Nevada Department of
Health and Human Services
Oral Health Program

NEVADA LICENSED CHILDCARE CENTER SURVEY 2021

Department of Health and Human Services
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This report is available on the Oral Health Program website:
http://dpbh.nv.gov/Programs/OH/OH-Home/

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Background

The Nevada Division of Public and Behavioral Health, Oral Health Program through a grant from the Nevada Department of Education, designed an oral health surveillance project. The purpose of this study was to evaluate the oral health status of children (ages 3-5 years of age) receiving care from licensed childcare centers in rural Nevada. A similar project was completed by the Nevada Oral Health Program in 2017-2018 when the oral health status of children in rural Head Start programs was assessed. Aggregate results of this study will be compared to the reports from the 2017-2018 Head Start oral health assessment. Oral health promotion, early detection, and classroom education were novel elements that were included in this project that have not been included in previous state basic screening survey designs. Nevada Registry approved oral health webinars were offered to educators and to equip teachers with oral health information that could be shared with the children in their care. Classroom toothbrushing stations were also established within each center.

Introduction

In 2003, a dental screening was conducted by what was then the Nevada State Health Division Oral Health Program to review oral health data on children enrolled in Nevada Head Start programs. The protocol used for the screening was the Association of State and Territorial Dental Directors (ASTDD) Basic Screening Survey (BSS). All 44 Head Start sites were screened and a report was issued on the results.[1]

In 2007, the Nevada Oral Health Program completed a second dental screening, and all 44 Head Start sites were again screened using the BSS protocol. A report from that survey summarized the findings of the 2007 screening, compared the findings with Federal Healthy People 2010 objectives, and provided high-level comparison between the 2003 and 2007 screening results.[2]

In 2017, the Nevada Division of Public and Behavioral Health (DPBH), Oral Health Program partnered with the Department of Education's Office of Early Learning and Development (DOE), Head Start State Collaboration Office to conduct another dental screening to collect oral health data on Nevada rural Head Start children. The BSS protocol was again used to assess for caries, caries experience, untreated decay, and the need for urgent dental treatment. It should be noted that the BSS is not considered research or direct patient treatment but is classified as public health surveillance. All 16 Head Start Centers located in 11 of the 17 Nevada counties were screened (Figure 1). Las Vegas and Reno were not included in this survey because the Head Starts in these greater metropolitan areas were already screened regularly through dental hygiene programs at the College of Southern Nevada and Truckee Meadows Community College, through Community Health Alliance, and through a research project conducted by the University of Nevada, Las Vegas School of Dental Medicine (UNLV SDM). Overlap of these similar projects in these regions was deemed undesirable.

[1] http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/OH/Oral_Health_Program_Reports/healthysmilehappychildsurvey2003.pdf
[2] http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/OH/Oral_Health_Program_Reports/BSSheadstart2007final73007.pdf

In 2020, the DPBH, Oral Health Program again partnered with the DOE to conduct a dental surveillance project. The DPBH, Oral Health Program, which was housed through contract (C 23271) at the UNLV SDM, received a grant from the DOE (C22479) to conduct a dental surveillance project in Nevada's rural LCC.

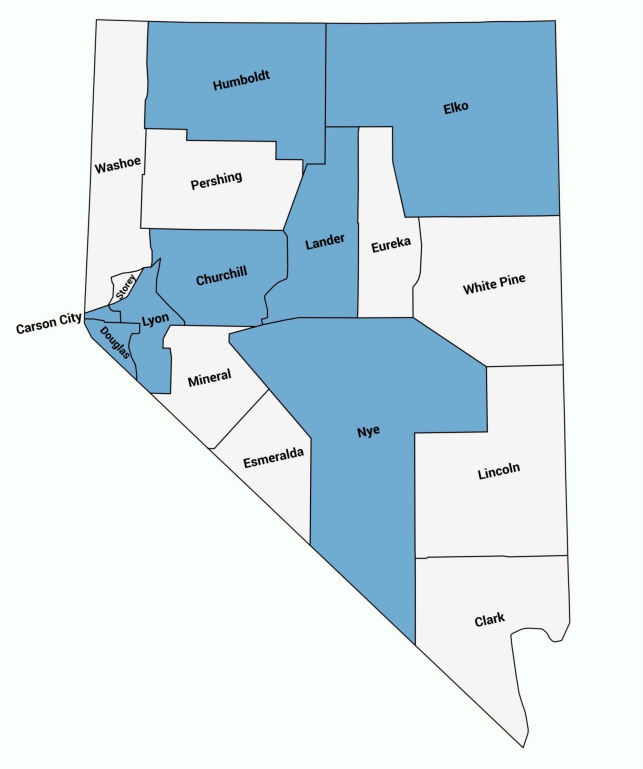
The purpose of the project was to obtain information on the oral health of children attending non-Head Start childcare and preschool programs in rural Nevada and compare the results with the survey of children enrolled in rural Head Start programs which was previously completed (2017-2018). A list of the rural childcare facilities licensed by the state of Nevada was obtained from the Nevada Department of Health and Human Services. In Nevada, licensed childcare facilities fall into three categories based on their size: center, group care home, or family care homes. The sampling frame was limited to facilities designated as "centers" or "group care." Centers are facilities that stand alone and provide all-day curriculum childcare. "Group care" facilities within an individual's residential home, can care for up to 12 children within the home, and require one additional caregiver and a curriculum. For this study, 91 licensed childcare facilities were identified within the target geographic location of rural Nevada. In Nevada, this includes all childcare centers outside of the urban centers of Las Vegas and Reno. Though all LCC were not included in this survey, this data is important in that it focuses on oral health in Nevada's rural population and documents the extent of oral health needs in young children in these areas. According to Oral Health in America: A Report of the Surgeon General,[3] children from low-income families have more tooth decay, more extensive tooth decay, and suffer more pain than children from families with higher incomes. Screening results are expected to aid in targeted interventions to prevent oral disease so that growth, development, and overall quality of life for all of Nevada's children is enhanced.

Data was collected through a BSS; an "open-mouth" screening conducted with parental consent to assess for caries, caries experience, untreated decay, and the need for urgent dental treatment. The BSS was developed by the ASTDD to monitor the burden of oral disease at state and local levels for evaluation against *Healthy People* objectives. The BSS is a nationally recognized tool for public health surveillance. Therefore, this project is not research but a public health surveillance project to inform Nevada public health action, planning, and program evaluation. The underlying project goal is to gather aggregate data that will focus programs and State funds to improve oral health care by increasing the number of young children with dental "homes" and decreasing the number of children with untreated tooth decay. There were 29 LCC located in 8 of the 17 Nevada counties that were screened (Figure 1).

Oral health promotion, early detection, and classroom education were novel elements that were included in this project that have not been included in the previous State BSS designs. Nevada Registry approved oral health webinars that were offered to educators and equipped teachers with oral health information that could be shared with the children in their care. Classroom toothbrushing stations were also established within each center. By providing in-service training and positively altering the attitudes of childcare educators, the residual influence of oral health promotion will influence the oral health habits of students.

[3] U.S. Dept. of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Dept. of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of health, 2000.

Figure 1. *License Childcare Centers Oral Health Survey Locations 2020-2021*



Key Findings – 2021

Compared to children attending Head Start in rural Nevada, children attending preschool at Licensed Childcare Centers in rural Nevada have a substantially lower prevalence of decay experience and a lower prevalence of untreated decay.

26.8% of children enrolled in rural Licensed Childcare Centers in this survey had **caries experience** (one or more teeth with untreated or treated decay) as compared to the 50% of rural Head Start children in the survey. This finding is lower than the *Healthy People 2020* objective for untreated decay (27.9%).

Caries experience **increases** with age, with 14% of 3-year-olds, 33% of 4-year-olds, and 36% of 5-year-olds having caries experience.

20.2% of children enrolled in rural Licensed Childcare Centers in this survey had **untreated decay** as compared to the 26% of rural Head Start children. This finding **exceeds** the Healthy People 2020 objective for untreated decay (11.9%).

Although the prevalence of decay experience is similar for rural Nevada preschool children and the U.S. average (27% and 28% respectively), preschool children in rural Nevada have a **higher** prevalence of untreated decay (20% vs. 12%).

19% of children enrolled in rural Licensed Childcare Centers in this survey **needed either early or urgent dental care**, compared with the 29% of these rural Head Start children who needed either early or urgent dental care in the 2017 survey.

52% of parents reported that the cost of dental care was the reason their child was not able to get dental care when they needed it, followed by office closures caused by COVID-19 (43%), inability to take time off work (19%), and not having dental insurance (14%).

Methodology

Since all 29 LCC were screened, the results of this screening are reported as a "census." It was determined that, rather than research, this dental screening was considered an oral health surveillance effort to continue to monitor the oral health status of this population. While the program may share the name of screened children with the childcare facility center administrator for follow-up, no individual child will be identified in any reports. Only aggregate results will be reported (e.g., from centers, counties, or regions). Participating childcare centers will be the first to receive such reports.

Letters went out first to each site Administrator for their approval to participate in the project (see appendices). The letter included information on the project and an optional oral health webinar. Follow-up calls were made to secure participation, answer questions, and schedule a screening visit.

After securing participation, all consent forms were mailed in advance to the childcare facility for distribution to parents. Packets included a letter to parents, a fluoride varnish brochure, a consent form, and a questionnaire (see appendices). All documents distributed to parents were available in English and Spanish. To improve consent form return, children were given a colored wrist band to remind their parents that they went home with paperwork that required attention. Assessment questions within the consent form provided information on local access to care and the child's susceptibility to dental decay. This questionnaire allowed the study to assess oral health at a state and local level.

Compensation to subjects consists of a free screening, a free fluoride varnish application, and a free patient care bag with a toothbrush, toothpaste, floss, timer, and sticker. The administrators and teachers within the identified LCC were vital to encouraging the completion of parental consent forms and ensuring that documents are returned promptly. The project offered school incentives in the form of a $100 gift card to Lakeshore Learning for those sites reaching a 70% response rate to improve the return rates of consent forms. The percentage of completed consent forms was associated with forms with a parental signature regardless of whether the parent accepts or denies the child's participation in the study.

In addition, a webinar was offered to all staff, educators, and administration within each of the identified LCC. A vital component of this project was equipping educators with tools and information on oral health. In total, seven comparable, 2.5-hour Nevada Registry-approved webinars were offered that provided an overview of the dental screening (BSS) process, evidence-based oral health education, dental first aid, and tips to incorporate oral health into the daily curriculum. These webinars met the standards set forth by the Department of Education's Silver State Stars Quality Rating and Improvement System (QRIS). Content mastery was evaluated using a pre- and post-survey. Colgate Bright Smiles, Bright Futures (BSBF) was an integral partner in providing these webinars. Colgate BSBF contributed to both the presentation and suppling the LCC and educators with oral hygiene supplies.

Prior to the site visits, follow-up confirmation and reminder calls were made to the centers a week before the visit date, and then the day before the visit.

The screening portion was based on the ASTDD Basic Screening Survey (BSS) protocol. All children with a signed positive consent form who were present the day of screening were screened in an area designated by the Childcare Center. The dental screenings were completed by the Nevada-licensed Interim State Public Health Dental Hygienist, who was calibrated on the BSS protocol beforehand. The State Dental Health Officer, who has similarly been standardized on the BSS protocol, was available to provide screening support as needed. Screenings were conducted with a headlamp, disposable gloves, a disposable mirror, and gauze (as needed to remove debris). A fluoride varnish application was provided to those children who meet all of the following indications: separate consent for the fluoride varnish, no contraindications listed on the consent form, and willingness to cooperate with the procedure. The screener entered the screening results for each child on a paper screening form on-site and filled out "Take Home Findings" to be sent home with the child that included post-fluoride varnish application instructions and dental care tips. A list of low-cost community dental clinics in Nevada was also attached (see appendices). Children received an oral health supply bag with a toothbrush, toothpaste, floss, and a timer for use with brushing to take home with them.

A Microsoft Access database was created and tested, and decision rules were written for data entry. The data recorder entered all information into the database.

Conditions were recorded as follows:

1. ***Non-Cavitated White Spot*** (y/n) was marked yes if at least one tooth had decalcification with no break in the enamel. Included were the number of teeth fitting the description.
2. ***Untreated Decay*** (y/n) was marked if at least one tooth had a break in the enamel that was large enough to be detected visually. Staining was not included as untreated decay. Included were the number of teeth fitting the description.
3. ***Treated Decay*** (y/n) was marked if at least one tooth was extracted due to decay or had amalgam (silver) or composite (white) fillings, stainless steel crowns, white-faced crowns, or "other." Included was the number of teeth fitting the description.
4. ***Treatment Urgency*** was considered the whole mouth, with "Urgent" marked for signs or symptoms that included pain, or infection, swelling or soft tissue ulceration of more than two-weeks' duration as determined by questioning were present. "Early" was marked if visible caries without accompanying signs or symptoms were present, or there was spontaneous bleeding of the gums or suspicious white or red soft tissue areas. "None" was marked if the child was without any of the problems listed above.

Oral health education and health promotion for the entire classroom were key components to this project. An interactive presentation on oral health, nutrition, the classroom toothbrushing station, and a child appropriate story on dental health was read to each classroom. Children were able to ask questions and interact during the demonstrations.

Classroom toothbrushing stations were established within each of the centers. Enough supplies were provided to cover 880 children with oral hygiene kits to be used in the classroom. However, in-classroom toothbrushing implementation was delayed due to COVID-19 related safety standards. The follow-up survey with the centers assessed the benefits of the toothbrushing station.

Following the site visits, a satisfaction survey was sent to each site administrator for project feedback. The survey asked for feedback received from staff, parents, or children regarding project, the screening, the educational presentation, or any aspects of the project.

Summary of Basic Screening Survey Protocol Changes Across Surveys from 2003-2021

The basic screening survey (BSS) is a nationally recognized tool for public health surveillance. The basic screening survey was developed by the Association of State and Territorial Dental Directors to monitor the burden of oral disease at state and local levels for evaluation against Healthy People objectives. The screening includes visual observation of the child's dental health with a mouth mirror and light.

- The 1999 version had one data element for race and another for ethnicity. Field testing found two problems with the 1999 method – missing data, and the inability to code multi-racial children. The 2003 version of BSS updated the method for collecting race and ethnicity information by combining them into one question (to reduce the amount of missing data) and included a code for multi-racial children.

- The 1999 version of *Basic Screening Surveys: An Approach to Monitoring Community Oral Health* included "untreated decay" and "caries experience" as two of the screening indicators. Combining these two indicators, however, did not allow states to determine which children had received previous treatment for caries. In 2007, the ASTDD Executive Committee approved changing the "caries experience" indicator to "treated decay."

- It was then recommended that caries experience, which is still an indicator for the National Oral Health Surveillance System (NOHSS), be calculated from untreated decay and treated decay.

- As states developed their oral health surveillance infrastructure, some indicated interest in collecting information on disease severity in addition to prevalence data. The 2008 version of BSS added a set of options for each indicator, ranging from a simple "no/yes" prevalence measure to more complex measures indicating severity of disease. If a severity option is selected, prevalence can still be calculated as one of the NOHSS indicators.

- In 2015, the early childhood caries (ECC) indicator – decay experience on maxillary anterior teeth – was deleted because the generally accepted definition of ECC is decay on any tooth rather than only on the maxillary anterior teeth. The optional questions were updated to align with national surveys.

- In 2017, optional indicators for dental sealants on primary molars and potentially arrested decay were added for states wishing to monitor the use of primary molar sealants and caries arresting agents such as silver diamine fluoride. The optional questions were again updated to align with current national surveys. (Note: "sealants on primary teeth" and "potentially arrested decay" were not recorded in the 2017 Nevada Head Start Survey.

Response Rates and Demographics

In 2020, there were 69 childcare facilities in rural Nevada designated as either "centers" or "group care". The state Oral Health Program attempted to contact and invite all 69 facilities:

- 29 facilities agreed to participate
- 3 facilities were closed
- 6 facilities declined to participate
- 25 facilities did not respond to multiple enquiries

The participating childcare facilities distributed a combined consent form/questionnaire to all parents. The consent form allowed parents to consent to a dental screening and/or a fluoride varnish application. The questionnaire included several questions regarding their child's oral health, oral health related habits, access to dental care, and demographics. A total of 749 consent forms/questionnaires were distributed to parents/caregivers and 445 were returned to the school (55%). Of these, 414 were for children 3-5 years of age. Of the 414 children aged 3-5 years:

- 48 had parents that refused the screening
- 366 had parents that allowed their child to have a screening
- 321 children aged 3-5 years received a screening (45 children were absent on the day of the screening)

A fluoride varnish application was offered along with the screening. Many parents chose not to participate in this free fluoride varnish application for their children, with 209 children (65%) receiving fluoride varnish. While the option for refusal could be due to allergies (4%), medical issues (0%), and/or recent fluoride application (14%), nearly 78% did not provide consent for fluoride application. This result may reflect continuing attitudes of mistrust related to fluoride and fluoride preventive regimens.

A $100 gift card to an online educational supply store was offered as an incentive for centers with at least a 70% consent return rate. Of the 29 schools, 12 met or exceeded the 70% rate (Table 1). Gift cards were distributed following the visit to the centers.

Table 1. *Consent Form Return Rate*

Consent Return Rate	Number of Schools
100%	1
90-99%	2
80-89%	5
70-79%	4
Below 70%	17

The demographic characteristics of age, gender, and race/ethnicity for the 2021 rural Nevada Licensed Childcare Center survey participants can be seen in Figures 2 and 3.

