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Healthy teeth: Building dental health awareness among Head Start parents using health education interventions

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Abstract

In the U.S and state of California, tooth decay is the most common chronic disease and concerning health issue among children. The Head Start program in Monterey County serves about 1, 245 children annually from birth to five years of age. One requirement is that children obtain dental health checkups every six months, and receive dental treatment, if needed, as part of adhering to California's dental periodicity schedule. Over the past years, an increase of failed dental health assessments was observed among many children enrolled in the program.

Obtaining and following through with treatment was an obstacle. The purpose of this capstone project is to identify dental health beliefs of parents using the health belief model. It is to inform parents of the severity of dental health issues through a dental health education class. The project was implemented in two Head Start sites: the Seaside Childhood Development Center and First Steps located in Salinas. Although no significant concerns or obstacles were identified coming from parents to ensure their children receive proper dental health at home, results from the dental health education class demonstrated parents gained awareness of dental health issues.

Keywords: *dental health, Head Start program, children, health education*

I. Agency and Communities Served

A. Agency, mission, and purpose

In 1964, the 36th president of the U.S, Lyndon B. Johnson declared "The War on Poverty" in his stated Union Speech (Office of Head Start, 2015). He gathered experts and doctors from John Hopkins and Yale University to develop a child development program that would aid disadvantaged and underprivileged communities of children and families (Office of Head Start, 2015). Through research, and studying poverty and educational effects, Head Start founders considered "culturally responsive" intervention strategies. The following year, the program launched during the summer serving more than 560,000 children and families (Office of Head Start, 2015). Furthermore, in 1998 and 2007, Headstart was reauthorized to expand full-day and full-year services, serving millions of children and their families in all 50 states, the District of Columbia, and Puerto Rico (Office of Head Start, 2015).

In 1965, Head Start in Monterey County, a public-agency, started in Castroville serving 100 children and families (Monterey County Office of Education [MCOE], n.d). By 1972, the number of residents served increased from 300 to 1,245 in 2009 (MCOE, n.d). Throughout its forty years of service, it has reached and educated over 30,000 children and families (MCOE, n.d). The Monterey County Office of Education, Head Start program's mission in partnership with the community, "is to provide the highest quality early childhood education and comprehensive child and family services to all children" (MCOE, n.d). Its vision is to be, "Recognized as leaders in research-based early childhood education and family development, we provide high-quality, comprehensive, seamless services based on community assessments and the individual needs of families" (MCOE, n.d). Head Start values include being committed to providing a safe, respectful, and engaging environment (MCOE, n.d). They extend opportunities for children's growth and their families. They promote and practice healthy eating and lifestyle principles (MCOE, n.d). Head Start guiding principles include representing Head Start with utmost integrity, professionalism, accountability, and honesty. Lastly, the program's leaders collaborate as a team and family to learn from mistakes (MCOE, n.d).

B. Communities served**General population data.**

In 2014, about 25% of children age five and under in Monterey County were eligible for Head Start, which is a total of 10, 122 children. Of those eligible, Head Start served 12.3% of the 25%. Most children served are predominately Hispanic/Latino with 96% making up Head Start and 86% Early Head Start. Moreover, 71% of Head Start families identify Spanish as the primary language spoken at home, while 65% of Early Head Start families recognize it as a language spoken at home. Single parent households made up 37% of Head Start families.

Children health data.

The health and safety services of Head Start allows children's health to be examined yearly for preventative and primary care. Children are made sure they have health insurance, immunizations, and that their health histories are reviewed. Head Start addresses health concerns that are also evident throughout Monterey County. The percentages of children in Monterey County who experienced "delayed health care" and "did not receive care" rose from 7.2% in 2005 to 11.8% in 2013 (Kids Data, n.d). Moreover, from 2010-2014, about 7.7% of children ages 0-5 were uninsured, meaning they had no health insurance. Of those uninsured, 10% of them were Hispanic/Latino (Kids Data, n.d). In 2015, approximately 5% of kindergartners had immunization exemptions because of personal beliefs and other unknown reasons (Kids Data, n.d). In all, Monterey County children had 18.1% of "fair" and "poor" health (California Health Interview Survey [CHIS], n.d).

