Promoting Healthy Smiles Through Education & Prevention

Preventive Services Program

Final School Year Report

2018-2019
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What is PSP?

The Missouri Oral Health Preventive Services Program (PSP) was created by the Missouri Department of Health and Senior Services (DHSS) to help children with various oral health needs. The program is operated under the guidance of the State Dental Director, and carried out by the Office of Dental Health. The program is coordinated with five regional oral health consultants, all of whom are Registered Dental Hygienists. The consultants support their regions by promoting oral health care at; daycares, schools, head start centers, preschools, health clinics, and other settings where children are present. The consultants facilitate the ordering of PSP supplies for events, all of which are funded through the Office of Dental Health, including:

- Technical Assistance
- Offering DHSS Educational Materials
- Providing Oral Health Supplies (Toothbrushes, Floss, Toothpaste)
- Providing Oral Health Screening Supplies (Disposable Mouth Mirrors and Screening Forms)
- Fluoride Varnish
- Online Calibration for Registered Dental Professionals Who Perform Oral Screenings, as well as Online Training for Parents and Volunteers Who Apply Fluoride Varnish

One of the main reasons for PSP’s success is the community-based aspect. If it were not for the engagement and interest from the school nurses and others promoting the program, this program may not have the level of success it has gained over the last few years. Local volunteers include dentists and hygienists who provide the screenings, and volunteers and parents who help apply the fluoride varnish.
Figure 1: Map of PSP Participants

Number of Participants

- **1-100**
- **101-250**
- **251-500**
- **501-1000**
- **1000-5000**
- **Over 5000**
- **None**
Oral Health Care is a growing concern in the United States for a number of reasons. Chronic oral health problems can be precursors to more serious heart and lung diseases, they can be symptoms of serious viral infections such as HIV and Herpes, and they can also cause more serious health issues such as severe bacterial infections. The Oral Health in America: A Report of the Surgeon General defined a four pronged approach to combating oral health issues in America:

1. oral health means much more than a healthy teeth;
2. oral health is integral to general health;
3. safe and effective disease prevention measures exist that everyone can adopt to improve oral health and prevent disease; and
4. general health risk factors, such as tobacco use and poor dietary practices, also affect oral and craniofacial health.¹

Since the Missouri Preventive Services Program (PSP) focuses on children, this report will focus on how oral health impacts children only. Studies have shown that children with dental pain and poor oral health often miss school and have difficulties with speaking, eating, and learning.¹ More than 51 million school hours are lost each year due to children having a dental related illness.¹ Even more concerning, children aged 5-17 years old are 5 times more likely to have had at least one cavity or filling than a reported history of asthma.¹

- 51.6% of Children ages 5-9 have had at least one cavity or filling in the coronal (crown of tooth) portion of their primary or permanent teeth.¹
- 77.9% of children age 17 have had at least one cavity or filling in the coronal (crown of tooth) portion of their primary or permanent teeth.¹
- 84.7% of individuals ages 18 and older have had at least one cavity or filling in the coronal (crown of tooth) portion of their primary or permanent teeth.¹
There were a total of 91,384 participants in the Preventive Services Program (PSP) for the 2018-2019 school year.

Figure 2: Total PSP Participants by School Year
Demographics of PSP Participants

PSP events are mostly held in school settings. Due to the timing of these events being held during the school year months, it is easier to categorize children based on their school type rather than their specific grade level.

Similar to previous years, the bulk of students seen are Elementary School aged students.

**Tabel 2: Total Number of PSP Participants by Grade Level**

<table>
<thead>
<tr>
<th></th>
<th>Preschool</th>
<th>Kindergarten</th>
<th>Elementary School</th>
<th>Middle School</th>
<th>High School</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9,607</td>
<td>12,138</td>
<td>57,992</td>
<td>7,953</td>
<td>1,970</td>
</tr>
</tbody>
</table>
PSP Participants by Gender

There were 1,923 more male students than female participants. The split between the genders has increased compared with 2017-2018 report.

