

4964

**Evaluation and Expansion of the IHS/Head Start/CDC
Baby Bottle Tooth Decay (BBTD) Prevention Project**

Area: Headquarters - West

Status As Of: 9/30/92

Number: Evaluation-1 1-91

Estimated Cost - \$64,198 Disbursed - \$64,198



SYNOPSIS OF STUDY

The purpose of this project was to provide a comprehensive evaluation of the exportation of the technology from the Indian Health Service/Head Start/Centers for Disease Control Baby Bottle Tooth Decay Prevention (BBTD) Project to other Indian Health Service(IHS) sites where BBTD prevalence is 15 percent or greater. Strategies included the development of a marketing plan, the establishment of a hotline and newsletter, and the identification and training in two communities. The results of the evaluation will be used to recommend effective and appropriate methods of exportation to other IHS sites with a high prevalence of BBTD.

CONTRACTUAL MECHANISM

In House; contract portions of project via a Buy Indian contractor.

STATUS

During Fiscal Year '91 and Fiscal Year '92, this project has accomplished the following:

1. Developed the strategies for technology exportation.
2. Developed a marketing plan.
3. Rewrote the technical five-year report: Summary Report.
4. Developed a support network to transfer technology from original 12 pilot sites to other interested tribal groups.
5. Developed a policy and procedures manual for network operation.
6. Hired and trained .5 full time equivalent staff to provide technical assistance.
7. Established a hotline for technical assistance. Responded to 122 communications.
8. Produced and distributed four quarterly newsletters.
9. Revised and printed three training manuals.
10. Printed BBTD education materials.
11. Provided on-site training for the community at **Acoma-Canoncito-Laguna** Service Unit.
12. Provided on-site training for the **Coeur D'Alene** tribe at Plummer, Idaho.

A few unexpected spin-offs of the Office of Planning, Evaluation, and Legislation (OPEL) grant deserve mention:

-  The hotline and newsletters established a link between Indian and non-Indian BBTD sites that resulted in sharing of strategies, resources, and education materials. The support network also stimulated research on various topics related to BBTD.
-  The Centers for Disease Control (CDC), with IHS consultation, developed a videotape about BBTD.
-  CDC is implementing the recommended strategies for technology exportation for non-Indian communities interested in the prevention of BBTD.
-  A preschool curriculum, developed by the private company *Colgate*, will include information for parents about the prevention of BBTD.

PROJECT OFFICER

Eric Bothwell
Director
Dental Research
(505) 262-6319

CO-PROJECT OFFICER

Ray Burgess
Program Evaluation
Branch, DPEPA
(301) 443-4700

PROJECT DIRECTOR

Mary Beth Kinney
Education Specialist
Western Oregon S.U.
(503) 399-593 1

LIST OF ATTACHMENTS

- A. *Public Health Reports* Article
- B. Marketing Plan
- C. Summary Evaluation Report
- D. Policies and Procedures Manual
- E. List of Communications
- F. Newsletters
- G. Agendas and evaluation forms
- H. Budget

BACKGROUND INFORMATION

The Baby Bottle Tooth Decay (BBTD) program was originally pilot tested in 12 Indian communities over a five year period from 1984-1989. The BBTD prevention project represents a cooperative effort by three Department of Health and Human Service agencies:

- * Administration for Children, Youth, and Families, Head Start Bureau
- * Indian Health Service, Dental Program-
- * Centers for Disease Control, Dental Disease Prevention Activity.

The BBTD program is a multi-disciplinary, community-based intervention. Two approaches were chosen as intervention strategies. The first approach is one-to-one counseling with the caretakers of young children. Health professionals, parents, and tribal employees are trained to counsel parents both individually and through group meetings. The second major approach is implementation of a media campaign designed to raise awareness and knowledge about BBTD community-wide. The BBTD sites have customized and added to the strategies and developed additional education materials.

During the initial five year period of program implementation, the prevalence of BBTD was decreased from 57 to 39 percent, resulting in a 32 percent reduction of BBTD. Not only is this decrease statistically significant ($p < .001$), it also, represents a significant cost-savings in dental treatment, trauma, pain, and related health problems. If one assumes a conservative cost estimate and a reduction of 32 percent in BBTD cases at the 12 sites, then BBTD was prevented in 448 children whose treatment would have cost \$313,600.

Given the success of the original BBTD program, issues arose concerning the transfer of the BBTD program to other Indian communities. The OPEL grant has served to provide the resources to explore the exportation of this technology.

See Attachment A: *Public Health Reports* Article

1. STRATEGIES FOR TECHNOLOGY EXPORTATION

Several strategies were chosen for technology exportation. The strategies included the development of a marketing plan, on-site training at two new sites, development and distribution of the five-year report rewritten in lay language, development of a newsletter, and development of a national hotline. Each of these strategies is discussed further in the following sections of this report.

2. MARKETING PLAN

The marketing plan outlines two themes and logos and describes their applications for the newsletter, hotline, and other communications. The "Moccasin Telegraph" theme and logo have been widely used and accepted. The "Out of the Mouths of Babes" has not been used as widely as expected, but it is being used by CDC as the title for their new BBTD videotape. The marketing plan also outlines the strategies for raising awareness about the BBTD program and technology exportation for interested communities.

See Attachment B: Marketing Plan

3. SUMMARY EVALUATION REPORT

The original five-year report was written for those well versed in research and it describes the evaluation methodologies and statistical analyses. It was decided that a simpler report was needed for wide distribution to IHS communities so the technical five-year report was rewritten in lay terms. The "Summary Evaluation Report" is brief, easy to understand, and includes more graphics and artwork than the original report. The Summary Report was distributed with the first newsletter. It has also been sent across the country to those requesting information about the BBTD program.

See Attachment C: Summary Evaluation Report

4. SUPPORT NETWORK

In order to export the BBTD program, a support network was created to facilitate the technology transfer. The vehicles for communication are the newsletter, the hotline, and on-site training of new sites. These “vehicles” need drivers. The real support network is the people who provide the expertise for the technology transfer. The technical consultants are the members of the original core group of planners, the trained staff member who answers the hotline, and perhaps most important, the people from existing BBTD sites who share their expertise with other communities.

5. POLICY AND PROCEDURES MANUAL

A policy and procedures manual was developed to train the staff member who answers the hotline. The manual provides background information about the BBTD program and describes appropriate procedures for handling communications.

See Attachment D: Policy and Procedures Manual

6. STAFF

One staff person was hired to work half-time, primarily handling **communications** generated by the newsletter and assisting in the implementation of the other strategies for technology transfer. The staff member was trained by a BBTD technical consultant, but most of her expertise has come through her experience on the job.

The staff member hired for the project is a Native American woman who is working toward a degree in sociology. Her qualifications included previous work experience with IHS in support positions and good communication skills. Because of her skill and enthusiasm, this staff person has also participated in the BBTD trainings in two communities.

7. *HOTLINE*

Since one of the goals of the technology transfer was to generate interest in the BBTD program, a hotline was created to answer questions and disseminate information about the BBTD program. Since its inception, the hotline has responded to 122 communications. This number does not include communications received by other technical consultants through mechanisms other than the hotline. The communications received through the hotline were from IHS staff, tribal employees, Women, Infant, and Children (WIC) and Maternal and Child Health (MCH) staff, Head Start staff, researchers, State and County Health Department staff, private dentists, National Health Service core staff, physicians, and various other sources. The hotline answers technical questions about BBTD programs, shares resources for BBTD education materials, disseminates written materials, and shares information between BBTD sites. For example, if a site is interested in a certain strategy, they might be told to contact another site that has successfully implemented that strategy.

See **Attachment E: List of Communications**

8. *NEWSLETTERS*

Four quarterly newsletters, "The Moccasin Telegraph", were designed and distributed during the grant period. Each newsletter highlighted a successful site, summarized recent research, provided information for ordering education materials, and gave information of general interest to those trying to prevent BBTD. The newsletter was originally distributed to each IHS dental clinic, Indian WIC programs, Head Start programs, and a selection of key community organizers and researchers across the country. People interested in remaining on the newsletter mailing list were asked to contact our staff. Eventually, the newsletter was mailed only to those on the mailing list.

See **Attachment F: Newsletters**

9-10 *TRAINING MANUALS and PRINTING*

Three manuals were originally developed for the BBTD program:

- * How To Organize A BBTD Program
- * BBTD Training Manual
- * BBTD Training of Trainers Manual

These manuals were revised and printed during the grant period. "How To Organize A BBTD Program" is routinely distributed in response to requests for further information about setting up a BBTD program. The training manuals were used at the trainings for the two new sites and will be used for future training of new sites.

OPEL grant monies were used to print BBTD education materials as needed for training and also to meet requests from existing BBTD programs.

Manuals available upon request

11-12 ON-SITE TRAININGS

Two communities were self-selected for on-site training: **Acoma-Canoncito-Laguna S.U.** and Coeur D'Alene tribe. Both sites responded to a call for communities interested in establishing BBTD programs. It was also required that training sites have at least a 20 percent prevalence of BBTD. Fifteen IHS health professionals and tribal employees were trained at **Acoma-Canoncito-Laguna** on March 10-11, 1992. The training at Coeur D'Alene on September 14-15, 1992 included fifteen participants who were a mix of tribal health employees, a day-care administrator, and an elder who is a health advocate for the community.

The BBTD training program is designed to help communities prepare themselves for implementing the BBTD Prevention Program. The training is suitable for health professionals from various disciplines, **para-professionals**, and parent or grandparent volunteers who are interested in becoming involved in the project.

The training provides information on oral diseases with a focus on the etiology and prevention of BBTD and an overview of the BBTD program. Then, skills are taught that will enhance the counseling relationship between the workers and the caretakers of infants in the community. Skill-building focuses on empathic listening and non-judgmental transfer of information. Trainees are then given information to improve their skills in providing group presentations. Finally, an exercise guides participants in designing their own BBTD program customized to the community. Closure involves an exercise that helps trainees articulate their personal and their community's strengths and weaknesses and a second exercise for short-term goal setting.

TRAINING OBJECTIVES:

1. During role playing, each trainee will demonstrate knowledge of the cause and prevention of Baby Bottle Tooth Decay.
2. In a one to one setting, each trainee will demonstrate effective listening and persuasion skills towards the prevention of BBTD.
3. Each trainee will be able to list the four basic principles for making an effective group presentation on BBTD.
4. Each community group will complete the "Community Planning Worksheet" as a draft of the BBTD program that they plan to establish in their local community.

The evaluation forms asked participants to rate the quality of the training by asking questions about the clarity of training objectives, audiovisual materials, manuals, handouts, instructor communication, and instructor attentiveness to group needs. On a scale of 1-5, with 5 as the high score, the participants rated these items an average 4.8 at both training sites.

See Attachment G: Agendas, Evaluation Forms

SPIN-OFFS

Several significant “spin-offs” evolved during the OPEL grant period as a result of the large effort made to export the technology for successful BBTD programs:

 **The hotline and newsletters established a link between Indian and non-Indian BBTD sites with sharing of strategies, resources, and education materials between the two.**

It was not expected that so many hotline communications would come from researchers and administrators of non-Indian programs across the country. BBTD programs are now being initiated in State and County Health Departments. These programs have relied heavily on the IHS BBTD materials and strategies. We have reviewed program plans, survey forms, and other materials for these agencies. One example is the state of Washington where King County Health Department is working in conjunction with other organizations to distribute 30,000 Stop BBTD **tippee** cups and pamphlets to WIC clients at the six-month assessment of infants. The University of Washington is conducting a research project in conjunction with the state-wide BBTD program to assess the impact of toothbrushing on the development of BBTD. Additional research has been stimulated in the areas of disease progression, chemotherapeutic approaches, and qualitative investigation of parental attitudes and beliefs about child-rearing.

 **The Centers for Disease Control (CDC), with IHS consultation, developed a videotape about BBTD.**

This videotape is targeted to caretakers of infants and can be used as an education tool in local communities. A second section of the videotape outlines the BBTD program and its keys to success. This portion is targeted to program administrators and task force members. The videotape was produced with IHS consultation to assure appropriateness in Native American communities. The videotape is also available in Spanish and will be distributed widely during the coming year.

 **CDC is implementing the recommended strategies for technology exportation for non-Indian communities interested in the prevention of BBTD.**

CDC is offering on-site BBTD training to non-Indian communities interested in the prevention of BBTD. CDC will require 20 percent prevalence of BBTD for on-site training and technical assistance. The first such training was in March, 1992 in Minnesota. The need was so great that CDC has entered into a contract with a trainer who has experience training the original IHS BBTD sites. The first training is scheduled in October with a community organized by the Illinois State Health Department. This effort will export the BBTD program virtually nationwide. CDC will use the IHS organization and training manuals. CDC is currently making minor revisions on the manuals, translating them into Spanish, and will distribute them to Native and non-Native communities upon request. Furthermore, CDC has agreed to print and distribute the BBTD education materials. This alleviates the need for a warehouse/distribution network in IHS.



A preschool curriculum, developed by Colgate, will include information for parents about the prevention of BBTD.