Some areas of concern include the dental and nutritional assessments. Child obesity and a poor lack of dental hygiene are evident among Head Start children (A. Suarez, personal communication, March 8, 2016). Reasons for this is because of habits children develop at home. Most children, especially among Hispanic/Latino households, which is the largest ethnic population Head Start serves, have unhealthy food eating habits and inadequate dental care (A. Suarez, personal communication, March 8, 2016)

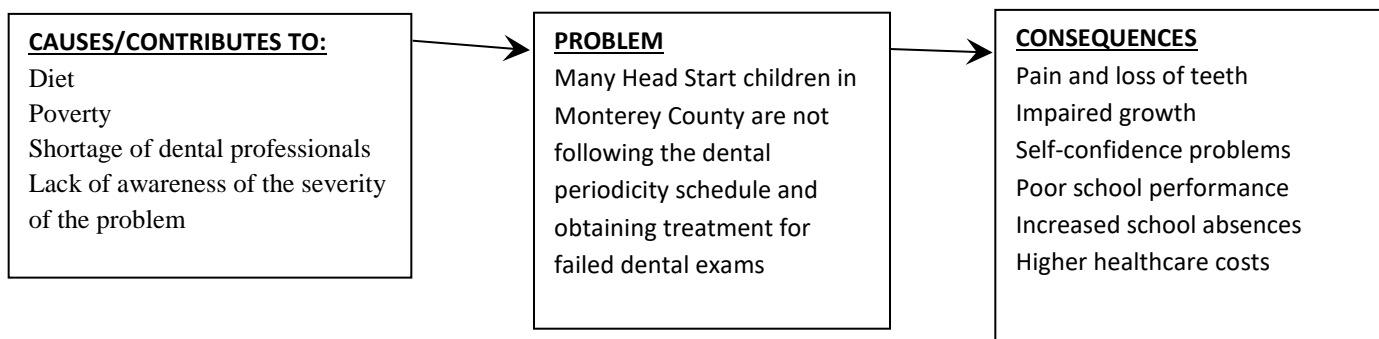
II. Dental Health Problem Issue and Need

Problem definition and description at large

Reasons for untreated dental decay are attributed to several factors including diet, barriers to accessing dental health services, shortages of dental professionals, and lack of awareness of the severity of the problem. Monterey County's general education attainment compared to the state was 71 percent vs. 81 percent (Dientes Community Dental [DCD], 2016). Having lower levels of education is associated with having no regular dental care check-ups according to a report by Dientes Community Dental. Research shows that low-income families have poorer dental care compared to the general population (DCD, 2016).

Monterey County holds a large population of agricultural workers than other counties in California. It is reported that agricultural workers have a worse level of dental health compared to the general population because of financial barriers and accessibility to health care (DCD, 2016). If a family struggles financially, a child's parent might not have the resources for it, or they might have developed poor dental hygiene habits growing up, and as a result, parents have not practiced nor enforced it among their children (DCD, 2016). Lastly, the shortages of dental professionals contribute to poor dental health. The 2013 Monterey County Community Health Assessment states that the Dental Health Professional Shortage Areas (HPSA) are based on a dentist to population ratio of 1:5,000. Two areas in Monterey County fall under the dental health professional shortage areas, primarily in the "Southern Coast and South County." Dental health is essential in a child's early developmental stages because it contributes to their overall health. If dental problems are left untreated due to cavities or gum disease, it can cause a child to experience "pain, loss of teeth, impaired growth, sleep and speech issues, self-confidence problems, poor school performance, and increased school absences" (Kids Data, 2014). If conditions worsen, they can become hospitalized and require anesthesia for procedures needed, which can be costly (CDA, n.d).

Figure 1. A model illustrating the causes, problem, and consequences of dental decay.



Dental Health among Head Start Children

Problem Statement

Head Start children in Monterey County have high rates of not adhering to the dental periodicity schedule, and obtaining treatment for failed dental exams (A. Suarez, personal communication, April 19, 2017).

Figure 2. The following chart demonstrates the percentage of children who received dental treatment, who needed treatment and did not receive treatment.