Figure 4: PSP Participants by Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>46492</td>
<td>51%</td>
</tr>
<tr>
<td>Female</td>
<td>44569</td>
<td>49%</td>
</tr>
</tbody>
</table>

Table 3: PSP Participants by Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Percent</th>
<th>Female</th>
<th>Percent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years old</td>
<td>9362</td>
<td>20.6%</td>
<td>8728</td>
<td>20.00%</td>
<td>18090</td>
</tr>
<tr>
<td>6-12 years old</td>
<td>33949</td>
<td>74.6%</td>
<td>32867</td>
<td>75.30%</td>
<td>66816</td>
</tr>
<tr>
<td>13 years and older</td>
<td>2213</td>
<td>4.9%</td>
<td>2048</td>
<td>4.69%</td>
<td>4261</td>
</tr>
<tr>
<td>Total</td>
<td>45524</td>
<td></td>
<td>43643</td>
<td></td>
<td>89164</td>
</tr>
</tbody>
</table>
The 6-12 year old age group has the highest number of participants among both genders. The second highest number of participants were in the 0-5 age group category, and the last was in the 13 years and older group.

**Figure 5: Age Group by Gender**

The 6-12 year old age group has the highest number of participants among both genders. The second highest number of participants were in the 0-5 age group category, and the last was in the 13 years and older group.

**Table 4: PSP Participants by Race/Ethnicity Totals**

<table>
<thead>
<tr>
<th></th>
<th>African-American</th>
<th>Asian/Pacific Islander</th>
<th>Hispanic</th>
<th>Other</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7498</td>
<td>1349</td>
<td>3785</td>
<td>4868</td>
<td>72717</td>
</tr>
</tbody>
</table>
A majority of participants were identified as “White”. The category “Other” includes all categories the screeners have identified as “Unknown Non-White”, “American Indian”, and “Mixed-Race”.

Of the 115 counties in Missouri, students were screened from 109 of them. Ninety-six of them are designated as rural counties and 14 are designated as urban counties. There are 5.6% more PSP participants in rural counties than urban ones.

**Table 5: Geographic Distribution of PSP Participants**

<table>
<thead>
<tr>
<th>Designation</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>48,260</td>
</tr>
<tr>
<td>Urban</td>
<td>43,124</td>
</tr>
</tbody>
</table>
There are 12 counties in Missouri without a licensed dentist with a local address in these counties: Caldwell, Holt, Mercer, Monroe, Oregon, Ralls, Reynolds, Ripley, Shannon, Sullivan, Wayne, and Worth. All 12 counties had PSP participants. However, the number of children in these counties combined accounted for only 2% of all PSP participants.
Oral Hygiene of PSP Participants

Poor oral hygiene is defined by moderate to heavy plaque on the teeth with red gums and tissue. Male 13 years and older were more likely than females of any age group and males in the other two groups to have poor oral hygiene. The group with the highest percent of good oral hygiene was female ages 0-5 years old.

Figure 9: Poor Oral Hygiene by Age Group and Gender
The highest percent of poor oral hygiene was detected in children whose race was marked as “Other.” The second highest group was children marked as “Asian/Pacific Islander.”

Figure 10: Poor Oral Hygiene by Race/Ethnicity

Urban children had a higher percent of children with poor oral hygiene (25%) compared to rural children (19.0%). Rural children had a higher rate of good oral hygiene (81%) compared to urban children (75%).

Figure 11: Oral Hygiene by Geography
Children who lived in a county with at least one dentist had a higher rate of poor oral hygiene (21.8%) than children in counties with no dentist (16.2%).
Dental sealants are a clear plastic coating that are applied to the chewing surface of permanent molars to help prevent cavities. Once a permanent molar erupts, it is best to have a dental staff member apply sealants as soon as possible. Typically, around the age of 7 is when the first permanent molar will erupt, and age 10 is when the second permanent molar erupts.

Unfortunately, there were more children screened that did not have dental sealants than those that did. However, among those that had sealants, female ages 6-12 years old were more likely to have had their teeth sealed than males in both age groups.

Figure 13: Dental Sealants by Gender and Age
Hispanic children had the highest percent of dental sealants, and African-American children had the lowest.

Children in urban counties were 3% more likely to have dental sealants than those in rural ones.
Children who resided in counties with at least 1 dentist had higher percent of sealants present compared with children who resided in counties with no dentist.

