

The Oral Health of Whatcom County's Children: 2010 Smile Survey



PUBLIC HEALTH always working for a SAFER AND HEALTHIER WHATCOM COUNTY

*“Tooth decay is an infectious, transmissible disease with multiple contributing factors and serious implications for overall health and school achievement. It is the most common chronic disease of childhood; five times more common than asthma. The consequences of dental disease are damaging for children: pain, reduced attention for learning, behavior issues, missed school days, trouble sleeping and eating, lethargy, lowered self-esteem, and the potential for life-long dental and general health problems. However, the good news is that **tooth decay is highly preventable.**”*

--Whatcom County Oral Health Coalition member



Whatcom County Smile Survey 2010

May 2011

A Partnership of the Whatcom County Health Department & the Whatcom County Oral Health Coalition, in affiliation with the Whatcom Alliance for Healthcare Access

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For a copy of the Washington Smile Survey 2010:

The state report is posted on the Department of Health MCH Oral Health Program website in a pdf format at:

www.doh.wa.gov/CFh/oralhealth/datapubs/

For persons with disabilities, this document is available on request in other formats.

To submit a request, please call (1-800) 525-0127 (TTY/TDD 711 or 1-800-833-6388) or contact:

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Schools—Kindergarten & 3rd Grade Classes

(in alphabetical order)

Birchwood Elementary School—Bellingham
Custer Elementary School—Custer
Geneva Elementary School—Bellingham
Happy Valley Elementary School—Bellingham
Harmony Elementary School—Deming
Isom Intermediate School—Lynden
Larrabee Elementary School—Bellingham
Nooksack Elementary School—Everson
Silver Beach Elementary School—Bellingham
Skyline Elementary School—Ferndale
Sumas Elementary School—Sumas
Sunnyland Elementary School—Bellingham
Wade King Elementary School—Bellingham

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Glossary

Dental Caries (or Dental decay)

A dental disease process that can result in dental decay (cavity). When left untreated, dental decay can lead to pain, infection, and swelling (abscess).

Decay Experience

The presence of an untreated cavity, a filling or a permanent tooth that is missing because it was extracted due to decay. High rates of decay experience suggest missed opportunities for preventing dental decay at the population level.

Dental Sealants

Transparent or opaque plastic coatings placed on the top of permanent molar (back) teeth to help prevent dental decay. It is applied on first molars during first and second grade and on second molars during sixth or seventh grade.

Early Childhood Caries (or decay)

Presence of decay, fillings, or missing teeth due to decay in the top front baby teeth of children under six years of age. It can be due to the use of baby bottle continuously for nursing, bacterial saliva contamination from mother or caregiver, and/or frequent ingestion of sugar and starches.

Free and Reduced Lunch Program (FRL)

A program available in schools to eligible low-income children.

Need for dental care

Refers to the level of treatment urgency that the child is classified as determined by his or her oral health status, as follows: Urgent care: when the child has pain, infection or swelling (abscess), and therefore needs to see a dental professional in 24-48 hours. Early Care: when the child has untreated decay but has no pain or infection, and needs to see a dentist within the next several weeks or before their next regularly scheduled dental appointment. A child with a broken or missing filling, but no other untreated decay, would be classified as needing early dental care.

No need for dental care: when the child shows no obvious problems and can wait until the next regular dental checkup.

Rampant Decay

Presence of seven or more teeth that are untreated and/or have fillings. Represents high severity of dental decay and suggests low levels of both disease prevention and access to dental care.

Untreated Decay

A cavity or hole in the tooth that is at least ½ mm in size, with a brown to dark-brown color. Suggests difficulty in accessing dental care due to phobia, transportation, lack of insurance, or other issues.

Executive Summary

During the 2009-2010 school year, the Washington State Department of Health Oral Health Program conducted the fourth statewide oral health screening survey of three groups of children: (1) low-income preschoolers enrolled in Head Start/ ECEAP, (2) public school kindergarteners, and (3) public school third graders. Concurrently, Whatcom County Health Department conducted a SMILE Survey within Whatcom County. As part of this assessment, 1137 children in kindergarten and third grade and 208 children in Head Start (190 3-5 year olds) received a brief oral health screening.

The purpose of the Whatcom County 2010 Smile Survey was to provide current surveillance information to support the development of programs and policies that ensure all children in Whatcom County are healthy and ready to learn. This is the first countywide oral health survey, though a similar study was done with 3rd graders in Bellingham in 2005. The following are key findings from the 2010 survey.

Dental disease is a serious health issue for many Whatcom County children

- ☐ 43% of Head Start children aged 3-5 years (n=82) already had tooth decay experience and 28% had untreated decay (n=53)
- ☐ By 3rd grade, the majority of children (61%) have evidence of decay experience.
- ☐ In 2010, Whatcom County kindergarteners and third grade students compared unfavorably to most state findings; two exceptions were the third grade sealant rate and third grade need for treatment.

