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Oral Health Status of Children in Santa Clara County

Results of The Health Trust
2001 Needs Assessment

December 2001



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Abstract

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Title. OPERATIONAL APPLICATION OF A COUNTY WIDE ORAL HEALTH NEEDS ASSESSMENT

Objective. To assess the practical application of an oral health needs assessment in Santa Clara County, California.

Methods. The Health Trust commissioned Kathy Phipps, DrPH, to conduct the first ever, oral health needs assessment for Santa Clara County, California. A randomly selected, statistically significant number of children in Head Start, kindergarten and third grades were screened by dentists who looked for decayed, missing and filled teeth. Protective sealants on permanent molar teeth were also noted. Data on oral health status and access to care was obtained through a questionnaire sent home with the children that asked for information on socioeconomic and insurance status. Demographic data, such as race/ethnicity and the educational level of the primary care giver, was obtained. The families were also questioned about their child's dental history and barriers, if any, to receiving care. The results were released in April 2002.

Results. The results are devastating for certain populations of children and indicative of the magnitude of challenge that remains before every child in Santa Clara County has a dental home. Dental disease is a significant public health problem for children throughout the county and one that will take a collective, community wide effort to solve. The children at highest risk of dental disease are also the least likely to have access to professional dental care, with low income and minority children suffering disproportionately. The demographics of Santa Clara County (25 % Hispanic and 20 % Asian), the 11th largest county in the United States, amplifies the problem. The full results of the oral health needs assessment are available at www.healthtrust.org.

Conclusions. The Health Trust is committed to implementing programs that will improve access to care and minimize the gaps in service that have created these disparate outcomes. The expected result is timely, comprehensive, culturally sensitive, quality oral health care for all children in Santa Clara County. The oral health needs assessment has been an invaluable tool in advancing this mission. The results have been leveraged many ways including an opened community wide dialogue with all critical stakeholders, the convening of a collaborative of service providers, defined strategic planning, implementation of creative programs and targeted fundraising. A needs assessment conducted within a defined community can translate into programs and funding that will have an immediate and direct impact on service delivery.

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Oral Health Status of Children in Santa Clara County

Results of The Health Trust's 2001 Needs Assessment

Introduction

This document presents the results of The Health Trust 2001 Oral Health Needs Assessment. The primary goal of the needs assessment was to evaluate the oral health status of two primary groups – Head Start enrollees plus elementary school children (kindergarten and third grade) in Santa Clara County, California.

Head Start Children

Sampling

One target population of the needs assessment was children enrolled in the Head Start Program of Santa Clara County. Only those children that returned a positive consent form (signed by a parent and returned with the child), were screened. Of the 832 children enrolled in the Head Start Program, 478 were screened, a response rate of 57 percent .

Screening Methodology

Dentists, dental hygienists and registered dental assistants that participated in a half-day training session completed the screenings (number of screeners=7). The screenings were completed using gloves, penlight, disposable mirror, and tongue blade. If necessary, a toothpick or cotton tipped swab was used to remove excess debris. The diagnostic criteria outlined in *Basic Screening Surveys: An Approach to Monitoring Community Oral Health* (Appendix A), were used.

General Information

Five hundred sixty two (562) parents returned the questionnaire (Appendix B) and consent form (Appendix C). Of these, 538 gave permission for their child to be screened while 24 requested that their child not receive a screening. Of the 538 who gave positive consent, 478 children received a dental screening (60 children were absent, unavailable or uncooperative on the day of the screening).

The Head Start children who received a dental screening were ethnically diverse – 67 percent Hispanic, 20 percent Asian, 6 percent white non-Hispanic, and 6 percent were African American. Refer to Table 1 and Figure 1 for more information on the race/ethnicity and gender of the children.

Oral Health Status – Key Findings (Table 2, Figures 4-6)

- 478 children received a dental screening
- 52 percent of the children screened were caries free while 48 percent had a history of dental caries – at least one tooth with untreated decay and/or a filling
- 33 percent of the children screened had untreated decay at the time of the examination
- 10 percent of the children had a history of rampant decay – seven or more teeth with a history of dental decay
- 26 percent of the children had decay or fillings on their upper front teeth (maxillary incisors) – a condition commonly referred to as early childhood caries, baby bottle tooth decay or nursing caries
- 16 percent of the children had “white spots” or decalcification on their teeth – this type of white spot is the early stage of a cavity that can be reversed with proper care
- 34 percent of the children screened needed dental care – 27 percent for routine dental care and an additional 7 percent for urgent care because of pain or infection

Demographics – Key Findings (Table 3, Figures 2 & 3)

- While 478 children were screened, 562 parents returned the questionnaire – some children were absent on the day of the screening and some parents returned the questionnaire but refused the screening
- 43 percent of the parents reported that they spoke English at home, while Spanish was the primary language for 41 percent and Vietnamese was the primary language for 14 percent
- 42 percent of parents reported more than a high school education, 31 percent reported a high school education and 27 percent reported less than a high school education

Access to Care – Key Findings (Tables 3-5)

- While 478 children were screened, 562 parents returned the access to care questionnaire – some children were absent on the day of the screening and some parents returned the questionnaire but refused the screening
- 84 percent of the parents reported having some type of dental insurance for their child (Table 3)
- 82 percent of the children had been to the dentist in the last year while 13 percent had never been to the dentist (Table 3)
- The primary reasons for NOT having been to the dentist in the last year were “my child is too young to see a dentist” (28%), “no reason to go” (26%), and “cost” (21%) (Note: Parents could provide multiple answers to this questions) (Table 4)

- 25 percent of the parents reported that during the last 2 years there was a time when they wanted dental care for their child but could not get it (Table 3)
- The primary reasons for not getting dental care were “no insurance” (33%) and “could not afford it” (33%) (Note: Parents could provide multiple answers to this question) (Table 5)

Race/Ethnicity

Parents were asked to provide information on their child’s race/ethnicity. When the parent did not provide this information, the screener determined race/ethnicity. The number of children in each of the following racial categories was small, therefore data for these groups were excluded from all comparisons by race/ethnicity: white non-Hispanic (6%), African American (6%), American Indian/Alaska Native (0.4%), and multi-racial (2%).

Impact of Race/Ethnicity on Oral Health Status – Key Findings (Table 6, Figures 7-10)

When stratified by race/ethnicity, there was no significant difference in oral health status between the Asian and Hispanic children (caries history, untreated decay, rampant decay, or urgent need). It should be noted that once socioeconomic status is controlled for, racial/ethnic differences in oral health tend to disappear. Since enrollment in Head Start is based on income, racial differences noted in other age groups are not apparent in this age cohort.

Impact of Race/Ethnicity on Demographics – Key Findings (Table 9)

- English was the primary language spoken at home for 41 percent of the Hispanic children and 19 percent of the Asian children
- 15 percent of the primary caregivers for Hispanic children had less than a 9th grade education compared to 9 percent for caregivers of the Asian children

Impact of Race/Ethnicity on Access to Care – Key Findings (Table 9)

- A higher proportion of Hispanic children had no insurance (19%) compared to Asian children (11%)
- A higher proportion of Hispanic children had NEVER visited the dentist (14%) compared to Asian children (8%)
- A higher proportion of Hispanic children reported trouble getting dental care in the last two years (28%) compared to Asian children (19%)

Comparison to Healthy People 2010 Objectives (Figure 17)

Healthy People 2010 includes the following national oral health objectives for preschool children.

- Reduce the proportion of young children aged 2-4 years with dental caries experience in their primary teeth to 11 percent.

- Reduce the proportion of young children aged 2-4 years with untreated dental decay in their primary teeth to 9 percent.
- Increase the proportion of children who use the oral health care system each year to 83 percent.

Significant improvements in the oral health of Santa Clara County Head Start children must be made in order to meet the Healthy People 2010 objectives. For example, the prevalence of caries experience is four times higher in Santa Clara County's Head Start children compared to the national objective (48% vs. 11%). In addition, the prevalence of untreated decay is more than three times higher in our Head Start children compared to the national objective (33% vs. 9%). The Head Start children of Santa Clara County did meet the national objective for proportion who use the oral health care system each year (82% vs. 83%).

Elementary School Children

Sampling

The target population for this portion of The Health Trust's 2001 Needs Assessment was children attending public elementary schools in Santa Clara County. An electronic file of all public schools in California was obtained from the Department of Education (www.cde.ca.gov). The file was limited to those schools in Santa Clara County that had children enrolled in either kindergarten or third grade (247 schools). The file was narrowed to include only those schools with at least 25 students in kindergarten and/or third grade (241 schools). The 241 potential schools were ordered according to their CDS Code number – a unique code for each school provided by the Department of Education. A random number between 1-9 was selected. This represented the first school in the sample. Every ninth school was then selected for a total of 27 schools. Each school in the original sample was assigned a replacement school – the school with the next highest CDS Code number. If the original school refused to participate, the replacement school was contacted. Of the 27 schools selected, 15 agreed to participate in the survey for a school response rate of 56 percent. When compared to the entire sample, those schools that agreed to participate had a higher proportion of children receiving free or reduced-price meals (33% vs. 37%). This suggests that higher-income schools are less likely to participate in oral health surveys.

A combination of passive (sent home with child informing parent of screening, but not returned with the child) and positive (signed by a parent and returned with the child) consent was used because of the differing requirements of each school district. In five schools all children who either returned a positive consent or who did not return a consent form were screened. In the other 10 schools, only those children who returned a positive consent form were screened.

Screening Methodology

Dentists and registered dental assistants that participated in a half-day training session completed the screenings (6 screeners). The screenings were completed using gloves, penlight, disposable mirror, and tongue blade. If necessary, a toothpick or cotton tipped swab was used to remove excess debris. The diagnostic criteria outlined in *Basic Screening Surveys: An Approach to Monitoring Community Oral Health* (Appendix A) were used.

Results – Kindergarten Children

General Information

Five hundred eighty six (586) parents returned the questionnaire (Appendix B) and consent form (Appendix C). Of these, 481 gave permission for their child to be screened while 105 requested that their child not receive a screening. Of the 481 who gave positive consent, 447 children received a dental screening (34 children were absent or unavailable on the day of the screening). At five schools, another 155 children were screened based

on passive rather than positive consent. A total of 602 children were screened at all schools.

The 15 schools that participated in the survey had a total kindergarten enrollment of 1,307 for a response rate of 46 percent. If the enrollment at all 27 schools (n=2,338) is used as the denominator for the response rate, the response rate drops to 26 percent.

The kindergarten children who received a dental screening were ethnically diverse – 37 percent Hispanic, 29 percent Asian and 27 percent white non-Hispanic. Refer to Table 1 and Figure 1 for more information on the race/ethnicity and gender of the children.

Oral Health Status – Key Findings (Table 2, Figures 4 & 6)

- 602 children received a dental screening
- 50 percent of the children screened were caries free while 50 percent had a history of dental caries - at least one tooth with untreated decay and/or a filling
- 31 percent of the children screened had untreated decay at the time of the examination
- 13 percent of the children had a history of rampant decay – seven or more teeth with a history of dental decay
- 29 percent of the children screened needed dental care – 19 percent for routine dental care and an additional 10 percent for urgent care because of pain or infection

Demographics – Key Findings (Table 3, Figures 2 & 3)

- 582 parents returned the questionnaire, however, not all parents answered every question
- 57 percent of the parents reported that the primary language spoken at home was English, while Spanish was the primary language for 20 percent and Vietnamese was the primary language for 12 percent
- The majority of parents, 66 percent, reported more than a high school education while 17 percent reported a high school education and 17 percent reported less than a high school education

Access to Care – Key Findings (Tables 3-5)

- 582 parents returned the access to care questionnaire, however, not all parents answered every question
- 84 percent of the parents reported having some type of dental insurance for their child
- 75 percent of the children had been to the dentist in the last year while 18 percent had never been to the dentist (Table 3)
- The primary reasons for NOT having been to the dentist in the last year were “no reason to go” (42%), “cost” (27%), “my child is too young to see a dentist” (15%), and

“do not have or know a dentist” (15%). NOTE: Parents could provide multiple answers to this question so percentages may add to more than 100% (Table 4)

- 17 percent of the parents reported that during the last 2 years there was a time when they wanted dental care for their child but could not get it (Table 3)
- The primary reasons for not getting dental care were “no insurance” (51%) and “could not afford it” (51%). NOTE: Parents could provide multiple answers to this question so percentages may add to more than 100% (Table 5)

Race/Ethnicity

Parents were asked to provide information on their child’s race/ethnicity. When the parent did not provide this information, or when the questionnaire was not returned (passive consent), the screener determined race/ethnicity. The proportion of children in the following racial categories were small, therefore data for these groups have been excluded from all comparisons by race/ethnicity: African American (2%), American Indian/Alaska Native (1%), and multi-racial (3%).

Please note that in this population, race, socioeconomic status and education were highly correlated. While 6 percent of white children and 21 percent of Asian children were eligible for the free or reduced meal program – almost 63 percent of Hispanic children were eligible for the same program. In terms of education, only 2 percent of the white children had parents with less than a high school education compared to 12 percent for the Asian children and 34 percent for the Hispanic children.

Impact of Race/Ethnicity on Oral Health Status – Key Findings (Table 7, Figures 7-10)

- A lower proportion of white non-Hispanic children has a history of caries (21%) compared to both Asian (59%) and Hispanic (64%) children
- A lower proportion of white non-Hispanic children had untreated decay (14%) compared to both Asian (35%) and Hispanic (42%) children
- A lower proportion of white non-Hispanic children had a history of rampant decay (3%) compared to both Asian (15%) and Hispanic (18%) children
- A lower proportion of white non-Hispanic children were in need of urgent dental care (2%) compared to both Asian (10%) and Hispanic (16%) children

Impact of Race/Ethnicity on Demographics – Key Findings (Table 10)

- English was the primary language spoken at home for 90 percent of the white non-Hispanic children, 43 percent of the Hispanic children and 36 percent of the Asian children
- Only 2 percent of the white non-Hispanic children had caregivers with less than a 9th grade education compared to 15 percent of the Hispanic children and 11 percent of the Asian children

Impact of Race/Ethnicity on Access to Care – Key Findings (Table 10)

- A lower proportion of white non-Hispanic and Asian children (11% for each) had no dental insurance compared to Hispanic children (26%)
- A higher proportion of Asian (82%) and white non-Hispanic (79%) children had visited the dentist in the last year compared to Hispanic (69%) children
- A lower proportion of white non-Hispanic (14%) and Asian (13%) children had NEVER been to the dentist compared to Hispanic children (22%)
- A lower proportion of white non-Hispanic (8%) and Asian (10%) children reported that they needed care in the last 2 years but were unable to get it compared to Hispanic children (28%)

Socioeconomic Status (Free or Reduced-Price Meal Program)

Eligibility for the free or reduced-price meal program is often used as a surrogate measure of socioeconomic status. In 2000-2001, the free or reduced-price meal program had an income ceiling of \$31,500 for a family of four. Parents were asked to provide information on their child's eligibility for the free or reduced-price meal program. This information was available for 314 of the 602 kindergarten children screened (52%).

