

2011-2012  
**HEAD START ORAL HEALTH SURVEY**  
Nevada

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**Department of Health and Human Services  
Nevada State Health Division  
Oral Health Program**

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# Thanks to All Participating Head Starts

## Northern Nevada

Agnes Risley Head Start  
Bernice Mathews Head Start  
Cottonwood Head Start  
Desert Heights Head Start  
Dresslerville Head Start  
Echo Loder Head Start  
Elko Early Head Start  
Fallon Migrant Seasonal Head Start  
Fallon Northside Head Start  
ITCN Head Start Program Elko  
ITCN Head Start Program Fallon  
ITCN Head Start Program Yerington  
Head Start of Northeastern Nevada, Elko  
Head Start of Northeastern Nevada, Jackpot  
Little People's Head Start  
Lovelock Head Start  
McDermitt Head Start  
Owyhee Head Start  
Pyramid Lake-Nixon Head Start  
Pyramid Lake-Wadsworth Head Start Center  
Schurz Head Start  
Smithridge Head Start  
Stewart Head Start Washoe Tribe  
Sun Valley Head Start  
Sutro Head Start  
Winnemucca Migrant Seasonal Head Start  
Wooster Head Start  
Yerington Head Start

## Southern Nevada

Cecile Walnut Head Start  
Head Start Learning Center – Henderson  
Head Start Learning Center – Spring Valley  
Herb Kaufman Head Start  
Martin Luther King Head Start  
Moapa Indian Head Start  
Professional Development Center Head Start  
Reach Out Head Start  
Reynaldo Martinez Head Start  
Stewart Ave Head Start  
Sunflower Head Start  
Yvonne Atkinson Gates Head Start

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# INTRODUCTION

During the 2011-2012 academic year, the Oral Health Program conducted a survey of Head Start students in Nevada, the third of its kind. The primary purpose of the survey was to obtain population parameter estimates for four oral health indicators: untreated dental decay, treated dental decay, caries experience, and early childhood caries. As a secondary benefit, the screenings directly impacted the students by educating them about healthy oral hygiene habits and informing their parents or guardians of the need for dental care. For this survey cycle, Body Mass Index (BMI) was added to determine if there is a relationship between BMI and overall oral health.

The statewide measures generated from the survey were then used to determine Nevada's status relative to the national targets specified in *Healthy People 2020*, a set of health objectives for the nation to achieve over the second decade of the new century. The *Healthy People 2020* initiative lists 33 specific oral health objectives to prevent and control oral diseases and reduce oral health disparities. In addition to the estimates, 95% confidence intervals are given, which is a range of values that is used to describe the uncertainty around a point estimate.

The results on the following pages demonstrate that Nevada must make considerable progress before meeting any of the three oral health targets. Only through a combination of public health policy, improvements in access to dental services, and concerted oral health interventions can Nevada make strides toward achieving these important aims.

The first section of this report provides an overview of the key findings of the survey, the overall oral health outcome estimates for the state. The subsequent section examines these estimates more closely by various demographic characteristics and according to the affordability and accessibility of dental care. The third section focuses on BMI and its possible relationship, if any, with the oral health outcomes. Finally, the last two sections detail the surveying methods used to conduct the screenings.

<b>Total Number of Head Start Schools</b>	39 (Southern Nevada – 12, Northern Nevada – 27)
<b>Total Number of Enrolled Children</b>	2,777
<b>Total Number of Consent Forms Returned</b>	2,257
<b>Total Number of Head Start Schools Visited</b>	39

## DEFINITIONS

The 2009 revised Association of State and Territorial Dental Directors *BSS: An Approach to Monitoring Community Oral Health* provided the following definitions:

**Untreated Dental Decay** – A tooth is considered to have untreated decay when the screener can readily observe breakdown of the enamel surface; only cavitated lesions are considered to be untreated decay.

**Treated Decay** – determined by the presence of any type of filling, including a temporary filling or a tooth that is missing because it was extracted as a result of tooth decay.

**Caries Experience** – the presence of Untreated Dental Decay or Treated Dental Decay or both, which is one or more decayed (non-cavitated or cavitated lesions), missing (due to caries) or filled tooth surfaces in any tooth.

**Early Childhood Caries (ECC)** – an infectious and transmissible disease influenced by multiple factors and requiring a combination of approaches for improvement. The presence of one or more of their six maxillary anterior teeth decayed (non-cavitated or cavitated lesions), missing (due to caries) or filled tooth surfaces in any primary tooth in a child under the age of six.

## SURVEY METHOD

As with previous surveys, active consent was required of a student's parent or guardian before he or she could be screened. The consent form was combined with a questionnaire that gathered basic demographic information and asked questions concerning socioeconomic status and the accessibility, availability, and affordability of dental services. Only children of consenting parents or guardians were screened.

Individual surveys were conducted by visual oral health screening in accordance with the diagnostic criteria outlined in the Association of State and Territorial Dental Directors: *Basic Screening Surveys: An Approach to Monitoring Community Oral Health*. For each survey, the screener wore a fresh pair of gloves and used a disposable mouth mirror and a flashlight. Cotton swabs were also used as needed.

The screeners for the survey were either members of the Oral Health Program team or dental hygiene students from the Dental Hygiene Program at Truckee Meadows Community College. Team staff provided additional training to the students regarding the survey and calibrated them to the evaluation criteria to ensure consistent returns.

At each school, a list of students identified as in need of dental treatment was submitted to the school nurse for follow-up with the child's parent or guardian, and all students were educated about the importance of dental hygiene and taught healthy oral hygiene habits.

A total of 2,257 children responded to the survey. For each variable, the number of responses ranged from 1,858 (82%) to 2,257 (100%). This is most likely due to incomplete consent forms or participants indicating multiple responses to one question.

All analyses were conducted with SAS version 9.3 (SAS Institute Inc., Cary, NC). The SAS procedure SURVEYFREQ was used in the analysis to account for weighting and design effects of clustering.

## WEIGHTING METHODOLOGY

Weighting was done for each survey question, oral health outcome, and Body-Mass-Index-for-Age to account for non-response and improve the precision of estimates. Weights were calculated by dividing the total number of Head Start students enrolled by the number of Head Start students who responded in each Head Start location. The total number of students enrolled in all Head Start programs was 2,777, and 2,257 responded. During analysis, each Head Start location was considered a cluster, that is, a primary sampling unit (PSU). Each observation belongs to one PSU and if clustering is not specified, each observation is treated as a PSU.

## BMI-FOR-AGE CALCULATIONS

BMI-for-Age was calculated using a SAS program developed and published by the Centers for Disease Control and Prevention (CDC) in accordance with the CDC's 2000 growth chart percentiles for children two years of age and older. The program is available at:

<http://www.cdc.gov/nccdphp/dnpao/growthcharts/resources/sas.htm>

The following six variables were used by this program:

**AGEMOS: Student's age in months**

This variable was calculated from the screening and birth dates variables.

**SEX: Student's sex**

Sex was collected as 1=Male, 2=Female.

**HEIGHT: Student's height in centimeters**

Two height measurements were taken in centimeters using a stadiometer. These were averaged to obtain the final height in centimeters.

**RECUMBNT: Variable to indicate if height was taken while standing or recumbent**

This value was set to zero for all records since height was taken while the children were standing.

**WEIGHT: Student's weight in kilograms**

Two weight measurements were taken in kilograms. These were averaged to obtain the final weight in kilograms. Weight measurements for children with casts or leg braces were excluded from BMI-for-Age calculations.



**HEADCIR: Student’s head circumference in centimeters**

This value was set to missing for all records since it was not collected.

**BMI-for-Age categories**

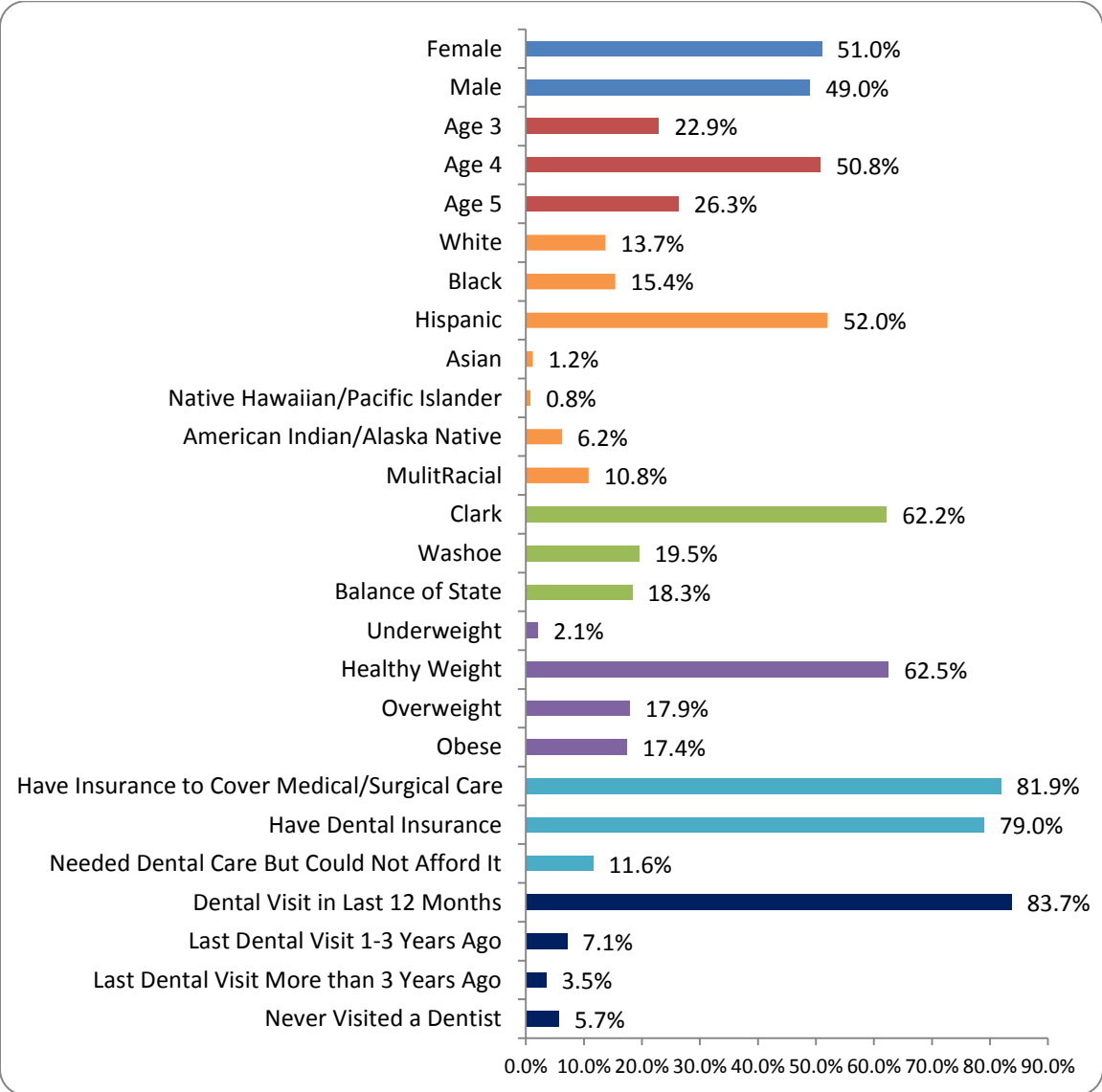
<b>Weight Status</b>	<b>Percentile Range</b>
Underweight	Less than the 5 <sup>th</sup> percentile
Healthy weight	5 <sup>th</sup> percentile to less than the 85 <sup>th</sup> percentile
Overweight	85 <sup>th</sup> to less than the 95 <sup>th</sup> percentile
Obese	Equal to or greater than the 95 <sup>th</sup> percentile