Figure 2. *Gender Distribution of Children in Rural Nevada Licensed Childcare Centers Screened in 2020-2021*

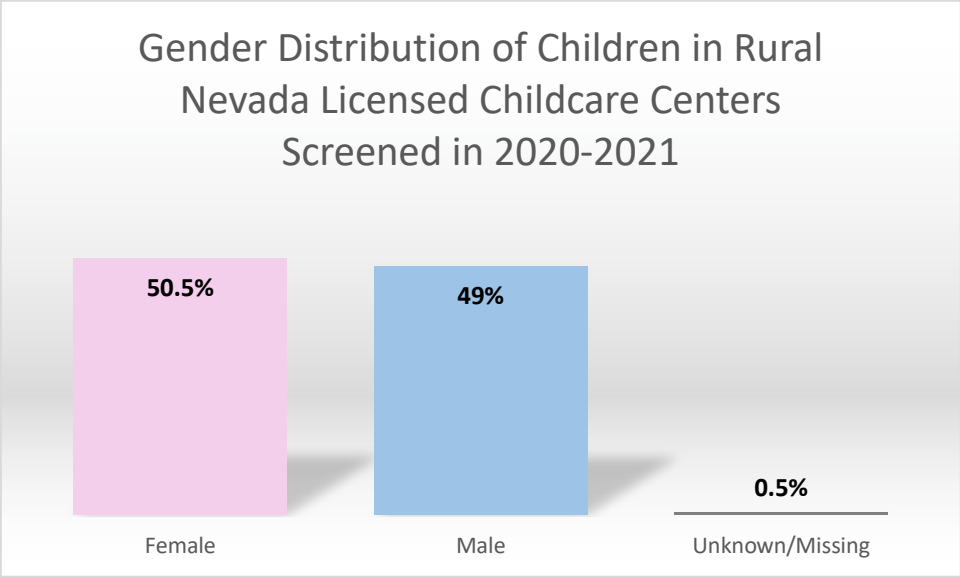
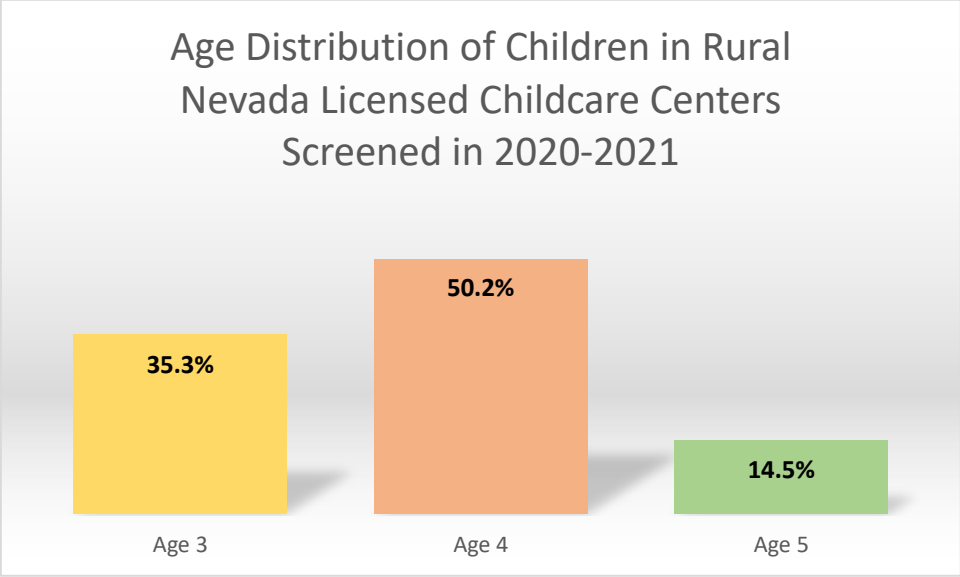


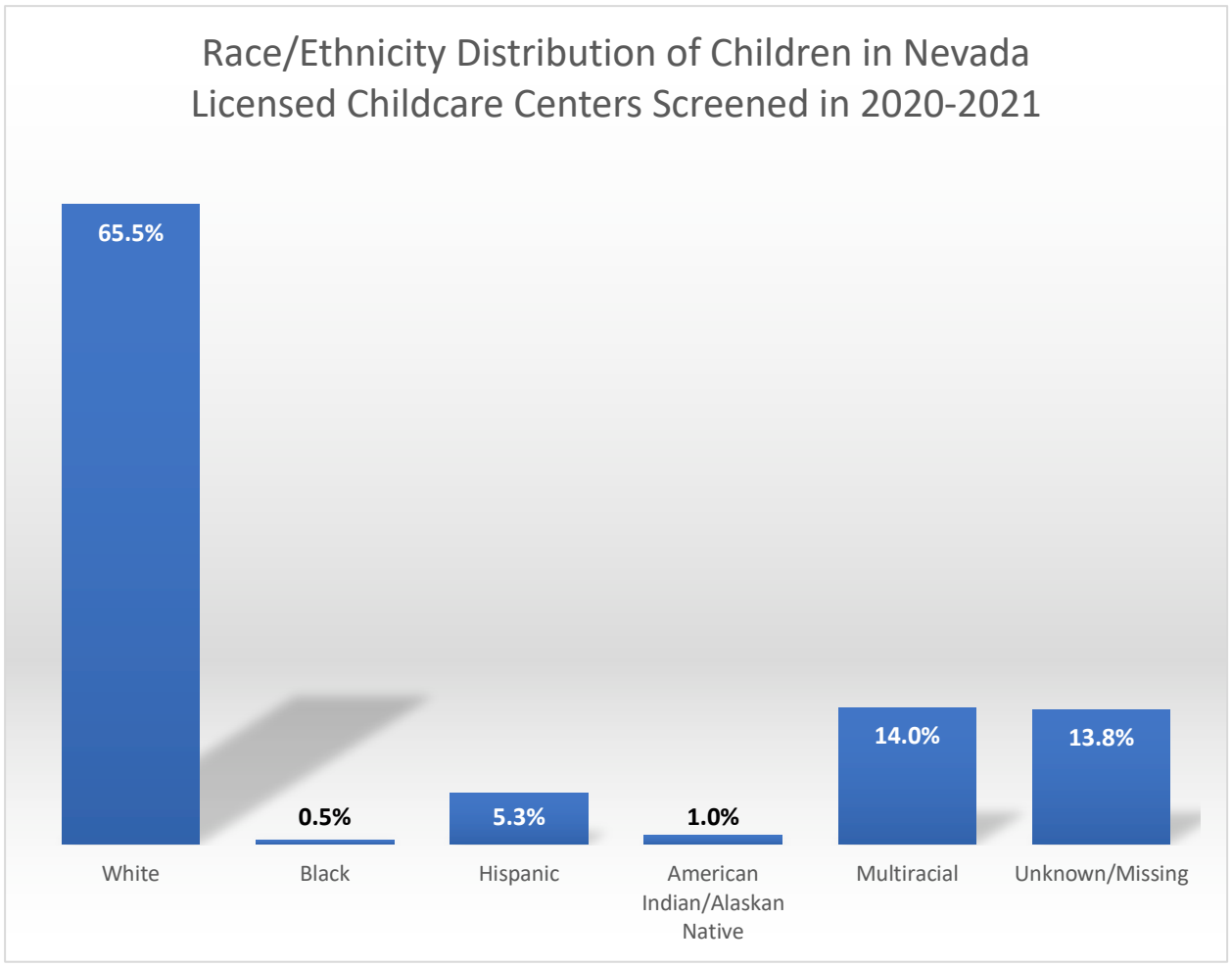
Figure 3. *Age Distribution of Children in Rural Nevada Licensed Childcare Centers Screened in 2020-2021*



Race/Ethnicity – On the consent form, the parent/guardian could select one or more choices from the following list: White, Black/African American, Asian, Hispanic/Latino, Native Hawaiian/Pacific Islander, American Indian/Alaska Native, Multi-Racial and Unsure. For summary purposes the responses were organized into mutually exclusive groups using the following logic. If Hispanic was selected as one of the choices, then the child was categorized as Hispanic. If only White was selected, then the child was categorized as White. If only Black was selected, then the child was categorized as Black. If only American Indian/Alaska Native was selected, then the child was categorized as American Indian/Alaska Native. If a parent selected

multi-racial or multiple selections (not including Hispanic) the child was categorized as multi-racial.

Figure 4. *Race/Ethnicity Distribution of Children in Nevada Licensed Childcare Centers Screened in 2020-2021*



Healthy People 2020

Healthy People 2020 is a set of health objectives for the nation to achieve by the year 2020.[4] There are 17 specific oral health objectives to prevent and control oral diseases and reduce oral health disparities. Three oral health indices are included for children three to five years of age.

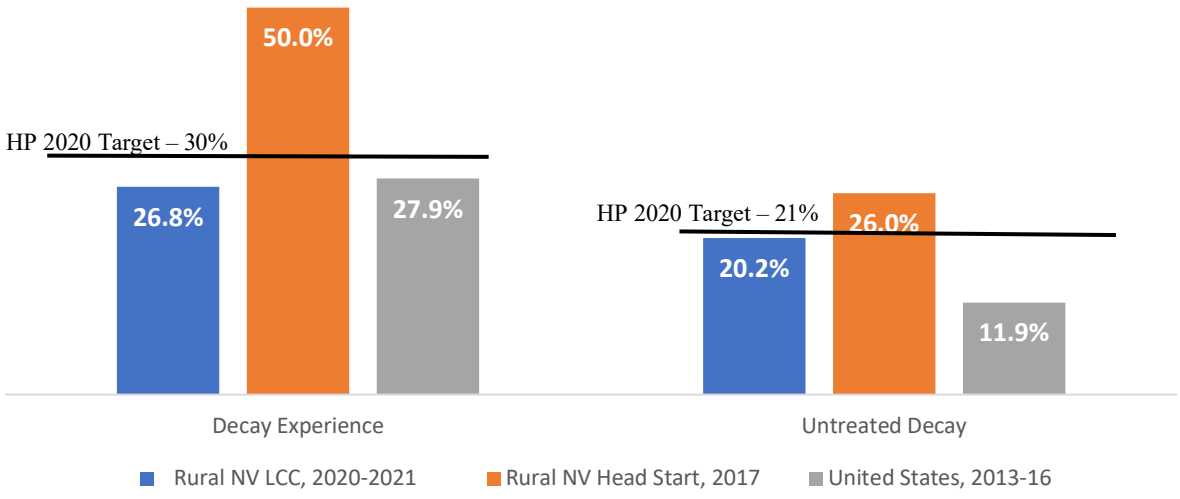
OH 1.1 Reduce the proportion of children aged 3 to 5 years with dental caries experience in their primary teeth (target – 30%)

OH 2.1 Reduce the proportion of children aged 3 to 5 years with untreated dental decay in their primary teeth (target 21.4%)

OH 12.1 Increase the proportion of children aged 3 to 5 years who have received dental sealants on one or more of their primary molar teeth (target 1.5%)

Figure 5 compares caries experience and untreated decay for children in Nevada LCC (age three to five) to *Healthy People 2020* objectives 1.1 and 2.1. This clearly demonstrates the gap in achieving the *Healthy People 2020* objectives for children of families with low incomes. The LCC survey did not assess dental sealants on primary teeth.

Figure 5. *Children Aged 3-5 Years in Rural NV with Decay Experience and Untreated Decay Compared to Health People 2020 Target*



[4] https://www.healthypeople.gov/

Comparison of 2017 Head Start and 2021 Licensed Childcare Center Screening Results

A comparison of 2021 rural LCC screening results to the results of children in the 2017 rural Head Start programs indicates that oral health status is more favorable (Figure 6). Caries experience, untreated decay, and need for treatment were all lower in the 2021 survey compared to results for rural Head Start children in 2017. The overall caries experience prevalence of 27%, is lower than the 50% prevalence for rural Head Start children in 2017. Untreated decay shows a prevalence of 20% compared to rural Head Start children prevalence 26% in 2017. Rural LCC children exceeded both the caries experience and untreated decay *Healthy People 2020* goals while the Nevada Head Start Children fell short of the of 30% for caries experience and 21% for untreated decay.

Figure 6. *Comparison of 2017 Rural NV Head Start and 2021 Rural NV Licensed Childcare Screening Results – Caries Experience and Untreated Decay*

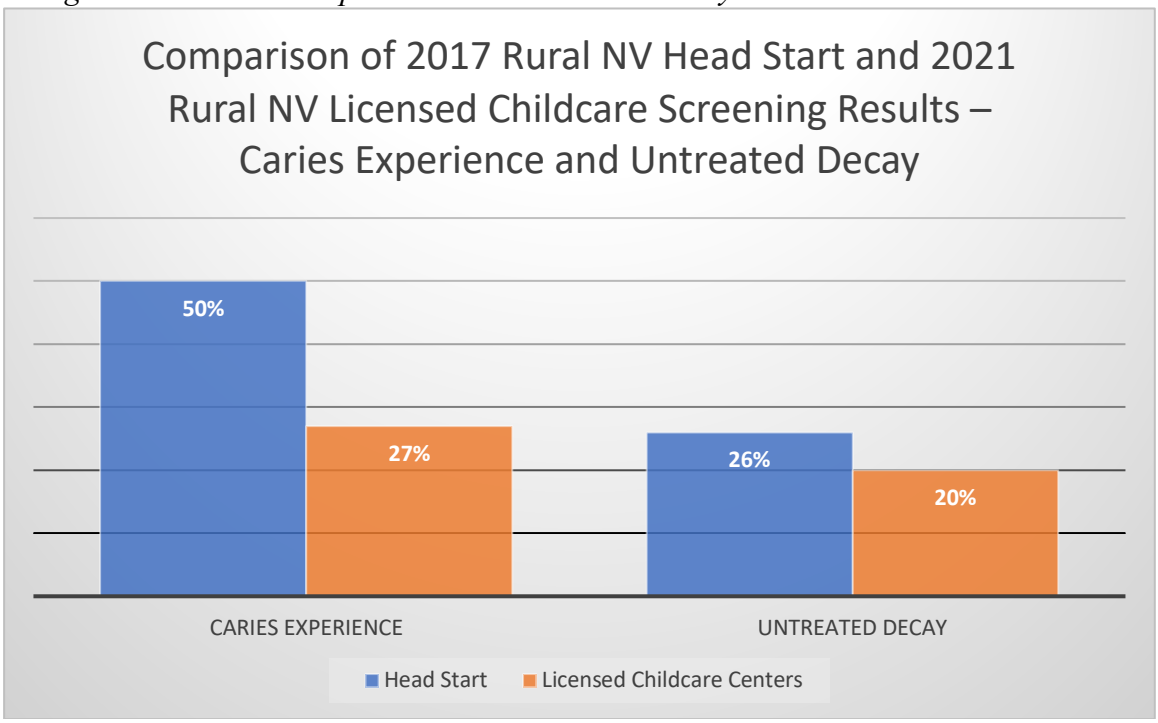
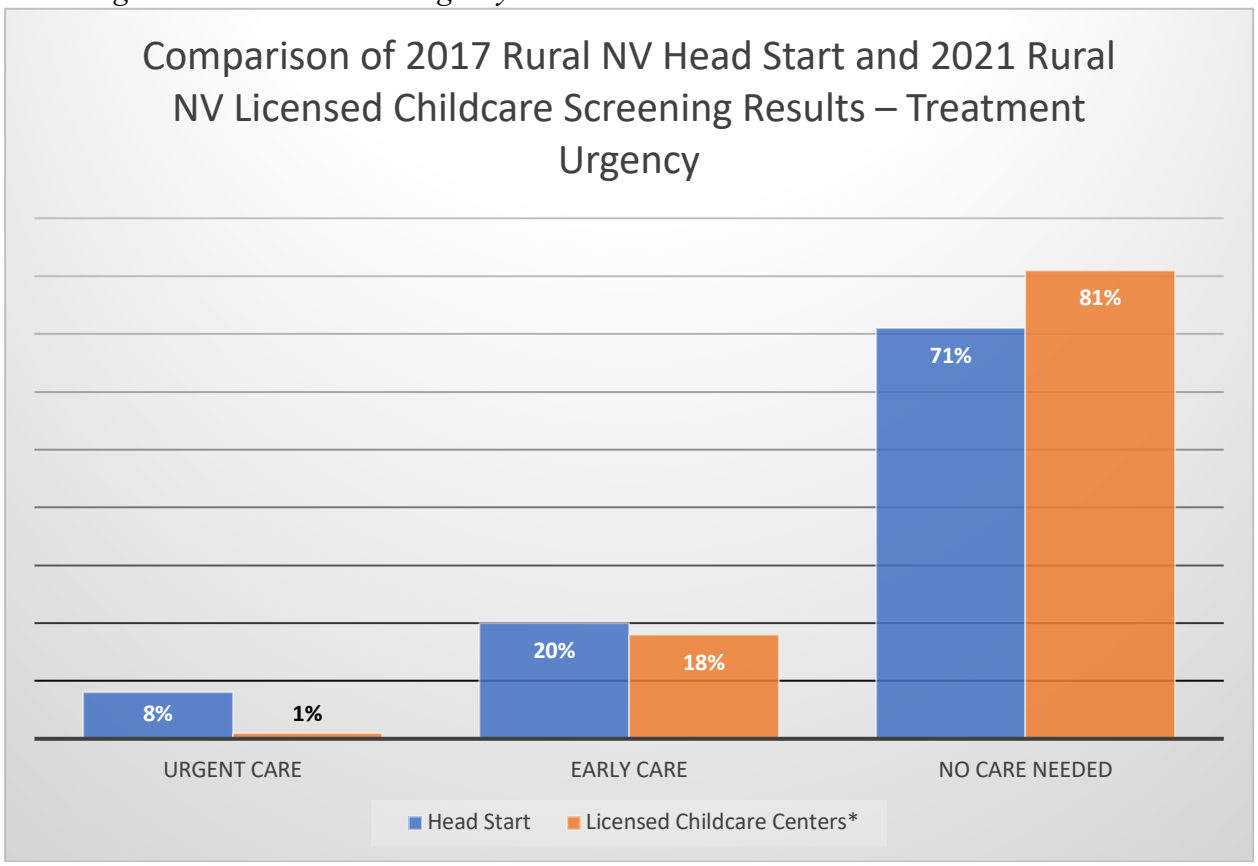


Figure 7 displays the distributional findings of treatment need for rural Nevada LCC children from the 2021 survey compared to rural Nevada Head Start children from the 2017 survey. In comparing to rural results for the 2021 survey and combining "urgent" and "early" dental needs, the 2021 results reveal that 19% of rural LCC children have need for dental care, compared to 28% of rural Nevada Head Start children in 2017. The 1% of children with "urgent" need for dental care represents children with dental pain or infection at the time of the screenings is significantly less than the 8% of urgent need reported from the 2017. The survey showed that 81% of children in rural Nevada LCC were not in immediate need of dental care, far less than the 71% surveyed in 2017.

Figure 7. *Comparison of 2017 Rural NV Head Start and 2021 Rural NV Licensed Childcare Screening Results – Treatment Urgency*



*Note: Information on urgency of need for dental care was missing for 14 children. It is assumed that they were not in need of care.

