



United South and Eastern Tribes, Inc.

Nashville Area Oral Health Screening Survey 2009



ACKNOWLEDGEMENTS

This is the initial Nashville Area Oral Health Screening Report. The report represents the combined efforts of the Tribal Health Program Support section of United South and Eastern Tribes, Inc. and majority of the Nashville Area (NA) Tribes. Both dental and non-dental personnel have contributed to the oral health survey. The United South and Eastern Tribes, Inc. (USET), Nashville Area Oral Health Report and its sister Indian Health Service (IHS)/Tribal/Urban (I/T/U) specific reports would not be possible without the dedicated and professional work of Nashville Area I/T/U health program personnel. We want to extend special thanks to all the Nashville Area I/T/U personnel that participated in the Oral Health Screening Survey.

Screeners/ Reviewers:

Ann Christopher
Myra Battise
Joyce Biberica
Belkys Bueno
Jessica Burns
Mellie Burns
Kerri Cook
Paul Dirkes
Patty Flake
Donna Harris
Cathy Hollister
Veronica Lopez
Claudia Otero
John Otteson
Juan Packer
Rhonda Plake

Pat Planck
Mary Repole
Jennifer Segura
Jeff Stuart
Carol Taylor-Sprague
Beth Tilmont
Stacey Wilder
Rhonda Plake
Florance Thomas

USET Staff Contributors

Chris Compher
Wes Cornelius
Christy Duke
Edna Faye
John Mosely Hayes
Byron Jasper
Trudie Raymond
Dianna Richter
Dee Sabbatus

Project Consultant and Data Analysis

Kathy Phipps, DrPH

For Copies Contact:

Cathy Hollister, RDH, MSPH, PhD
Dental Support Center
United South and Eastern Tribes, Inc.
711 Stewarts Ferry Pike
Nashville, TN 37076
615-872-790

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NASHVILLE AREA TRIBES PARTICIPATING IN THE ORAL HEALTH SCREENING SURVEY

Alabama-Coushatta Tribe of Texas

Aroostook Band of Micmac Indians

Catawba Indian Nation

Chitimacha Tribe of Louisiana

Coushatta Tribe of Louisiana

Eastern Band of Cherokee Indians

Houlton Band of Maliseet Indians

Jena Band of Choctaw Indians

Mashpee Wampanoag Tribe

Miccosukee Tribe of Indians of Florida

Mississippi Band of Choctaw Indians

Narragansett Indian Tribe

Native American Lifelines

Oneida Indian Nation

Passamaquoddy Indian Township

Passamaquoddy Pleasant Point

Penobscot Indian Nation

Poarch Band of Creek Indians

Seminole Tribe of Florida

Seneca Nation of Indians

St Regis Mohawk Tribe

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SUMMARY AND KEY FINDINGS

Tooth decay (dental caries) is an infectious disease process affecting both children and adults. Even though the prevalence of tooth decay has declined in the U.S. over the last 30 years, it remains the most prevalent and yet easily preventable disease known to man. Certain groups suffer disproportionately including both low-income and minority children. The public perception among many is that tooth decay is a natural and minor occurrence that deserves little attention or dollars. If left untreated, however, tooth decay can lead to needless pain and suffering; difficulty in speaking, chewing, and swallowing; lost school days, increased cost of care; and loss of self-esteem. The good news is that tooth decay is largely preventable through early risk assessment and comprehensive prevention strategies at the community and clinic level.

During 2009, 21 Tribes in the Nashville Area participated in an oral health survey of American Indian children 2-5 and 8-10 years of age. More than 1,000 children 2-5 years of age and 740 children 8-10 years of age participated. Findings from the survey have been organized into the following six key findings. These findings highlight the current oral health of children in the Nashville Area.

1. Dental decay is a significant health problem for American Indian children in the Nashville Area.
2. Many American Indian children in the Nashville Area do not get the dental care they need.
3. Half of the American Indian children in the Nashville Area have dental sealants, a well accepted clinical intervention to prevent tooth decay on molar teeth.
4. Treatment is good. Prevention is better. Early prevention is best.
5. There are significant oral health disparities in the Nashville Area with American Indian children having the highest level of dental disease.
6. Although Nashville Area children have a high burden of oral disease, their oral health is better than American Indian children from other IHS Areas.

ORAL HEALTH AT-A-GLANCE

AGE GROUP	ORAL HEALTH STATUS
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2-5 Years

Decay Experience:	55% of 2-5 year old children have experienced dental decay
Untreated Decay:	42% have untreated decay
Need for Care:	42% need dental care, 17% need urgent care because of pain, infection or 6 or more cavities

8-10 Years

Decay Experience:	75% of 8-10 year old children have experienced dental decay
Untreated Decay:	45% have untreated decay
Need for Care:	51% need dental care, 12% need urgent care because of pain, infection or 6 or more cavities
Dental Sealants:	50% of 8-10 year old children have dental sealants

INTRODUCTION

The Nashville Area Oral Health Screening Survey collected data throughout the Nashville Area on the presence of dental decay, decay experience, need for dental care and dental sealants for children 2-5 and 8-10 years of age. Of the 25 United South and Eastern, Inc. member tribes, 21 (84%) and one urban center participated in this survey. Tribes with direct dental care plus Tribes that provide dental care only through Contract Health Services (CHS) participated. This screening survey was intended to compliment the more comprehensive Indian Health Service Oral Health Survey that includes more indicators on a wider age range of patients. This report documents findings from both clinic patients and community members.

*You are not
healthy without
good oral health.*

Primary Oral Health Indicators

The Nashville Area Oral Health Screening Survey was conducted using the indicators outlined in the Association of State and Territorial Dental Directors' Basic Screening Survey.¹ The protocols were adapted slightly for this survey that included both community-

based dental screenings and dental record reviews. This report provides data that is comparable to previous IHS Oral Health Surveys and most state surveys.