2010 Summary: Whatcom & Washington State Percentages

ORAL HEALTH CATEGORIES	HEAD START/ECEAP Preschoolers		Public School Kindergartener		Public School Third Graders (n=589)	
	Whatcom* (n=190)	Washington (n=1,597)	Whatcom (n=548)	Washington (n=2,858)	Whatcom (n=589)	Washington (n=2,875)
Decay experience	43%	40%	42%	39%	61%	58%
Untreated decay	28%	13%	16%	14%	13%	15%
Rampant decay	**	17%	15%	15%	26%	19%
Dental sealants	**	5%	4%	5%	56%	51%
Need for care	**	12%	16%	13%	14%	15%

*Whatcom numbers are for 3-5 year olds only, Washington numbers for all children screened. **These numbers are not available.

Oral health disparities are extensive

- ☐ Children in low-income families were significantly more likely to have tooth decay experience, untreated tooth decay, rampant decay, and the need for immediate dental treatment than those from families with higher incomes. Percentages of children (K+3rd combined) with untreated decay were statistically higher for children receiving free or reduced lunch (FRL) (19%) than for those not receiving FRL (12%).
- ☐ Hispanic or Asian children were more likely to have decay experience or rampant decay than white, non-Hispanic children (68% and 61% for Hispanic and Asian respectively vs. 49% for white, non-Hispanic). Hispanic, Asian or African American children were also more likely to have untreated decay and follow-up care needs.
- ☐ There is high variability of oral health status between schools, even those with similar income groupings. This variability is greater for children who do *not* have FRL.



Whatcom County is doing well with preventive dental sealants

- ☐ Over 56% of third grade students have dental sealants, an effective measure for preventing decay in permanent teeth. Whatcom County rates exceed the Healthy People 2020 objective for 6-9 year olds (28.1%) and this finding does not vary by income, race/ethnicity, or language group. This positive accomplishment is likely due to school based dental sealant programs.

Summary

Smile Survey data suggest the need for ongoing attention to oral health as a public health issue. While high sealant rates are a positive finding, too many children in Whatcom County are experiencing initial decay in their primary teeth. Lack of access to fluoride in community water systems and lack of early preventive dental care may contribute to these findings. Improving the oral health of mothers (during and after pregnancy) may be one area of intervention that could help prevent transmission of bacteria that cause dental caries to young children. Schools, health care and social service providers, and the community-at-large all have roles to play in improving the oral health of children in our community.

History and Background

Why oral health is important

In May 2000, the United States Surgeon General released a report on Oral Health in America and highlighted dental disease in children as a common, chronic problem and infectious disease.¹ Indeed, dental disease has been described as the single most common chronic disease of childhood and five times more common than asthma.² Dental problems impact a child's ability to eat, sleep and attend to learning.

Dental caries, the destructive process which causes cavities, begins in early childhood and continues throughout life. Cavities are the result of irreversible breakdown in the tooth enamel caused by bacterial infection. Harmful oral bacteria can be transmitted from parent to child. Excessive sugar and other dietary factors contribute to growth of bacteria and promote the decay process. Fluoride helps protect teeth from damage by making enamel more resistant to decay. If identified early, potential cavitations can be prevented and the breakdown of the tooth enamel (demineralization) can be reversed.³ Fillings, while the standard treatment for restoring the tooth structure, do not prevent or treat the infection that caused tooth decay.

Children in 3rd grade are at the height of dental caries experience in the primary teeth. Evaluation of the prevalence of tooth decay, treated or untreated, in primary teeth is an indicator of risk for tooth decay in the permanent teeth that are just now beginning to come into the mouth. Cavities and fillings, by third grade, are a measure of total disease experience in primary teeth. Visible dental sealants in the third grade are one measure of prevention for permanent teeth, since the permanent teeth have recently begun to erupt into the mouth. Preventive dental sealants target the pits and fissures of permanent molars, which is where 87% of dental caries in permanent teeth will occur.⁴

History of direct oral health surveillance in Washington

Approximately every five years, the Washington State Department of Health (DOH) conducts a statewide oral health screening of children at elementary schools and HeadStart/ECEAP program sites, called the SMILE Survey. In the 1996

¹ Satcher D. Oral Health in America: A Report of the Surgeon General, May 2000.

² Edelstein B, Douglass C. Dispelling the cavity free myth. Public Health Reports 1995, 110:522-30.

³ Featherstone JD. Remineralization, the natural caries repair process--the need for new approaches. *Adv Dent Res*. 2009;21(1):4-7.

⁴ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Preventing Dental Caries. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2005.
<http://www.cdc.gov/NCCdphp/publications/factsheets/Prevention/oh.htm>.

state survey, no Whatcom County schools were surveyed. In 2000, the statewide SMILE Survey included two elementary schools in Whatcom County. In 2005 and 2010, the statewide randomized samples did not include any Whatcom County elementary schools, however Whatcom County Health Department (WCHD) conducted our own surveys. In 2005, the Whatcom SMILE Survey focused only on 3rd-graders in *Bellingham* public elementary schools. In 2010, the Whatcom survey sample included randomized schools throughout the county.