Consent Form and Parent Questionnaire Results

This study involves only minimal risk as it meets the definition set by the Federal Regulations at 45CFR46.102(i), "*Minimal risk means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests."*

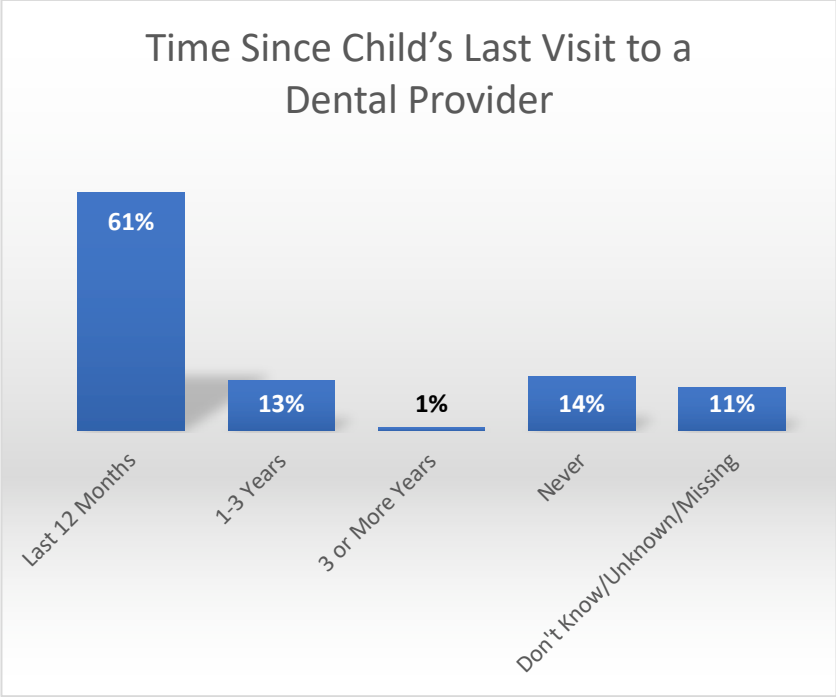
Standard questions were included on the parent consent form to obtain further information from parents that could be related to the oral health status of the children. General health questions asked parents whether their child had asthma, allergies, medical conditions, current medications, current fluoride tablets or drops, and fluoride varnish treatment in the past three months. There were relatively few positive responses to these questions, with 4% reporting their children had asthma, about 17% reporting allergies, about 3% reporting medical conditions, more than 5% reporting that the child was currently taking medications, about 3% reporting that the child was currently getting fluoride tablets or drops, and about 16% of the children having received a fluoride varnish application in the past three months. Compared with the results of the 2017 survey where 5% reported their children had asthma, about 11% reported allergies, about 3% reported medical conditions, more than 5% reported that the child was currently taking medications, about 3% reported that the child was currently getting fluoride tablets or drops, and about 8% of the children having received a fluoride varnish application in the past three months.

The parental consent form includes a brief questionnaire and a parental permission section that included the statement, "Yes, I give permission for my child to have a dental screening. I understand that this screening does not replace a full dental exam, and that my child should still go to a dentist. I understand that the results of this screening may be shared with the Nevada Department of Health and Human Services, Head Start, and with dental providers for my child." The consent form allows the parent to either accept or withhold their child's participation. This project requires only nominal participant involvement as the parental consent form and questionnaire takes less than five minutes to complete. Participation is voluntary, and a parent may withdraw consent at any time. Administrators, site coordinators, parents, and teachers are encouraged to ask questions about the project.

Consent forms were collected by the screener upon arrival to the centers. The consent and screening forms from the sites were placed in a locked compartment of the suitcase used for this project's supplies. Data forms were then transferred to a locked file box to be secured until entry and analysis was complete. The data on the forms was entered and kept in password-protected State-issued computers within the DPBH Oral Health Program located at UNLV SDM. No home addresses were collected; only home zip codes to be used to identify areas of decay and consequent need. The data was sent to the ASTDD for analysis via an encoded file. State protocol for electronic transfer was followed. Only aggregate data has been included in this report. Hard-copy screening and consent forms will be maintained for three years and subsequently destroyed.

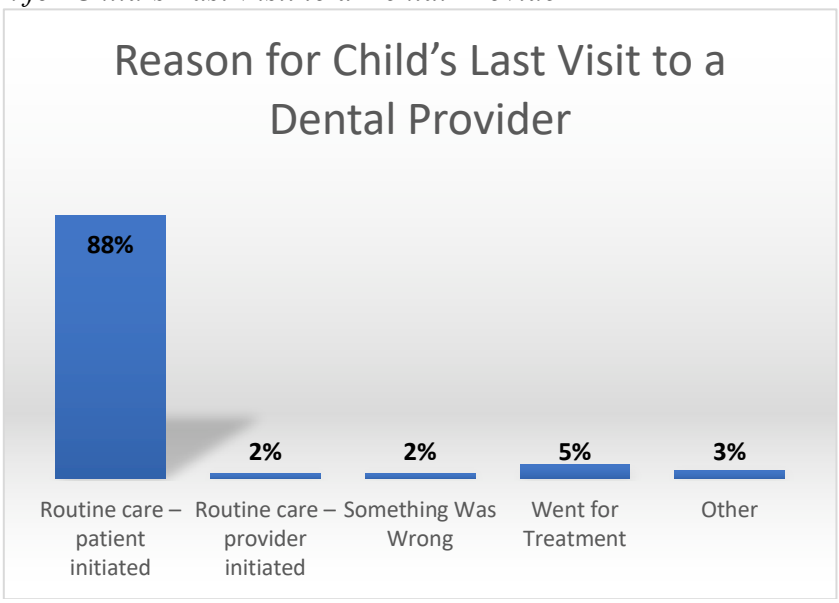
The consent form also included questions directly related to the dental care and oral health of the child. When asked about time since the child last visited a dental provider, over 60% of parents reported that child has seen within the last year. The full results for this question are shown in Figure 8.

Figure 8. *Time Since Child's Last Visit to a Dental Provider*



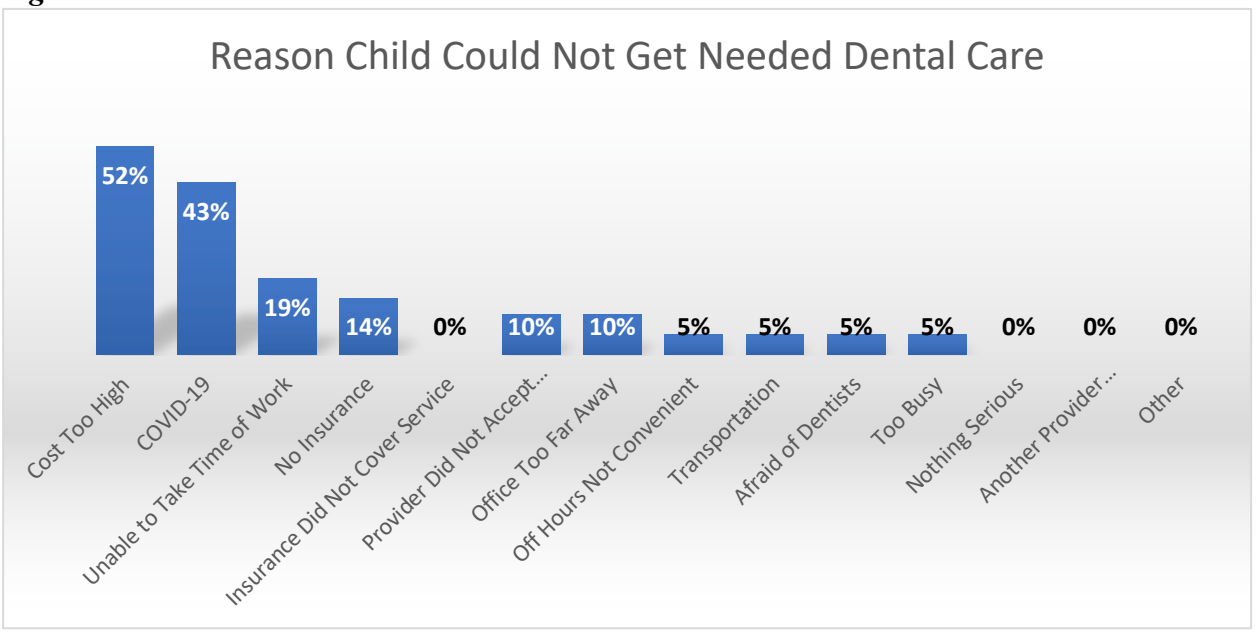
Most children (90%) had visited the dental provider for a routine recall, either initiated by the parent or by the dental provider. Only 3% of the dental visits were related to a dental problem or dental pain. The distribution of reasons for a dental visit are shown in Figure 9.

Figure 9. *Reason for Child's Last Visit to a Dental Provider*



A further indication of dental care access was addressed by a question asking parents if they had experienced trouble getting their child needed dental care in the past 12 months. A total of 26% of parents indicated that their child needed care but could not get it. The reasons for why the child could not get dental care are seen in Figure 10.

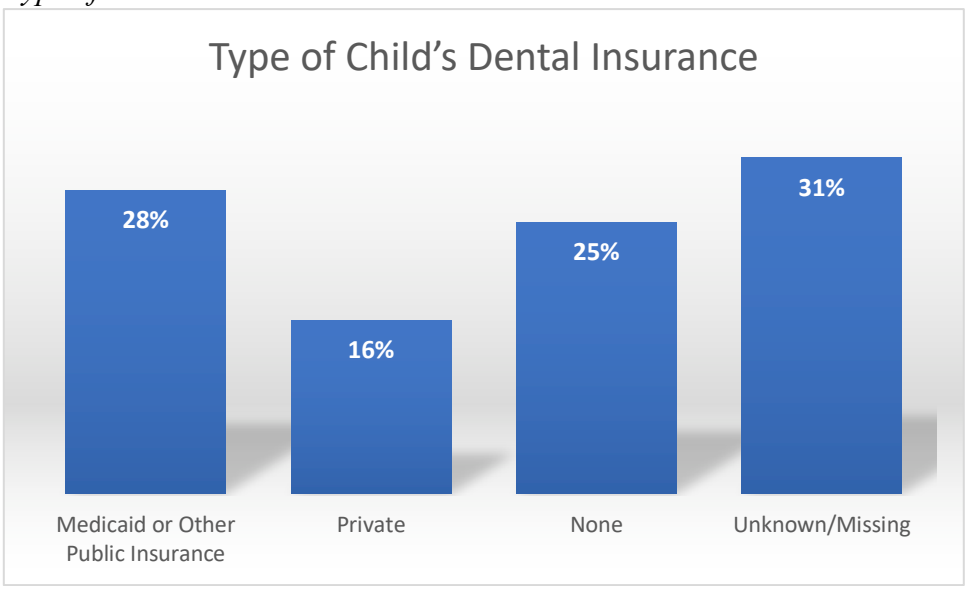
Figure 10. *Reason Child Could Not Get Needed Dental Care*



*Note: Parents could select more than one response, total percentage may exceed 100.

When asked specifically about dental insurance, the most frequent response was Medicaid or other public insurance (Figure 11).

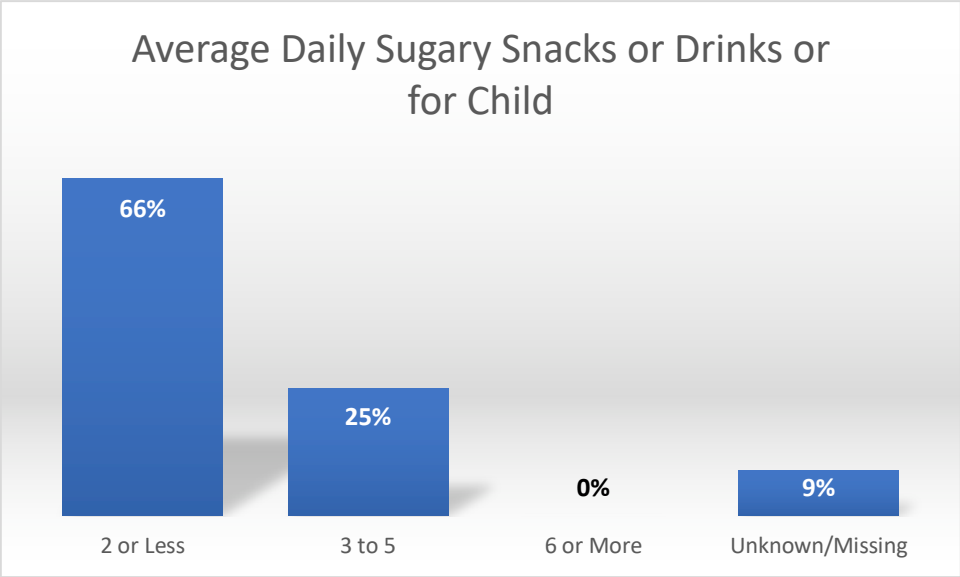
Figure 11. *Type of Child's Dental Insurance*



*Note: Four children had both private insurance and Medicaid; they were classified as having private insurance.

Finally, most parents reported a low daily frequency of sugary snacks and drinks for their children. The results for this question are displayed in Figure 12.

Figure 12. *Average Daily Sugary Snacks or Drinks for Child*



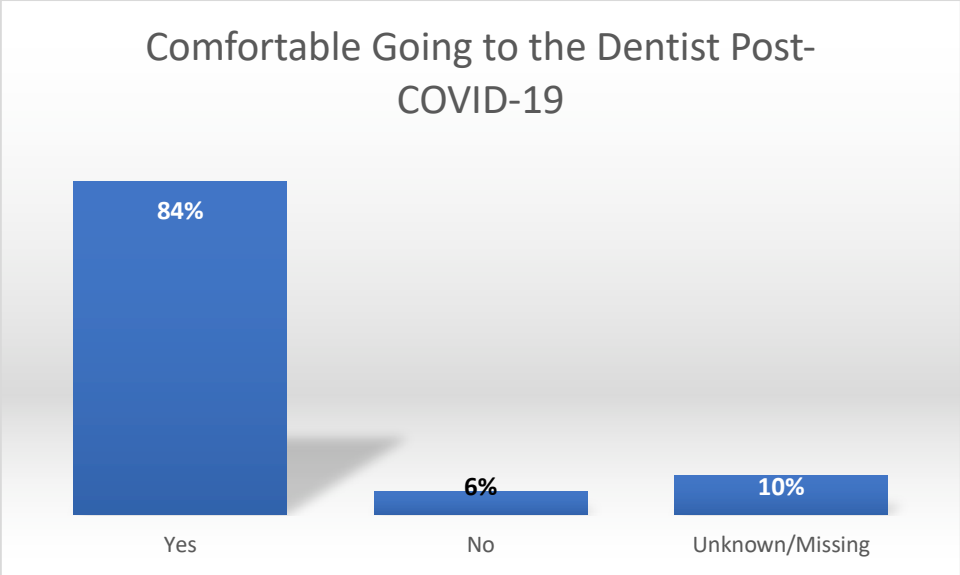
Special Considerations - COVID-19

The contract for this project was originally projected to start December 2019 but the original contract was revised due to the COVID-19 pandemic. The primary activity of the contract was to provide dental screenings and classroom education for childcare centers in rural Nevada. Due to the closure of childcare centers during the COVID-19 pandemic, all travel and visits were postponed. As childcare centers began to reopen the trips were rescheduled for November 2020 to February 2021. State motor pool closed during the month of December which resulted in additional delays.

Since this project was completed during the COVID-19 pandemic, at a time when centers were facing unprecedented challenges, many centers that would have been included in the study notified the team that they were planning to close due to loss of enrollment, were undergoing quarantine, or were uncomfortable with outside visitors.

For the sites that were included in the survey, additional infection control measures were implemented as outlined by the Center for Disease Control and Prevention (CDC)[5] and Occupational Safety and Health Administration (OSHA).[6] Dental screenings and oral health education fall under low to moderate risk for disease transmission as they are non-/low-aerosolizing procedures. All members of the team visiting the childcare centers had a daily temperature check, wore surgical bouffant cap, disposable gown, eye protection, level III surgical mask, and gloves. All surfaces were disinfected with EPA-approved cleaners before, between, and after each screening.

Figure 13. *Comfortable Going to the Dentist Post-COVID-19*



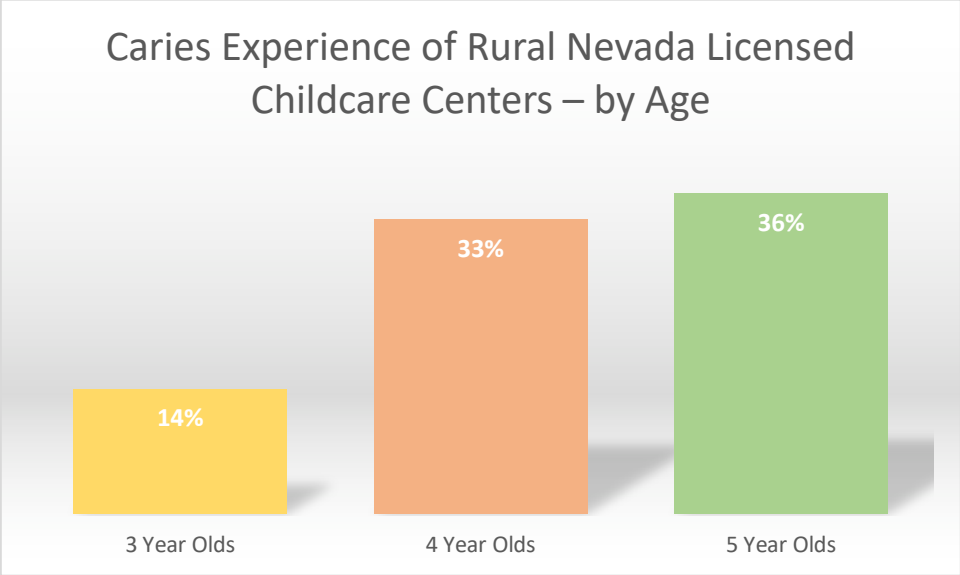
[5] https://www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html
[6]https://www.osha.gov/SLTC/covid19/dentistry.html?fbclid=IwAR3Rv52Zrg_rNDmU3Fc_GyNfTAZDc6ipadD0kA7iVafaOUgpsfXMu_0BA3o

2021 Summary - Caries Experience

Caries experience includes the presence of fillings and untreated decay in primary (baby) teeth, and primary teeth missing due to caries. Almost 27% of Nevada rural LCC 3 to 5-year-old children have decay experience. There was a higher prevalence of caries experience in males (31%) than females (22%) with caries experience. The following results show caries experience for these children by age, race/ethnicity and other potentially associated variables from the parent questionnaire.

As expected, caries experience increases with age, increasing in prevalence by 22% between ages 3 and 5 (Figure 14), with 27% of rural Nevada 3 to 5-year-old LCC children having caries experience. For reference, the National Health and Nutrition Examination Survey (NHANES) for 2013-2016 found an estimated 28% of all 3 to 5-year-olds (not just rural LCC or Head Start children) had caries experience.[7] NHANES results did show higher caries experience with lower family income level.