The core indicators for this survey were: untreated dental decay, decay experience (decay, fillings, crowns or extractions due to decay), presence of dental sealants (older children only), and treatment urgency. Prior to beginning the survey, the project coordinator met with local dental and/or administrative staff to discuss the survey, procedures and possible application of the data. Each site developed a unique screening form designed to meet local needs.

Dental Decay

Dental decay, also known as dental caries, is the most common disease in children today. In the US, dental decay is five times more common than childhood asthma and seven times more common than hay fever.² Common risk factors for dental decay are a diet high in sugars, frequency of exposure to sugars, presence of plaque, low exposure to fluorides, and episodic dental care.

Left untreated, dental decay may lead to pain, infection, poor nutrition, failure to thrive, difficulty in eating and speaking, poor self esteem and tooth loss. For this reason the former Surgeon General of the US, C. Everett Coop stated, "You are not healthy without good oral health."² The 2000 report *Oral Health in America* stated that oral health can impact general health, and is critical to overall health. The report concludes that due to the

extent of existing dental disease, this may well be a “silent epidemic” affecting our most vulnerable citizens such as children and many members of racial and ethnic groups.²

Treatment Urgency

One of the core indicators of this survey was “dental treatment urgency”. A child was considered to need urgent care if they had pain or infection or had six or more cavities. Urgent care has also been called “rampant decay” in similar surveys. Regardless of the label, urgent care reflects severe dental disease. Treatment of severe disease consumes many local resources and may require specialty care, often delivered in the operating room under general anesthesia. Tracking urgent needs can provide valuable information to local programs in terms of budgeting, planning and evaluation of clinical and prevention programs.

Dental Sealants

A dental sealant is a thin coating applied to the chewing surface of back teeth; the teeth that are most vulnerable to tooth decay. Sealants are so effective at preventing decay that the IHS uses sealant placement as one of the Government Performance and Results Act (GPRA) indicators. Previous IHS surveys have shown that IHS has one of the leading sealant programs in the world. The 1999 IHS Oral Health Survey reported that 66% of children aged 8-10 had at least one molar sealant.³

Access to Clinical and Preventive Services

The mission of the Nashville Area Dental Support Center is to improve access to quality clinical and preventive services to American Indians/Alaska Natives in the Nashville Area. Surveillance that tracks the status of oral health in the Area is critical to program evaluation and decision making at the local level for both clinical and preventive programs. Oral health data reported in this survey will allow local programs to monitor disease trends, compare local rates with Area or state disease rates, evaluate local prevention programs, and plan for future needs.

To increase access to both clinical and preventive dental services, all children found to have routine or urgent needs were referred for follow up care and all children with a signed consent received a fluoride varnish treatment at the time of the screening.



Photo Courtesy United South and Eastern Tribes, Inc.

METHODS

The target groups for the Nashville Area Oral Health Screening Survey were children aged 2-5 and 8-10 years. Data were collected using two methods: face to face screenings and chart reviews. Both methods used the same definitions of disease and treatment needs. Regardless of data collection method, the core indicators included untreated decay, decay experience (current decay, restorations or extractions due to decay), presence of molar sealants, and treatment urgency (no obvious need, routine needs or urgent need). Other indicators were added by individual Indian Health Service/Tribal/Urban (I/T/U) programs, according to local needs. Additional indicators included tobacco use, orthodontic status, oral hygiene, dental visit in the past year, and dental cleaning in the past year.

Screenings were conducted at various community sites such as Head Start, schools, health fairs, holiday celebrations, and sporting events. Head Start children had consent on file for routine dental exams and treatment. Passive or active consent was used for elementary school children. Fluoride varnish was applied to children with a signed consent form. Children screened using passive consent were not given a fluoride treatment. All Tribal members who attended a community event were offered a dental screening. Parents were informed of obvious dental needs. Fluoride varnish was applied to children accompanied by parent or guardian who signed consent for the treatment. Those individuals with urgent needs were referred to appropriate Tribal staff for referral or follow up.

Screenings, completed by a dentist or dental hygienist, were visual only using a mouth mirror and light source; no x-rays were taken. Children who refused the screening or for whom oral status could not be determined were excluded from the analysis.

Chart reviews were done by reviewing comprehensive examination forms in either a hard copy dental chart or electronic dental record. To identify records, computer searches were done to identify patients in the target age groups who had an examination with full mouth charting (codes 0150 or 0120) between October 1, 2008 and December 31, 2009. All charts that met the search criteria were included in the survey.

Many of the charts included in this survey were from Head Start examinations. Because a dental examination is required for Head Start, and not the result of individuals seeking dental care, Head Start chart reviews were considered “screenings” (community surveys) rather than “chart reviews” (clinical surveys).

Screeners and chart reviewers were trained and calibrated prior to screening. In the case of screening, all examiners received instructions printed by ASTDD regarding classification of each indicator. In the case of multiple reviewers for a single site, all reviewers completed 5-10 screenings or chart reviews. Screening results were written on paper forms and then entered into an Excel Spreadsheet. Data analysis was completed using SAS 9.1.

This screening survey included a convenience sample of patients with a dental exam between 10/1/2008 and 12/31/2009 plus children screened in community settings. If a child had an examination and was screened in the community, only data from the chart review was included in the analysis.

Dental Decay

Teeth were considered to have untreated decay if there was an obvious lesion more than .5mm in diameter. White spots or teeth treatment planned for sealants or preventive resin restorations were considered sound. Decay experience was evaluated on the presenting or charted teeth only. Decay experience included untreated decay, restorations and teeth extracted because of decay.

Sealants

Screening: teeth were evaluated visually only. Sealants were judged present if any permanent molar had a partially or fully intact sealant.

Chart Reviews: Sealants were judged present if an intact sealant was charted on a permanent molar on the exam form.

Treatment Urgency

Dental needs were scored “urgent” if there was documentation of pulpal involvement or if the individual had six or more decayed teeth. This definition varies slightly from the ASDTT protocols,¹ where urgent need is based on pain or infection. Because this survey included chart reviews where pain was not always documented, six or more decayed

teeth was included in the definition of “urgent needs”.

