Kansas Head Start

SMILES FOR LIFE

THE ORAL HEALTH OF KANSAS HEAD START CHILDREN

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Head Start
Smiles for Life
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Acknowledgments

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Executive Summary

With *Head Start Smiles for Life*, the Kansas Department of Health and Environment takes its first in-depth look at the oral health status of a representative sample of Head Start children throughout the state. During the 2015-2016 school year, a total of 1,443 Head Start children ages 3-5 years received a dental screening at 25 Head Start centers. Head Start children were screened because Head Start is the target preschool population for the National Oral Health Surveillance System. The findings presented in this report support the need for four key strategies under the categories of *culturally appropriate evidence-based and community-based prevention programs, screening and referral services, dental care, and collaborative partnerships to improve the oral health of Kansas' Head Start children.*

KEY FINDINGS

1. For children enrolled in Head Start, Kansas has met the Healthy People 2020 objective for decay experience and exceeded the Healthy People 2020 objective for untreated decay.

2. Most children in Kansas are receiving needed dental treatment for tooth decay. Compared to similarly aged children throughout the United States, Head Start children in Kansas are less likely to have untreated tooth decay.

3. Tooth decay is still a significant public health problem in Kansas. Almost 1 in 3 Kansas Head Start children (31%) has already experienced tooth decay at an early age.

4. There are geographic disparities in oral health among Head Start children in Kansas. Compared to children living in urban counties, rural children are more likely to have untreated tooth decay and are less likely to have had a dental visit in the last year.

5. There are racial and ethnic disparities in oral health among Head Start children in Kansas. Compared to non-Hispanic white children, Hispanic children are more likely to have experienced tooth decay and are less likely to have dental insurance.

6. Children with dental insurance are more likely to have an annual dental visit and are less likely to have untreated tooth decay. In Kansas, more than 9 out of 10 Head Start children (94%) have dental insurance.

7. Children with a dental visit in the past year are less likely to have untreated tooth decay. In Kansas, most Head Start children (88%) have been to the dentist in the past year.

8. The primary reason for not obtaining dental care by parents of Head Start enrolled children was financial (18%).

Because teeth develop before birth and start to appear in the mouth when a child is about 6 months of age, efforts to prevent tooth decay must start with educating moms during pregnancy and continue throughout childhood.

KEY STRATEGIES

Evidence-based and Community-based Prevention Programs

- Expand efforts to incorporate oral health promotion and preventive services such as caregiver education and fluoride varnish into programs geared to children 0-5 years of age such as well-child visits; Women, Infants, Children (WIC) programs; Early Head Start and Head Start; Parents as Teachers; Healthy Families; and other early childhood programs.
- Expand oral health prevention programs at preschools with children at high risk for dental disease to include, at a minimum, daily tooth brushing, application of topical fluorides including silver diamine fluoride, and oral health education.
- Conduct ongoing educational campaigns to (1) encourage the first dental visit by age 1, (2) increase oral health literacy and awareness in preschools, (3) promote the importance of oral health as part of general health and well-being, and (4) promote the benefits of water fluoridation and additional topical fluoride applications for the prevention of dental disease.

Screening and Referral Services

- Offer oral health screenings and referral to local dental care settings in early childhood programs that serve children at greatest risk.
- Develop case management systems that help caregivers navigate the complex dental care delivery and payment system to assure that children needing dental care obtain it.

Dental Care

- Increase the number of preschool children ages 3-5 who use the annual dental exam and other dental benefits offered through their insurance coverage.
- Advocate for the expansion of dental services for rural and other high-risk populations.
- Educate dental providers about the benefits of dental sealants in primary teeth in high-risk children and minimally invasive dentistry including silver diamine fluoride and interim therapeutic restorations.
- Assess and address issues regarding Medicaid participation among dentists.
- Provide professional development opportunities for medical and dental providers regarding the safety and importance of dental services for pregnant women and young children.

Collaborative Partnerships

- Encourage investment in early childhood programs in Kansas including Early Head Start, Head Start, Healthy Families, Home Visiting programs, and Parents as Teachers.
- Work closely with early childhood programs to engage families in oral health conversations and assist them with oral health goal setting. Recognize opportunities to integrate oral health in curricula and trainings including training of home visitors.
- Continue partnerships with Kansas Department of Health and Environment Bureau of Family Health Maternal and Child Block Grant to address identified needs and priorities for young children and those transitioning to kindergarten and elementary school programs. Focus state and local programs on employing strategies related to objectives in the Title V Block Grant by: 1) promoting oral health care with special emphasis on routines in home settings such as tooth brushing, drinking fluoridated water and reducing consumption of sugar sweetened beverages and food; 2) improving connections among schools, families, communities and health and dental care providers through programs such as school-based clinics and interprofessional care in community health centers; and 3) partner with 2016-21 implementation of Kansas Initiative for Developmental Ongoing Screening (KIDOS-2) to expand and effectively coordinate, improve and track screenings and referrals for toddlers across early childhood support systems at the state and local levels.

QUICK FACTS

31%

DECAY EXPERIENCE:
Thirty-one percent (31%) of Kansas' Head Start children have experienced tooth decay at an early age.

10%

UNTREATED TOOTH DECAY:
Ten percent (10%) of Kansas' Head Start children have untreated tooth decay.

9%

NEED FOR DENTAL CARE:
Nine percent (9%) of Kansas' Head Start children are in need of dental care including 1% needing urgent dental care because of pain or infection.

20%

SELF-REPORTED ORAL PROBLEM:
Twenty percent (20%) of parents reported their Head Start child had a dental problem in the last year.

94%

DENTAL INSURANCE:
Ninety-four percent (94%) of Kansas' Head Start children have dental insurance.

88%

DENTAL VISIT IN LAST YEAR:
Eighty-eight percent (88%) of Kansas' Head Start children had a dental visit in the last year.

11%

UNABLE TO OBTAIN DENTAL CARE:
Eleven percent (11%) of parents reported that their Head Start child needed dental care in the last year but was unable to obtain the needed care.

ORAL HEALTH DISPARITIES:
In Kansas, Hispanic children and rural children have poorer oral health outcomes.

Purpose

The Centers for Disease Control and Prevention (CDC) recommends that health events be considered for ongoing surveillance if they affect many people, require large expenditures of resources, are largely preventable and are of public health importance (German RR, 2001). In 2007, the Kansas Bureau of Oral Health implemented an ongoing oral health surveillance system designed to monitor trends in oral health among Kansas' preschool and elementary school population. With *Head Start Smiles for Life,* the Kansas Department of Health and Environment takes its first in-depth look at the oral health status of a representative sample of Head Start children throughout the state. *Head Start Smiles for Life* is now being added to this surveillance system.

Data collected through *Head Start Smiles for Life* will be used to:

- measure the current burden of early childhood tooth decay
- identify populations at higher risk of early childhood tooth decay
- monitor trends in the prevalence of early childhood tooth decay
- guide the planning, implementation, and evaluation of public programs designed to prevent and control early childhood tooth decay
- develop and evaluate public policies regarding oral health and dental care
- prioritize the allocation of oral health resources

This method of oral health surveillance aligns with the mission of the Kansas Bureau of Oral Health to increase awareness and improve the oral health of all Kansans through oral health data collection, surveillance and dissemination, statewide oral health education, promotion and collaboration, development of science based oral health policy, and programming dedicated to dental disease prevention.

The 2017 Kansas *Head Start Smiles for Life* report presents the results of a Kansas Basic Screening Survey, a statewide, nationally recognized oral health survey of children's oral health. Using the survey protocol designed by the CDC and the Association for State and Territorial Dental Directors (ASTDD), the survey collected clinical information on tooth decay among Head Start-enrolled children 3-5 years of age. A total of 1,443 children ages 3-5 years received a dental screening at 25 Head Start centers. *Head Start Smiles for Life* provides oral health advocates and partners, government officials, researchers and policy makers with important information regarding early childhood decay in Kansas Head Start children. The report also contains information regarding the importance of good oral health, the need for dental care, use of dental services, dental insurance coverage, and oral health disparities present in this population.

Importance of Good Oral Health

Tooth decay is a disease affecting both children and adults. When exposed to sugars and other carbohydrates, some bacteria in the mouth produce acids that dissolve the minerals in the outer layer of the tooth that can advance to form a cavity.

Tooth decay can occur at any age after teeth erupt into the mouth. For most children, teeth begin to erupt at about 6 months of age; by 3 years of age, they will have a full set of 20 primary (baby) teeth. Particularly damaging forms of decay can begin in early childhood, when developing primary teeth are especially vulnerable. This type of decay is called early childhood caries (ECC). ECC is the most common chronic early childhood disease in the United States, five times more common than asthma in children younger than age 6. (U.S. Department of Health and Human Services, 2000) Cavities can develop quickly and, if untreated, can infect the tooth's pulp tissue that can lead to an abscess, destruction of supporting bone, and spread of infection via the bloodstream, resulting in a medical and dental emergency that could require hospitalization. (Sheller, Williams, & Lombardi, 1997) The longer ECC remains untreated, the worse the condition gets, making it more difficult to treat. (American Academy of Pediatric Dentistry, 2014) Advanced ECC requires complicated dental procedures such as extractions and crowns, often performed using general anesthesia. These complicated procedures are more expensive and must be performed by dentists with specialty training in treating children (pediatric dentists).

Oral health and general health are intertwined, so poor oral health can affect a child's overall health and well-being. Dental disease can result in pain, infection, the inability to chew foods well, and distraction from play and learning. Tooth decay in the primary teeth is of special importance because it increases the child's risk for future oral health problems. For example, abscessed primary teeth can potentially damage permanent teeth, (Fung, Wong, Lo, & Chu, 2013) and if baby teeth are lost early, the child's permanent teeth are more likely to erupt out of proper position, leaving them more susceptible to decay, gum disease and the need for braces. (American Academy of Pediatric Dentistry, 2014)

Other short- and long-term impacts of advanced tooth decay on the overall health of young children include:

- Increased vulnerability to infections in other parts of the body, such as the ears, sinuses, and the brain (Moazzam, Rajagopal, Sedghizadeh, Zada, & Habibian, 2015; Simuntis Kubilius, & Vaitkus, 2014; Alaki, Burt, & Garetz, 2008)

- Failure to thrive, impaired speech development, and reduced self-esteem (U.S. Department of Health and Human Services, 2000)

- Shyness, unhappiness, feelings of worthlessness, and reduced friendliness (Guarnizo-Herreño & Wehby, 2012)

The good news is that most tooth decay is preventable if children have access to evidence-based prevention strategies. To prevent tooth decay, the American Academy of Pediatrics (2015) recommends several strategies for enhancing the oral health of young children including parent/family education on oral health (particularly eating nutritious foods and limiting sugars, and brushing teeth with a toothpaste containing fluoride); first preventive visit to a dentist within six months of the first tooth erupting and no later than age 1, with preventive check-ups thereafter; a series of topical fluoride applications to children's teeth; and drinking fluoridated water.