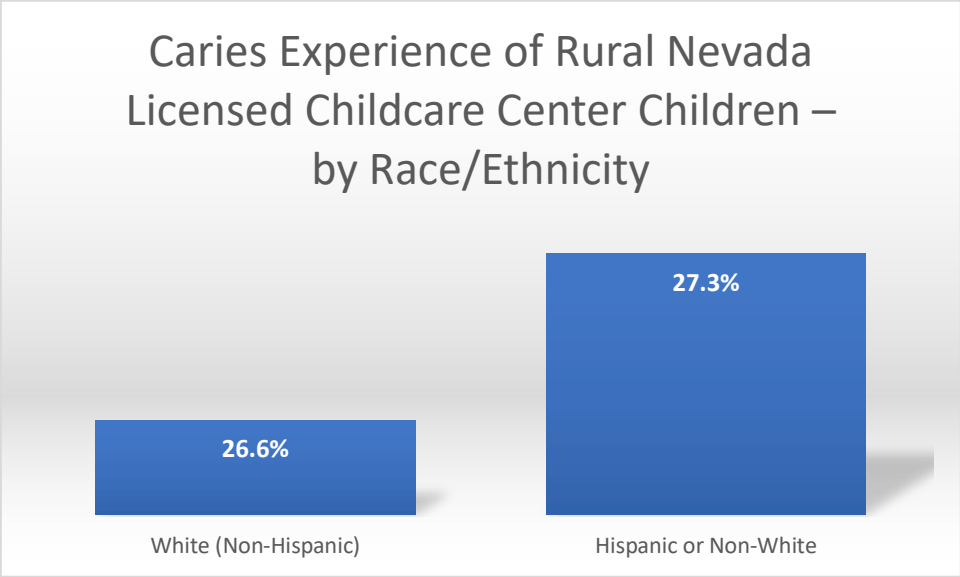
Figure 14. *Caries Experience of Rural Nevada Licensed Childcare Centers – by Age*



Hispanic or non-White children in LCC had slightly higher prevalence of caries experience (27.3%) than their White (not Hispanic) counterparts (26.6%).

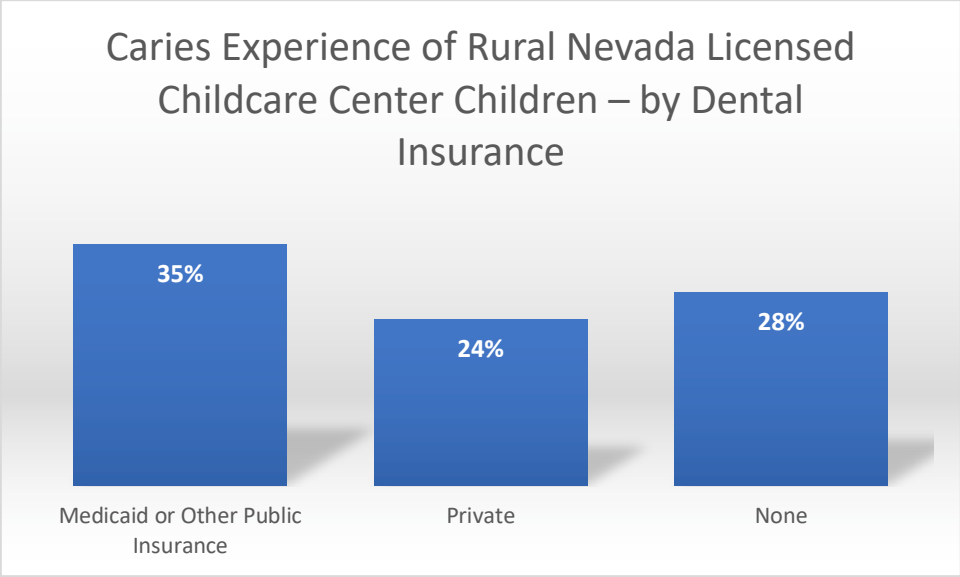
[7] https://www.healthypeople.gov/2020/data-search/Search-the-Data?nid=4992

Figure 15. *Caries Experience of Rural Nevada Licensed Childcare Center Children – by Race/Ethnicity*



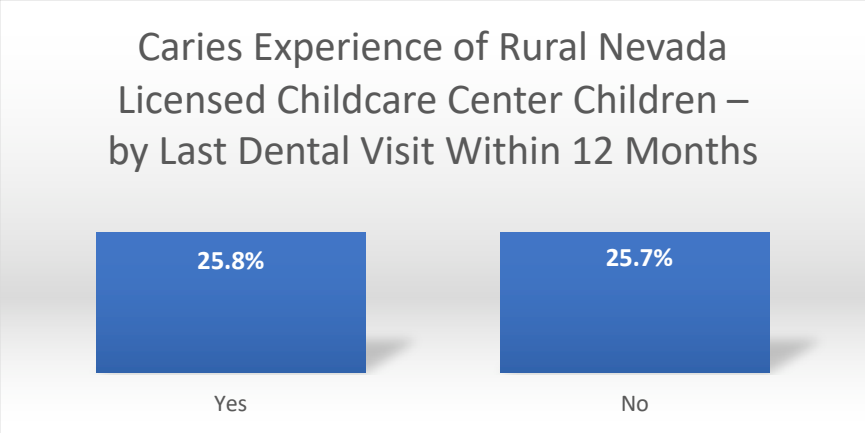
Caries experience is lowest for Nevada LCC children with private dental insurance and highest for those with Medicaid or other public insurance (Figure 16).

Figure 16. *Caries Experience of Rural Nevada Licensed Childcare Center Children – by Dental Insurance*



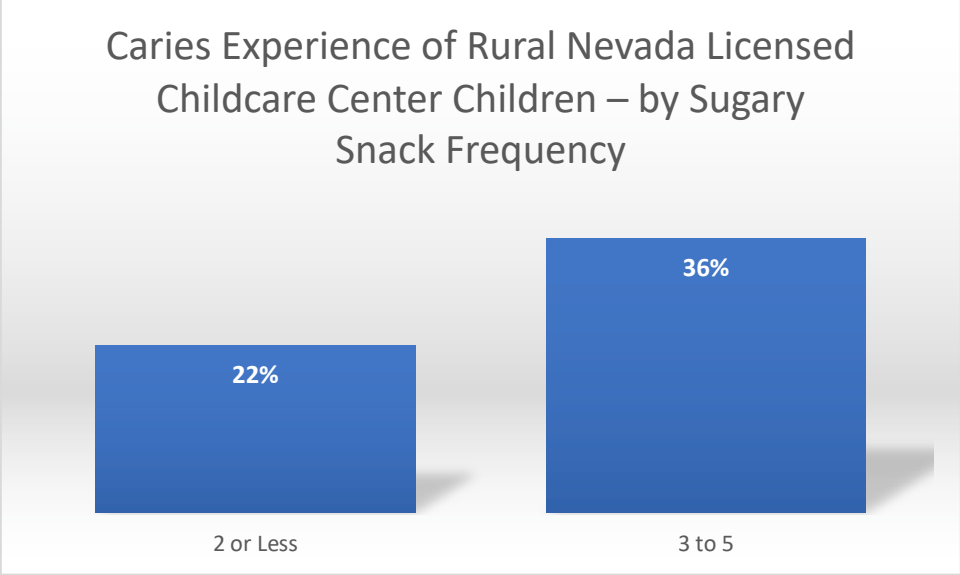
There was no significant difference in caries experience between children seen by a dentist in the last year (25.8%) and those that had not (25.7%). Caries experience considers both treated and untreated decay and indicates that children either have dental decay or have been to the dentist to remove decay.

Figure 17. *Caries Experience of Rural Nevada Licensed Childcare Center Children – by Last Dental Visit Within 12 Months*



Lower caries experience was seen in children with lower frequency of sugary drinks and snacks consumption (Figure 18).

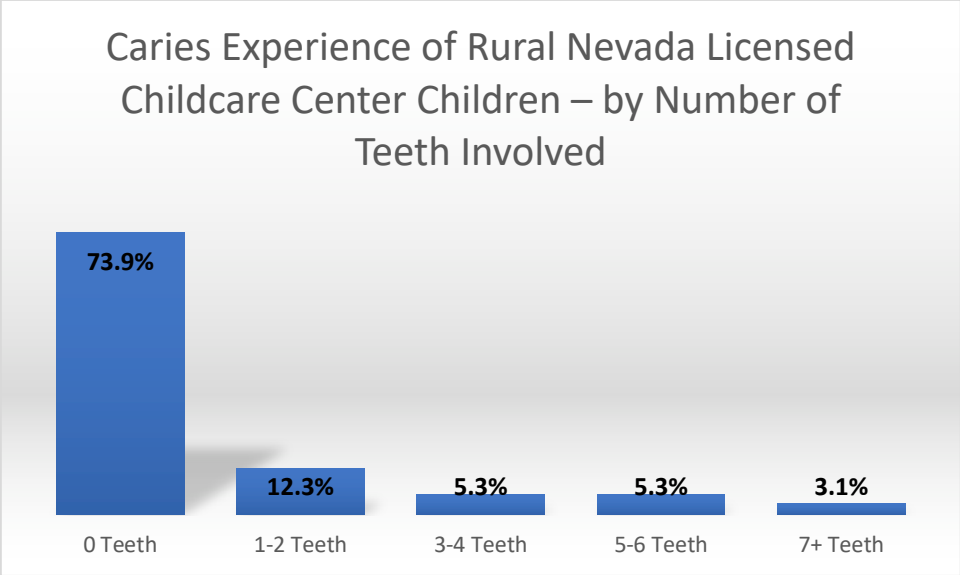
Figure 18. *Caries Experience of Rural Nevada Licensed Childcare Center Children – by Sugary Snack Frequency*



Each child present, whose parent/guardian gave permission, was screened for untreated and treated decay (caries experience). Per the BSS criteria, untreated decay and treated decay in the following categories were counted: cavitated carious lesions, amalgam (silver) or composite (white) filled, stainless steel crowns, white-faced crowns (a type of esthetic crown for front teeth) and extracted teeth.

Of the children screened, 27% had decayed or treated primary teeth (caries experience). Of those children with any type of decayed or treated teeth, 12% had one or two teeth, 5% had three to four teeth, 5% had five to six teeth, and 3% had seven or more teeth that were involved (Figure 19).

Figure 19. *Caries Experience of Rural Nevada Licensed Childcare Center Children – by Number of Teeth Involved*



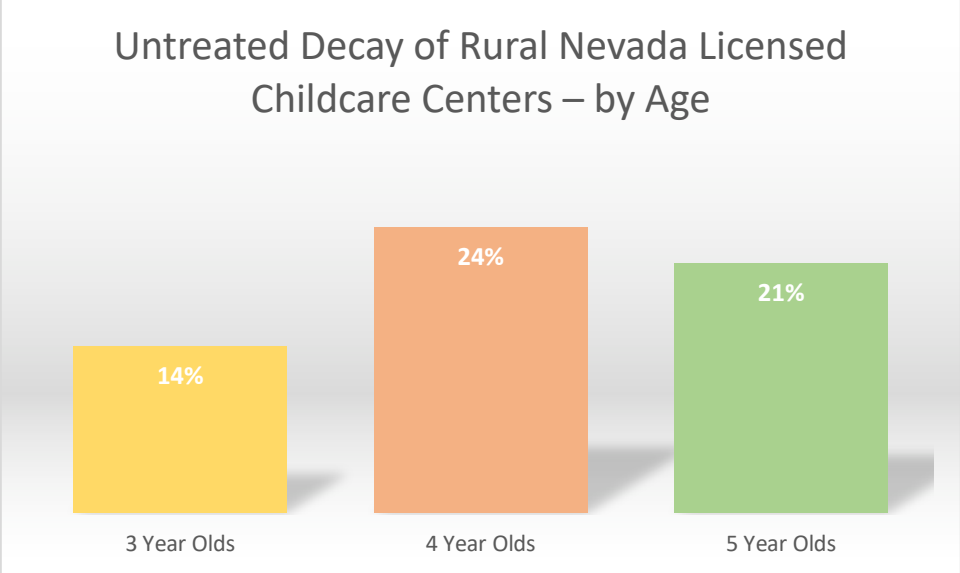
*Note: Information on the number of teeth with caries experience was missing for three children.

2021 Summary - Untreated Decay

Untreated decay refers to caries experience (a cavity) that is visible but has not been filled or treated. More than one in five (20%) of Nevada LCC children have untreated decay. There was a higher prevalence of caries experience in males (23%) than females (18%) with untreated decay. The following results show caries experience for these children by age, race/ethnicity and other potentially associated variables from the parent questionnaire.

Untreated decay prevalence shows the biggest change between ages 3 and 4, with an additional increase also seen by age 5 (Figure 20), with 20% of rural LCC 3 to 5-year-old children having untreated cavities overall. The National Health and Nutrition Examination Survey (NHANES) for 2013-2016 found an estimated 12% of all 3 to 5-year-olds (not just rural LCC or Head Start children) had untreated decay.[8] And as with NHANES results for caries experience, results showed higher prevalence of untreated decay with lower family income level.

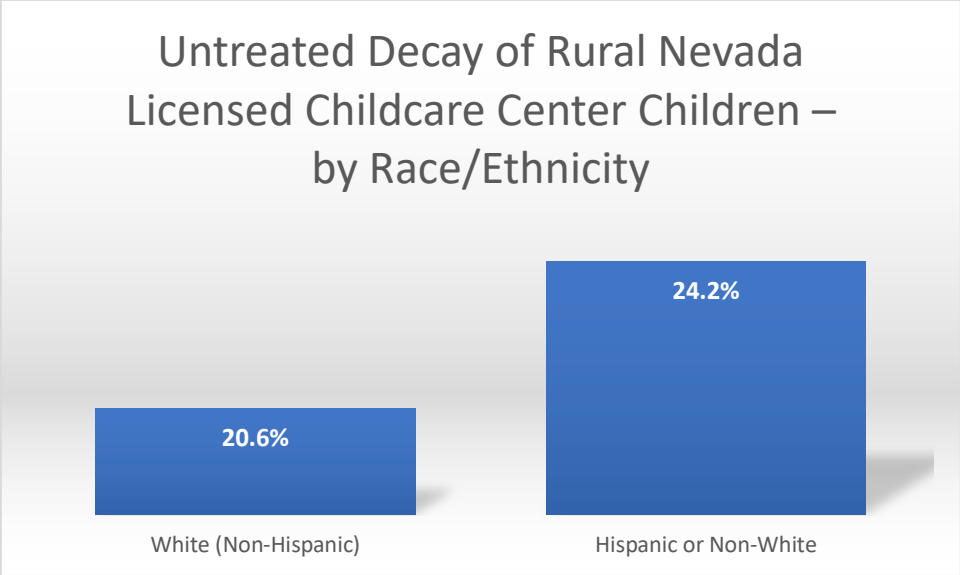
Figure 20. *Untreated Decay of Rural Nevada Licensed Childcare Centers – by Age*



Hispanic or non-White children in LCC had higher prevalence of caries experience (24.2%) than their White (not Hispanic) counterparts (20.6%).

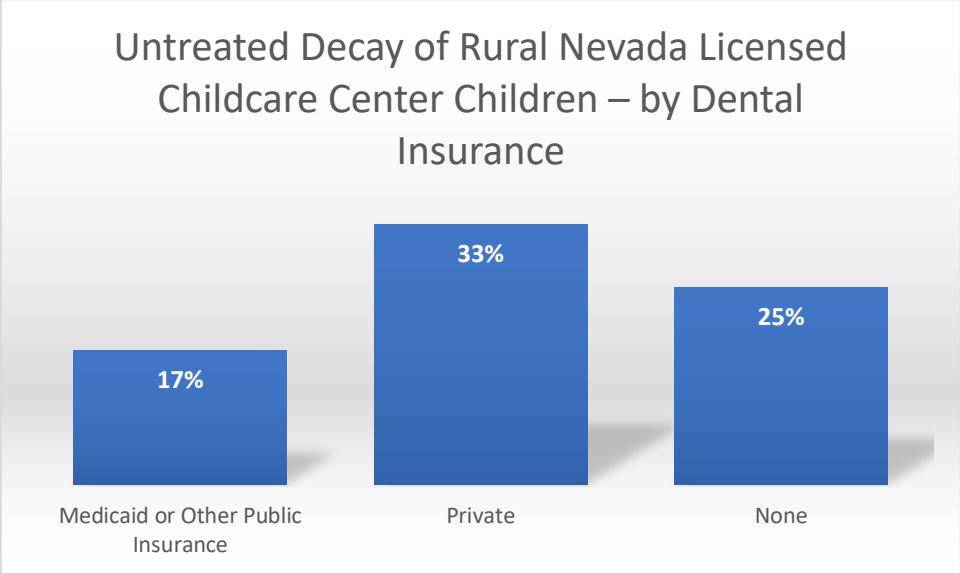
[8] https://www.healthypeople.gov/2020/data-search/Search-the-Data?nid=5016

Figure 21. *Untreated Decay of Rural Nevada Licensed Childcare Centers – by Race/Ethnicity*



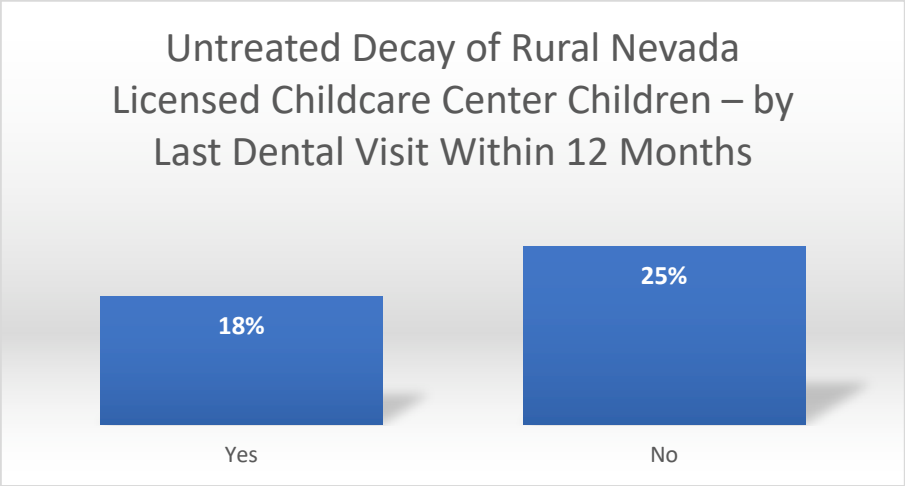
Untreated decay is lowest for Nevada LCC children with private dental insurance and highest for those with Medicaid or other public insurance (Figure 22).

Figure 22. *Untreated Decay of Rural Nevada Licensed Childcare Center Children – by Dental Insurance*



Lower prevalence of untreated caries was seen in children with a dental visit in the past year (26%) than children not seen in the last year (29%) (Figure 23).

Figure 23. *Untreated Decay of Rural Nevada Licensed Childcare Center Children – by Last Dental Visit Within 12 Months*



Like caries experience, children with a lower frequency of sugary snacks and beverage consumption had a lower prevalence of untreated decay (Figure 24).