Limitations

The use of a convenience sample limits the ability to generalize the results to the population. However, the large sample size improves generalizability; approximately 27% of the 2-5 and 8-10 year olds with at least one medical visit in FY08 were included.

There are limitations to each form of data collection, both screenings and chart reviews. Chart reviews represent a selection bias by only including those individuals who choose to seek dental services. This may result in underestimation of dental disease because individuals who value dental health may seek regular care. In the case of very young children, however, it may overestimate the disease burden because parents who see obvious disease or have children in pain may be more likely to come to the dental clinics than parents of young children with healthy teeth and no dental complaints.

Community screenings and school screenings are more likely to reveal a true representation of the community’s oral health. However, screenings may not detect cavities between teeth that would be detected in a comprehensive examination. Because of the differences in data collection, this report includes results of all participants, and separate reports of clinic based (chart reviews) and community based (screenings) findings. Untreated decay may be underreported in community screenings. However rampant decay that is readily evident in visual screenings is much more

likely to be accurately reported in both community screenings and chart reviews.

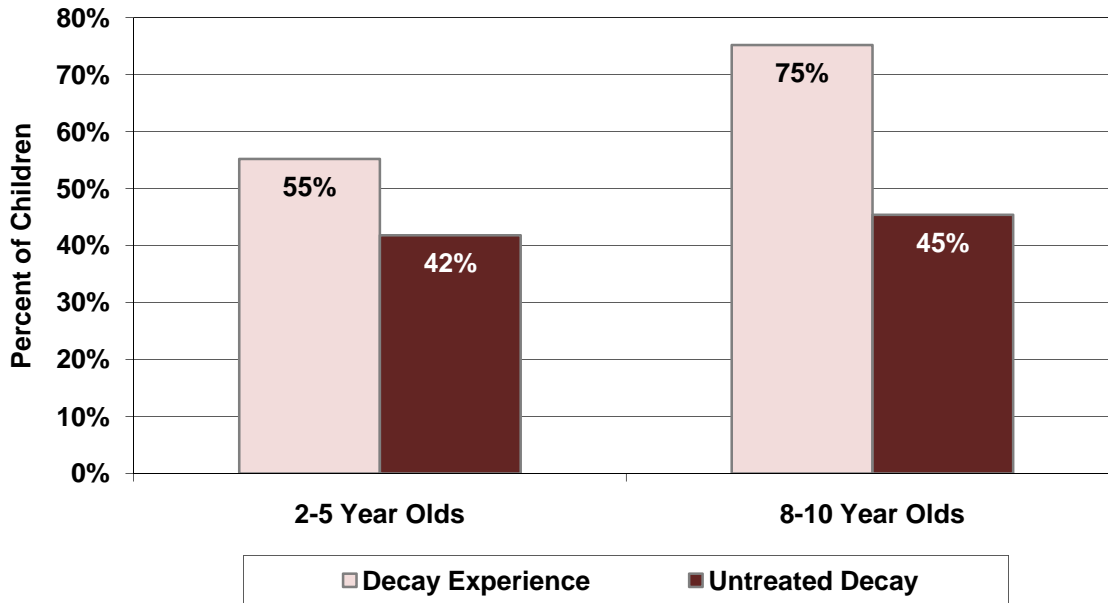
One further limitation is the small sample size in some individual Tribes. The total sample for the Nashville Area represented 27%

children in the primary target groups. But within smaller tribes, the sample was frequently much smaller. Therefore conclusions for individual I/T/Us may be limited due to small samples.



KEY FINDING #1: DENTAL DECAY IS A SIGNIFICANT HEALTH PROBLEM FOR AMERICAN INDIAN CHILDREN IN THE NASHVILLE AREA.

Percent of American Indian Children in the Nashville Area with Decay Experience and Untreated Tooth Decay, 2009



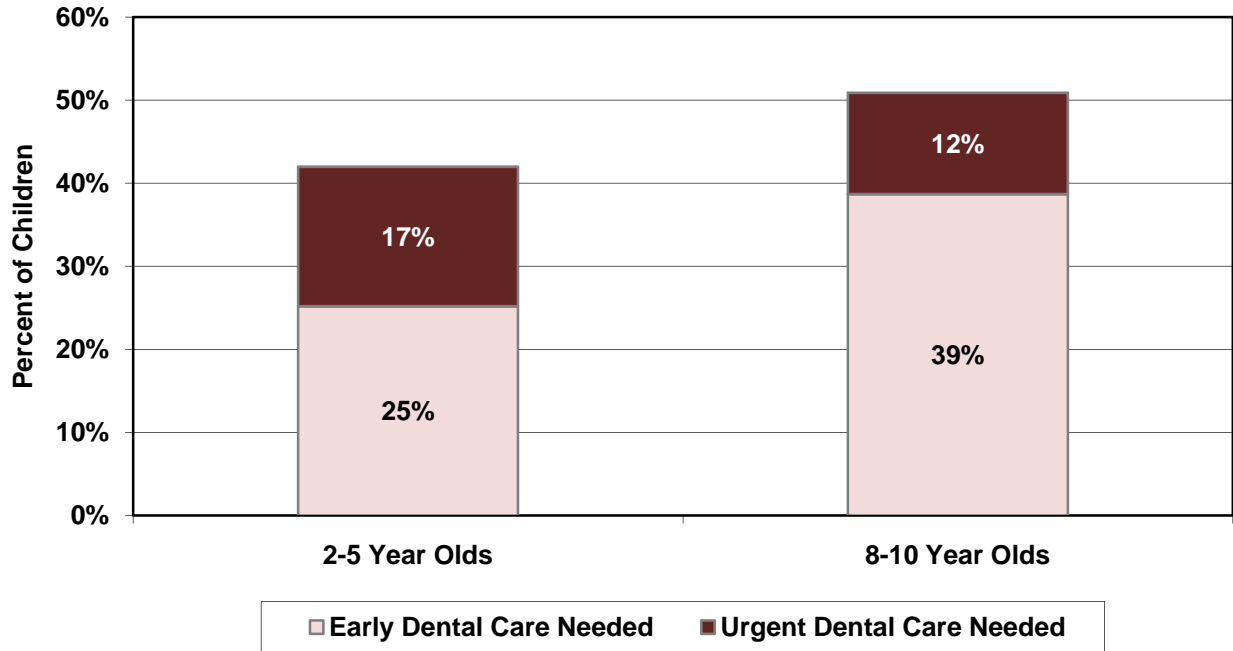
Decay experience means that a child has had tooth decay in the primary (baby) and/or permanent (adult) teeth in his or her lifetime. Decay experience can be past (fillings, crowns, or teeth that have been extracted because of decay) or present (untreated tooth decay or cavities). In the Nashville Area, 55% of the 2 to 5 year old children *already* have decay experience and more than 1 out of 3 have untreated tooth decay. By age 8-10 years, more than 75% of children have experienced tooth decay and almost 1 out of 2 has untreated tooth decay.