Please note that in this population, race and socioeconomic status were highly correlated. While 6 percent of white children and 21 percent of Asian children were eligible for the free or reduced meal program – almost 63 percent of Hispanic children were eligible for the same program.

Impact of Socioeconomic Status on Oral Health Status – Key Findings (Table 12, Figures 12-15)

- A lower proportion of children not eligible for the F/R lunch program had a history of caries (37%) compared to lower income children that were eligible for the F/R lunch program (74%)
- A lower proportion of children not eligible for the F/R lunch program had untreated decay (20%) compared to lower income children that were eligible for the F/R lunch program (52%)
- A lower proportion of children not eligible for the F/R lunch program had a history of rampant decay (8%) compared to lower income children that were eligible for the F/R lunch program (24%)
- A lower proportion of children not eligible for the F/R lunch program were in need of urgent dental care (7%) compared to lower income children that were eligible for the F/R lunch program (23%)

Impact of Socioeconomic Status on Access to Care – Key Findings (Table 14)

- A lower proportion of children not eligible for the F/R lunch program (10%) had no dental insurance compared to lower income children that were eligible for the F/R lunch program (21%)

- A higher proportion of children not eligible for the F/R lunch program (82%) had visited the dentist in the last year compared to lower income children that were eligible for the F/R lunch program (69%)
- A lower proportion of children not eligible for the F/R lunch program (13%) had NEVER been to the dentist compared to lower income children that were eligible for the F/R lunch program (21%)
- A lower proportion of children not eligible for the F/R lunch program (7%) reported that they needed care in the last 2 years but were unable to get it compared to lower income children that were eligible for the F/R lunch program (35%)

Comparison to Healthy People 2010 Objectives (Figure 18)

Healthy People 2010 outlines several oral health status objectives for children between the ages of six to eight years. These include:

- Decrease the proportion of children who have experienced dental caries in permanent or primary teeth to 42 percent.
- Decrease the proportion of children with untreated dental caries in permanent or primary teeth to 21 percent.
- Increase the proportion of children who use the oral health care system each year to 83 percent.

Improvements in the oral health of Santa Clara County's kindergartners must be made in order to meet the Healthy People 2010 objectives. For example, the prevalence of caries experience is higher in Santa Clara County's kindergarten children compared to the national objective (50% vs. 42%). In addition, the prevalence of untreated decay is higher in our kindergarten children compared to the national objective (31% vs. 21%). Kindergarten children in Santa Clara County also lag behind the national objective for proportion that uses the oral health care system each year (75% vs. 83%).

Results – Third Grade Children

General Information

Six hundred thirty two (632) parents returned the questionnaire (Appendix B) and consent form (Appendix C). Of these, 469 gave permission for their child to be screened while 163 requested that their child not receive a screening. Of the 469 who gave positive consent, 451 children received a dental screening (18 children were absent or unavailable on the day of the screening). At five schools, another 149 children were screened based on passive rather than positive consent. A total of 600 children were screened at all schools.

The 15 schools that participated in the survey had a third grade enrollment of 1,257 for a response rate of 48 percent. If the enrollment at all 27 schools (n=2,357) is used as the denominator for the response rate, the response rate drops to 26 percent.

The third grade children who received a dental screening were ethnically diverse – 38 percent Hispanic, 29 percent Asian and 25 percent white non-Hispanic. The children ranged in age from 7-9 years with a mean of 8.0 years (standard deviation =0.44). Refer to Table 1 and Figure 1 for more information on the race/ethnicity and gender of the children.

Oral Health Status – Key Findings (Table 2, Figures 4 & 6)

- 600 children received a dental screening
- Only 28 percent of the children screened were caries free while 72 percent had a history of dental caries – at least one tooth with untreated decay and/or a filling
- 30 percent of the children screened had untreated decay at the time of the examination
- 18 percent of the children had a history of rampant decay – seven or more teeth with a history of dental decay
- 22 percent of the children had a dental sealant on one or more permanent molar
- 30 percent of the children screened needed dental care – 17 percent for routine dental care and an additional 13 percent for urgent care because of pain or infection

Demographics – Key Findings (Table 3)

- 632 parents returned the questionnaire, however, not all parents answered every question
- 58 percent of the parents reported that they spoke English at home while Spanish was the primary language for 18 percent and Vietnamese was the primary language for 11 percent. The remaining 12 percent spoke another language including Chinese, Farsi, Korean, Japanese, French, Dutch, and several African languages

- The majority of parents, 65 percent, reported more than a high school education while 15 percent reported a high school education and 20 percent reported less than a high school education

Access to Care – Key Findings (Tables 3-5)

- 632 parents returned the access to care questionnaire, however, not all parents answered every question
- 85 percent of the parents reported having some type of dental insurance for their child (Table 3)
- 83 percent of the children had been to the dentist in the last year while 3 percent had never been to the dentist (Table 3)
- The primary reasons for NOT having been to the dentist in the last year were "cost" (38%), "no reason to go" (30%) and "do not have or know a dentist" (12%). NOTE: Parents could provide multiple answers to this question so percentages may add to more than 100% (Table 4)
- 18 percent of the parents reported that during the last 2 years there was a time when they wanted dental care for their child but could not get it (Table 3)
- The primary reasons for not getting dental care were "no insurance" (61%) and "could not afford it" (41%). NOTE: Parents could provide multiple answers to this question so percentages may add to more than 100% (Table 5)

Race/Ethnicity

Parents were asked to provide information on their child's race/ethnicity. When the parent did not provide this information, or when the questionnaire was not returned (passive consent), the screener determined race/ethnicity. The proportion of children in the following racial/ethnic categories were small, therefore, data for these groups have been excluded from all comparisons by race/ethnicity: African American (3%), American Indian/Alaska Native (0.5%), Native Hawaiian/Pacific Islander (0.7%), and multi-racial (4%).

Please note that in this population, race, socioeconomic status and education were highly correlated. While 7 percent of white children and 28 percent of Asian children reported being eligible for the free or reduced meal program – almost 72 percent of Hispanic children reported being eligible for the same program. In terms of education, only 2 percent of the white children had parents with less than a high school education compared to 21 percent for the Asian children and 37 percent for the Hispanic children.

Impact of Race/Ethnicity on Oral Health Status – Key Findings (Table 8, Figures 7-11)

- A higher proportion of white non-Hispanic children were caries free (49%) compared to both Asian (25%) and Hispanic (16%) children
- A lower proportion of white non-Hispanic children had untreated decay (15%) compared to both Asian (26%) and Hispanic (43%) children

- A lower proportion of white non-Hispanic children had a history of rampant decay (7%) compared to both Asian (19%) and Hispanic (26%) children
- A higher proportion of white non-Hispanic children had dental sealants (30%) compared to both Asian (22%) and Hispanic (15%) children
- A lower proportion of white non-Hispanic children were in need of urgent dental care (3%) compared to both Asian (8%) and Hispanic (23%) children

Impact of Race/Ethnicity on Demographics – Key Findings (Table 11)

- English was the primary language spoken at home for 94 percent of the white non-Hispanic children, 47 percent of the Hispanic children and 34 percent of the Asian children
- Only 1 percent of the white non-Hispanic children had caregivers with less than a 9th grade education compared to 23 percent of the Hispanic children and 18 percent of the Asian children

Impact of Race/Ethnicity on Access to Care – Key Findings (Table 11)

- A lower proportion of white non-Hispanic and Asian children (9% for each) had no dental insurance compared to Hispanic children (26%)
- A higher proportion of white non-Hispanic (91%) and Asian (88%) children had visited the dentist in the last year compared to Hispanic (66%) children
- A lower proportion of white non-Hispanic (0%) and Asian (3%) children had NEVER been to the dentist compared to Hispanic children (7%)
- A lower proportion of white non-Hispanic (7%) and Asian (13%) children reported that they needed care in the last 2 years but were unable to get it compared to Hispanic children (34%)

Socioeconomic Status (Free or Reduced-Price Meal Program)

Eligibility for the free or reduced-price meal program is often used as a surrogate measure of socioeconomic status. In 2000-2001, the free or reduced-price meal program had an income ceiling of \$31,500 for a family of four. Parents were asked to provide information on their child's eligibility for the free or reduced-price meal program. This information was available for 357 of the 600 third grade children screened (60%).

Please note that in this population, race, socioeconomic status and education were highly correlated. While 7 percent of white children and 28 percent of Asian children reported being eligible for the free or reduced-price meal program – almost 72 percent of Hispanic children reported being eligible for the same program. In terms of education, only 2 percent of the white children had parents with less than a high school education compared to 21 percent for the Asian children and 37 percent for the Hispanic children.

Impact of Socioeconomic Status on Oral Health Status – Key Findings (Table 13, Figures 12-16)

- A higher proportion of children not eligible for the F/R lunch program were caries free (41%) compared to lower income children that were eligible for the F/R lunch program (15%)
- A lower proportion of children not eligible for the F/R lunch program had untreated decay (20%) compared to lower income children that were eligible for the F/R lunch program (42%)
- A lower proportion of children not eligible for the F/R lunch program had a history of rampant decay (14%) compared to lower income children that were eligible for the F/R lunch program (25%)
- A higher proportion of children not eligible for the F/R lunch program had dental sealants (26%) compared to lower income children that were eligible for the F/R lunch program (16%)
- A lower proportion of children not eligible for the F/R lunch program were in need of urgent dental care (6%) compared to lower income children that were eligible for the F/R lunch program (21%)

Impact of Socioeconomic Status on Access to Care – Key Findings (Table 15)

- A lower proportion of children not eligible for the F/R lunch program (9%) had no dental insurance compared to lower income children that were eligible for the F/R lunch program (20%)
- A higher proportion of children not eligible for the F/R lunch program (91%) had visited the dentist in the last year compared to lower income children that were eligible for the F/R lunch program (74%)
- A lower proportion of children not eligible for the F/R lunch program (2%) had NEVER been to the dentist compared to lower income children that were eligible for the F/R lunch program (6%)
- A lower proportion of children not eligible for the F/R lunch program (7%) reported that they needed care in the last 2 years but were unable to get it compared to lower income children that were eligible for the F/R lunch program (35%)

Comparison to Healthy People 2010 Objectives (Figure 19)

Healthy People 2010 outlines several oral health status objectives for children between the ages of six to eight years. These include:

- Decrease the proportion of children who have experienced dental caries in permanent or primary teeth to 42 percent.
- Decrease the proportion of children with untreated dental caries in permanent or primary teeth to 21 percent.

- Increase the proportion of eight-year-olds receiving protective sealing of the occlusal surfaces of permanent molar teeth to 50 percent.
- Increase the proportion of children who use the oral health care system each year to 83 percent.

Almost 73 percent of the third grade children in Santa Clara County had experienced dental caries in their primary or permanent teeth – substantially higher than the Year 2010 objective of 42 percent. Thirty percent of the Santa Clara County third graders had untreated caries compared to the Year 2010 Objective of 21 percent. Only 22 percent of the third graders examined had dental sealants, significantly lower than the objective of 50 percent. Third grade children in Santa Clara County did meet the national objective for use of the oral health care system with 83 percent having visited the dentist in the last year.

Dental Insurance, Access to Care, and Oral Health

National data indicates that availability of dental insurance plays a significant role in a child's access to dental care. The needs assessment found this to be true in Santa Clara County. Of the children screened, about 15-16 percent had no dental insurance (depending on age). Fifty-eight percent of the Head Start children had government insurance while 26 percent had private insurance. For the elementary school students, 31 percent had government insurance while 53 percent had private insurance.

Elementary school students with no insurance were six times more likely to report having trouble accessing dental care and were almost three times more likely to have not had a dental visit in the last year (Figure 20).

As previously mentioned, Hispanic and Asian children were more likely to have untreated decay compared to white non-Hispanic children. This disparity may be associated with access to dental insurance. Hispanics were twice as likely to have no insurance compared to both whites and Asians. Of the Hispanics that spoke Spanish at home, 30 percent reported no health insurance – slightly higher than Hispanics that spoke English (21%) and three times higher than whites (10%). The proportion with private insurance was highest for white children followed by Asian and Hispanic children (Figure 21).

Figure 22 compares the oral health status of children with different insurance coverage. Children with no insurance or government insurance (Medicaid or Healthy Families) are in poorer oral health compared to children with private insurance.

Comparison to California and Other States

Comparison to California (Figure 23)

In 1993-94, the California Oral Health Needs Assessment of Children was completed. The California assessment screened 2,520 preschool children at 44 Head Start and 40 non-Head Start programs. In addition, 3,225 children in grades K-3 were screened at 32 elementary schools. This study, conducted by the Dental Health Foundation, is the most recent, comprehensive oral health review for the entire state.

Because of sampling differences, a direct comparison between the California survey and the Santa Clara County survey should be viewed with caution. For example, while the California survey screened children in both Head Start and non-Head Start programs, the Santa Clara County survey screened only those children enrolled in Head Start. For elementary school students, the California survey screened children in kindergarten, first, second, and third grade while the Santa Clara County survey only screened children in kindergarten and third grade.