Figure 24. *Untreated Decay of Rural Nevada Licensed Childcare Center Children – by Sugary Snack Frequency*

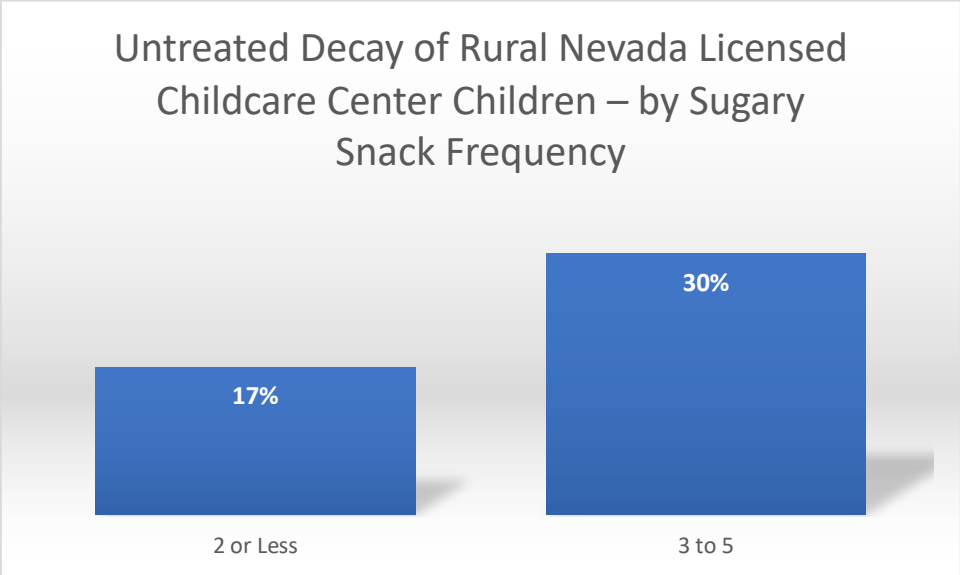
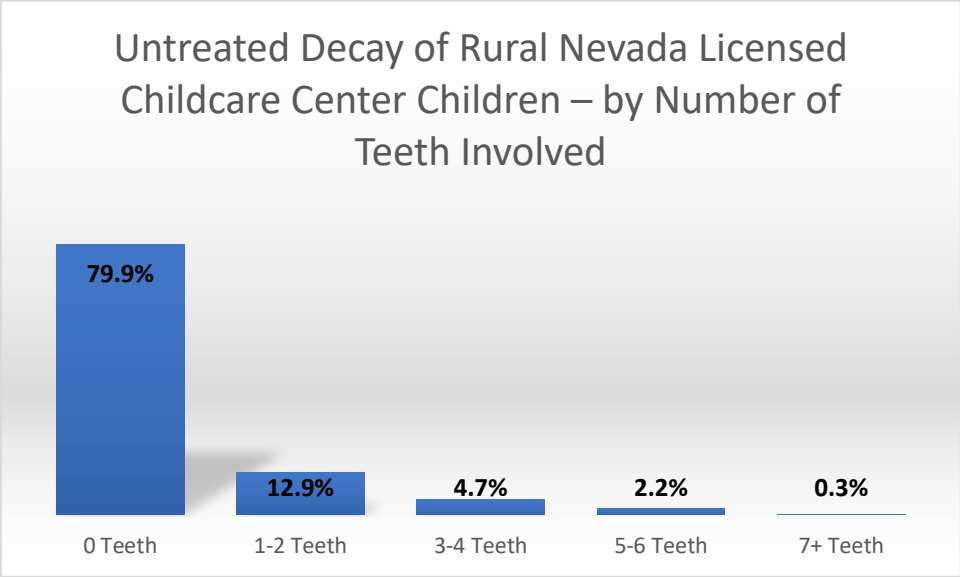


Figure 25. *Untreated Decay of Rural Nevada Licensed Childcare Center Children – by Number of Teeth Involved*

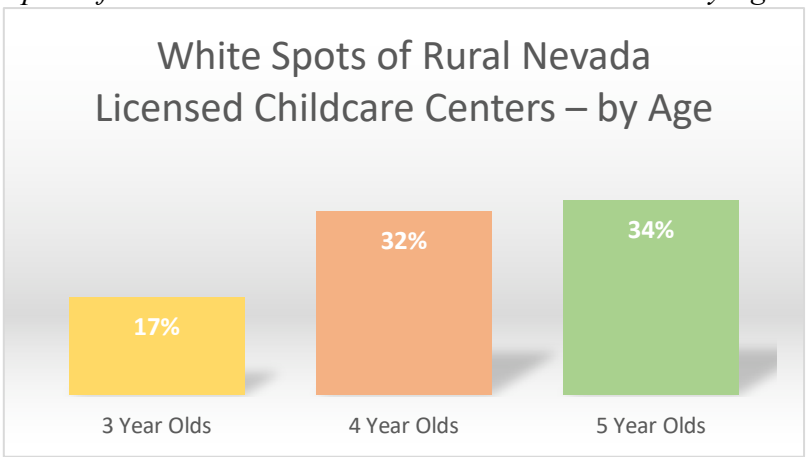


2021 Summary – White Spots

In addition to untreated cavitated lesions, the children were screened for white spots that may indicate initiation of a carious lesion. Standardization of screeners for identifying white spots is more difficult than standardization for cavitated carious lesions, but we were interested in assessing children who may have developing caries even if there are no frank cavitated lesions yet. Screenings revealed that 27% of these rural Nevada LCC children had one or more teeth with white spots, indicating a significant proportion of these children have teeth in the early stages of future tooth decay, and should be targeted for preventive measures.

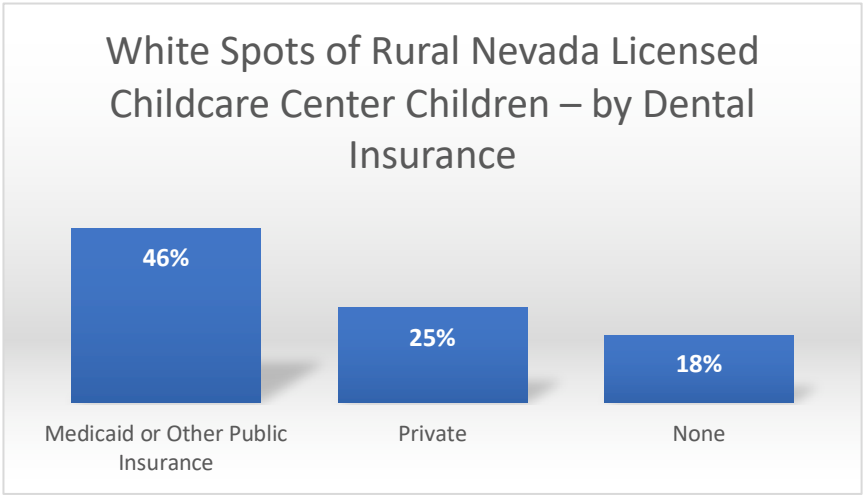
As expected, caries experience increases with age, increasing in prevalence by 17% between ages 3 and 5 (Figure 26), with 27% of rural Nevada 3 to 5-year-old LCC children having white spot lesions.

Figure 26. *White Spots of Rural Nevada Licensed Childcare Centers – by Age*



White spot lesions were lowest for Nevada LCC children with private dental insurance and highest for those with Medicaid or other public insurance (Figure 27).

Figure 27. *White Spots of Rural Nevada Licensed Childcare Center Children – by Dental Insurance*



2021 Summary - Treatment Urgency

After screening was completed for each child, the screener assigned the child to one of three treatment urgency categories. The categories were:

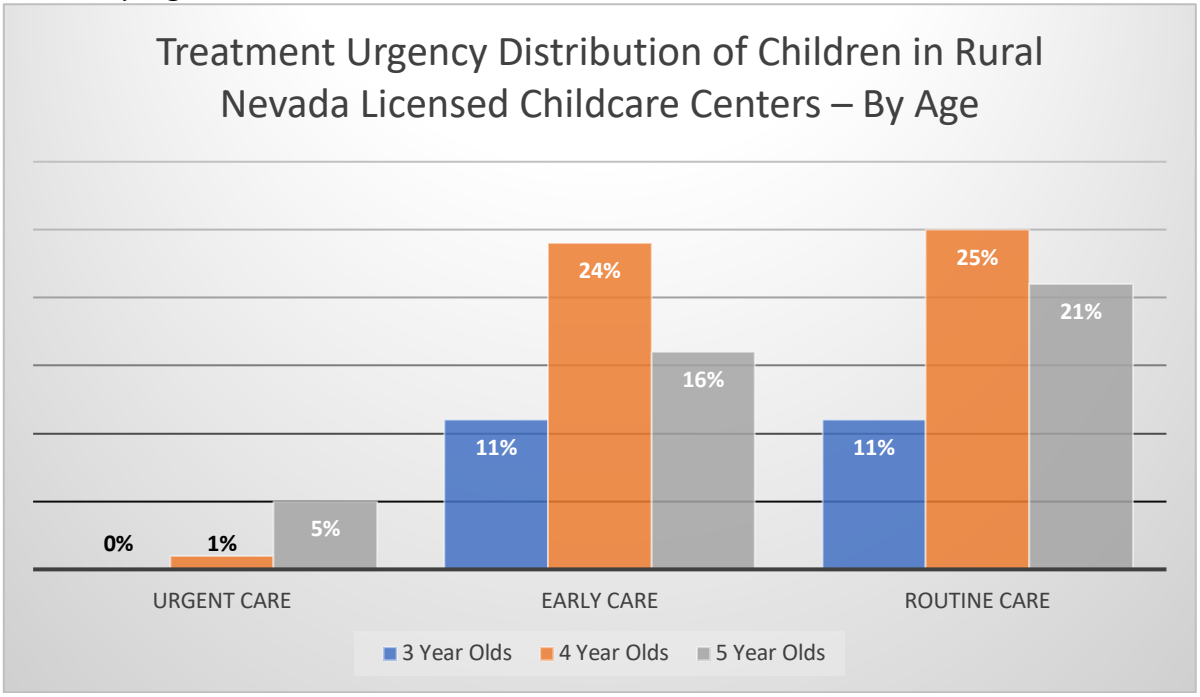
1. **No Obvious Problem** – continue with routine dental checkups
2. **Needs Dental Care** – needs to be seen soon (before their next regularly scheduled dental visit)
3. **Urgent Care Needed** (Pain, Swelling or Infection present) - needs immediate dental care within 24 – 48 hours

The following results summarize the overall treatment urgency for children in rural Nevada LCC: urgent dental care needed (1%), early dental care needed (18%), and no immediate dental care needed (20%). The *Nevada Policy for Urgent Dental Issues Identified During Community Screening*[9] was followed for those children identified as 'urgent' in this study.

Note: Information on urgency of need for dental care was missing for 14 children. Based on information provided on the forms, it is assumed that they were not in need of care.

The only difference evident when the data was evaluated by gender was a slightly higher percentage of females categorized as having urgent treatment needs. Treatment urgency by age is displayed in Figure 28. There was some variation in treatment urgency by age, with a slight decrease in five-year-old children with no treatment need.

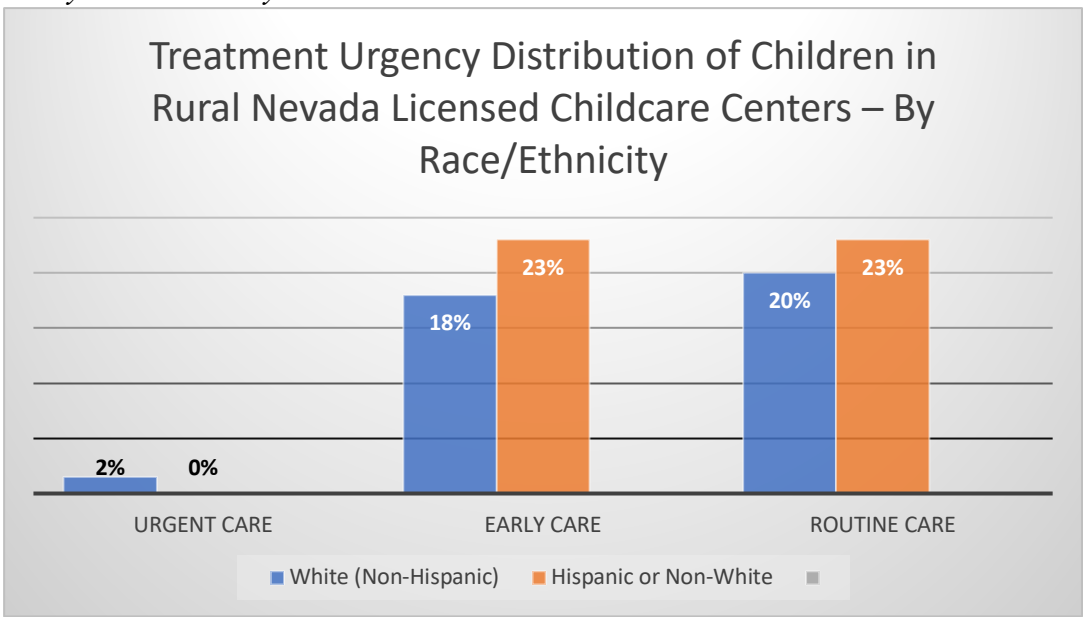
Figure 28. *Treatment Urgency Distribution of Children in Rural Nevada Licensed Childcare Centers – By Age*



[9]https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/OH/dta/Boards/2018_Meetings/Policy%20for%20Urgent%20Dental%20Issues%20Identified%20During%20Community%20Screening-Nina%20Edits.pdf

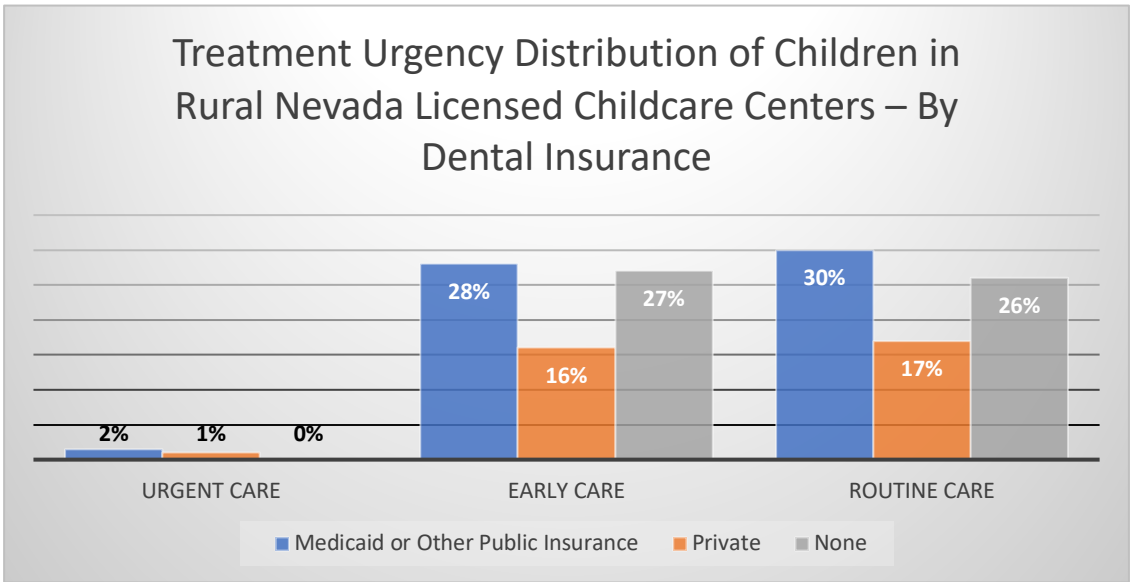
White children in LCC had slightly higher prevalence of urgent dental needs and a lower prevalence of no immediate dental needs than their Hispanic or non-White counterparts

Figure 29. *Treatment Urgency Distribution of Children in Rural Nevada Licensed Childcare Centers – By Race/Ethnicity*



Rural Nevada LCC children with no dental insurance had the lowest prevalence of urgent dental needs while Medicaid or other public insurance had the highest. Medicaid or other public insurance and uninsured children has a similar rate of early dental care needs (Figure 30).

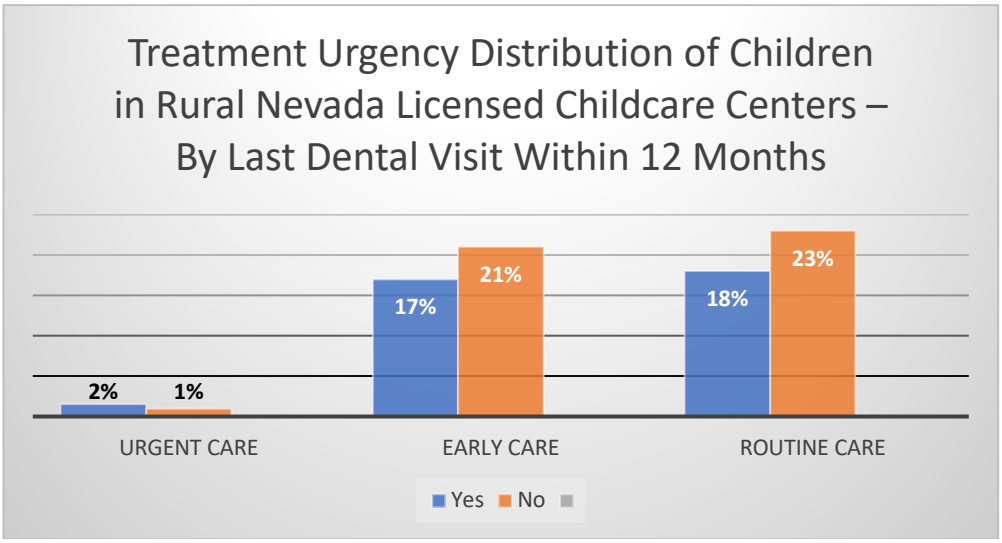
Figure 30. *Treatment Urgency Distribution of Rural Licensed Childcare Children - By Dental Insurance*



Treatment urgency results by last dental visit correspond with results seen for caries experience and untreated decay – children with better access to dental care generally have less dental disease

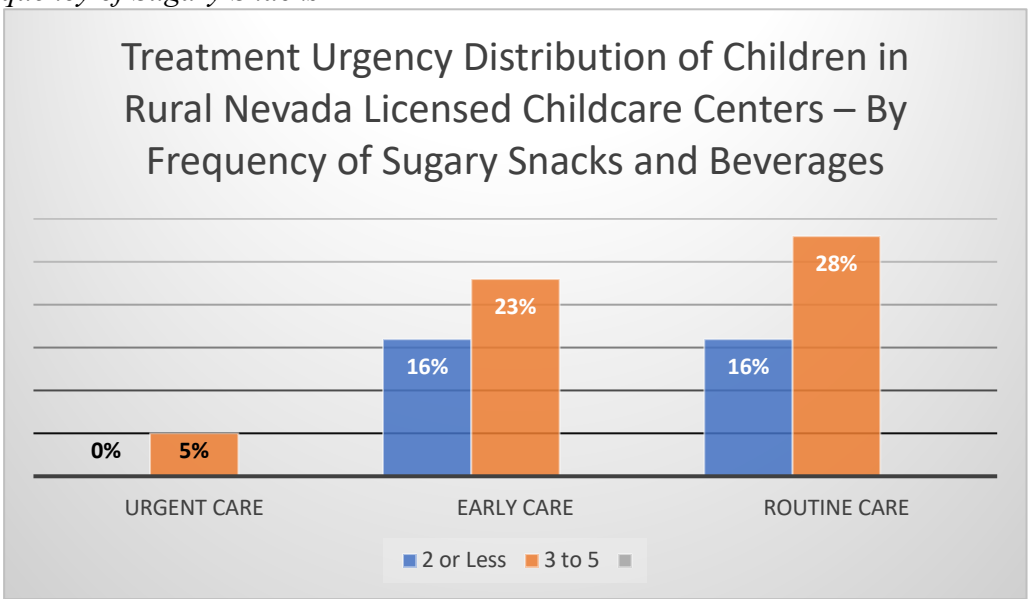
and treatment needs. Children with a dental visit within the past year had the lowest dental needs (Figure 31).