Untreated tooth decay hurts, and it introduces infection into the body, but it does more than that. Left untreated, tooth decay often has serious consequences, including needless pain and suffering, difficulty chewing (which compromises children’s nutrition and can slow their development), difficulty speaking (which can slow their intellectual and social development), and lost days in school.⁴

Refer to Table 1.

KEY FINDING #2: MANY AMERICAN INDIAN CHILDREN IN THE NASHVILLE AREA DO NOT GET THE DENTAL CARE THEY NEED.

Percent of American Indian Children in the Nashville Area Needing Early or Urgent Dental Care, 2009



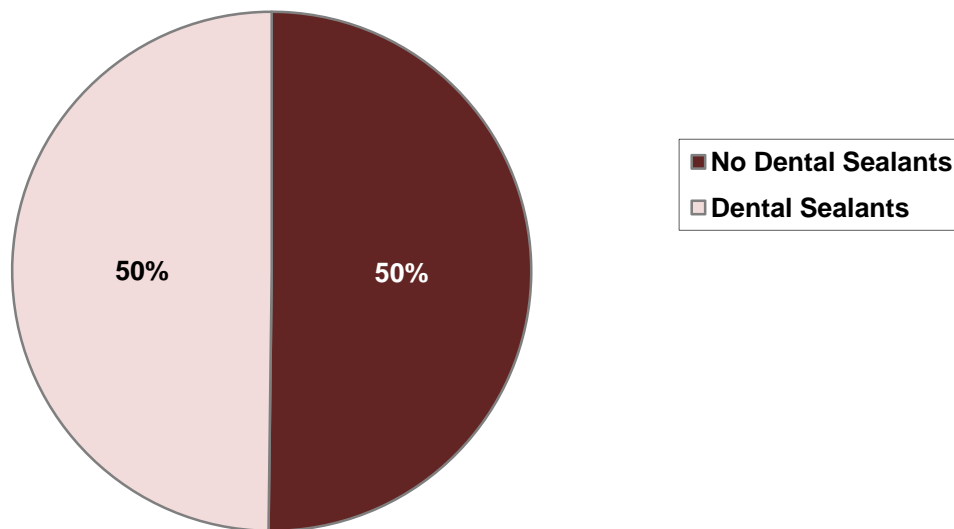
Forty-two percent of the 2-5 year old children and 51% of the 8-10 year old children screened had a need for dental care – with 17% of the younger and 12% of the older children needing **urgent dental care**. In 2009 there were about 3,500 children 2-5 years old and 2,200 children 8-10 years old in the Nashville Area. If about 15% are in urgent need of dental care, this means that 855 young children are in pain, have an oral infection or have 6 or more cavities. That’s just those two age groups. If this percentage is extrapolated to all children 2-11 years of age, approximately 6,302 children in the Nashville Area, **about 945 children may need urgent dental care**.

For 62% of the children assessed we did not do a complete diagnostic dental examination. We did dental screenings - “Say ‘Ah,’” a look inside with a dental mirror, no x-rays, and none of the more advanced diagnostic tools. So we probably missed some problems. It is reasonable to assume that these numbers actually **underestimate the proportion of children needing dental care**.

Refer to Table 1.

KEY FINDING #3: HALF OF THE AMERICAN INDIAN CHILDREN IN THE NASHVILLE AREA HAVE DENTAL SEALANTS, A WELL ACCEPTED CLINICAL INTERVENTION TO PREVENT TOOTH DECAY ON MOLAR TEETH.

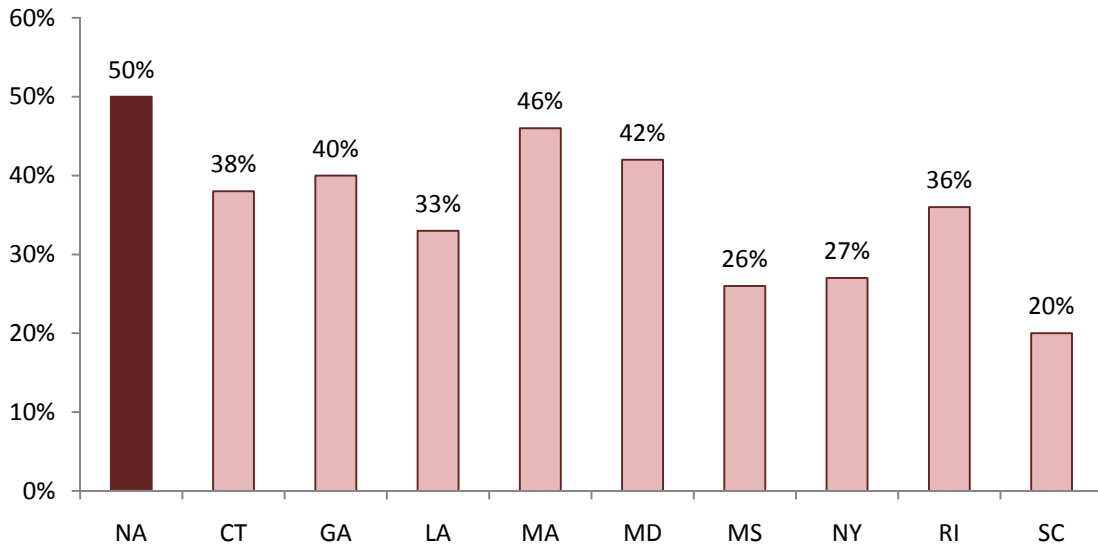
Percent of American Indian Children 8-10 Years of Age in the Nashville Area with Dental Sealants, 2009