A new curriculum to prevent dental disease and promote oral health has been developed for preschool children and their families. This effort is funded by Colgate. The curriculum was recently completed and the first teacher training will be conducted for Indian Head Start programs in Minnesota during October. Both Native American and non-Native preschool children and their families will be using the curriculum. The curriculum itself has 23 activities which include songs, posters, an oversized book, toothbrush kits, parent take-home materials, and much more. During one section of the curriculum, flyers about BBTD are sent home to parents. The information about BBTD is taken from the IHS BBTD program materials and will provide an excellent addition to the current BBTD program.

RECOMMENDATIONS

Successful exportation of the BBTB program will require an ongoing effort to provide training, technical assistance, and a network for communication between established BBTB sites. The OPEL grant has allowed us to experiment with a range of strategies and the following recommendations have emerged:

1. **Establish technical consultants** to answer questions from both new and established BBTB programs. These consultants could be chosen from the original BBTB core group of planners. It is also necessary to establish a contact person for those people interested in organizing BBTB programs in Indian communities. Upon initial requests for information, the summary five-year report and "How To Organize a Pilot Site" manual should be mailed.
Estimated Cost: In Kind
2. **Publish and distribute the newsletter two times a year.** The purpose of the newsletter should be to link BBTB programs by providing a network for communication. The newsletter should be sent to those on the newsletter mailing list.
Estimated Cost: \$3000
3. **Continue to offer the BBTB training** to communities interested in organizing a BBTB program. These sites should document a 20 percent prevalence of BBTB. We have NOT found an acceptable alternative to on-site training. The BBTB training appears to create a level of enthusiasm, skill building, and technology transfer that cannot be produced by less intensive methods. Furthermore, it is recommended that all such trainings include a 1-2 hour planning session where the training participants actually conduct their first BBTB planning meeting. These sessions have been highly productive.
Estimated Cost: \$6000
4. **Continue efforts to establish linkages between Native American and non-native BBTB programs.** Although culturally diverse, the information shared between all BBTB programs and research projects can be beneficial to building the technology for successful programs. This can be achieved through the newsletter and continuation of the hotline. Continuation of the hotline would require one .5 FTE staff member. The staff member can also handle initial contacts requiring information about the BBTB program, assist in printing and distributing education materials, organize trainings, gather newsletter materials, and provide a link between BBTB sites and the technical consultants.
Estimated Cost: \$8000
5. **Continue the coordination of efforts with the Centers for Disease Control.** By sharing resources and technical consultation, both Native and non-Native BBTB programs will benefit from the increased resources and efforts of two coordinating agencies.
Estimated Cost: In Kind

county. Other national MCH health objectives that could be used in this way include objectives to reduce infant and maternal mortality rates (I). Because of the small number of births occurring in Umatilla County, even during a 14-year period, the significance of these measures would be difficult to interpret. Still other national health objectives could be used for AI communities, although comparable data for the non-AI population may not be readily available. As an example, the IHS is establishing surveillance systems to estimate the proportion of AI women who smoke or use alcohol during pregnancy. The surveillance will allow local AI communities to set and measure public health objectives designed to protect fetuses, as well as mothers. IHS area offices will be able to monitor progress on these objectives in several local AI communities and evaluate the efficacy of public health intervention efforts to achieve the objectives.

We conclude that (a) vital record data can be used to assess changing health patterns in small areas for both minority and majority populations,

(b) additional risk data should be collected and used to focus preventive health care programs in local areas, and (c) vital record and behavioral risk data together can be used to monitor achievement of public health objectives. The IHS, in collaboration with State health departments, plans to pursue this strategy in the 1990s.

References

1. Public Health Service: Promoting health, preventing disease. Objectives for the nation. U.S. Government Printing Office, Washington, DC, 1980.
2. Community-oriented primary care: from principles to practice, edited by P. A. Nutting. U.S. Government Printing Office, Washington, DC, 1987.
3. American Public Health Association: Model standards: a guide for community preventive health services. Ed. 2. Washington, DC, 1985.
4. Oregon Health Division: Health objectives for the year 2000. Report of the Oregon health 2000 project. Portland, OR, 1988.

Preventing Baby Bottle Tooth Decay in American Indian and Alaska Native Communities: A Model for Planning

BONNIE BRUERD, MPH, DrPH Cand.
MARY BETH KINNEY, RDH, MPH
ERIC BOTHWELL, DDS, MPH, PhD

Ms. Bruerd worked as a Prevention Coordinator for the Indian Health Service from 1983 to 1988 and is now self-employed as a health policy consultant in Salem, OR. Ms. Kinney is a Dental Education Specialist with the Dental Disease Prevention Activity of the Centers for Disease Control. She also coordinates the Head Start interagency agreement with the Indian Health Service's Dental Branch. Ms. Kinney is stationed in Salem, OR. Dr. Bothwell is Director of Dental Research and Program Communications for the Indian Health Service, Dental Services Branch, at the Field Support and Program Development Section in Albuquerque, NM. The opinions expressed in this paper are those of the authors and do not necessarily reflect the views of the Indian Health Service.

Tearsheet requests to Mary Beth Kinney, Chemawa Indian Health Center, 3750 Hazelgreen Road, NE, Salem, OR 97305.

Synopsis

Baby bottle tooth decay (BBTD) is a preventable dental disease which surveys have shown affects more than 50 percent of Native American children. An experimental program to prevent BBTD was implemented in 12 Native American communities. The project represented a cooperative effort by three Department of Health and Human Service agencies: Administration for Children, Youth, and Families, Head Start Bureau; Indian Health Service, Dental Program; and Centers for Disease Control, Dental Disease Prevention Activity,

Intervention strategies included the training of parent volunteers, health professionals, and the tribal employees who counseled caretakers of young children and made group presentations. There was also a media campaign in each community that ran for a 3-year period. Numerous educational materials were developed including training manuals, counseling booklets, tippee cups, posters, and bumper stickers. The BBTD project's planners encouraged tailoring the education materials and

strategies to fit each community. Preliminary results documented statistically significant decreases in the prevalence of BBTD at the pilot sites. This

multidisciplinary, comprehensive intervention offers a model for organizing members of minority communities to prevent health problems.

PREVENTING BABY BOTTLE tooth decay (BBTD) is the goal of several imaginative campaigns underway in Native American communities. The BBTD project is an experiment, and it offers a model for designing interventions in minority communities. The purpose of this paper is to describe the interventions aimed at the prevention of baby bottle tooth decay (BBTD) in Native American communities. It is a cooperative effort of three agencies of the Department of Health and Human Services: Administration for Children, Youth, and Families, Head Start Bureau; Indian Health Service, Dental Program; and Centers for Disease Control, Dental Disease Prevention Activity. Development of the program began in 1984, and it was implemented at the first four sites in 1985. In 1986, eight more sites were added. Assessment will continue until 1990, and it is anticipated that the project will continue indefinitely. The design and implementation of the intervention are described in this paper, and preliminary evaluation results are reported. The authors wrote the original grant proposal for the BBTD project and served on the core planning group.

Background

Baby bottle tooth decay is dental disease that is often severe in the primary dentition. It is characterized by a unique pattern of decay beginning with the maxillary primary incisors followed by the primary molars, in order of eruption (Z-IO). Long-term ramifications of BBTD may include otitis media, orthodontic problems, speech disorder, and possible psychosocial concerns (10).

Baby bottle tooth decay is the result of one or both of the following behaviors: leaving a bottle with a child at nap or bedtime and permitting a child to walk around or sit with a bottle during waking hours (1,10). Any liquid with fermentable sugar can cause BBTD. These liquids include formula, milk, juice, and pop (1,11). Inappropriate breast feeding, usually the result of a mother and infant sleeping together with the child nursing at will throughout the night, has also been reported to cause BBTD in rare instances (12).

In 1983-84, an Indian Health Service (IHS) survey of 1,321 children 0-4 years old documented

that approximately 52 percent of the children had BBTD (13). In 1985, a survey of 514 Native American children in Oklahoma and Alaska reported 53 percent prevalence of BBTD with a range of 17 to 85 percent in the 18 communities surveyed (14). In a survey of 1,607 Cherokee and Navajo Head Start students (15), 70 percent of the children were affected by BBTD, and 87 percent of those affected displayed the most severe manifestation of the disease. "Severe" was defined as two or more maxillary anterior tooth surfaces with caries, plus one or more teeth with pulpal involvement or mandibular anterior decay, or both. Head Start and IHS cost estimates, based on children treated under contract by pediatric dentists in private practice, are \$700 to \$1,200 for a moderate to severe case of BBTD. If hospitalization is necessary, the cost is approximately doubled.

Program Design and Description

Head Start dental consultants gathered preliminary data on the prevalence of BBTD in Native American communities. The authors outlined an intervention and submitted a grant proposal in 1984 to the Head Start Bureau for funding. When the grant was awarded to the IHS dental program, a core group of 12 experts in children's health, dental disease, nutrition, health education, and research was formed to design the intervention and an evaluation of its effects. The core group also provided technical consultation and continuity to the project sites throughout the implementation and evaluation stages of the project.

The question to be answered by the evaluation was whether a community-based health education intervention could effectively reduce the prevalence of BBTD among Native American children. At the onset, the measurable goal established was to reduce the number of children with BBTD by 50 percent in a 5-year period.

The target population of this program was actually the caretakers of young children, since only by their actions can BBTD be prevented. Through the 12 Indian Head Start programs that are the grantees, the BBTD project serves more than 4,700 children and their families. In addition, the project has expanded to the majority of the remaining 93

Indian Head Start grantees to include more than 14,000 Head Start children and their families.

There were initially four pilot sites: Cherokee Nation, OK; Rosebud Sioux, SD; Leupp (Navajo), AZ; and **Tlingit-Haida**, AK. These were labeled "high intensity" sites because the site coordinators and parent volunteers were trained directly by professionals of the project development team who visited each site during the first year of the project. In 1986, it was decided to test the intervention at different intensity levels. Four "medium intensity" sites-Isleta Pueblo, NM, Northern Cheyenne, MT, White Mountain Apache, AZ, and Yakima Nation, WA-were selected. Four "low intensity" sites included Oglala Sioux, SD; Pauma Valley, CA; San Carlos, AZ; and Eastern Band of Cherokee Indians, NC. At the medium intensity sites, the site coordinators received training from the project development team at a central location, while the site coordinators from the low intensity sites received no training; they were given only the educational materials developed for the project.

The program was designed to be a multidisciplinary, community-based intervention. It closely followed the PRECEDE model for planning health education programs (16). The steps in the PRECEDE model include a social diagnosis, epidemiologic diagnosis, behavioral diagnosis, educational diagnosis, selection of educational strategies, administrative diagnosis, and evaluation.

The epidemiologic diagnosis resulted in the documentation of BBTD prevalence rates ranging from 40-84 percent at the 12 pilot sites. These data were presented to community leaders to demonstrate that a problem existed at each site. A nationwide health initiative would have seemed impersonal to the people in these rural communities without proof that the problem existed among their own children.

Once it was affirmed that a serious health problem existed, informal surveys and information gathering assisted in making a behavioral diagnosis. Further, the trainers who visited the high intensity sites engaged parents in discussions about the values, attitudes, and behaviors surrounding prolonged bottle feeding in Native American communities. The information that they gained was relayed to the core group who used this feedback to direct the design of the interventions. Among the causes of BBTD in Native American communities were caretakers permitting prolonged use of the baby bottle past 1 year of age, routinely giving bottles to a child during sleeping hours, and frequently giving bottles to toddlers to sip on over

extended periods during the day. During site visits and through other communications with the local communities, the core group learned that, although some of these behaviors could be attributed to neglect or a desire to keep a child quiet, much of the behavior was overindulging the child or unwillingness to wean the child from a beloved bottle. Apparently, a large percentage of Native American women breastfeed their infants but later wean them to the bottle instead of a cup.

The educational diagnosis was complex; the core group attempted to determine the factors leading to the behaviors that cause BBTD. The program that the group designed was aimed at impacting the knowledge, attitudes, beliefs, and values of the caretakers of young children. During site visits, the trainers from the core group began to understand the cultural significance of prolonged bottle feeding. Native American women's identities are often closely bound to being a mother. There was a reluctance by parents and grandparents alike to making the child give up this symbol of babyhood. Also, because many families are large, the bottle may be a surrogate babysitter when the mother is overwhelmed by daily responsibilities. Other necessary enabling factors were to teach caretakers parenting skills, emphasizing the need to say "no" when it was for the good of the child's health. To overcome resistance to saying "no" to children, analogous situations were identified, such as not letting them play in the street or play with matches.

Prolonged bottle feeding and children with decayed front teeth were so common and socially acceptable in the pilot communities that there was no peer pressure or community norm to encourage weaning children from the bottle. The entire community had to be involved so that eventually the behaviors leading to BBTD would become socially unacceptable.

The selection of the educational strategies involved linking the diagnostic criteria with methods of education. In these Indian communities, this choice was also directed by a concern for the cultural appropriateness of each strategy.

