Oral Health

in West Virginia Head Start & Early Head Start Children

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Oral Health in West Virginia's Head Start and Early Head Start Children

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Editorial Review Board: West Virginia Academy of General Dentistry, WV Academy of Pediatric Dentistry, West Virginia Head Start Association

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The course is approved by the WV Office of Maternal, Child and Family Health for Nurses and Social Workers; Nursing Code WV 1999-0297 for 2.4 CEU, and social workers registration 490089 approved for 2 credit hours. The WVAGD/PACE has approved this course for two 2 hours for dental professionals.

Educational Objectives

Upon completion of this course, the clinician/provider will be able to:

1. Understand the West Virginia Head Start Program and its commitment to the promotion of oral health;
2. Describe the pathophysiology and risk factors of early childhood caries;
3. Promote the Dental Home concept within their respective profession;
4. Articulate proper anticipatory guidance messages to parents/caregivers of Head Start Children.

Abstract

Improving children's oral health is one of the most challenging and often neglected aspects of preventive health care. This course discusses the role of both the dental and non-dental professional in delivering oral health care education to Head Start parents and caregivers. It also explores the delivery of preventive care by dentists and dental hygienists in order to meet the oral health needs of young children enrolled within the West Virginia Head Start Program. Particular attention will be given to the new national dental home initiative between the Office of Head Start and the American Academy of Pediatric Dentistry.

Glossary of Terms

Pathophysiology-the functional changes that accompany a particular syndrome or disease.

Head Start Performance Standards-the mandatory regulations that grantees and delegate agencies must implement in order to operate a Head Start program. The standards define the objectives and features of a quality Head Start program in concrete terms; they articulate a vision of service delivery to young children and families; and they provide a regulatory structure for the monitoring and enforcement of quality standards.

Dental Home-an accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective source of oral health care.

Dental Caries-an infectious disease process leading to tooth decay.

Early Childhood Caries-the presence of one or more decayed teeth, missing teeth (resulting from caries), or filled tooth surfaces in a child up to age 6.

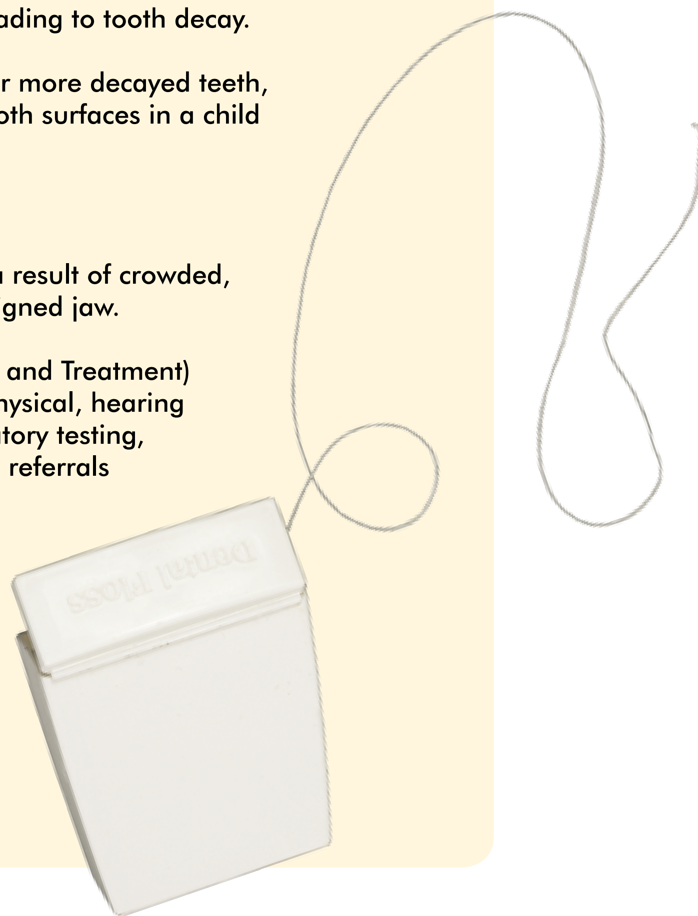
Etiology-the cause or origin of disease.

Malocclusion-teeth that fit together poorly as a result of crowded, missing or crooked teeth, extra teeth or a misaligned jaw.

EPSDT (Early and Periodic Screening, Diagnosis and Treatment) - program which provides dental screenings, physical, hearing and vision examinations, immunizations, laboratory testing, developmental assessment, medical history and referrals for further diagnostic and treatment services.

Anticipatory Guidance-health care professionals providing appropriate health care messages to parents/caregivers.

CAT-the Caries Assessment Tool can be used to help the health professional classify dental caries risk at a given point in time.



Introduction

The Centers for Disease Control and Prevention reports that dental caries is perhaps the most prevalent of infectious diseases in our nation's children. Dental caries is five times more common than asthma and seven times more common than hay fever in children.[1] More than 40% of children have tooth decay by the time they reach kindergarten.[2] Infants who are of low socioeconomic status, whose mothers have a low education level, and who consume sugary foods are 32 times more likely to have caries at the age of three years than children in whom those risk factors are not present.[3] Decay of primary teeth can affect children's growth, lead to malocclusion, and result in significant pain and potentially life-threatening swelling.