Figure 31. *Treatment Urgency Distribution of Rural Nevada Licensed Childcare Center Children – By Last Dental Visit Within 12 Months*



Treatment urgency results by frequency of sugary snack and beverage consumption reflect results for caries experience and untreated decay showing more oral health concerns with higher frequency of sugary snacks and beverage consumption (Figure 32). The lowest percentage of urgent and total dental treatment needs were seen in those children with the lowest frequency of sugary snacks and beverage consumption.

Figure 32. *Treatment Urgency Distribution of Rural Nevada Licensed Childcare Center Children – By Frequency of Sugary Snacks*



Silver State Smiles in the Childcare Centers Webinar

Key components within the 2020-2021 basic screening survey for licensed childcare centers (LCC) in rural Nevada were health promotion, oral health education, and oral hygiene support. The project began by providing directors of LCC with a program overview and an offering an opportunity for all educators, administrators, and their staff to attend a 2.5-hour webinar that would provide approved NV Registry continuing education credits. In-service training is a new but powerful component that should be included in any future BSS to educate children and improve oral hygiene habits. Research demonstrates the positive association between oral health activities in a childcare setting and a teacher's oral health values, dental training, and perceived oral health self-efficacy.[10]

To assess the transfer of knowledge gained in the webinar, a pre- and post-webinar survey assessed participant's oral health attitudes and perceptions. To further substantiate the benefits of a classroom toothbrushing program, the Childsmile program, the nationwide supervised nursery school toothbrushing program funded by the Scottish Government and National Health Service, was evaluated in the webinar. The Childsmile program has been successful year after year in decreasing actual and anticipated costs associated with dental treatment for five-year-old children. Highlighting that "the nursery toothbrushing programme not only reduces costs and improves dental health but also reduces health inequalities."[11] With this in mind, establishing a classroom toothbrushing station and regiment within underserved areas of Nevada's rural communities was critical. The teacher in-service introduced a step-by-step, classroom toothbrushing routine and was reiterated during in-person visits. Each classroom received a toothbrushing packet that included cleaning supplies, toothbrush sterilization equipment, individual toothbrushes, plaque indicating toothpaste, and a laminated instruction sign that could be posted in the class toothbrushing center. From this review of relevant research, it is evident that the childcare setting affords a unique opportunity to reduce dental decay, improve a child's oral health and dietary behaviors, and establish oral health awareness for both children and educators.

Seven 2.5-hour Nevada Registry-approved webinars were provided to forty-nine rural childcare providers who influence the health habits of hundreds of school-age children. Six equivalent webinars were offered in October ahead of the in-person basic screening survey, and one webinar was offered in January as a makeup course. Educators were trained on dental emergencies, basic oral hygiene, and tools to activate dental resources for children in their care. A pre- and post-survey were applied to evaluate a change in attitudes and knowledge. Fifty-nine pre-tests were taken, indicating that additional individuals planned to take the webinar who were not able to attend.

The thirteen-question pre-test revealed that educators had an average understanding of oral health before the presentation. Educators indicated that a majority had worked in a childcare setting within 1 to 2 years. Additionally, a majority 69.5%, have children of their own. Educators indicated that they were hoping to learn creative ways to teach children to brush their teeth, how to get

[10] Kranz, A. M., Rozier, R. G., Zeldin, L. P., & Preisser, J. S. (2012). Oral health activities of Early Head Start and Migrant and Seasonal Head Start programs. *Journal of health care for the poor and underserved*, *23*(3), 1205–1221. https://doi.org/10.1353/hpu.2012.0090

[11] Anopa, Y., Mcmahon, A. D., Conway, D. I., Ball, G. E., Mcintosh, E., & Macpherson, L. M. (2015). Improving Child Oral Health: Cost Analysis of a National Nursery Toothbrushing Programme. *Plos One, 10*(8). doi:10.1371/journal.pone.013621

children interested in brushing without a fight, how to teach the importance of oral health, how to discuss oral health with parents, and how to encourage families to improve oral health at home. The webinar did not include a section to assist educators in having oral health conversations with parents. Future presentations should consist of creative ways to introduce these topics with families and tips for teachers aware that students are suffering from oral pain.

The post-webinar survey included 13 questions that compared attitudinal responses from the pre-webinar survey and examined the understanding of the project goals and satisfaction with the presentation. Table 2 studies the pre- and post-webinar results. The respondents indicated that 40% were very satisfied with the presentation within the post-test survey, and 47.5% were satisfied.

Future considerations that may be of value would be to conduct a statewide survey like those surveyed in the state of Florida to define baseline oral health regulations in childcare centers within the state and the relationship between director's experience, attitudes, and self-perceived barriers and oral health promotion practices within the center. The survey questions were similar in type to the pre- and post-webinar survey questions, but more expansive. Results of the study completed in Florida indicate that directors who have been associated with a Head Start program in the past, have longer working experiences, more positive pediatric oral health attitudes, and were more likely to promote oral health activities within their childcare center.[12] A similar descriptive research project in Nevada might identify those centers that require more targeted training and support.

Table 2. *Webinar Pre- and Post-Survey Results*

	Pre-test	Post-test
Q 1: Evaluate this statement: Adults can spread the germs that cause cavities. Do not put anything in a child's mouth (such as a pacifier or spoon) if it has been in another person's mouth.	96% Yes	97.5% YES
Q2: Evaluate this statement: Children should see a dentist by their first birthday.	88.14% True	100% True
Q3: Evaluate this statement: Children, like adults, should brush their teeth with fluoride toothpaste twice each day; after breakfast and before bedtime at night.	88.14% True	95% True

[12] Bhoopathi, V., Joshi, A., Ocanto, R., & Jacobs, R. J. (2018). Oral health promotion practices: a survey of Florida childcare center directors. BMC oral health, 18(1), 96. https://doi.org/10.1186/s12903-018-0562-y

Q4: Evaluate this statement: Children need an adult's help in brushing their teeth until they are 8 years old.	93.22% True	97.5% True
Q5: Please rate your knowledge of oral health prior to the presentation/ following the presentation	42.37% Average	57.5% Excellent

Satisfaction Survey of Participating Licensed Childcare Centers

In the effort of continuous improvement, a post-visit satisfaction survey was developed as a tool to aid in the assessment of overall performance. The survey was created using an online survey platform. The survey included ten questions that assessed overall satisfaction of the project, content relevance, implementation of program elements at the centers, and any additional feedback. A link to the survey was emailed out to each site administrator with an additional reminder email sent after two weeks. A total of 17 surveys were completed from the 34 sites (50% response rate).

Feedback from the project was overwhelmingly positive. 94% of respondents stated that overall, they rated the project as excellent or very good. Noting that the project team was "well prepared, but most importantly, interactively worked with 3- and 4-year-olds appropriately!" Additionally, 100% of respondents rated the oral health screening that was provided as meeting expectations or outstanding. 100% of respondents rated the oral health materials provided (toothbrushing station, sterilizers, toothbrush kits for the children, etc.) as exceeding expectations or outstanding. 81% stated that they planned to implement a classroom toothbrushing station with the supplies provided.

When asked if there were any specific recommendations for future versions of this project, one respondent stated "I hope that this is something that can continue! We are rural and these kinds of things are so needed."

When asked if the parents or children had any feedback regarding this project, the screening, the educational presentation, or any aspects of the project, they stated: "The parents were so amazed that the children had learned about brushing at school. Plus, it gave them the opportunity to focus on it with their children. Especially flossing."

Conclusion

Nonparental childcare is an accepted necessity for working parents. Childcare facilities allow parents to work while their children learn and grow in a safe, nurturing environment. It is so common that by age five, nearly 75% of children in the United States will be cared for by a childcare center, nursery/preschool, or Head Start Program.[13] Children at this young age are exceptionally vulnerable, and the environment and influence of childcare centers will have lifelong impact on their health and well-being. Improving the quality of childcare should be an established goal within state government policy. Childcare for young children, especially those within pre-kindergarten age groups, focuses on meeting their basic needs for safety and security. However, to foster growth and educational attainment, nutrition, overall health, hygiene, and oral health should also be essential components of any childcare curriculum. According to the 2011 U.S. Census, sixty-one percent of children or twelve and a half million preschoolers age zero to four regularly received childcare from someone other than their parents.[14] With so many children under the influence of childcare outside the home, childcare educators have an immense responsibility, and childcare centers can establish permanent habits and attitudes on health behaviors.

To ensure equality in school readiness for all children, low-income families who might not have access to childcare educational services are offered the opportunity to enroll their children in Head Start programs. Head Start is a federal program that serves children birth through age five. Head Start sets specific guidelines that require children to obtain a medical and dental evaluation, and the Head Start program must assist parents in accessing necessary health care services. Furthermore, 45 CFR 1302.40 establishes the purpose of Head Start programs and states, "a program must provide high-quality health, oral health, mental health, and nutrition services that are developmentally, culturally, and linguistically appropriate and that will support each child's growth and school readiness."[15] Federal regulations also outline oral health practices, child nutrition, family support services for health, nutrition, and mental health that should be provided to children.

Head Start programs prioritize oral health, nutrition, and hygiene to overcome social determinants of health that negatively impact the health of low-income children. However, these priorities are a powerful tool that should be available to all children. The American Academy of Pediatric Dentistry (AAPD) encourages childcare centers of all variety to implement health promotion activities to reduce early childhood decay. AAPD released a list of oral health guidelines for childcare centers to strengthen the implementation of health promotion activities within an environment where children spend most of their day (American, 2020). Among the AAPD's dental decay prevention strategies, several are highlighted by this project, including:

1. Utilize oral health consultations and screenings
2. Educate caregivers and parents to establish a dental home
3. Establish written procedures for a medical and dental emergency

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[13] Kim, Juhee, Kaste, Linda M, Fadavi, Shahrbanoo, & Neelon, Sara E. Benjamin. (2012). Are state childcare regulations meeting national oral health and nutritional standards? *Pediatric Dentistry*, *34*(4), 317–324.

[14] US Census Bureau. (2019, August 27). Childcare. Retrieved May 10, 2021, from https://www.census.gov/programs-surveys/sis/resources/visualizations/child-care.html

[15] ECLKC. (2020, October 16). Head start program performance standards related to oral health. Retrieved May 10, 2021, from https://eclkc.ohs.acf.hhs.gov/oral-health/article/head-start-program-performance-standards-related-oral-health

4. Sponsor age-appropriate live oral health educational presentations for children
5. Provide in-serve training for childcare educators
6. Promote supervised oral hygiene practices once daily after a snack or meal.

If these Head Start health standards are considered national standards, one might wonder if state-LCC are modeled after similar guidelines. A national study reviewed state nutrition and oral health policies and practices, and wide variation was noted. It revealed that all states have regulations that cover nutrition topics, but seven states had no mention of oral health in state childcare regulations.[13] Nevada was found to have implied oral health screening and the availability of toothbrushes for preschool children. In contrast, Nevada met five of the eleven nutritional content standards, including water availability and avoidance of bottle use for infants.

While each state has specific requirements for LCC, the model in Nevada does not outline health standards for LCC that are on par with Head Start Programs. The expectation that the incidence of caries risk is higher among low-income children and those eligible for Medicaid has been identified in the research. An evaluation of Head Start centers and non-Head Start centers identified a higher risk of dental decay in children within Head Start centers.[16] The purpose of this surveillance project was to specifically evaluate the oral health status of children receiving care from LCC in rural Nevada to the oral health status of children in rural Head Start programs as reported in the 2018 Head Start oral health assessment.

Childcare centers offer a rich environment to instill educational lessons and social, cultural, and hygiene habits. There children learn how to interact with the world and model caregiver's behavior. Including education for childcare providers and equipping centers with the tools to continue oral hygiene routines should be an essential element within any project that provides in-person oral health surveillance. Maximizing every opportunity to impact the lives of those who are evaluated should be prioritized to improve oral health more broadly. Seemingly small acts such as daily classroom toothbrushing can significantly impact the oral health of young children. Advocates of health and wellness should explore creative approaches and licensing regulations to establish the importance of oral health in the development of young children.

[16] Gupta, R. S., Pascoe, J. M., Blanchard, T. C., Langkamp, D., Duncan, P. M., Gorski, P. A., & Southward, L. H. (2009). Child health in child care: A multi-state survey of head start and non–head start child care directors. *Journal of Pediatric Health Care, 23*(3), 143-149. doi:10.1016/j.pedhc.2008.01.002

Appendices

Introduction Letter to Head Start Administrator
Oral Health Webinar Flyer
Consent Form Instruction Letter
Letter to Parents
Brochure on Fluoride Varnish
Consent Form and Questionnaire
Survey Screening Form
Take-Home Findings Letter to Parents
Nevada Dental Provider Directory
Classroom Circle Brushing Guide
Dental First Aid Action Plan

STEVE SISOLAK
Governor

RICHARD WHITLEY, MS
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LISA SHERYCH
Administrator

IHSAN AZZAM, Ph.D., M.D.
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Dear Licensed Childcare Facility Administrator,

The Nevada Division of Public and Behavioral Health (DPBH), Oral Health Program (OHP) has partnered with the Department of Education's Office of Early Learning and Development to assess children's oral health at licensed childcare centers across the state. Our goal is to increase the number of young children with dental "homes" and to decrease the number of children with untreated tooth decay. This information will help determine the extent of children's dental needs and allocate resources. But it all starts with dental screenings of students like yours.

DPBH,OHP is offering a dental screening to all children 3-5 years of age within identified licensed childcare facilities who provide parental consent. Parents can also consent to a fluoride varnish application for their child to strengthen teeth and reduce dental decay. This year, we will also be working with you to establish a toothbrushing station. Our team will conduct the oral health services from October 2020 – January 2021. All services are of no cost to you or your students.

Our team will call to schedule the screening at a time that is convenient for each site and mail the forms in advance for distribution (please see enclosed samples, which will also be available in Spanish). The screening and application of fluoride varnish will be conducted by a licensed dental professional who will follow all current infection control protocols and wear proper personal protective equipment(PPE). The process should take about two minutes per child. Each participating classroom within an individual childcare center will receive a grade-level appropriate, oral health educational session to equip children with dental hygiene and nutritional information and to remove any apprehension about the dental screening. Supplies for the in-classroom toothbrushing station will also be provided. Following the screening, children will receive a toothbrush, toothpaste, floss, written take-home findings for the parents, and contact information of dental providers where treatment can be rendered for issues identified during the screening.

We are pleased to offer a webinar as part of the 2020 Nevada Licensed Childcare Oral Health Survey which has been approved by the Nevada Registry. While the screening targets 3-5-year olds, this webinar is for all educators, staff, and administrators of licensed childcare facilities. This training will provide a working understanding of the landscape of dental disease in Nevada children, the etiology of tooth decay and prevention strategies, the relationship between nutrition and oral health, and tips to implement a classroom tooth brushing program. **We ask that you and your team register for this free virtual 2.5-hour webinar prior to your screening date. Multiple dates and times are available. The registration page can be found here: https://tinyurl.com/y3l27u72 Also included is a flyer on this webinar.**

Nevada Department of Health and Human Services
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

Helping People --
It's Who We Are And What We Do

Licensed childcare facilities that enroll in the QRIS star quality rating may use participation in this program to meet compliance under the QRIS indicator Health and Safety 3T: Preschool children receive annual oral health education.

Evaluation of past surveys from similar state studies have shown that these dental screenings are well received. In 2007, 95% said that the screening was important for measuring children's oral health, and 91% said that the screening was valuable to their programs. Previously written-in comments include:

- "It helps to identify children who are in need of dental treatment who may not have access or have not visited a dentist to receive routine care."
- "Good feedback from staff about identifying children with emergency needs which might have gone unmet without the screening team visit."
- "We had two different teams come out to our center and they were very child friendly, courteous and professional".

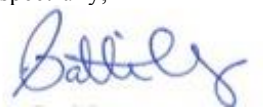
While the names of the children screened may be shared with the licensed childcare facility coordinator for follow-up, no individual child will be identified in any reports. Only aggregated results will be reported (e.g., from centers or counties). The information will be used to inform policy makers and others on what is needed to improve oral health for young children. Participating licensed childcare facilities and administrators will be the first to receive these reports.

Your center's participation is very important even if the children regularly visit a dentist. Your site may be representative of a geographic section of Nevada that may not otherwise be characterized. Participating in the screening can help the children currently attending your center and the aggregated reports will assist in designing programs to meet the needs of young children in years to come.

We sincerely hope that you will accept this opportunity, and let your site staff know of your support. The Nevada Oral Health Program will contact you for your response within the week.

Thank you for your attention in this matter.

Respectfully,



Patti Oya
Director,
Office of Early Learning and Development

Antonina Capurro, DMD, MPH, MBA
State Dental Health Officer,
Division of Public and Behavioral Health

Jessica Woods, RDH, MPH
Interim State Dental Hygienist,
Division of Public and Behavioral Health

Nevada Ready!
The Nevada Department of Education

2020 Nevada Licensed Childcare Oral Health Webinar

Presented by the Nevada Division of Public and Behavioral Health, Oral Health Program through a grant with the Department of Education's Office of Early Learning and Development and in collaboration with Colgate.

This free webinar has been approved by the Nevada Registry and is for educators, staff, and administrators of licensed childcare facilities.

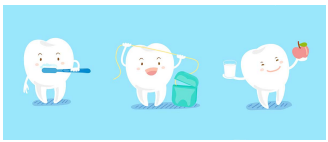
During this virtual training we will be discussing:

- Dental disease in children
- Oral health and hygiene
- Strategies to implement a classroom toothbrushing program
- First aid for pediatric dental trauma
- The relationship between nutrition and oral health

We ask that you and your team register for this webinar prior to your screening date.

This webinar is offered several times. Select the date/time that is most convenient to you.
Pre-registration is required.
Every registered participant will receive a:

- Certificate of completion and
- FREE whitening toothbrush kit



Register here:
https://tinyurl.com/y3l27u72

Email Jessica Woods at jwoods@health.nv.gov with any registration questions.

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Director

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Dear Licensed Childcare Facility Administrator,

The Nevada Division of Public and Behavioral Health (DPBH), Oral Health Program (OHP) is looking forward to our visit to your facility. As a reminder, we have partnered with the Department of Education's Office of Early Learning and Development to assess children's oral health at licensed childcare centers across the state. Our goal is to increase the number of young children with dental "homes" and to decrease the number of children with untreated tooth decay. DPBH, OHP is offering a dental screening to all children 3-5 years of age within identified licensed childcare facilities who provide parental consent. This year, we will also be working with you to establish a toothbrushing station. All services are of no cost to you or your students.