Dental sealants are a plastic coating applied to the chewing surfaces of the back teeth. They are a safe, effective way to prevent tooth decay among schoolchildren. Sealants have been shown to significantly reduce a child's risk for having untreated decay. In some cases, sealants can even stop tooth decay that has already started.⁵ In the Nashville Area, 50% of the 8-10 year old American Indian children screened had dental sealants.

KEY FINDING #3 (CONTINUED): TRIBAL PROGRAMS EXCEED MOST STATES IN SEALANT PLACEMENT.

Dental Sealants Children Age 8-10*

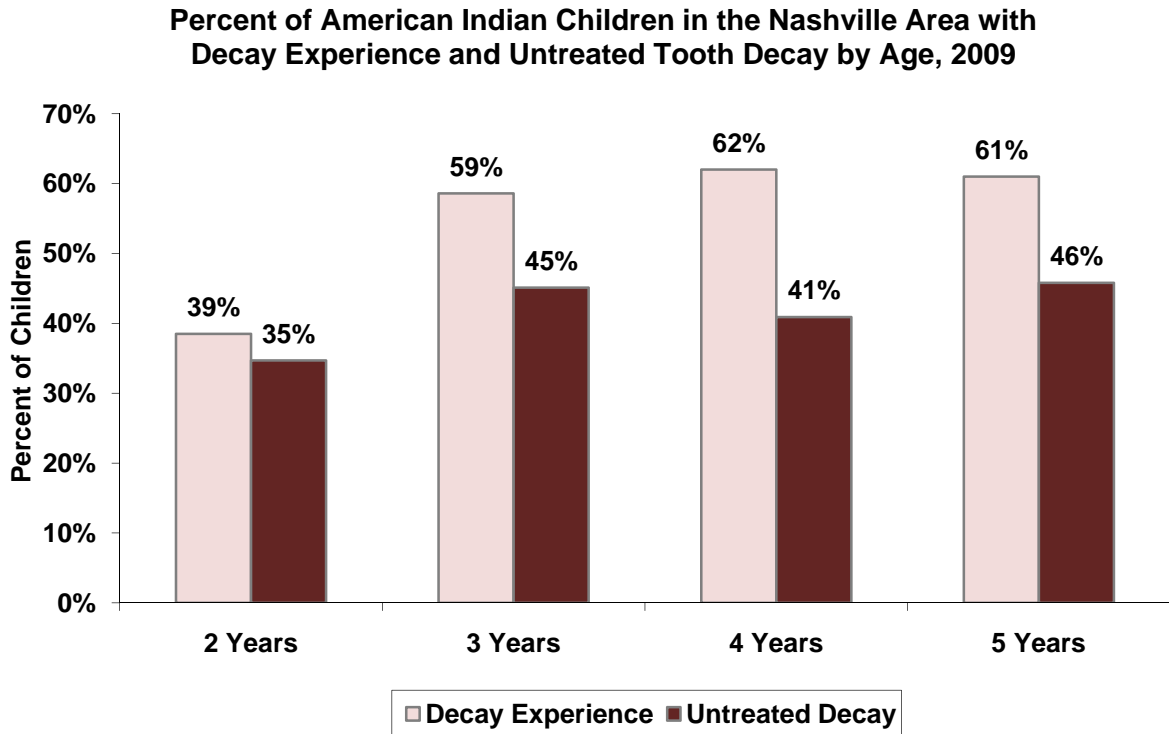


Most dental decay starts on the chewing surfaces of teeth. Dental sealants protect that chewing surface so bacteria cannot pool on the vulnerable surfaces, thus preventing much dental decay. Because this is such a successful method of preventing tooth decay, dental sealants are one of the IHS Government Performance and Results Act (GPRA) indicators.

In recent years much progress has been achieved in the Nashville Area to increase sealants. Thanks to the combined efforts of the Area Dental Officer, the Dental Support Center and local dental programs, sealant placement has increased by 73% in the last 3 years.⁶ Without the increase in dental sealants, untreated decay might have been much higher in this age group.

Refer to Table 1.

KEY FINDING #4: TREATMENT IS GOOD. PREVENTION IS BETTER. EARLY PREVENTION IS BEST.