Calibration weights were used at the beginning of each screening day. Two height measurements were taken using a stadiometer. Students were asked to remove heavy clothing like jackets. Height and weight measurements were taken for students with braces or those who did not remove jackets to avoid discrimination. However, these weights were not used in the BMI-for-age calculations.

# NEVADA HEAD START DEMOGRAPHICS

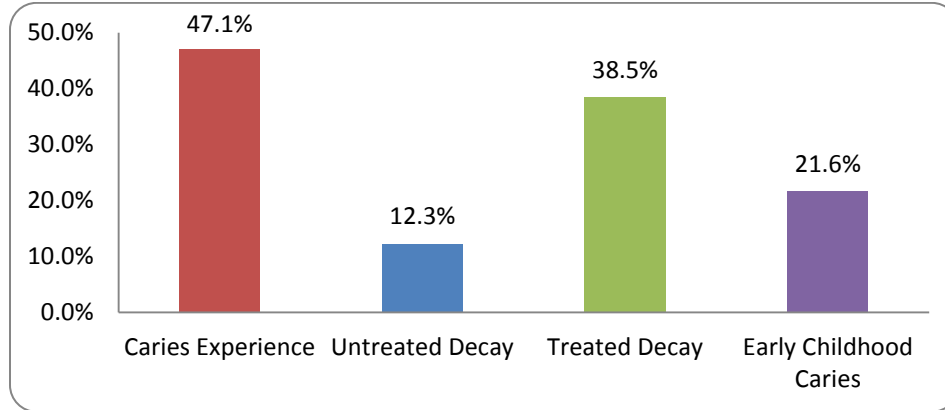
Of the Head Start students surveyed, 51% were female and 49% were male. Students surveyed were ages three (22.9%), four (50.8%), and five (26.3%). Over half of the students surveyed were Hispanic (52.0%) followed by Black (15.4%), White (13.7%), Multiracial (10.8%), American Indian/Alaska Native (6.2%), Asian (1.2%), and Native Hawaiian/Pacific Islander (0.8%). Of students surveyed, 62.2% resided in Clark County, 19.5% in Washoe County, and 18.3% in the rural and frontier territories. When considering Body Mass Index-for-Age, 2.1% of students surveyed were Underweight, 62.5% were Healthy Weight, 17.9% were Overweight, and 17.4% were Obese.

**Figure 1 – NEVADA STATEWIDE HEAD START DEMOGRAPHICS 2011-2012**



## KEY FINDINGS

Figure 2 – NEVADA STATEWIDE ORAL HEALTH OUTCOMES 2011-2012



In the 2011-2012 Head Start Basic Screening Survey for Nevada, the overall health outcomes for the four main oral health indicators were as follows:

**Caries Experience:** 47.1% of Head Start students

**Untreated Dental Decay:** 12.3% of Head Start students

**Treated Dental Decay:** 38.5% of Head Start students

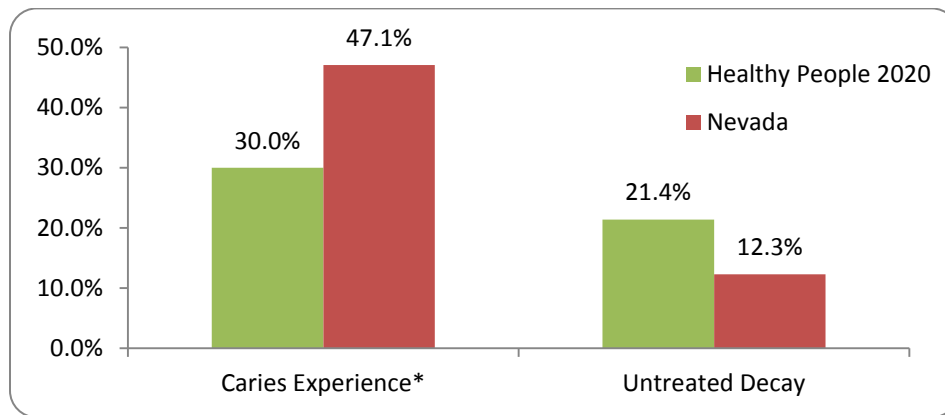
**Early Childhood Caries (ECC):** 21.6% of Head Start students

## HEALTHY PEOPLE 2020

In the third decade of Healthy People, there are two specific health objectives from the oral health module for which this survey generated comparative measures:

- **OH1.1:** “Reduce the proportion of young children aged three to five with dental caries experience in their primary teeth.” The target was set at 30%. *This target was not achieved.*
- **OH2.1:** “Reduce the proportion of young children aged three to five with untreated dental decay in their primary teeth.” The target was set at 21.4%. *This target was achieved.*

**Figure 3 – ORAL HEALTH OUTCOMES VERSUS HEALTH PEOPLE 2020 TARGETS**

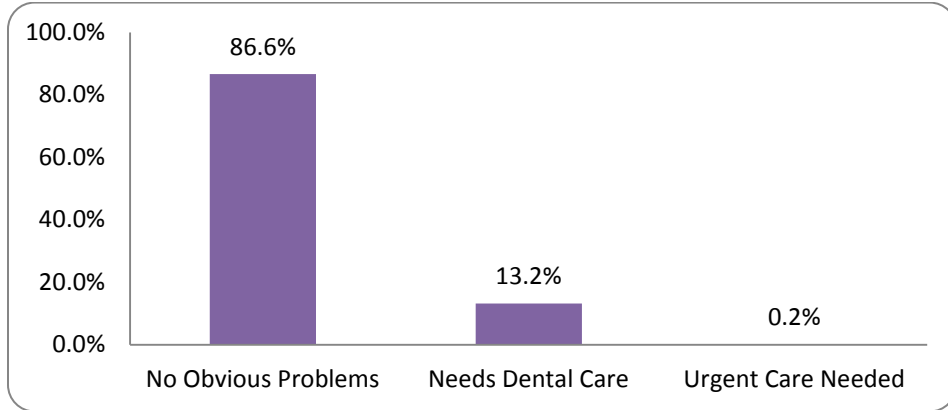


- To meet the HP2020 target, Nevada must reduce the prevalence of caries experience by 36.3% to drop from 47.1% to 30.0%, a difference of 17.1 percentage points.
- For Untreated Decay, Nevada exceeded the target by 74.0%, a difference of 9.1 percentage points.

## TREATMENT URGENCY

Depending on the combination of oral health outcomes observed at the time of screening, the need for dental care was also evaluated for each Head Start student. The survey indicates that while 86.6% of Head Start students in Nevada exhibited no obvious dental problem, 13.2% needed dental care, and 0.2% were in need of urgent dental care due to pain or infection (numbers are statistically significant).

**Figure 4 – TREATMENT URGENCY**

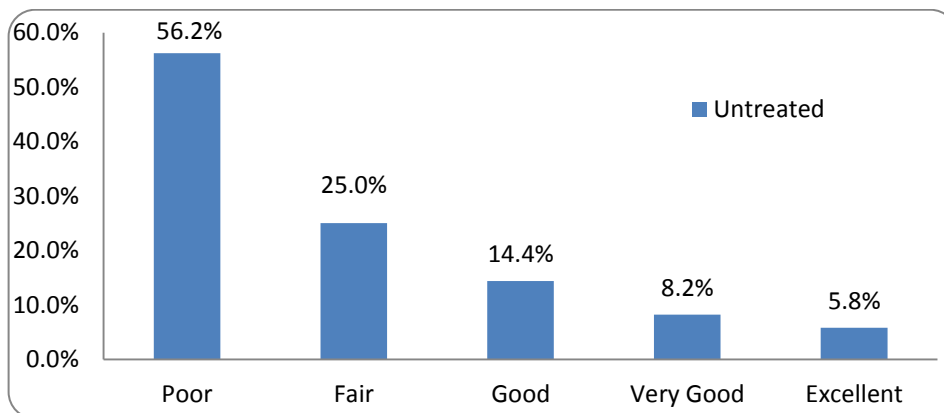


## AREAS OF INTEREST

### A CLOSER LOOK AT UNTREATED DENTAL DECAY

There were no statistically significant differences in the percentage of children with untreated dental decay by age or sex, nor was there enough evidence to conclude that there were significantly significant differences in the percentage of children with untreated decay throughout the state. Untreated dental decay was significantly higher in American Indian/Alaska Native (27.2%) groups when compared to Multiracial (13.6%), White (8.8%), Black (11.7%), and Hispanic (12.3%). There was not enough evidence in the survey to conclude any other relationships with respect to ethnicity and untreated dental decay.