According to the Children's Dental Health Project, a nationally recognized children's advocacy group, the oral health of children has significant and lasting impact on the productivity of our existing and future workforce and leaders. **For the first time in 40 years, tooth decay in young children is again on the rise.** Untreated dental disease is progressive and can be devastating to children's long-term health, educational achievement, and overall success. Without immediate action, the impact of dental decay among today's young children will be felt for years to come.

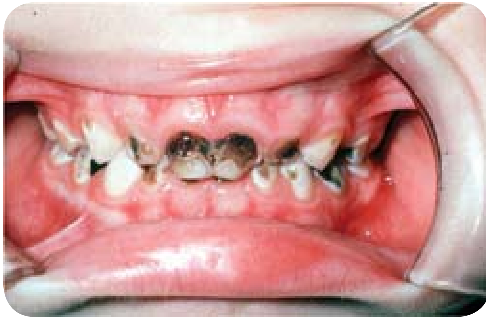
While this course specifically addresses children enrolled in West Virginia Head Start, the best practice guidelines are applicable to all children. According to the West Virginia Healthy Kids and Families Coalition, approximately 60 percent of West Virginia's children covered by either West Virginia Medicaid or WV CHIP (Children's Health Insurance Program) are at high risk for developing dental disease. With the expansion of the WV CHIP program eligibility guidelines this year in 2009, the WV CHIP population will be even greater.

Nurses and social workers have an important role in the promotion of oral health in West Virginia children. They can help to address proper nutrition and brushing in conjunction with meals as well as providing anticipatory guidance to parents and caregivers. Nurses and Social workers also play a key role in facilitating the placement of children into a dental home.

The Cost of Ignoring Children's Oral Health

- Cavities are the result of an infectious disease.
- Dental decay is the number one chronic condition of childhood.
- Nearly half of all children enter kindergarten with cavities.
- 3-4 million children nationwide suffer daily from dental pain and dysfunction.
- Dental disease is preventable.

Source: Children's Dental Health Project



Etiology, Complications & Risk Assessment of Early Childhood Caries

Oral infection and disease impact a child's ability to eat, the foods they choose, how they look, and the way they communicate.[4] These efforts are even more critical for a young child's emotional and social development.

Dental caries results from an overgrowth of specific organisms that are part of normally occurring human dental flora.[5] Streptococcus mutans and Lactobacillus species are considered to be principal indicator organisms of these acidogenic bacteria responsible for caries. Human dental flora is site specific, and an infant is not colonized with normal dental flora until the eruption of the primary dentition at approximately 6 to 30 months of age.[6,7] The vertical colonization of Streptococcus mutans from mother to infant is well documented.[8a,8b,9] In fact, genotypes of Streptococcusus mutans in infants appear identical to those present in mothers in approximately 71% of mother-infant pairs.[10] Furthermore, evidence suggests that specific organisms exhibit discrete windows of inoculation; the acquisition of Streptococcus mutans occurs at an average age of approximately two years.[11]

The significance of this information becomes focused when considering three points. First, high caries rates run in families and are passed from mother to child from generation to generation.[12] The children of mothers with high caries rates are at a higher risk of decay.[13] Second, approximately 70% of all dental caries are found in 20% of our nation's children.[14] Third, the modification of the mother's dental flora at the time of the infant's colonization can significantly impact the child's caries rate.[15–17]

The child health professional needs to consider all the information gathered from the history and physical examination to determine a child's risk. Many tools are available to support this assessment including the American Academy of Pediatric Dentistry Caries Risk Assessment Tool (CAT) found on the following page. The CAT is just one tool that can be used to help the child health professional classify dental caries risk at a given point in time. It should be applied periodically to assess changes in an individual's risk status.[18]

"Once I found out what vertical transmission truly meant, I could relay that information to parents in layman's terms that could be easily understood and applied. I share the CAT with Head Start staff, parents and caregivers because it is so beneficial to have those behaviors that could be harmful to the oral cavity identified so early.

I am always amazed at how involved the Head Start Staff is in the dental treatment of the children, and how the staff recognizes the importance of a dental home and routine preventive treatment, this makes future visits that might require restorative procedures much easier, if only every child could establish that relationship with the dental team that early." – Lisa Dyer, RDH, Private Practice Hygienist

American Academy of Pediatric Dentistry
Caries-risk Assessment Tool (CAT)