Two approaches were chosen as interventions. The first was a one-to-one approach; parent volunteers, health professionals, and tribal employees talked to parents both individually and through group meetings. Each site coordinator recruited 15 or more parents and tribal employees from health related programs to be trained in BBTD prevention. The training was provided by a team of two core group members, with experience in adult education, and the local site coordinator. The



The media campaign against BBTB used posters, public service announcements, and newspaper articles. Messages were changed quarterly and the campaign continued for 3 years.

training consisted of 32 hours of instruction for 15 or more people. The 4-day training provided technical information about the consequences and prevention of BBTB. Discussions and role-playing designed to improve communication skills were part of the training. A counseling booklet was given to each trainee; "Parents Helping Parents" is a captioned picture story about BBTB and how to prevent it. The trainees were encouraged to individualize the information for their communities by using prevalence data for their site and telling anecdotes from their own experiences.

The trainees were also taught how to make group presentations and organize social gatherings called "swap parties" to encourage parents to "swap" their child's bottle for a cup by 1 year of age. A slide presentation was developed from the "Parents Helping Parents" booklet to use during group presentations. Parents who attended the community meetings were given a two-handled training cup imprinted with a "Stop BBTB" logo. Participants were also given "Stop BBTB" bumper stickers and BBTB coupons to give to friends and relatives who might want to trade their children's bottles for cups at local "swap shops."

In addition to the initial training, staff at each site conducted training sessions for other health professionals and tribal employees in order to raise awareness about the BBTB project and to encourage these professionals and para-professionals to take part in the intervention. As a result, physicians, nurses, nutritionists, Foster Grandparent groups, Community Health Representative programs (tribal health employees), health educators, and WIC (Women, Infant, and Children supplemental food program) staff became involved in counseling and group presentations. Some IHS and tribal employees also joined parent volunteers and the site coordinator to develop a task force at each site. The role of the task force was to organize the implementation of the intervention, organize data collection, identify local funding sources, order educational materials, and organize the media campaign. Thus, the BBTB program became integrated into each community using varying sets of "players." It was deemed important that the project be directed by the individual communities according to their specific health system and social structure.

The second major approach consisted of a media campaign designed to raise awareness and knowledge about BBTB community-wide. Its intent was to make prolonged bottle feeding less socially acceptable in Native American communities. A series of posters, public service announcements, and newspaper articles were released quarterly over a 3-year period. The messages changed with each release, and the target population varied to include parents, grandparents, siblings, and other caretakers of young children. The planning group was especially proud of recruiting the famous Cherokee Indian country and western singer, Crystal Gayle, to be photographed for three BBTB posters.

Two training manuals were designed. One outlined the steps in organizing a BBTB intervention in Native American communities. It included forms for obtaining tribal permission and support for the project, forms for recording the prevalence of BBTB, and an inventory of organizational tasks and responsibilities to ensure both health professional and lay community involvement. The second manual included the necessary information to conduct training of volunteers in the community.

A knowledge and attitude survey was administered to the caretakers of young children-parents, grandparents, older siblings, and tribal employees-at the four high intensity sites. This survey will be readministered during 1990, the final year of the project, to monitor changes in knowledge and attitudes. It may have served as an intervention

in itself by raising the salience of BBTD with those surveyed. The health professionals who administered the surveys seized the "teachable moment" as they reviewed the questionnaire answers with individual respondents. The central planning group used information gleaned from analyses of the survey results to direct future interventions and to design subsequent educational materials. The behavioral and educational diagnoses, in effect, were ongoing processes.

In addition to the core group's strategies, people at the BBTD pilot sites came up with several strategies as they became more involved in the project. For example, the Rosebud Sioux WIC Program designed a picture holder printed with the BBTD logo. The WIC staff photographs infants soon after birth and again in 1 year. Parents who have weaned their babies to a cup by 1 year are given the photos in the BBTD holder. Pictures are treasured in this Indian community, and they have served as both an incentive and reward for practicing a positive health behavior.

The **Tlingit-Haida** staff developed a computer list so that mailings can be sent to parents of a 1-year-old to remind them to wean their child to a cup. The staff also put together packets containing a balloon, toothbrush kit, and pamphlets on BBTD that have been distributed at health fairs, by mail, and during home visits. Yakima Nation organized a mailing of "Happy Birthday" letters to 1-year-olds. **Isleta Pueblo** and **Oglala Sioux** organized mailings to the parents of all newborns. Those mailings included a coupon for the BBTD **tippee cup**.

Leupp volunteers sponsored baby contests, designed billboards and posters, and produced a lo-minute videotape that features BBTD task force members and Navajo children to personalize the problem to the reservation. The volunteers also distributed pacifiers, a somewhat controversial practice, that the project's leaders left to the discretion of the individual communities.

Cherokee Nation, OK, aggressively promoted the prevention of BBTD by using the media. Two television shows, radio spots, and articles in not only tribal publications but also in surrounding city newspapers carried the prevention messages. The task force members also initiated the revision of the "Parents Helping Parents" booklet which they produced and marketed.

At Northern Cheyenne, health center staff wear BBTD T-shirts each Wednesday, and a bulletin board in the lobby of the health center was created from "Parents Helping Parents." This site has also



*Persuading parents to exchange the child's bottle for a **tippee cup** at 12 months was part of the Stop **Baby Bottle Tooth Decay** campaign.*



Fun/Run/Walk/Crawl races were among the events used to promote the campaign to prevent tooth decay among Native American children.

'In 1985, a survey of 514 Native American children in Oklahoma and Alaska reported 53 percent prevalence of BBTD with a range of 17 to 85 percent in the 18 communities surveyed. In a survey of 1,607 Cherokee and Navajo Head Start students, 70 percent of the children were affected by BBTD, and 87 percent of those affected displayed the most severe manifestation of the disease.'

initiated a monthly "poster child" campaign that features a child free from BBTD. Both San Carlos and Northern Cheyenne sites sponsored BBTD Fun/Run/Walk/Crawl races. Northern Cheyenne's race was reported in the July issue of Walking magazine. San Carlos staff made a videotape of their race and used it as a public relations tool. Several sites expanded the media strategy by building floats for parades, holding baby contests and poster contests, and participating in community health fairs and other tribal-sponsored social events.

Finally, the administrative diagnosis included the development of a budget, allocation of resources for each intervention strategy, identification of additional funding sources, and assessment of the strength of the IHS and Head Start Programs at each pilot site to ensure a high level of participation in the project. Over the past 4 years, grants totaling \$121,000 have been received for the development, implementation, evaluation, and continued distribution of the project materials. The core planning group decided in its initial deliberations to brainstorm ideas for interventions without worrying about financial constraints. Occasionally, it was impossible to fund an idea because the cost was prohibitive but, generally, for a particularly ingenious idea, rather than compromising the integrity of the interventions, a funding source was located. For example, it was believed that **tippie** cups were essential to the intervention because caretakers would be more likely to wean from a bottle if a cup were provided. Initially, this appeared to be too expensive an item, but after considerable research and negotiations, Hanksraft, a division of Gerber, agreed to produce the cups imprinted with the BBTD logo. Hanksraft has donated thousands

of cups, and the rest have been sold to the project for cost.

The essential ingredient of the program was the contribution of in-kind and volunteer services. Each site assigned either an Indian Health Service or tribal employee to coordinate the BBTD project, and these people added this responsibility to their full-time jobs. At each site, the IHS dental staff contributed extensively to the implementation and evaluation stages, and various other health professionals and tribal employees incorporated BBTD "duties" into their schedules. Task force members often donated time outside their paid work hours. It has become impossible to track accurately the hours that this ever expanding group of people have contributed. As the programs became integrated into the communities, people who had never formally been attached to this effort started spreading the word about BBTD and its prevention.

Evaluation Design and Preliminary Findings

The evaluation plan was designed in conjunction with the intervention, but it was refined during the second year of the intervention and expanded to include additional process evaluation. The American Public Health Association advocates the use of five concepts essential in planning evaluations of public health interventions (17). It thus seems appropriate to discuss this project briefly in the context of these concepts: (a) appropriateness, (b) adequacy, (c) effectiveness, (d) efficiency, and (e) side effects.

The BBTD program was appropriate from both the consumers' and providers' perspective because this preventable condition was extremely prevalent among the IHS population. IHS resources have been overburdened with treating BBTD, and the children and their families have suffered both physical and emotional pain as a result of the disease. Therefore, parents and community leaders acknowledged the appropriateness of the project after they became informed about the magnitude of the problem in the community.

Defining adequacy of an intervention required that the planning group establish an "adequacy" benchmark. Reducing the prevalence of BBTD at project sites by 50 percent in 5 years was selected as a challenging objective that was potentially achievable with the available resources. Such a reduction would have significant positive impact on dental treatment resources. Furthermore, a reduction of this magnitude could potentially result in sufficient social change in the respective communi-

ties such that a modeling effect would help sustain continued reduction in BBTD prevalence.

Effectiveness required measuring the impact of activities on attaining the specified objectives. It was decided that dental screenings would be conducted at the local Head Start centers each year to track the prevalence of BBTD. The progression of BBTD is such that no change was expected until at least the third year of the project. Thereafter, BBTD would continue to decrease significantly each year if the program was successful.

Preliminary data document an overall decrease in BBTD prevalence from 57 to 43 percent at 12 sites, resulting in a 25 percent reduction ($P < .001$) with 1 year remaining in the project (see table). At the high intensity sites, BBTD has decreased from 53 to 35 percent, resulting in a 33 percent reduction ($P < .001$).

The prevalence of BBTD decreased at all sites except Tlingit-Haida, Pauma Valley, and Isleta Pueblo. Tlingit-Haida experienced a 20 percent increase in BBTD, but the numbers at this site are extremely small, and the 1989 sample was smaller than the 1986 sample. Pauma Valley and Isleta Pueblo have dropped out of the BBTD project. Enthusiasm waned, key personnel were transferred, and the program administrators did not obtain prevalence data in 1989. Therefore, to include the effect of the failure at these two sites, it is assumed that BBTD prevalence has remained the same. These two sites, however, will be surveyed during the final year of the project. The yearly IHS Dental Services Data Report, which records dental treatment provided to IHS eligible patients nationwide, will be used as concurrent validation for the findings of the Head Start surveys. The yearly report offers information about the sites that did not participate in the intervention.

The strength of the intervention is tracked by quarterly site reports and monitoring the distribution of educational materials. In 1987, more than 250 requests for educational materials were filled and, in 1988, more than 340 requests were filled. Requests have come from international and national health agencies. Many State, county, and local health departments have adopted the materials and the slide presentation has been translated into five languages. More than 1,500 copies of "Parents Helping Parents," approximately 100,000 cups and bumper stickers, and 63,000 posters have been distributed. Demand far exceeds the supply of educational materials.

Assessing efficiency, or the cost of the observed effects, offers one of the more difficult challenges

Reduction in prevalence of baby bottle tooth decay (BBTD) by level of intervention

Intensity	Number screened	BBTD		Percent reduction	P value
		Number	Percent		
High (4 sites):					
1985..	384	204	53
1989..	383	133	35	33	.001
Medium (4 sites):					
1986..	544	353	65
1989..	549	292	53	18	<.001
Low (4 sites):					
1986..	455	238	52
1989..	640	245	38	27	<.001
All sites:					
Baseline..	1,383	795	57
1989..	1,572	670	43	25	<.001

of evaluation. The direct funding was easily assessed, but the volunteer hours and in-kind contributions were difficult to track and assign dollar values. Nonetheless, efficiency will be assessed by estimating the cost of BBTD treatment, calculating savings in the cost of treatment averted by the decline in the prevalence of BBTD, and comparing these savings to expended project funds and estimated in-kind services.

If one assumes a conservative cost estimate and an average reduction of 25 percent in BBTD cases at the 12 sites, then BBTD was prevented in 302 children whose treatment would have cost \$211,400. This estimate excludes expenses for general anesthesia or hospitalization. By the final year of the project, an entirely new cohort of children will be surveyed, and it is expected that the savings will eventually be multiplied many times over. No attempt was made to estimate the cost benefit in terms of emotional trauma and pain avoided, decreases in ear and speech problems, or the long-term savings in orthodontic treatment since it is nearly impossible to quantify these savings.

The assessment of side effects required documenting both desirable and undesirable outcomes other than the intended purpose of the project. The planning group anticipated positive side effects related to developing health networks in the pilot communities, but there have been unanticipated side effects as well. Side effects were tracked through quarterly reports from each pilot site and other communications between the pilot sites and the project administrators.

Two negative side effects have thus far been identified. The first is a potentially unhealthy competitiveness across project sites relative to who

'The essential ingredient of the program was the contribution of in-kind and volunteer services. Each site assigned either an Indian Health Service or tribal employee to coordinate the BBTD project, and these people added this responsibility to their full-time jobs.'

is "the best." At times, the sites have appeared to be in a race to see who can attain the lowest levels of BBTD. Fortunately, implementation of the project required equal dissemination of educational materials and ongoing communication among sites to share creative ideas. The second negative side effect was that some of the medium and low intensity sites deviated from the research protocol by implementing the project at a higher level than they had originally agreed to. As the lower intensity sites raised community and health professional awareness about BBTD, some became impatient to "do more" about the problem and thus contaminated the evaluation design.