**Figure 5 – UNTREATED DENTAL DECAY BY PARENT’S ORAL HEALTH PERCEPTION**



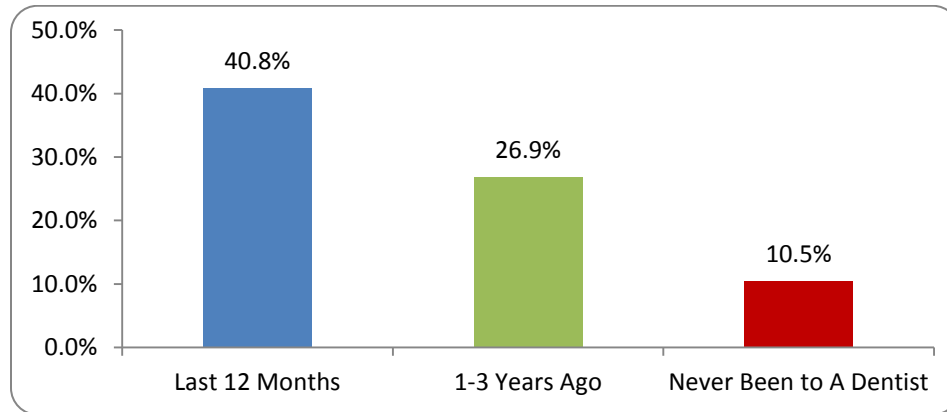
Parents of children with untreated decay were more likely to have a poor perception of their child’s oral health (See Figure 5.).

When untreated decay was examined by medical insurance coverage, a higher percentage of students with untreated decay also did not have medical insurance. The percentage of students who had untreated decay and no dental insurance (16.1%) was higher than students who had untreated decay and had dental insurance (11.4%). The percentage of students who had untreated decay and neither medical nor dental insurance (18.6%) was higher than students who had both insurances (11.2%) or had medical insurance but no dental insurance (6.1%), which was significantly significant. Finally, of the children who needed dental care but could not afford it, 23.6% had untreated dental decay and 10.6% did not present any untreated decay.

## A CLOSER LOOK AT TREATED DENTAL DECAY

There were no statistically significant differences in the percentage of children with treated dental decay by sex or geographical region. There were more 4-year-olds with treated decay (39.6%) than 3-year-olds (28.0%). However, there was only enough evidence to conclude that there was a higher rate of treated dental decay among Hispanics (43.6%) than Whites (30.1%) or Blacks (33.3%). No other conclusions could be made when comparing race/ethnicity groups.

**Figure 6 – TREATED DENTAL DECAY BY LAST DENTIST VISIT**



There was a relationship between the last time a child visited a dentist and experiencing treated dental decay. Figure 6 shows that a higher percentage of students had treated decay if they had seen a dentist in the last 12 months (40.8%) than those who had visited a dentist one to three years ago (26.9%) or who had never visited a dentist (10.5%).

**Figure 7 – TREATED DENTAL DECAY BY REASON FOR DENTIST VISIT**

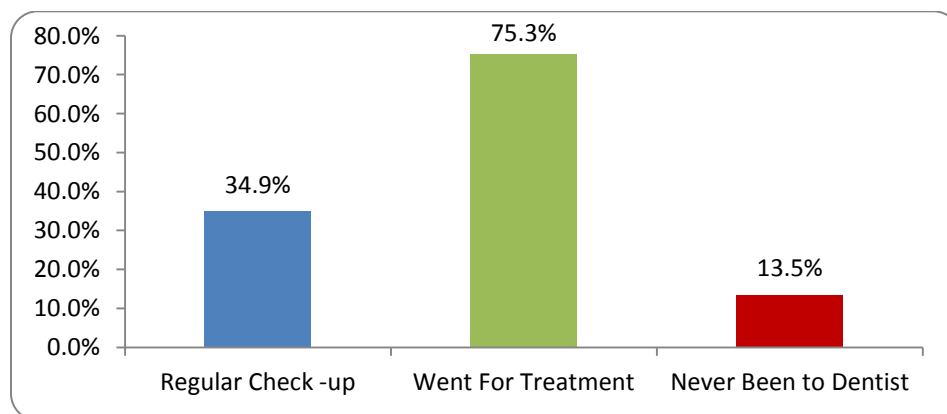
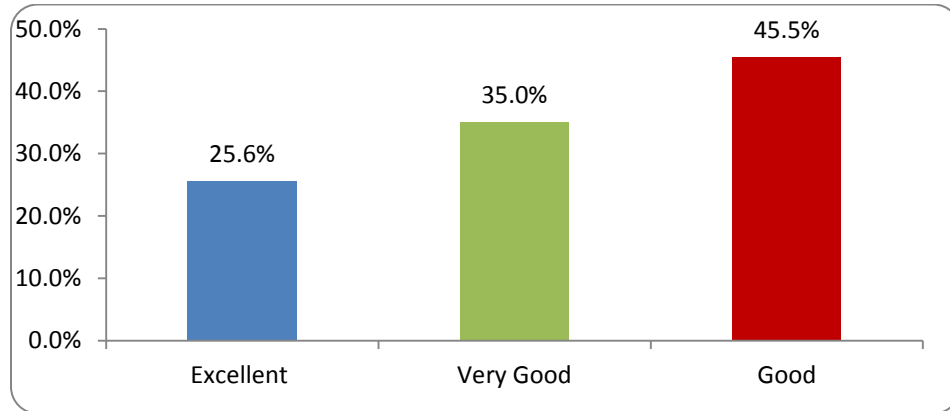


Figure 7 shows that treated dental decay was found to be significantly lower in students who had never visited a dentist (13.5%) than those students who go to a regular dentist check-up (34.9%) or for those who went for treatment (75.3%).

**Figure 8 – TREATED DENTAL DECAY BY PARENT’S ORAL HEALTH PERCEPTION**



A relationship was found between treated dental decay and parents’ perception of their child’s oral health. Parents of children with treated decay were more likely to have a poor perception of their child’s oral health. Parents who think their child had excellent oral health actually had treated decay 25.6% of the time. Parents who responded that their child had very good oral health had treated decay 35.0% of the time, and those who said had good oral health had treated decay 45.5%.

**Figure 9 – TREATED DENTAL DECAY BY MEDICAL & DENTAL INSURANCE**

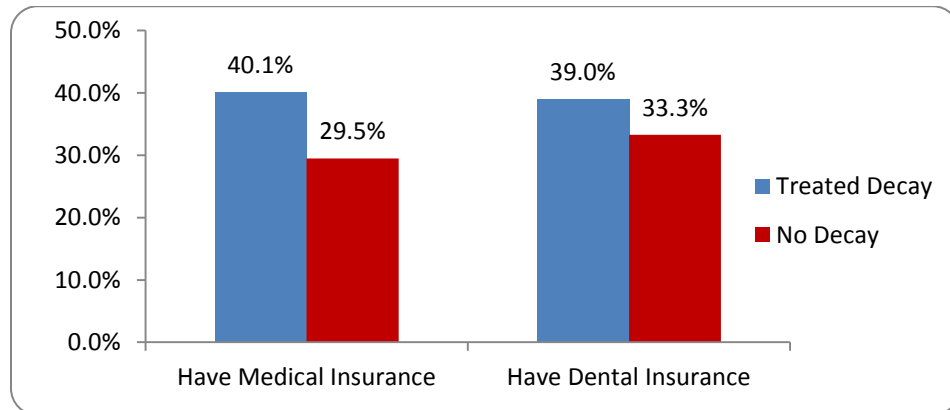


Figure 9 shows that children with medical insurance had a higher percentage of treated decay than those without medical insurance. Of students with medical insurance, 40.1% had treated decay compared to 29.5% with no treated decay. Dental insurance showed the same relationship, with a higher percentage of students who had dental insurance with treated decay. Of students with dental insurance, 39.0% had treated decay while 33.3% of students had no treated decay.

The percentage of students with treated decay who did not have medical or dental insurance (29.0%) was lower than the percentage of students who had both medical and dental insurance (39.2%) and students who had only medical insurance but no dental insurance (50.6%). These differences were statistically significant.



## A CLOSER LOOK AT EARLY CHILDHOOD CARIES (ECC)

There were no statistically significant differences in the percentage of children with ECC by age or sex. There was not enough evidence to conclude that there was a higher percentage of ECC in Washoe County than Clark County. When compared across race/ethnicity groups, ECC was significantly higher in Hispanics (24.5%) than Whites (16.1%). No other conclusions could be made when comparing race/ethnicity groups.

**Figure 10 – EARLY CHILDHOOD CARIES BY LAST DENTIST VISIT**

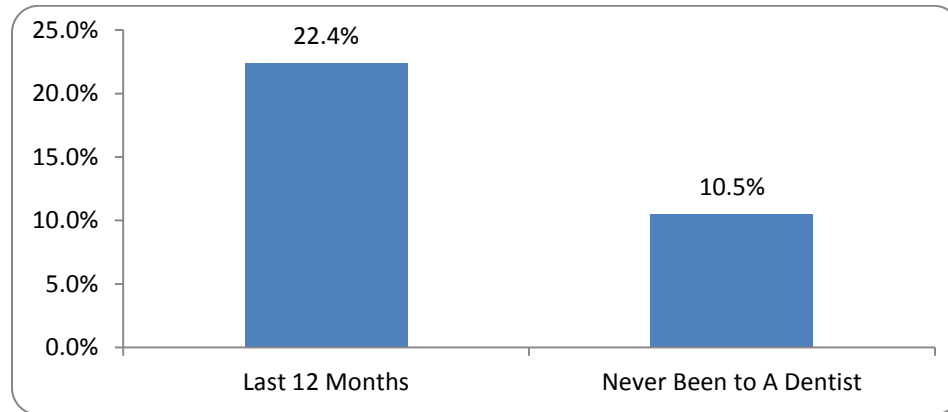


Figure 10 shows that ECC were significantly lower in students who had never seen a dentist (10.5%) than those students who had visited a dentist in the last 12 months (22.4%). Although this finding seems counterintuitive, it is likely due to a selection bias in that those who have an oral health problem are more likely to visit the dentist for treatment. There was also statistical significance between ECC and reason for dental visit. ECC was significantly higher in students whose reason for their dentist visit was “something was wrong” (58.8%) than those who went to the dentist for a “regular check-up” (18.9%), were “called by dentist for check-up” (26.8%), and those who had “never been to a dentist” (11.3%).