RISK FACTORS TO CONSIDER (For each item below, circle the most accurate response found to the right under "Risk Indicators")	RISK INDICATORS High	Moderate	Low
Part 1- History (determined by interviewing the parent/primary caregiver)			
Child has special health care needs, especially any that impact motor coordination or cooperation[A]	Yes		No
Child has condition that impairs saliva (dry mouth)[B]	Yes		No
Child's use of dental home (frequency of routine dental visits)	None	Irregular	Regular
Child has decay	Yes		No
Time lapsed since child's last cavity	<12 months	12 to 24 months	>24 months
Child wears braces or orthodontic/oral appliances[C]	Yes		No
Child's parent and/or sibling(s) have decay	Yes		No
Socioeconomic status of child's parent[D]	Low	Mid-level	High
Daily between-meal exposures to sugars/cavity-producing foods (includes on demand use of bottle/sippy cup containing liquid other than water; consumption of juice, carbonated beverages, or sports drinks; use of sweetened medications)[E]	>3	1 to 2	Mealtime only
Child's exposure to fluoride[F,G]	Does not use fluoridated toothpaste; drinking water is not fluoridated and is not taking fluoride supplements	Uses fluoridated toothpaste; usually does not drink fluoridated water and does not take fluoride supplements	Uses fluoridated toothpaste; drinks fluoridated water or takes fluoride supplements
Times per day that child's teeth/gums are brushed	<1	1	2-3
Part 2 - Clinical evaluation (determined by examining the child's mouth)			
Visible plaque (white, sticky buildup)	Present		Absent
Gingivitis (red, puffy gums)[H]	Present		Absent
Areas of enamel demineralization (chalky white-spots on teeth)	More than 1	1	None
Enamel defects, deep pits/fissures[I]	Present		Absent
Part 3- Supplemental professional assessment (Optional)[J]			
Radiographic enamel caries	Present		Absent
Levels of mutans streptococci or lactobacilli	High	Moderate	Low

Each child's overall assessed risk for developing decay is based on the highest level of risk indicator circled above (ie, a single risk indicator in any area of the "high risk" category classifies a child as being "high risk").

See Table Legend on page 23

Courtesy of American Academy of Pediatric Dentistry

Head Start

Head Start is a national program that promotes school readiness by enhancing the social and cognitive development of enrolled children birth through five years, and their families. This is achieved through the provision of educational, health, nutritional, social and other services. Early Head Start focuses on positive birth outcomes for pregnant women, and on healthy physical and cognitive development for infants and young children. Both Head Start and Early Head Start provide comprehensive education and health services in the context of family and community.[19] West Virginia Head Start serves approximately 7,500 children. There are a total of 22 programs throughout the state, including five designated Early Head Start programs.

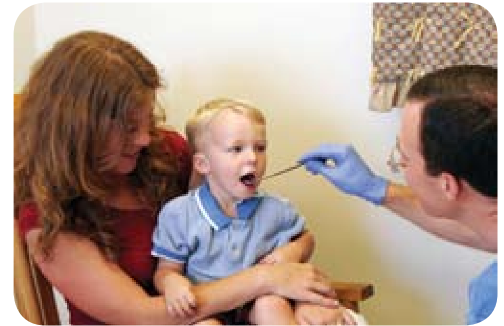
What is Head Start's Commitment to Oral Health?

Head Start health services are based on the premise that a child must be healthy to be ready to learn. Good oral health is essential to a child's overall growth and development, including the development of speech, language and behavior. Parent involvement is a key component of Head Start. Parents, as their children's primary caregivers, play the most important role in ensuring that their children's health and development needs are met. Head Start staff provides health-promotion messages to parents to help them understand the benefits of good oral health care and the importance of establishing a dental home early in life.

Federally mandated Head Start Performance Standards state that programs, in collaboration with parents, must determine each child's oral health status within 90 days of entry into the program. (See Head Start Performance Standards – Appendix A.)

Implementations of Head Start Performance Standards include:

- Determining whether or not the child has a dental home, (a continuous, accessible source of oral health care) and if the child does not, assisting parents in obtaining a source of care.
- Obtaining a determination from a dental professional as to whether or not the child is up to date on the EPSDT schedule of age-appropriate preventive and primary care and if the child is not up to date or scheduled, assisting parents in scheduling a dental appointment to fulfill this requirement.
- Obtaining or arranging for further diagnostic testing, examination, and treatment performed by a dentist for each child who has observable, known or suspected problems.
- Developing and implementing a follow-up plan for any identified problems.



"We had the pleasure of working with our local Head Start coordinator and their staff on the Colgate Dental Van. We performed dental exams for at least 120 children in the short time we had the Colgate Dental Van. The coordination between the program personnel, teachers and their staff was excellent. The exam experience for the children, for the most part, was pleasurable and educational. We have personally received many "Thank yous" from the Head Start centers that participated and had many of these children schedule dental treatment in our office. Had we not performed the exams, many of these kids would not have had any of their dental needs addressed."

David Najar, General Dentist
Princeton, WV

Despite these standards, children enrolled in Head Start often experience barriers to receiving dental care. One such identified recurrent barrier to care in West Virginia is transportation in relation to geography. It is important to note that Head Start Performance Standards require that the program provide the necessary transportation to the dental office.

As referenced earlier, 10% of each Head Start program's enrollment opportunities are reserved for children with disabilities and special health care needs. If you are interested in additional continuing education on the topic of children with special health care needs, please log onto http://www.mchoralhealth.org/SpecialCare/. This training is approved by the American Dental Hygiene Association for four hours of continuing education.

Why Are Head Start Children at Higher Risk for Oral Disease?

Head Start staff and parents report that the number one health issue among children enrolled in Head Start nationwide is access to oral health services.

While oral health is emphasized in Head Start Performance Standards, many children enrolled in Head Start continue to encounter other barriers to care in addition to transportation. For example, many general dentists do not feel comfortable providing services to infants and very young children, despite an agreement within the oral health community that children should have their first dental check by the time of their first birthday.

Aside from improvements in oral health status nationally, profound oral health disparities remain in certain population groups, including children enrolled in Head Start. These children, like other children from families with low incomes, experience more tooth decay and resultant pain and suffering than children from families with higher incomes.