A two-edged side effect is the level of ownership that the pilot sites have assumed for the BBTD project. The ownership has been positive in that the communities now accept responsibility for preventing BBTD. Assumption of responsibility inspired the creation of additional strategies and led to an individualized program at each pilot site. On the Navajo reservation, the tribe supported the expansion of the BBTD pilot site to the entire reservation, and it now reaches 3,298 children through 30 Head Start centers with a staff of 300 volunteers. On the negative side, however, individualization has clouded distinctions between different intensities of implementation. Also, the level of ownership has become so intense that at some sites there has been resistance to outside interference or requests for process and outcome data from the national program coordinators.

A most significant positive side effect has been the cooperative networks that have been developed across the communities and organizations (for example, schools, WIC, Head Start, IHS, and so forth). BBTD has been addressed in the Year 2000 Health Objectives for the Nation. Changes within the IHS system are another effect. For example, health administrators in many IHS clinics have had prevention of BBTD added to their performance standards. Furthermore, similar cooperative efforts

to prevent other health problems, for example, periodontal disease and use of smokeless tobacco, are modeling the BBTD project. The increased credibility and visibility of the dental programs in the community appears to be contributing to greater community support for water fluoridation and policies limiting the sale of tobacco products. Finally, and possibly the most significant effect, is that the success of the BBTD project may empower members of the community to address other critical public health and social problems.

An unexpected side effect has been the special awards earned by the BBTD project. The project received the 1988 American Dental Association's "Community Preventive Dentistry Meritorious Award." Dr. Jeff Mabry, a core group member, received the 1988 American Academy of Pediatric Dentistry's "Public Awareness Award" for his role in developing the BBTD project. Crystal Gayle received the 1988 American Association of Public Health Dentistry's "Presidential Award" for her efforts to improve the oral health of children through the BBTD project. The Rosebud WIC program received the national WIC "Focus on Management Award" for creating the photo folders for the BBTD project. Most recently, the BBTD core group received the Department of Health and Human Service's, U.S. Public Health Service "Outstanding Unit Citation" for their efforts on the BBTD project.

Discussion

There are several lessons to be learned from the BBTD project. First, it appears important to follow the theoretical planning models documented in the health education literature. Each step of the PRECEDE model for planning was closely followed in the BBTD project with the exception of the "social diagnosis." According to the PRECEDE model, the health problems of a community should be viewed in light of its social problems. Those who work in health agencies that serve minorities rarely have the resources or political power to address the bigger societal problems of economics, racism, education, and so forth that are closely related to health problems. According to the model, the health concerns should then be prioritized for the allocation of limited health education resources. Unfortunately, IHS is organized in a way that often results in a compartmentalized approach to health planning. The BBTD project did, however, develop a network of several disciplines actively participating in the intervention. This network

assisted in creating the critical mass of community awareness necessary for behavior change.

The epidemiologic diagnosis was a critical step not only for planning but for rallying community support. It was essential that health status data be specific to the community. National data are too obscure and impersonal to generate enthusiasm and ownership in local communities. The BBTB program demonstrated that once a community became aware of a specific health concern and educational materials were made available, the project gained momentum.

The behavioral and educational diagnoses were important steps in the planning process. It would be presumptuous, particularly in minority communities, for health professionals and administrators to assume that they understand all the beliefs, attitudes, and behaviors underlying a particular health problem. Therefore, knowledge and attitude surveys, focus groups, and community representation on task force groups were essential. Also, the BBTB project, as an ongoing experimental enterprise, allowed changes and additions to the original package of interventions as feedback from the communities directed these modifications. Although this flexibility favors a heuristic and at times muddled research design, it resulted in tailored and evolving interventions at each pilot site.

The core planning group was paramount in the success of the BBTB project. This group was funded for central planning sessions and was given freedom to design the educational strategies. The key ingredients to supporting the planning group were the provision of an identity, adequate time, and adequate resources. A combination of structure and flexibility resulted in a level of creativity often stifled in other settings.

The quasi-experimental research design used a nonequivalent control group (18). This design should control many of the threats to internal validity including history, maturation, testing, instrumentation, selection, and attrition. Since the sites were chosen nonrandomly, external validity may be limited to similar Native American communities. We have anecdotal reports that the program has been implemented successfully in other minority communities where BBTB is a health concern.

The decrease in BBTB prevalence appears to be related, at least in part, to the level of intensity at the pilot site. The high intensity sites realized the greatest reduction in disease, but the designated low intensity sites experienced a greater reduction in BBTB than the medium intensity sites. Oglala Sioux and Cherokee low intensity sites both solic-

ited additional support from outside sources in the form of training and funding. This support was given despite the reluctance of the core group to agree to this change. The additional training and funding may explain the large decrease in percentages of affected children at these sites where the level of support was similar to that of the higher intensity sites. The enthusiasm at the pilot sites further contaminated the research design but intensified the level of intervention at Oglala and Cherokee.

The true reduction of BBTB in the pilot communities may never be known because the program's effects were measured only in Head Start children. The project was implemented community-wide, and it may have had a positive effect on all children in the community, not just those who attended Head Start. This sampling limitation probably underestimates program effects.

In summary, although the program has thus far reduced prevalence of BBTB by 25 percent, participation in the BBTB project may prove to be more powerful than the reduction of disease. The pilot sites have successfully organized themselves for community action. Health promotion-disease prevention programs should favor models of intervention that encourage community organization because the skills learned may further empower minority communities to organize and create their own interventions to achieve social change.

Conclusions

1. The BBTB prevention project has achieved statistically significant decreases in BBTB, and thus it offers a potentially effective model for other health interventions in minority communities.

2. A key element of the project was the establishment of a core group of planners representing many disciplines. This work group was given an identity, adequate time, adequate resources, and a balance of flexibility and structure to encourage creativity in designing the experimental project.

3. A theoretical model for planning health education interventions was followed. Consistent with this model, each community was allowed the flexibility and provided resources to "customize" the program in accord with its individual social structure, health system, and cultural beliefs.

4. The evaluation plan included not only process and outcome indicators of effectiveness but also the tracking of negative and positive side effects. The positive side effects may eventually prove to be the most powerful results of the intervention.

5. The BBTD program appears to have' **mobilized** communities whose members have learned how to organize themselves for positive change.

References*

1. **Johnsen, D. C.:** Characteristics and backgrounds of children with "nursing caries." *Pediatr Dent* **4:218-224** (1982).
2. **Walton, J. L., and Messer, L. B.:** Dental caries and fluorosis in breast-fed and bottle-fed children. *Caries Res* **15:124-137** (1981).
3. **Gardner, D. E., Norwood, J. R., and Eisenson, J. F.:** At-will breast feeding and dental caries: four case reports. *J Dent Child* **44:186-191** (1977).
4. **Derkson, G. D., and Ponti, P.:** Nursing bottle syndrome: prevalence and etiology in a non-fluoridated city. *J Can Dent Assoc* **48:389-393**, June 1982.
5. **Dilley, G. J., Dilley, D. H., and Machen, J. V.:** Prolonged nursing habit: a profile of patients and their families. *J Dent Child* **47:102-108**, March-April 1980.
6. **Ripa, L. W.:** Nursing habits and dental decay in infants: "nursing bottle caries." *J Dent Child* **45:274-275**, July-August 1978.
7. **Johnsen, D. C., et al.:** Background comparisons of pre-3%year-old children with nursing caries in four practice settings. *Pediatr Dent* **6:50-54** (1984).
8. **Goose, D. H., and Gitters, E.:** Infant feeding methods and dental caries. *J Public Health (London)* **83:72-76**, January 1968.

9. **Johnsen, D. C.:** Dental caries patterns in preschool children. *Dent Clin North Am* **28:3-10**, January 1984.
10. **Nowak, A. J.:** *Public Health Currents*. Ross Laboratories, Columbus, OH, 1985.
11. **Fass, F. N.:** Is bottle feeding of milk a factor in dental caries? *J Dent Child* **29:245-251** (1962).
12. **Kotlow, L. A.:** Breast feeding: a cause of dental caries in children. *J Dent Child* **44:192-193**, May-June 1977.
13. **Niendorff, W., and Collins, R.:** Oral health status of Native Americans, selected findings from a survey of dental patients conducted in FY 1983-4 by the Indian Health Service. Paper presented at the annual meeting of the American Public Health Association, Las Vegas, NV, Oct. 1, 1986.
14. **Kelly, M., and Bruerd, B.:** The prevalence of baby bottle tooth decay among two Native American populations. *J Public Health Dent* **47:94-97** (1987).
15. **Broderick, E., Mabry, J., Robertson, D., and Thompson, J.:** Baby bottle tooth decay in Native American children in Head Start centers. *Public Health Rep* **104:50-54**, January-February 1989.
16. **Green, L. W., Kreuter, M. W., Deeds, S. G., and Partridge, K. B.:** *Health education planning: a diagnostic approach*, Mayfield Publishing Co., Palo Alto, CA, 1980.
17. **APHA Committee on Evaluation and Standards:** Glossary of evaluative terms in public health. *Am J Public Health* **60:1546-1552** (1970).
18. **Cook, T. D., and Campbell, D. T.:** *Quasi-experimentation: design and analysis issues for field settings*. Houghton Mifflin Company, Boston, 1979.

Participation Rates, Weight Loss, and Blood Pressure Changes Among Obese Women in a Nutrition-Exercise Program

RICHARD A. LASCO, PhD
 ROBERT H. CURRY, MD, MPH
 V. JOANN DICKSON, MSPH
 JUDY POWERS
 SANDRA MENES
 ROBERT K. MERRITT

Three of the authors are with the Centers for Disease Control (CDC). Dr. Lasco is Senior Evaluation Specialist, and Mr. Merritt is a Program Analyst, Cardiovascular Health Branch, Center for Chronic Disease Prevention and Health Promotion (CCDPHP), CDC. Ms. Powers is a Statistical Assistant, Adolescent and School Health, CCDPHP, CDC. Dr. Curry and Ms. Dickson are with Emory University. Dr. Curry is Principal Investigator and Ms. Dickson is Project Coordinator. Ms. Menes was with Emory University and served as a Research Associate. This investigation was funded by Cooperative Agreement No. **V50-CCU400919**.

Tearsheet requests to Dr. Lasco, Cardiovascular Health Branch, CCDPHP, CDC, Atlanta, GA 30333.

Synopsis

Since 1985, a black urban community in Atlanta has planned, implemented, and evaluated a cardiovascular risk reduction project. The Community Health Assessment and Promotion Project (CHAPP) was developed to reduce the high incidence of cardiovascular risk factors in the neighborhood's predominantly black population. Based on data from a needs assessment, a community coalition designed and directed a 10-week exercise and nutrition intervention targeted to obese residents between the ages of 18 and 59 years. The intervention consists of an orientation, attitudes assessment, selection of a specific exercise class, and twice-weekly information on nutrition and community resources.

The program uses a wide range of strategies, including individual consultations, reminder telephone calls, incentives, and rewards, and free transportation and child care, to encourage participation. The exercise-nutrition intervention was provided to two separate groups. A total of 70 participants completed the intervention over a 7-

MARKETING PLAN

EXPORTATION OF TECHNOLOGY FROM THE BABY BOTTLE TOOTH DECAY PREVENTION PROJECT

THEMES

The overall purpose of the BBTD technology transfer project is to motivate communities with a BBTD problem to establish a BBTD program and to transfer the technical information and education materials to build an effective program. Another purpose of the technology transfer project is to keep existing sites motivated and to encourage them in the transfer of their **"tips"** for new BBTD sites. Therefore, the overall goal of the project is **communication** between existing sites, new sites, potential sites, and the core group of planners. Two marketing themes and corresponding logos will be developed to accomplish the communication goals.

The primary theme will be called **"The Moccasin Telegraph"** and will promote the idea of Indian people sharing information about the BBTD program and community organization with other Indian people. The marketing plan will build on this theme by using American Indian people of all ages and levels of involvement to convey the knowledge and technical information needed to establish successful BBTD sites. By using community members, we can interject an **abundance of** practical knowledge. The "Moccasin Telegraph" will be the title for the newsletter and the hotline.

The second theme will be called **"Out of the Mouths of Babes"**. The theme will be extended by using the concept of babies and young children to pass on valuable information about **the** BBTD program and parenting techniques. Parenting skills are often a sensitive issue. By using the image of babies as teachers, perhaps the topic can be approached in a sensitive, caring, and humorous manner. Much of the information will be given as though the babies themselves have produced the **"advice"**. This theme will build on the introductory video being produced by the Centers for Disease Control. The video is titled **"Out of the Mouths of Babes"** and uses preschoolers to convey an overview of the BBTD program and the steps to getting started towards establishing a BBTD site. A section of each newsletter will feature an **"Out of the Mouths of Babes"** article about parenting tips. The information the babies pass on will of course represent the core group of planners for the BBTD project.

LOGOS

A logo will be developed to match each of the two themes. They will be used for different purposes.

The **"Moccasin Telegraph"** logo will picture either a circle or a string of Indian people of all ages, both traditional and nontraditional. Some will be parents, some children, grandparents,

health professionals, etc. The intent is to convey the image of Indian people passing on information to other Indian people.