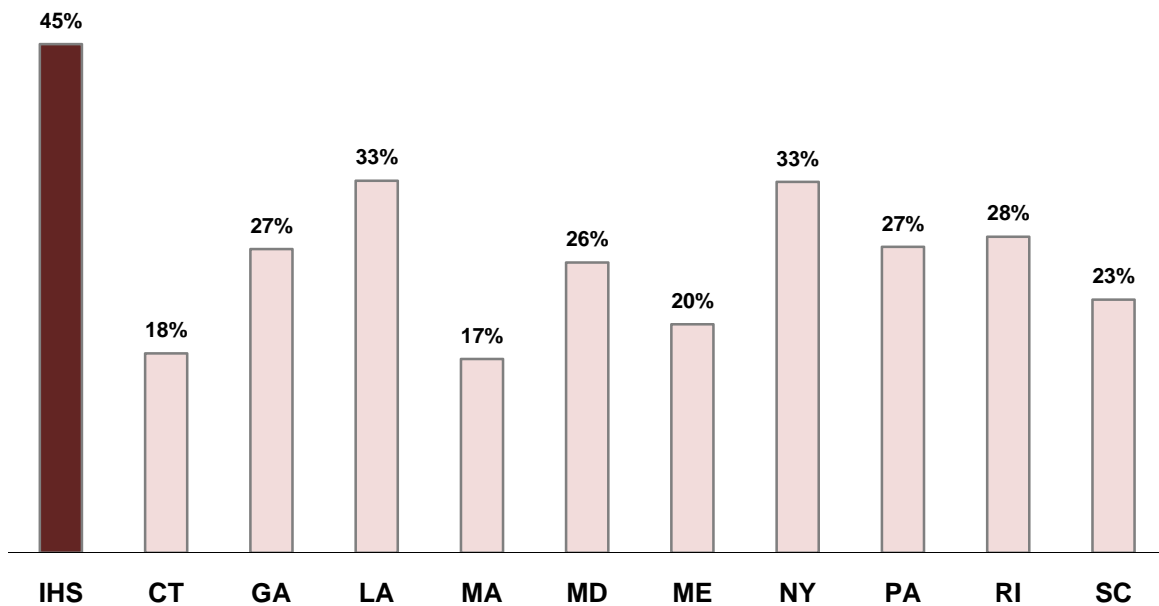
If we want to eradicate dental disease in American Indian children in the Nashville Area, we have to get them started right with early prevention efforts. Look at the graph: Almost 40% of 2-year-old children in the Nashville Area already have decayed teeth - and the percentage with a history of decay rises with age. If we hope to prevent disease, we have to start before the age at which most of the population already has the disease. The medical and dental professions must focus dental disease prevention efforts on children less than 2 years of age because ***“two is too late and five is way too late.”***

The American Academy of Pediatric Dentistry recommends several strategies, focused on the mother (or the primary caregiver) and the infant. Mothers need to learn about: the use of fluoride in water and toothpaste, oral hygiene starting in infancy, proper diet, treatment of decay, and how cavity-causing bacteria get transmitted from mother to child.⁷ For high-risk children, dental decay prevention strategies should be an integral part of health care messages given by pediatricians, nurses, health department staff, teachers, health educators, and day-care providers.

Refer to Table 2.

KEY FINDING #5: THERE ARE SIGNIFICANT ORAL HEALTH DISPARITIES IN THE NASHVILLE AREA WITH AMERICAN INDIAN CHILDREN HAVING THE HIGHEST LEVEL OF DENTAL DISEASE.

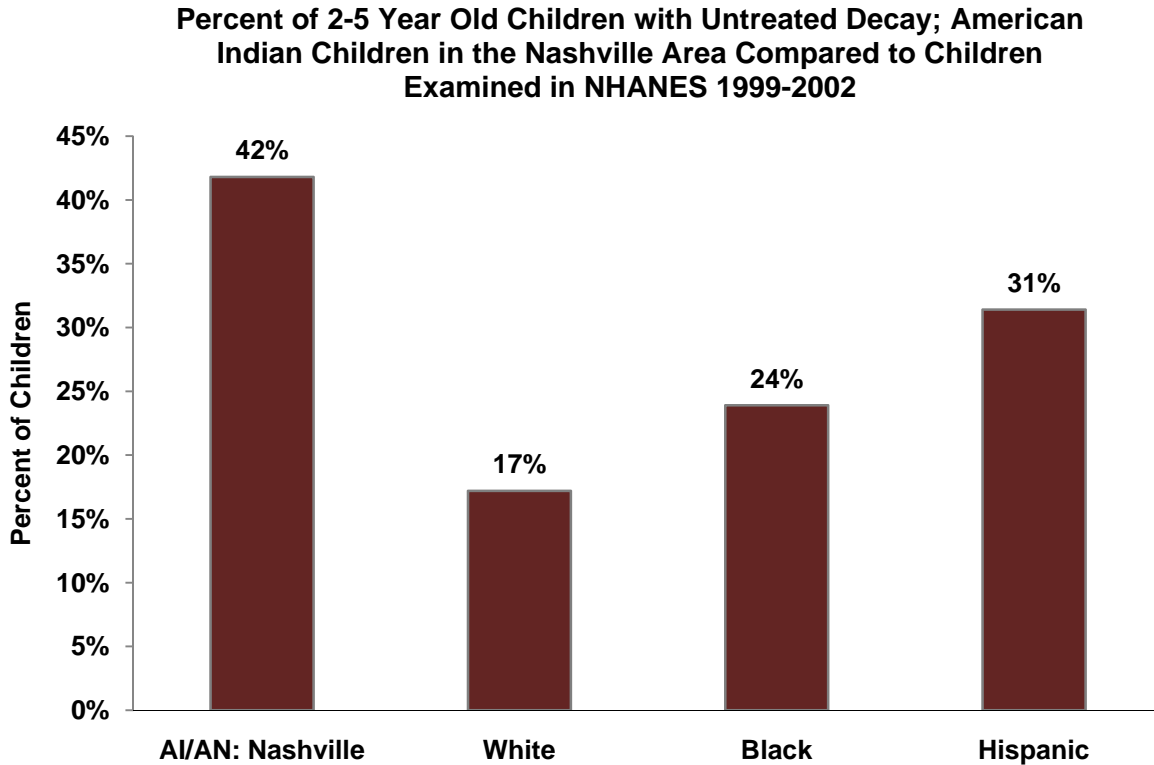
Percent of American Indian 8-10 Year Olds with Untreated Decay Compared to Third Grade Students from Selected States in the Nashville Area



In the Nashville Area, American Indian children have a higher prevalence of untreated decay than children screened in oral health surveys conducted by state health departments in the Area. Forty-five percent of the 8-10 year old American Indian children screened had untreated decay compared to 33% of third grade children in New York and only 17% of third grade children in Massachusetts.^{8,9}

Refer to Table 1.