Recent Strategies to improve Oral Health and Oral Health Literacy in Head Start Families

Head Start programs provide comprehensive early childhood education, health, nutrition, and parent involvement services to low-income children and their families. The family income for most Head Start children is below the federal poverty level. The program's services and resources are designed to foster stable family relationships, enhance children's physical and emotional well-being, and establish an environment to develop strong cognitive skills. In 2008, the Kansas Head Start Association (KHSA) developed the Kansas Cavity Free Kids program that is committed to improving the oral health of pregnant women and young children through improved access to care, advocacy and oral health education. Educational resources developed by the KHSA include: "Teeth for Tots" oral health resource guide for parents and caregivers of infants and toddlers as well as "Teeth for Tots" oral health workshops; "Fast Facts" library of colorful oral health flyers covering topics such as a child's first dental visit, proper use of toothpaste, and the importance of baby teeth; "Teeth for Two" oral health resource guide for those who serve pregnant women; "Circle Time for Teeth" toolkit of engaging oral health activities for preschool group teaching; and "All Aboard the Cavity Free Express" family event filled with oral health activities. These resources are available at http://www.saavsus.com/kansas-head-start-association/.

Factors That Impact The Oral Health of Young Children

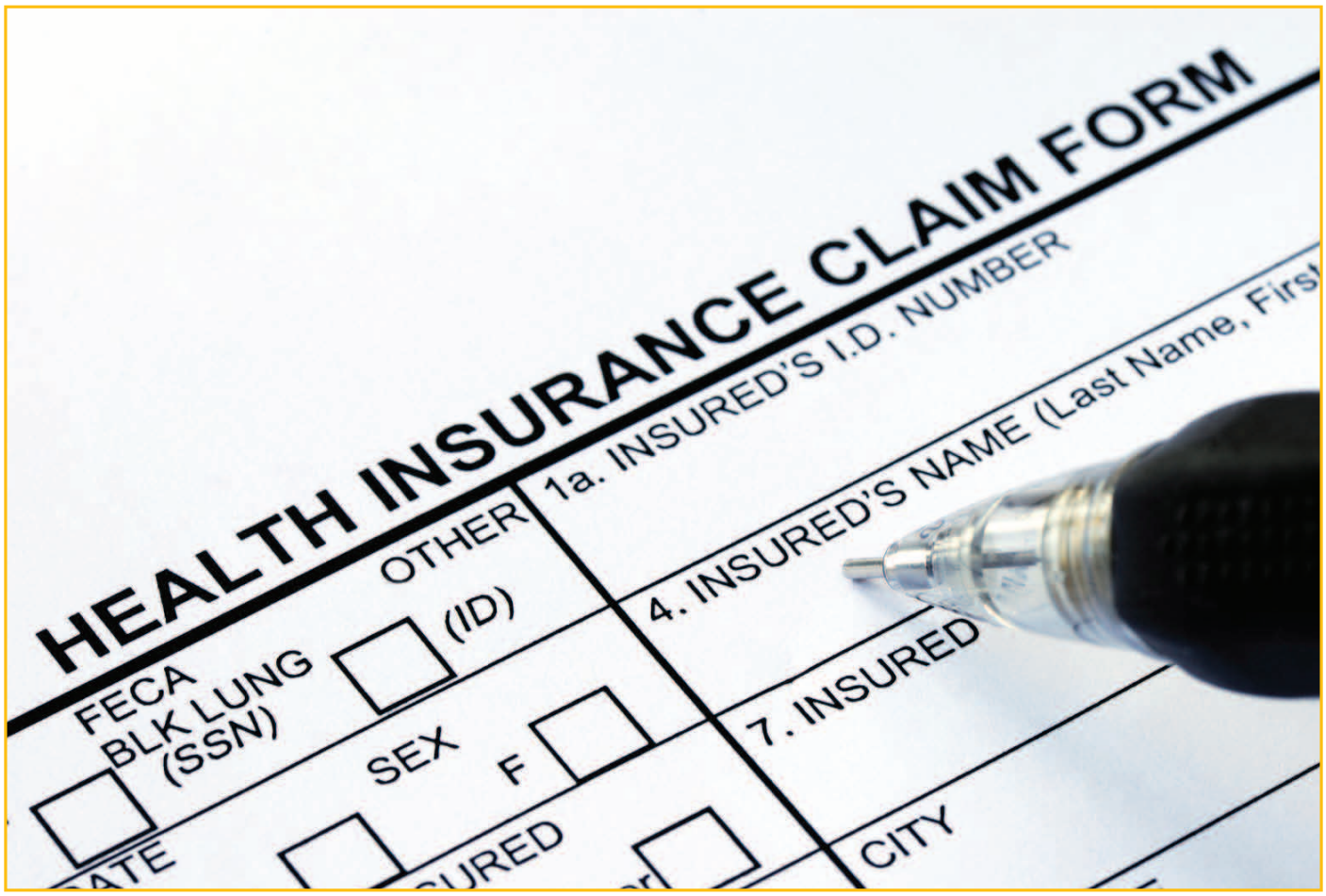
Demographics

Social determinants of health such as where people live and income level can affect oral health. Kansas is divided into 105 counties with 628 cities. The U.S. Census Bureau estimates there are approximately 2.9 million residents living in the state (2014). Kansas' geographic layout ranges from urban to frontier counties. Within each of the state's regions there are a few cities intermixed with multiple rural areas. This creates challenges to service delivery but also an opportunity for sharing resources among populations. Kansas grew in population from 1992-2014 by 13%. In 2014, an estimated 39,922 infants lived in Kansas, about 1% of the total population. Race and ethnicity for women of reproductive age (15-44 years of age) in Kansas was estimated at 74% non-Hispanic white, 6% non-Hispanic black, 1% American Indian or Alaska Native, 4% Asian and Pacific Islander, 2% multiple race and 13% Hispanic (any race). The Kansas population, like that of the nation, is becoming more racially and ethnically diverse. Thirty percent of Kansas children and adolescents belong to a racial or ethnic minority. Across the age groups, 32% of young children (1-5 years) are part of a racial/ethnic minority versus about 28% of young adults (20-22 years).

In 2014, the federal poverty level was $24,230 for a family of four. Children living in families with incomes below the federal poverty level are referred to as poor. Research suggests that, on average, families need an income about twice the federal poverty level to meet their basic needs. In 2014, based on the Small Area Income and Poverty Estimates, compared to the U.S. population, 14% of Kansans lived in households with incomes below the federal poverty level (vs. 16% for the U.S.), with 18% of children younger than age 18 living in such households (vs. 22% for the U.S.). From 2005-2014, Kansas experienced a significant increase in the poverty rate for children younger than age 18 with 125,562 of them living in poverty. Most of these children live within four population centers: Sedgwick County (Wichita), Wyandotte and Johnson Counties (Kansas City metropolitan area), Shawnee County (Topeka), and Douglas County (Lawrence). Five counties accounted for more than half of all Kansas children (64,982) in poverty: Sedgwick (25,795), Wyandotte (15,554), Johnson (11,484), Shawnee (8,804), and Douglas (3,345). However, the rural southeastern portion of the state has many counties with high concentrations of children in poverty. Poverty is more common in Kansas families headed by single females, especially those with children in the household (39%), regardless of race or ethnicity. The percentage of children and youth with special health care needs varies by income group in Kansas, with 26% in the low-income families (0-99% of the FPL).

Health Insurance Coverage

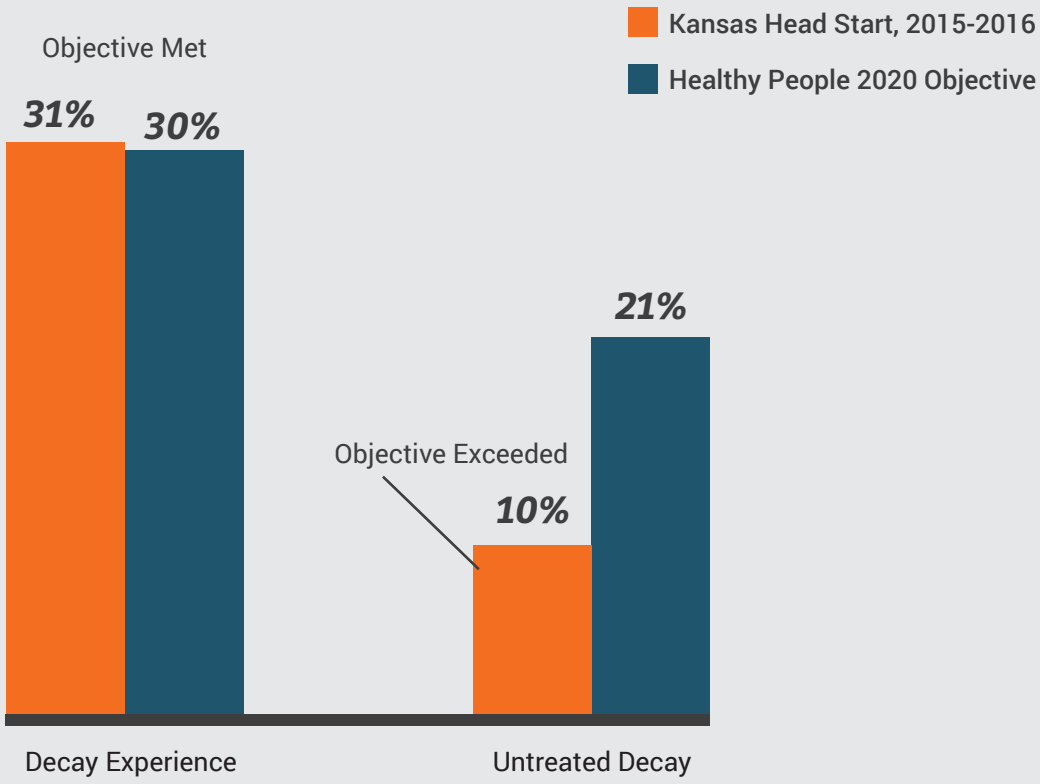
Health insurance coverage influences overall health and, therefore, oral health. Data from the Small Area Health Insurance Estimates show the percentage of Kansas children younger than age 18 without health insurance decreased from 8% in 2008 to 6% in 2014, a 35% decrease. One reason was an increase in public coverage of Kansas children, probably due to factors such as a weak economy and the state's active outreach efforts to enroll children who needed coverage. Paralleling the poverty rates, 54% of uninsured Kansas children younger than age 18 live in the four largest population centers, and the southwestern part of the state has a largely Hispanic population where many are not KanCare (CHIP) eligible. While the southeastern portion of the state has a cluster of counties with high poverty rates, the children are more likely to be insured than those in southwestern Kansas. (National Survey of Children's Health, 2011/12 .)



