed:	❑ Yes	❑ No	**If No:** ❑ Consent for FLV only Other reason: _____ ❑ Child uncooperative
FLV Applied:	❑ Yes	❑ No	**If No:** ❑ Consent for screening only ❑ Related allergies ❑ Child uncooperative ❑ HS has other FLV prgm ❑ Intra-oral inflammation ❑ Ulcerative gingivitis Other:
Finding Sheet Marked:	❑ Urgent ❑ Early ❑ None ❑ Fluoride varnish applied. ❑ Fluoride varnish not applied.		
Comments on Findings Sheet:			

Provider Signature **X**_____ _____ _____
Provider Number Date

Recorder Signature **X**_____ _____
Recorder Number

How to Record Conditions for the Basic Screening Survey – Head Start
April 2017
Judy A. White

	Yes	No
Non-cavitated white spots • Baby teeth • Permanent teeth	• Decalcification without a break in the enamel	• Stained pits & fissures • Shadowing beneath the enamel without a break in the enamel • Decalcification *with* a break in the enamel
Untreated Decay • Baby teeth • Permanent teeth	• Can readily observe enamel breakdown in pits & fissures or smooth surfaces • Untreated decay on a primary tooth about to be lost • Decalcification *with* a break in the enamel • Fillings (whole or broken) or crowns with recurrent decay • Broken teeth with decay • Retained roots • Arrested decay (hard, black surface) with a break in the enamel	• Stained pits & fissures • Shadowing beneath the enamel without a break in the enamel • Broken fillings without decay • Broken teeth without decay • Non-cavitated white spots • Hypoplasia or enamel defect without decay
Treated Decay • Baby teeth • Permanent teeth	• Teeth that have been extracted because of decay • Permanent or temporary crowns; amalgams, composites, resins • Temporary fillings • Broken fillings without decay	• Teeth that have been extracted because of orthodontics • Teeth that are lost due to injury • Crowns or fillings placed as a result of injury • Dental sealants

2017 Nevada Head Start Oral Health Survey
Take-Home Findings

Child's Name _____ **School Name** _____ **Date** _____

Dear Parent/Guardian,

Today your child's entire mouth was checked by a licensed dental professional. We want you to know the following:

1. ☐ **This was only a screening.** It does not replace a complete dental exam. Your child should still have *regular* dental check-ups.

2. ☐ **Urgent! Your child has a tooth or teeth that appear to need immediate care**. Contact your family dentist right away to make an appointment for a complete evaluation.

3. ☐ **Early Care.** You child has one or more teeth that need to be evaluated by your family dentist. Your child needs to be scheduled now for a follow-up dental visit. Your dentist will determine whether treatment is needed.

4. ☐ **No obvious problems were seen.** Remember that this was not a complete exam with x-ray films, and does not take the place of one. Your child should visit a dentist regularly.

5. **If you marked "yes" on the Permission Slip for your child to have fluoride varnish:**

   ☐ **Fluoride varnish was applied. Remember:**

   *For best results, do not brush or floss your child's teeth until tomorrow morning.
   *Your child's teeth may look yellow, but the varnish will brush off.
   *Your child should avoid eating anything sticky, crunchy, chewy, or hot until tomorrow. Give your child a soft diet for the rest of the day.
   *Your child should not be given fluoride drops or tablets for two days. You may continue providing fluoride supplements two days from today.
   *If any difficulties are experienced, you can quickly and easily remove the fluoride varnish by using a toothbrush and floss. Your child should then rinse his/her mouth with warm water and spit.
   *If you have any questions or concerns, please call the Nevada State Dental Health Officer, Dr. Antonina Capurro, at (702) 774-2573.

   ☐ **Fluoride varnish was not applied. Comments:** _____

Remember...

- **Baby teeth are important! Some baby teeth stay in the mouth until a child is about 12 years old. They help with chewing and speaking, and they help guide the permanent teeth into place. Have your child see a dentist regularly.**
  Cavities will not go away on their own, and they are less costly to fix if they are caught early.

- **If your child has Medicaid, then they have dental benefits from birth to age 21. No referral is needed, regardless of the child's age. Transportation to and from the dental appointment may also be covered; call 1-844-879-7341.**

- **Be sure that your child brushes twice a day. Children should be assisted with brushing up to age eight so that *all* of the teeth are cleaned. Floss should be used every day between teeth that touch.**

