

**Caring for Children's Oral Health version 3.2**  
(Revised 3/26/07)

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## **LEARNING OBJECTIVES**

After reading this Module, Trainers will be able to:

- Describe national trends in the incidence of children's oral health problems and needs
- Describe early childhood stages of oral development
- Explain major oral health problems:
  - dental caries (tooth decay)
  - Early Childhood Caries (ECC)
  - malocclusions
  - periodontal disease
- Explain key prevention strategies for oral disease and infections:
  - early and regular dental check-ups
  - cleaning teeth and gums
  - good nutrition
  - regular dental visits
  - use of fluoride
  - use of sealants
  - use of fluoride varnish
  - injury prevention
- Know the best methods for storing children's toothbrushes
- Identify ways to respond to dental emergencies
- Describe factors to consider in meeting oral health needs of children with special needs
- List sources of payment for children's dental care
- Understand factors affecting access to dental care
- Compare their state regulations for children's oral health needs to the *CFOC* standards
- Identify areas where Child Care Health Consultants can advocate on behalf of children's oral health needs
- Identify oral health education needs of children, child care providers, and parents
- Know national, state, and local resources on oral health and how to make referrals to these resources

# Caring for Children's Oral Health

## Session Flow Chart

Content	Type of Activity	Materials	Time Needed
<p><b>CARING FOR CHILDREN'S ORAL HEALTH</b></p> <p>What the CCHC Should Know</p> <ul style="list-style-type: none"> <li>• Developmental Stages of Children's Oral Health</li> <li>• Major Oral Health Problems for Children</li> <li>• Key Prevention Strategies</li> <li>• Techniques for Promoting Oral Health in Child Care</li> <li>• Oral Health for Children with Special Needs</li> <li>• Children's Access to Dental Care</li> </ul> <p>The Role of the CCHC</p> <ul style="list-style-type: none"> <li>• Education</li> <li>• Assistance</li> <li>• Advocacy</li> </ul> <p>Where to Find More Information</p>	<p>Activity 1 Individual</p> <p>Activity 2 Individual</p> <p>Activity 3 Individual</p> <p>Activity 4 Individual</p> <p>Activity 5 Individual</p>	<p>WS Integrating Oral Health Education into Child Care</p> <p>WS Accessing and Utilizing Oral Health Resources</p> <p>WS Comparing Your State Regulations for Oral Health with CFOC Standards</p> <p>WS Improvements Needed in State and Local Oral Health Regulations</p> <p>WS Advocating for Children's Oral Health Needs</p>	

WS: Worksheet

**Estimated Total Time:**

## **CARING FOR CHILDREN'S ORAL HEALTH**

### **What the CCHC Should Know**

Proper oral health in children is essential to meeting their general health needs. "Although dental problems don't command the instant fears associated with low birth weight, fetal death, or cholera, they do have the consequence of wearing down the stamina of children and defeating their ambitions" (Kozol, 1991). Particularly disturbing is the fact that many oral diseases can easily be prevented.

Current reports on the status of oral health for America's children include the following facts:

- Tooth decay is the most common disease of childhood in the United States, affecting 17% of children by the time they are 2-4 years old. By the age of 8, approximately 52% of children have experienced decay, and by age 17, dental decay affects 78% of children (Centers for Disease Control [CDC], 2003).
- Up to 50% of tooth decay in children from low-income families remains untreated, often resulting in problems of chronic pain that affects a child's ability to chew food, thrive, and speak and can lead to poor appearance which may in turn reduce a child's ability to succeed (CDC, 2001a; Jones, Tinanoff, Edelstein, Schneider, DeBerry-Summer, Kanda, et al, 2000).
- Thirty percent of all U. S. health care expenditures for children are dental, yet children still suffer from oral health-related problems (Kanellis, Damiano and Momany, 2000; Lewit and Monheit, 1992).

### ***Developmental Stages of Children's Oral Health***

The eruption of children's primary teeth begins between 5 and 7 months of age, although it may occur later or earlier in some children. The actual forming of a child's teeth, however, begins in utero. For this and other fetal health reasons, mothers should receive good prenatal care, eat balanced meals, and avoid using tobacco products and alcohol during pregnancy. Because of hormonal changes, mothers are more likely to develop gingivitis during pregnancy so extra attention to teeth cleaning procedures is in order. Pregnant women should continue to visit their dentist during pregnancy to ensure optimal oral health. In general, the mother's development of positive health behaviors during pregnancy will help ensure that the child's teeth develop properly (American Academy of Pediatrics [AAP], 2001a; American Dental Association [ADA], 2001a; Casamassimo, 1996).