Key Finding #1

For children enrolled in Head Start, Kansas has met the Healthy People 2020 objective for decay experience and exceeded the Healthy People 2020 objective for untreated decay.

Percent of Kansas Head Start Children with Decay Experience and Untreated Tooth Decay Compared to Healthy People 2020 Objectives, 2015-2016



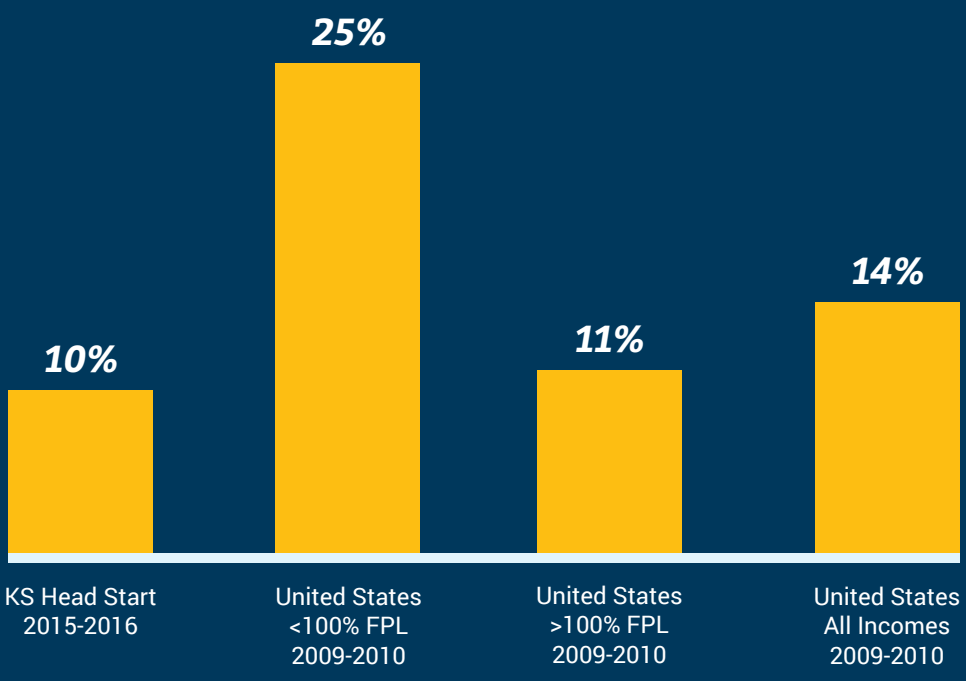
Healthy People 2020 (HP2020) is the federal government's prevention agenda for building a healthier nation-national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. HP2020 has two oral health objectives for children ages 3-5 years: reduce the prevalence of decay experience to 30% and reduce the prevalence of untreated decay to 21%.

Recommendation: Kansas should continue to invest in prevention and dental care programs that promote oral health.

Key Finding #2

Most children in Kansas are receiving needed dental treatment for tooth decay. Compared to similarly aged children throughout the United States, Head Start children in Kansas are less likely to have untreated tooth decay.

Percent of Children 3-5 Years with Untreated Tooth Decay
Kansas Head Start Compared to United States (Dye, 2012)



FPL = Federal Poverty Level

Having untreated decay means that a child has tooth decay that has not received appropriate treatment. Untreated tooth decay in children can be painful and can lead to more serious and advanced infections that spread to other parts of the body, resulting in systemic disease and even death.

The data suggest that Head Start children in Kansas have fairly good access to the dental care system, possibly due to expanded dental insurance coverage, case-management services provided by Head Start and other programs, and an increase in the number of safety-net dental clinics. Although Kansas is doing better than other states, having 1 in 10 children with untreated decay is still too high.

Recommendation: Kansas must continue to develop and implement programs to assure that all children have access to dental care.

Key Finding #3

Tooth decay is still a significant public health problem in Kansas. Almost 1 in 3 Kansas Head Start children (31%) has already experienced tooth decay at an early age.

HEAD START CHILDREN IN KANSAS WITH DECAY EXPERIENCE

Decay “experience” means that a child has had tooth decay at some point, either in the past (indicated by fillings, crowns, or teeth that have been extracted) or they currently have untreated tooth decay..

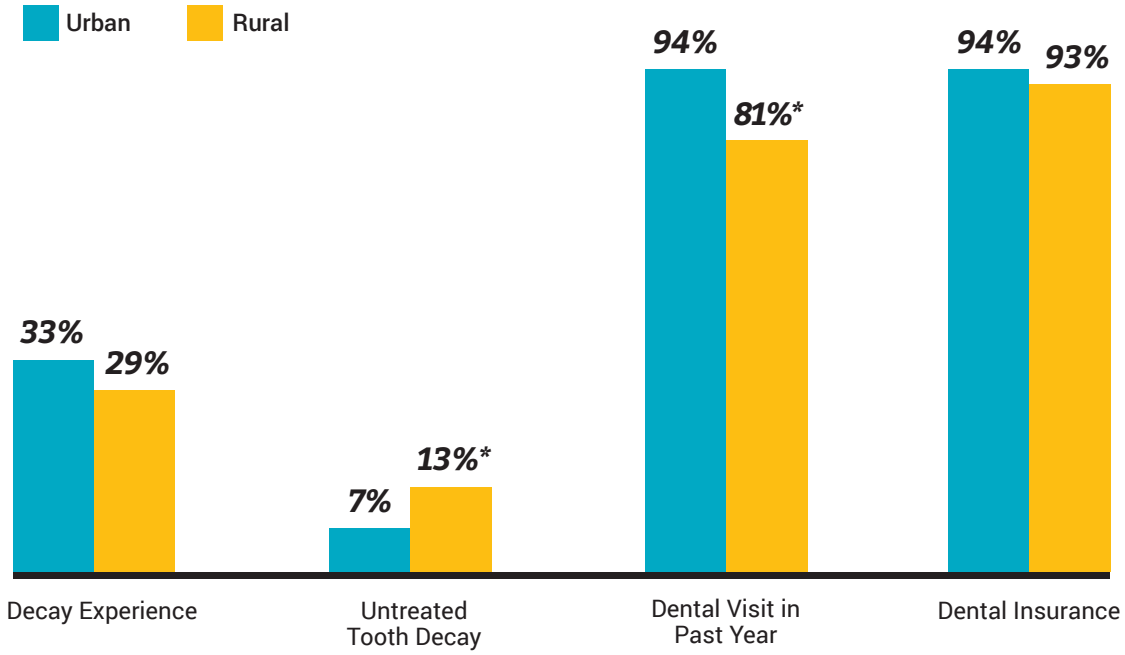
With early prevention efforts, tooth decay can be prevented. Medical, dental and public health professionals must focus dental disease prevention efforts on families with children younger than 2 years of age because ***two is too late.*** The American Dental Association, the American Academy of Pediatric Dentistry, and the American Academy of Pediatrics all recommend preventive dental care and parent education by age 1.

Recommendation: Kansas must improve access to evidence-based, community-based primary prevention programs for pregnant women, infants, toddlers, and their families.

Key Finding #4

There are geographic disparities in oral health among Head Start children in Kansas. Compared to children living in urban counties, rural children are more likely to have untreated tooth decay and are less likely to have had a dental visit in the last year.

Percent of Kansas Head Start Children with Decay Experience, Untreated Decay, a Dental Visit in the Last Year and Dental Insurance by Urban/Rural Status, 2015-2016



*Significantly different from urban children p<0.05

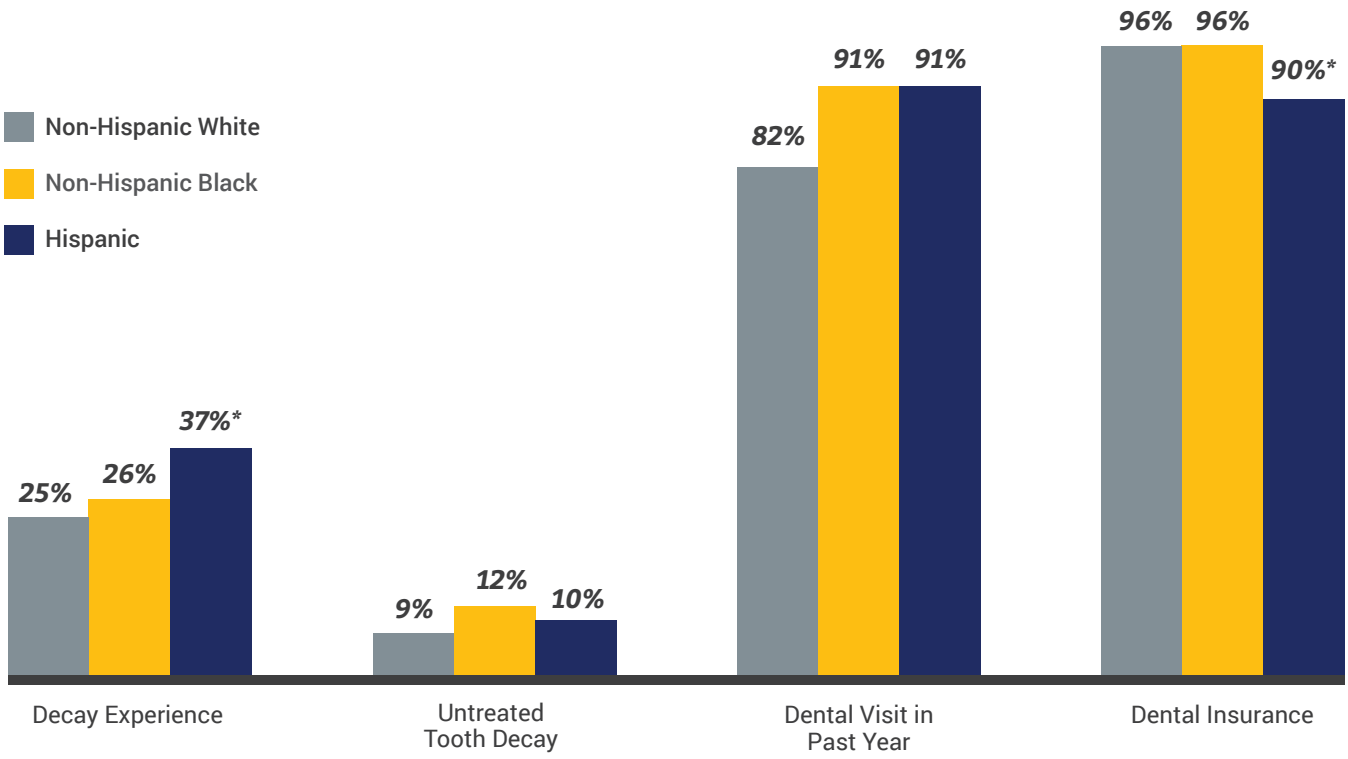
According to the U.S. Office of Management and Budget, there are 17 urban counties and 88 rural counties in Kansas. While 94% of urban Head Start children had a dental visit in the past year, only 81% of rural Head Start children had a dental visit. As a result, the percentage of rural children with untreated decay is almost twice as high as for urban children (13% vs. 7%). This suggests that access to dental care is a problem for children living in rural counties. Of Kansas' 88 rural counties, 17 (19%) do not have a dentist. Seventy of 105 counties in Kansas have a Medicaid dental provider, leaving 30 counties without any.