"The Head Start Program in my area has really made great efforts in reinforcing good patient etiquette, and the importance of a dental home, the Head Start patients in our practice show-up for their appointments, and are respectful of the staff and office, and see the connection between a healthy mouth and a healthy body." Annette Gaskins, RDH, Private Practice Hurricane, WV

The American Academy of Pediatric Dentistry, American Dental Association, and Academy of General Dentistry all state that children should see the dentist by age one.

The Dental Home Initiative

The term "dental home" refers to an ongoing relationship between a dentist and patient, inclusive of all aspects of oral health care delivery, in a comprehensive, continuously accessible, coordinated and family-centered way. The American Academy of Pediatric Dentistry and other professional organizations involved in children's oral health recommend that a dental home be established by no later than 12 months of age and include referrals to dental specialists when appropriate.

The American Academy of Pediatric Dentistry (AAPD) is partnering with the Office of Head Start (OHS) to provide dental homes to young children who may otherwise go without care. The OHS has awarded a five-year, $10 million contract to AAPD to help establish dental homes for approximately one million children across America each year.

This program will recruit dentists to provide dental homes for Head Start children. This national network of pediatric and general dentists will be organized as an integrated system of regional consultants (one per Head Start Region), national consultants, state leaders and local champions. A Head Start Leadership Team will be established for each state. The team will be composed of dentists (State Leaders), Head Start staff and representatives from other child-serving organizations.

The Dental Home Initiative will allow for Head Start and Early Head Start children to access oral health care through the development of a national network of pediatric dentists and general dentists to:

- Provide quality dental homes for Head Start and Early Head Start children;
- Train teams of dentists and Head Start personnel in optimal oral health care practices; and
- Assist Head Start programs in obtaining comprehensive services to meet the full range of Head Start children's oral health needs.

The AAPD-OHS collaboration also will help provide parents, caregivers and Head Start staff with the latest evidence-based information on how they can help prevent tooth decay and establish a foundation for a lifetime of good oral health.

Head Start Oral Health Requirements

The OHS requires grantees to document efforts to ensure that enrolled children are linked with a dental home. Each child should be connected to a source of comprehensive, continuously accessible, coordinated and family-centered oral health care provided by a licensed dentist. Each

"The Head Start folks in my area of the state have been very willing to work with me in order to help facilitate timely dental care for their children. The Head Start program has acted as a go-between to line up needed care for many children whose parents don't know where to turn. All children deserve a dental home. With the Dental Home Initiative, and with the participation of both general and pediatric dentists, I feel Head Start is a great program to assist with all of our efforts to ensure access to care for all of our state's children. As a pediatric dentist, I know the importance of the early establishment of a dental home for the prevention of dental disease, anticipatory guidance, and reassurance for young parents."

Don Skaff, Pediatric Dentist
Charleston, WV

"My office has been working with the WV Head Start program for many years. The program has been of great value here in Braxton County. We find that many of the parents of these small children are totally unaware of any dental needs their child may have. The parents are very appreciative of the service that is being provided and eager to help their children maintain proper oral hygiene after they have been instructed. An added bonus we have in this county is that the Head Start social service representatives will personally bring the children to our office for treatment when their parents are otherwise unavailable to come for the appointments. It is certainly a valued program for the children of Braxton County."

Dr. Laura Marple, General Dentist
Sutton, WV

child should receive an initial exam and linkage to a dental home with 90 days of enrolling in Head Start as well as linkage to a definitive diagnosis, restorative and rehabilitative treatment. The dental home will also incorporate an individualized preventive dental health program based upon a caries-risk assessment as well as anticipatory guidance about growth and development issues (i.e. teething, digit or pacifier habits).

What Will it Mean to be Part of this Dental Network?

Becoming a part of the network offers the opportunity to make a difference in the life of children by alleviating their unnecessary discomfort inflicted by dental disease. You can help bring a healthy smile to each and every child, and work to ensure that no child has to live in pain.

Participation by oral health professionals may include:

- Providing a dental home for a defined number of Head Start children.
- Participating in regular communication with a partnering Head Start program to help them overcome family-related barriers to dental care.
- Participating in the Head Start program's Health Advisory Board.
- Providing on-site oral health information to Head Start staff, children and/or parents.
- Accessing materials and training provided by State Leaders and Regional Oral Health Consultants.

The State Leadership Advisory Team and the mentorship teams are vital to development of collaborative networks throughout the state. Local networks will consist of local dentists and Head Start personnel as well as other community leaders who work together to identify strategies to overcome any barriers to Head Start children's access to dental homes. [20]

To date, several West Virginia dental teams have had great success in partnering with the Head Start Program.

Anticipatory Guidance

Anticipatory guidance is defined as health care professionals providing appropriate health care messages to parents and caregivers. Proper dental care is a lifelong commitment and most importantly a learned behavior. Parents play a pivotal role in helping their children develop either healthy or harmful habits. Both dental and non-dental professionals should not assume that all parents know the value of primary (baby) teeth and permanent teeth. Many parents may not be aware of the effect their own oral health has on their baby's health. Even if parents/caregivers do not implement all of the identified strategies communicated through anticipatory guidance, it is important to begin the process of education.