The first teeth that appear are the upper and lower front teeth, called the incisors. By the age of 2 or 3 years, a child will have all 20 primary teeth (Wisconsin Department of Health & Family Services, Division of Health, 1996).

Children begin the process of teething before teeth actually appear. The child's gums may become red, swollen, and tender preceding the eruption of one or more teeth. Children also become restless and fussy, have excess saliva, and want to bite and chew

because their gums are hurting. To ease some of these symptoms, a child may be given a one-piece teething ring. It can be especially soothing if the ring is kept cold before giving it to a child. In general, teething does not cause an increase in temperature, and if this should occur, the child should see a physician (AAP, 2001a, Wake et al, 2000).

A child's primary teeth are very important and should be cared for properly, even though they are eventually replaced with permanent teeth. Primary teeth enable a child to eat and speak as well as retain space for the permanent teeth. Permanent teeth begin to erupt at 5 or 6 years of age, but the last primary molar is not shed until the 12<sup>th</sup>–14<sup>th</sup> year.

### ***Major Oral Health Problems for Children***

#### **a) Dental Caries**

Dental caries (i.e. tooth decay) is an infectious, communicable disease whereby bacteria in dental plaque metabolize sugars and other fermentable carbohydrates from the diet. The acid that is produced as a metabolic by-product dissolves the hard surfaces of the teeth. This disease may cause the loss of minerals from the teeth, known as demineralization. This occurs when exposure to the acid is prolonged and exceeds the natural ability of the teeth to remineralize or heal. "Unchecked, the bacteria can penetrate the dissolved surface of the teeth, attack the underlying dentin, and reach the soft pulp tissue" (CDC, 2001b). Dental caries is the disease that leads to cavities.

The younger the age of the child at the first onset of caries, the greater the likelihood of caries at later ages (O'Sullivan and Tinanoff, 1993; US DHHS, 2000). A child's resistance to dental caries and the level of the caries attack can be managed by good oral hygiene, use of fluorides and sealants, good dietary habits, and physical or chemical reduction of dental plaque (Casamassimo, 1996).

#### **b) Early Childhood Caries (ECC) [4.014](#)**

Early Childhood Caries (ECC), also known as Baby Bottle Tooth Decay, refers to early and severe tooth decay in infants and pre-school age children. A common cause of ECC is giving a child a bottle containing milk, formula, juice, soda pop, or any drink with sugar for extended periods of time to encourage sleep, comfort and/or to calm the child. For example, children may be given a bottle when put to bed, or be allowed to carry a bottle around with them during awake hours. The sugary drink pools in the child's mouth and becomes a breeding ground for bacteria that may result in cavities. If a child has ECC, his/her teeth may appear flat white, brown or have yellow spots or cavities, and some teeth may be partially broken. Estimates indicate that 5-10 percent of all children experience ECC, and children in poverty are most affected (Casamassimo, 1996; Edelstein, 1999). Some measures recommended to prevent ECC are:

- Eliminate bottles at bedtime/naptime. If this is not practical, fill the bottle with water, and hold the child until they fall asleep.
- Explore alternative methods for calming a child and getting him/her to sleep, such as reading a book or listening to music.

- Clean the child's teeth and gums each day with a toothbrush that has a small head and soft bristles.
- Offer the child drinks with a cup as soon as he/she can sit up alone.
- Eliminate use of bottles after one year of age.
- Avoid unlimited or frequent access to milk or sugary drinks (from either a bottle or cup) throughout the day. After eruption of the first tooth, children should only be given fruit juice at mealtimes (no more than 1 cup per day) (AAP, 2003).

### **c) Periodontal Disease**

Periodontal disease includes both gingivitis and periodontitis. Gingivitis is a disease of the gums that may occur among children. The first signs of gingivitis are red, swollen gums and bleeding while brushing. Often, however, there are no physical symptoms of gingivitis, and regular dental visits can be the only way to detect gingivitis in its early stages (ADA, 2004). Periodontitis, the disease of the gums and supporting bone, is rare in healthy children. If a child has periodontitis, it may be an indication of an underlying condition and the child should be referred to a physician for evaluation. Both gingivitis and periodontitis can be prevented and controlled by using plaque-removing techniques such as brushing and flossing (Casamassimo, 1996). However, flossing is unnecessary until a child's teeth begin to touch one another. Until that time, brushing is sufficient.