Recommendation: Kansas must develop and implement programs that increase access to dental care in rural counties.

Key Finding #5

There are racial and ethnic disparities in oral health among Head Start children in Kansas. Compared to non-Hispanic white children, Hispanic children are more likely to have experienced tooth decay and are less likely to have dental insurance.

Percent of Kansas Head Start Children with Decay Experience, Untreated Decay, Dental Visit in the Past Year and Dental Insurance by Race-Ethnicity, 2015-2016



*Significantly different from non-Hispanic white children p<0.05

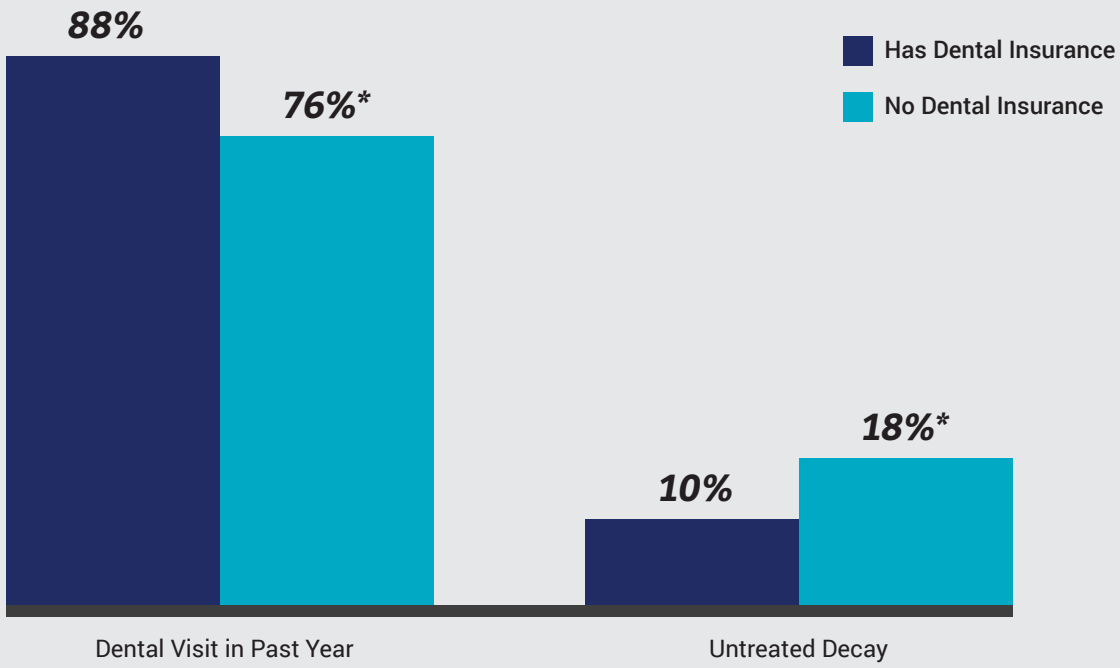
Approximately 37% of the Head Start children screened were non-Hispanic white, 15% were non-Hispanic black and 38% were Hispanic. As with national data, Kansas' Hispanic Head Start children are significantly more likely to have decay experience and less likely to have dental insurance than white or black children. There were no racial differences in the percent of children with untreated decay.

Recommendation: Kansas must implement culturally appropriate, evidence-based, community-based prevention programs for Hispanic pregnant women, infants, toddlers, and their families.

Key Finding #6

Children with dental insurance are more likely to have an annual dental visit and are less likely to have untreated tooth decay. In Kansas, more than 9 out of 10 Head Start children (94%) have dental insurance.

Percent of Kansas Head Start Children with a Dental Visit in the Past Year and Untreated Tooth Decay by Insurance Coverage, 2015-2016



*Significantly different from those with dental insurance, p<0.05

Dental care can be costly, and without dental insurance, low-income families cannot afford comprehensive dental care. Most Kansas Head Start children (94%) have dental insurance with the primary coverage being Medicaid or KanCare. Compared to non-Hispanic white children, Hispanic children are significantly less likely to have dental insurance (96% vs. 90%).

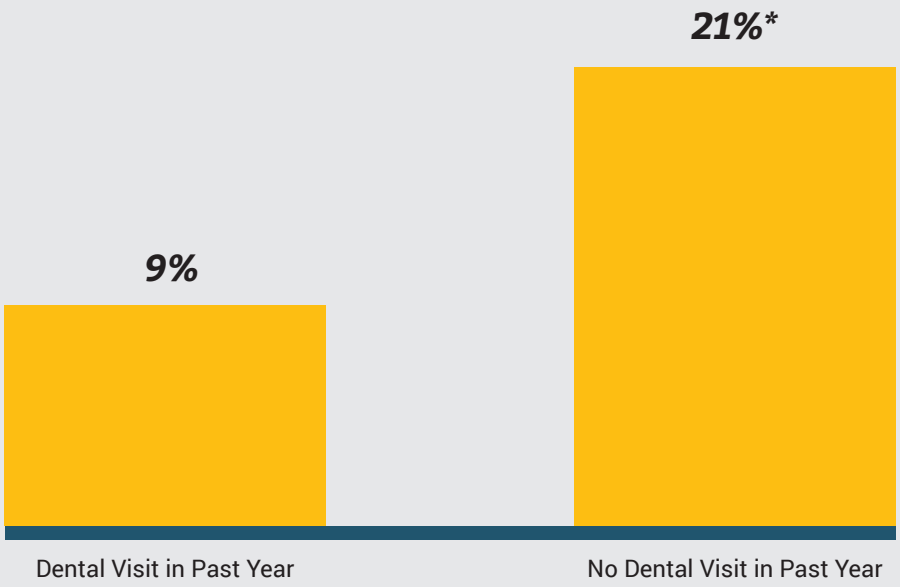
However, insurance coverage alone, especially publicly-funded coverage such as Medicaid/KanCare, does not guarantee access to dental care. Many dentists are reluctant to participate in Medicaid/KanCare because they are reimbursed about one-half of what they would receive from private insurance companies. In Kansas, 30 counties do not have a dentist who accepts Medicaid/KanCare patients.

Recommendation: Kansas must continue to develop and implement programs that help expand Medicaid/KanCare coverage along with expanding the network of participating dentists.

Key Finding #7

Children with a dental visit in the past year are less likely to have untreated tooth decay. In Kansas, most Head Start children (88%) have been to the dentist in the past year.

Percent of Kansas Head Start Children with Untreated Tooth Decay by Time Since Last Dental Visit, 2015-2016



*Significantly different from those with a dental visit in past year, p<0.05

The American Academy of Pediatrics recommends that all children have their first preventive dental visit no later than age 1, with preventive check-ups thereafter. Although the frequency of preventive check-ups is dependent on individual risk for dental disease or other oral health problems, most children benefit from having a dental visit at least once a year to increase the likelihood that dental disease will be detected and treated at an early stage.

About 88% of Kansas Head Start children had a dental visit in the past year, compared to only 55% of similarly aged children enrolled in Kansas' Medicaid program (CMS-416, 2014). Head Start programs work hard to assure that all children have a dental examination within 90 days of enrollment. To accomplish this, programs develop relationships with local dental providers and assist parents in finding dental care.

Recommendation: Kansas must increase the proportion of non-Head Start Medicaid children with an annual dental visit.

Key Finding #8

The primary reason for not obtaining dental care by parents of Head Start enrolled children was financial (18%).

During the Head Start survey, parents were asked if there was a time in the past year when their child needed dental care but could not get it; 11% said yes. There was no difference among racial/ethnic groups. A higher percentage of rural compared to urban families (14% vs. 8%) and those without dental insurance (24% vs. 10%) reported problems, but the differences weren't statistically significant.

For those reporting having trouble obtaining dental care, the primary reasons were:

- Could not afford it 18%
- Unable to take time off of work 15%
- Dentist hours not convenient 11%
- Dentist did not take Medicaid 11%
- Other reason 11%
- Dental office too far away 10%
- Insurance did not cover care 8%
- Afraid of/do not like dentists 6%
- No problems or problems not serious enough 5%
- Too busy 3%

SUMMARY OF KEY STRATEGIES THAT WILL HELP TO IMPROVE ORAL HEALTH IN YOUNG CHILDREN IN KANSAS

The results of *Head Start Smiles for Life* highlight the need for improvements in the oral health of preschool children living in Kansas. Access to culturally appropriate evidence-based and community-based prevention programs and dental care must be improved, especially for Hispanic children and those living in rural Kansas. The Kansas Department of Health and Environment, in collaboration with various stakeholders, has identified several strategies that could improve the oral health of preschool children in Kansas. The strategies are grouped into four general categories: evidence-based and community-based prevention programs, screening and referral services, dental care, and collaborative partnerships. Because teeth develop before birth and start to appear in the mouth when a child is about 6 months of age, efforts to prevent tooth decay must start during pregnancy and continue throughout childhood. Evidence based strategies for preventing tooth decay in young children includes: twice daily brushing with fluoride toothpaste, professionally applied topical fluorides, community water fluoridation, good eating habits, early and regular dental visits, dental sealants in primary teeth in high-risk children, and culturally appropriate oral health education.