2016		2017	
71%	children who received a dental exam	76%	children who received a dental exam
18.9%	needed treatment	19.3%	needed treatment
14.2%	received treatment	17.1%	received treatment
4.7%	did not receive treatment	2.2%	did not receive treatment

The periodicity schedule states that all children between 3 to 10 years of age need to visit the dentist every six months to maintain good dental health to prevent caries or gum disease (California Department of Health Care Services [CDHCS], 2016). Head Start follows the periodicity schedule and requires all children in the program to provide proof of visiting the dentist twice a year. At the beginning of the program, parents are required to bring in a physical form filled by a physician. The physical form has a dental part to it which explains if a child either needs further dental treatment or does not. If the child receives an II or III classification, the child has caries or other dental problems. Moreover, Head Start workers see obtaining treatment the second time as an obstacle when asking parents to retake their child to the dentist.

Capstone Project Description and Justification

Project title: Building awareness among Head Start parents to lower the number of failed dental health assessment using the health belief model and health education interventions.

Project, purpose, and justification.

The project is a health education intervention, and the purpose is to identify dental health beliefs, and to build awareness among parents on the severity of dental health issues. The goal is to gain a better understanding of the health beliefs parents have regarding dental health, whether that is socio-economical, cultural, or if other contributing factors might inhibit them from enforcing dental practices at home for their children. It is to build an awareness and to provide knowledge and skills to head start parents on the importance of reinforcing healthy dental skills for good dental health.

In addition to the project's purpose, parents received an overview of the steps Head Start takes to ensure children have healthy teeth including explaining what the teachers and the Family Service Advocates (FSA's) do for the children, the periodicity schedule Head Start follows, and the purpose and safety of sedation. The project's results provide suggested intervention strategies and methods for future Head Start children and parents. It will better serve children and families since Head Start's mission is to provide not just the highest quality early childhood education, but "comprehensive" child and family services. This project provides Head Start's program to grasp a better understanding of health behaviors and actions potentially affecting the number of failed dental health assessments.

Evidence-based.

As reported by a Head Start community-focused oral health education and care, ways in which Head Start has addressed this health issue nationally is by, "extending oral health

education, distributing oral hygiene supplies, and dental health services for children and families" (Administration for Children and Families [ACF], p. 39, 2008). Specifically, it has been delivered in forms of presentations, workshops, parent training, and dental fairs-- where health professionals are present offering teeth cleaning and other services (ACF, 2008).

Moreover, in a telephone interview recording 52 Head Start sites nationally or referred to as the study mentions "grantees," 92 percent provided some oral health education for parents. The main topics covered were how they would cater educational messages to parents and the approaches they would best take to reach them. Furthermore, the six most common messages to health education intervention included, " (1) the importance of children's oral health to development and systemic health; (2) causes of oral disease and emphasis on their infectious nature; (3) early detection of oral health problems through visual inspection, such as the "Lift the Lip" method; (4) what to expect at the dental office; (5) oral hygiene instruction; and (6) the importance of oral health prevention for the entire family" (ACF, p. 39, 2008). What was also included were culturally-sensitive approaches to health education such as presenting information and providing handouts that covered the language most parents spoke (ACF, 2008).

Supplemental.

Over the past two years, a substantial amount of Monterey County Head Start children have failed to obtain dental health exams. In 2016, 793 children got a dental exam, making that 71 percent of all children who received it (A. Suarez, personal communication, May 2017). Out of those who got an exam, 150 needed dental treatment. And from those who needed dental treatment, 113 of those received treatment. The 37 children who didn't get dental treatment could have had worse dental outcomes that impact overall health (A. Suarez, personal communication, March 8, 2017). However, this year's outcomes were better, with 895 children receiving a dental

exam making that 76% of all children who received one (A. Suarez, personal communication, March 8, 2017). Out of the 895 children, 173 needed treatment, and 153 of them received it, meaning that 20 children did not get any treatment (A. Suarez, personal communication, March 8, 2017).

Project Implementation

The project was carried out by a collaboration of current workers at Head Start including the Health and Safety Coordinator, Family Service Advocates from the Seaside Child Development Center (SCDC) and First Steps site in Salinas, and teachers. Next, a dental health specialist from the Central Coast Pediatric group was involved, presenting the importance of dental health to both sites. Post surveys were distributed at the end of the presentations. Detailed implementation methods and scope of work is in appendix D.