### **d) Malocclusions**

Malocclusion refers to the improper alignment of the jawbone and teeth. Malocclusions can be either skeletal, when the upper and lower jaw do not align in relation to the skull, or dental, when the teeth in either jaw do not align properly. Many malocclusions are genetically determined. However, a common preventable form of malocclusion occurs as a result of non-nutritive sucking habits (e.g., sucking fingers, thumb, or pacifier). For this reason, sucking habits should be discouraged by age four, or before permanent teeth erupt. Another common form of malocclusion occurs when a primary tooth is lost prematurely and a nearby permanent tooth shifts into the space leaving inadequate room for the permanent replacement tooth (American Academy of Pediatric Dentistry [AAPD], 1999a). Many malocclusions are primarily aesthetic concerns, but those that affect oral functioning require treatment.

## ***Key Prevention Strategies***

### **a) Cleaning Teeth and Gums** [3.010-3.011, 5.095](#)

Cleanliness is the single most important preventive goal that *child care providers can easily implement* to reduce dental caries and gingivitis. It is important for CCHCs to ensure that both providers and parents understand how to clean the teeth and gums of their children correctly. The cleaning of a child's teeth or gums can begin as early as birth (AAPD, 1999b). The caregiver should clean an infant's gums using a damp cloth or piece of gauze moistened with water. Eventually the infant will progress to a small head toothbrush that fits his/her mouth (e.g., a brush with a *very small head, very soft bristles*, and a *long handle*). Advice as to when a child should begin using fluoridated toothpaste has not been consistent.

However, the current recommendation of the AAPD is that all children should use toothpaste containing fluoride and the American Dental Association *Seal of Acceptance*, shown below (ADA, 1995-2004). The AAPD also recommends that the caregiver supervise brushing to ensure young children, especially those pre-school age or younger, do not swallow the toothpaste.



(ADA, 1995-2004)

Parents sometimes become concerned that their children's permanent teeth appear less white than their primary teeth. This is normal; permanent teeth exhibit variations in color that are not present in primary teeth. At age two, caregivers should begin assisting children in brushing their teeth with fluoridated toothpaste at least twice per day. At about age three, children should begin to learn how to brush their own teeth with direct supervision of the caregiver (Casamassimo, 1996). By age 4, children should brush their own teeth. However, the caregiver will still need to ensure that the teeth are thoroughly cleaned, probably through age 6. If children are unable to follow this developmental schedule, the caregiver should brush their teeth for them. The caregiver should be knowledgeable about the correct brushing method. If children do their own brushing, the caregiver should demonstrate step by step. [3.010](#)

Since they snack frequently, it is usually not feasible for children to brush their teeth after every snack. At times when brushing after eating is impractical, drinking water should be offered instead and children should be encouraged to swish the water in order to wash away food particles and sugars.

#### **Basic Brushing Skills**

- Use a soft, polished bristled, straight handle toothbrush.
- Squeeze a pea-size amount of fluoride toothpaste on the toothbrush.
- Place the head of the toothbrush at a 45-degree angle toward the gumline.
- Brush the front (cheek side) of each tooth, top and bottom, using gentle circular scrubbing motions.
- Brush the backs (tongue side) the same way, top and bottom.
- Then scrubbing back and forth gently brush the chewing surfaces of the teeth.
- Hold the toothbrush up and down to brush the insides of the teeth. Use the front tip of the brush and move it up and down.
- Finally, brush the tongue by rolling the toothbrush back to front, or by gently scrubbing back and forth. This may tickle the child at first, but with practice it will become easy (Peppe, 1991).

**b) Good Nutrition** [4.001-4.007](#)

The best nutrition for children's oral health is the same as that for their general health: a healthy balanced diet consisting of a variety of foods. For pre-school age children, a daily balanced diet consists of two servings of protein products (meat, fish, poultry, eggs, beans), three servings vegetables, two servings of fruit, six servings of grains/breads/cereals, and two servings of dairy products (USDA Food Guide Pyramid for Young Children, 1999). (Also see section on Meeting Children's Nutritional Needs in NTI's *Nutrition* and Physical Activity training module). Prior to age 5-6, a diet rich in calcium (dairy products) is especially important to strengthen permanent teeth while they are forming, and to keep the gums and mouth healthy as they emerge (National Resource Center for Health and Safety in Child Care, 1997). Vitamin D is essential for bodily absorption of calcium. Commercial milk is fortified with Vitamin D. The body itself also generates Vitamin D with at least 20 minutes of sunlight a day. Vitamin C is critical for healthy gums (Casamassimo, 1996).