Dental Services -- Nevada											
	County/ Area Served	Location	Provider/Clinic	Type of Program	Population Served	Services Offered	Discounted/Reduced Fees/Sliding Fee Scale	Medicaid A-Adult, C-Child	Clinic/Service address	Contact Number	Notes
Clinics	Carson	Carson City	Partnership Carson City Dental Referral Program--PILOT PROGRAM ENDING SEPT 30, 2017	Provides Referrals	Children	Cleaning, sealants, restorative, extractions	No Charge	No	1711 N Roop St. Carson City, NV 89706	(775) 841-4730	Children w/o insurance, including not eligible for Medicaid or Nevada Check-up, but who qualify for FRL.
	Churchill	Fallon	Fallon Tribal Health Center	Tribal	Children/Adults	Full Service	Yes- Tribal Members Only	A/C	1001 Rio Vista Dr. Fallon, NV 89406	(775) 423-3634	Tribal members only.
	Clark	Las Vegas	College of Southern Nevada Dental Hygiene Prgm. (Charleston Campus)	RDH School	Children/Adults	Preventive	Yes	A/C	6375 W Charleston Blvd. Las Vegas, NV 89146	(702) 651-4660	
	Clark	Las Vegas	Dental Care International	Clinic	Age 20 and under	Full Service; ortho available	Yes	C	1750 Wheeler Peak Dr. Las Vegas, NV 89106	(702) 272-1100	
	Clark	Las Vegas	Huntridge (Medical is First Person Care Clinic)	FQHC	Adults/Children	Full Service	Sliding fee, payment plans	A/C	2100 S Maryland Pkwy, Ste 5 Las Vegas, NV 89104	(702) 575-0866	
	Clark	Las Vegas	Nevada Health Centers-- Eastern Family Health Center	FQHC	Children/Adults	Full Service	Yes	A/C	2212 S Eastern Ave. Las Vegas, NV 89104	(702) 597-3898	
	Clark	Las Vegas	Foundation for Positively Kids-- Child Haven		Children		Yes	C	701 N Pecos Road at Bonanza Las Vegas, NV 89101	(702) 262-0037	
	Clark	Las Vegas	UNLV School of Dental Medicine	Dental School	Children/Adults/ Special HC Needs	Full Service	Yes	A/C	1700 W Charleston Blvd. Las Vegas, NV 89102	(702) 774-2400	Medicaid only covers emergency services for adults.
	Clark	Las Vegas	UNLV School of Dental Medicine General Practice Residency Program	Dental School	Special HC Needs	Full Service	Yes	A/C	1700 W Charleston Blvd. Ste 290 Las Vegas, NV 89102	(702) 671-5134	Medicaid only covers emergency services for adults.
	Clark	Las Vegas	UNLV School of Dental Medicine Ortho Dental Residency Program	Dental School	Children/Adults	Orthodontics	Yes	C	1700 W Charleston Bovd. Las Vegas, NV 89102	(702) 744-2690	
	Clark	Las Vegas	UNLV School of Dental Medicine Pediatric Dental Residency Program	Dental School	Children/ Special HC Needs	Full Service	Yes	C	1700 W Charleston Blvd. Las Vegas, NV 89102	(702) 774-2415	
	Clark	Las Vegas	UNLV School of Dental Medicine Specialty Saturday Clinics/Women's Clinic	Dental School	Women's Clinic	Full Service	No Charge	No	1700 W Charleston Blvd. Las Vegas, NV 89102	(702) 774-2461	For women from local shelters.
	Clark	Las Vegas	UNLV School of Dental Medicine Specialty Saturday Clinics Sgt. Clint Ferrin Memorial Clinic	Dental School	Veterans-- Qualifications Apply	Full Service	No Charge	No	1700 W Charleston Blvd. Las Vegas, NV 89102	(702) 774-2461	One Sat/month; varies. Income <$25,000/yr, no dental insurance, be eligible as a dental treatment training case.
	Clark	Las Vegas	UNLV --Specialty Saturday Clinics Uninsured Children	Dental School	Children	Full Service	No Charge	No	1700 W Charleston Blvd. Las Vegas, NV 89102	(702) 774-2461	
	Clark	Las Vegas	UNLV School of Dental Medicine/Huntridge/First Person	Dental School	Children	Full Service	Yes	C	2100 S Maryland Pkwy. Las Vegas, NV 89104	(702) 732-8776	
	Clark	Las Vegas	Volunteers in Medicine	Clinic	Ages 12-32	Cleaning, fillings, prosthodontics	Free Clinic--must meet income requirements	No	1240 N Martin Luther King Blvd. Las Vegas, NV, 89106	(702) 967-0530	
	Douglas	Gardnerville	Washoe Tribal Dental Center	Tribal	Children/Adults	Full Service	10% disc for no ins	A/C	1559 Watasheamu Rd. Gardnerville, NV 89460	(775) 265-4215	Non-tribal members may be seen here, but as of Jan 2017 they are not accepting new non-tribal pts.
	Elko	Elko	Nevada Health Centers Elko Family Health Center	FQHC	Children/Adults	Full Service	Yes	A/C	762 14th St Elko, NV 89801	(775) 738-1553	
	Elko	Owyhee	Owyhee Commuity Health Facility	Tribal-routine care; emergency-	Children/Adults	Full Service	Yes	A/C	NV-225, PO Box 130 Owyhee, NV 89832	(775) 757-2403 ext. 4226	
	Elko	Elko	Southern Bands Dental Clinic	Tribal	Children/Adults	Full Service	No	A/C	515 Shoshone Cir. Elko, NV 89801	(775) 738-2252	Must be a tribal member to utilize dental clinic.
	Lyon	Yerington	Healthy Smiles Family Dentistry	Office	Children/Adults	Full Service	Yes	A/C	513 Bridge St. Yerington, NV 89447	(775) 463-1800	If child is on Medicaid, parent in same household qualifies for 50% discount; seniors may receive discount w/SSI letters to show amt of fixed income.
	Mineral	Schurz	Walker River Tribal Health Center	Tribal	Children/Adults	Full Service	No Charge	A/C	1025 Hospital Rd. Schurz, NV 89427	(775) 773-2005	Tribal members only. Must pay crown/denture lab fees; dentures at no cost if enrolled in tribal diabetes program.
	Northern NV	Reno	Adopt a Vet	Veterans	Adults	Full Services	Commitment Fee (may be reduced depending on need)	No	Truckee Meadows Community College 7000 Dandini Boulevard, RDMT 415-A Reno, Nevada 89512	(775) 470-8707	
	Northern NV	Reno	VA Dental Clinic	Clinic	Veterans	Full Service	No charge for eligible veterans			(775) 326-2995	
	Washoe	Reno	Reno Sparks Indian Colony	Tribal	Children/Adults	Full Service	Yes		1715 Kuenzli St. Reno, NV 89502	(775) 329-5162	Tribal Members Only.
	Washoe	Reno	Truckee Meadows Community College Dental Hygiene Program	RDH School	Children/Adults	Preventive	Yes	No	7000 Dandini Boulevard, RDMT 415-A Reno, Nevada 89512	(775) 673-8293	