III. Project Results

Assessment of the Project Outcomes

A. Expected outcomes.

The first expected outcome was achieved through a dental health education class, and its effectiveness was measured using a post-survey. Similarly, the second expected outcome measured the dental health belief survey given after each dental health education class. The post-surveys were then analyzed using excel. The following are the anticipated outcomes:

1. to build awareness and reinforce positive behaviors for dental health change among Head Start parents
2. to understand parent's dental health beliefs at the end of the project and identify obstacles, and provide recommendations

B. Assessment plan.

The dental health belief post-survey was composed of five questions stemming from the health belief model, which studies six components that explain people's health behavior action and ability to act (National Cancer Institute [NCI], 2005). From the six, five were chosen to study parents dental health beliefs. The following is what each questioned measured:

(1) **Perceived susceptibility** is the beliefs about the chances of children being at risk of getting caries if they do not brush their teeth regularly (NCI, 2005).

(2) **Perceived severity** measured if parents believed that not receiving dental treatment can result in children experiencing pain, loss of teeth, impaired growth, and sleep and speech issues.

(3) **Perceived benefits** are beliefs about the effectiveness of taking action to practice good dental habits for life (NCI, 2005).

(4) **Perceived barriers** refer to any challenges and obstacles faced by the population that prevents them from making sure their child has good dental health at home.

(5) Lastly, **self-efficacy** refers to an individual's confidence in their ability to take action to ensure their children brush his or her teeth daily and take their children for dental check-ups (NCI, 2005).

The second post-survey was used to assess the learning that took place in the health education class. The survey came from the Head Start program distributed among all Head Start sites for evaluation of a class or meeting. Questions in the assessment were yes/no, and open-ended questions that asked parents what they learned, what they liked most about the

presentation, if the presentation was efficient and precise in learning skills to take home for their child, and suggestions for improvement for any future head start presentations. The evaluation questions also included a happy, neutral, and sad face that parents had to circle on how they felt about the presentation.

Project Results and Findings

A. Expected outcome results.

The health belief survey was distributed in both Head Start sites. In the Seaside Childhood Development Center (SCDC), 15 parents took the survey, and in First Steps 18 parents took it. The purpose of the health belief model in both sites achieved its outcomes, which was to understand parent's dental health beliefs. However, according to survey results, no major factors or barriers were identified in either site, except one parent. One parent identified having a lack of health insurance as a barrier. Parents received four Likert scale questions to allow them to express how much they agree or disagree with a statement. Most parents either "Strongly Agreed" or "Agreed" with the Likert scale questions 1, 2, 3, and 5. Overall, parents were aware of the susceptibility of their children getting caries, the severity of poor dental health, and the benefits of having good dental health. Parents felt confident in ensuring their child properly brushes their teeth daily for good dental health. Question number four was a multiple choice and open-ended question. Results from the fourth question among both sites demonstrated that most parents were not facing any barriers to ensuring their child has good dental health.

Figure 3. A visual representation of the dental health belief post-survey results in the Seaside Childhood Development Center for questions 1, 2, 3, and 5:

	Strongly Agree	Agree	Don't Know	Strongly Disagree	Disagree
1) A child who doesn't brush their teeth regularly is at risk of getting caries	15				
2) Children who have caries and don't receive treatment can experience pain, loss of teeth, impaired growth, sleep and speech issues	14		1		
3) Children who brush and floss teeth are more likely to brush and floss as they get older	13	2			
5) I feel confident on properly ensuring my child brushes his or her teeth daily	13	1	1		

Figure 4. A visual representation of the dental health belief post-survey results in First Steps located in Salinas, questions 1, 2, 3, and 5:

	Strongly Agree	Agree	Don't Know	Strongly Disagree	Disagree
1) A child who doesn't brush their teeth regularly is at risk of getting caries	18				
2) Children who have caries and don't receive treatment can experience pain, loss of teeth, impaired growth, sleep and speech issues	17	1			
3) Children who brush and floss teeth are more likely to brush and floss as they get older	16	2			
5) I feel confident on properly ensuring my child brushes his or her teeth daily	18				