The main goals of Anticipatory Guidance are:

- **Minimize risk of oral infection**
- **Optimize oral hygiene**
- **Reduce dietary sugars**
- **Educate parents on oral health development**
- **Injury prevention**
- **Administration of fluorides**

The importance of primary teeth is often missed and or dismissed. Primary teeth are critical for maintaining space. The loss of baby teeth due to caries is a common cause of malocclusion. Healthy teeth are needed for adequate nutrition, normal speech development and for the protection of an older child's self-esteem. Once caries have progressed to the point of cavitation, the disease is irreversible and cumulative. If baby teeth become severely involved, then restoration under general anesthesia is often necessary. [21]

Parents should be encouraged to model good oral hygiene by brushing at least twice a day, flossing daily, and making regular visits to the dentist. *Please see Appendix B for anticipatory guidance charts.*

Tips for Providers when Giving Anticipatory Guidance

- Use multiple learning methods including discussion, pamphlets, demonstrations, and active participation. For example, let the parent/caregiver practice brushing/flossing the child's teeth while you watch.
- Respect the parent/caregiver as an adult with knowledge, life experience, viewpoints and values.
- Ask both open and closed ended questions, such as "Have you started cleaning your child's teeth yet?"
- Listen to the parent/caregiver and ask for ideas about what he or she thinks might work on issues like weaning, daily brushing, and diet modification. Use culturally and linguistically appropriate methods of communication in working with patients of diverse ethnic, linguistic, cultural, and socio-economic backgrounds and abilities.
- Remain non-judgmental and friendly towards both the child and the parent/caregiver. They will be more likely to trust you and listen to your advice.
- Take small steps, suggesting 1-2 changes for the family's focus.
- Give positive reinforcement. Let the parent/caregiver know that you are on their side. Keep in mind that health behavior change is a process, not a single event. It usually takes many triggers over time to change health behavior. Try not to get discouraged, but consider each counseling visit as getting one step closer to change.

Summary

Childhood dental decay is present within all cultural and economic populations. Dental caries is an infectious disease usually passed from mother to child and from generation to generation. The establishment of a dental home early in childhood is critical to effectively combat this disease. It is the responsibility of both dental and the non-dental health care providers to deliver the appropriate oral health education and guidance to the parent or caregiver of a young child.

By participating in a national dental network of providers working with Head Start children and their families, a great deal can be done to protect and strengthen the oral health of children into their adulthood. Because children enrolled Head Start are at a higher risk for dental problems, this partnership effort to provide them with a dental home and to give anticipatory guidance to their parents and caregivers is critically important. Improved oral health outcomes are directly connected to improved educational, social, behavioral and developmental outcomes as well.

For more information about how you can become involved in this important initiative, please e-mail your request to WV Dental Home Project Consultant Dr. Richard Meckstroth at rmeckstroth@hsc.wvu.edu or phone 304-293-5912.

Here's to a cavity-free future for our West Virginia children!

"Head Start not only educates the children, on oral health and the importance of a dental home, but the parents and caregivers as well, I think this is one of the keys to their success, I applaud Head Start and the great efforts they have taken to advance good oral health."
— Mary Beth Shea, RDH, Wood County Health Department

Appendix A

Head Start Performance Standards 1304.20(a)(1)(i)

(a) Determining child health status

(1) In collaboration with the parents and as quickly as possible, but no later than 90 calendar days the grantee and delegate agencies must:

(i) Make a determination as to whether or not each child has an ongoing source of continuous, accessible health care (which includes dental health). If the child does not have a source of ongoing health care, grantee and delegate agencies must assist the parents in accessing a source of care.

1304.20(c) (3) (1) & (ii)

(3) Dental follow-up and treatment must include:

(i) Fluoride supplements and topical fluoride treatments as recommended by dental professionals in communities where a lack of adequate fluoride levels has been determined or for every child with moderate to severe tooth decay; and

(ii) other necessary preventative measures and further dental treatment as recommended by the dentist professional

1304.23 (b) (3)

(3) Staff must promote effective dental hygiene among children in conjunction with meals

**Failure to comply with the above performance standards may result in a non-compliant and or deficiency report. Such reports could result in Head Start programs losing their grant funding.*

Appendix B

PRENATAL

TAKE HOME MESSAGES FOR CAREGIVERS	• Baby teeth are important. • Parents'/caregivers' oral health affects baby's oral health. • Parents/caregivers should obtain regular dental check-up and get treatment if necessary. • Schedule child's first dental appointment by age one. • Use of fluorides, including tooth brushing with fluoride toothpaste, is the most effective way to prevent tooth decay.
ORAL HEALTH AND HYGIENE	• Encourage parents/caregivers to obtain dental check-up and, if necessary, treatment before birth of baby to reduce cavity-causing bacteria that can be passed to the baby. • Encourage parents/caregivers to brush teeth with fluoride toothpaste.
ORAL DEVELOPMENT	• Describe primary tooth eruption patterns (first tooth usually erupts between 6-10 months old). • Emphasize importance of baby teeth for chewing, speaking, jaw development and self-esteem.
FLUORIDE ADEQUACY	• Evaluate fluoride status in residential water supply. • Review topical and systemic sources of fluoride. • Encourage mother to drink fluoridated tap water.
ORAL HABITS	• Encourage mother to stop smoking.
DIET AND NUTRITION	• Emphasize eating a healthy diet and limiting number of exposures to sugar snacks and drinks. • Emphasize that it is the frequency of exposures, not the amount of sugar that affects susceptibility to caries. • Encourage breastfeeding. • Remind parents/caregivers never to put baby to bed with a bottle with anything other than water in it or to allow feeding 'at will.'
INJURY PREVENTION	• Encourage child-proofing of home including electrical cord safety and poison control. • Emphasize use of properly secured car seat. • Encourage caregivers to keep emergency numbers handy.