Year	SMILE Survey in Whatcom County
1996	NA
2000	Two elementary schools in Whatcom County were included in WA DOH state-wide SMILE Survey sample.
2005	<u>Bellingham</u> Public Elementary Schools; <u>All</u> 3 rd -grade classrooms.
2010	Kindergarten Third Grade Head Start /ECEAP

The oral health information from these surveys helps communities understand the prevalence of dental disease as well as the disproportionate impact of dental disease on children from low-income families, children from minority groups, and children from immigrant/refugee families. This report includes comparison of the oral health of children in Whatcom County with those throughout the State of Washington. The local data from 2010 is not comparable to 2005 so is not included in this report.

Survey Methodology

Concurrent with Washington's administration of the statewide 2010 Smile Survey, Whatcom County chose to do an oversample at the county level to provide current county-specific surveillance information. The assessment occurred during the 2009-2010 school year in local kindergarten and 3rd grade classes. Individual schools were selected through a randomization process. Participation was subject to approval by school administrative staff.

Dentists and dental hygienists, who attended a one day training session, screened school children using gloves, a disposable dental mirror and penlight. Screenings were completed at:

- 8 Head Start/ECEAP sites (in 208 preschoolers) and
- 13 elementary schools (in 548 kindergarteners and 589 third graders).

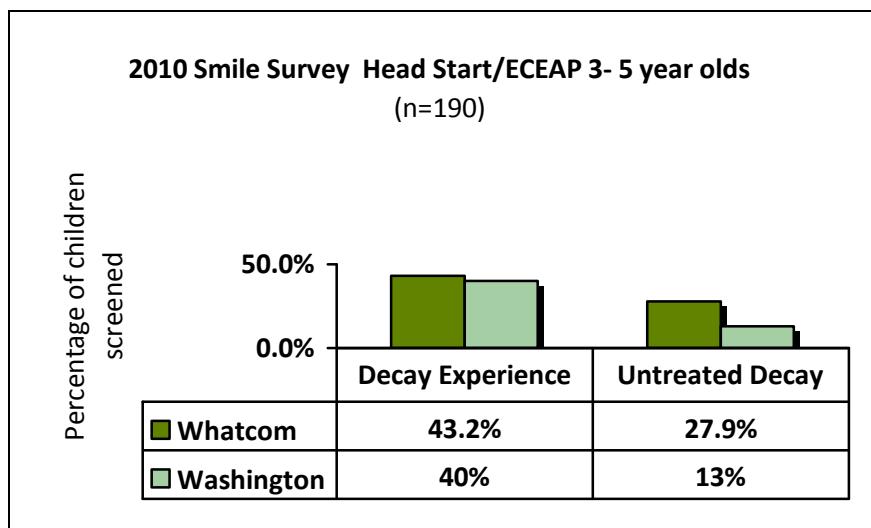
Response rates were 80% percent for kindergarteners and 84% percent for third graders. Of the 208 pre-school children enrolled in Head Start programs, 190 children in the 3-5 year age range completed screening. Other pre-school children were either younger, refused to participate, or age was unknown.

Detailed survey methodology is available in Appendix A. Survey results by grade are available in Appendix B.

Key Finding #1—Dental disease is a serious health issue for many Whatcom County children

What the data shows

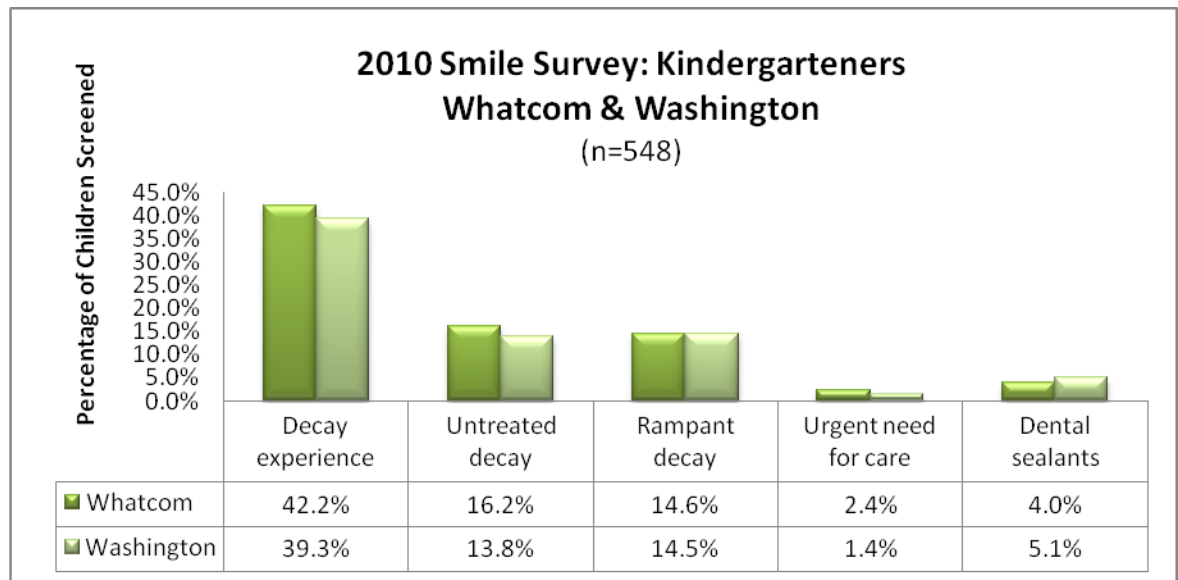
- ▣ **Preschool Children:** Of the 190 Head Start children who were screened, 43.2% had decay experience compared to 40.3% in Washington overall. Of greater concern are the high levels of untreated decay evident for 27.9% of these children, more than double the 2010 state percentage of 13.0% and falling short of the Healthy People 2020 goal of 21% for preschoolers.