Figure 5. A visual representation of the dental health belief post-survey question #4 results for SCDC and First Steps:

4) What are some barriers that prevents you from making sure your child has good dental health?		
	SCDC	First Steps
a. They are too young and don't have enough teeth yet		
b. A lack of insurance		1
c. I don't have enough time		
d. I haven't found a dentist in the area		
e. I don't face any barriers	6	13
f. I don't want my child receiving sedation		
g. none	8	3
h. other	1	1

The second evaluation post-survey to measure the effectiveness of each dental health education class was only distributed in the First Steps, Salinas location since the dental health specialist from the CCPD was not able to present at the Seaside Childhood Development Center (SCDC). Nonetheless, results demonstrated that all 18 parents from First Steps rated the presentation with a happy face, meaning they were satisfied with the presentation. All parents said the information was clear, and that they had gained practical skills to take home for their children since they understood the importance of dental health risks and concerns. From the 18 that attended, ten parents filled out the short answer responses saying that they liked the information given to them about dental health, the importance of it, and its helpfulness in learning ways to help their child at home. The other 8 left the question blank.

B. Strengths and Successes

Both surveys achieved its outcomes by identifying dental health beliefs and building the importance of dental health awareness among parents. Other strengths included doing surveys in English and Spanish. Majority of parents responded the surveys in Spanish for both sites. All

parents stayed throughout the end of presentations and asked questions at the end. The dental health belief questions were also framed to provide awareness of the consequences of having poor dental health. It could have moved parents successfully in understanding the dental health belief questions. Moreover, past research was taken into consideration for suggestions on how to frame the health belief questions to demonstrate, "(1) the relation of attitudes, motives, and beliefs to subsequent behavior; (2) the effects of changing certain attitudes and beliefs on dental behavior; and (3) the effect of changing dental behavior on attitudes and beliefs" (Kegeles and Hafner, 1974, p.3). The second evaluation form, given in only one location, had open-ended questions so parents can express what they thought or felt about the presentation, and suggest ways it can improve.

C. Limitations/Challenges

Limitations and challenges varied among both sites. In the SCDC site, parents received information on what Head Start does for their children throughout the program. They did not have a presenter from the Central Coast Pediatric Group since there was a last-minute cancellation. As a result, they only received the dental health belief survey. The second anticipated outcome was not achieved on this site. However, the first expected outcome was obtained to measure their dental health beliefs. Another limitation was that these two sites were not sites that had high rates of failing dental health assessments.

On the other hand, parents in the First Steps received a dental health education class by a CCPG dental health specialist. Therefore, two surveys were distributed for this site. As a result, the two anticipated outcomes were achieved. Other limitations of this project include not measuring the additional information given to parents at the beginning of each dental health

education class. All parents received information explaining what the teachers and FSA's do for the children's dental health, the periodicity schedule, and the purpose and safety of sedation.

IV. Personal Reflection and Final Thoughts

Conclusion/Interpretation

The project carried out two objectives: understanding dental health beliefs and building dental health awareness among parents. Although no major concerns were identified based on the dental health belief survey, the second objective should be continued. The presentation given by the Central Coast Pediatric Group provided parents on the importance of dental health and how to properly ensure their children are caring for their children's teeth at home. Also, what is recommended is to make dental health education one of the first presentations given to parents at the beginning of the program since children are required to visit the dentist twice a year. What is also recommended is explaining to parents during any future dental health education classes what Head Start does for their children's dental health throughout the program, and why. This includes what the FSA's do on behalf of children, California's dental periodicity schedule Head Start adheres to, and why Head Start requires for them to go twice a year. Lastly, what should also be included is the information on the purpose, procedures, and safety of sedation in the case their child needs extensive dental treatment. By providing a dental health education class at the beginning of the program, parents will be more aware of the susceptibility and severity of dental decay, and hopefully be more involved in their child's dental health at home.

Personal and Professional Growth

In this project, I learned that the problem is bigger and more complicated than I thought. Dental health in children is important to the point if it is not taken care of, children can have

other serious health effects. I learned that the problem at a state and county level varies, depending on the geographic location and a family's socioeconomic situation. Among Head Start's population in Monterey County, most families are of Latino descent and low-income which means these are factors to study and consider when serving them. For example, taking into consideration how this population views and practices dental health.