Heathy Kids, Healthy Teeth Program, Alameda County Department of Public Health

BIRTH - 1 YEAR OLD

TAKE HOME MESSAGES FOR CAREGIVERS	• Baby teeth are important. • Parents'/caregivers' oral health affects baby's oral health. • Parents/caregivers should obtain regular dental check-up and get treatment if necessary. • Parents/charegivers should avoid sharing with their child things that have been in their mouths. • Schedule child's first dental appointment by age one. • Prevention is less costly than treatment. • Use of fluorides, including tooth brushing with fluoride toothpaste, is the most effective way to prevent tooth decay.
ORAL HEALTH AND HYGIENE	• Encourage parents/caregivers to maintain good oral health and get treatment, if necessary, to reduce spread of bacteria that can cause tooth decay. • Encourage parents/caregivers to avoid sharing with their child things that have been in their mouths. • Encourage parents/caregivers to become familiar with the normal appearance of child's gums. • Emphasize using a washcloth or toothbrush to clean teeth and gums with eruption of the first tooth. • Encourage parents/caregivers to check front and back teeth for white, brown, or black spots (signs of cavities).
ORAL DEVELOPMENT	• Discuss primary tooth eruption patterns. • Emphasize importance of baby teeth for chewing, speaking, jaw development and self-esteem. • Discuss teething and ways to soothe sore gums, such as chewing on teething rings and washcloths.
FLUORIDE ADEQUACY	• Evaluate fluoride status in residential water supply. • Review topical and systemic sources of fluoride. • Encourage drinking fluoridated tap water. • Consider topical needs (e.g., toothpaste, fluoride varnish).
ORAL HABITS	• Encourage mother to stop smoking. • Advise mother that removing child from breast after feeding and wiping baby's gums/teeth with damp washcloth reduces the risk of ECC. • Review pacifier safety.
DIET AND NUTRITION	• Remind parents/caregivers never to put baby to bed with a bottle with anything other than water in it or to allow feeding 'at will.' • Emphasize that it is the <u>frequency</u> of exposures, not the <u>amount</u> of sugar that affects susceptibility to caries. • Encourage weaning from bottle to cup by one year of age. • Encourage diluting juices with water.
INJURY PREVENTION	• Review child-proofing of home including electrical cord safety and poison control. • Emphasize use of properly secured car seat. • Encourage caregivers to keep emergency numbers handy.

Heathy Kids, Healthy Teeth Program, Alameda County Department of Public Health

1 - 2 YEARS OLD

TAKE HOME MESSAGES FOR CAREGIVERS	• Baby teeth are important! • Parents'/caregivers' oral health affects baby's oral health. • Parents/caregivers should obtain regular dental check-up and get treatment if necessary. • Parents/charegivers should avoid sharing with their child things that have been in their mouths. • Schedule child's first dental appointment by age one. • Prevention is less costly than treatment. • Use of fluorides, including tooth brushing with fluoride toothpaste, is the most effective way to prevent tooth decay.
ORAL HEALTH AND HYGIENE	• Encourage parents/caregivers to maintain good oral health and get treatment, if necessary, to reduce spread of bacteria that can cause tooth decay. • Encourage parents/caregivers to avoid sharing with their child things that have been in their mouths. • Review parent's/caregiver's role in brushing toddler's teeth. • Discuss brush and toothpaste selection. • Problem solve on oral hygiene issues. • Schedule child's first dental visit by age one.
ORAL DEVELOPMENT	• Emphasize importance of baby teeth for chewing, speaking, jaw development and self-esteem. • Discuss teething and ways to soothe sore gums, such as teething rings, washcloths.
FLUORIDE ADEQUACY	• Re-evaluate fluoride status in residential water supply. • Review topical and systemic sources of fluoride. • Encourage drinking fluoridated tap water. • Review need for topical fluorides.
ORAL HABITS	• Remind mother that removing child from breast after feeding and wiping baby's gums/teeth with damp washcloth reduces the risk of ECC. • Begin weaning of non-nutritive sucking habits at two years old.
DIET AND NUTRITION	• Remind parents/caregivers never to put baby to bed with a bottle or allow feeding 'at will'. • Discuss healthy diet and oral health. • Emphasize that it is the frequency of exposures, not the amount of sugar, that affects susceptibility to caries. • Review snack choices and encourage healthy snacks.
INJURY PREVENTION	• Review child-proofing of home including electrical cord safety and poison control. • Emphasize use of car seat. • Emphasize use of helmet when child is riding tri/bicycle or in seat of adult bike. • Remind caregivers to keep emergency numbers handy.