Evidence-Based and Community-Based Prevention Programs

- Expand efforts to incorporate oral health promotion and preventive services such as caregiver education and fluoride varnish into programs geared to children 0-5 years of age such as well-child visits; Women, Infants, Children (WIC) programs; Early Head Start and Head Start; Parents as Teachers; Healthy Families; and other early childhood programs.
- Expand oral health prevention programs at preschools with children at high risk for dental disease to include, at a minimum, daily tooth brushing, application of topical fluorides including silver diamine fluoride, and oral health education.
- Conduct ongoing educational campaigns to (1) encourage the first dental visit by age 1, (2) increase oral health literacy and awareness in preschools, (3) promote the importance of oral health as part of general health and well-being, and (4) promote the benefits of water fluoridation and additional topical fluoride applications for the prevention of dental disease.

Screening and Referral Services

- Offer oral health screenings and referral to local dental care settings in early childhood programs that serve children at greatest risk.
- Develop case management systems that help caregivers navigate the complex dental care delivery and payment systems to assure that children needing dental care obtain it.

Dental Care

- Increase the number of preschool children ages 3-5 who use the annual dental exam and other dental benefits offered through their insurance coverage.
- Advocate for the expansion of dental services for rural and other high-risk populations.
- Educate dental providers about the benefits of dental sealants in primary teeth in high-risk children and minimally invasive dentistry including silver diamine fluoride and interim therapeutic restorations.
- Assess and address issues regarding Medicaid participation among dentists.
- Provide professional development opportunities for medical and dental providers regarding the safety and importance of dental services for pregnant women and young children.

Collaborative Partnerships

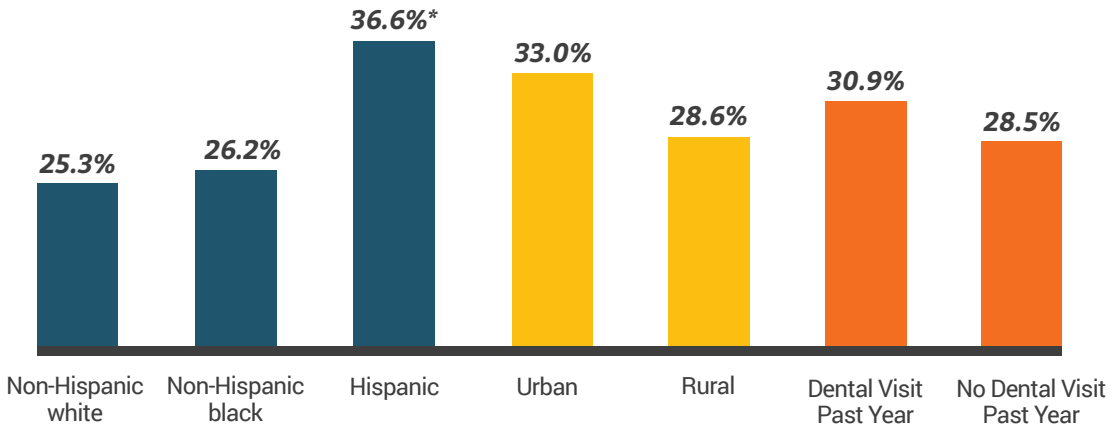
- Encourage investment in early childhood programs in Kansas including Early Head Start, Head Start, Healthy Families, Home Visiting programs, and Parents as Teachers.
- Work closely with early childhood programs to engage families in oral health conversations and assist them with oral health goal setting. Recognize opportunities to integrate oral health in curricula and trainings including training of home visitors.
- Continue partnerships with Kansas Department of Health and Environment Bureau of Family Health Maternal and Child Block Grant to address identified needs and priorities for young children and those transitioning to kindergarten and elementary school programs. Focus state and local programs on employing strategies related to objectives in the Title V Block Grant by: 1) promoting oral health care with special emphasis on routines in home settings such as toothbrushing, drinking fluoridated water and reducing consumption of sugar sweetened beverages and food; 2) improving connections among schools, families, communities and health and dental care providers through programs such as school-based clinics and interprofessional care in community health centers; and 3) partner with 2016-21 implementation of Kansas Initiative for Developmental Ongoing Screening (KIDOS-2) to expand and effectively coordinate, improve and track screenings and referrals for toddlers across early childhood support systems at the state and local levels.

Details of Survey with Data Tables

Decay Experience

In Kansas, 31% of Head Start children have decay experience.

Percent of Kansas Head Start Children with Decay Experience by Selected Characteristics, 2015-2016

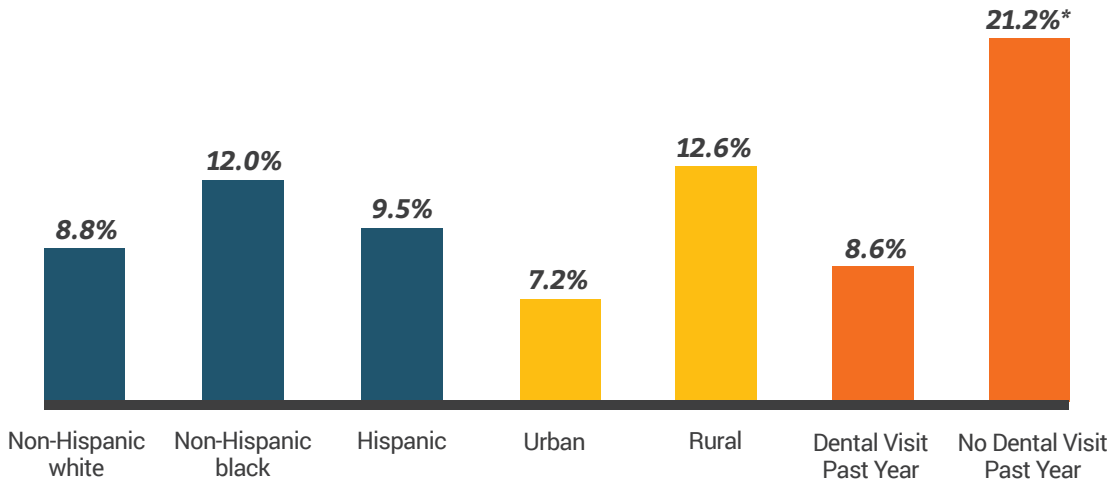


**Significantly different from non-Hispanic white children, p<0.05*

Untreated Decay

In Kansas, 10% of Head Start children have untreated decay.

Percent of Kansas Head Start Children with Untreated Decay by Selected Characteristics, 2015-2016

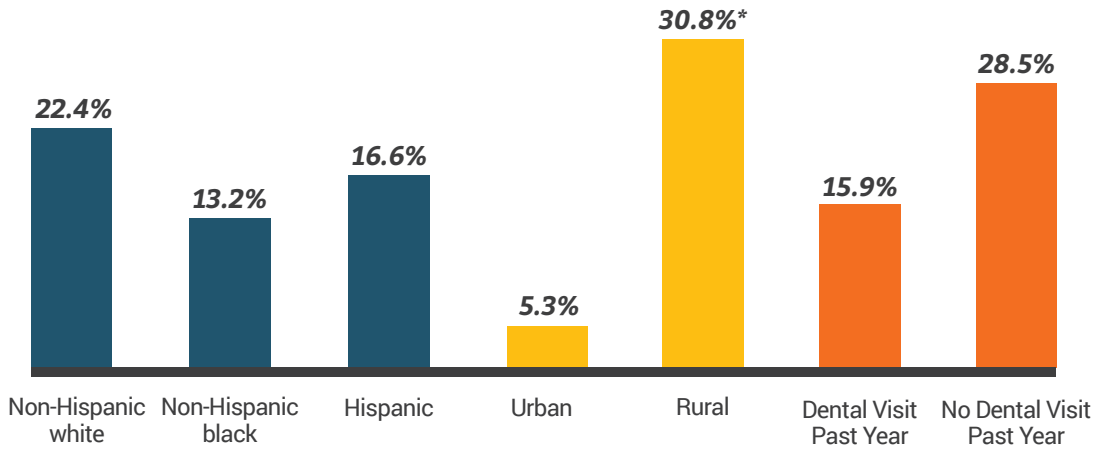


**Significantly different from children with a dental visit, p<0.05*

Demineralization: the very early stages of tooth decay that can be reversed through use of topical fluorides

Approximately 18% of Kansas Head Start children have demineralization.

Percent of Kansas Head Start Children with Demineralization by Selected Characteristics, 2015-2016

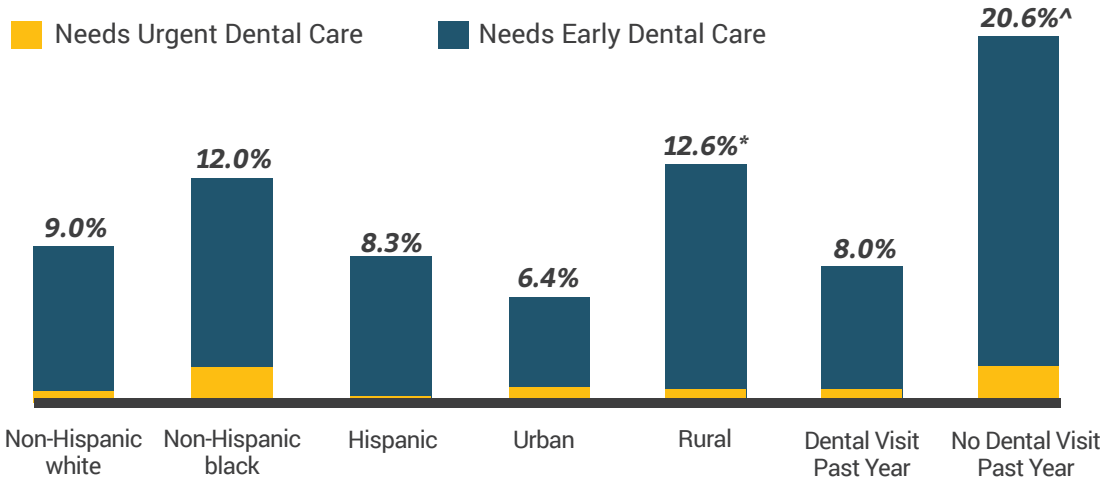


**Significantly different from urban children, p<0.05*

Need for Restorative Dental Care

About 8% of Head Start children in Kansas need non-urgent restorative dental care. This means they have a cavity or another oral health problem (i.e., broken or lost filling) requiring restorative dental care. An additional 1% needs urgent dental care which means they have pain or an infection.