From a dental point of view, the most harmful foods are those containing sugars, e.g., sucrose, fructose, glucose, lactose, dextrose and maltose. All sugars promote tooth decay, even the sugars and starches in foods that are essential to a healthy diet. Fruits, some vegetables, and most milk products contain at least one type of sugar. Also, many processed foods that do not appear sweet, such as peanut butter and ketchup, list sugar as a major ingredient on their labels. Not only do sugary foods have cavity causing potential, but the longer sugars remain in contact with the teeth and gums, the greater the risk for decay. This is particularly a problem with infants who are habitually nursed or given a bottle of milk, juice, or sweetened liquid as a pacifier or comforter at bedtime or allowed frequent access to milk or sweetened liquids throughout the day. It is specifically addressed in the preceding section, *Major Oral Health Problems for Children*, under Early Childhood Caries, pp.5-6.

Since many foods containing sugars also provide nutrients that a child needs, the AAPD (1999d) and the AAP (2001b) stress that they not be eliminated, but selected and served wisely. Some specific recommendations are as follows:

- Avoid sweets, including sweetened soft drinks and other sugary liquids. When sweets are eaten it's preferable that they be included with a meal rather than eaten as a snack. At meals the combination of foods eaten helps to dilute the sugar concentration and wash the sugars away. Also, children are more likely to brush their teeth after a meal than after a snack.
- At snack time limit sticky, starchy foods (raisins, crackers, bananas) that cling to the teeth for relatively long periods of time and are not easily washed away.
- After snacking, if brushing is not feasible, rinse the mouth with water.

- Avoid snacking before bedtime or naptime since the potential for foods to adhere to the teeth surfaces for a longer period of time increases and salivary flow decreases.
- Limit the frequency of snacks. Although children need snacks, every time they eat they are exposing their teeth to potential decay. Providing larger snacks with less frequency will reduce the total number of exposures.

**c) Regular Dental Visits [3.011](#)**

Regular dental visits insure the practice of good preventive methods such as checking for the proper amount of fluoride treatment, teaching proper brushing techniques, and checking for oral health problems and early signs of tooth decay (ADA, 2001b). The ADA (2001b), the AAPD (1999b), and the AAP (2003) recommend that children have their first dental appointment and establish a dental home within 6 months after the eruption of the first tooth and no later than 12 months of age. The establishment of a dental home provides the child with comprehensive, accessible and affordable dental health care (AAP, 2003). Subsequent check-ups for children are recommended on a twice-yearly basis unless there is evidence of increased risk of tooth decay, unusual growth patterns, or poor oral hygiene.

**d) Use of Fluoride [3.010](#)**

The widespread use of fluoride in the United States is the primary factor in preventing dental caries among both children and adults. The effects of fluoride include:

- increased resistance of the tooth structure to demineralization.
- improved remineralization of early carious lesions.
- reduction in the development of dental cavities.

A child can receive fluoride in two ways, systemically and/or topically. Systemically, fluoride is ingested into the metabolic system through fluoridated drinking water or through fluoride supplements (tablets or drops). Topical fluorides, which reach the teeth directly, include fluoridated water (washing over the tooth surface), fluoride toothpastes, fluoride mouthwashes, and fluoride treatments applied by a dental professional. Current research indicates that the topical application of fluoride is the more important of the two methods in preventing decay (Featherstone, 1999; Centers for Disease Control and Prevention, 1999).

Two of the most common sources of fluoride are tap water and fluoridated toothpaste. Fluoride occurs naturally in some water, but in most major municipalities it is added to the water as a public health measure to help prevent tooth decay. However, all communities are not optimally fluoridated. When adequately fluoridated drinking water is *not* available, dental and other health professionals prescribe fluoride supplements (fluoride vitamins, drops, tablets) for children and adolescents. In cases where the CCHC is uncertain as to whether or not a water system is adequately fluoridated, s/he should contact the local and

state health departments and request that the water be tested. Fluoride supplements should not be given if the primary water source is already adequately fluoridated.