Some time in mid-October, please expect to receive an email confirming a site visit date. Before the visit to your site, the following items should be completed.

- **Please** have the parent/guardian completely fill out the permission form (Consent with Family Demographics) that are **included in this packet**. The forms are in English and Spanish. All offered dental services are for all students **regardless of dental insurance coverage**.
- Any parent that **does not** wish for their child to have the Dental Visual Exam performed, ***PLEASE*** have the parent complete the permission slip form and check "**No, I do not want my child to have either of the services mentioned above**" on the permission slip form.
- You are vital to encouraging completion of parental permission forms and ensuring that forms are returned in a timely manner. Each participating facility that reaches a **70% permission form return rate** will receive a **$100 gift card to Lakeshore Learning**. The percentage of completed permission forms will be associated with forms that have a parental signature regardless of whether or not the parent accepts or denies the child's participation in the dental screening. Gift cards will either be distributed on the day of the screening or will be mailed to site coordinators after the screening date.

- Please make parents are **aware they must fill** out the permission form (Consent with Family Demographics) to have their child receive the **Free Dental Kit.** Encourage parents to do so that way no child in the class is without one. Kids all want to participate for a Goodie Bag
- The enclosed **self-adhesive colored wristbands** can be used as a reminder for children and parents that a consent form has gone home for signature.
- **On the day** of the dental screening, we will visit the classrooms to provide a brief oral health presentation. We will work with you to ensure your students are ready at **your scheduled time** for the presentation and dental screening.
- Please have the permission forms (Consent with Family Demographics) completed and ready for Hygienist upon his/her arrival into your classroom. Please make sure that parent has **completely** filled out and signed the forms.
- The Hygienist will leave a **Take-home Findings** form and **oral hygiene kit** for you to give to the parents with their child's results of the Dental Visual Exam.
- Your center's participation is very important even if the children regularly visit a dentist. Your site may be representative of a geographic section of Nevada that may not otherwise be characterized.

THANK YOU for all your help during this process. It is a great experience and provides a needed service for Nevada's children. It is a day to learn about oral health and have fun! We could not do this without your help!

Respectfully,

Antonina Capurro, DMD, MPH, MBA
State Dental Health Officer,
Division of Public and Behavioral Health

Jessica Woods, RDH, MPH
Interim State Dental Hygienist,
Division of Public and Behavioral Health

Nevada Oral Health Program
Saving Nevada Smiles, One Tooth at a Time
http://dpbh.nv.gov/Programs/OH/OH-Home/

Dear Parent:

The 2020 Nevada Licensed Childcare Oral Health Survey is about to take place! The State dentist and dental hygienist will be screening children across Nevada to help learn about children's oral health. A healthy mouth is an important part of total wellbeing, and helps a child be ready to learn. Combined results of dental screenings at licensed childcare facilities will help us identify community needs so that we can plan dental programs for Nevada's children. For this reason, your participation is important! We hope that you will allow your child to participate in the screening even if s/he already visits a dentist.

With your consent, a dentist or dental hygienist will look at your child's teeth using a small mouth mirror and a light. We will send a report home to you that describe any findings, along with a list of dental providers in your area. Please note that this screening does not take the place of a complete dental exam.

In addition, your child can also have a thin coat of fluoride varnish painted on the teeth with a tiny brush. Fluoride varnish helps prevent new cavities, and it can help stop some cavities that have just started (please read the enclosed brochure). The fluoride varnish is sticky and if a child finds it uncomfortable on their teeth, the thin film of fluoride varnish can be removed immediately with a toothbrush and floss, and then by rinsing with and spitting out warm water.

The screening and fluoride varnish application take only about two minutes, and they are completely free. These services are voluntary and your child can leave at any time. Every child who participates will receive a free toothbrush, floss, and toothpaste. All information will be kept confidential**,** and your child's name will NOT be used in any reporting.

If you want your child to participate in either or both of the services, then you must sign the attached Consent Form— we cannot see any child without consent signed by the parent. **It would be helpful if you would return the form even if your child does not participate. Please return the form to your child's teacher as soon as possible, so that we can plan for our visit.**

For questions, please call the Nevada State Dental Health Officer, Dr. Antonina Capurro, at (702) 774-2573. Thank you for your attention in this important matter.

Respectfully,

Patti Oya
Director, Office of Early Learning and Development

Antonina Capurro, DMD, MPH, MBA
State Dental Health Officer, Division of Public and Behavioral Health

Jessica Woods, RDH, MPH
Interim State Dental Hygienist, Division of Public and Behavioral Health

Oral Hygiene Tips

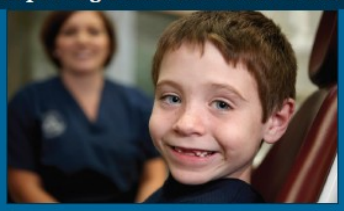
- Eat fruits and vegetables and drink plenty of water. Avoid sugar, soda pop, and juice. A healthy diet is important.
- Visit the dentist regularly starting when the first tooth erupts at about 6-12 months of age.
- Brush for two minutes twice a day with a fluoride toothpaste and floss regularly.
- Use a smear of toothpaste before age 3 and a pea size amount for older kids who can spit out the toothpaste.

Smear vs Pea size

- Remember, even baby teeth and gums are important. Never put baby to bed with a bottle and clean baby's mouth with a damp cloth after each feeding.

"You are not healthy without good oral health"
Dr. C. Everett Koop, Surgeon General of the United States, 1981-1989

Improving Dental Health in Nevada



Department of Health and Human Services

Division of Public and Behavioral Health

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Carson City, Nevada 89076

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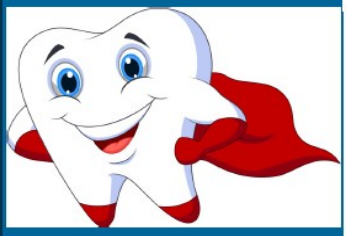
Fluoride Varnish

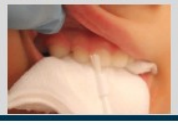


Your tooth's cavity fighter!

Saving Nevada Smiles One Tooth At A Time

How Is Fluoride Varnish Applied?

* A trained health professional will dry the teeth, mix the varnish, and paint a tiny amount on the teeth with a small disposable brush.
* The varnish application takes less than 2 minutes and may have a slightly tangy taste.
* The sticky temporary coating dries quickly and slowly releases fluoride to the tooth surface.
* Fluoride varnish is an easy way to brush on prevention and keep your teeth healthy.



Fluoride Varnish-Is It Safe?

Yes, fluoride varnish is safe. The sticky varnish dries quickly and creates a thin coating over the teeth.

Why Use Fluoride Varnish?

- Fluoride is a natural mineral found in water sources. Fluoride varnish contains 5% sodium fluoride
- Fluoride varnish helps strengthen the outer (enamel) layer of teeth and makes them more resistant to the bacteria that cause decay.
- Children as young as 12 months old can get cavities.
- Cavities in both baby and permanent teeth can cause real pain! Cavities can prevent children from eating, speaking, sleeping and learning.
- Fluoride varnish can help prevent cavities—some studies say up to 40%.

Fluoride Varnish Can Help Prevent Tooth Decay.

"Tooth decay is the single most common chronic childhood disease—5 times more common than asthma, 4 times more common than early childhood obesity, and 20 times more common than diabetes."
American Academy of Pediatric Dentistry

After The Varnish Is Applied:

* Water is safe to drink after application.
* Avoid chewy, crunchy, or hot foods. Instead, eat soft foods until the next day.
* Brush and floss your teeth the next morning. Sometimes the fluoride varnish looks yellow—this will all brush off.
* Do not take a fluoride supplement the day of application and 2 days after.

How Long Will It Last?

Fluoride varnish sticks to the teeth until it's brushed away the next day, but the benefits can last several months.

Fluoride varnish can be safely applied every 3 to 4 months

Nevada Department of Health and Human Services
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

Nevada Ready!
The Nevada Department of Education

Nevada 2020 Consent Form

For office use only:
Screening Date _____
Center Name _____
Record # _____

Please Note: Your child's name will NOT be used in tracking data. The Record # will be used for recording grant data.

Please answer the following questions about your child. Complete a separate form for each child.

1. **Child's Name** (print) _____

2. **Child's Birth Date** _____ / _____ / _____ **3. Name of Child's Dentist** _____or ☐ **None**

4. **Gender** ☐ Male ☐ Female

5. **Note: You must answer *all* of the questions for #5 if you want your child to have a fluoride varnish application. Does your child have any of the following:** (Circle **"Y"** for yes and **"N"** for no for each question)
   - **Y N Asthma**
   - **Y N Allergy to pine nuts or colophony**
   - **Y N Any other allergies** (list) _____
   - **Y N Any medical condition** (list) _____
   - **Y N Taking any medication** (list) _____
   - **Y N Takes fluoride tablets or drops at home**
   - **Y N A fluoride varnish treatment within the last three months**

Parental Permission for Services

IMPORTANT NOTE: You must mark "Yes", SIGN, and return this slip if you want your child to be screened and/or to have fluoride varnish. No services can be provided without marking the boxes and signing your consent.

☐ **Yes, I give permission for my child to have a dental screening. I understand** that this screening does not replace a full dental exam, and that my child should still go to a dentist. **I understand** that the results of this screening may be shared with the Nevada Department of Health and Human Services, licensed childcare facility, Nevada Department of Education, and with dental providers for my child.

☐ **Yes, I give permission for my child to have a fluoride varnish application.**

☐ **No, I do not want my child to have either of the services mentioned above**.

X _____
Signature of Parent/Legal Guardian **Date**

The following information is important to help us understand access to dental care in your community. Please mark the best answer.

6. **How would you rate the condition of your child's teeth and gums? (circle one)**
   a. Excellent b. Very good c. Good c. Fair d. Poor
7. **Due to COVID-19, do you feel comfortable coming into a dental office for an appointment?**
   a. Yes b. No Comment:
8. **How many times a day does your child have sugary drinks or snacks?**
   a. 2 or less b. 3 to 5 c. 6 or more
9. **Is your child reluctant to brush their teeth?**
   a. Yes b. No c. Sometimes

Over

10. About how long has it been since your child last visited (saw) a dentist? Include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists. (Circle only one)

a. 12 months or less
b. More than 1 year, but not more than 3 years ago
c. More than 3 years ago
d. My child has never been to a dentist
e. Don't know/don't remember

11. What was the main reason your child last visited a dentist? (Circle only one)

a. Went in on own for routine check-up, examination or cleaning
b. Was called in by the dentist for check-up, examination or cleaning
c. Something was wrong, bothering or hurting
d. Went for treatment of a condition that dentist discovered at earlier check-up or examination
e. Other
f. Don't know/don't remember

12. During the past 12 months, was there a time when your child needed dental care but could not get it at that time? (Circle only one)

a. Yes b. No c. Don't know/don't remember

13. IF YES: **What were the reasons that your child could not get the dental care she/he needed?** (Circle all that apply)

a. Cost was too high	**b.** Dental office is not open at convenient times	**c.** I did not think anything serious was wrong/expected dental problems to go away
d. Dental office is too far away	**e.** Another dentist recommended not doing it	**f.** Transportation or lack of reliable transportation
g. Unable to take time off of work	**h.** Afraid or do not like dentists	**i.** Dentist did not accept insurance
j. No insurance	**k.** Too busy	**l.** Insurance did not cover recommended procedures
m. Other	**n.** Don't know/don't remember	**o.** COVID-19/pandemic

14. Do you have any kind of insurance that pays for some or all of your child's DENTAL CARE? (Note: NO insurance will be billed – these services are completely free). (Check only one)

a. Private dental insurance
b. Medicaid
c. Other government dental insurance
d. None

15. Which of the following best describes your child? (Check all that apply)

☐ White ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Multiracial
☐ Asian ☐ Hispanic/Latino ☐ American Indian/Alaskan Native ☐ Don't know/unsure

Thank you for your participation!

2020 Nevada Licensed Childcare
Oral Health Survey-Data Form

Licensed Childcare Facility BSS ID[1]	**Screener ID and Initials**		**Date of Screening (mm/dd/yyyy)**		
	Record ID of Child		**Gender**	❑ Male	❑ Female
	Licensed Childcare Location				
	Consent Signed	❑ Yes	❑ No		
	Med. History Reviewed	❑ Yes	❑ No		
	Screening Completed:	❑ Yes	❑ No		
	Fluoride Varnish Applied:	❑ Yes	❑ No	If No: ❑ Consent for screening only ❑ Intra-oral inflammation ❑ Related allergies ❑ Ulcerative gingivitis ❑ Child refused/uncooperative	

Basic Screening Survey Data Collection

Untreated Decay	Treated Decay	Non-Cavitated White Spots	Treatment Urgency	Urgent Care
❑ Yes	❑ Yes	❑ Yes	❑ **No Obvious Problem** – continue with regular dental checkups	❑ Pain
❑ No	❑ No	❑ No	❑ **Needs Dental Care** – needs to be seen soon (before their next regularly scheduled dental visit)	❑ Abscess
_____ # of teeth	_____ # of teeth		❑ **Urgent Care Needed** (Pain, Swelling or Infection present) - needs immediate dental care within 24 – 48 hours	❑ Other (broken or knocked out tooth)

Other Findings:_____

2020 Nevada Licensed Childcare
Oral Health Survey
Take-Home Findings

Child's Name _____ **Center Name** _____ **Date** _____

Dear Parent/Guardian,
Today your child's entire mouth was checked by a licensed dental professional. We want you to know the following:

1. ☐ **This was only a screening.** It does not replace a complete dental exam. Your child should still have *regular* dental check-ups.

2. ☐ **Urgent! Your child has a tooth or teeth that appear to need immediate care**. Contact your family dentist right away to make an appointment for a complete evaluation.

3. ☐ **Early Care.** You child has one or more teeth that need to be evaluated by your family dentist. Your child needs to be scheduled now for a follow-up dental visit. Your dentist will determine whether treatment is needed.

4. ☐ **No obvious problems were seen.** Remember that this was not a complete exam with x-ray films, and does not take the place of one. Your child should visit a dentist regularly.

5. **If you marked "yes" on the Permission Slip for your child to have fluoride varnish:**

☐ **Fluoride varnish was applied. Remember:**

*For best results, do not brush or floss your child's teeth until tomorrow morning.
*Your child's teeth may look yellow, but the varnish will brush off.
*Your child should avoid eating anything sticky, crunchy, chewy, or hot until tomorrow. Give your child a soft diet for the rest of the day.
*Your child should not be given fluoride drops or tablets for two days. You may continue providing fluoride supplements two days from today.
*If any difficulties are experienced, you can quickly and easily remove the fluoride varnish by using a toothbrush and floss. Your child should then rinse his/her mouth with warm water and spit.
*If you have any questions or concerns, please call the Nevada State Dental Health Officer, Dr. Antonina Capurro, at (702) 774-2573.

☐ **Fluoride varnish was not applied. Comments:** _____

Remember...

- **Baby teeth are important! Some baby teeth stay in the mouth until a child is about 12 years old. They help with chewing and speaking, and they help guide the permanent teeth into place. Have your child see a dentist regularly. Cavities will not go away on their own, and they are less costly to fix if they are caught early.**
- **If your child has Medicaid, then they have dental benefits from birth to age 21. No referral is needed, regardless of the child's age. Transportation to and from the dental appointment may also be covered; call 1-844-879-7341.**
- **Be sure that your child brushes twice a day. Children should be assisted with brushing up to age eight so that *all* of the teeth are cleaned. Floss should be used every day between teeth that touch.**

Dental Providers

William Todd Thompson	DMD		Battle Mountain Dental	100 Carson Rd	Suite 1	Battle Mountain	NV	89820	(775) 635-3300	Lander
Donald Chamberlain	DDS		Elko Dental Care	2560 Mountain City Hwy	Suite 102	Elko	NV	89801	(775) 777-7751	Elko
James W Cruson	DMD		James W Cruson DMD	1389 Lamoille Hwy		Elko	NV	89801	(775) 753-8670	Elko
Daniel Egbert	DMD		Elko Family Medical and Dental Center	762 14th Street		Elko	NV	89801	(844) 227-6867	Elko
David Ellefsen	DDS		All Smiles Family Dental	900 N 5th St		Elko	NV	89801	(775) 738-8888	Elko
Morris Gallagher	DDS			810 Court St		Elko	NV	89801	(775) 738-6122	Elko
Michael Gladwell	DMD, MD	Oral Surgery	Elko Dental Specialists	1760 Browning Way	Ste B	Elko	NV	89801	(801) 262-7447	Elko
David T Grove	DMD, MS	Orthodontist (Braces)		137 B Sage Street		Elko	NV	89801	(775) 753-4870	Elko
Travis Kirkland	DDS		AnyDay Dental	2575 N 5th St	Ste A	Elko	NV	89801	(775) 738-9666	Elko
Clayton T Neilson	DMD		Clayton T. Neilson DMD LLC	2552 Idaho St		Elko	NV	89801	(775) 738-7666	Elko
Darrell Osterhoudt	DMD		7 Day Dental	2575 N 5th St	Ste A	Elko	NV	89801	(801) 568-0178	Elko
Meenakshi Patel	DMD		Elko Family Dentistry	674 N. Cedar St.	Ste. #A	Elko	NV	89801	(775) 777-3737	Elko
Stephen C Price	DDS		Clayton Neilson DMD	2552 Idaho St.		Elko	NV	89801	(775) 738-7666	Elko
Richard Pulsipher	DDS	Endodontist (Root Canal)	Elko Dental Specialists	1760 Browning Way		Elko	NV	89801	(775) 753-6118	Elko
Bryce Putnam	DMD		Elko Family Medical and Dental Center	762 14th Street		Elko	NV	89801	(775) 738-1553	Elko
Erik Smith	DMD	Pediatric Dentist	Children's Dentistry of Elko	2578 Idaho St		Elko	NV	89801	(775) 299-4790	Elko
Thomas Sorensen	DDS	Pediatric Dentist	AnyDay Dental	2575 N 5th St.	Ste. A	Elko	NV	89801	(775) 753-6118	Elko
Treagan White	DDS	Pediatric Dentist	Elko Dental Specialists	1760 Browning Way		Elko	NV	89801	(775) 753-6118	Elko
Thomas Dickson	DDS			690 Thistle Lane		Spring Creek	NV	89815	(775) 738-3500	Elko
David Diehl	DMD		Marina Hills Dental	282 Spring Creek Pkwy	Ste 202	Spring Creek	NV	89815	(775) 738-3110	Elko
Joseph Johnson	DDS			445 Frisco Court		Spring Creek	NV	89815	(435) 882-0099	Elko
Robert Petersen	DDS		Marina Hills Dental	282 Spring Creek Pkwy	Ste 202	Spring Creek	NV	89815	(775) 738-3110	Elko
Barry Sorenson	DMD		Family Dental Care	263 Spring Valley Pkwy	#A-3	Spring Creek	NV	89815	(775) 738-3500	Elko
Joseph Weber	DMD			480 Heather Dr		Spring Creek	NV	89815	(775) 738-3110	Elko
Scott Forvilly	DDS		Gentle Dental Care	50 East Haskell St	Ste C	Winnemucca	NV	89445	(775) 782-0022	Humboldt
Austin James Gibson	DMD		Gibson Dental	465 W Haskell St		Winnemucca	NV	89445	(775) 623-2364	Humboldt
Rickey Lynn Grant	DMD			P O Box 417		Winnemucca	NV	89446	(775) 623-1228	Humboldt
Jeremy M. Keener	DDS		Jeremy M. Keener DDS, PC	15 Paradise Ave		Winnemucca	NV	89445	(775) 625-7763	Humboldt
Nathan wensen	DMD		Nate Swensen DMD, LLC	530 Melarky	Ste 9	Winnemucca	NV	89445	(775) 623-5093	Humboldt