For preschool children, the 1993-94 California survey found that 31 percent had experienced tooth decay compared to 45 percent of the Head Start children in Santa Clara County. Sixty-nine percent of the California elementary school students (K-3) had experienced tooth decay compared to 61 percent of the Santa Clara kindergarten and third grade students. In terms of untreated decay, the California survey found that 55

percent of K-3 students had cavities compared to 31 percent of the Santa Clara students screened.

Comparison to Other States (Figure 24)

Two other western states have collected oral health data on third grade children – Washington and New Mexico. Both Washington and New Mexico used sampling strategies similar to Santa Clara and the data is comparable. Figure 24 compares the oral health of Santa Clara County third graders with both Washington and New Mexico. When compared to Washington, a higher proportion of Santa Clara County children have a history of caries and untreated decay while a lower proportion have dental sealants. Similar patterns were noted when Santa Clara County was compared to New Mexico except that the prevalence of untreated decay was higher in New Mexico.

Tables

Table 1
Response Rates, Age, Race/Ethnicity, and Gender of Children Screened in
Santa Clara County, California
(Includes only those children who received a dental screening)

Variable	Head Start	Kindergarten	Third Grade
Number Screened	478	602	600
Overall Response Rate	57.4	25.7	25.5
Response Rate in Participating Schools	57.4	46.1	47.7
Mean age (age range)	3.6 (2-6 years)	4.9 (4-6 years)	8.0 (7-9 years)
% Eligible for Free/Reduced Meals	NA	32.8	41.2
% White non-Hispanic	5.5	26.8	24.9
% Hispanic	67.1	37.3	38.0
% Asian	19.6	29.3	28.6
% Black/African American	5.5	2.0	3.3
% American Indian	0.4	1.2	0.5
% Native Hawaiian/Pacific Islander	0.0	0.0	0.7
% Multi-racial	1.9	3.3	4.0
% Male	47.5	52.9	48.7
% Female	52.5	47.1	51.3

Table 2
Oral Health of Santa Clara County Children Stratified by Age Group
(Includes only those children who received a dental screening)

Variable	Head Start (n=478)	Kindergarten (n=602)	Third Grade (n=600)
% Caries Free <i>(no history of caries)</i>	52.3	49.7	27.5
% with Caries Experience	47.7	50.3	72.5
% with Untreated Decay	32.8	31.4	30.2
% with Rampant Decay*	10.0	13.0	18.0
% with Early Childhood Caries	25.7	NA	NA
% with White Spot Lesions	15.7	NA	NA
% with Sealants	NA	NA	22.0
% Needing Any Treatment <i>(routine and urgent)</i>	33.9	29.4	30.5
% Needing Urgent Treatment**	6.5	10.0	13.2

* Seven or more teeth with a history of decay

** Pain and/or swelling

Table 3
Demographics and Access to Care for Santa Clara County Children Stratified by Age Group
(Includes all children who returned a questionnaire)

Variable	Head Start	Kindergarten	Third Grade
Primary language at home (number)*	n=519	n=536	n=538
% English	43.4	56.7	58.0
% Spanish	40.7	20.3	18.4
% Vietnamese	13.5	11.9	11.3
% Other	2.5	11.0	12.3
Education of primary caregiver (number)*	n=480	n=481	n=492
% with less than high school	27.5	17.5	19.7
% with high school or GED	30.6	16.6	14.8
% with some college	24.6	43.5	44.1
% with college degree	17.3	22.5	21.3
Dental insurance (number)*	n=494	n=523	n=523
% with no insurance	16.4	16.3	14.9
% with Denti-Cal	39.3	14.5	20.3
% with Health Families	18.4	15.1	13.0
% with private insurance	25.9	54.1	51.8
Time since last dental visit (number)*	n=494	n=513	n=496
% in last year	82.1	74.7	83.1
% in last 2-5 years	5.1	7.0	13.5
% who have NEVER been to dentist	12.8	18.3	3.4
Trouble accessing care (number)*	n=424	n=468	n=463
% who had trouble	25.4	16.6	17.9

* Number = number of parents who answered the question

NOTE: Parents could provide multiple answers to this question, so percentages may add to more than 100%

Table 4
Primary Reasons why Child Had not Been to Dentist in Last 12 Months

Reason	Head Start n=80		Kindergarten n=130		Third Grade n=86	
	# of responses	Percent	# of responses	Percent	# of responses	Percent
Cost	17	21.2	35	26.9	33	38.4
No reason to go	21	26.3	54	41.5	26	30.2
My child is too young to see a dentist	22	27.5	19	14.6	4	4.7
Do not have/know a dentist	6	7.5	19	14.6	10	11.6
Difficulty in getting appointment	8	10.0	5	3.8	6	7.0
Fear, apprehension, pain, or dislike going	7	8.8	13	10.0	4	4.7
Cannot get to dental office/clinic	0	0.0	4	3.1	3	3.5
Other reason	6	7.5	11	8.5	4	4.7

NOTE: Parents could provide multiple answers to this question so percentages may add to more than 100%.

Table 5
Primary Reasons why Child Could not get Dental Care in Last 2 Years

Reason	Head Start n=97		Kindergarten n=73		Third Grade n=80	
	# of responses	Percent	# of responses	Percent	# of responses	Percent
Could not afford it	32	33.0	28	38.4	33	41.3
No insurance	32	33.0	37	50.7	49	61.3
Dentist did not accept Medicaid/insurance	9	9.3	3	4.1	1	1.3
Dental problems not a serious enough	9	9.3	6	8.2	10	12.5
Wait is too long in clinic/office	7	7.2	2	2.7	0	0.0
Difficulty in getting appointment	6	6.2	2	2.7	9	11.3
Don't like/trust/believe in dentists	3	3.1	1	1.4	4	5.0
No dentist available	0	0.0	1	1.4	1	1.3
Didn't know where to go	9	9.3	9	12.3	5	6.3
No way to get there	3	3.1	3	4.1	2	2.5
Dentist hours are not convenient	7	7.2	4	5.5	7	8.8
Speak a different language	0	0.0	2	2.7	2	2.5
Health of another family member	0	0.0	0	0.0	0	0.0
No child care	0	0.0	2	2.7	1	1.3
Other reason	4	4.1	3	4.1	2	2.5

NOTE: Parents could provide multiple answers to this question so percentages may add to more than 100%.

Variable	Hispanic n=318	Asian n=93
% Caries Free <i>(no history of caries)</i>	49.7	52.7
% with Caries Experience	50.3	47.3
% with Untreated Decay	33.0	34.4
% with Rampant Decay	10.4	11.8
% with Early Childhood Caries	27.4	29.0
% with White Spot Lesions	14.2	23.7
% Needing Any Treatment <i>(routine and urgent)</i>	34.0	35.5
% Needing Urgent Treatment	6.6	8.6

Variable	White non-Hispanic n=161	Hispanic n=224	Asian n=176
% Caries Free <i>(no history of caries)</i>	78.9	35.7	41.5
% with Caries Experience	21.1	64.3	58.5
% with Untreated Decay	14.3	42.4	34.7
% with Rampant Decay	3.1	18.3	14.8
% Needing Any Treatment <i>(routine and urgent)</i>	13.1	41.0	30.7
% Needing Urgent Treatment	1.9	15.6	10.2

Table 8
Oral Health of Santa Clara County's Third Grade Children Stratified by Race/Ethnicity

Variable	White non-Hispanic n=149	Hispanic n=227	Asian n=171
% Caries Free <i>(no history of caries)</i>	49.0	15.9	25.1
% with Caries Experience	51.0	84.1	74.9
% with Untreated Decay	14.8	42.7	26.3
% with Rampant Decay	7.4	26.0	19.3
% with Dental Sealants	30.2	15.0	22.2
% Needing Any Treatment <i>(routine and urgent)</i>	16.8	42.3	26.3
% Needing Urgent Treatment	3.4	22.9	7.6

Table 9
Access to Care for Santa Clara County's Head Start Children Stratified by Race/Ethnicity

Variable	Hispanic	Asian
Primary language at home		
% English	40.8	18.6
% Spanish	57.0	0.0
% Vietnamese	0.0	72.2
% Other	0.3	9.3
Education of primary caregiver		
% less than 9 th grade	15.4	9.4
% 9 th grade to HS graduate	50.0	37.7
% more than HS	34.6	52.9
% with no dental insurance	19.4	10.6
% with private dental insurance	26.4	24.5
% that visited dentist in last year	79.6	92.0
% who have never been to a dentist	14.2	8.0
% who needed care but could not get it	28.3	19.0

Table 10
Access to Care for Santa Clara County's Kindergarten Children Stratified by Race/Ethnicity

Variable	White non-Hispanic	Hispanic	Asian
Primary language at home	90.2	42.9	36.0
% English	1.5	57.1	0.0
% Spanish	0.0	0.0	36.6
% Vietnamese	8.3	0.0	27.4
Education of primary caregiver			
% less than 9 th grade	1.6	20.9	11.3
% 9 th grade to HS graduate	9.5	45.4	6.3
% more than HS	88.9	33.7	82.4
% with no dental insurance	11.4	26.2	11.2
% with private dental insurance	80.3	33.7	52.4
% that visited dentist in last year	78.9	69.1	81.5
% who have never been to a dentist	14.3	21.8	13.1
% who needed care but could not get it	7.9	28.0	10.3

Table 11
Access to Care for Santa Clara County's Third Grade Children Stratified by Race/Ethnicity

Variable	White non-Hispanic	Hispanic	Asian
Primary language at home			
% English	93.7	47.2	33.7
% Spanish	1.6	52.8	0.0
% Vietnamese	0.0	0.0	34.3
% Other	4.0	0.0	32.0
Education of primary caregiver			
% less than 9 th grade	0.8	23.0	18.0
% 9 th grade to HS graduate	8.2	36.0	16.2
% more than HS	91.0	41.0	65.8
% with no dental insurance	8.9	25.6	9.4
% with private dental insurance	81.5	33.5	43.9
% that visited dentist in last year	91.2	65.5	88.1
% who have never been to a dentist	0.0	7.1	3.0
% who needed care but could not get it	6.6	34.2	12.9

Table 12
Oral Health of Santa Clara County's Kindergarten Children Stratified by
Eligibility for the Free or Reduced-Price Meal Program

Variable	Not Eligible n=211	Eligible n=103
% Caries Free <i>(no history of caries)</i>	63.0	26.2
% with Caries Experience	37.0	73.8
% with Untreated Decay	20.4	51.5
% with Rampant Decay	8.1	24.3
% Needing Any Treatment <i>(routine and urgent)</i>	19.4	48.5
% Needing Urgent Treatment	7.1	23.3

Table 13
Oral Health of Santa Clara County's Third Grade Children Stratified by
Eligibility for the Free or Reduced-Price Meal Program

Variable	Not Eligible n=210	Eligible n=147
% Caries Free <i>(no history of caries)</i>	41.4	15.0
% with Caries Experience	58.6	85.0
% with Untreated Decay	19.5	41.5
% with Rampant Decay	14.3	24.5
% with Dental Sealants	26.2	15.6
% Needing Any Treatment <i>(routine and urgent)</i>	19.5	40.8
% Needing Urgent Treatment	5.7	21.1

Table 14
Access to Care for Santa Clara County's Kindergarten Children Stratified by Eligibility for the Free or Reduced-Price Meal Program

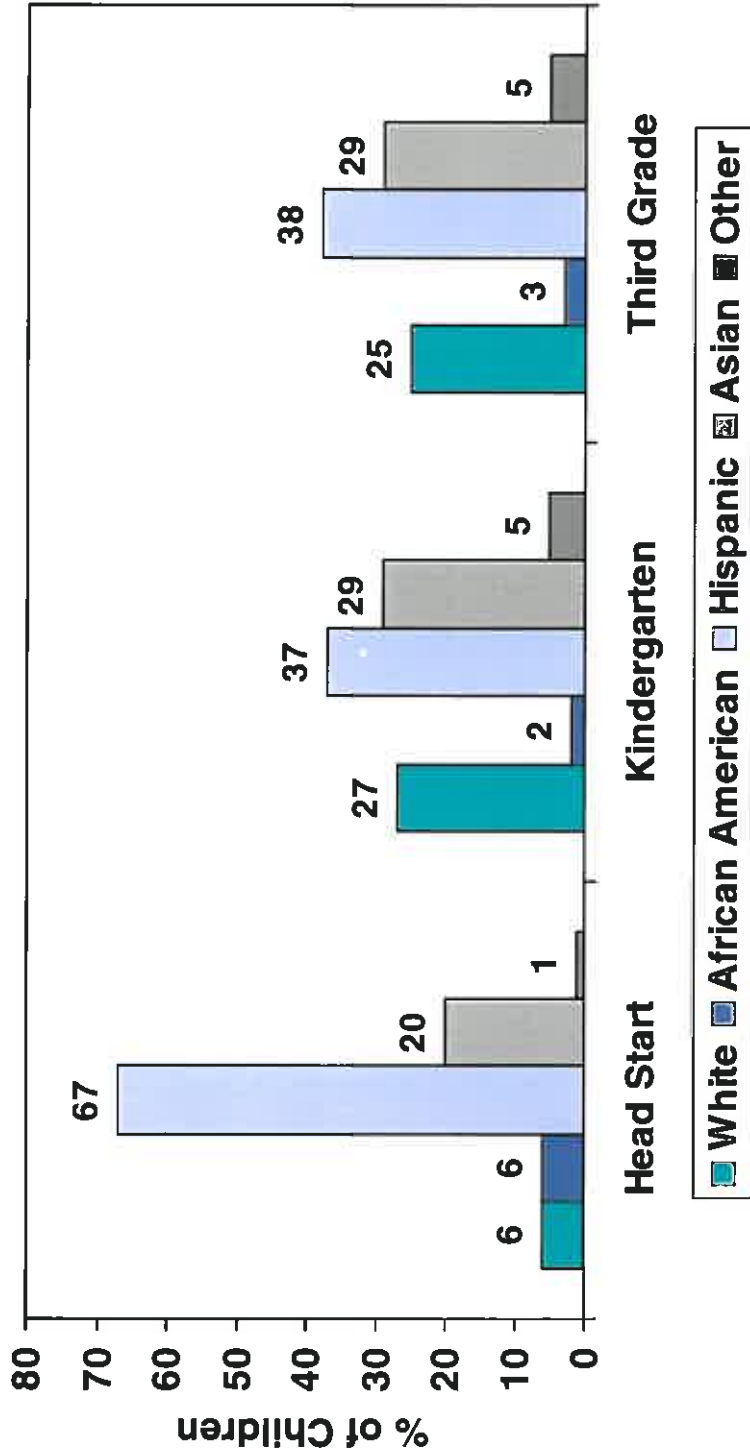
Variable	Not Eligible	Eligible
Primary language at home		
% English	69.2	34.4
% Spanish	6.7	47.5
% Vietnamese	9.5	15.6
% Other	14.6	2.5
Education of primary caregiver		
% less than 9 th grade	7.2	27.6
% 9 th grade to HS graduate	10.6	39.1
% more than HS	82.2	33.3
% with no dental insurance	10.4	21.2
% with private dental insurance	73.7	18.6
% that visited dentist in last year	82.1	69.1
% who have never been to a dentist	12.7	20.9
% who needed care but could not get it	7.4	35.0