Home water filters have increased in popularity, and many families rely on bottled water for drinking because they believe it provides greater purity than tap water. However, home filters may remove fluoride from water, and in general, tap water is more rigorously controlled and monitored than bottled water and thus more likely to be optimally fluoridated. Unless bottled water specifies the level of fluoride supplementation, consumers don't have access to this information. Bottled water for young children, often referred to as "nursery water", contains the same dosage of fluoride supplementation as fluoridated tap water (1 ppm) but is much more expensive. In summary, children from families who rely on home filters and/or bottled water for drinking and cooking (i.e., as their primary water source) may not receive the appropriate amount of daily fluoride. The AAP (1995), and the AAPD (1995) recommend the following dosages of fluoride supplementation:

Age	Fluoride Ion Level in Drinking Water (ppm)*		
	<0.3 ppm	0.3-0.6 ppm	>0.6 ppm
Birth - 6 months	None	None	None
6 months - 3 years	0.25 mg/day <sup>†</sup>	None	None
3-6 years	0.50 mg/day	0.25 mg/day	None
6-16 years	1.0 mg/day	0.50 mg/day	None

\*1.0 ppm = 1 mg/liter

<sup>†</sup> 2.2 mg sodium fluoride contains 1 mg fluoride ion. (AAP, 1995; AAPD, 1995)

The fluoride supplements provided by dental or other health professionals are sold in many forms. For example, fluoride drops are available for young children 6 months of age and older; while older children and adolescents may be given chewable tablets with or without vitamins. There are limits, however, to the amount of fluoride a child should be given. Too much fluoride during the period of active enamel calcification can cause enamel fluorosis (harmless discoloration or mottling) on unerupted permanent teeth. Most cases of enamel fluorosis result from children taking fluoride supplements when their drinking water is already optimally fluoridated. For example, a dentist may automatically prescribe fluoride supplements for a child who relies predominantly on well water, assuming the water is under-fluoridated. However, some well water is naturally highly fluoridated. In general, testing of children's primary source of drinking water should occur prior to supplementation (AAPD, 1999c; AAPD, 1999e). Information about natural water fluoride levels can often be found at County Health Departments.

**e) Use of Sealants [3.011](#)**

Dental sealants are thin plastic coatings applied to the chewing surfaces of the molars (back teeth) by a dental professional. Approximately 80% of tooth decay in children's permanent teeth occurs on these surfaces (AAPD, 1999f). Sealants help prevent tooth decay by creating a physical barrier protecting the grooves and pits of the molars where food and plaque stick. Dental sealants are usually applied to

children's permanent molars, the first of which erupt around 6 years of age. Second molars appear around age 12. Occasionally sealants are applied to primary teeth if the child is considered at high risk for dental caries. Dental sealants can last for as long as 5 to 10 years. They should be checked regularly after application, and reapplied if no longer in place (CDC, 2001c).

**f) Fluoride Varnish [3.011](#)**

Fluoride varnish is a high concentration topical fluoride gel that is painted directly onto the teeth. It adheres and is absorbed over a 24-hour period, then wears away. It can prevent decay on both the smooth surfaces and groove and fissure areas of the teeth. It has been used effectively to prevent tooth decay in primary and permanent teeth in European countries for more than 25 years, but is only recently available in the United States (Bawden, 1998; CDC, 2001b). This method of fluoride application is ideal for young children because no special equipment is needed, the application is relatively quick and easy, it requires little training or supervision for the physician or dentist, and the taste is not unpleasant. Fluoride varnish can be applied by a health care professional with a brush or even with a finger. Another significant advantage of fluoride varnishes for infants and young children is that their potential for fluoride ingestion is relatively low compared to other topical fluoride treatments (Bawden, 1998; CDC, 2001b).

**g) Injury Prevention**

Common oral injuries include crown fractures and tooth loss from sockets, as well as fractures of the jaw and alveolar (the ridgelike border of the upper and lower jaws containing the sockets of the teeth). The types of injuries that commonly occur depend upon the developmental stage and age of the child. Young children are most likely to suffer injury from falls, which often result in damage to the incisors or front teeth. Some general methods for preventing tooth damage from falls in young children include:

- Removing low furniture with sharp edges (e.g., coffee tables) or installing bumper guards around them.
- Placing infants and toddlers in safety seats when in a motor vehicle and making sure that the seat is installed properly.
- Placing baby gates at both the top and the bottom of stairs.
- Insuring children who are passengers on bikes or ride bikes wear helmets and safety pads.
- Putting safety mechanisms on windows and cabinet doors.
- Placing a safety belt on children riding in shopping carts.
- Making sure children wear mouth guards when playing sports (Casamassimo, 1996).