The "**Out** of the Mouths of **Babes**" logo will picture a group of multi-ethnic children under the age of **three talking on telephones**, using fax machines, parenting, etc. The "**Out** of the Mouths of Babes" logo will be used whenever the intent is to convey information about parenting. This logo will be used on various marketing brochures and correspondence between the core group of planners and the pilot sites.

HOTLINE

The hotline is already established and a trained assistant is ready to answer the telephone. The hotline will be answered "**Hello, you have reached The Moccasin Telegraph**". A policy and procedures manual was developed to train and **assist** the secretary in answering the telephone and written requests in a manner that conforms to the theme and purpose of the project.

NEWSLETTER

The newsletter will be published quarterly, beginning September 1991. The first issue will introduce the BBTD Technology Transfer project, advertise the hotline, solicit tips and education materials from existing sites, and bring everyone up to date on current issues in the prevention of BBTD. An attachment will be the Five-Year Evaluation Report (short version). The following three newsletters will include an update on BBTD activities with special emphasis on the sharing of strategies and materials from BBTD sites. Short articles will be solicited from child-care experts. Topics will include positive parenting techniques, otitis media, speech problems, dental needs of children with BBTD, and other topics as identified.

OTHER MARKETING TOOLS

The project will print letterhead and business cards with the "Moccasin Telegraph" logo. All correspondence will be signed by "**The Moccasin Telegraph**" if it relates to the **technical transfer** of the BBTD program and "**Out** of the Mouths of **Babes**" if it relates to parenting skills.

MARKETING TASKS

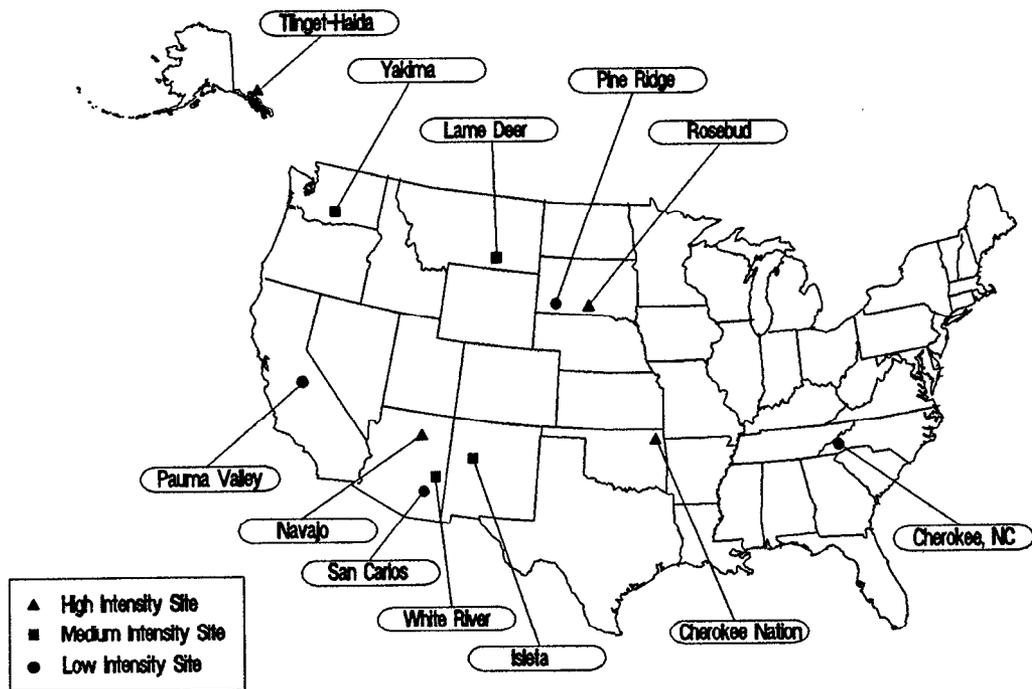
Completion Date

- Step 1: Develop logo **9/91**
- Step 2: Revise the Five Year Evaluation Report to be less technical and more pictorial for dissemination to potential BBTD sites **7/91**
(attached)
- Step 3: Write article for the IHS Provider **7/91**
(attached)
- Step 4: Design the first quarterly newsletter to serve as a marketing tool and distribute it widely to both Indian and non-Indian existing and potential BBTD sites. **9/91**
- Step 5: Enlist the support of existing sites to share their "secrets to **success**" and "**tips** for effectiveness" with new and existing sites. If necessary, sites will be contacted personally to gather information for the newsletter. ongoing
- Step 6: Collect unique photographs and education materials. These will be displayed via the newsletter as a "**show and tell**". ongoing
- Step 7: Market the training of new site personnel through the newsletter and personal contacts. July-Ott 91

"How To Organize a Pilot **Site**" manual and "**Out** of the Mouths of Babes" videotape will be used to educate and recruit new sites for the BBTD program.

THE BABY BOTTLE TOOTH DECAY PREVENTION PROJECT

1990 FIVE-YEAR EVALUATION REPORT



Submitted by: Bonnie Bruerd, DrPH
Health Policy Consultant



Table of contents

Background Information	2
Program Description	3
Results	5
Costs and Benefits	7
Keys and Steps	8
Strategies and Materials	9
Awards	10
References	11

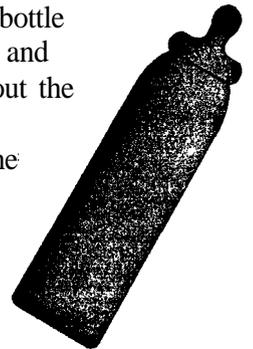


BACKGROUND INFORMATION

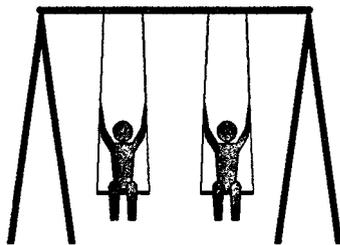
What is BBTD?

Baby bottle tooth decay (BBTD) is a preventable dental disease that surveys have shown affects many preschool children. BBTD is caused by inappropriate feeding practices, such as giving a child a bottle at nap or bedtime or letting a child walk around or sit with a bottle during the day. (1,10) Inappropriate breast feeding, usually the result of a mother and infant (6 months or older) sleeping together, with the child nursing at will throughout the night, has also been reported to cause BBTD in rare instances. (12)

Any liquid with fermentable sugar can cause BBTD. (1,11) The liquid in the bottle might be juice, soda pop, milk, or formula, but the resulting damage is the same. The fragile baby teeth decay rapidly and may cause pain. BBTD is characterized by a unique pattern of decay beginning with the maxillary primary incisors followed by the primary molars, in order of eruption. (1-10) The problems resulting from BBTD include many cavities, crooked permanent teeth, ear and speech problems, orthodontic problems, and possible psychosocial problems. (10)



How many children have BBTD?



In 1983-84, an Indian Health Service (IHS) survey of 1,321 children 0-4 years old documented that approximately 52 percent of the children had BBTD (13). In 1985, a survey of 514 Native American children in Oklahoma and Alaska reported 53 percent prevalence of BBTD with a range of 17 to 85 percent prevalence in the 18 communities surveyed (14). In a survey of 1,607 Cherokee and Navajo Head Start students (15), 70 percent of the children were affected by BBTD, and 87 percent of those affected displayed the most severe manifestation of the disease. "Severe" was defined as two or more maxillary anterior tooth surfaces with caries, plus one or more teeth with pulpal involvement or mandibular anterior decay, or both.

How much does it cost to treat BBTD?

Head Start and IHS cost estimates, based on children treated under contract by pediatric dentists in private practice, are **\$700 to \$1,200** for a moderate to severe case of BBTD. If hospitalization is necessary, the cost is approximately doubled.





PROGRAM DESCRIPTION

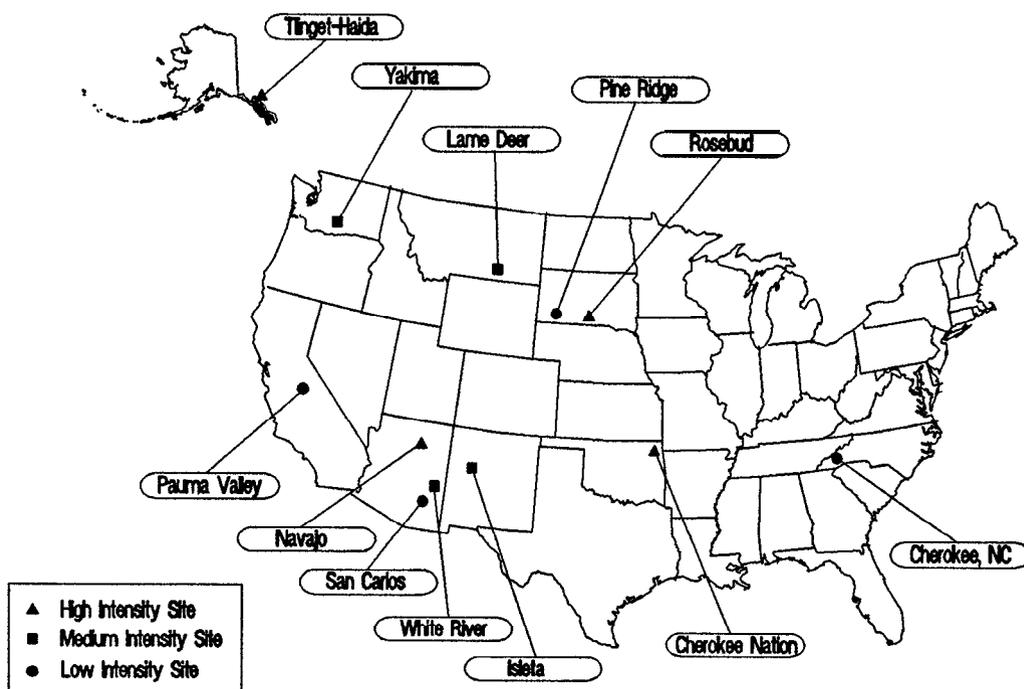
What is the BBTD Program?

The BBTD program is an experimental program, implemented in 12 Native American communities, aimed at the prevention of BBTD. The BBTD prevention project represents a cooperative effort by three Department of Health and Human Service agencies:

Administration for Children, Youth, and Families, Head Start Bureau
Indian Health Service, Dental Program
Centers for Disease Control, Dental Disease Prevention Activity.

When the grant was awarded to the IHS dental program, a core group of 12 experts in children's health, dental disease, nutrition, health education, and research was formed to design the intervention and evaluation components. The core group also provided technical consultation and continuity at the project sites throughout the implementation and evaluation stages of the project.

Development of the program began in 1984, and implementation began at the **first** four sites in 1985. These four sites were considered "high-intensity sites" in that training was provided in the community by two members of the core planning group. In 1986, eight more sites were added. Four of these sites were "medium-intensity" in that training was provided at a central location and four sites were "low-intensity" in that no formal training was provided, although one of the sites later arranged for their own training.





The target population of the program was actually the caretakers of young children, since only by their actions can BBTD be prevented. Through the 12 Indian Head Start programs that are the grantees, the BBTD project serves more than 4,700 children and their families. In addition, the project has expanded to the majority of the remaining 93 Indian Head Start grantees to include more than 14,000 Head Start children and their families. .

The program was designed to be a multidisciplinary, community-based intervention. It closely followed the PRECEDE model for planning health education programs (16). The steps in the PRECEDE model include a social diagnosis, epidemiologic diagnosis, behavioral diagnosis, educational diagnosis, selection of educational strategies, administrative diagnosis, and evaluation. For a more complete program description and a discussion of the construct utilized in the BBTD program, refer to "Preventing Baby Bottle Tooth Decay in American Indian and Alaska Native Communities: A Model for Planning". [17]

Two approaches were chosen as interventions. The first approach was one-to-one counseling with the caretakers of young children. Health professionals, parents, and tribal employees were trained to counsel parents both individually and through group meetings. As a result, physicians, nurses, nutritionists, Foster Grandparent groups, Community Health Representative programs (tribal health employees), health educators, and WIC (Women, Infant, and Children supplemental food program) staff became involved in counseling and group presentations. The second major approach consisted of a media campaign designed to raise awareness and knowledge about BBTD community-wide. Its intent was to make prolonged bottle feeding less socially acceptable in Native American communities. A series of posters, public service announcements, and newspaper articles were released quarterly over a 3-year period. The messages

changed with each release, and the target population varied to include parents, grandparents, siblings, and other caretakers of young children. The planning group was especially proud of western singer, Crystal Gayle, who was photographed for three BBTD posters.

Two training manuals were designed.

One outlined the steps in organizing a BBTD intervention in Native American communities. It included forms for obtaining tribal permission and support for the project, forms for recording the prevalence of BBTD, and an inventory of organizational tasks and responsibilities to ensure both health professional and lay community involvement. The second manual included the necessary information to conduct training of volunteers in the

community.

In addition to the core group's strategies, people at the BBTD pilot sites came up with several strategies as they became more involved in the project. The multitude of strategies and education materials developed at the various sites are outlined elsewhere. [17]

The staff included primarily volunteers and government employees who provided in-kind services to the project. Each site assigned either an Indian Health Service or tribal employee to coordinate the BBTD project, and these people added this responsibility to their full-time jobs. At each site, the IHS dental staff contributed extensively to the implementation and evaluation stages, and various other health professionals and tribal employees incorporated BBTD duties into their schedules. Task force members often donated time outside their paid work hours. As the programs became integrated into the communities, people who had never formally been attached to this effort started spreading the word about BBTD and its prevention.