Percent of Kansas Head Start Children Needing Restorative Dental Care by Selected Characteristics, 2015-2016

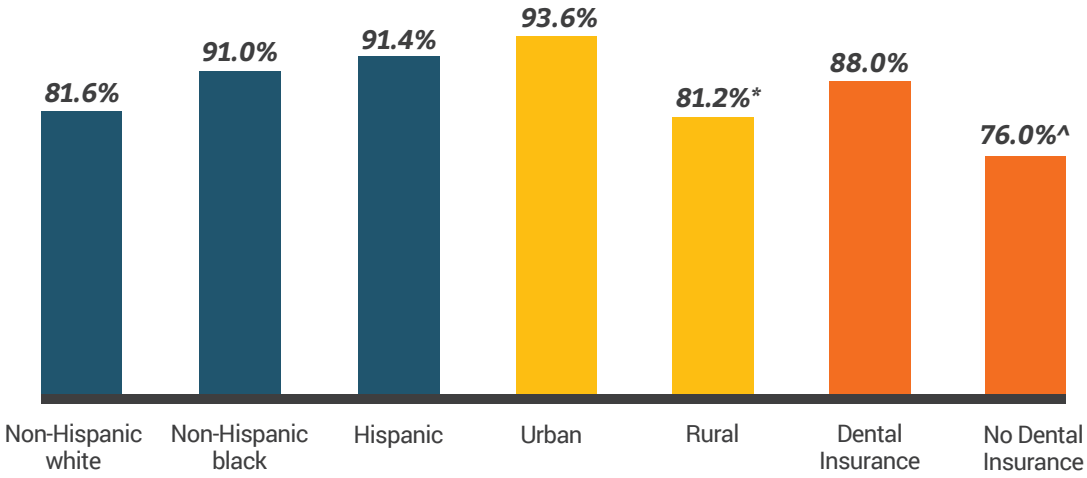


**Significantly different from urban children, p<0.05*
^Significantly different from children with a dental visit in the past year, p<0.05

Time Since Last Dental Visit

About 88% of parents reported their child had been to the dentist in the past year, 6% reported it had been more than a year, while 7% reported their child had never been to a dentist.

Percent of Kansas Head Start Children with a Dental Visit in the Past Year by Selected Characteristics, 2015-2016

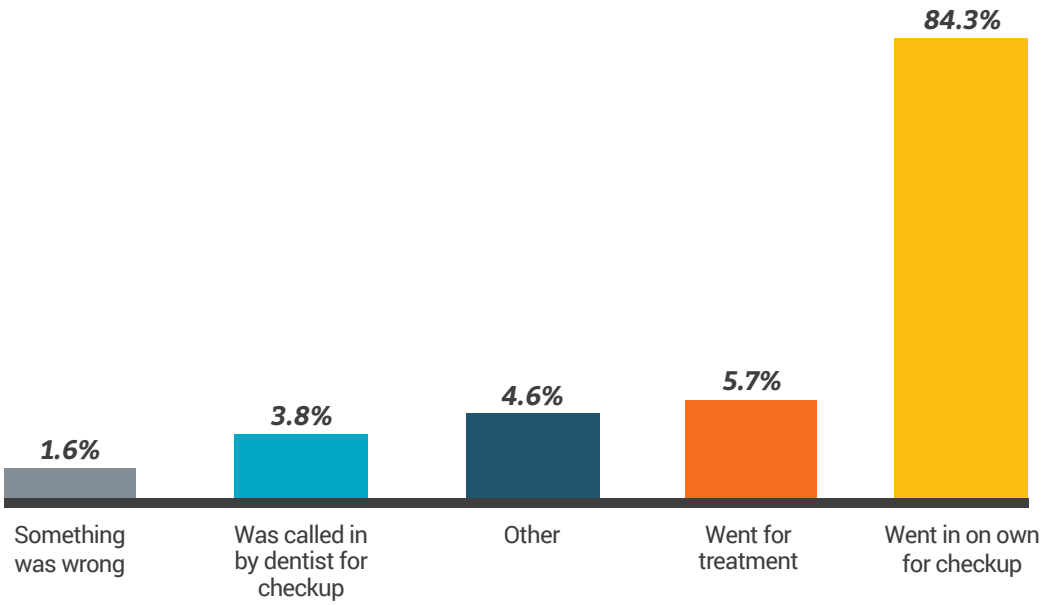


**Significantly different from urban children, p<0.05*

^Significantly different from children with dental insurance, p<0.05

Reason for Last Dental Visit

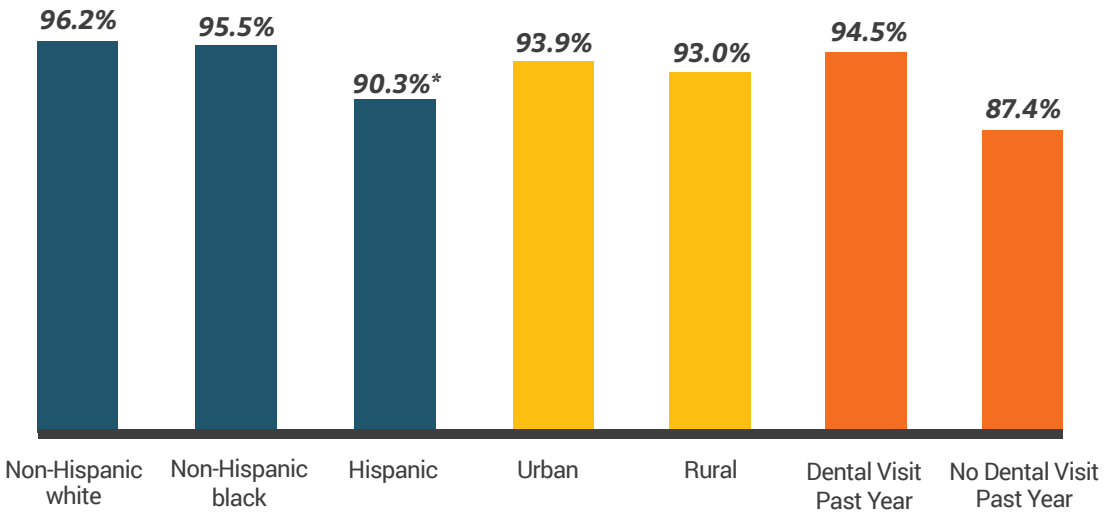
Reason for Last Dental Visit Among Kansas Head Start Children, 2015-2016



Dental Insurance

Most of the parents (94%) reported their child had some type of dental insurance coverage.

Percent of Kansas Head Start Children with Dental Insurance by Selected Characteristics, 2015-2016

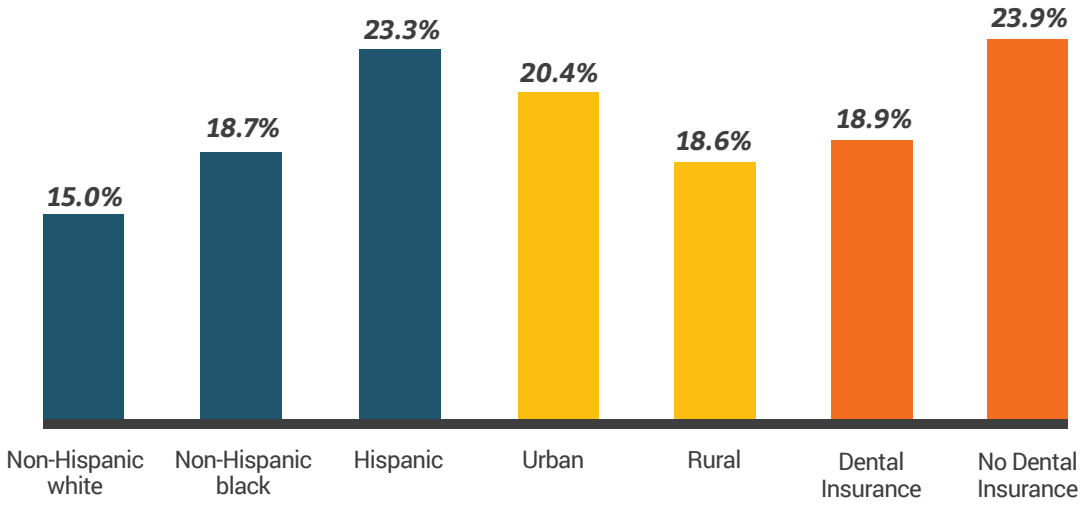


**Significantly different from non-Hispanic white children, p<0.05*

Self-Reported Oral Problem in Past Year

Parents were asked if their child had a toothache, decayed tooth or unfilled cavity in the past year. About 20% of the parents reported their child had an oral problem in the past year.

Percent of Kansas Head Start Children with an Oral Problem in the Past Year by Selected Characteristics, 2015-2016



Survey Methods

Head Start Smiles for Life sampled children in enrolled in Head Start, the target preschool population for the National Oral Health Surveillance System. All Head Start centers in Kansas were included in the sampling frame. The sampling frame was stratified by urban/rural status of the county, and a systematic probability proportional to size cluster sampling scheme was used to select 25 Head Start centers with a total funded enrollment of 3,271. One of the Head Start centers closed prior to the survey and was replaced with another center randomly selected from the same sampling interval. Data are available for all 25 sampling intervals.

Screenings were completed during the 2015-2016 school year. Letters were sent home to parents explaining the goals of the survey. Parents were asked to return a signed consent form along with a one-page questionnaire. The questionnaire collected the following information: age, race/ethnicity, self-reported oral health problems in the past 12 months, time since last dental visit, main reason for last dental visit, difficulty in accessing dental care, reasons for not getting needed dental care, and dental insurance coverage. The parent letter, consent form and questionnaire were available in English and Spanish.