Figure 16: Dental Sealants by Number of Dentists
Treated Decay of PSP Participants

Treated tooth decay is apparent by the number of fillings recorded on the teeth (either primary or permanent) during the screening. Primary teeth are more colloquially referred to as baby teeth.

Tabel 7: Treated Decay by Gender and Tooth Type

<table>
<thead>
<tr>
<th>Treated Decay by Tooth Type</th>
<th>Male</th>
<th>Percent</th>
<th>Female</th>
<th>Percent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent Only</td>
<td>1919</td>
<td>6.5%</td>
<td>2014</td>
<td>6.8%</td>
<td>3933</td>
</tr>
<tr>
<td>Primary and Permanent</td>
<td>2121</td>
<td>7.2%</td>
<td>1946</td>
<td>6.6%</td>
<td>4067</td>
</tr>
<tr>
<td>Primary Only</td>
<td>11465</td>
<td>38.8%</td>
<td>10056</td>
<td>34%</td>
<td>21521</td>
</tr>
</tbody>
</table>

Males ages 6-12 year olds had the highest percent of total treated decay. The percent of treated decay were tied for both male and female children 0-5 year olds.

Figure 17: Treated Decay by Gender and Age Group

Male:
- 0-5 years old: 38% (male), 37% (female)
- 6-12 years old: 38% (male), 37% (female)
- 13 years and older: 38% (male), 37% (female)

Female:
- 0-5 years old: 35% (male), 35% (female)
- 6-12 years old: 35% (male), 35% (female)
- 13 years and older: 35% (male), 35% (female)
Table 8: Treated Decay by Race/Ethnicity and Tooth Types

<table>
<thead>
<tr>
<th>Treated Decay by Tooth Type</th>
<th>African-American</th>
<th>Asian/Pacific Islander</th>
<th>Hispanic</th>
<th>Other</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>5312</td>
<td>806</td>
<td>2348</td>
<td>62%</td>
<td>48869</td>
</tr>
<tr>
<td>Permanent Only</td>
<td>303</td>
<td>42</td>
<td>148</td>
<td>4%</td>
<td>3217</td>
</tr>
<tr>
<td>Primary and Permanent</td>
<td>296</td>
<td>79</td>
<td>186</td>
<td>5%</td>
<td>3188</td>
</tr>
<tr>
<td>Primary Only</td>
<td>1536</td>
<td>410</td>
<td>1078</td>
<td>29%</td>
<td>16990</td>
</tr>
</tbody>
</table>

Overall, children identified as “African-American” had the lowest percent of treated decay. Children identified as “Asian” and “Other” had the highest percent of treated decay.

Figure 18: Treated Decay by Race/Ethnicity
Rural and urban students had similar rates of treated decay during their screenings with rural children having slightly higher rates than urban children.

Counties that have no dentist have higher rates of treated decay than counties that have at least one dentist residing in the county.
Untreated Decay of PSP Participants

Untreated decay is determined during the oral screening when obvious decay is noted with a flashlight and disposable mouth mirror. Decay is caused by plaque, a sticky substance that forms on the teeth which causes a breakdown in the tooth’s enamel and eventually leads to cavity, also called decay, and can be found on a primary or permanent tooth.\(^2\)

**Table 9: Untreated Decay by Gender and Tooth Type**

<table>
<thead>
<tr>
<th>Untreated Decay by Tooth Type</th>
<th>Male</th>
<th>Percent</th>
<th>Female</th>
<th>Percent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent Only</td>
<td>1513</td>
<td>3%</td>
<td>1550</td>
<td>4%</td>
<td>3063</td>
</tr>
<tr>
<td>Primary and Permanent</td>
<td>1058</td>
<td>2%</td>
<td>1132</td>
<td>3%</td>
<td>2190</td>
</tr>
<tr>
<td>Primary Only</td>
<td>7307</td>
<td>16%</td>
<td>6330</td>
<td>15%</td>
<td>13637</td>
</tr>
<tr>
<td>None</td>
<td>35424</td>
<td>78%</td>
<td>34434</td>
<td>79%</td>
<td>69858</td>
</tr>
</tbody>
</table>

Male children had slightly higher rates of untreated decay on primary teeth. Untreated decay on permanent only and primary and permanent teeth was higher among girls.