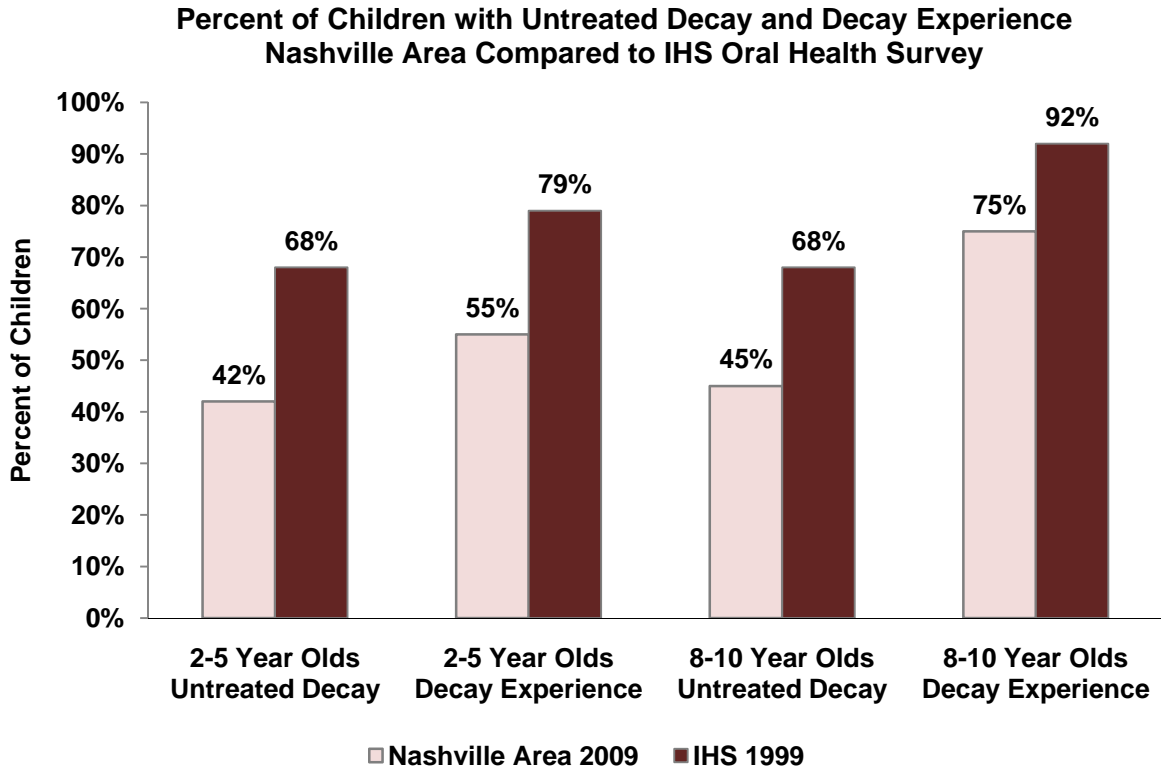
KEY FINDING #5 (CONTINUED): THERE ARE SIGNIFICANT ORAL HEALTH DISPARITIES IN THE NASHVILLE AREA WITH AMERICAN INDIAN CHILDREN HAVING THE HIGHEST LEVEL OF DENTAL DISEASE.



Of the 2-5 year old American Indian children screened as part of the Nashville Area Oral Health Survey, 42% had untreated decay. This graph compares the percent of white, black and Hispanic 2-5 year old children in the United States with untreated tooth decay to the percent of American Indian preschool children in the Nashville Area with untreated decay. Compared to white children throughout the U.S., twice as many American Indian preschool children in the Nashville area have untreated tooth decay; their dental disease burden is substantially higher than all other racial/ethnic groups.

Refer to Table 1.

KEY FINDING #6: ALTHOUGH NASHVILLE AREA CHILDREN HAVE A HIGH BURDEN OF ORAL DISEASE, THEIR ORAL HEALTH IS BETTER THAN AMERICAN INDIAN CHILDREN FROM OTHER IHS AREAS.



In 1999, Indian Health Service completed a nationwide oral health survey of American Indian and Alaska Native dental patients. This graph compares the results of the IHS 1999 and Nashville Area 2009 oral health surveys. Although American Indian children in the Nashville have more dental decay than other racial groups in the United States, they have better oral health than their AI/AN peers from other Areas.

Refer to Table 1.

KEY STRATEGIES AND RECOMMENDATIONS

Several strategies and recommendations have been identified to help improve the oral health of American Indian children in the Nashville Area. They include:

- Expand comprehensive decay prevention activities to include all pregnant women, infants, and toddlers.
- Increase the percent of 0-5 year old children who receive early dental screenings and topical fluoride treatments.
- Provide oral health anticipatory guidance to parents in health and social service settings such as well-child clinics, WIC, Early Head Start, and Head Start.
- Educate medical care providers about the importance of providing oral health anticipatory guidance and topical fluorides during well child examinations.
- Teach parents how to use the dental health care system and encourage them to establish a dental home for their children in the first year of life.
- For older children, continue the aggressive use of sealants and topical fluorides.
- Expand preschool and school-based dental prevention programs to include dental sealants, oral hygiene instruction, professionally applied fluorides, and tooth brushing with fluoride toothpaste.
- Provide caries control and/or definitive restorations to all children with urgent dental needs.
- Provide training for all dentists on Interim Therapeutic Restorations and evaluate all young children with untreated decay for caries control treatment.
- Increase the number of dental providers in the Nashville Area.
- To monitor oral health disease trends in the Nashville Area, conduct an oral health surveillance survey every 3-5 years.