Any level of dental disease in children is undesirable. The 2010 Whatcom Smile Survey, however, shows that dental disease is worse in our County than at the state level with very few exceptions.

★★★★★★★★★★
 The national 2020 Healthy People objectives for preschool prevalence:
 21% for untreated decay
 ★★★★★★★★★★

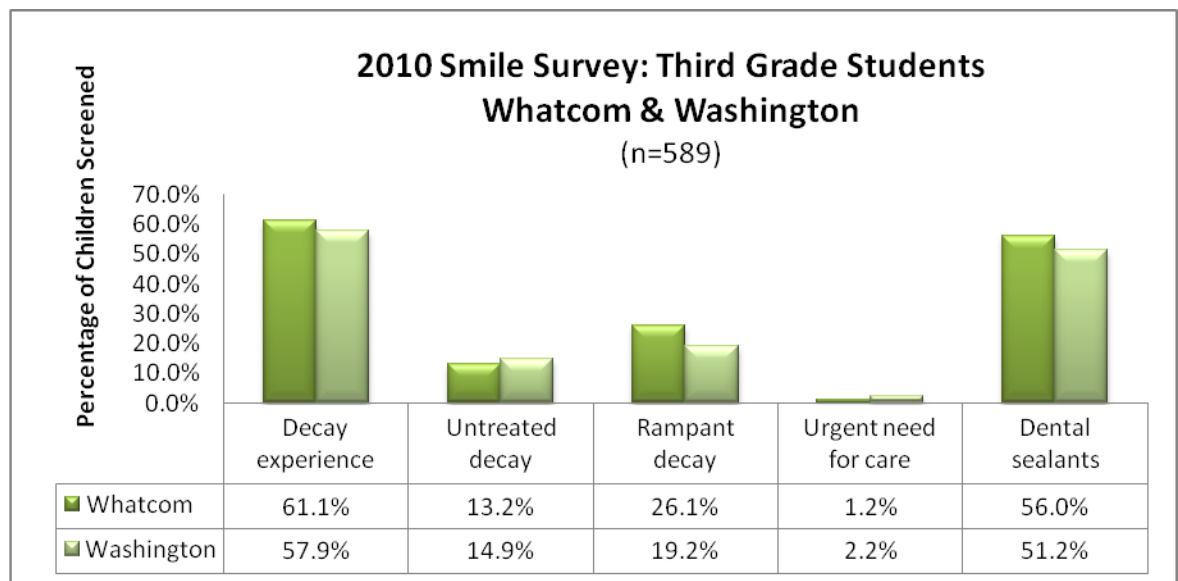
☐ **Kindergarteners:** Of the 548 Whatcom children who were screened, Whatcom percentages were all higher than state percentages for decay experience, untreated decay, and urgent need for dental care. The percentage with rampant decay (7+ cavities) was only slightly higher. The percentage with dental sealants was slightly less than the state.



The national 2020 Healthy People objectives for 3rd grade prevalence:
42% decay experience and 21% untreated decay



☐ **Third graders:** Findings for third graders were mixed. Decay experience and rampant decay percentages were higher than in Washington and both Whatcom and the state fell short of the 2020 Healthy People objectives for decay experience. However, both Whatcom and the state exceeded national objectives for untreated decay. The percentage of Whatcom third graders with sealants was high (56%).