Teenagers had the lowest amount of untreated decay, with females slightly better than males. 0-5 year old and 6-12 year old males had the highest percent of untreated decay, however it was only slightly more than females ages 6-12.

**Figure 21: Untreated Decay by Gender and Age Group**
### Table 10: Untreated decay by Race/Ethnicity and Tooth Type

<table>
<thead>
<tr>
<th>Untreated Decay Tooth Type</th>
<th>African-American</th>
<th>Asian/Pacific Islander</th>
<th>Hispanic</th>
<th>Other</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>5487</td>
<td>73.6%</td>
<td>973</td>
<td>72.6%</td>
<td>2799</td>
</tr>
<tr>
<td>Permanent Only</td>
<td>379</td>
<td>5.1%</td>
<td>39</td>
<td>2.9%</td>
<td>142</td>
</tr>
<tr>
<td>Primary and Permanent</td>
<td>302</td>
<td>4.1%</td>
<td>54</td>
<td>4.0%</td>
<td>118</td>
</tr>
<tr>
<td>Primary Only</td>
<td>1288</td>
<td>17.3%</td>
<td>275</td>
<td>20.5%</td>
<td>698</td>
</tr>
</tbody>
</table>

Overall, children identified as “White” had the lowest percent of untreated decay. Children identified as “Asian/Pacific Islander” had the highest percent of untreated decay for primary only tooth type. Children identified as “African American” had the highest percent of untreated decay among permanent only tooth type.

Figure 22: Untreated Decay by Race/Ethnicity
Table 11: Total Number of Untreated decay by Geography and Tooth Type

<table>
<thead>
<tr>
<th>Designation</th>
<th>None</th>
<th>Permanent</th>
<th>Primary and Permanent</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>38268</td>
<td>1863</td>
<td>1297</td>
<td>7906</td>
</tr>
<tr>
<td>Urban</td>
<td>33201</td>
<td>1353</td>
<td>955</td>
<td>6067</td>
</tr>
</tbody>
</table>

Children in rural counties had a higher rate of untreated decay than children in urban counties. However, children who lived in a county with no dentist had significantly higher rates of untreated decay.

Figure 24: Untreated Decay by Number of Dentists
One of the biggest services PSP offers is that parents and guardians are informed when a dental issue that needs immediate attention is detected during a screening. If a problem is detected, PSP organizers will provide referrals to local dental offices or clinics so the child can receive proper follow up. There are two classifications for need of treatment; early dental care and urgent dental care. Early dental care is recommended for injuries or conditions that need to be addressed within the coming months. Urgent dental care is recommended for injuries or conditions that need to be addressed immediately and typically recommended they be remedied within the next 24 hours.

**Figure 2.5: Treatment Urgency by Age Group**

<table>
<thead>
<tr>
<th>Age</th>
<th>Male None</th>
<th>Male Early Dental</th>
<th>Male Urgent Care</th>
<th>Female None</th>
<th>Female Early Dental</th>
<th>Female Urgent Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years old</td>
<td>78.4%</td>
<td>18.9%</td>
<td>2.7%</td>
<td>79.9%</td>
<td>17.3%</td>
<td>2.8%</td>
</tr>
<tr>
<td>6-12 years old</td>
<td>78.2%</td>
<td>18.3%</td>
<td>2.9%</td>
<td>78.9%</td>
<td>18.0%</td>
<td>2.8%</td>
</tr>
<tr>
<td>13 years and older</td>
<td>80.1%</td>
<td>17.6%</td>
<td>2.3%</td>
<td>83.8%</td>
<td>14.7%</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

Male Children Ages 0-5 years had the most referrals for early dental care. Male children ages 6-12 years had the most referrals for urgent care. Teenage girls had the lowest number of referrals for dental care among all age groups for both genders.
African-American children had the highest percent of students needing early dental care. Asian/Pacific Islander students had the highest percent of students needing urgent care. Overall, white students had the lowest percent for any treatment urgency.
Children living in rural counties had higher rates for treatment urgency referrals than kids in urban counties. Children living in counties with no dentist had a slightly higher rates for treatment urgency referrals than those residing in counties with at least 1 dentist.