Table 15
Access to Care for Santa Clara County's Third Grade Children Stratified by Eligibility for the Free or Reduced-Price Meal Program

Variable	Not Eligible	Eligible
Primary language at home		
% English	68.8	40.9
% Spanish	4.8	37.1
% Vietnamese	7.7	18.9
% Other	18.7	3.1
Education of primary caregiver		
% less than 9 th grade	6.6	26.2
% 9 th grade to HS graduate	10.9	36.1
% more than HS	82.5	37.7
% with no dental insurance	8.8	20.4
% with private dental insurance	73.2	23.6
% that visited dentist in last year	91.4	73.9
% who have never been to a dentist	1.6	5.6
% who needed care but could not get it	6.5	35.4

Oral Health Needs Assessment

Ethnic Diversity of Children Screened

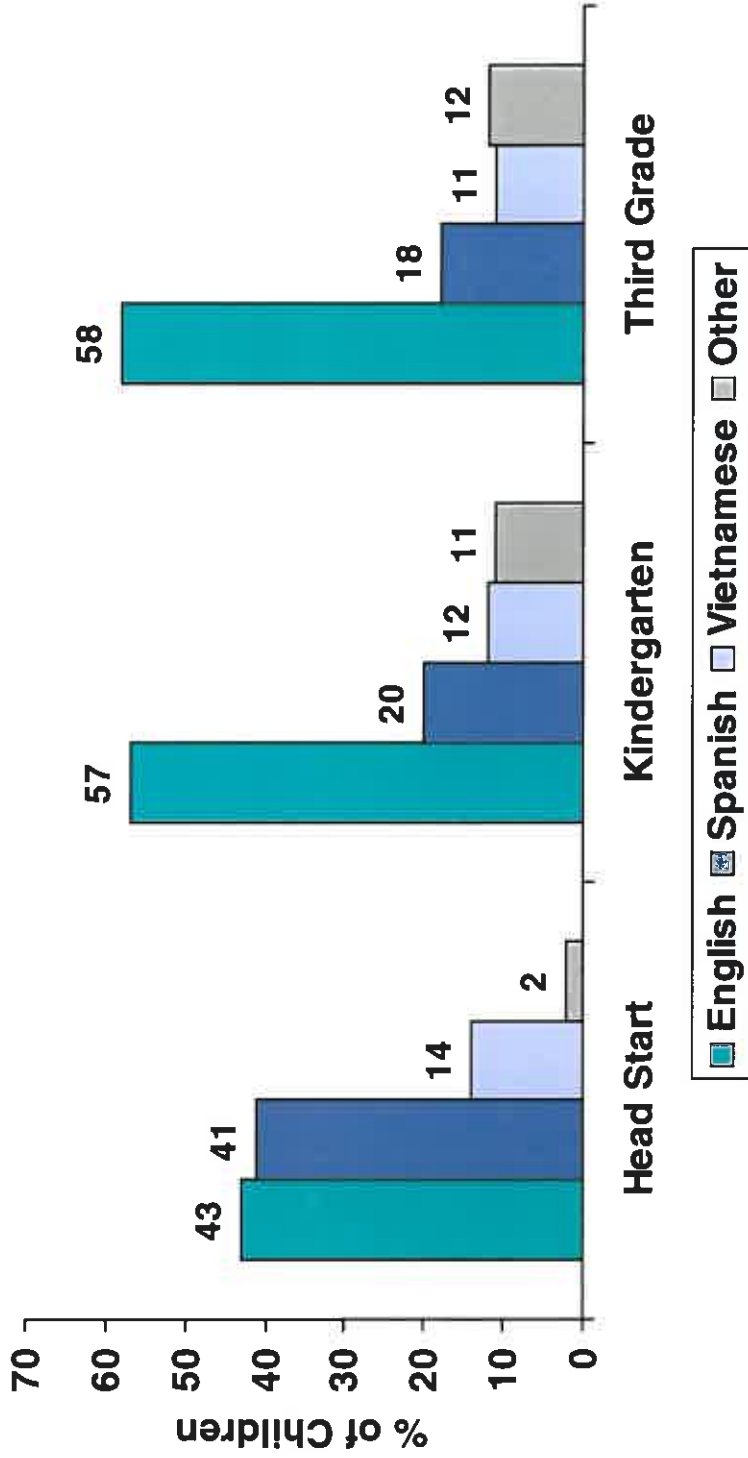


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Primary Language Spoken at Home

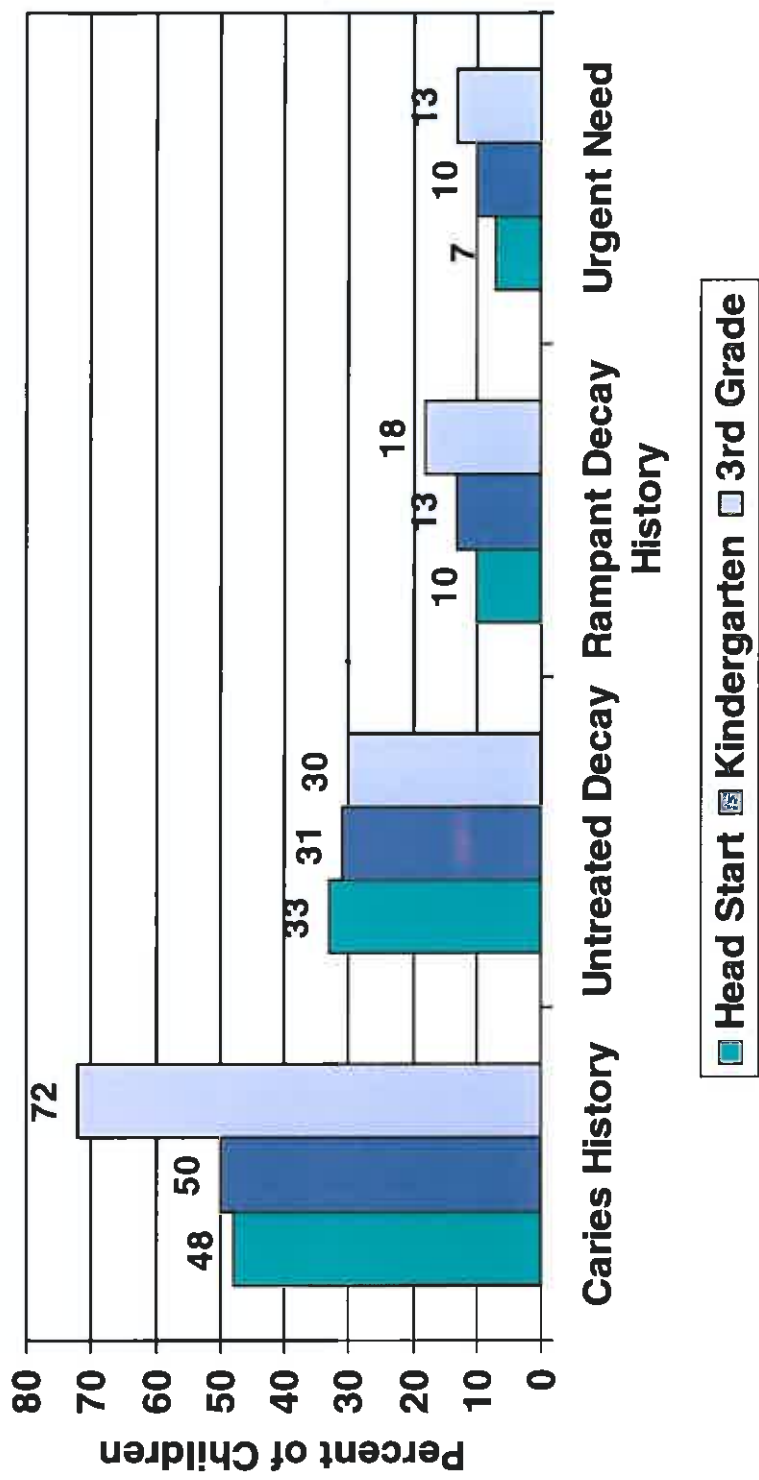


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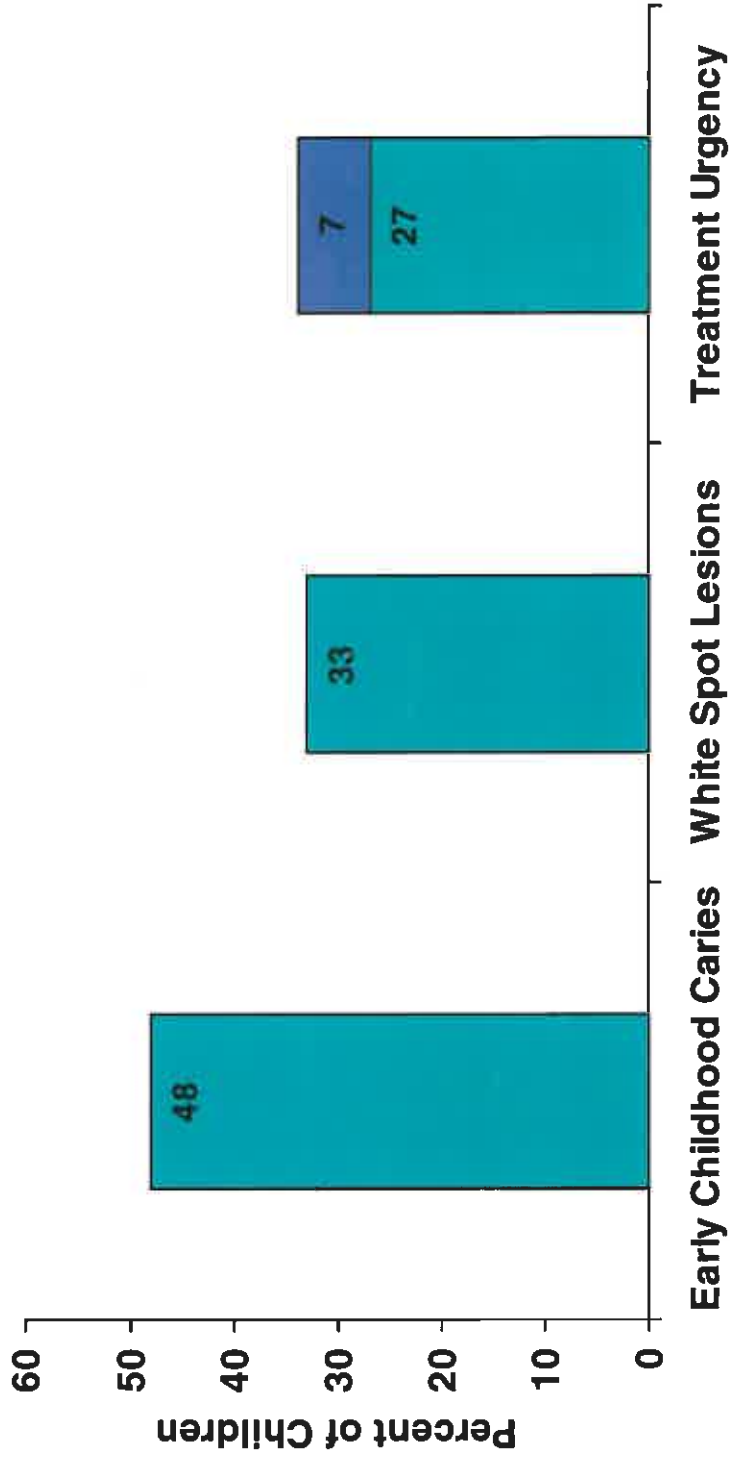
Oral Health of Santa Clara County Children Stratified by Age Group



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Oral Health of Head Start Children Santa Clara County