Moreover, since diet is a factor that determines a person's dental health, a population's food and customs are important to consider when doing research and implementing a project. Coming from a Latino-low income background, I could understand most of the population served, which gave me insight on how to address this concern among Head Start children and parents. However, I had to put aside my own biases regarding dental health among a low-income population because I grew up in a different geographic location than the population served. The contribution it made to the agency was to investigate and examine any underlying health beliefs and concerns coming from parents to ensure their children receive proper dental health services and practice good dental health at home. The project also provided reachable suggestions/improvements for the agency.

Broader social significance

In a broader perspective, dental health problems are rooted in socio-economic disparities such as a lack of money, a lack of knowledge in accessing services, and language barriers. For this dental health problem among Head Start children, my project explored if there were any socio-economic disparities that parents and children faced, since big, scaling problems usually begin small, and are profound, which reveal other complications.

Other suggestions to combat this problem are one-on-one interventions among those children who have ongoing dental health problems, especially in Head Start sites who have this

problem continually. Other ideas include monitoring a child's health and the parents who receive a health intervention whether that is one-on-one or through a dental health education class. The reason for one-on-one interventions is because each family may face different obstacles and have different concerns.

To future Head Start interns: my advice includes making sure to find a problem to address that you are interested in and that it is a subject that is an ongoing concern/need among Head Start children and families. Second, I recommend collaborating among different Head Start workers to address the problem to implement the project, such as the Family Service Advocates and Health and Family Specialists. Lastly, I'd recommend exploring other ideas and possibilities on how to address the problem as early as possible by researching what other scholars have done while giving your project a touch of your creativity.

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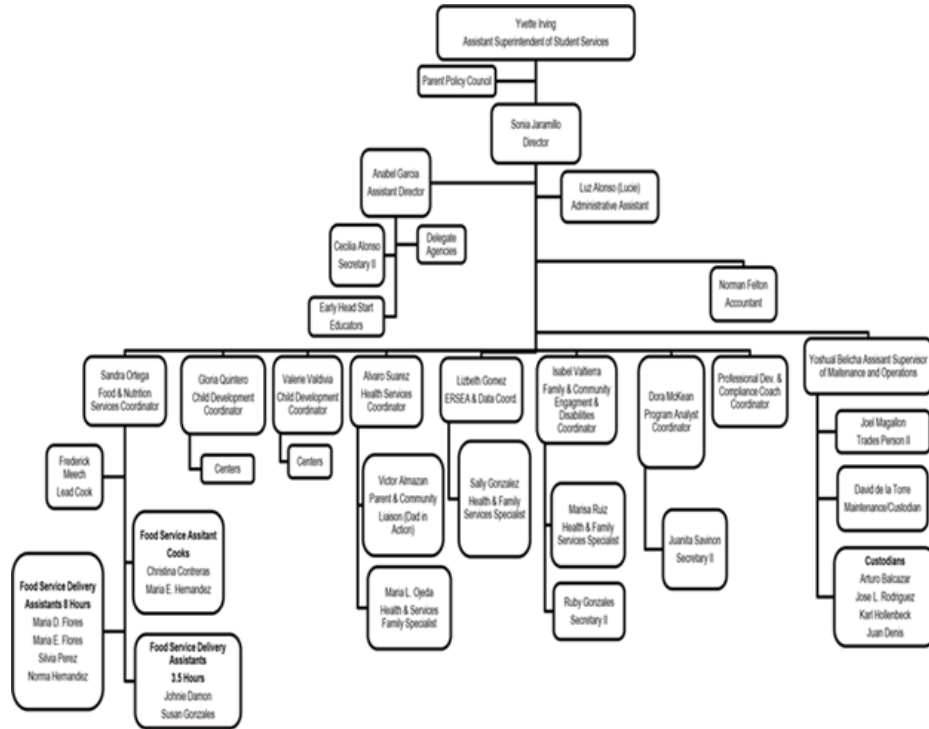
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VI. Appendices

Appendix A: Organizational Chart



Appendix B: Planning Questions

1. What data aside from Child Plus will I need? (i.e., interviews, additional county and population data)
2. What are some major limitations Head Start has addressed when intervening to better dental health outcomes?
3. What are other powerful health initiatives that have helped reduce dental decay among children?
4. Is there a health belief and practice (i.e., culture) that is affecting the child's health related to the identified health concern?