As the programs became integrated into the communities, people who had never formally been attached to this effort started spreading the word about BBTD and its prevention.



RESULTS



THE PROGRAM WORKS!

BBTD prevalence

The BBTD program was successful in reducing the prevalence of BBTD at the pilot sites. Overall, prevalence decreased from 57 to 39 percent, resulting in a 32 percent reduction of BBTD. Not only is this decrease statistically significant ($p < .001$), it also represents a significant cost-savings in dental treatment, trauma, pain, and other related health problems.

Table I: Prevalence of BBTD among Head Start children at 12 pilot sites in the BBTD program.

	<u>1986</u>			<u>1990</u>			<u>Change</u>
	n	BBTD	%	n	BBTD	%	% Reduction
<u>High Intensity Sites</u>							
Rosebud Sioux-SD	142	58	41	186	40	22	46
Cherokee Nation-OK	70	44	63	73	10	14	78
Navajo-AZ	88	68	77	132	63	48	38
Tlinget-Haida-AK	133	54	40	90	43	48	+20
Total:	433	224	52	481	156	32	38
<u>Medium Intensity Sites</u>							
		<u>1987</u>					
Lame Deer-MT	125	54	43	133	55	41	5
Yakima-WA	126	74	59	131	69	53	10
White River-AZ	206	184	84	152	107	70	17
Isleta-NM	58	27	47	80	20	25	47
Total:	515	339	66	496	251	51	23
<u>Low Intensity Sites</u>							
		<u>1987</u>					
Pauma Valley-CA	61	30	50	43	11	26	48
Cherokee-NC	137	68	50	130	39	30	40
Pine Ridge-SD	137	58	42	119	30	25	40
San Carlos-AZ	121	82	68	78	38	49	28
Total:	456	238	52	370	118	32	38
<u>Totals</u>							
All sites combined	1404	801	57	1347	525	39	32



Knowledge, attitude, and behavior

A knowledge, attitudes, and behavior survey was designed during the second year of the program and administered to approximately 50 people at each of the pilot sites. The survey was readministered during 1990. There were between 244-290 respondents to each question, on both the pretests and posttests. The knowledge, attitudes, and behavior survey resulted in increases in knowledge and attitudes about BBTD that were not statistically significant. (See Table) As with most health concerns today, the public is already knowledgeable and may even have the positive attitudes that lead to improved health behavior. There were, however, statistically significant improvements in reported behavior that were confirmed by the reduced prevalence of BBTD.



Table 2: Results of Knowledge, Attitudes, and Behavior Survey

	PRETEST (% correct)	POSTTEST (% correct)	P-VALUE
KNOWLEDGE			
Age child should be weaned from the bottle	80	80	.383
Problems associated with BBTD	78	89	.588
Prevention of BBTD	66	68	.136
Causes of BBTD	65	62	.013
ATTITUDES			
Lost baby tooth is a problem	74	83	.106
Important for baby teeth to look good	95	95	.201
Inevitability that children will get BBTD	52	55	.578
BEHAVIOR			
Put child to bed without a bottle	77	88	<.001
If bottle is used, liquid is water	64	74	<.001



Costs and benefits of the program

Over the 5 years of the project, grants totaling \$121,000 have been received for the development, implementation, evaluation, and continued distribution of the project materials. Further support has been provided from private industry. For example, Hanksraft a division of Gerber, agreed to produce **tippie** cups imprinted with the BBTD logo. They have donated thousands of cups, and the rest have been sold to the project for cost. Finally, the program has depended on the contribution of in-kind and volunteer services at each pilot site. It has become impossible to track accurately the hours that this ever expanding group of people have contributed. Assessing the total cost of the BBTD program is impossible, therefore, only the direct funding can be taken into consideration when developing cost-benefit estimates.



If one assumes a conservative cost estimate and a reduction of 32 percent in **BBTD** cases at the 12 sites, then **BBTD** was prevented in 448 children whose treatment **would have cost** \$313,600.

This estimate excludes expenses for general anesthesia or hospitalization. Each year of the project, an entirely new cohort of children was surveyed, so that the savings were multiplied many times over. No attempt was made to estimate the cost benefit in terms of emotional trauma and pain avoided, decrease in ear and speech problems, or the long-term savings in orthodontic treatment since it is nearly impossible to quantify these savings.

A few final words

The BBTD program offers a model for planning successful interventions, particularly in Native American communities. The results of the knowledge and attitude surveys should guide planners to focus on methods aimed at broad social change combined with one to one counseling interventions. It appears that brief interventions aimed at improved knowledge and attitudes are not sufficient to create changes in health behavior.

The success of the BBTD

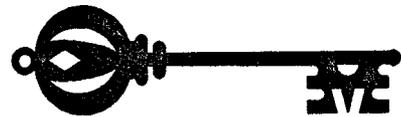


program goes beyond decreased rates of dental decay. The involvement of Native American communities in this program has empowered many of the pilot sites to take on other health issues using the BBTD program model. A future goal should be the application of the model to other health problems in minority communities. It is recommended that the BBTD program continue and expand to include more communities in this **community-**based prevention program.



Keys to success

- ➔ A multi-strategy approach
- ➔ A multi-disciplinary approach
- ➔ Effective site coordinator
- ➔ Development of a task force
- ➔ Involvement of Women, Infant, and Child (WIC) or Maternal Child Health agencies
- ➔ Plan for 100 percent contact with the caretakers of infants through one to one counseling and media approaches
- ➔ Use of the complete package of education materials



REPITITION and CONSISTENCY

Steps to getting started

All of the effective sites followed these steps

1. Establish local baseline prevalence of BBTD
2. Select a site coordinator
3. Obtain support contracts from local agencies
4. Assemble a task force
5. Design a program plan
6. Develop an evaluation plan
7. Build in a reward or support system for the staff involved in the program

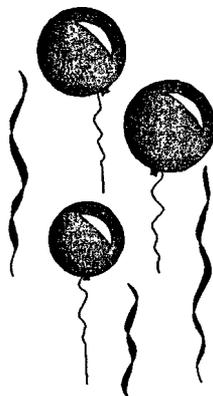




STRATEGIES

1. Provision of ongoing BBTD training to health professionals and parents
2. One-to-one counseling with parents
3. Media campaign
4. Involvement in community activities
5. Development of strategies customized to the local community and culture

EDUCATION MATERIALS



“How to Organize a BBTD Program” manual

Training Manual

Counseling Books and Slides

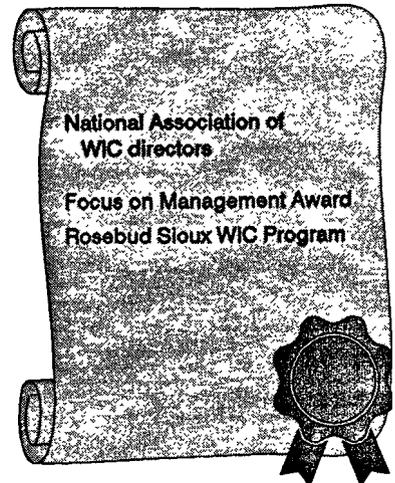
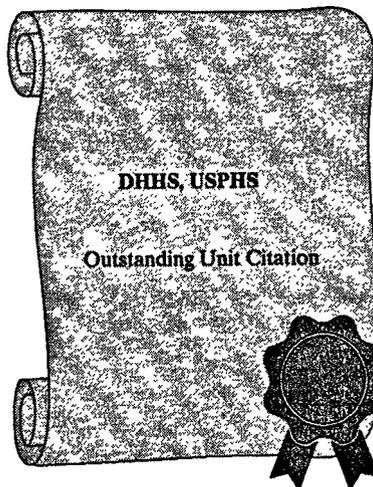
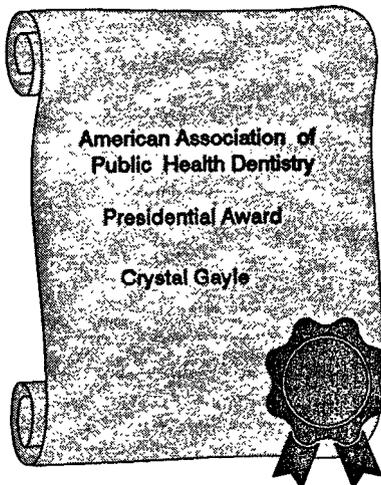
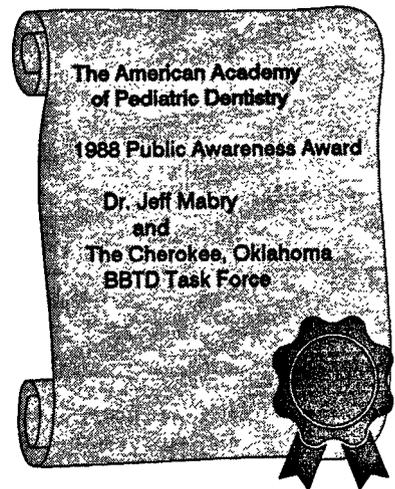
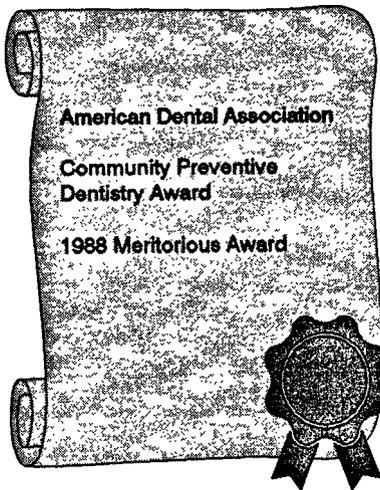
Cups . . . Balloons . . . Photo Holders

Sewing Cards . . . Stickers . . . flyers

Posters . . . PSAs . . . News Article



AWARDS





REFERENCES

- 1. Johnsen D.C.:** Characteristics and backgrounds of children with "nursing caries." *Pediatr Dent* **4:218-224** (1982).
&Walton J.L., and Messer L.B.: Dental caries and fluorosis in breast-fed and bottle-fed children. *Caries Res* **15:124-137** (1981).
&Gardner D.E., **Norwood J.R.**, and Eisensohn J.F.: At-will breast feeding and dental caries: four case reports. *J Dent Child* **44:186-191** (1977).
- 4. Derkson G.D.,** and Ponti P.: Nursing bottle syndrome; prevalence and etiology in a non-fluoridated city. *J Can Dent Assoc* **48:389-393** June 1982.
- 5. Dilley G.J.,** Dilley D.H., and **Machen J.V.:** Prolonged nursing habit: a profile of patients and their families. *J Dent Child* **47:102-108** March-April 1980.
- 6. Ripa L.W.:** Nursing habits and dental decay in infants: "nursing bottle caries." *J Dent Child* **45:274-275** July-August 1978.
- 7. Johnsen D.C.,** et al.: Background comparisons of pre-3 1/2-year-old children with nursing caries in four practice settings. *Pediatr Dent* **6:50-54** (1984).
- 8. Goose D.H.,** and Gitters E.: Infant feeding methods and dental caries. *J Public Health (London)* **83:72-76** January 1968.
- 9. Johnsen D.C.:** Dental caries patterns in preschool children. *Dent Clin North Am* **28:3-10** January 1984.
- 10. Nowak A.J.:** *Public Health Currents*. Ross Laboratories, Columbus, OH, 1985.
- 11. Kotlow L.A.:** Breast feeding: a cause of dental caries in children. *J Dent Child* **44:192-193** May-June, 1977.
- 12. Fass EN.:** Is bottle feeding of milk a factor in dental caries? *J Dent Child* **29:245-251** (1962).
- 13. Niendorff W.,** and Collins R.: Oral health status of Native Americans, selected findings from a survey of dental patients conducted in FY 1983-4 by the Indian Health Service. Paper presented at annual meeting of the American Public Health Association, Las Vegas, NV, Oct. **1, 1986**.
&Kelly M., and Bruerd B.: The prevalence of baby bottle tooth decay among two Native American populations. *J Public Health Dent* **47:94-97** (1987).
- 15. Broderick E.,** Mabry J., Robertson D., and Thompson J.: Baby bottle tooth decay in Native American children in Head Start centers. *Public Health Rep* **104:50-54**, January-February 1989.
&Green L.W., Kreuter M.W., Deeds S.G., and **Partridge K.B.:** *Health education planning: a diagnostic approach*. Mayfield Publishing Co, Palo Alto, 1980.
- 17. Bruerd B,** Kinney M.B., and **Bothwell E:** Preventing Baby Bottle Tooth Decay in American Indian and Alaska Native Communities: A Model for Planning. *Public Health Rep.* **104:631-40**, Nov-Dee 1989.

THE MOCCASIN TELEGRAPH



POLICIES AND PROCEDURES MANUAL FOR "THE MOCCASIN TELEGRAPH" COMMUNICATIONS

The purpose of this manual is to train and assist personnel in answering the BBTD hotline and written requests in a manner that conforms to the theme and purpose of the project.