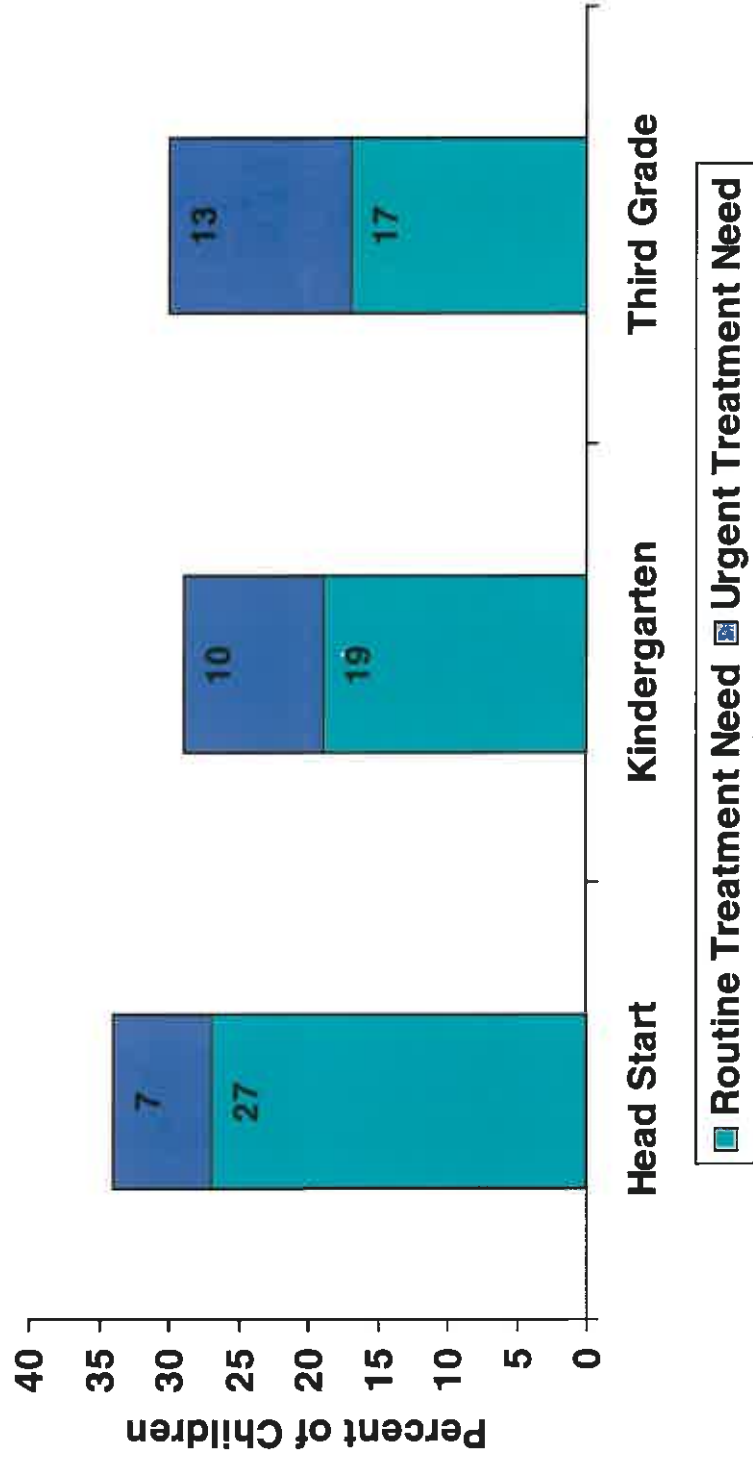


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Percent of Children Needing Dental Treatment Stratified by Age Group

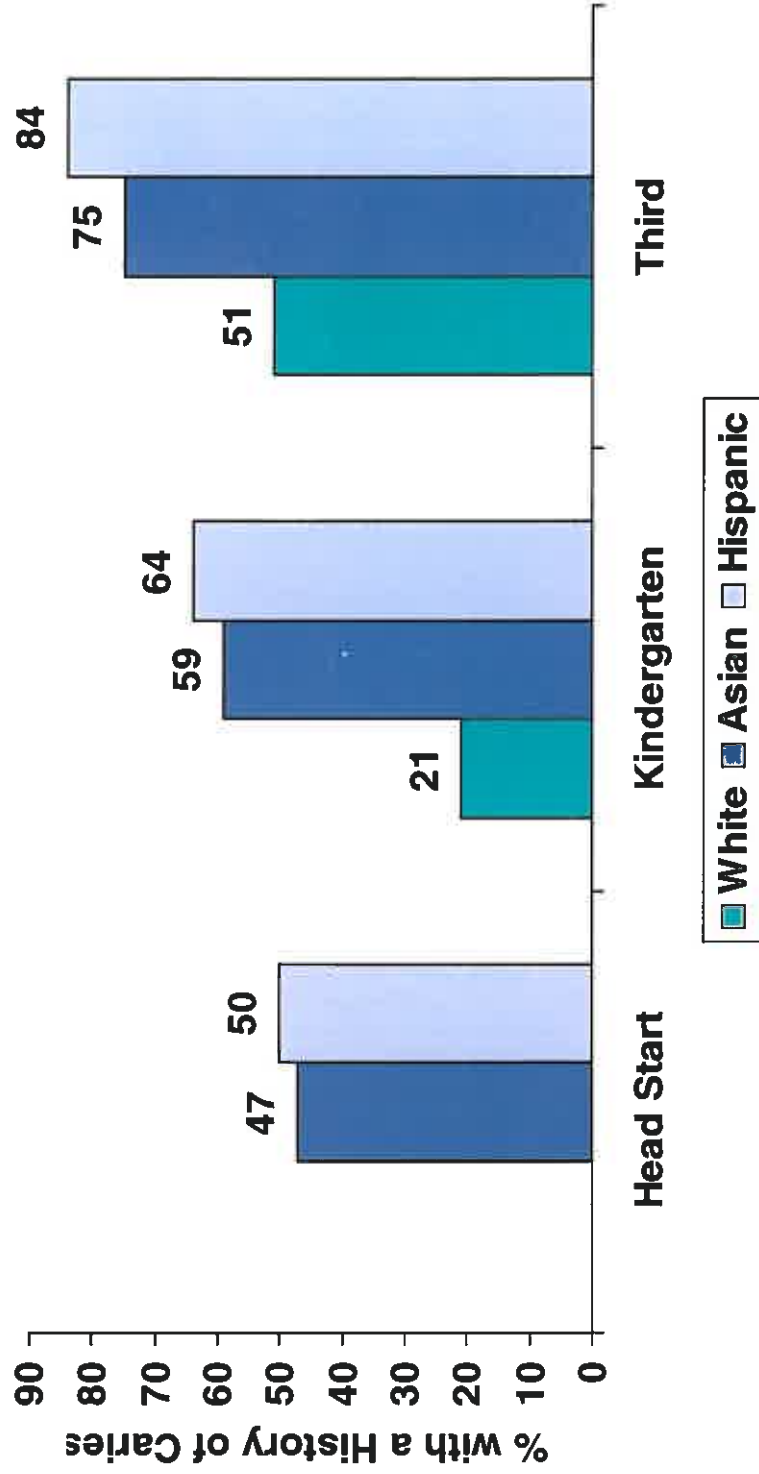


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Impact of Race/Ethnicity on Caries History

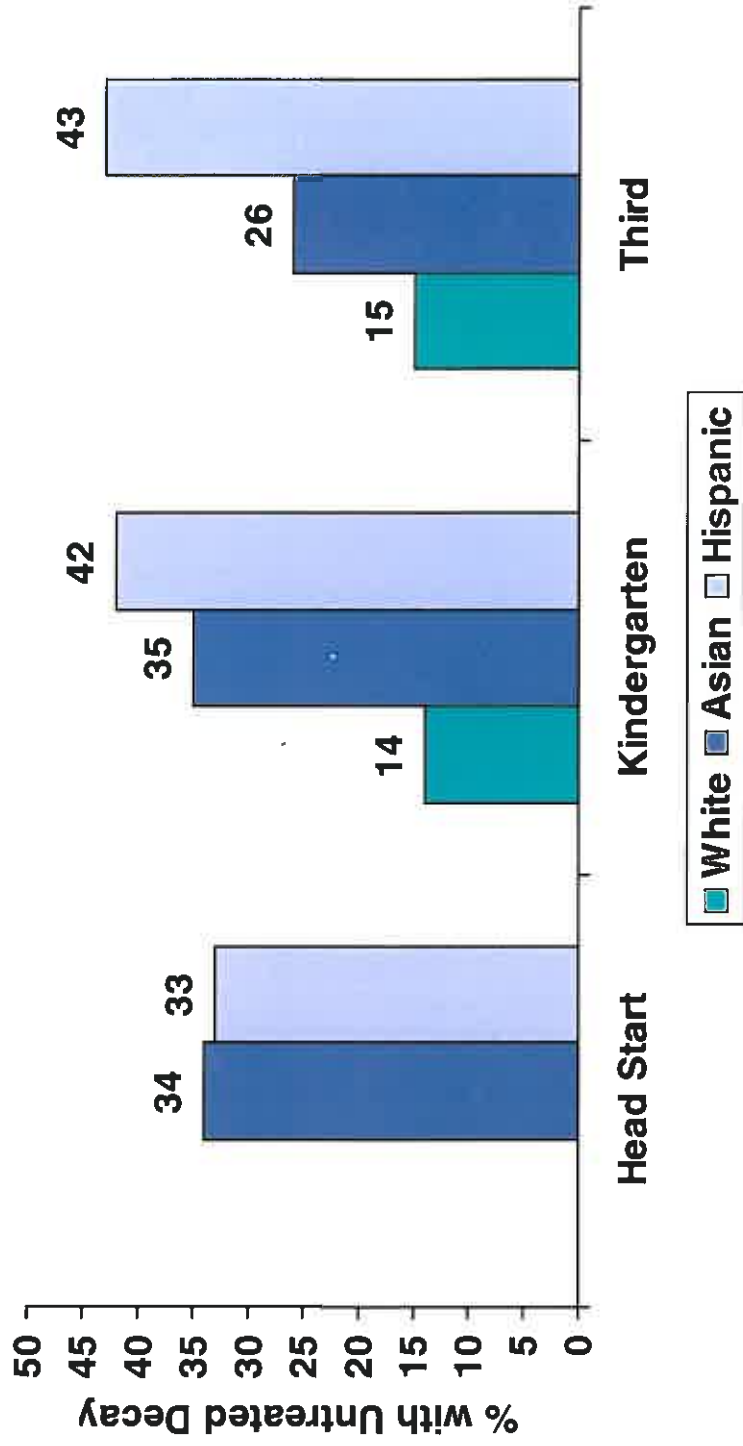


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Impact of Race/Ethnicity on Untreated Decay

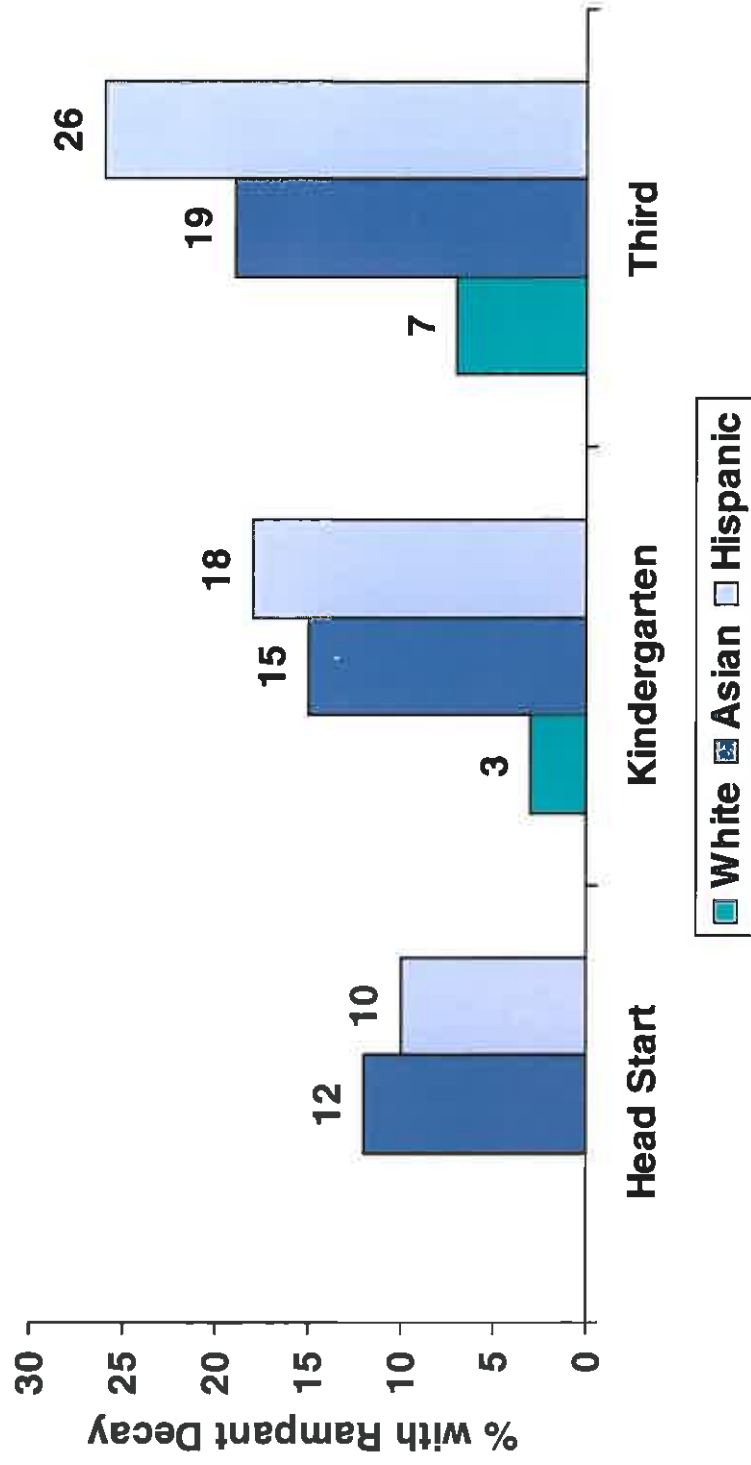


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Impact of Race/Ethnicity on History of Rampant Decay