**Figure 11 – ECC BY NEEDED DENTAL CARE LAST 12 MONTHS**

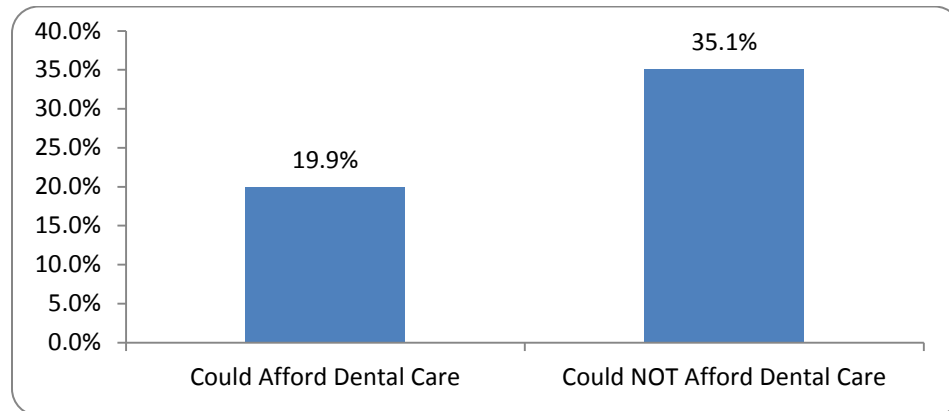


Figure 11 shows that there was also a higher percentage of students with ECC who needed dental care in the last 12 months but could not afford it (35.1%) versus those students who could afford dental care (19.9%). This relationship supports the case that the affordability of dental insurance impacts the treatment of ECC in students.

## A CLOSER LOOK AT CARIES EXPERIENCE

There were no statistically significant differences in the percentage of children with caries experience by sex or geographical region. Caries experience was higher in 5-year-olds (51.7%) than both 4-year-olds (48.9%) and 3 year olds (37.7%). No other determinations can be made with respect to age. The only statistically significant relationship between caries experience and race/ethnicity was that there was a higher rate of caries experience in American Indian/Alaska Native (63.6%) than Multiracials (42.7%), Blacks (42.4%), and Whites (36.5%). No other conclusions could be made when comparing race/ethnicity groups.

**Figure 12 – CARIES EXPERIENCE BY LAST DENTIST VISIT**

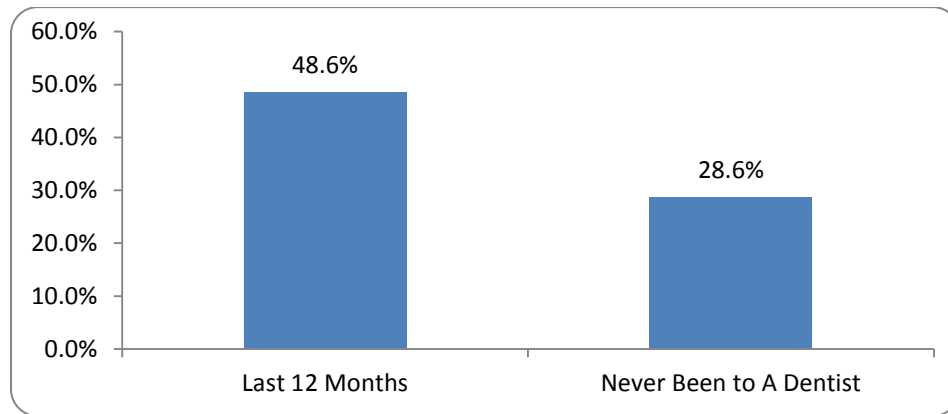
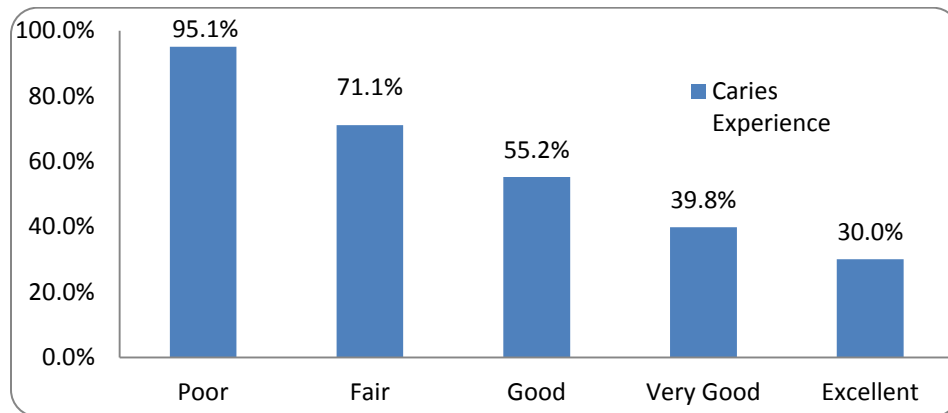


Figure 12 shows when caries experience was compared to the child’s last dentist visit, students were more likely to have had caries experience if they had seen a dentist in the last 12 months (48.6%) when compared to students who had never visited a dentist before (28.6%). This finding is likely a result of the same selection bias as with ECC.

**Figure 13 – CARIES EXPERIENCE BY PARENT’S ORAL HEALTH PERCEPTION**



Again, parents of children with caries experience were more likely to also have a poor perception of their child’s oral health. As parental perception got better, the presence of caries experience decreased;

“Poor” was 95.1%, “Fair” was 71.1%, “Good” was 55.2%, “Very Good” was 39.8%, and finally, “Excellent” 30.0%.

**Figure 14 – CARIES EXPERIENCE BY NEEDED DENTAL CARE LAST 12 MONTHS**

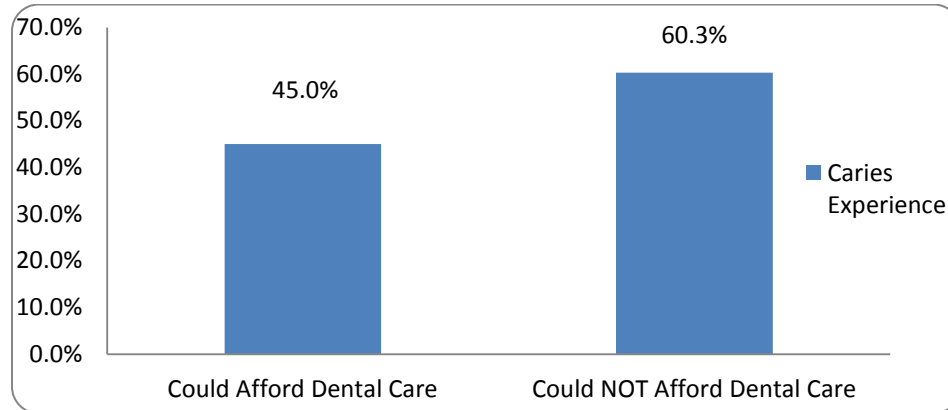


Figure 14 shows a higher proportion of students with caries experience who needed dental care in the last 12 months but could not afford it (60.3%) than among students who could afford dental care (45.0%). This relationship supports the case that affordability of dental insurance impacts the treatment of caries experience in students.

## **A CLOSER LOOK AT TREATMENT URGENCY**

There were no statistically significant differences in treatment urgency by age, sex, or geographical region. There were significantly more American Indian/Alaska Natives (30.3%) that “Need Dental Care” than Multiracials (14.0%), Hispanics (13.2%), Blacks (11.9%), and Whites (10.2%). No other conclusions could be made when comparing race/ethnicity groups.

**Figure 15 – TREATMENT URGENCY (NEEDS DENTAL CARE) BY LAST DENTIST VISIT**

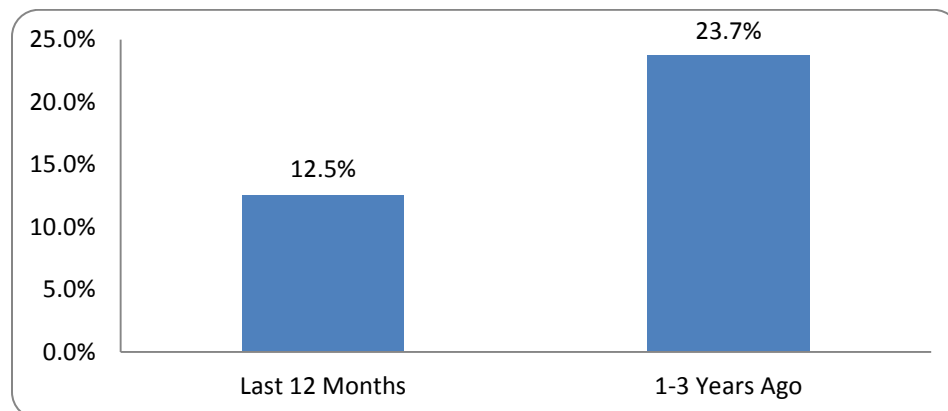
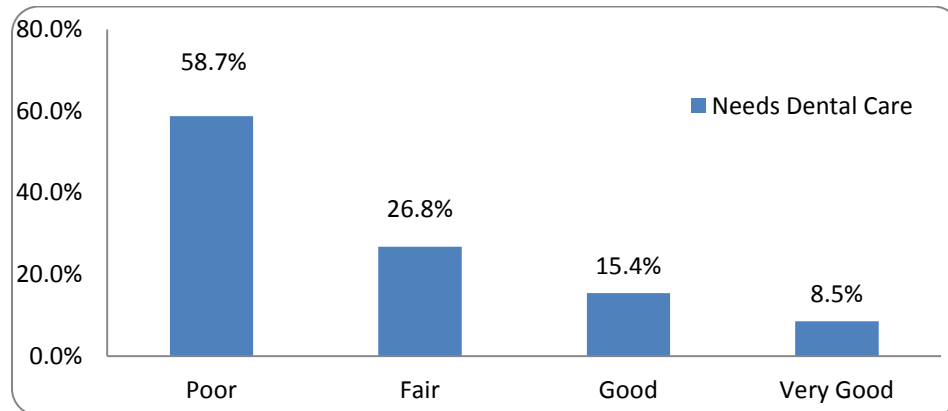