## ***Techniques for Promoting Oral Health in Child Care***

### **a) Responding to Dental Emergencies**

Many dental injuries incurred by pre-school aged children may have serious and long-term effects (Nowak, Johnsen, Waldman, McTigue and Casamassimo, 1995). Some dental injuries require immediate attention. These include dislodged teeth, chipped or loosened teeth, teeth pushed through gums, toothache, tissue injuries, and a broken or dislocated jaw. If a dislodged tooth is a primary tooth, it may or may not need repositioning depending on whether the repositioning might damage the incoming permanent tooth. Permanent teeth should be reinserted into their sockets immediately or at least within 30 minutes for best results. The tooth that was dislodged should be kept moist in cold milk and transported with the child to the dentist. In the case of chipped teeth, teeth pushed through gums, or toothache, the child should be seen by a dentist for immediate attention. When injuries occur such as soft tissue tears, tongue lacerations, and puncture wounds, the immediate stoppage of bleeding is essential to prevent infection and promote healing. In the case of a broken or dislocated jaw, the child should be taken to the emergency room immediately (Peppe, 1991).

### **b) Storing and Labeling Children's Toothbrushes** [5.095, 5.151](#)

A habit essential to promoting oral health and preventing oral disease in child care is the proper storage and labeling of children's toothbrushes. Toothbrushes can become contaminated with blood and saliva, both of which can carry disease. Common sense as well as good hygiene practices should be used in caring for and using toothbrushes. The CDC offer the following recommendations for the use and care of toothbrushes in child care facilities:

- Each toothbrush should be clearly marked with a child's identification. The sharing and borrowing of toothbrushes should not be permitted.
- Toothbrushes should be allowed to air-dry and stored so they are not in contact with one another. Paper cups should be used for rinsing, and should be disposed of properly.
- If a toothbrush should become contaminated through contact with another brush or child, it should be discarded or sanitized in a dishwasher.
- Tooth brushing should be supervised by an adult to insure that toothbrushes are handled properly (CDC, 2001d).

Concurrently, the *CFOC Standards* (2nd ed. 2002) state that children's toothbrushes should be personally labeled, stored so that they do not drip on each other, and separated from one another (bristles up, exposed to the air to dry, and without contacting any surface). The toothbrushes should be replaced when the bristles have lost their tone (approximately every three months). [5.095](#)

### ***Oral Health for Children with Special Needs***

Surveys report a higher incidence of untreated oral disease in children with special needs (Nowak, et al, 1995). Possible reasons are that oral health may have a lower priority in families where the child has other health needs, and some dentists are less willing to see

children with special needs. Moreover, some children with special needs may require medication, diets, or treatments detrimental to oral health. Others may have mental or physical abilities that complicate oral care. Factors to consider in meeting the oral health needs of children with special needs are:

- Physical limitations
- Medications
- Communication limitations
- Psychological obstacles
- Decreased saliva
- Inability to clean teeth
- Variations in teeth and jaw structures
- Difficulty in chewing or swallowing

Generally speaking, however, the oral health of children with special needs benefits from the same preventive approaches recommended for all children; namely, effective brushing and flossing, moderate snacking, adequate fluoride, regular professional cleanings, fluoride treatments, and sealants (AAPD, 1999g). Whenever possible, it is best for children with special needs in particular to be referred to a pediatric dentist. The education of these specialists includes care for children with special needs, and pediatric dental offices are designed to be physically accessible for special needs patients.

### ***Children's Access to Dental Care***

#### **a) Factors Affecting Access to Dental Care**

Since the early 1990s, low income parents and racial and ethnic minorities have identified access to oral health services as their number one child health concern (Jones, Tinanoff, Edelstein, Schneider, DeBerry-Summer, Kanda et al, 2000). A recent national study found that 66 % of children between the ages of 2-4 years had not had a dental visit during the preceding year (National Center for Education in Maternal and Child Health, 1998). The major barrier low income parents face in obtaining needed oral treatment for their children is lack of financial resources (National Center for Education in Maternal and Child Health, 1998). Other reasons include low numbers of dentists accepting Medicaid patients, lack of experience among general dentists in treating children, lack of pediatric dentists, long waiting periods for appointments, extensive travel time to appointments in rural areas, and parents and families lack of awareness about dental care needs (Edelstein, 2000; Jones, Tinanoff, Edelstein, Schneider, DeBerry-Summer, Kanda et al, 2000).