Only those children whose parents returned a positive consent form were screened. Of the 3,271 funded positions, 1,443 Head Start children between 3-5 years of age were screened for an estimated response rate of 44%. Trained dental examiners completed the screenings using gloves, penlights, and disposable mouth mirrors. The diagnostic criteria outlined in the Association of State and Territorial Dental Directors' publication, *Basic Screening Surveys: An Approach to Monitoring Community Oral Health*, were used. (ASTDD, 2015)

Data were collected on paper forms, and Microsoft Excel was used to enter the data. All statistical analyses were performed using the SAS software complex survey procedures (Version 9.3; SAS Institute Inc., Cary, NC). Sample weights were used to produce population estimates based on selection probabilities and indicating the number of children in the sampling interval each screened child represented.

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Data Tables

Table 1: Age, gender, race/ethnicity, and urbanicity of Kansas Head Start children that participated in *Head Start Smiles for Life*, 2015-2016

Demographic Characteristic	Number of Children	Weighted Percent	Lower 95% CL	Upper 95% CL
Age				
3 years	562	37.9	33.9	41.9
4 years	770	54.3	51.5	57.2
5 years	111	7.8	5.1	10.4
Gender				
Female	704	49.1	46.6	51.6
Male	730	50.9	48.4	53.4
Race/Ethnicity				
White (non-Hispanic)	426	36.5	26.7	46.3
Black (non-Hispanic)	210	14.8	8.3	21.3
Hispanic (any race)	560	37.2	26.4	48.0
Asian (non-Hispanic)	33	2.7	0.4	5.0
American Indian / Alaska Native (non-Hispanic)	8	0.9	0.1	1.7
Pacific Islander (non-Hispanic)	4	0.2	0.0	0.5
Multi-racial (non-Hispanic)	118	7.7	5.0	10.4
Urbanicity				
Rural	767	48.0	27.0	69.0
Urban	676	52.0	31.0	73.0

CL = Confidence limit

Table 2: Responses to parent questionnaire for Kansas Head Start children that participated in *Head Start Smiles for Life*, 2015-2016

Characteristic	Number of Childrend	Weighted Percent	Lower 95% CL	Upper 95% CL
Had oral problem in last year (toothache, cavity)				
Yes	273	19.8	17.1	22.4
No	1,087	80.2	77.6	82.9
Time since last dental visit				
< 1 year	1,223	87.9	83.7	92.0
1-3 years	64	4.9	2.4	7.3
> 3 years	11	0.6	0.1	1.2
Never been to a dentist	83	6.6	4.5	8.8
Needed dental care but could not get it				
Yes	156	11.3	8.0	14.6
No	1,169	88.7	85.4	92.0
Has dental insurance				
Yes	1,262	93.7	92.2	95.2
No	94	6.3	4.8	7.8

Table 3: Percent of Kansas Head Start children aged 3-5 years with decay experience and untreated decay by selected characteristics, 2015-2016

Characteristic	Decay Experience			Untreated Decay		
	Percent	Lower 95% CL	Upper 95% CL	Percent	Lower 95% CL	Upper 95% CL
All Children	30.9	27.4	34.3	9.8	7.2	12.5
Gender						
Female	30.6	26.0	35.2	9.8	7.5	12.2
Male	31.0	26.6	35.3	9.8	6.1	13.5
Race/Ethnicity						
White (non-Hispanic)	25.3	21.2	29.4	8.8	4.9	12.8
Black (non-Hispanic)	26.2	15.6	36.8	12.0	3.6	20.4
Hispanic (any race)	36.6	31.3	41.8	9.5	5.1	13.9
Urbanicity						
Rural	28.6	23.7	33.5	12.6	8.9	16.4
Urban	33.0	28.4	37.7	7.2	3.6	10.9
Time since last dental visit						
< 1 year	30.9	27.5	34.3	8.6	6.1	11.1
> 1 year or never	28.5	20.7	36.4	21.2	12.9	29.6
Dental insurance						
Yes	29.8	26.6	32.9	9.6	7.0	12.3
No	42.0	27.9	56.1	18.0	7.5	28.5

Table 4: Percent of Kansas Head Start children ages 3-5 years with demineralization and needing dental treatment by selected characteristics, 2015-2016

Characteristic	Demineralization			Needs Early or Urgent Dental Treatment			Needs Urgent Dental Treatment		
	Percent	Lower 95% CL	Upper 95% CL	Percent	Lower 95% CL	Upper 95% CL	Percent	Lower 95% CL	Upper 95% CL
All Children	17.5	13.0	22.1	9.3	7.0	11.7	0.7	0.0	1.4
Gender									
Female	17.5	12.3	22.7	9.8	7.3	12.3	0.4	0.0	0.9
Male	17.3	12.1	22.5	8.9	6.0	11.8	1.0	0.0	2.2
Race/Ethnicity									
White (non-Hispanic)	22.4	13.9	30.9	9.0	5.0	12.9	0.4	0.0	1.2
Black (non-Hispanic)	13.2	1.9	24.5	12.0	3.6	20.4	2.3	0.0	4.6
Hispanic (any race)	16.6	8.6	24.6	8.3	4.6	11.9	0.2	0.0	0.6
Urbanicity									
Rural	30.8	22.2	39.5	12.6	9.0	16.1	0.7	0.0	1.7
Urban	5.3	2.4	8.3	6.4	3.4	9.3	0.7	0.0	1.7
Time since last dental visit									
< 1 year	15.9	11.5	20.4	8.0	5.9	10.2	0.6	0.0	1.2
> 1 year or never	28.6	16.6	40.7	20.6	12.6	28.6	2.3	0.0	5.0
Dental insurance									
Yes	17.7	13.0	22.4	9.0	6.7	11.3	0.7	0.0	1.4
No	22.4	13.6	31.2	18.9	8.3	29.4	1.5	0.0	4.7

Table 5: Mean number of teeth with untreated decay and treated decay plus mean number of teeth with decayed or treated teeth among Kansas Head Start children aged 3-5 years by selected characteristics, 2015-2016

Characteristic	Mean	Standard Error	Mean	Standard Error	Mean	Standard Error
All Children	0.23	0.03	1.12	0.09	1.30	0.09
Gender						
Female	0.23	0.04	1.15	0.14	1.33	0.13
Male	0.23	0.04	1.08	0.11	1.27	0.12
Race/Ethnicity						
White (non-Hispanic)	0.16	0.04	0.74	0.09	0.90	0.10
Black (non-Hispanic)	0.34	0.12	0.80	0.17	1.14	0.18
Hispanic (any race)	0.21	0.05	1.46	0.17	1.67	0.16
Urbanicity						
Rural	0.30	0.05	0.76	0.09	1.02	0.12
Urban	0.16	0.04	1.46	0.14	1.57	0.12
Time since last dental visit						
< 1 year	0.20	0.03	1.22	0.09	1.36	0.09
> 1 year or never	0.52	0.11	0.29	0.13	0.82	0.17
Dental insurance						
Yes	0.21	0.03	1.07	0.08	1.23	0.09
No	0.61	0.15	1.43	0.50	2.05	0.53

Table 6: Gender, urbanicity and responses to parent questionnaire for Kansas Head Start children aged 3-5 years by race/ethnicity, 2015-2016

Characteristic	White			Black			Hispanic		
	Percent	Lower 95% CL	Upper 95% CL	Percent	Lower 95% CL	Upper 95% CL	Percent	Lower 95% CL	Upper 95% CL
Gender									
Female	49.8	44.2	55.4	45.7	38.9	52.6	49.7	45.8	53.6
Male	50.2	44.6	55.8	54.3	47.4	61.1	50.3	46.4	54.2
Urbanicity									
Rural	68.6	47.0	90.1	26.5	2.9	50.1	40.1	15.3	65.0
Urban	31.4	9.9	53.0	73.5	49.9	97.1	59.9	35.0	84.7
Had oral problem last year									
Yes	15.8	11.7	19.9	18.7	14.3	23.2	23.3	18.8	27.9
No	84.2	80.1	88.3	81.3	76.8	85.7	76.7	72.1	81.2
Time since last dental visit									
< 1 year	81.6	72.3	90.9	91.0	86.2	95.8	91.4	87.9	94.9
> 1 year or never	18.4	9.1	27.7	9.0	4.2	13.8	8.6	5.1	12.1
Needed care but couldn't get it									
Yes	11.3	4.6	18.0	11.8	7.8	15.8	9.3	5.1	13.5
No	88.7	82.0	95.4	88.2	84.2	92.2	90.7	86.5	94.9
Dental insurance									
Yes	96.2	94.4	97.9	95.5	92.2	98.8	90.3	87.8	92.7
No	3.8	2.1	5.6	4.5	1.2	7.8	9.7	7.3	12.2

Table 7: Gender, race/ethnicity and responses to parent questionnaire for Kansas Head Start children aged 3-5 years by urban/rural status, 2015-2016

Characteristic	Urban			Rural		
	Percent	Lower 95% CL	Upper 95% CL	Percent	Lower 95% CL	Upper 95% CL
Gender						
Female	50.5	48.5	52.4	48.0	43.7	52.3
Male	49.5	47.6	51.5	52.0	47.7	56.3
Race/Ethnicity						
White (non-Hispanic)	21.7	12.7	30.8	53.3	35.7	70.9
Black (non-Hispanic)	22.4	12.3	32.5	7.6	0.0	15.4
Hispanic (any race)	42.0	30.3	53.8	31.7	14.9	48.5
Had oral problem in last year						
Yes	20.4	17.1	23.8	18.6	14.7	22.6
No	79.6	76.2	82.9	81.4	77.4	85.3
Time since last dental visit						
< 1 year	93.6	90.1	97.2	81.2	73.9	88.4
> 1 year or never	6.4	2.8	9.9	18.8	11.6	26.1
Needed care but couldn't get it						
Yes	8.4	5.9	10.9	14.1	8.4	19.8
No	91.6	89.1	94.1	85.9	80.2	91.6
Dental insurance						
Yes	93.9	91.6	96.1	93.0	91.1	94.9
No	6.1	3.9	8.4	7.0	5.1	8.9

Appendix 1 Parent Letter

Curtis State Office Building
1000 SW Jackson St., Suite 540
Topeka, KS 66612-1367

Kansas
Department of Health & Environment

Phone: 785-296-0461
Fax: 785-368-6368
www.kdheks.gov

Susan Mosier, MD, Secretary

Sam Brownback, Governor

Dear Parent/Guardian:

Your child's Head Start Program has been chosen to take part in the state health department's *Smiles Across Kansas* survey. The purpose of the *Smiles Across Kansas* survey is to gather information on the dental health needs of children throughout Kansas. This will allow us to create a plan to improve dental care for all Kansas children.