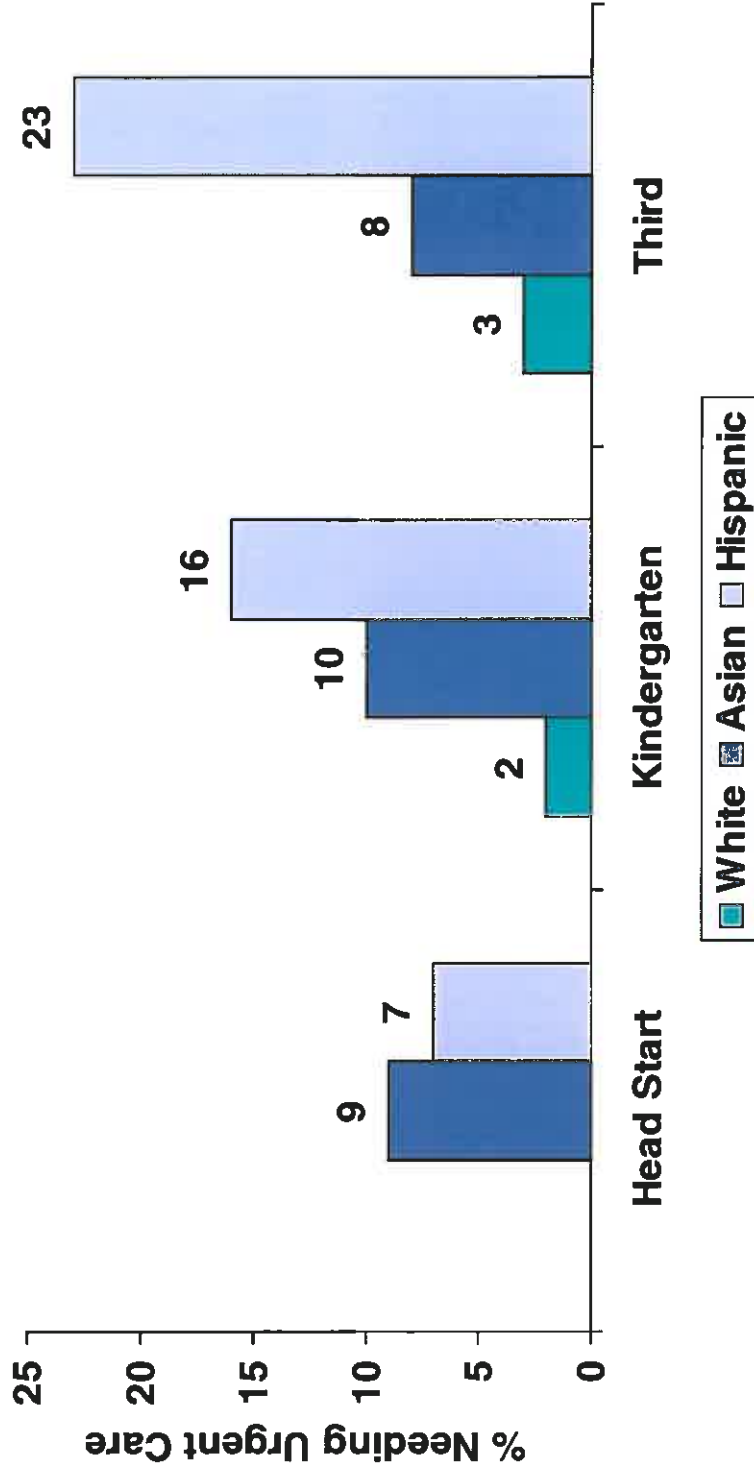


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Impact of Race/Ethnicity on Need for Urgent Dental Treatment

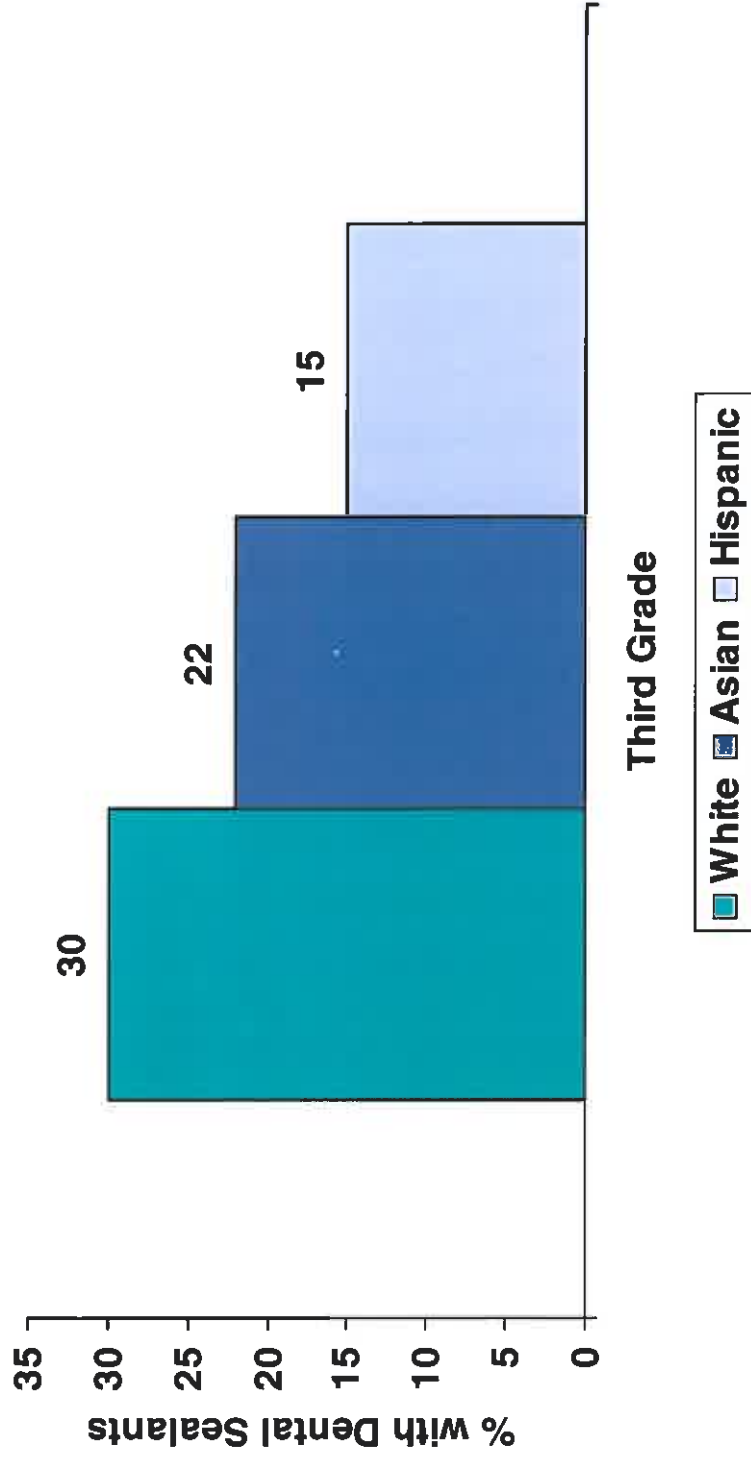


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Impact of Race/Ethnicity on Prevalence of Dental Sealants

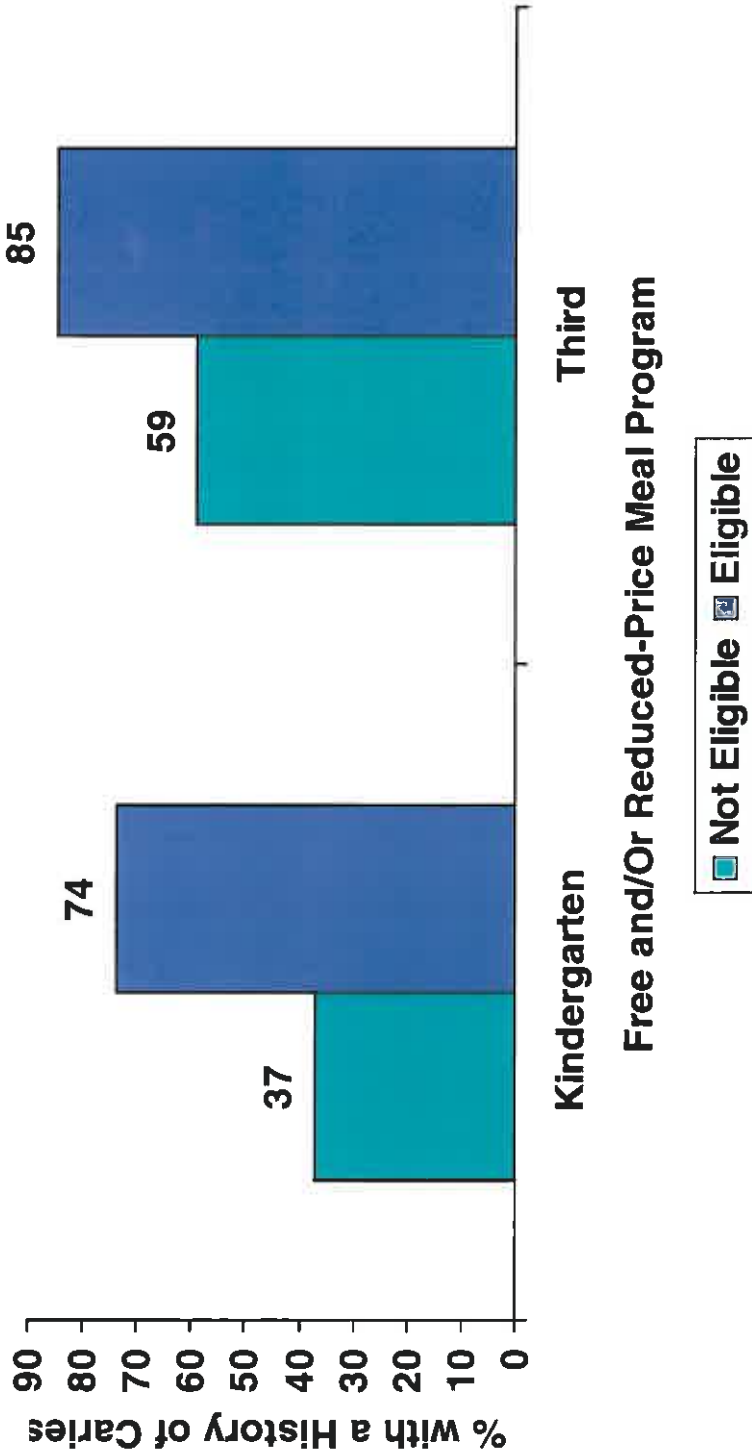


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Impact of Socioeconomic Status on Caries History

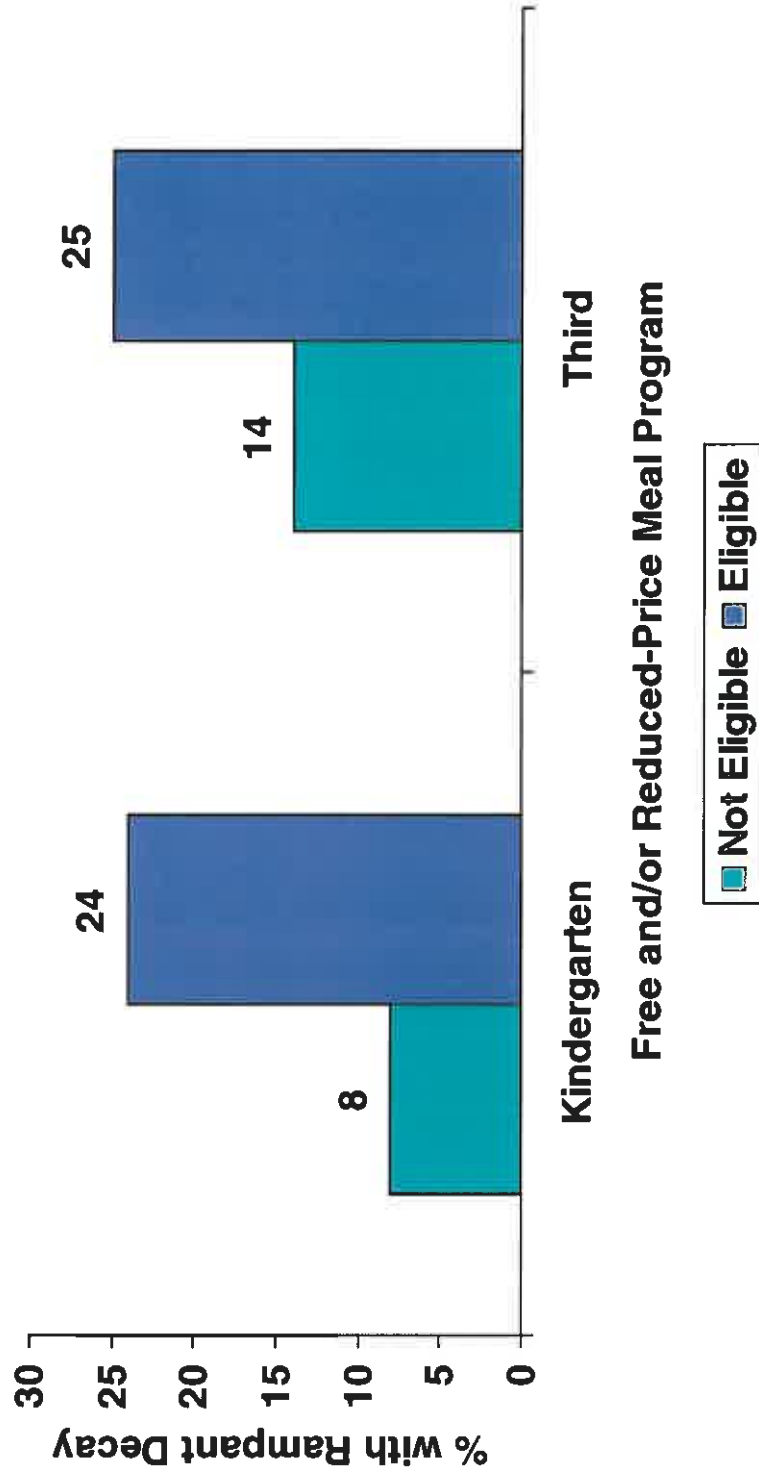


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Impact of Socioeconomic Status on History of Rampant Decay