*Figure 27: Treatment Urgency by Geography*

*Figure 28: Treatment Urgency by Dentist Availability*
Caries for PSP Participants

Dental Caries is one of the most common childhood diseases. Caries is the Latin word for “rotten.” Caries is just a more technical term for cavity. A cavity is a late manifestation of a bacterial infection. A cavity is the result of plaque forming over a tooth and dissolving the enamel. Plaque occurs when bacteria form a gelatinous film that adheres to the tooth’s surface. When plaque is considered cariogenic (causing decay) a single site on a tooth could have close to half a billion bacteria living there, including Streptococcal mutans. Once these bacteria are on the tooth, they begin to ferment sugars and carbohydrates that form lactic and other acids that lead to the eventual erosion of the enamel covering the tooth. Once that protective enamel layer is gone, the tooth begins to decay from bacterial infection.

In the 2018-2019 school year, males ages 6-12 had the highest rate of rampant caries. Females ages 13 years and older had the lowest rate of rampant caries.

**Table 14: Rampant Caries by Gender and Age Group**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Rampant Caries</td>
<td>Rampant Caries Present</td>
</tr>
<tr>
<td>0-5 years old</td>
<td>91.6%</td>
<td>8.4%</td>
</tr>
<tr>
<td>6-12 years old</td>
<td>90.6%</td>
<td>9.4%</td>
</tr>
<tr>
<td>13 years and older</td>
<td>96.5%</td>
<td>3.5%</td>
</tr>
</tbody>
</table>
Males aged 0-5 years old had the highest percent of childhood caries while teenage girls had the lowest childhood caries.

### Table 15: Early Childhood Caries by Age Group and Gender

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Childhood Caries</td>
<td>Childhood Caries</td>
</tr>
<tr>
<td>0-5 years old</td>
<td>89.2%</td>
<td>10.8%</td>
</tr>
<tr>
<td>6-12 years old</td>
<td>97.7%</td>
<td>2.3%</td>
</tr>
<tr>
<td>13 years and older</td>
<td>99.4%</td>
<td>0.6%</td>
</tr>
</tbody>
</table>
Children in rural counties had slightly higher percent of rampant caries and the highest percent of early childhood caries.
Children who were identified as “Asian/Pacific Islander had the highest rate in rampant caries and childhood caries. Children who were identified as “White” had the lowest early childhood caries while children identified as “African-American” had the lowest rampant caries.
Figure 35: Early Childhood Caries by Dentist Availability

Children in counties with no dentists had higher percentages of rampant caries and early childhood caries.

Figure 36: Rampant Caries by Dentist Availability
White Spot Lesions of PSP Participants

White spot lesions are the first signs of decay in children under the age of 5. White spots appear pale and chalky just around the gum line. While white spots are a sign of decay, they are reversible. When treated with fluoride early enough, the enamel can strengthen and help fight off the decay. If fluoride isn’t applied, the spots will continue to decay and turn yellow or brown.

Figure 37: White Spot Lesions by Gender

White Spot lesions are only included for children ages 0-5 years old. Males were more likely to have white spot lesions.
Children identified as “Hispanic” had the highest percent of white spot lesions, and children identified as “African-American” had the lowest percent of white spot lesions.

Children in urban counties had a higher percent of white spot lesions than children in rural counties.
Children residing in counties with at least one dentist had a higher percent of white spot lesions compared with those who resided in counties with no dentist.

*Figure 40: White Spot Lesions by Dentist Availability*
Fluoridated Water Supplies and PSP Students

Fluoridated water supplies are very beneficial to oral health. According to the CDC, fluoride helps strengthen permanent teeth for children under 8 years old while it leads to strong and healthy teeth among adults. Fluoridated water can help prevent at least 25% of tooth decay in children. Fluoridated water also saves money over time. The American Dental Association estimates that every $1 spent in water fluoridation saves about $38 in dental costs in most cities. Despite numerous claims suggesting fluoridated water supplies are toxic, erode lead pipes, and can cause health problems, scientists have shown through many evidence based studies that there is no scientific basis to these claims.