BACKGROUND INFORMATION

OVERALL GOAL: To develop and evaluate the use of a support network to export the BBTB program to other Indian communities where BBTB prevalence is in excess of 20 percent.

OBJECTIVES

Phase I: Develop a support network for technology transfer.

- a. Incorporate "How To Organize a Pilot **Site**" manual and "Out of the Mouths of **Babes**" videotape to educate interested sites about the BBTB program.
- b. Develop a newsletter to assist sites in technology transfer including technical consultation, questions and answers, linking of sites through local news, and support for innovation at all sites.
- c. Establish a "hotline" for answering questions about the technology and its effective implementation.
- d. Establish ongoing consultation services via the "hotline" where program and evaluation plans will be reviewed by a BBTB expert.

Phase II: Implement **BBTB** technology at four new sites.

- a. Select sites using criteria established in the Transferability Report.
- b. On-site training at each new site.
- c. Offer continued training and technical assistance to the four new sites.

Phase III: Evaluate the progress of the technology transfer.

- a. Evaluate the outcome using BBTB prevalence surveys each year of the project period.
- b. Evaluate the structure to include the kinds of intervention strategies utilized and their frequency and intensity.
- c. Evaluate the support network as a model for transferring the BBTB program to new sites.
- d. Write year-end report to funding source.

ADDITIONAL SUPPORT MATERIALS

Please read the attached Five Year Evaluation Study and the Transferability Report.

THEME

The overall purpose of the BBTB technology transfer project is to motivate communities with a BBTB problem to establish a BBTB program and to transfer the technical information and education materials to build an effective program. Another purpose of the technology transfer project is to keep existing sites motivated and to encourage them in the transfer of their "tips" for new BBTB sites. Therefore, the overall goal of the project is communication between existing sites, new sites, potential sites, and the core group of planners. Two marketing themes and corresponding logos will be developed to accomplish the communication goals.

The primary theme will be called "The Moccasin Telegraph" and will promote the idea of Indian people sharing information about the BBTB program and community organization with other Indian people. The marketing plan will build on this theme by using American Indian people of all ages and levels of involvement to convey the knowledge and technical information needed to establish successful BBTB sites. By using community members, we can interject an abundance of practical knowledge. The "Moccasin Telegraph" will be the title for the newsletter and the hotline.

The second theme will be called "Out of the Mouths of Babes". The theme will be extended by using the concept of babies and young children to pass on valuable information about the BBTB program and parenting techniques. Parenting skills are often a sensitive issue. By using the image of babies as teachers, perhaps the topic can be approached in a sensitive, caring, and humorous manner. Much of the information will be given as though the babies themselves have produced the "advice". This theme will build on the introductory video being produced by the Centers for Disease Control. The video is titled "Out of the Mouths of Babes" and uses preschoolers to convey an overview of the BBTB program and the steps to getting started towards establishing a BBTB site. A section of each newsletter will feature an "Out of the Mouths of Babes" article about parenting tips. The information the babies pass on will of course represent the core group of planners for the BBTB project.

Trained personnel will field all correspondence between the Moccasin Telegraph, BBTB site personnel, and the public. All information given through The Moccasin Telegraph will represent the BBTB core group of planners.

I. ANSWERING THE TELEPHONE

A. The First Response

Some callers will ask for The Moccasin Telegraph while others will have never heard of the Moccasin Telegraph but just want information about the BBTD program. Your response is the same in either case: "**Hello**, you've reached The Moccasin Telegraph. Can I help you?"

If you are asked what the Moccasin Telegraph is, your response should be, "**The** Moccasin Telegraph is a network of people who can answer all of your questions about BBTD and the BBTD program."

B. Technical information

The following questions are just a few of the tough technical questions you might receive:

Can fluoride toothpaste prevent BBTD?

At what intervals should parents be counseled about BBTD?

Are sealants effective in preventing BBTD?

Whenever you receive a technical question, record the question(s), tell the person that you will get an answer, get the caller's telephone number and name, and contact one of the BBTD consultants.

DO NOT attempt to answer technical questions unless you are absolutely sure of the answer because it is by far better to refer the question than it is to give an inaccurate answer.

C. Requests for materials

When people are interested in obtaining materials, they can order them from you. You must record their name, address, and telephone number. Then fill out an order form and contact CDC to order the materials and have them sent directly to the people ordering the materials. If an unusually large order comes in or if there are any doubts about the order, contact one of the BBTD consultants.

When people are interested in obtaining the materials that must be purchased, send them an order form.

When people request BBTD articles or other written materials that are not mass distributed, take their name, address, and telephone number. Send the materials if you have them. If not, ask the BBTD consultants to assist you in obtaining the materials.

D. Interest in developing a new BBTD site

If someone calls who has never been involved in a BBTD program, take their name, address, and telephone number. Send the person a copy of "**Out** of the Mouths of **Babes**" videotape and "**How To Organize a Pilot Site**" manual.

KEEP A LOG OF EVERY TELEPHONE CALL IN THE BBTD HOTLINE LOG

II. RESPONDING TO WRITTEN CORRESPONDENCE

A. Technical information

All technical correspondence should be directed to one of the BBTB consultants for a reply.

B. Requests for materials

All free materials can be ordered through CDC. The purchased materials should be ordered directly between the people wanting the materials and the vendors. Requests for any items not routinely mass produced should be directed to the BBTB consultants. Any unusually large orders should be brought to the attention of the BBTB consultants.

C. Interest in developing a new BBTB site

Send the person a copy of "Out of the Mouths of Babes" videotape and "How To Organize a Pilot **Site**" manual.

LOG ALL WRITTEN CORRESPONDENCE IN THE MANUAL MD PUT THE CORRESPONDENCE IN A FILE

III. GATHERING MATERIAL FOR THE NEWSLETTER

During your daily involvement with BBTB sites, you will come across all kinds of interesting tidbits for the BBTB newsletter. You must be alert to information that might be helpful to compiling the newsletter.

A. Tips for success

Whenever people tell you about something great they have done to prevent BBTB, make a note for the newsletter. These "tips" will be shared with other sites via the newsletter.

B. Problems

As problems arise at BBTB sites, the solving of these problems can offer important insight for other sites and will be shared in the newsletter.

C. Pictures

If you hear about something interesting that a site has done, ask for a photograph. The photo might be of a parade float, a special event, a bulletin board, a "poster child", or a new education material that has been useful at that site. These photos will be incorporated in the newsletter to make it more interesting.

D. Examples of innovative education materials and strategies

As people tell you about something they have developed to complement the BBTB education materials, ask for a description of the strategy and a sample of any corresponding materials so that we can share it with other sites via the newsletter.

You need to be a bit of a detective to gather information for the newsletter.

KEEP ALL GATHERED NOTES, MATERIALS, MD PHOTOGRAPHS IN THE FILE MARKED "**BBTB** NEWSLETTER"

BBTD TELEPHONE LOG

NAME DATE REASON FOR CALL ACTION

PHONE: _____ ADDRESS: _____

COMMENTS: _____

NAME DATE REASON FOR CALL ACTION

PHONE: _____ ADDRESS: _____

COMMENTS: _____

NAME DATE REASON FOR CALL ACTION

PHONE: _____ ADDRESS: _____

COMMENTS: _____

NAME DATE REASON FOR CALL ACTION

PHONE: _____ ADDRESS: _____

COMMENTS: _____

NAME DATE REASON FOR CALL ACTION

PHONE: _____ ADDRESS: _____

COMMENTS: _____

NEWSLETTER ITEMS

NAME OF PERSON YOU GATHERED INFORMATION FROM

DATE

PHONE NO.

SITE/ADDRESS

DESCRIBE THE NEWSLETTER ITEM HERE AND ATTACH ANY PHOTOS,
ARTICLES, OR OTHER MATERIALS TO THIS SHEET.

BABY BOTTLE TOOTH DECAY
CORRESPONDENCE LOG
November 25, 1991

7/31/91

1. Cynthia Knipple
Portsmouth Health Dept.
PO Box 1454
800 Crawford Parkway
Portsmouth, VA 23704
(804) 393-8585 x1 12

She was interested in information to order the BBTD tippæe cups. These are being used in a WIC Education program and not a BBTD site. I sent her an order form for CDC educational materials.

8/5/91

2. Tanya Pagan Ragsio
Primary Care Health Services
7227 Hamilton Ave.
Pittsburgh, PA 15208
(412) 244-4700

She is a Health Center Director. She has seen a lot of BBTD lately in her area, as well as restorations. Has some classroom settings, prenatal, breastfeeding, young mothers. Requested any information, not necessarily to set up a site, but for her own use. They had just finished a health fair, I suggested BBTD involvement next year. I sent her materials. (Summary of 1990 Five Year Evaluation Report, resource list)

3. Dr. I Emenike
115 Kismed Drive
Columbia, SC 29210
office: (803) 253-5241
home: (803) 750-0457

I tried several times to reach Dr. Emenike at these numbers and was able to reach someone only once. They knew nothing about the BBTD project and my message was not returned. I sent materials.

8/13/91

4. Lisa Paikin
County of San Diego
Dept of Health Services
Division of Public Health Education
PO Box 85222

San Diego, CA 921865222
(619) 236-2705

She was very enthusiastic about seeing the advertisement in Nation's Health. They are just starting a dental **health/BBTD** focus. BBTD is a big problem in her area clinics. County of San Diego has 8 public health centers/clinics. Provide no cost medical care for low income families, programs include well-child check-ups, child health disability prevention. Also interested in information regarding training of volunteers. Materials were sent. **11/25** Just out of curiosity-- I called her to see if what I had sent was useful, she wasn't in. I'll wait for a return phone call. **12/4/91** She returned my phone call. She enjoyed the newsletter and was very happy to see so much information on BBTD, as it is top priority in her program. I will send her the complete evaluation report and another copy of the resource list for her use in training and counseling. Sent **12/10/91**.

5. Debbie **Strucko**
One Investment Place
11th Floor
Towson, MD 21204

This address was on a fax from CDC, no phone number. Materials were sent.

6. Sarah **Harpor/Dr. Keith Hampden**
City of Dallas
Health and Human Services, Health Education
4500 Spring Avenue
Dallas, TX 75210

She has both classroom and clinic situations and wanted to see if our materials could be used in her program. Materials were sent.

7. Warren LeMay
Dental Health Director
Bureau of Public Health
1400 East Washington Avenue
Madison, WI 53703
(608) 266-5152

Materials sent.

1 **0/28/91** -- I **recieved** a letter from Warren **LeMay**, with the corrected address above. He found Moccasin Telegraph very interesting, asked to be put on mailing list. No additional materials sent at this time.

1/17/91 -- Sent him Trainer's Guide, Trainer's Manual, and "How To Organize BBTD Prevention Program" along with an Order form for CDC.

8/16/91

8. Denise Higgins
Rockland County Health Dept.
Sanitorium Rd.
Bldg. D
Ponoma, NY 10970
(914) 354-0200 x2651

Materials sent.

9. **Margo** Quiriconi
Kauffman Foundation
9300 Ward Parkway
PO Box 8480
Kansas City, MO 64114
(816) 966-4033

Materials sent.

10. Kay Midgett
514 East Grace St.
Puntagorde, FL 33950
(813) 693-1 181

Materials Sent.

11. Jennifer Robertson
1400 SW 5th Avenue, Room 508
Portland, OR 97201
(503) 731-4098

Materials sent.

12. Samantha Steven
(415) 468-3175

I tried several times, no messages returned. There was no address on the fax from CDC.

13. Erlinda Binghay
Winfield Mood Health Center
1276 North Clybourn
Chicago, IL 60610
(312) 337-1 073

14. Beverly Saldivar
Kaiser Permanente Medical Center
6600 Bruceville Road
Sacramento, CA 95823

Materials sent, no phone number.

8/28/91

15. Steve Lehman
Child Health Program
3147 Loma Vista Road
Ventura, CA 93003

No phone number given. Materials sent, phone number requested.

16. Bonnie Haun
Genesee County Health Dept.
630 South Saginaw
Flint, MI 48502-1540
(313) 257-3133

Materials sent.

1 0/8/91

17. Dr. Tom Chang
Martha Elliott Health Center
33 Dick Ford Street
Jamica Plain, MA 02130
(617) 522-5300 x126

He left message for me, regarding BBTD. I called twice, no return calls. Added to mailing list, materials sent.

1 0/21/91

18. Lesa Weber
Shawnee Indian Health Center
2001 South Gordon Cooper Drive
Shawnee, OK 74801
(405) 275-4111

Wished to be on mailing list. Not interested in other materials at this time.

1 0/23/91

19. Caterine K. Lavigne, RDH. MS
Dental Health Education Supervisor
Dept. of Health
60 Main Street
PO Box 70
Burlington, VT 05402

I recieved a letter requesting "First Aid for Dental Emergencies" poster.

I sent her a letter, **10/28/91**, to let her know it is no longer available.
11/29/91 I found some "dental emergencies" posters, I sent one.

19. Oscar Rivera
San Felipe Health Service
San Felipe Pue., NM 87001

I recieved a notice of address change. I sent another copy of the newsletter.