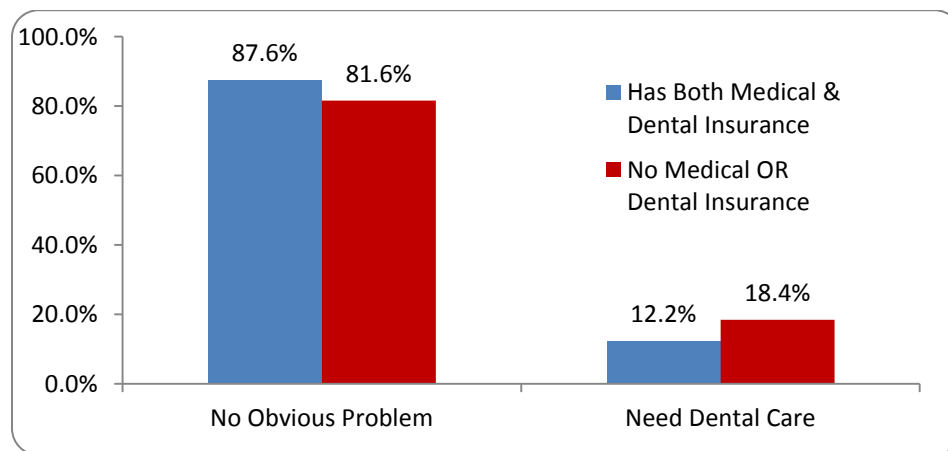
Figure 15 shows that there was a significantly lower percentage of students who needed dental care who had visited the dentist in the last 12 months (12.5%) than students who last visited the dentist one to three years ago (23.7%).

**Figure 16 – TREATMENT URGENCY (NEEDS DENTAL CARE) BY PARENT’S ORAL HEALTH PERCEPTION**



Parents of children who needed dental care were more likely to have a poor perception of their child’s oral health. As parental perception worsened, there was a higher percentage of students who needed dental care; “Poor” was 58.7%, “Fair” was 26.8%, “Good” was 15.4%, and “Very Good” was 8.5%.

**Figure 17 – TREATMENT URGENCY BY MEDICAL & DENTAL INSURANCE**



The presence of both medical and dental insurance correlated strongly with treatment urgency. There were significantly more students with no obvious dental problems who had both insurances (87.6%) than students who had neither insurance (81.6%). There were also a higher percentage of students who needed dental care who had neither insurance (18.4%) than students who had both medical and dental insurance (12.2%). This relationship supports the case that having both medical and dental insurance reduces the need for dental restorations.

**Figure 18 – TREATMENT URGENCY BY NEEDED DENTAL CARE LAST 12 MONTHS**

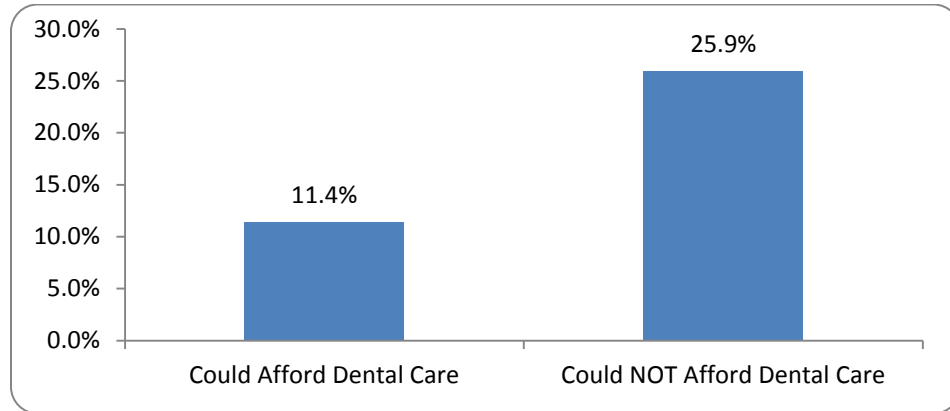


Figure 18 shows a significantly higher percentage of students who needed dental care in the last 12 months but could not afford it (25.9%), versus those students who needed dental care in the last 12 months but could afford dental care (11.4%). This relationship supports the case that the affordability of dental insurance decreases the need for treatment urgency.

## A CLOSER LOOK AT BODY MASS INDEX-FOR-AGE

There were no statistical differences found between Body Mass Index-for-Age and the following:

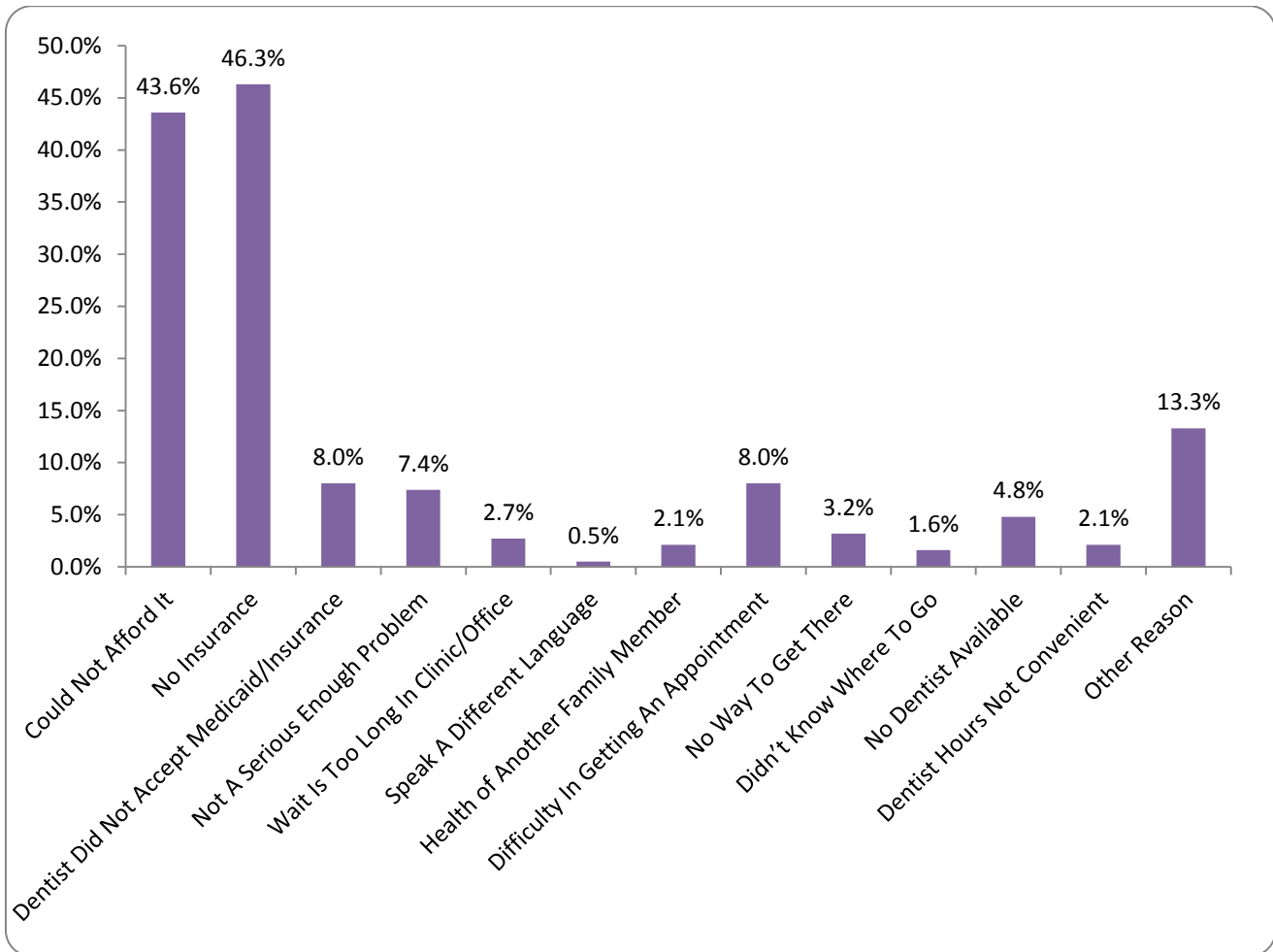
- Age
- Sex
- Geographical Region
- Untreated Dental Decay
- Treated Dental Decay
- Early Childhood Caries (ECC)
- Caries Experience
- The last time the student visited the dentist
- Reason for visiting the dentist
- Parental perception on the oral health of their child
- Medical insurance, dental insurance, or any combination of either insurance
- Needing dental care in the last 12 months but could not afford it

The only statistically significant association was a very specific relationship with the race/ethnic group American Indian/Alaskan Native. A lower percentage of American Indian/Alaska Natives were of healthy weight (36.5%) than Whites (70.6%), Blacks (68.0%), Multiracials (62.5%), and Hispanics (61.9%). A higher percentage of American Indian/Alaska Natives were overweight (26.5%) than both Blacks (14.5%) and Whites (13.8%). Finally, a significantly higher percentage of American Indian/Alaska Natives were obese (36.2%) than Multiracials (18.1%), Hispanics (17.2%), Blacks (14.5%), and Whites (12.6%). These were the only relationships that were supported by the data with respect to BMI-for-age. No other conclusions could be made when comparing race/ethnicity groups.

## REASONS FOR NOT RECEIVING CARE

Due to issues of accessibility, availability, and affordability, dental care may not be available when needed. Figure 19 displays all the responses from the BSS. Parents had the opportunity to check more than one of the following answers, hence the response rates do not add up to 100%. The two most frequently given reasons for not receiving care were “Could Not Afford It” (43.6%) and “No Insurance” (46.3%). In the future, the BSS data suggests that oral health professionals should focus on interventions that address insurance concerns to help influence oral health change.