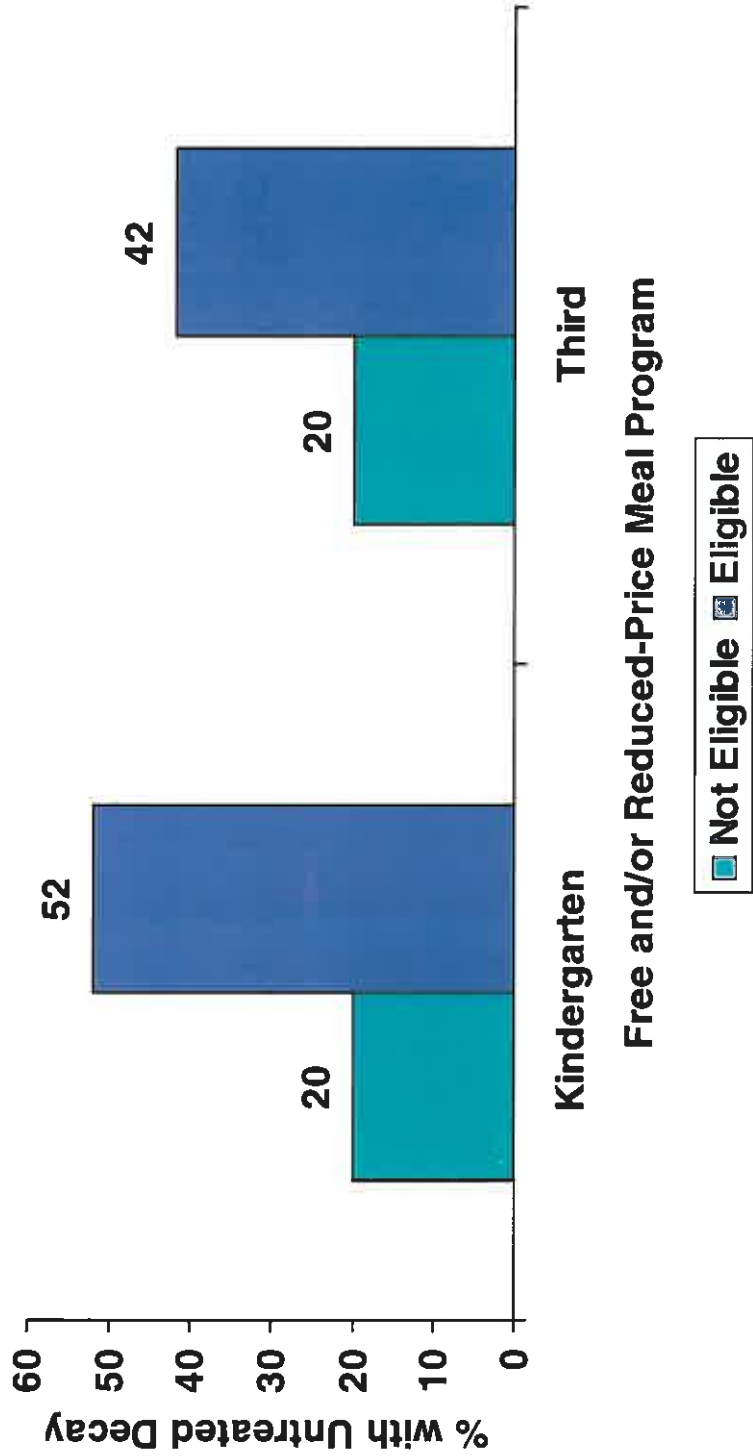


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Impact of Socioeconomic Status on Untreated Decay

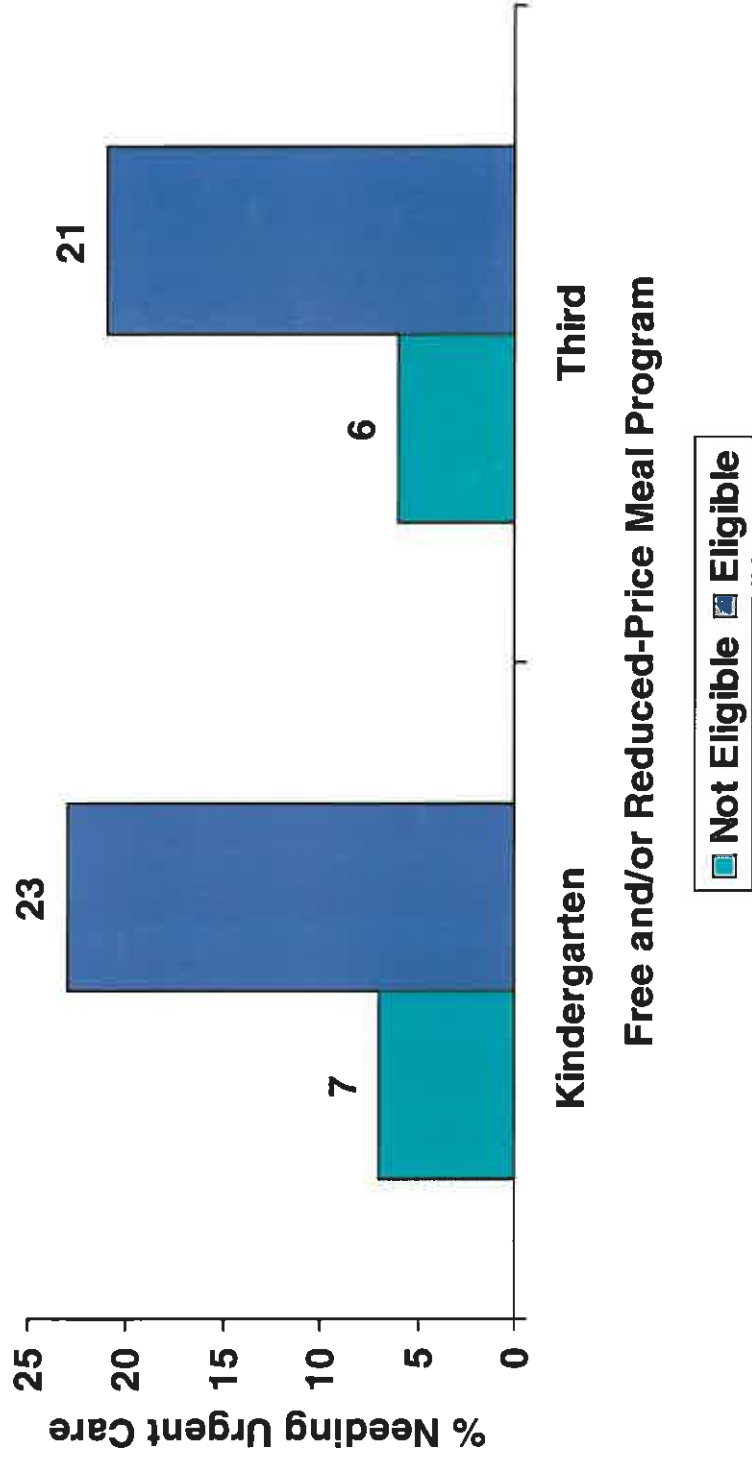


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Impact of Socioeconomic Status on Need for Urgent Dental Care

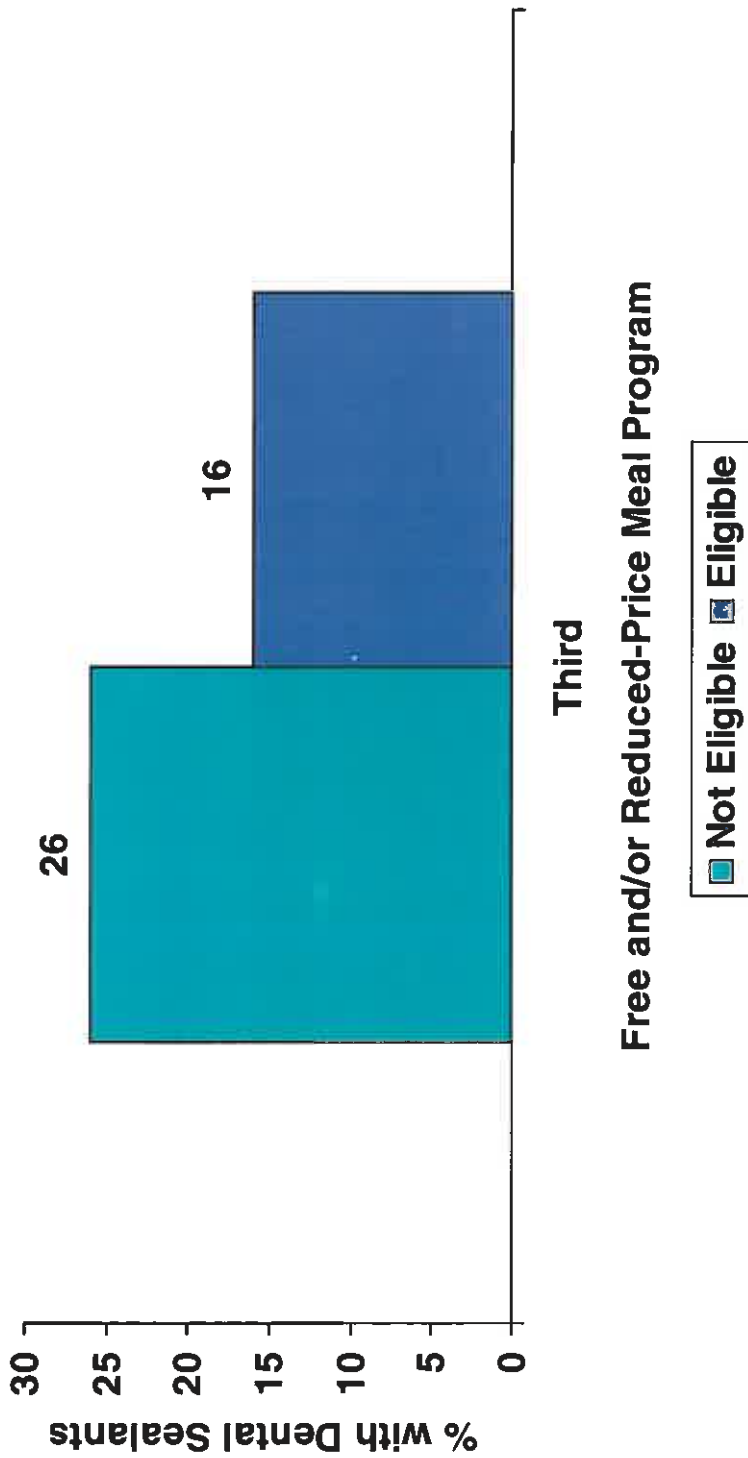


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Impact of Socioeconomic Status on Prevalence of Dental Sealants



Free and/or Reduced-Price Meal Program

Not Eligible Eligible

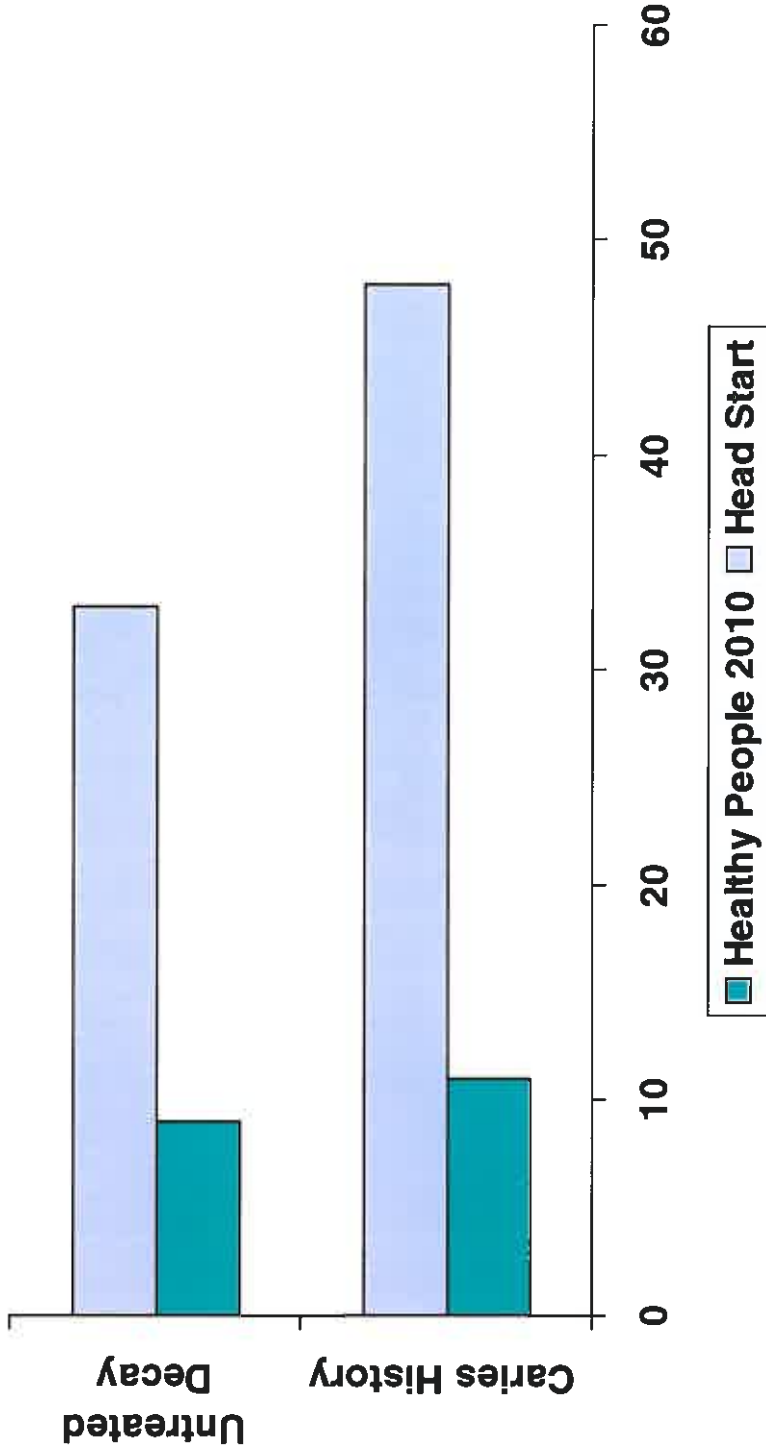


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Santa Clara's Head Start Children Compared to HP 2010 Objectives