Nevada Department of Health and Human Services
Oral Health Program

Dental Providers

Douglas	Karwoski	DDS		Karwoski Dental	901 Medical Center Dr, Suite 200	Dayton	NV	89403	(775) 246-7122
Steven	Calderwood	DDS		The Dentists' Office	1241 S Taylor St	Fallon	NV	89406	(775) 423-7400
Jason	Ferguson	DDS		Nevada Dental Arts	56 Commercial Way	Fallon	NV	89406	(775) 423-9990
Tony	Guillen	DDS			320 West A St	Fallon	NV	89406	(775) 423-6547
Trinidad	Guillen	DDS			2277 Lovelock Hwy	Fallon	NV	89406	(775) 273-2909
Joseph	Hansen	DMD			2300 Mount View Dr	Fallon	NV	89406	(775) 423-3634
Cary	Jaques	DDS			451 Heron Ln	Fallon	NV	89406	(775) 423-5213
Derek	Johnson	DMD			1162 Bon Accord Ln	Fallon	NV	89406	(775) 423-7400
Tomas	Kutansky	DDS			966 Venturacci Ln	Fallon	NV	89406	(775) 423-9990
Kallie	Moorefield	DDS			368 Crystal Court	Fallon	NV	89406	(775) 423-7400
John	Shepphird	DMD		Fallon Family Dental Care	300 W A Street	Fallon	NV	89406	(775) 423-5213
James	Smerdon	DMD		The Dentists' Office	1241 S Taylor St	Fallon	NV	89406	(775) 423-7400
Paul	Hardman	DMD			1196 Jasmine Ln	Fernley	NV	89408	(775) 426-2811
Andrew	Korcek	DDS			1000 Agate Way	Fernley	NV	89408	(775) 426-2811
Cindy	Miller	DDS		C D Jackson-Miller DDS Inc	805 E Main St, Suite B	Fernley	NV	89408	(775) 575-2555
Bradford	Munninger	DDS		Desert Valley Dental	300 Hwy 95A S, #110	Fernley	NV	89408	(775) 575-0777
Carter	Christensen	DMD		Arrowhead Dental Center	1513 US HWY 395 N	Gardnerville	NV	89410	(775) 782-0022
Richard	Dragon	DMD		Dragon Dental	1234 Waterloo Ln	Gardnerville	NV	89410	(775) 782-9755
Stuart	Drange	DDS		Carson Valley Dental Arts Implant Dentistry	1480 Hwy 395	Gardnerville	NV	89410	(775) 782-7169
Edward	Gray	DMD	Oral Surgeon	Carson Valley Oral Surgery	1516 Charlotte Way, Suite A	Gardnerville	NV	89410	(775) 782-6491
Raymond	Murdock	DDS			1569 Putter Ln	Gardnerville	NV	89460	(775) 265-4215
Eric	Park	DDS		Eric S Park DDS PC	1126 Bell St	Gardnerville	NV	89410	(775) 782-2251
Timothy	Pinther	DDS		Sierra View Dental Center	1064 Riverview Drive	Gardnerville	NV	89460	(775) 782-3638
Matthew	Torres	DMD			1366 Macenna Lane	Gardnerville	NV	89410	(775) 392-3209
Jack	Harrington	DDS			2070 The Back Rd	Glenbrook	NV	89413	(775) 267-2244
Bruce	Dow	DDS			120 Aurora St	Hawthorne	NV	89415	(775) 945-2438
Jason	Acevedo	DDS		Jason R Acevedo, DDS LLC	897 Ironwood Dr, Suite 203	Minden	NV	89423	(775) 783-0888
Mark	Allen	DDS		Mark A. Allen, DDS	1701 County Rd, Suite K	Minden	NV	89423	(775) 782-9177
Daniel	Budd	DDS		Minden Dental	1664 US Hwy 395 N, Suite 201	Minden	NV	89423	(775) 782-7705
Ronnie	Cook	DDS, MS	Orthodontist		1702 Rosso Ct	Minden	NV	89423	(602) 843-7501
Maxwell	Doxey	DMD		Minden Dental	1664 US Hwy 395 N, Suite 201	Minden	NV	89423	(775) 782-7705
Celeste	Eckerman	DDS		Celeste Eckerman DDS	1702 County Rd, Suite E	Minden	NV	89423	(775) 782-2799
David	James	DMD		Dr. James the Dentist, APC	1664 US Hwy 395, Suite 103	Minden	NV	89423	(775) 782-7799
David	Newell	DDS			1673 Lucerne St, Suite C	Minden	NV	89423	(775) 782-4525
Rick	Parigini	DDS	Orthodontist	Parigini Orthodontics	1702 County Rd, Suite G	Minden	NV	89423	(775) 782-3600
Heather	Parsons	DMD	Pediatric Dentist	Valley Pediatric Dentistry	1701 County Rd, Suite I	Minden	NV	89423	(775) 782-8077
Frank	Raschilla	DDS		Frank L Raschilla, DDS	1625 Hwy 88, Suite 201	Minden	NV	89423	(775) 783-9898
James	Seyfried	DDS		James Seyfried, DDS	1624 Library Ln	Minden	NV	89423	(775) 782-8176
Thomas	Unruh	DDS		Thomas Unruh, DDS PC	1664 Hwy 395 #202	Minden	NV	89423	(775) 782-0411
Alan	Leinassar	DMD		Scott Leinassar DMD	2311 Hwy 208	Smith	NV	89430	(775) 465-2388
Andrea	Leinassar	DDS		Scott Leinassar DMD	2311 Hwy 208	Smith	NV	89430	(775) 465-2388
Dennis	Bowman	DDS		Dennis Bowman, DDS	PO Box 4461	Stateline	NV	89449	(775) 588-4021
Jeffrey	Askins	DDS, MS	Orthodontist		441 Tibbals Way	Yerington	NV	89447	(775) 829-8930
Steven	Draper	DDS		Mason Valley Family Dental	20 State Route 208	Yerington	NV	89447	(775) 463-3171
Frederic	Nelson	DDS			505 South St, Apt A	Yerington	NV	89447	(775) 773-2005
Nicole	Gordon	DDS			P O Box 10341	Zephyr Cove	NV	89448	(530) 544-1050
Monica	Saldana	DDS			P O Box 11464	Zephyr Cove	NV	89448	(907) 442-7325

Gary	Aglietti	DMD		Park Dental Management Co	501 S Division St	Carson City	NV	89703	(775) 882-1195
Michael	Almaraz	DDS	Periodontist	Dr. Michael Almaraz	1675 Vista Ln	Carson City	NV	89703	(775) 882-3033
John	Amorati	DDS			1201 N Nevada St	Carson City	NV	89703	(775) 882-2290
Jared	Bauerle	DMD	Periodontist		4201 Numaga Pass	Carson City	NV	89703	(775) 882-3033
Francis	Beglin	DDS	Orthodontist	Beglin Orthodontics	525 W Washington St	Carson City	NV	89703	(775) 882-5911
Keith	Benson	DMD		Northern Nevada Correctional Center	1721 Snyder Ave	Carson City	NV	89701	(505) 865-4618
Shannon	Brewer	DDS		Coombs & Brewer Dentistry	525 W Washington Street	Carson City	NV	89703	(775) 882-4247
Jared	Buck	DDS	Endodontist	Modern Endodontics	1177 N Division St #1	Carson City	NV	89703	(775) 883-3434
Gregory	Carman	DMD		Clear Creek Dental LLC	3790 Highway 395, Suite 103	Carson City	NV	89705	(775) 267-2244
Clifton	Carpenter	DDS		Absolute Dental	3405 Market St	Carson City	NV	89706	(775) 461-1180
Ryan	Coombs	DDS		Coombs & Brewer DDS	525 W Washington St	Carson City	NV	89703	(775) 882-4247
Russell	Curtis	DMD		Courtesy Dental & Orthodontics	307 W Winnie Ln, Suite 2	Carson City	NV	89703	(775) 885-2323
Vincent	D'Ascoli	DDS	Orthodontist	D'Ascoli Orthodontics	1407 N Carson St	Carson City	NV	89701	(775) 782-3788
William	Downie	DDS			4091 County Line Rd	Carson City	NV	89703	(775) 684-3092
Steven	Dryden	DDS	Oral Surgeon		1470 Medical Parkway, Ste 260	Carson City	NV	89703	(775) 884-4433
Nicholas	Duncan	DDS			7465 Center Drive	Carson City	NV	89701	(775) 832-3466
Clinton	Euse	DDS		Advance dentistry by Design LLC	403 W Nye Ln, Suite A	Carson City	NV	89706	(775) 883-7244
Kelly	Euse	DDS		Advanced Dentistry by Design	403 W Nye Ln, Suite A	Carson City	NV	89706	(775) 883-7244
Mark	Funke	DDS		Mark D Funke, DDS	1898 College Pkwy, Suite 101	Carson City	NV	89706	(775) 882-5525
William	Holmes	DDS			1647 Buzzy's Ranch Rd	Carson City	NV	89701	(775) 882-4247
Benjamin	Horgan	DDS		Capital City Dental Inc	725 N. Minnesota St.	Carson City	NV	89703	(775) 883-6700
Andrek	Ingersoll	DMD	Pediatric Dentist	Carson City Pediatric Dentistry	4530 S Carson St, Suite 5	Carson City	NV	89701	(775) 461-3800
Frederick	John	DMD	Pediatric Dentist	Carson City Pediatric Dentistry	4530 S Carson St	Carson City	NV	89701	(775) 461-3800
Melissa	Jones	DDS, MS	Orthodontist	Carson City Orthodontics	3790 Hwy 395 S. #406	Carson City	NV	89705	(775) 434-0494
Justin	Kiggins	DMD		Kiggins Family Dentirsty	602 E Caroline St	Carson City	NV	89701	(775) 882-7676
Richard	Klein	DDS			501 S Carson St, Suite 100	Carson City	NV	89701	(775) 883-0565
George	Leonakis	DDS			2060 College Pkwy, Suite 44	Carson City	NV	89702	(775) 882-0638
Christopher	Lingard	DMD	Endodontist	Carson City Endodontics	2874 N Carson St, Suite 230	Carson City	NV	89706	(775) 884-2111
Jamie	Marvel	DDS		Marvel Dental Carson City LLC	410 Fleischmann Way, Suite A	Carson City	NV	89703	(775) 623-2364
Susan	McElhany	DMD			908 Jeanell Dr	Carson City	NV	89703	(775) 882-4242
Marc	Nelson	DMD		Marc Nelson DMD	710 N Division St	Carson City	NV	89703	(775) 882-4242
Kevin	Olson	DMD	Pediatric Dentist	Carson City Pediatric Dentistry	4530 S. Carson St, Suite 5	Carson City	NV	89701	(775) 461-3800
Elizabeth	Park	DDS		Elizabeth Park DDS	501 S. Division St	Carson City	NV	89703	(775) 887-1195
Mardelle	Petersen	DDS		Northern Nevada Correctional Center	1721 E Snyder Ave	Carson City	NV	89701	(775) 887-9297
Kevin	Peterson	DDS		Lone Mountain Family Dentistry	461 Hot Springs Rd	Carson City	NV	89706	(775) 883-1092
Andrew	Robison	DDS		Redrock Dental	220 N Nevada St	Carson City	NV	89703	(775) 885-9446
Matthew	Ross	DMD		Dentists of Carson City	1457 S Carson St, Ste 101	Carson City	NV	89701	(775) 372-9898
Matthew	Schofield	DMD		Mountain Dental	913 N Mountain St	Carson City	NV	89703	(775) 882-4433
Joel	Smith	DDS		Dentists of Carson City	1457 S Carson St, Ste 101	Carson City	NV	89701	(775) 372-9898
Aimee	Snell-Killam	DDS	Pediatric Dentist	Big Blue Pediatric Dentistry	1789 E College Pkwy, Ste 121	Carson City	NV	89706	(775) 331-9477
Scott	Sutter	DDS, MS	Endodontist	Modern Endodontics	1177 N. Division Street, Suite 1	Carson City	NV	89703	(775) 359-3934
Benjamin	Syndergaard	DMD	Periodontist	Carson Periodontics	1675 Vista Ln	Carson City	NV	89703	(775) 882-3033
Chelsie	Todd	DMD		Carson Kids Dentistry	1621 E William St, Ste H	Carson City	NV	89701	(702) 869-0032
Duong	Ton	DDS		First Care Dental	314 West 5th St	Carson City	NV	89703	(775) 882-1111
Ronald	West	DMD		Carson Dental Designs	412 W. John St, Suite 100	Carson City	NV	89703	(775) 882-4122
Payden	Wildman	DDS			885 Valley Crest Dr	Carson City	NV	89705	(775) 782-0022
Randall	Wright	DDS		Advanced Dentistry by Design	403 W Nye Ln, Suite A	Carson City	NV	89706	(775) 883-7244

CLASSROOM CIRCLE BRUSHING

1. Sitting at table in circle, children brush teeth as a group activity every. day.
2. Give each child a small paper cup, a paper towel and a soft-bristled, child-sized toothbrush.
3. Put a small (pea-sized) dab of fluoride toothpaste on the inside rim of each cup, and have children use their toothbrushes to pick up dabs of toothpaste.
4. Brush together for two minutes, using an timer or a song that lasts for two minutes.
5. Brush your teeth with the children to set an example, and remind them to brush all their teeth, on all sides.
6. When the two minutes are up, the children spit any extra toothpaste into their cups, wipe their mouths and the throw the cups and paper towels away.
7. Children can go to the sink in groups to rinse their toothbrushes and put the toothbrushes in the holders to dry.

ORAL HEALTH FOR CHILDREN

birth-3 years

- Babies should be seen by a dentist soon after the first tooth comes in, or by one year of age at the latest.
- Milk or formula left on the teeth overnight causes cavities. Babies should never be put to bed with a bottle.
- As soon as babies get their first teeth, caregivers should clean them every day with a small smear of fluoride toothpaste. Between 9 and 24 months of age, children should have at least four fluoride varnish treatments by a health care provider.
- Parents and caregivers should provide healthy snacks. Sodas, sweets and refined starches should be limited or cut out altogether.

3-5 years

- Every child should have s dental home – dental clinic or private practice – where they can receive comprehensive oral health care.
- Children should receive fluoride varnish treatments every 3 to 4 months to protect teeth from cavities.
- Parents should consider having dental sealants applied to a child's molars if they are found to be at high risk for cavities.
- Parents and caregivers should make sure children know how important it is to brush their teeth twice a day with a small (pea-sized) dab of fluoride toothpaste.
- Parents and caregivers should provide healthy snacks. Sodas, sweets and refined starches should be limited or cut out altogether.

Nevada Department of Health and Human Services
Oral Health Program
http://dpbh.nv.gov/Programs/OH/OH-Home/

Following a Head or Mouth Injury:

➔ Calm the injured person.
➔ Check to determine the type of injury and refer to the Action Plan.
➔ If swelling, apply a cold compress to the area.
➔ *If minor bleeding:*
- Apply direct pressure with sterile gauze or clean cloth. If bleeding doesn't stop within ten minutes, contact parent and arrange to take child to the emergency room.

➔ *If bleeding profusely:*
- Contact parent and arrange for emergency services by an emergency squad or emergency room.

DENTAL FIRST AID
Action Plan

KNOCKED OUT PERMANENT (ADULT) TOOTH (AVULSED TOOTH)
- Find tooth, but do not handle it by the root (hold tooth by the crown).
- If tooth is dirty, rinse gently with tap water—don't scrub or use antiseptic.
- Attempt to gently replant tooth into the socket. Have the child hold in place with a tissue or gauze. If not possible to replant tooth, place tooth in a tooth preservation system* or if unavailable, a glass of cool skim or low-fat milk. If skim or low-fat is not available, use 2% or whole milk. **Such as the Save-A-Tooth transport system*
- If milk is unavailable, place tooth in saliva by spitting into a cup.
- Place tooth in saline solution or water only as a last resort. Tooth must not dry out!
- Contact parent and arrange to take child and tooth to dentist immediately. Replantation within 15–20 minutes is best.

KNOCKED OUT PRIMARY (BABY) TOOTH
- Primary (baby) tooth should not be put back into the socket.
- If bleeding, have child bite on a clean cloth or gauze for 15 minutes. If bleeding persists, repeat procedure again over area. If bleeding does not stop, seek emergency care.
- Contact parent. Arrange to take child to dentist as soon as possible.

LOOSENED/CHIPPED TOOTH/ TOOTH PUSHED INTO GUMS
- Gently clean the area with warm water.
- If there is swelling, apply a cold compress to the area.
- If bleeding, apply direct pressure to the bleeding area with a clean cloth or gauze.
- Do not attempt to move tooth into correct position.
- Contact parent. Arrange to take child to dentist immediately.

TOOTHACHE
- Do not place aspirin on gum tissue of aching tooth (aspirin will burn tissue!)
- Contact parent. Arrange to take child to dentist as soon as possible.

INJURY TO LIPS, TONGUE, CHEEK (INCLUDING CUTS OR BITTEN MOUTH)
- Rinse affected area with warm water.
- If injury is due to a fall or if tooth is chipped, contact parent and arrange to take child to dentist immediately.

(Foreign matter lodged in lip may cause infection.) Also, see "Toothache" above.

BROKEN OR DISLOCATED JAW
- If a broken or dislocated jaw is suspected, keep the jaw from moving.
- Immobilize jaw by placing a scarf, necktie, or towel under the chin tying the ends on top of the head.
- Contact parent. Arrange to take child to dentist as soon as possible.

Nevada Department of
Health and Human Services
Oral Health Program
http://dpbh.nv.gov/Programs/OH/OH-Home/

IMPORTANT EMERGENCY INFORMATION

Know who to call in an emergency...

Dentist Contact:

_____

Medical Doctor Contact:

_____

Emergency Personnel:

_____

Your Facility Name and Address:

_____

_____