**Figure 19 – REASONS FOR NOT RECEIVING CARE**





## APPENDIX A – PREVALENCE TABLES

Table 1: Demographics of Head Start Students Surveyed, Nevada BSS 2011-2012			
Demographic	Grouping	Percentage	95% Confidence Interval
Age	3	22.9	19.1-26.8
	4	50.8	48.4-53.1
	5	26.3	21.9-30.7
Sex	Male	49.0	46.4-51.6
	Female	51.0	48.4-53.6
Race/Ethnicity	Multi-Racial	10.8	8.0-13.6
	White	13.7	7.6-19.7
	Black	15.4	8.6-22.2
	Asian	1.2	0.5-1.9
	Hispanic	52.0	42.8-61.1
	Native Hawaiian/Pacific Islander	0.8	0.5-1.1
	America Indian/Alaska Native	6.2	1.6-10.9
Region	Clark	62.2	42.0-82.4
	Washoe	19.5	4.7-34.2
	All Other Counties	18.3	5.1-31.6
BMI	Underweight	2.1	1.5-2.7
	Healthy Weight	62.5	60.1-65.0
	Overweight	17.9	16.3-19.6
	Obese	17.4	15.3-19.6

Table 2: Prevalence of Head Start Students Surveyed, Nevada BSS 2011-2012			
Health Outcome	Grouping	Percentage	95% Confidence Interval
Caries Experience	Yes	47.1	43.7-50.5
Untreated Decay	Yes	12.3	10.6-14.1
Treated Decay	Yes	38.5	35.3-41.7
Early Childhood Caries	Yes	21.6	19.0-24.1
Treatment Urgency	No Obvious Problems	86.6	84.6-88.7
	Needs Dental Care	13.2	11.2-15.2
	Urgent Care Needed	0.2	0.00-0.4

Table 3: Question Responses of Head Start Students Surveyed, Nevada BSS 2011-2012			
Health Outcome	Grouping	Percentage	95% Confidence Interval
Last Visited Dentist	Last 12 Months	83.7	80.6-86.9
	1-3 Years Ago	7.1	5.4-8.7
	More Than 3 Years Ago	3.5	2.3-4.6
	Never Been To Dentist	5.8	3.6-7.9
Reason For Visiting Dentist	Regular Check-up	78.5	75.8-81.2
	Called By Dentist for Check-up	2.3	1.7-3.0
	Something Wrong	3.1	2.3-4.0
	Went For Treatment	7.6	6.1-9.1
	Other	2.7	1.7-3.7
	Never Been to Dentist	5.7	3.6-7.9
Perceived Child's Dental Health	Excellent	24.9	21.6-28.3
	Very Good	29.3	27.5-31.2
	Good	33.2	29.8-36.6
	Fair	10.3	8.3-12.2
	Poor	2.3	1.6-3.0
Medical or Surgical Insurance	No	18.1	15.5-20.7
	Yes	81.9	79.4-84.5
Dental Insurance	No	21.0	18.4-23.6
	Yes	79.0	76.4-81.6
Needed Care But Could Not Afford It Last 12 Months	No	88.4	86.5-90.3
	Yes	11.6	9.7-13.5

**Table 4: Untreated Decay by Demographics and Surveyed Questions, Nevada BSS 2011-2012**

Health Outcome	Grouping	Percentage	95% Confidence Interval
Age	3	12.6	9.6-15.5
	4	13.4	11.1-15.7
	5	10.2	7.3-13.2
Sex	Male	12.7	10.3-15.2
	Female	12.2	10.0-14.4
Race/Ethnicity	Multi-Racial	13.6	9.7-17.6
	White	8.8	5.5-12.1
	Black	11.7	7.7-15.7
	Asian	4.3	0.0-11.5
	Hispanic	12.3	9.1-15.6
	Native Hawaiian/Pacific Islander	6.3	0.0-19.1
	America Indian/Alaska Native	27.2	22.4-31.9
Region	Clark	11.2	8.9-13.5
	Washoe	11.9	9.1-14.6
	All Other Counties	16.7	13.4-20.1
Last Visited Dentist	Last 12 Months	11.7	9.7-13.7
	1-3 Years Ago	19.1	11.4-26.8
	More Than 3 Years Ago	13.1	4.4-21.7
	Never Been To Dentist	18.8	11.0-26.6
Reason For Visiting Dentist	Regular Check-up	11.6	9.5-13.7
	Called By Dentist for Check-up	14.6	2.1-27.1
	Something Wrong	18.2	8.5-28.0
	Went For Treatment	10.5	6.1-14.8
	Other	15.5	7.2-23.8
	Never Been to Dentist	20.1	11.5-28.7
Perceived Child's Dental Health	Excellent	5.8	2.6-9.0
	Very Good	8.2	6.3-10.1
	Good	14.4	11.1-17.6
	Fair	25.0	19.2-30.9
	Poor	56.2	42.7-69.7
Medical or Surgical Insurance	No	19.0	15.4-22.6
	Yes	11.1	9.0-13.1
Dental Insurance	No	16.1	13.0-19.2
	Yes	11.4	9.3-13.5
Needed Care But Could Not Afford It Last 12 Months	No	10.7	8.6-12.7
	Yes	23.7	19.9-27.4

**Table 5: Treated Decay by Demographics and Surveyed Questions, Nevada BSS 2011-2012**

Health Outcome	Grouping	Percentage	95% Confidence Interval
Age	3	28.0	24.0-32.0
	4	39.6	35.8-43.3
	5	45.4	40.9-49.9
Sex	Male	38.5	34.7-42.2
	Female	38.5	34.2-42.7
Race/Ethnicity	Multi-Racial	32.4	27.4-37.3
	White	30.1	23.5-36.7
	Black	33.3	26.8-39.8
	Asian	47.0	29.6-64.4
	Hispanic	43.6	38.9-48.3
	Native Hawaiian/Pacific Islander	19.5	0.0-40.0
	America Indian/Alaska Native	44.4	35.5-53.3
Region	Clark	37.1	33.0-41.2
	Washoe	43.5	38.9-48.1
	All Other Counties	38.0	32.7-43.2
Last Visited Dentist	Last 12 Months	40.9	37.3-44.4
	1-3 Years Ago	26.9	20.4-33.3
	More Than 3 Years Ago	38.0	23.2-52.8
	Never Been To Dentist	10.5	5.7-15.2
Reason For Visiting Dentist	Regular Check-up	34.9	31.6-38.2
	Called By Dentist for Check-up	51.6	32.3-71.0
	Something Wrong	73.1	61.0-85.1
	Went For Treatment	75.3	68.1-82.4
	Other	32.4	14.7-50.1
	Never Been to Dentist	13.5	7.7-19.2
Perceived Child's Dental Health	Excellent	25.6	21.1-30.1
	Very Good	35.0	30.7-39.3
	Good	45.5	41.2-49.8
	Fair	51.6	44.3-58.9
	Poor	50.5	35.8-65.3
Medical or Surgical Insurance	No	29.5	24.5-34.5
	Yes	40.1	36.8-43.5
Dental Insurance	No	33.3	28.8-37.7
	Yes	39.0	35.8-42.1
Needed Care But Could Not Afford It Last 12 Months	No	37.8	34.6-41.0
	Yes	41.3	33.9-48.6

**Table 6: Caries Experience by Demographics and Surveyed Questions, Nevada BSS 2011-2012**

Health Outcome	Grouping	Percentage	95% Confidence Interval
Age	3	37.7	34.4-41.0
	4	48.9	45.0-52.8
	5	51.7	46.5-56.9
Sex	Male	47.3	43.2-51.5
	Female	46.7	42.7-50.7
Race/Ethnicity	Multi-Racial	42.7	37.5-48.0
	White	36.5	29.9-43.1
	Black	42.4	36.2-48.6
	Asian	47.0	29.6-64.4
	Hispanic	52.0	46.9-57.1
	Native Hawaiian/Pacific Islander	19.5	0.0-40.0
	America Indian/Alaska Native	63.6	56.2-71.1
Region	Clark	44.8	40.5-49.1
	Washoe	51.7	46.8-56.6
	All Other Counties	49.9	45.5-54.3
Last Visited Dentist	Last 12 Months	48.6	44.7-52.5
	1-3 Years Ago	42.2	33.2-51.3
	More Than 3 Years Ago	46.9	31.6-62.3
	Never Been To Dentist	28.6	19.8-37.4
Reason For Visiting Dentist	Regular Check-up	43.0	39.3-46.6
	Called By Dentist for Check-up	62.3	45.6-78.9
	Something Wrong	85.9	76.9-95.0
	Went For Treatment	80.5	75.0-86.0
	Other	42.4	25.7-59.1
	Never Been to Dentist	31.8	22.3-41.4
Perceived Child's Dental Health	Excellent	30.0	25.5-34.6
	Very Good	39.8	35.2-44.4
	Good	55.2	50.1-60.2
	Fair	71.1	65.2-76.9
	Poor	95.1	88.6-100.0
Medical or Surgical Insurance	No	44.9	39.0-50.9
	Yes	47.4	43.6-51.3
Dental Insurance	No	46.5	41.1-52.0
	Yes	46.7	43.2-50.3
Needed Care But Could Not Afford It Last 12 Months	No	45.0	41.4-48.6
	Yes	60.3	52.6-68.0