Key Finding #2—Oral health disparities were extensive

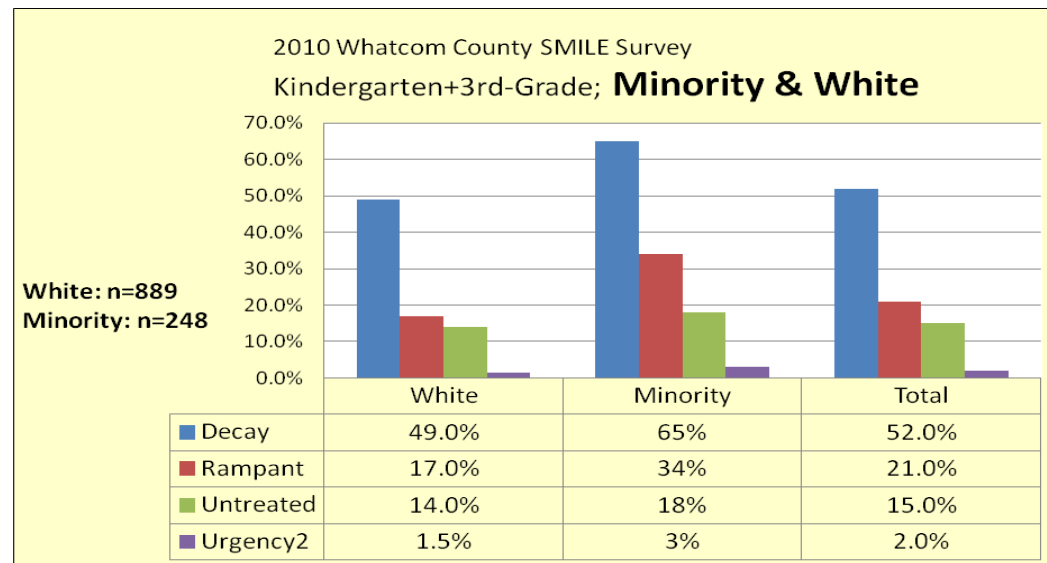
Why disparity matters



In a democratic society health should be within the reach of every citizen. The mounting evidence that health outcomes are extensively tied to differences in race, ethnicity, and socio-economic status is disturbing. Even more unsettling is when disparities impact children, as in the case of oral health disparities. When dental disease impacts a child’s educational experience then disparities are likely to have lifelong impacts.

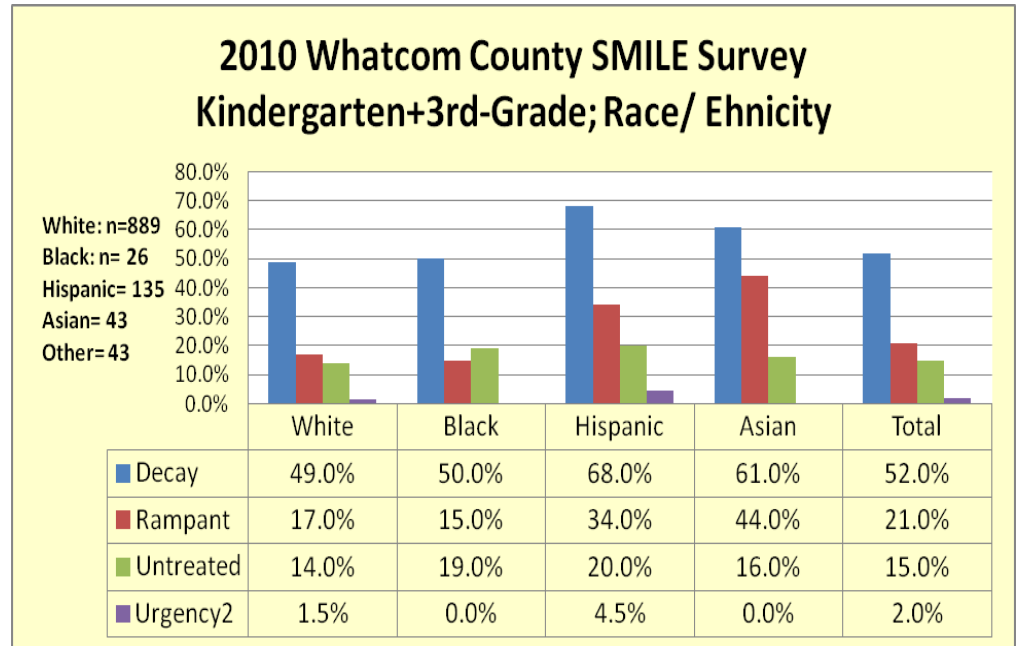
What the data shows

☐ **Disparities overall:** Minority kindergarten and third grade students had higher percentages of decay, rampant decay, untreated decay and the need for urgent care than did white students. In particular, rampant decay was twice as prevalent for minority children—34% versus 17% for white children.



☐ **Disparities by race/ethnicity:** Oral health outcomes varied for different minority children.⁵

- Hispanic children had the highest percentage decay experience—68% versus 49% of white, non-Hispanic children.
- Rampant decay was the most prevalent in Asian children (44%) and Hispanic children (34%).
- 20% of Hispanic children had untreated decay.
- Hispanic children also had the highest percentage “follow-up care recommended” (22%)⁶ and “urgent care needed” (4.5%).
- African American children also had high rates of untreated decay (19%). On a positive note, they had the highest percentage for visible sealants (64%).⁷



☐ **Disparities by language:** The 138 non-English speaking children (K & 3rd grades) had consistently higher percentages of decay experience, rampant decay, untreated decay, follow-up care recommended, and urgent care needed. They had a slightly higher percentage of visible sealants, as shown in the following table:

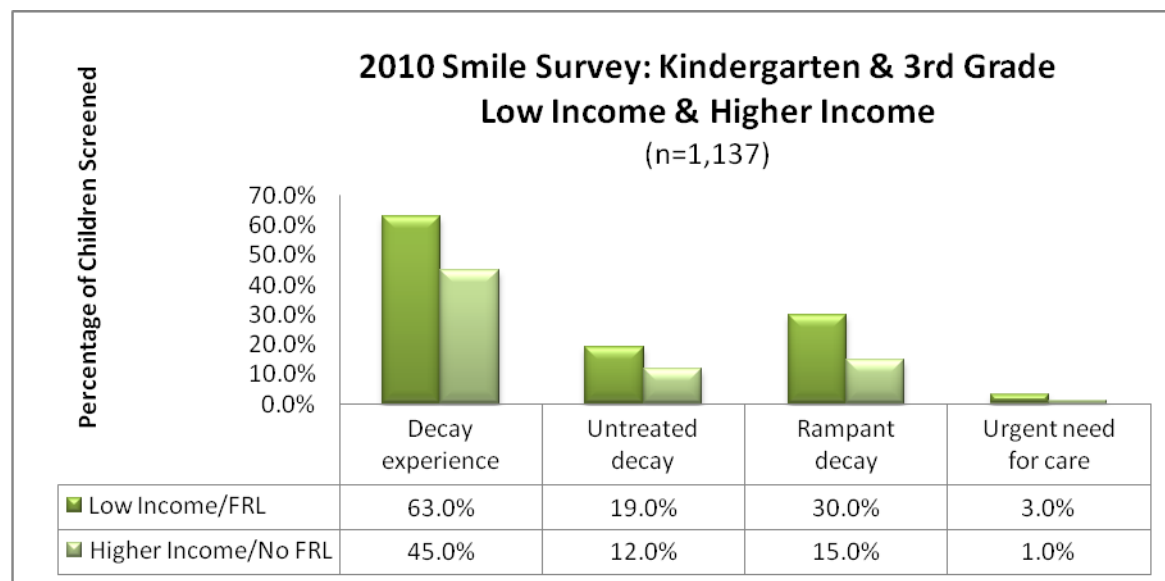
	English-speaking (n=999)	Other Languages (n=138)
Decay experience	50%	69%
Rampant decay (7+ teeth)	18%	39%
Untreated decay	14%	17%
Follow-up care recommended	14%	18%
Urgent care needed	1.5%	4.3%
Visible sealants	56%	59%

⁵ Screening numbers were not large enough for American Indian/Alaska Native (n=16) and “Other” (n=25) to provide comparison numbers with other minorities.

⁶ This finding is not shown in the chart.

⁷ This finding is also not shown in the chart.

☐ **Disparities by socio-economic status:** The Smile Survey uses eligibility for Free or Reduced Lunch (FRL) as a placeholder for socio-economic status. Survey data shows that children who receive FRL have higher percentages of dental disease than their counterparts who are not eligible for FRL and considered to have a higher income level.



In addition to findings highlighted in the chart above, data show that rampant decay was much more common for third graders from low-income families—37% compared to 20% for students from higher-income families. Kindergarteners from low-income families also had very high percentages of untreated decay, including urgent needs for dental care due to pain and infection. Untreated decay for these students was 22% compared to 13% for those children whose families had higher incomes.

☐ There is high variability of oral health status between schools, even those with similar income groupings. This variability is greater for children who do *not* have FRL. However, due to small numbers of children at each individual school, findings must be viewed with caution and individual school data are not reported in this document.

Key Finding #3—Whatcom County is doing well with preventive dental sealants

Why dental sealants are part of an effective prevention program

Dental sealants are thin plastic coatings applied to the grooves on the chewing surfaces of the back teeth as soon as they erupt in the mouth. The back teeth are where most dental decay in children and teens occurs. Sealants significantly reduce a child's risk for having decay. In some cases, sealants can even stop dental decay that has already started.⁸ School dental sealant programs are especially important for reaching children from low-income families who are less likely to receive dental care otherwise.

What the data shows

- ☐ Over 56% of third grade students have preventive dental sealants.
- ☐ The percentage of children with sealants is consistent across income, race/ethnicity, and language group. For instance, 57% of 3rd graders from low-income families had visible sealants compared to 56% for children from higher-income families.

The positive news is that the percentage of Whatcom County children with preventive dental sealants exceeds both Washington 2010 Smile survey findings AND national Healthy People 2020 objectives.

★★★★★★★★★★
The national 2020 Healthy People objectives for sealant prevalence:
28% for third graders
★★★★★★★★★★

⁸ American Dental Association. Evidence-based Clinical Recommendations for Dental Sealants 2009 at <http://www.ada.org/4194.aspx?currentTab=2>.