Heathy Kids, Healthy Teeth Program, Alameda County Department of Public Health

3 - 5 YEARS OLD

TAKE HOME MESSAGES FOR CAREGIVERS	• Baby teeth are important! • Parents'/caregivers' oral health affects child's overall health. • Parents/caregivers should obtain regular dental check-up and get treatment if necessary. • Parents/caregivers should avoid sharing with their child things that have been in their mouths. • Prevention is less costly than treatment. • Use of fluorides, including tooth brushing with fluoride toothpaste, is the most effective way to prevent tooth decay.
ORAL HEALTH AND HYGIENE	• Encourage parents/caregivers to maintain good oral health and get treatment, if necessary, to reduce spread of bacteria that can cause tooth decay. • Encourage parents/caregivers to avoid sharing with their child things that have been in their mouths. • Discuss parents/caregivers continued responsibility to help children under age eight to brush their teeth. • Encourage parents/caregivers to consider dental sealants for primary and first permanent molars.
ORAL DEVELOPMENT	• Emphasize importance of baby teeth for chewing, speaking, jaw development and self-esteem.
FLUORIDE ADEQUACY	• Re-evaluate fluoride status in residential water supply. • Review sources of fluoride. • Review need for topical or other fluorides.
ORAL HABITS	• Discuss consequences of digit sucking and prolonged non-nutritive sucking (e.g. pacifier) and begin professional intervention if necessary.
DIET AND NUTRITION	• Review and encourage healthy diet. • Remind parents/caregivers about limiting the frequency of exposures to sugar. • Review snacking choices. • Emphasize that child should be completely weaned from bottle and drinking exclusively from a cup.
INJURY PREVENTION	• Review child-proofing of home including electrical cord safety and poison control. • Emphasize use of car seat. • Emphasize use of helmet when child is riding tri/bicycle or in seat of adult bike. • Remind caregivers to keep emergency numbers handy.

Sources for this guide include, NIOCR-CANDO-MAYAUS4 DE142501 and the OPENWIDE Curriculum developed by the Oral Health Unit of the Connecticut Department of Public Health.
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Heathy Kids, Healthy Teeth Program, Alameda County Department of Public Health

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21,22. Sources for this guide include, NIDCR –CANDO –MAYA –U54 DE142501 and The OPENWIDE Curriculum developed by the Oral Health Unit of the Connecticut Department of Public Health.

TEST/EVALUATION FORM

1. What is the most common chronic childhood disease in the United States?
    a. Asthma
    b. Tooth decay
    c. Obesity
    d. Diabetes mellitus

2. Which of the following is a not a potential outcome of oral health problems in young children?
    a. Impaired speech development
    b. Inability to concentrate
    c. Failure to thrive
    d. Impaired kidney function

3. When should the first oral health examination performed by a dentist take place?
    a. When the child is developmentally ready
    b. No later than 1 year of age
    c. No later than 3 years of age
    d. When the child is able to sit in the dental chair unaccompanied

4. What is anticipatory guidance?
    a. information for parents on how to file a tax return
    b. health care professionals providing appropriate health care messages
    c. parents telling the dentist how to prepare a tooth for a restoration

5. What is a dental home?
    a. a place in the home where toothbrushes and toothpaste are kept
    b. a home-based oral health program
    c. a record of a child's oral health
    d. an accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective source of oral health care

6. Low socio-economic status of a child's parent is a risk factor for Early Childhood Caries?
    a. True
    b. False

7. When should parents begin to clean their child's mouth
    a. at birth
    b. when an infant or child is able to sit still and cooperate
    c. when an infant or child is developmentally ready
    d. as soon as the first tooth erupts

8. The purpose of using CAT on a child is to
    a. classify their dental caries risk
    b. determine when they last had a cavity
    c. assess what type of topical fluoride they should have applied
    d. determine the dose of fluoride supplements

9. When a CAT is used it is done one time for the patient and is not to be repeated at a future date.
    a. True
    b. False

10. The CAT is not influenced by the oral health of a parent or sibling.
    a. True
    b. False

11. Which one of the following is a criteria of a high caries risk patient?
    a. no cavity in the last 24 months
    b. no dental home
    c. uses fluoridated toothpaste but does not regularly drink fluoridated water
    d. 1-2 exposures to sugar between meals daily

12. Head Start performance standards are a suggestion of how to operate a Head Start program?
    a. True
    b. False

13. All of the following have been identified barriers to care except:
    a. transportation
    b. dentists unwilling to take the medical card
    c. dentists feeling guilty to take the exsorbant amount of money Medicaid pays for dental services
    d. broken appointments

14. The primary purpose of Head Start is to:
    a. potty train the child to ensure they are school-ready
    b. teach children to eat with utensils
    c. to improve the school readiness of children ages 3 to 5 from families with low-incomes.