#### **b) Sources of Payment for Children's Dental Care**

##### **- Private Insurance**

Private dental insurance may be offered through employers or bought individually by families. However, only one fourth of all children under the age of eight have private dental insurance (National Center for Education in Maternal and Child Health, 1998). Many families cannot afford private

dental insurance, and their medical insurance does not cover preventive dental care.

Local and state health departments should be able to provide information on the following sources of payments for children's dental care:

- **Medicaid**

By federal mandate, all children under 21 who are enrolled in Medicaid are eligible for routine dental services. However, the extent of services offered may vary from state to state. Local and state health departments should be able to provide information on Medicaid coverage of children's dental care in your state/community.

- **State Children's Health Insurance Programs (SCHIP)**

Most states include dental services in their SCHIP programs. Detailed information on individual state programs is available online. Available at: <http://cms.hhs.gov/schip>. Accessed May 10, 2005.

As with Medicaid, local and state health departments should be able to provide information on SCHIP coverage of children's dental care in your state/community.

- **Community Sponsored Programs**

Some clinics, dental societies, nonprofit organizations, churches, dental schools, and private practitioners provide free or lower cost dental services to families in need.

## **The Role of the CCHC**

### **Education** [2.064-2.067, 3.011](#)

The CCHC should:

- a) Educate the child care provider on how to incorporate good oral health practices into the children's daily routine;
- b) Educate the parents and child care providers in the proper oral health care of their children, insurance and payment structures for care, and the availability of dentists willing to see young children;
- c) Educate the parents, children, and child care providers about easy oral disease prevention methods, understanding major oral health problems, how to respond to oral health emergencies, and ways to receive and pay for care;
- d) Remind parents to discuss their child's fluoride needs with their dentist to assure optimal protection. (With the increased use of home water filters and

bottled water among families, many children may no longer be receiving the appropriate amount of daily fluoride);

- e) Provide parents and child care providers with the knowledge they need to determine which dental professional is best able to meet their child's oral health needs;
- f) Help parents and child care providers educate dental professionals about ways to make children with special needs feel more welcome. (The county dental society may welcome a presentation on this topic at one of their regular meetings. Some suggested topics for presentation are:
  - inclusion of dental staff members who have worked with children with special needs,
  - removal of physical barriers in the dental office, and
  - special accommodations for the special needs child); and
- g) Encourage dental professionals to:
  - obtain as much information as possible about the special needs child's particular condition, including talking to the child's parents, day care providers, and health professionals; and
  - be more flexible and willing to modify traditional methods of prevention. For example, a child who has a cleft lip and/or palate may require collaboration with other health professionals such as speech therapists, orthodontists, nutritionists and physicians. Another child may have hemophilia and require extra precautions during dental procedures (Nowak, et al, 1995).

**Activity 1**

**Integrating Oral Health Education into Child Care**

Answer the following questions to complete the table below:

- (1) What oral health education needs do you think the CCHC should address? Please answer this question for the five audiences listed (children, parents, child care providers, health care providers, and community).
- (2) What oral health education resources (agencies, speakers, and materials) are available in your community to address these needs?

<b>Health Education Needs</b>	<b>Community Resources</b>
<b>Children:</b> 1.  2.  3.	
<b>Parents:</b> 1.  2.  3.	
<b>Child Care Providers:</b> 1.  2.  3.	
<b>Health Care Providers:</b> 1.  2.  3.	
<b>Community:</b> 1.  2.  3.	