Table 7: ECC by Demographics and Surveyed Questions, Nevada BSS 2011-2012			
Health Outcome	Grouping	Percentage	95% Confidence Interval
Age	3	19.9	15.3-24.5
	4	22.6	19.8-25.4
	5	21.0	18.2-23.8
Sex	Male	21.8	19.8-24.1
	Female	21.2	17.5-24.9
Race/Ethnicity	Multi-Racial	20.7	15.2-26.1
	White	16.1	10.8-21.4
	Black	19.3	13.1-25.5
	Asian	14.4	5.8-23.0
	Hispanic	24.5	21.4-27.6
	Native Hawaiian/Pacific Islander	-	-
Region	America Indian/Alaska Native	26.3	13.8-38.8
	Clark	19.8	16.9-22.6
	Washoe	27.4	22.5-32.4
Last Visited Dentist	All Other Counties	21.5	16.8-26.3
	Last 12 Months	22.4	19.9-25.0
	1-3 Years Ago	15.9	9.5-22.4
	More Than 3 Years Ago	27.7	14.2-41.1
Reason For Visiting Dentist	Never Been To Dentist	10.5	4.0-17.0
	Regular Check-up	19.0	16.3-21.6
	Called By Dentist for Check-up	26.8	16.9-36.7
	Something Wrong	58.8	46.8-70.9
	Went For Treatment	38.7	29.9-47.5
	Other	22.5	13.0-32.1
Perceived Child's Dental Health	Never Been to Dentist	11.3	4.6-18.0
	Excellent	14.1	11.0-17.2
	Very Good	17.4	13.9-20.8
	Good	23.2	20.1-26.4
	Fair	34.1	25.6-42.7
Medical or Surgical Insurance	Poor	68.8	53.3-84.2
	No	20.1	15.7-24.5
Dental Insurance	Yes	21.8	18.8-24.7
	No	22.1	18.3-25.8
Needed Care But Could Not Afford It Last 12 Months	Yes	21.5	18.6-24.3
	No	19.9	17.4-22.4
	Yes	35.1	26.6-43.6

Table 8: Treatment Urgency by Demographics and Surveyed Questions, Nevada BSS 2011-2012			
Treatment	Grouping	Percentage	95% Confidence Interval
No Obvious Problem	Male	86.5	84.0-89.1
	Female	86.5	84.0-89.0
Needs Dental Care	Male	13.4	10.9-15.8
	Female	13.3	10.8-15.7
Urgent Care Needed	Male	0.1	0.0-0.3
	Female	0.3	0.0-0.5
No Obvious Problems	Clark	88.0	85.6-90.5
	Washoe	87.2	83.5-90.9
	All Other Counties	81.1	75.4-86.9
Needs Dental Care	Clark	11.7	9.4-14.0
	Washoe	12.8	9.1-16.5
	All Other Counties	18.9	13.1-24.6
Urgent Care Needed	Clark	0.3	0.0-0.6
	Washoe	-	-
	All Other Counties	-	-
No Obvious Problems	Regular Check-up	87.5	85.5-89.6
	Called By Dentist for Check-up	85.1	72.3-97.9
	Something Wrong	81.6	71.8-91.4
	Went For Treatment	84.5	78.8-90.2
	Other	83.2	74.1-92.3
	Never Been to Dentist	80.8	72.5-89.1
Needs Dental Care	Regular Check-up	12.3	10.3-14.4
	Called By Dentist for Check-up	14.9	2.09-27.7
	Something Wrong	18.4	8.6-28.2
	Went For Treatment	14.9	8.9-21.0
	Other	16.8	7.7-25.9
	Never Been to Dentist	19.2	10.9-27.5
Urgent Care Needed	Regular Check-up	0.1	0.0-0.3
	Called By Dentist for Check-up	-	-
	Something Wrong	-	-
	Went For Treatment	0.6	0.0-1.8
	Other	-	-
	Never Been to Dentist	-	-

Table 9: Body Mass Index (Underweight) by Demographics and Surveyed Questions, Nevada BSS 2011-2012			
Health Outcome	Grouping	Percentage	95% Confidence Interval
Age	3	1.9	0.8-3.1
	4	2.0	1.3-2.7
	5	2.5	0.9-4.1
Sex	Male	2.2	1.2-3.2
	Female	2.1	1.4-2.8
Race/Ethnicity	Multi-Racial	1.6	0.0-3.4
	White	3.0	0.4-5.6
	Black	3.0	0.4-5.6
	Asian	5.3	0.0-16.7
	Hispanic	1.8	1.0-2.6
	Native Hawaiian/Pacific Islander	-	-
	America Indian/Alaska Native	0.8	0.0-2.4
Region	Clark	2.0	1.2-2.7
	Washoe	2.1	1.3-2.9
	All Other Counties	2.7	0.9-4.5
Last Visited Dentist	Last 12 Months	2.2	1.6-2.9
	1-3 Years Ago	3.5	0.7-6.3
	More Than 3 Years Ago	-	-
	Never Been To Dentist	1.8	0.0-4.4
Reason For Visiting Dentist	Regular Check-up	2.0	1.4-2.7
	Called By Dentist for Check-up	4.6	0.0-10.7
	Something Wrong	1.3	0.0-3.9
	Went For Treatment	2.9	0.6-5.1
	Other	3.3	0.0-7.2
	Never Been to Dentist	1.8	0.0-4.4
Perceived Child's Dental Health	Excellent	2.1	0.8-3.5
	Very Good	1.8	0.8-2.8
	Good	2.5	1.5-3.6
	Fair	2.1	0.3-4.0
	Poor	1.7	0.0-5.0
Medical or Surgical Insurance	No	1.1	0.1-2.1
	Yes	2.4	1.6-3.2
Dental Insurance	No	1.3	0.4-2.3
	Yes	2.3	1.5-3.1
Needed Care But Could Not Afford It Last 12 Months	No	2.2	1.5-2.9
	Yes	1.1	0.0-2.3



Table 10: Body Mass Index (Healthy Weight) by Demographics and Surveyed Questions, Nevada BSS 2011-2012			
Health Outcome	Grouping	Percentage	95% Confidence Interval
Age	3	65.1	60.7-69.6
	4	62.7	59.1-66.7
	5	59.9	54.0-65.8
Sex	Male	61.8	58.2-65.4
	Female	63.2	60.1-66.3
Race/Ethnicity	Multi-Racial	62.5	56.9-68.1
	White	70.6	66.0-75.2
	Black	68.0	65.3-70.6
	Asian	66.5	40.9-92.2
	Hispanic	61.9	59.2-64.5
	Native Hawaiian/Pacific Islander	51.1	23.3-78.9
	America Indian/Alaska Native	36.5	26.1-46.9
Region	Clark	64.7	62.7-66.6
	Washoe	61.7	56.3-67.1
	All Other Counties	56.1	47.3-64.9
Last Visited Dentist	Last 12 Months	62.1	59.6-64.6
	1-3 Years Ago	59.7	51.4-68.0
	More Than 3 Years Ago	63.9	55.0-72.8
	Never Been To Dentist	65.2	56.0-74.4
Reason For Visiting Dentist	Regular Check-up	63.3	60.6-66.0
	Called By Dentist for Check-up	57.4	43.5-71.4
	Something Wrong	59.4	45.2-73.7
	Went For Treatment	56.8	47.0-66.5
	Other	55.9	42.4-69.4
	Never Been to Dentist	64.2	55.7-72.7
Perceived Child's Dental Health	Excellent	62.2	58.2-66.3
	Very Good	63.4	59.8-67.0
	Good	62.8	59.1-66.5
	Fair	57.4	50.6-64.3
	Poor	64.5	50.5-78.6
Medical or Surgical Insurance	No	59.0	53.4-64.6
	Yes	63.0	60.8-65.2
Dental Insurance	No	57.8	51.3-64.4
	Yes	63.6	61.2-66.0
Needed Care But Could Not Afford It Last 12 Months	No	62.1	59.5-64.7
	Yes	64.6	59.3-69.9

Table 11: Body Mass Index (Overweight) by Demographics and Surveyed Questions, Nevada BSS 2011-2012			
Health Outcome	Grouping	Percentage	95% Confidence Interval
Age	3	17.1	13.7-20.4
	4	17.1	14.5-19.7
	5	20.3	16.5-24.1
Sex	Male	16.3	14.0-18.6
	Female	19.5	17.3-21.8
Race/Ethnicity	Multi-Racial	17.8	11.9-23.7
	White	13.8	10.6-17.1
	Black	14.5	11.1-18.0
	Asian	18.8	0.0-41.8
	Hispanic	19.1	16.7-21.4
	Native Hawaiian/Pacific Islander	28.7	1.9-55.4
	America Indian/Alaska Native	26.5	18.4-34.5
Region	Clark	16.9	14.8-19.1
	Washoe	18.0	14.4-21.7
	All Other Counties	21.3	18.9-23.8
Last Visited Dentist	Last 12 Months	17.9	16.2-19.7
	1-3 Years Ago	16.3	10.1-22.5
	More Than 3 Years Ago	14.0	4.4-23.5
	Never Been To Dentist	19.0	11.6-26.4
Reason For Visiting Dentist	Regular Check-up	16.9	15.0-18.9
	Called By Dentist for Check-up	20.3	9.7-30.9
	Something Wrong	18.9	10.0-27.7
	Went For Treatment	23.2	14.9-31.6
	Other	14.7	5.2-24.3
	Never Been to Dentist	22.4	15.9-28.9
Perceived Child's Dental Health	Excellent	20.3	16.9-23.7
	Very Good	17.6	14.4-20.7
	Good	15.3	12.8-17.7
	Fair	20.7	14.9-26.4
	Poor	24.0	12.3-35.7
Medical or Surgical Insurance	No	20.6	15.8-25.4
	Yes	17.4	15.8-19.0
Dental Insurance	No	21.9	16.4-27.4
	Yes	16.8	15.2-18.4
Needed Care But Could Not Afford It Last 12 Months	No	18.0	15.9-20.0
	Yes	18.3	13.5-23.0

Table 12: Body Mass Index (Obese) by Demographics and Surveyed Questions, Nevada BSS 2011-2012			
Health Outcome	Grouping	Percentage	95% Confidence Interval
Age	3	15.9	10.8-20.9
	4	18.2	15.5-20.9
	5	17.3	13.5-21.2
Sex	Male	19.7	17.0-22.5
	Female	15.2	12.5-18.0
Race/Ethnicity	Multi-Racial	18.1	12.9-23.2
	White	12.6	9.5-15.7
	Black	14.5	10.1-19.0
	Asian	9.3	2.5-16.1
	Hispanic	17.2	14.9-19.6
	Native Hawaiian/Pacific Islander	20.2	0.0-40.5
	America Indian/Alaska Native	36.2	23.5-48.9
Region	Clark	16.5	15.0-18.0
	Washoe	18.2	12.2-24.1
	All Other Counties	19.9	11.5-28.2
Last Visited Dentist	Last 12 Months	17.7	15.7-19.8
	1-3 Years Ago	20.5	12.7-28.2
	More Than 3 Years Ago	22.2	12.3-32.1
	Never Been To Dentist	14.0	7.2-20.9
Reason For Visiting Dentist	Regular Check-up	17.8	15.7-19.8
	Called By Dentist for Check-up	17.7	6.3-29.1
	Something Wrong	20.4	9.4-31.5
	Went For Treatment	17.1	9.8-24.4
	Other	26.2	14.9-37.4
	Never Been to Dentist	11.7	5.7-17.7
Perceived Child's Dental Health	Excellent	15.4	11.8-19.1
	Very Good	17.3	14.1-20.4
	Good	19.4	15.9-23.0
	Fair	19.8	14.6-25.0
	Poor	9.8	1.4-18.3
Medical or Surgical Insurance	No	19.3	14.5-24.2
	Yes	17.2	15.2-19.1
Dental Insurance	No	19.0	13.9-24.1
	Yes	17.3	15.1-19.4
Needed Care But Could Not Afford It Last 12 Months	No	17.7	15.6-19.9
	Yes	16.1	11.5-20.7