15. For the first time in 40 years, tooth decay in young children is on the rise.
    a. True
    b. False

16. The dental home initiative is designed to:
    a. Address the silent epidemic of children's tooth decay and help parents and caregivers secure quality dental homes for all Head Start children.
    b. Challenge Medicaid to raise fees
    c. Train nurses to perform dental exams

17. Dental disease is preventable.
    a. True
    b. False

18. EPSDT stands for
    a. Early Performance standards and diagnostic treatment
    b. Early, Periodic Screening Diagnostic Tool
    c. Evening Parental Supervision Dental Team

19. Childhood decay is never seen within affluent families.
   a. True
   b. False

20. Dental caries is an infectious disease usually passed from father to child and from generation to generation.
   a. True
   b. False

21. EPSDT provides which of the following;
   a. Physical
   b. Immunizations
   c. Referral for further diagnostic and treatment services
   d. All of the Above

22. Malocclusion teeth are teeth that fit together properly, and have a near perfect alignment.
   a. True
   b. False

23. Head Start serves only pregnant woman and children age four to five.
   a. True
   b. False

24. More than ___ children have tooth decay by the time they reach Kindergarten.
   a. 25%
   b. 40%
   c. 90%
   d. 55%

25. Good oral health is not essential for which of the following?
   a. Proper speech development
   b. Overall growth
   c. Proper nutrition
   d. Adequate eyesight

ANSWER SHEET

Mail completed answer sheet to: WVU School of Dentistry, Department of Dental Practice and Rural Health/Head Start, P.O.Box 9415 Morgantown, WV 26506

Name/Title ____

Street Address ____

City ______________________ State __________ Zip __________

License Number ______________________

Type: LPN ____ RN ____ Social Work ____ Dentist ____ Dental Hyg ____ CDA ____

Official Use Only		
Score P/F ________	**Date Received** ________	**Date Certified Mail** ________

Requirements for successful completion of the course and to obtain continuing education credits:
1) Read the entire course. 2) Complete information above. 3) Complete answer sheet in either pen or pencil. 4) Mark only one answer for each question. 5) A score of 80% on this test will earn you CE credits.

Please feel free to make copies of this answer sheet.

Fill in the appropriate blocks to indicate your answers. Remember, you must answer all of the questions to receive continuing education credit.

1. [ ] A [ ] B [ ] C [ ] D
2. [ ] A [ ] B [ ] C [ ] D
3. [ ] A [ ] B [ ] C [ ] D
4. [ ] A [ ] B [ ] C
5. [ ] A [ ] B [ ] C [ ] D
6. [ ] A [ ] B
7. [ ] A [ ] B [ ] C [ ] D
8. [ ] A [ ] B [ ] C [ ] D
9. [ ] A [ ] B
10. [ ] A [ ] B
11. [ ] A [ ] B [ ] C [ ] D
12. [ ] A [ ] B
13. [ ] A [ ] B [ ] C [ ] D
14. [ ] A [ ] B [ ] C
15. [ ] A [ ] B
16. [ ] A [ ] B [ ] C
17. [ ] A [ ] B
18. [ ] A [ ] B [ ] C
19. [ ] A [ ] B
20. [ ] A [ ] B
21. [ ] A [ ] B [ ] C [ ] D
22. [ ] A [ ] B
23. [ ] A [ ] B
24. [ ] A [ ] B [ ] C [ ] D
25. [ ] A [ ] B [ ] C [ ] D

If you are interested in finding out more information on your local West Virginia Head Start program check here:

______**Yes, please send me more information.**

Detach or Photocopy

Table Legend *(For Caries-Risk Assessment Tool found on page 6.)*

(For Caries-Risk Assessment Tool found on page 6.)

A Children with special health care needs are those who have a physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, health care intervention, and/or use of specialized services. The condition may be developmental or acquired and may cause limitations in performing daily self-maintenance activities or substantial limitations in a major life activity. Health care for special needs patients is beyond that considered routine and requires specialized knowledge, increased awareness and attention, and accommodation.

B Alteration in salivary flow can be the result of congenital or acquired conditions, surgery, radiation, medication, or age-related changes in salivary function. Any condition, treatment, or process known or reported to alter saliva flow should be considered an indication of risk unless proven otherwise.

C Orthodontic appliances include both fixed and removable appliances, space maintainers, and other devices that remain in the mouth continuously or for prolonged time intervals and which may trap food and plaque, prevent oral hygiene, compromise access of tooth surfaces to fluoride, or otherwise create an environment supporting caries initiation.

D National surveys have demonstrated that children in low-income and moderate-income households are more likely to have caries and more decayed or filled primary teeth than children from more affluent households. Also, within income levels, minority children are more likely to have caries. Thus, socioeconomic status should be viewed as an initial indicator of risk that may be offset by the absence of other risk indicators.

E Examples of sources of simple sugars include carbonated beverages, cookies, cake, candy, cereal, potato chips, french fries, corn chips, pretzels, breads, juices, and fruits. Clinicians using caries-risk assessment should investigate individual exposures to sugars known to be involved in caries initiation.

F Optimal systemic and topical fluoride exposure is based on use of a fluoride dentifrice and American Dental Association/American Academy of Pediatrics guidelines for exposure from fluoride drinking water and/or supplementation.

G Unsupervised use of toothpaste and at-home topical fluoride products are not recommended for children unable to expectorate predictably.

H Although microbial organisms responsible for gingivitis may be different than those primarily implicated in caries, the presence of gingivitis in an indicator of poor or infrequent oral hygiene practices and has been associated with caries progression.

I Tooth anatomy and hypoplastic defects (eg, poorly formed enamel, developmental pits) may predispose a child to develop caries.

J Advanced technologies such as radiographic assessment and microbiologic testing are not essential for using this caries risk assessment tool.

http://oralhealthwv.org/default.htm