### ***Assistance***

The CCHC should:

- a) Ensure that child care providers and parents work with the child's health care provider or dentist to set up a proper oral health exam schedule;
- b) Assist children and families of at-risk populations to receive needed oral health services;
- c) Ensure that child care providers have emergency contact information about each child's dentist, health care provider, parent, and medical/dental insurance;
- d) Check for dentists in the community who might be willing to be on call should a dental emergency occur;
- e) Identify a dental health professional to whom s/he may refer oral health questions and concerns that arise in the child care setting; and
- f) Recommend that a child see a dentist or pediatric dentist in the following instances:
  - if the child sustains an injury to his/her face, mouth or teeth,
  - if the child's teeth show discolorization. This is often a sign of tooth decay, and/or
  - if the child's teeth seem to be sensitive to cold or hot liquids or foods. This could also be a sign of tooth decay.(AAP, 2001b)

**Activity 2**

**Accessing and Utilizing Oral Health Resources**

*In the boxes below, fill in your contacts for state and local oral health resources. Please include full contact information (i.e. name, position, address, phone and fax number, etc.) for each category. (Do not rule out private dentists in your resource building of oral health contacts.)*

**Who are your local oral health contacts?**

**Who are your state oral health contacts?**

**Who is your state dental public health director?**

**Advocacy**

The CCHC should advocate for improvement in children's oral health care.

**Activity 3**

**Comparing Your State Regulations for Oral Health with CFOC Standards**

- (1) *Obtain a copy of your state laws pertaining to oral health in child care. Copies may be available from your State or County Health Department. You may also access your state information through the Internet at: National Resource Center for Health and Safety in Child Care and Early Education. Individual states' child care licensure regulations. Available at: <http://nrc.uchsc.edu/STATES/states.htm>. Accessed May 10, 2005.*
- (2) *Read CFOC standards [1.027](#) (p. 23), [3.010-3.011](#) (p. 89-91), [4.014](#) (p. 157), [5.095](#) (p. 227), and [5.151](#) (p. 250).*
- (3) *Using your Stepping Stones to Using Caring for Our Children, 2<sup>nd</sup> ed., Compliance/Comparison Checklist, check off whether your state regulations for oral health compare with the CFOC Standards. (Additional copies of this checklist can be downloaded at: <http://nrc.uchsc.edu/STEPPING/index.htm>.)*

**Activity 4**

**Identifying Improvements Needed in State and Local Oral Health Regulations**

*Using the information from the previous activity, identify and record any state or local regulations that could be improved.*

<b>What Improvements Are Needed In Your State Oral Health Regulations?</b>	<b>What Improvements Are Needed In Your Local Oral Health Regulations?</b>



## **Where to Find More Information**

American Academy of Pediatrics. Oral health links.

<http://www.aap.org/commpeds/dochs/oralhealth/stateMap.cfm>

American Academy of Pediatric Dentistry

<http://www.aapd.org/>

Bright Futures Project Georgetown University

<http://www.brightfutures.org/>

Center for Disease Control and Prevention; National Center for Chronic Disease Prevention and Health Promotion; Oral Health Resources. Children's oral health.

<http://www.cdc.gov/OralHealth/topics/child.htm>

Colgate Bright Smiles, Bright Futures

A Global Oral Health Initiative

<http://www.colgatebsbf.com/>

MCH Alert

<http://www.mchlibrary.info/alert/default.html>

This listserv announces Maternal and Child Health news from the political and policy arenas. Details on how to subscribe to the listserv are posted on the website.

National Institute of Dental and Craniofacial Research

National Institutes of Health

<http://www.nidcr.nih.gov/>

National Maternal and Child Oral Health Resource Center

Georgetown University

<http://www.mchoralhealth.org/>

U.S. Department of Health and Human Services. Administration for Children and Families. Administration on Children Youth and Families. Head Start Bureau. Head Start Dental Health Curriculum. Washington, (DC): U.S. Government Printing Office; 1994.

U.S. Department of Health and Human Services

Health Resources and Services Administration (HRSA)

HRSA Information Center

<http://www.ask.hrsa.gov>

*At homepage, select: Oral Health in left frame*

U.S. Department of Health and Human Services; U.S. Department of Agriculture. Nutrition and your health: Dietary guidelines for Americans. 5th ed. Home and Health Bulletin, 2000.:

<http://www.health.gov/dietaryguidelines/dga2000/document/frontcover.htm>

U.S. Environmental Protection Agency. Local drinking water information.

<http://www.epa.gov/safewater/dwinfo.htm>

**Toothbrush Information:**

Oral B

Oral-B Consumer Services

<http://www.oralb.com/home.asp>

Prophy Perfect, Inc.

<http://www.prophyperfect.com>

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<http://www.aapd.org/publications/brochures/content/babycare.html>. Accessed May 10, 2005.

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