Recommendations

Following a review of the Whatcom County 2010 Smile Survey findings, Whatcom County Oral Health Coalition members met to reflect on what had been learned. Following a group discussion process, the Coalition offered the following recommendations or key strategies for improving the oral health of children in Whatcom County:

For Schools

- ☐ Consider incorporating oral health screening into kindergarten entry requirements.
- ☐ Promote targeted oral health interventions for schools.
- ☐ Conduct Smile-Survey-type basic oral health screening at additional schools within Whatcom County. In order to minimize cost, as well as extra work or disruption for schools, this can be incorporated into existing mobile dental program days at those schools.
- ☐ Expand and continue to promote access to school-based dental programs, including dental sealants.

For Health Care and Social Service Providers:

- ☐ Expand, improve, and promote access to comprehensive *decay prevention* (and treatment as needed) for pregnant women, infants, toddlers and preschoolers.
- ☐ Promote annual oral health exams and oral health education as a *minimum* standard of care for all children, particularly for higher-risk children, starting by one year of age.
- ☐ Continue to educate medical providers about the relationship between oral health and general health. Promote strategies to incorporate risk-assessment, education and dental referrals.
- ☐ Promote targeted oral health interventions for populations which demonstrate highest risk.
- ☐ Expand and promote access to community-based dental programs, including dental sealants.
- ☐ Develop strategies to maximize appropriate conservative restorative treatment.

For System Infrastructure:

- ☐ Consider water fluoridation in Whatcom County communities.

Appendix A: Detailed Survey Methodology

Methods

The 2010 Whatcom County SMILE Survey used the same methodology as the 2010 Washington State SMILE Survey*. An electronic data file of public elementary schools in Whatcom County was obtained from the Washington State Office of the Superintendent of Public Instruction (OSPI).

At the time of the screenings (between November 2009 and March 2010), demographic information was noted for each child including: age, gender, race/ ethnicity. Each child was asked what language their family usually speaks at home with the responses categorized as English, Spanish, or other language. Free-or-reduced fee lunch program status (as a proxy for low-income status) was obtained utilizing a code-based system to maintain school confidentiality policies.

All participating schools in Whatcom County used passive parental (guardian) consent. Two Licensed Registered Dental Hygienists, the “examiners” for Whatcom County, attended mandatory calibration training in Yakima in the fall of 2010. Examiners used only gloves, a penlight, cotton gauze, and a dental mirror to look at the children’s teeth for this survey at school. This 1-2 minute dental screening results in an *under*-estimation of dental disease. Oral health indicators recorded for the survey included untreated caries (decay), treated caries, rampant caries (7 or more teeth with decay experience-treated and/or untreated), dental sealants (on one or more on permanent teeth) & treatment urgency (none, early, urgent).

Each child received a toothbrush and mouth mirror, as well as a letter stating whether follow-up was recommended.

Sampling and Response Rate

The schools participating in the 2010 Whatcom County SMILE Survey were selected by WA State DOH using a similar sampling methodology as for the state-wide 2010 SMILE Survey conducted by WA State DOH. This increases the reliability of comparison

between results. If a school refused to participate, a replacement school within the sampling strata was randomly selected by DOH. Schools were stratified or ordered by the level of participation in Free and Reduced Lunch Programs (FRL). This ensured a representative sample of schools by income.

The Free-and- Reduced Fee Lunch program data (FRL) is a useful proxy for low-income because students whose families are at 185% of the federal poverty level qualify for this program and it is routinely reported by the Office of the Superintendent of Public Instructions (OSPI). The Medicaid Program also has a sharing agreement with OSPI to assure that children with Medicaid coverage are enrolled in FRL programs. This percent of children eligible for the FRL program was used to select a proportional probability sample. The term ‘low income’ will refer to participants that participated in the FRL in this survey analysis.

FRL data was obtained from OSPI Child Nutrition Program staff using a random code number assigned to each child to maintain confidentiality of his FRL eligibility. Code numbers were reported on the data collection form and on a class list. The code numbers were returned to the Child Nutrition staff, who identified which code numbers corresponded with students who participated in the low income program, and then recorded the code number on the data collection form after the oral assessment. Examiners did not know the income status of individual children.

Data entry and analysis

Data entry and analysis was completed using EPI INFO Version 3.2.2, which is a public access software program developed and supported by the Centers for Disease Control and Prevention (CDC).

*Note: The Washington State 2010 Smile Survey did not include any Whatcom schools in the random sample.

Screening Forms

Smile Survey 2010

Head Start / ECEAP

Preschoolers

Student #

All boxes must contain a valid code.