**Table 13: Question 7 Responses, Nevada BSS 2011-2012**

<b>Response</b>	<b>Percentage</b>	<b>95% Confidence Interval</b>
Could not afford it	43.6	34.6-52.7
No insurance	46.3	38.3-54.2
Dentist did not accept Medicaid/insurance	8.0	3.6-12.4
Speak a different language	0.5	0.0-1.7
Wait is too long in clinic/office	2.7	0.0-5.6
Health of another family member	2.1	0.1-4.2
Difficulty in getting appointment	8.0	2.6-13.4
No way to get there	3.2	0.3-6.1
Didn't know where to go	1.6	0.0-3.3
No dentist available	4.8	0.5-9.1
Not a serious problem	7.5	3.6-11.3
Dentist hours are not convenient	2.1	0.0-4.5
Don't like/believe in dentists	0.0	0.0-0.0
Other reason	13.3	6.5-20.1

# APPENDIX B – FORMS AND LETTERS

## Data Collection Form

Nevada State Health Division/Oral Health Program 2011 – 2012 Head Start Basic Screening Survey – Data form				
<b>Head Start BSS ID<sup>1</sup></b>	Screener ID and Initials		Date of Screening (mm/dd/yyyy)	
	Child's First Name		Child's Last Name	
	Birth Date (mm/dd/yyyy)		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Head Start Location			
	Early Head Start	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown/Missing
<b>1 – Please write BSS ID on Consent form</b>				
<b>Oral Health</b>				
Untreated Decay	Treated Decay	Early Childhood Caries (ECC)	Treatment Urgency	Urgent Care
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> No Obvious Problem – continue with regular dental checkups	<input type="checkbox"/> Pain
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> Needs Dental Care – needs to be seen soon (before their next regularly scheduled dental visit)	<input type="checkbox"/> Abscess
			<input type="checkbox"/> Urgent Care Needed (Pain, Swelling or Infection present) - needs immediate dental care within 24 – 48 hours	<input type="checkbox"/> Other (broken or knocked out tooth)
<b>Height and Weight</b>				
Height 1 (Centimeters)		Height 2 (Centimeters)		<b>Note: Please read and record to the nearest 0.1 cm</b>
Weight 1 (Kilograms)		Weight 2 (Kilograms)		<b>Note: Please read and record to the nearest 0.1 kg</b>
Comment:				

## Consent Form

Please complete this form and return it to your Head Start Program. Thank you.

_____	_____
Child's First Name	Child's Last Name
_____	____/____/____
Head Start Location	Child's Birth date (mm/dd/yyyy)
<div style="border: 1px solid black; padding: 5px;"><p><input type="checkbox"/> Yes, I give permission for my child to participate in the survey and have height and weight checked.</p><p><input type="checkbox"/> No, I do not give permission for my child to participate in the survey and have height and weight checked.</p></div>	<b>Race</b> (check all that apply)
_____	<input type="checkbox"/> White
Signature of Parent or Guardian	<input type="checkbox"/> Black/African American
_____	<input type="checkbox"/> Asian
Date	<input type="checkbox"/> Hispanic
	<input type="checkbox"/> Native Hawaiian/Pacific Islander
	<input type="checkbox"/> American Indian/Alaska Native

Please answer all of these questions. They help us learn more about how your child gets their teeth taken care of. Your answers will not be shared.

1. 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. (Please check one)  
 Within the last 12 months                       More than 3 years ago  
 More than 1 year ago, but not more than 3 years ago       Never has been to the dentist
2. What was the main reason that your child last visited a dentist? (Please check one)  
 Went in for regular check-up, examination or cleaning  
 Was called in by the dentist for check-up, examination or cleaning  
 Something was wrong, bothering or hurting  
 Went for treatment of a condition that dentist discovered at earlier check-up or examination  
 Other  
 Never has been to the dentist
3. What would you say about your child's dental health? (Please check one)  
 Excellent               Fair  
 Very good               Poor  
 Good
4. Do you have any kind of insurance that pays for some or all of your child's MEDICAL OR SURGICAL CARE? Include health insurance obtained through employment or purchased directly, as well as government programs like Medicaid.  
 Yes               No
5. Do you have any kind of insurance that pays for some or all of your child's DENTAL CARE? Include health insurance obtained through employment or purchased directly, as well as government programs like Medicaid.  
 Yes               No
6. During the past 12 months, was there a time when your child needed dental care but could not get it at that time?  
 Yes (Please go to Question 7)               No (You are done with the questionnaire)
7. 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? (Check all that apply)  
 Could not afford it                       Health of another family member               Not a serious enough problem  
 No insurance                               Difficulty in getting appointment               Dentist hours are not convenient  
 Dentist did not accept Medicaid/insurance       No way to get there                               Don't like/believe in dentists  
 Speak a different language               Didn't know where to go                               Other reason  
 Wait is too long in clinic/office               No dentist available

Letter that Accompanied Consent Form



Dear Parent/Guardian:

Your child's Head Start has been chosen to take part in the Nevada State Health Division's *Healthy Smile-Happy Child Survey*. The purpose of the *Healthy Smile-Happy Child Survey* is to gather information about the health of children's teeth in your county and across the state. This year we have added height and weight to our screening. The results will help the state to plan for children's health programs in Nevada.

With your signed permission a dental hygienist, or a dental hygiene student under the supervision of a faculty member, will check your child's teeth for tooth decay and other dental problems and measure their height and weight. The person checking your child's teeth will wear disposable gloves and use a new disposable mirror. Results of your child's screening will be added to those of other children, and your child will not be identified or singled out in any *Healthy Smile-Happy Child* report.

A healthy mouth is part of total health and wellness and makes a child more ready to learn. Your child will receive a toothbrush and a letter to take home that tells you about the health of your child's teeth and height and weight information (Body Mass Index-BMI).

By letting your child take part in this screening, you will not only take an active role in your child's health, you will help benefit all of Nevada's children. If you have any questions about the survey, please contact Syd McKenzie at (775) 684-5985 or by email at [smckenzie@health.nv.gov](mailto:smckenzie@health.nv.gov)

**Please sign and complete the consent form. This will allow your child to take part in the *Healthy Smile-Happy Child Survey*. PLEASE return the form to your child's teacher tomorrow.**

Sincerely,

Syd McKenzie, R.D.H., B.S.D.H.

Oral Health Program Specialist (Screening, Education, Fluoridation)

**Please note:** this is not a full dental exam or full physical exam. No x-rays will be taken. The *Healthy Smile-Happy Child Survey* is not meant to take the place of a routine dental examination or regularly scheduled health visits.

Letter Sent Home to Parents after the Screening

Dear Parents/Guardians:

Thank you for allowing your child to take part in the *Healthy Smile-Happy Child Survey*, which includes Body Mass Index (BMI). By looking at your child's mouth and measuring their height and weight it helps us understand what is happening with the teeth and growth of children in Nevada. Information collected on your child will be kept confidential. Recommended care for your child's teeth, along with height and weight information, is on the back of this page.

Please note that this was **not** a full dental check-up. This screening looked for your child's previous cavities and cavities that have not been fixed. Each tooth was not checked and x-rays were not taken. The screening does not take place of a regular dental check-up.

A healthy mouth is part of a healthy body. Studies show that a healthy child is more ready to learn in school. That is why it is important that you help your child brush and floss every day and have regular dental check-ups for good dental health.

Many things such as amount of playtime, eating habits, or family history can have an effect on height and weight in children. Body Mass Index (BMI) is calculated using a person's weight and height. **BMI should be considered a screening tool and not a definitive measure of overweight and obesity because the indicator has limitations.** For example, some athletes may have a higher than expected BMI due to their increased muscle mass, which weighs more than fat mass.

Your child's health care provider is the best person to assess whether or not his/her measurements are within a healthy range. If you have any concerns, please share the results with your child's health care provider, who may suggest changes in eating or physical activity or may have other information on how to improve your child's general health.

Your child's measurements were:	
Height: _____	Weight: _____
Body Mass Index-for-Age percentile: _____	

**(SEE BACK FOR BMI PERCENTILE GUIDELINES)**

**Body Mass Index Percentile Guide:**



- **BMI** less than 5<sup>th</sup> percentile – underweight
- **BMI** 5<sup>th</sup> percentile up to 85<sup>th</sup> percentile – healthy weight
- **BMI** 85<sup>th</sup> up to 95<sup>th</sup> percentile – overweight
- **BMI** equal to or greater than 95<sup>th</sup> percentile - obese

**Recommended Care for teeth:**

- No Obvious Problem** – continue with regular dental checkups
- Needs Dental Care** – needs to be seen soon (before their next regularly scheduled dental visit)
- Urgent Care Needed** (Pain, Swelling or Infection Present) – needs immediate dental care within 24-48 hours



**Comments, suggestions, and requests for further information may be addressed to:**

**Department of Health and Human Services  
Nevada State Health Division  
Oral Health Program**

4150 Technology Way Ste 210  
Carson City NV 89706  
(775) 684-4285  
[http://health.nv.gov/cc\\_oral](http://health.nv.gov/cc_oral)

This report is available on the State Health Division website:  
[http://health.nv.gov/cc\\_oralhealth.htm](http://health.nv.gov/cc_oralhealth.htm)