If you choose to let your child take part, a dental hygienist will perform a free one-minute "smile check" using a wooden tongue depressor and a flashlight. Dental gloves will be worn and a new tongue depressor will be used for each child. Results of your child's screening will be kept confidential, and your child will not be named in any *Smiles Across Kansas* report.

After the screening takes place, we will send home a letter to let you know if we find any dental problems in your child. This screening, however, does not take the place of regular dental check-ups by your family dentist. Even if you have a family dentist, we encourage you to participate in the *Smiles Across Kansas* survey. By screening children in Head Start programs, we will have a better understanding of the dental health needs of children throughout Kansas.

If you do not wish for your child to take part in this oral health screening, please check the "No" box on the attached form and return the form to your child's teacher tomorrow. Whether you decide to allow your child to take part in the oral health screening or not, the services provided by your child's Head Start Program will not be affected in any way.

If you decide to take part, please discuss the screening with your child. The screening will only take place if both you and your child consent to screening so we would like your child to understand the screening process. A toothbrush will be given to your child, which is yours to keep whether you would like your child to take part in the screening or not.

As you know, a healthy mouth is part of total health and wellness and makes a child more ready to learn. By letting your child take part in this dental screening, you will help contribute new information that may benefit all of Kansas' children. If you have any questions about the Smiles Across Kansas survey, please contact Jennifer Ferguson at (785) 296-5116.

Sincerely,

Cathleen Taylor-Osborne, DDS

Cathleen Taylor-Osborne, D.D.S., M.A.
Kansas Department of Health and Environment
Dental Director
Bureau of Oral Health

Appendix 2 Consent Form and Parent Questionnaire

Consent Form & Parent Questionnaire

Please complete the gray box shown below and return this form to your child's teacher **tomorrow**. This form is to establish consent for your child to be screened for the *Smiles Across Kansas* survey, which involves a minimally-invasive, one minute dental screening and oral health "smile check." If you decline to have your child screened, services provided by your child's Head Start program will not be affected in any way. You or your child may opt out of this screening at any time.

Child's Name_____ Child's Age_____

_____ Yes, I give permission for my child to participate in the "Smiles Across Kansas" survey. (Please sign below and complete questions 1-8)

_____ No, I do not give permission for my child to participate. (Please sign below)

_____ _____

Signature of Parent or Guardian Date

1. During the past 12 months, did your child have a toothache, decayed teeth, or unfilled cavities?
   ☐ Yes ☐ No ☐ Don't know/Don't remember

2. How long has it been since your child last visited a dentist? This includes dentists and dental hygienists. (Check one)
   ☐ 12 months or less
   ☐ More than 1 year ago, but no more than 3 years ago
   ☐ More than 3 years ago
   ☐ My child has never been to the dentist
   ☐ Don't know/Don't remember

3. What was the main reason that your child last visited a dentist? (check one)
   ☐ Went in on own for 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
   ☐ Don't know/Don't remember

4. During the past 12 months, was there a time when your child needed dental care but could not get it?
   ☐Yes (Go to Q5) ☐No (Go to Q6) ☐ Don't know/Don't remember (Go to Q6)

Please answer the questions on the other side of the page

Appendix 2 *Continued*

Consent Form and Parent Questionnaire

Kansas Department of Health and Environment

5. The last time your child could not get the dental care he/she needed, what was the ***main reason*** he/she could not get care? (check one)

- ☐ Could not afford the cost
- ☐ Did not want to spend the money
- ☐ Insurance did not cover the necessary care
- ☐ Dental office is too far away
- ☐ Dentist hours are not convenient
- ☐ Afraid of/do not like dentists
- ☐ Unable to take time off work
- ☐ Too busy
- ☐ I did not think anything serious was wrong/expected dental problems to go away
- ☐ Dentist did not take Medicaid/insurance
- ☐ Other reason
- ☐ Don't know/Don't remember

6. Do you have any kind of insurance that pays for some or all of your child's dental care? This includes insurance from your job as well as government programs like Medicaid (also known as KanCare, Sunflower, United, or Amerigroup)

☐ Yes ☐ No ☐ Don't know/Not sure

7. Is your Child Hispanic or Latino?

☐ Yes ☐ No ☐ Don't know/Not sure

8. Which of the following best describes your child? (check all that apply)

- ☐White
- ☐Asian
- ☐Black/African American
- ☐American Indian/Alaska Native
- ☐Native Hawaiian/Pacific Islander

Appendix 3

Oral Health Screening Form/Results

Smiles Across Kansas Oral Health Screening Form/Head Start Children

Screen Date: __/__/____	Site Code/Sort Order:	Screener's Initials:
ID Number:	Gender: ☐ Male ☐ Female	Decalcification: ☐ No ☐ Yes
Untreated Decay: ☐ No ☐ Yes # Decayed Teeth _____	Treated Decay: ☐ No ☐ Yes # Treated Teeth _____	Treatment Urgency: ☐ None ☐ Early ☐ Urgent
Total # Treated and Untreated Teeth: _____		

Screening Results Letter for Parents

Kansas Department of Health and Environment

KDHE Bureau of Oral Health

Child's Name: _____

Dear Parent or Guardian,

As part of the *Smiles Across Kansas* Survey, your child received a dental screening at school. No x-rays were taken and the screening does not replace an in-office dental examination by your family dentist. The results of the screening indicate that:

_____ Your child has no obvious dental problems but should continue to have routine examinations by your family dentist.

_____ Your child has a tooth or teeth that should be evaluated by your family dentist. Your dentist will determine whether treatment is needed.

_____ Your child has a tooth or teeth that appear to need immediate care. Contact your family dentist as soon as possible for a complete evaluation.

Comments:_____

_____

_____

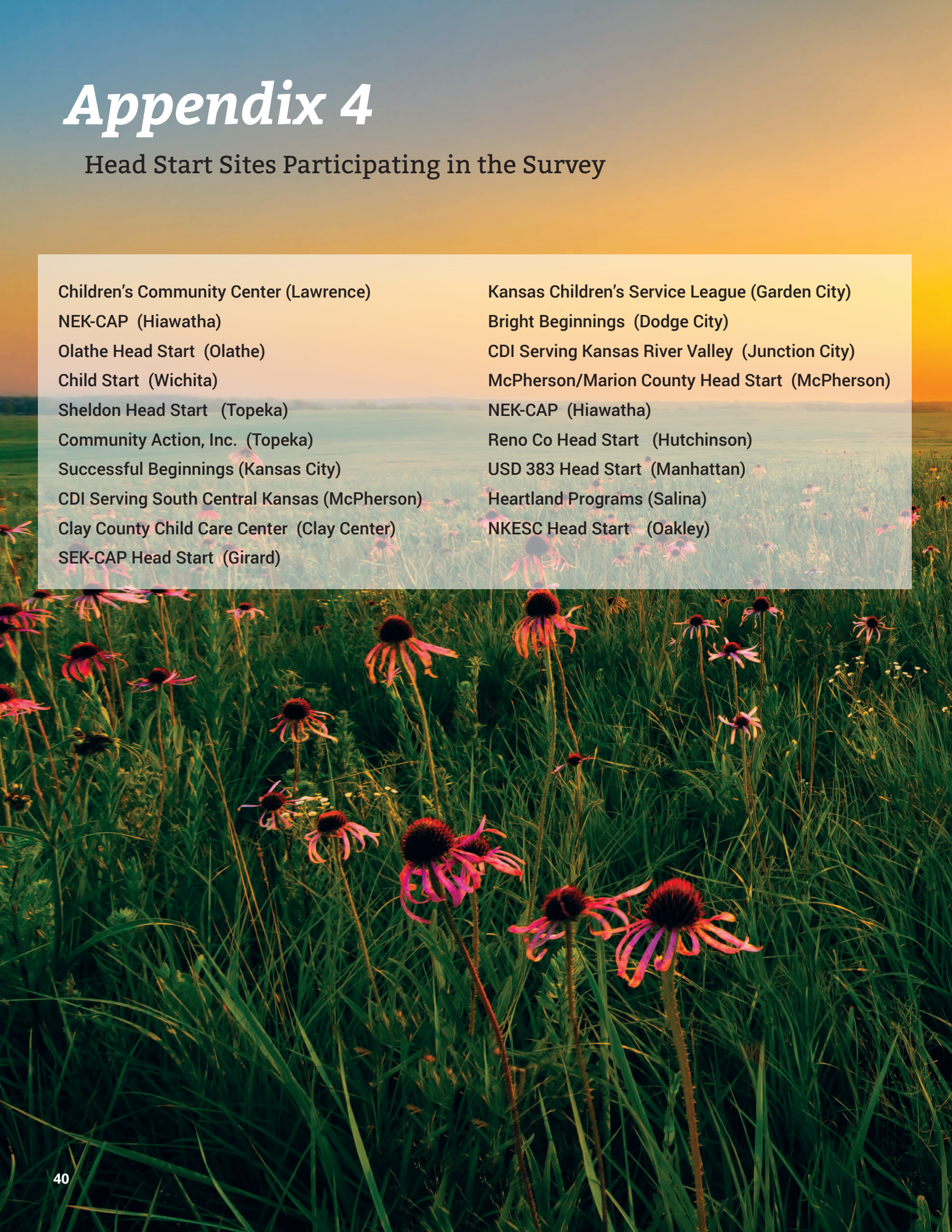
If you do not have a family dentist and you need help in obtaining dental care, your Head Start program may be able to help.

All forms and letters were also available in Spanish.

Appendix 4

Head Start Sites Participating in the Survey

Children's Community Center (Lawrence)
NEK-CAP (Hiawatha)
Olathe Head Start (Olathe)
Child Start (Wichita)
Sheldon Head Start (Topeka)
Community Action, Inc. (Topeka)
Successful Beginnings (Kansas City)
CDI Serving South Central Kansas (McPherson)
Clay County Child Care Center (Clay Center)
SEK-CAP Head Start (Girard)
Kansas Children's Service League (Garden City)
Bright Beginnings (Dodge City)
CDI Serving Kansas River Valley (Junction City)
McPherson/Marion County Head Start (McPherson)
NEK-CAP (Hiawatha)
Reno Co Head Start (Hutchinson)
USD 383 Head Start (Manhattan)
Heartland Programs (Salina)
NKESC Head Start (Oakley)



Kansas Head Start

SMILES FOR LIFE

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