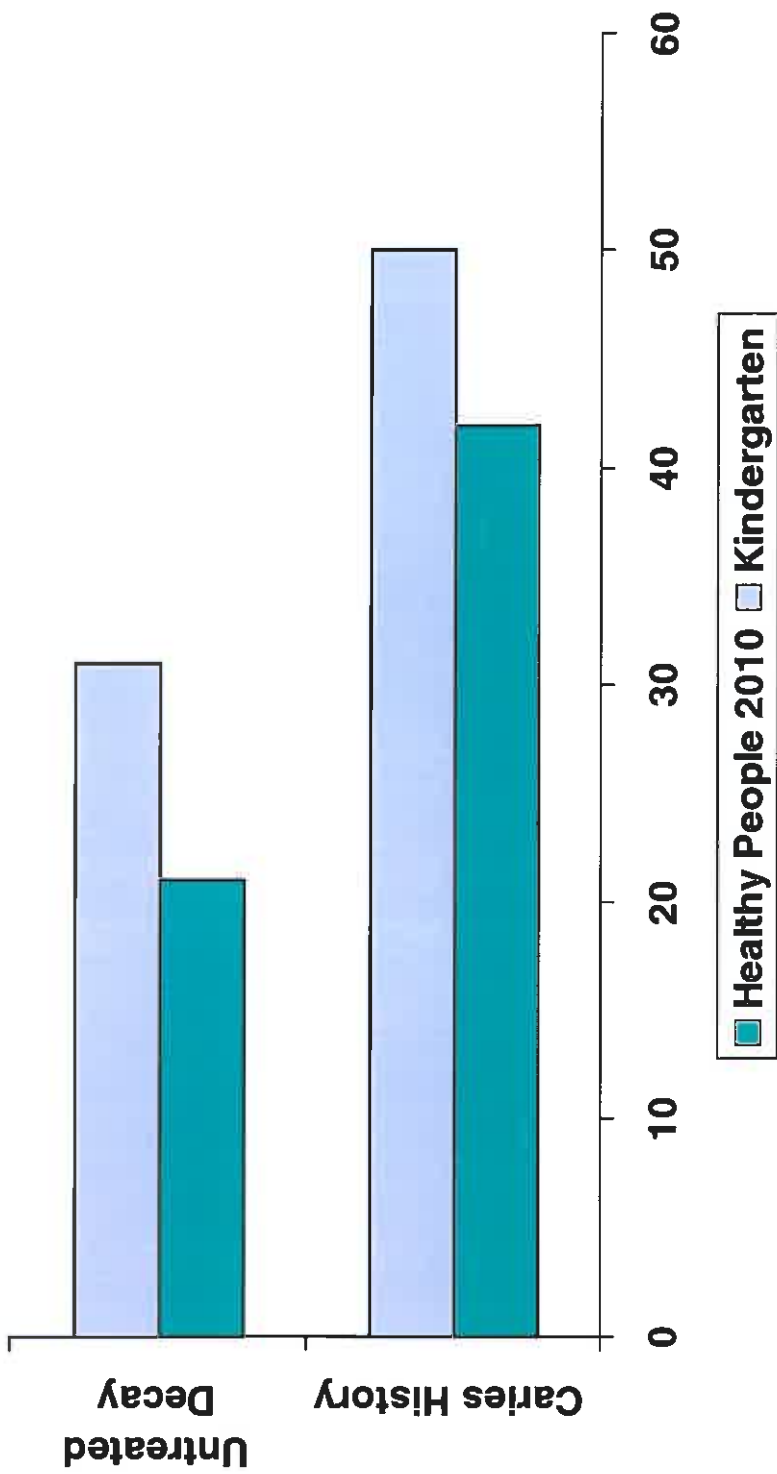


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Santa Clara's Kindergartners Compared to Healthy People 2010 Objectives

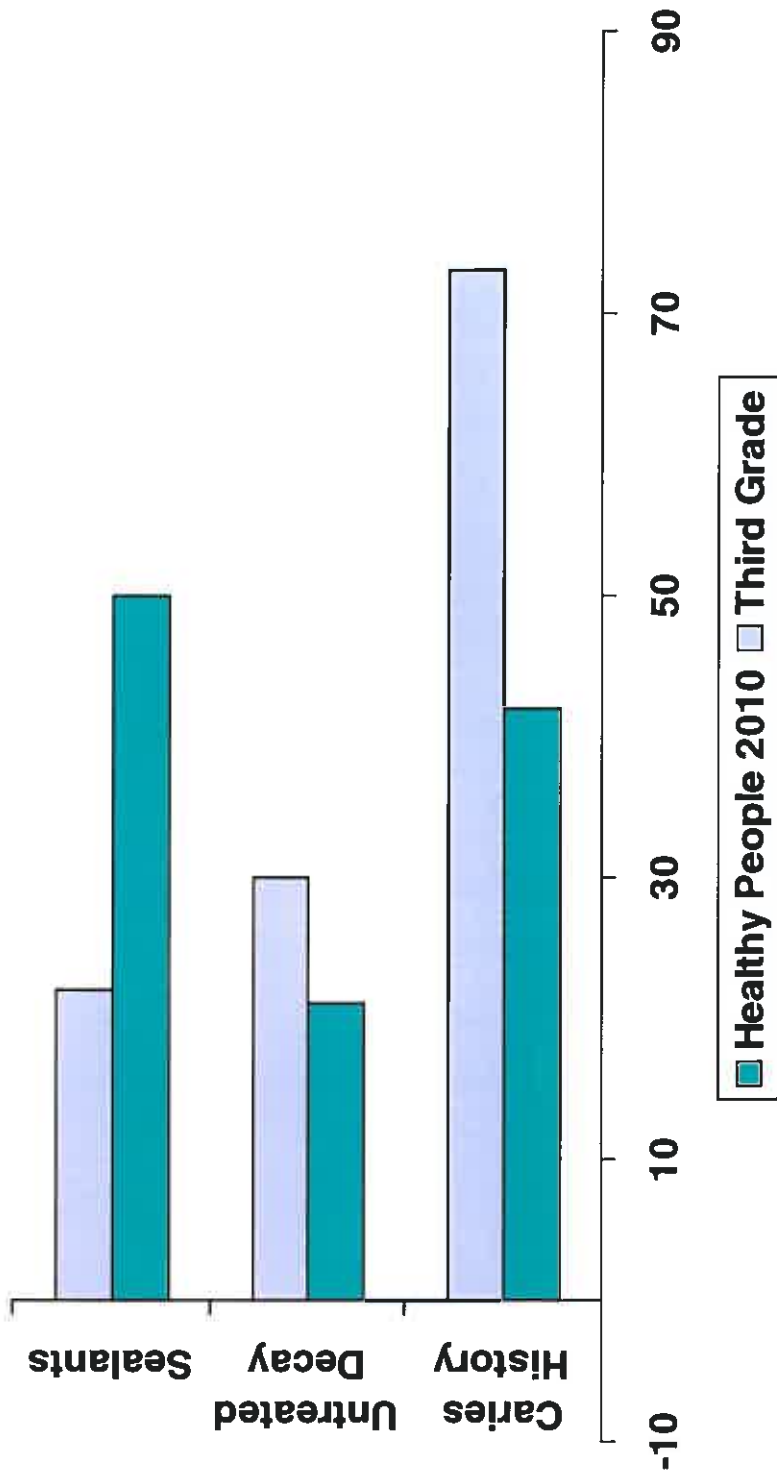


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Santa Clara's Third Graders Compared to Healthy People 2010 Objectives

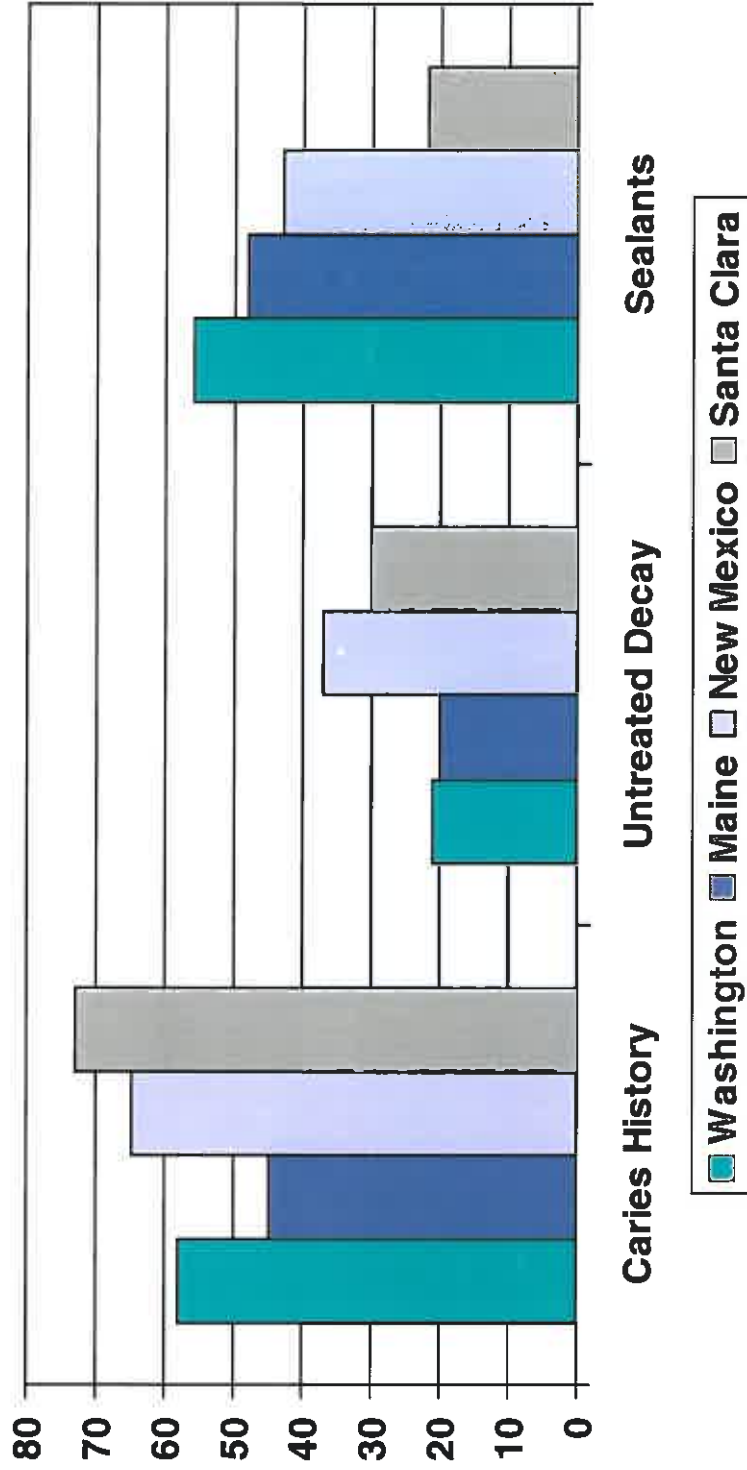


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Santa Clara's Third Graders Compared to Other States



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Santa Clara County

Demographics Relevant to Children's Oral Health

Santa Clara County Children's Report – Fall 2002

- ◆ Santa Clara County is 1,312 square miles – about the size of Rhode Island

- ◆ 5th largest population in California, 11th largest population in the United States
 - 1,719,600 residents
 - 456,402 children (27%) under the age of 18
 - 154,764 children (9% of total population) are age 5 and under
 - 301,638 children (18% of total population) are between ages 6 and 18

- ◆ Ethnicity of Children under the age of 18
 - Caucasians – 159,741 children (35% of total child population)
 - Latino – 150,613 children (33% of total child population)
 - Asian – 132,356 children (29% of total child population)
 - Berryessa Union Elementary, Cupertino Union Elementary, Evergreen Elementary, Milpitas Unified and Orchard Elementary School Districts contain the majority of the Asian children – Santa Clara County School Readiness Partnership Mapping Project – March 2003
 - African American – 18,256 children (4% of total child population)
 - Native American – 4,564 children (1% of total child population)

- ◆ Immigration Status
 - Native Americans – 1,134,936 residents (66% of total population)
 - Immigrants – 584,664 residents (34% of total population)

- ◆ Primary Language of Children Starting Kindergarten
 - English – 75% of children
 - Spanish – 15.5% of children
 - Vietnamese – 3.5% of children
 - Tagalog – 0.75% of children
 - Cantonese – 0.25% of children

- ◆ Free or Reduced Meal Program (130% Federal Poverty Level (FPL) or \$22,100 for free meals; 185% FPL or \$31,450 for reduced meals)
 - 69,050 children (23% of school aged children) are eligible for free or reduced meals
 - Lowest median income level families are found in the Palo Alto Unified, Luther Burbank Elementary, San Jose Unified, Franklin-McKinley Elementary, Santa Clara Unified, Campbell Union Elementary and Oak Grove Elementary School Districts – Santa Clara County School Readiness Partnership Mapping Project – March 2003

Santa Clara County School Readiness Partnership Mapping Project – March 2003

- ◆ Year 2000 Academic Performance Index (API) Scores
 - 67% of Santa Clara County's Schools are categorized as high performing
 - 16% of Santa Clara County's Schools are categorized as medium performing
 - 17% of Santa Clara County's Schools are categorized as low performing
 - Lowest performing schools are found in the Alum Rock Union Elementary, Franklin-McKinley Elementary, Gilroy Unified, Luther Burbank Elementary, Mountain View Elementary, San Jose Unified, Campbell Union Elementary and Santa Clara Unified School Districts
 - School districts with 50% or more low performing schools include Alum Rock Union Elementary, Franklin-McKinley Elementary and Gilroy Union

“A First Glance at the Children's Health Initiative in Santa Clara County” – Kaiser Foundation Report – August 2001

- ◆ Insurance Status of Children
 - 140,661 children at or below 300% FPL (family of 4 income level of \$54,000)
 - 91,239 children (65%) are at or below 133% FPL and qualify for MediCal/DentiCal
 - ✓ About 68,000 (August 2001) or 75% have enrolled
 - 32,771 children (23%) are between 134% and 250% FPL and qualify for Healthy Families
 - ✓ About 16,000 (August 2001) or 49% have enrolled
 - 16,651 children (12%) are between 251% and 300% FPL and qualify for Healthy Kids Santa Clara County (the Healthy Kids insurance product also covers children with undocumented alien status)
 - ✓ About 11,000 (January 2003) or 66% have enrolled
- ◆ Of the total population (140,661 children), over 95,000 (67.5%) have one of the three government sponsored insurance products

Santa Clara County Dental Society Membership Directory – 2001

- ◆ About 1,400 practicing dentists in Santa Clara County
 - 26 Pediatric Dentists
 - 1 in Gilroy
 - 2 in East San Jose
 - 34 Endodontists
 - 88 Orthodontists