DATA TABLES

Table 1: Oral Health of 2-5 and 8-10 Year Old Children in the Oral Health Survey

Variable	2-5 Year Olds* Percent of Children (N=1,049)	8-10 Year Olds Percent of Children (N=742)
Has Untreated Decay		
No	58.2%	54.6%
Yes	41.8%	45.4%
Has Treated Decay		
No	77.2%	39.7%
Yes	22.8%	60.3%
Has a History of Decay		
No	44.8%	24.8%
Yes	55.2%	75.2%
Has Dental Sealants		
No	NA	50.2%
Yes	NA	49.8%
Need for Dental Care		
No obvious need	58.0%	49.0%
Early care needed	25.3%	38.7%
Urgent care needed	17.0%	12.2%

* Age adjusted

Table 2: Oral Health of Children Screened Stratified by Age

Variable	Age in Years						
	2 (N=201)	3 (N=339)	4 (N=319)	5 (N=190)	8 (N=244)	9 (N=268)	10 (N=230)
% with untreated decay	34.7	45.1	40.9	45.8	40.6	51.1	43.9
% with treated decay	7.3	20.8	31.3	31.0	66.2	65.3	48.2
% with a history of decay	38.5	58.6	62.0	61.0	78.1	80.1	66.5
% with dental sealants	NA	NA	NA	NA	43.6	49.4	56.6
% needing any treatment*	34.7	46.3	40.8	45.8	47.8	55.8	48.4
% needing urgent treatment	15.1	19.2	15.7	17.4	10.2	15.5	10.4
% of data from a chart review	25.9	33.0	29.8	42.0	40.6	51.5	42.2

* Early & urgent need combined

Table 3: Demographics of 2-5 Year Old Children Screened, Source of Oral Health Data and Region

Variable	Number of Children (n=1,049)	Percent of Children
Age		
2 Years	201	19.2%
3 Years	339	32.3%
4 Years	319	30.4%
5 Years	190	18.1%
Gender		
Male	523	49.9%
Female	499	47.6%
Unknown	27	2.6%
Source of Data		
Screening	710	67.7%
Chart Review	339	32.3%
Region		
North	300	28.6%
South	749	71.4%

Table 4: Demographics of 8-10 Year Old Children Screened, Source of Oral Health Data and Region

Variable	Number of Children (n=742)	Percent of Children
Age		
8 Years	244	32.9%
9 Years	268	36.1%
10 Years	230	31.0%
Gender		
Male	376	50.7%
Female	351	47.3%
Unknown	15	2.0%
Source of Data		
Screening	408	55.0%
Chart Review	334	45.0%
Region		
North	226	30.5%
South	516	69.5%

APPENDIX 1: SAMPLE FORMS

SAMPLE SCREENING FORM

Screen Date:	Site Code or Tribe:		Screener's Initials	Type: (1) <input type="checkbox"/> Exam (2) <input type="checkbox"/> Screen (3) <input type="checkbox"/> ChRev
ID Number:	Age (In Years)	Grade: (N) <input type="checkbox"/> Not in school (P) <input type="checkbox"/> Preschool Grade _____	Gender: (1) <input type="checkbox"/> Male (2) <input type="checkbox"/> Female	
Untreated Decay: (0) <input type="checkbox"/> No Untreated (1) <input type="checkbox"/> Untreated (2) <input type="checkbox"/> Cannot be determined	Treated Decay: (0) <input type="checkbox"/> No Treated (1) <input type="checkbox"/> Treated (2) <input type="checkbox"/> Cannot be determined		Sealants on Permanent Molars (0) <input type="checkbox"/> No (1) <input type="checkbox"/> Yes (2) <input type="checkbox"/> Cannot be determined	
Treatment Urgency: (0) <input type="checkbox"/> No obvious problem (1) <input type="checkbox"/> Early Care Need (2) <input type="checkbox"/> Urgent Care (3) <input type="checkbox"/> Cannot be determined	Other data can be added as desired			

Coding information may be added for Community or school events

<input type="checkbox"/> 0140 Limited Exam	<input type="checkbox"/> 1310 Nutritional Counseling
<input type="checkbox"/> 0114 Screening Exam	<input type="checkbox"/> 1320 Tobacco Counseling
<input type="checkbox"/> 1203 Fluoride Treatment	<input type="checkbox"/> 1330 OHI

Provider

SAMPLE CONSENT FORM

Dental Screening Consent Form

Name: _____

Date of Birth: _____

Young children should have teeth checked regularly. This visual screening will find obvious dental needs. It does not replace the need for a complete dental exam. If you child has not seen a dentist in the last year, please schedule a dental exam.

Fluoride varnish can be painted on teeth to prevent tooth decay delivering a safe and effective dose of fluoride. The varnish sets up on contact with saliva so children usually cannot swallow the varnish. Used at the right levels, it is safe and effective. Swallowing too much fluoride can cause stomach upset or make white or brown spots on permanent teeth.

1. During the past 6 months, did your child have a toothache more than once, when biting or chewing?

1. No
2. Yes
3. Don't know/don't remember

2. About how long has it been since your child last visited a dentist?

1. 6 months or less
2. More than 6 months, but not more than 1 year ago
3. More than 1 year ago, but not more than 3 years ago
4. More than 3 years ago
5. Never have been
6. Don't know/don't remember

I DO _____ DO NOT _____ give consent for my child to receive have a dental screening and fluoride varnish.

Signature (Parent/Guardian)

SAMPLE NOTE TO PARENT/GUARDIAN

Dental Screening Program

Dear Parent/ Guardian:

Thank you for allowing your child to participate in the Children's Oral Health Screening Program.

_____ was screened on _____ .

This does not replace your child's need for a yearly dental examination by a dentist.

The following was found during your child's screening:

- No obvious problems- yearly dental exams are recommended.
- Better brushing and flossing is needed.
- Questionable area(s) on your child's teeth that should be examined by a dentist in the near future, or at your child's next exam.
- Urgent dental needs. Contact your dental clinic as soon as possible.

You are encouraged to make an appointment for your child with a dentist for a regular dental exam. Please contact your local dental program for information about receiving care.

Insert your clinic's name and contact information.

Please understand that the dentists are very busy. They will make every effort to see your child as soon as possible. If appointments are not kept, this may affect your ability to make further appointments.

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