5. What are some core strengths and assets Head Start children and families have that will help them achieve stronger health outcomes?

Appendix C: Scope of Work

Activities	Deliverables (items)	Timeline	Estimated completion dates
1. Introduction to sites and interaction with parents (Seaside Child Development Center, 4, 5, 6, Salinas: First Steps 1 and 2	none	August 21-31	August 31
2. Make surveys and gain approval	Approved survey	September 1-14	September 14
3. Prepare logistics- curriculum, presentation, agenda and activities	location, handouts	September 1-20	September 20
4. Contact stakeholders: FSA's, health specialists, dental hygienist	none	September 1	September 21
5. Health Education Workshop	Classrooms, presentations	October 24- November 8	November 8

6. Analyze evaluation	spreadsheets/ charts/graphs	November 8- 18	November 18
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Appendix D: Surveys

Appendix D (1)

Please circle one

1. A child who doesn't brush their teeth regularly is at risk of getting caries

Strongly agree / agree / don't know / disagree / strongly disagree

2. Children who have caries and don't receive treatment can experience pain, loss of teeth, impaired growth, sleep and speech issues

Strongly agree / agree / don't know / disagree / strongly disagree

3. Children who brush and floss teeth are more likely to brush and floss as they get older

Strongly agree / agree / don't know / disagree / strongly disagree

4. What are some barriers that prevent you from making sure your child has good dental health?

- a. They are too young and don't have enough teeth yet
- b. A lack of insurance
- c. I don't have enough time
- d. I haven't found a dentist in area
- e. I don't face any barriers
- f. I don't want my child receiving sedation
- g. None
- h. Other: _____

5. I feel confident in properly ensuring my child brushes his or her teeth daily

Strongly agree / agree / don't know / disagree / strongly disagree

Appendix D (2)

Por favor circule uno

1. Un niño que no se cepilla los dientes con regularidad está en riesgo de contraer caries
Estoy de acuerdo / Más bien sí / Sin opinión / No estoy de acuerdo / Más bien no

2. Los niños que tienen caries y no reciben tratamiento pueden sufrir de dolor, pérdida de dientes, crecimiento deteriorado, problemas para dormir y hablar

Estoy de acuerdo / Más bien sí / Sin opinión / No estoy de acuerdo / Más bien no

3. Los niños que cepillan y usan hilo dental son más propensos a cepillarse y usar hilo dental cuando crezcan

Estoy de acuerdo / Más bien sí / Sin opinión / No estoy de acuerdo / Más bien no

4. ¿Cuáles son algunos obstáculos que le impiden asegurarse de que su hijo tenga buena salud dental?

- a. Son demasiado jóvenes y no tienen suficiente dientes todavía
- b. Falta de seguro medico
- c. No tengo tiempo suficiente
- d. No he encontrado un dentista cerca de donde vivo
- e. No me enfrento a ningún obstáculo
- f. No quiero que mi hijo reciba sedación
- g. Ninguna
- h. Otro: _____

5. Me siento seguro de asegurarme adecuadamente que mi niño se cepille los dientes diariamente

Estoy de acuerdo / Más bien sí / Sin opinión / No estoy de acuerdo / Más bien no

Appendix D (3)

Head Start Parent Evaluation

Center/Centro: _____

Date/Fecha: _____

Topic/Tema: _____

Please check the face that expresses your opinion about the training/meeting:
Por favor escoja la cara que exprese su opinion acerca el entrenamiento/junta:



- 1. Was the information clear? Yes No
 Fue clara la información? Si No

- 2. What did you like most about the training/meeting?
 Qué fue lo que más le gusto del entrenamiento/junta?

- 3. Was the training/meeting effective in your understanding to help your child more?
 Fue efectiva el entrenamiento/junta en su comprensión para ayudar más a su hijo?

- 4. Do you have any suggestions to improve the training/meeting?
 Tiene usted alguna sugerencia para mejorar el entrenamiento/junta?

Comments/Comentarios: _____