Since water fluoridation varies from county to county, the fluoridated variable is broken into three groups: Counties with fluoridated county water systems, counties with no fluoride in any waters systems, and counties with fluoride in some water systems but not the county water system.

Table 16: PSP Participants by Fluoride Accessibility

<table>
<thead>
<tr>
<th>Fluoridated County Water System</th>
<th>No Fluoride in Any Water System</th>
<th>Fluoridated Water Systems, but Not County System</th>
</tr>
</thead>
<tbody>
<tr>
<td>11,324</td>
<td>8,845</td>
<td>71,015</td>
</tr>
</tbody>
</table>

Figure 41: PSP Participants by Fluoride Accessibility
Counties with some fluoride water in their supplies were tied with counties with no fluoride in their water system and they had lower percentage of poor oral hygiene.

For non-fluoridated counties, children were screened at slightly higher rates for treatment urgency issues than children from fluoridated counties, particularly in urgent care situations.
Counties with fluoridated county water supplies had much lower rates of treated and untreated decay. Primary teeth were the most commonly seen with both treated and untreated decay, and in both instances, counties with some fluoridated water supplies had the lowest decay rate. For ‘Permanent Only’ tooth type, counties with fluoridated water system had the lowest decay rate in both treated and untreated decay.
Figure 46: Rampant Caries by Fluoride Accessibility

Counties that have some fluoridated water systems had the lowest rate of rampant and childhood caries followed by counties with fluoridated water supplies.

Figure 47: Early Childhood Caries by Fluoride Accessibility
Counties with fluoridated water supplies had the lowest rate for white spot lesions.

Figure 48: White Spot Lesions by Fluoride Accessibility
County-Wide Fluoridation Water Systems

Figure 49: Fluoridation Map

Fluoridation
- **Blue**: Fluoridated County Water System
- **Green**: No Fluoride in Any Water System
- **Light Purple**: Fluoridated Water Systems, but Not County System
Dentist Availability in Missouri Counties

Figure 50: Dentist Availability Map

Dentist Availability

- **No Dentist**
- **Atleast 1 Dentist**
- **None PSP Participant**
Conclusion

The 2018-2019 school year had a 3.6% increase in students participating in PSP.

**Preventive Factors:**

- 78.3% of the children that participated in PSP events had what was considered good oral hygiene. Males ages 13 and up, and children whose race was marked as “Other” had the highest frequency of poor oral hygiene.

- Dental sealants were found on 23.9% of children screened ages 6 years and older. African-American children were the least likely to have dental sealants while Hispanic children were most likely.

**Tooth Decay:**

- 67.4% of screened students had no treated decay, and approximately 78.6% had no untreated decay. Children of other races were the most likely to have signs of treated and untreated decay.

- Rampant caries were seen in 8.4% of screened students. Children identified as “Asian or Pacific Islanders” had the highest percent of rampant caries. Children identified as “African-Americans” had the least percent of rampant caries.

**Treatment Urgency:**

- Approximately 21% of students screened were identified as needing early or urgent dental care. These students were sent home with a notification to their parent/guardian about the issue. Urgent dental care was required most in female children ages 6-12 years old.

**Early Childhood Findings:**

- White spot lesions were found in approximately 15% of screened children under the age of 5 years. White spot lesions were observed more in children whose race was marked as Hispanic.
**Caries:** Technical term for cavity

**Decay:** The breakdown of the enamel surface or staining in pits or fissures of primary or baby molars

**Dental Sealants:** Clear plastic coating that is applied to the chewing surface of permanent molars that help prevent cavities

**History of Decay:** The presence of decay and/or filled teeth

**Poor Oral Hygiene:** Moderate to heavy plaque on teeth with red gums and tissue

**Rampant Caries:** Suddenly appearing, widespread, rapid burrowing types of caries that result in early pulp involvement

**Treated Decay:** Defined as having a dental filling, crown, or a tooth extracted because of decay

**Untreated Decay:** Defined as having dental cavities or tooth decay that have not received appropriate treatment

**Urgent Care:** A child who needs care within the next 24-48 hours due to pain or an infection

**White Spot Lesions:** First signs of decay in children under five years old and appear pale and chalky around the gum line
References