School #

Grade <input type="text"/>	Child's Age <input type="text"/> <input type="text"/>	Gender <input type="text"/> 1=Male 2=Female
Language at Home <input type="text"/> 1=English 3=Other 2=Spanish 4=Unknown	F/R Lunch <input type="text"/> 0=Not eligible 1=Eligible 2=Unknown	Race/Ethnicity <input type="text"/> 1=White 3=Hispanic 5=AI/AN 7=Unknown 2=Black 4=Asian 6=Other
Untreated Cavities <input type="text"/> 0=No untreated cavities 1=Primary only 2=Primary & Permanent 3=Permanent only	Treated Cavities <input type="text"/> 0=No untreated cavities 1=Primary only 2=Primary & Permanent 3=Permanent only	
History of Rampant Caries <input type="text"/> 0=No Rampant Caries 1=Rampant \geq 7 teeth	Sealants on Permanent Molars <input type="text"/> 0=No sealants present 1=Sealants present	
Whitespot Lesions <input type="text"/> 0=No White spots on maxillary anteriors 1=White spots on maxillary anteriors	Treatment Urgency <input type="text"/> 0=No obvious problem 1=Early dental care 2=Urgent care	

Smile Survey 2010

Public Elementary School

Kindergartners and Third Graders

Student #

All boxes must contain a valid code.

School #

Grade <input type="text"/>	Child's Age <input type="text"/> <input type="text"/>	Gender <input type="text"/> 1=Male 2=Female
Language at Home <input type="text"/> 1=English 3=Other 2=Spanish 4=Unknown	F/R Lunch <input type="text"/> 0=Not eligible 1=Eligible 2=Unknown	Race/Ethnicity <input type="text"/> 1=White 3=Hispanic 5=AI/AN 7=Unknown 2=Black 4=Asian 6=Other
Untreated Cavities <input type="text"/> 0=No untreated cavities 1=Primary only 2=Primary & Permanent 3=Permanent only	Treated Cavities <input type="text"/> 0=No untreated cavities 1=Primary only 2=Primary & Permanent 3=Permanent only	
History of Rampant Caries <input type="text"/> 0=No Rampant Caries 1=Rampant \geq 7 teeth	Sealants on Permanent Molars <input type="text"/> 0=No sealants present 1=Sealants present	
Treatment Urgency <input type="text"/> 0=No obvious problem 1=Early dental care 2=Urgent care	Comments	

Appendix B: Survey Results

Elementary School Data

Demographics of Population Screened (Kindergarten and Third Grade):

Gender		Age		Primary Language Spoken at Home		Family Income		Race/ Ethnicity	
Male	51%	5 yrs-old	30.9%	English	87.9%	Low-income	38.4%	White	78.2%
Female	49%	6 yrs-old	17.1%	Spanish	8.4%	NOT Low-Income	61.6%	Hispanic	11.9%
		7 yrs-old	0.4%	Other	3.7%			Asian	3.8%
		8 yrs-old	34.4%					African-American	2.3%
		9 yrs-old	17.2%					American Indian/Alaska Native	1.4%
		10 yrs-old	0.2%					Other	2.2%
								Missing	0.2%

Overall Screening Numbers (Kindergarten and Third Grade):

K+3rd Grade	Findings	Number of Students	Percentage with Finding
	Enrollment		
	Screened	1137	NA (100%)
	Decay Experience	592	52%
	Rampant Decay (= 7+ teeth)	234	21%
	Untreated Decay	167	15%
	Need for Care (1 + 2)	169	15%
	Need for Care 2 (Urgent)	20	1.80%
3rd Grade	Findings	Number of Students	Percentage with Finding
	Enrollment		
	Screened	589	NA (100%)
	Decay Experience	361	61%
	Rampant Decay (= 7+ teeth)	154	26%
	Untreated Decay	78	13%
	Need for Care (1 + 2)	80	14%
	Need for Care 2 (Urgent)	7	1.20%
Kindergarten	Findings	Number of Students	Percentage with Finding
	Enrollment		
	Screened	548	NA (100%)
	Decay Experience	231	42%
	Rampant Decay (= 7+ teeth)	80	15%
	Untreated Decay	89	16%
	Need for Care (1 + 2)	89	16%
	Need for Care 2 (Urgent)	13	2.40%
Visible Dental Sealants (# is the total children, not total teeth)			
	Total # Screened	Number of Students	Percentage with Finding
3 rd Grade	589	330	56%
Kindergarten	548	22	4%

Head Start/ECEAP Data

Demographics of Population Screened-3 to 5 year olds only (n=190):

Gender		Age		Primary Language Spoken at Home		Race/ Ethnicity	
Male	96 (50.5%)	3	48 (25.3%)	English	99 (52.1%)	White	114 (60%)
Female	94 (49.5%)	4	84 (44.2%)	Spanish	20 (10.5%)	Hispanic	42 (22.1%)
		5	58 (30.5%)	Other	71 (37.4%)	Asian	9 (4.7%)
						African-American	3 (1.6%)
						American Indian/Alaska Native	1 (0.5%)
						Other	21 (11.1%)

Head Start and ECEAP 3 to 5 year olds only(n=190):

Findings	Number of Students	Percentage with Finding
Caries free	108	56.8%
Caries Experience	82	43.2%
Treated Decay	50	26.3%
Untreated Decay	53	27.9%
Treatment Needed		
• No obvious problem	137	72.1%
• Early dental care needed	46	24.2%
• Urgent dental care needed	7	3.7%