20. Sheila Buschette
White Earth Head Start
PO Box 418
White Earth, MN 56591
(218) 983-3285 x221
(218) 983-3221

I talked with her twice. She was very enthusiastic. This is Head Start program with 150 children in 7 classrooms. This is 4th year BBTD program., surveying every year. In the past prevalence was **37%-38%**; now it is 25%. Has gone down 13% in last three years. She was interested in any special recognition awards available for people in her program. A big concern was fundraising. Costs of events was also a main concern. She was asking for information about any available money/grants if we had any available. I told her there may be in the future, but not at this time. The next health fair is April 22, 1992. In the past couple of years they've had balloon lift-offs. It has become a big community event, a meal is served. They hope to have a teddy bear exchange next year vs. a balloon lift-off. They currently have many activities. Use BBTD cups/bibs. Local florists donate flower arrangements in BBTD **tippee** cups with balloons to put in local Doctor's offices and OB wards. Along with bumper stickers/bibs. Also involved with interagency school committees. She agrees to send me a list of their activities, minutes of last meeting with brainstorming, also a video of last balloon lift-off. This was never recieved. I sent her materials. **11/27/91** I called her to ask a few more questions per Mary Beth, hoping to get more information regarding eligibility for OPEL grant. I left two messages with her secretary explaining my position and its urgency. **12/3/91** I called again. My phone call was not returned. **1/9/92** I talked with Sheila and asked for a program description, including her program's financial need. She said she had sent the video and letter in November, but I did not **recieve** it. They now have 8 classrooms. She mentioned that the balloon lift-off scheduled April 22, 1992 is expected to cost \$200. I told her to go ahead and estimate the amount of money that would be needed to continue the floral arrangements, the teddy bear exchange, the bumper stickers, **tippee** cups, bibs etc. I also asked her to send a list of possible goals, or resources that the program needs. She said she will send some pictures along with the letter. These pictures need to be returned to her. This letter was to be out in the mail this afternoon. I also sent her a **complete** evaluation report.

21. Ted Banks
PHS Indian Hospital
Sisseton, SD 57262

Materials sent.

22. Mary Smith
Carl Albert Indian Hospital
1001 North Country Club Road
PO Box 1564
Ida, OK 74820

She left a message requesting to be placed on mailing list.
I later talked with Eric Bruce. He sees BBTD in even 6 month old babies. They also send birthday cards to 1 year olds.

23. John Zimmer
Dental Clinic
1000 Health Center Road
Kyle, SD 57752
(605) 455-2451

Materials sent.

24. Dr. Timothy Lozen
Hollywood Health center
6353 North 30th Street
Hollywood, FL 33024

Left message to be on mailing list.

25. Dr. Rebecca Neslund
PHS Indian Hospital
Cherokee, NC 28719

Left message requesting to be put on mailing list. Also interested in a copy of artwork from enclosed brochure "Keep Your Baby Smiling" - so they can publish their own copies. Artwork not available at this time, no phone number given.

26. Annie Owens
PHS Indian Hospital
Cherokee, NC 28719

Left message requesting to be put on mailing list.

27. Janna McNutt
Wewoka Indian Health Clinic
PO Box 1475
Wewoka, OK 74884
(405) 257-6281 x320

I recieved a message. 10/24 I left her a message. 10/29 Tried again. She wanted to look at all of our materials. Sent 10/29/91.

10/25/91

28. Evie Gardpipe
Benewah Dental clinic
PO Box 338
Plummer, ID 83851

I recieved a message wishing to be put on mailing list. They are trying to set up a BBTD program, requested materials. Materials sent.

11/13/91 -- Talked with Ebie Gardpipe again. Sent her the complete Evaluation Report.

29. Blake Harris
Trinity Rural health program
PO Box 1603
Weaverville, CA 96093
(916) 623-2287

Left a message requesting placement on mailing list and any other materials available. Sent materials 10/28.

30. Eileen Builford, WIC Coordinator
c/o Genesee County Health Dept.
630 South Saginaw St.
Flint, MI 48502-1540

I recieved a letter requesting to be put on mailing list.

31. John Foster
Dental Clinic
PO Box 241
Good Hue, MN 55027

I recieved a letter requesting to be put on mailing list, with an updated address.

10/29/91

32. Marty Duchschen
c/o Dental Clinic
PHS Indian Hospital
Crow Agency, MT 59022

Left message 10/21, no phone number. Requested to be put on mailing list, Materials Sent 10/29.

33. Chris Halliday
PHS Indian Health Center
Star Route 4, Box 5400
Blumfield, NM 87413

Called me to request any materials I had as they are setting up a new program. Have not decided what extent they want this program to be at. Will have a new phone number soon. Complete evaluation report and resource manual sent **10/29**.

10/30/91

34. Carol Mott
LCO Community Health Center
Rt. 2, Box 2750
Hayward, WI 54843
(715) 634-4795

I returned her call twice. She wanted the pamphlet that we sent out to have an Indian child involved. I asked her to check back with me at a later date, by then I might have a copy of the artwork available for her to do with as she wishes. She did not ask to be on the mailing list, but I put her on **anyways** and sent materials **11/13**.

10/31/91

35. Greg Jaso
United Indian Health Service
PO Box 420
Trinidad, CA 95510
(707) 677-3693

Expressed interest in mailing list. Sent materials **11/13**.

11/4/91

36. Jenni Noble
Genesee County Health Dept
630 South Saginaw
Flint, MI 48502
(313) 252-3576

Not necessarily interested in setting up BBTD site -- involved with **medicaid** screening, general medical, needy people, screening children under 21. Materials sent **11/4**.

37. Joy McCormick
Round Valley Indian Health Center
PO Box 247
Covelo, CA 95428
(707) 983-6182

Requested educational materials - training manual for BBTD
Possibly interested in OPEL Grant, Also interested in counseling books, slides. I referred her to Barbara Holcomb's series and pointed it out in the resource manual. Isolated community, 20 Head start children. Sent materials, including the complete evaluation report **11/4**.

11/6/91

38. Kathleen Kobus
Office of Clinical Management
US Public Health Service Region 4
101 Marietta Tower
Suite 1104
Atlanta, GA 30323

I recieved a message requesting to be put on the mailing list. Sent materials 11/13.

39. Diane Rogers
Community Health Education
921 North 23rd St.
Oklahoma City, OK 73105

Already on mailing list. Sent materials.

40. Sherry Paxson
Lapwai, ID

She is a dental hygienist, also involved in prenatal programs. She requested statistics of the BBTd rate in her area. We were able to get that for her. She also expressed interest in tippee cups and "Keep Baby Your Smiling " pamphlets. Materials were sent.

41. Jennifer Robertson
Oregon State Health Division
Dental Program
(503) 229-5636

Nothing needs to be sent at this time. She wanted to let us know that the pamphlet that was enclosed in the past newsletter is also available through her and the Oregon Health Division. She offered her HM/HB mailing list. She uses our IHS materials and has worked with Mary Beth Kinney and Mike Hess in the past. Her new address after 2/14/92 will be PO Box 14450, Ptld, OR 97214-0450.

11/13/91

42. Evie Gardpipe
Benewah Dental Clinic
PO Box 338
Plummer, ID 83851
(208) 686-1110

She is already on our mailing list. Expressed interest in a training program for BBTd. Also asked about the pamphlet that was enclosed in the newsletter, I referred her to her own state health department, Boise, ID. This reference is in the resource manual. Sent complete evaluation report.

11/18/91

43. Sherry Scott
American Indian Care Association
245 E. 6th Street
Suite 2499
St. Paul, MN 55101
(612) 293-0233

She has her own newsbrief which reaches 2700 people. This includes AIDS and various other health promotions. She wants to include BBTB resource manual and newsletter in a list in her own newsbrief as a low cost resources available. She also has a clearinghouse at an I-800 number that is also available for health resources. Nothing yet has been included regarding BBTB. She will also include our BBTB Prevention Project along with approximately 90 other projects. She requested our BBTB materials -- I sent her the BBTB resource manual, summary of 5 yr evaluation report to explain about our program, and a clean copy of the Moccasin Telegraph that may be reproduced as needed. She will send me a copy of her newsbrief , which has not yet been recieved.

44. Jennifer Robertson/Dental Health Consultant
Oregon Health Division
1400 SW 5th Avenue, Room 508
Portland, OR 97201

I recieved a letter with 9 names to be added to our mailing list. She also sent me a copy of the announcement for a new pamphlet regarding BBTB, dated 1990. She can be contacted to order these. Copies of Moccasin Telegraph sent to the following names:

45. Dr. Roger Lunt
Pedo Dept.
OHSU - School of Dentistry
611 SW Campus Drive
Portland, OR 97201
46. Dr. Donald Porter
Pedo Dept.
OHSU - School of Dentistry
611 SW Campus Drive
Portland, OR 97201
47. Ms. Marge Reveal
Pedo Dept.
OHSU - School of Dentistry
611 SW Campus Drive
Portland, OR 97201
48. Ms. Sue Sanzi-Schaedel
Multnomah County

Sch. Dental Health
6505 SE 11th
Portland, OR 97202

49. Peter Lax
CDRC
PO Box 574
Portland, OR 97207
50. Dr. Duane Paulson
OR Soc. of Dentistry for Children
511 SW 10th, Suite 810
Portland, OR 97205
51. Oregon Dental Association
17898 SW McEwan Rd.
Portland, OR 97224
52. Laura Leonard
HM/HB
1220 SE Morrison, Ste. 620
Portland, OR 97205
53. Mary Ellen Good
Migrant Education Service Center
Administration Bldg. 2nd Floor
700 Church St. SE
Salem, OR 97301

11/20/91

54. Henrietta Oudenhoven
IHS
Oneida Dental Clinic
PO Box 365
Oneida, WI 54155
(414) 869-2711 x157

She asked to be on the mailing list, also requested BBTD materials, Materials sent 11/20.

55. Annie Drake
WIC Program
Inter Tribal Council of NV
PO Box 7440
Reno, NV 89510

She is a nutritionist, requested to be put on mailing list.

56. Erin Procter

CHR/Coquille Tribe
PO Box 1435
Coos Bay, OR 97420

She is a new CHR worker for the Coquille Tribe. She will be in the field within the Coos area in Jan. She was interested in handouts and other information about how to approach the problem. Sent her a complete evaluation report along with the resource manual.

11/22/91

57. Merris Collins
CHR Program/ Klamath Tribe
PO Box 436
Chiloquin, OR 97624

No phone number given. Wished to be put on the mailing list.

58. Rene Scolaro
Salt River Health Center
Rt. 1, Box 216
Scottsdale, AZ 85256
(602) 379-4281

Requested copy of the last newsletter. Sent 11/23/91

11/26/91

59. Bob Bojarcas
Shoal Water Bay Clinic
PO Box 130
Tokeland, WA 98590

He left a message to be put on the mailing list.

12/11/91

60. Denise Higgins
Rockland County Dept of Health
Sanatorium Road
Pomona, NY 10970
(914) 354-0200 X2651

I called after receiving a fax from Linda Crossett. I left a message for her to return my phone call.

12/13/91

61. Dr. Brett Downing
UNO Service Unit

PHS Indian Health Service Clinic
PO Box 160
Ft. Duchesne, UT 84026

Jeff Thompson called looking for Dental **Emergencies** Poster. I sent three.

62. Suzanne Randall
Indian Health Center
2001 Gordon-Cooper Drive
Shawnee, OK 74801
(405) 275-1411

I received a message requesting information for BBTD and prenatal. I sent her the resource manual and the summary. She will also be added to the mailing list.

12/16/91

63. Diana Madrigal
20 N. Dewitt Ste. IO
Clovis, CA 93612

She called to be put on mailing list. She was looking for information to use in the clinic as well as classroom use, some Head Start. Materials sent.

12/17/91

64. Norine Wells, CHR
Nisqually Health Clinic
4816 She-Nah-Num Drive SE
Olympia, WA 98503
(206) 456-5221 x683

I received a letter requesting to be put on mailing list. She currently is working for the Nisqually Indian Tribe as a Community Health Representative. Looking for BBTD information for newsletters and also as hand-outs to clients. I sent her a summary of the evaluation report and a resource manual **12/17/91**.

12/19/91

65. Dr. Brett Downing
UNO Service Unit
PHS Indian Health Service Clinic
PO Box 160
Ft. Duchesne, UT 84026

Dr. Downing called. He requested nine more Dental Emergencies posters. There are 12 Head Start classrooms and it is a requirement for them to have a poster of this sort in each **class**. I sent him nine more.

12/23/91

66. Nancy Rifle called. She is trying to get Gerber to make the **tippee** cups in a less threatening color, possibly yellow, green, blue, Gerber said they only make them in red. She is holding the purchase order until this is cleared up. Mary Beth needs to get back to her.

1/3/92

67. David Rollason
Isabel Community Clinic
Box 209
Isabel, SD 57633
605-466-2120

I recieved his name on a fax from CDC. I left a message. This is a **fedderrally** funded community health center. Clinic network MT, WY, UT, ND, SD. Out of the funding requirement CHC deals with BBTD in clinical component, protocal, tracking system, random sample, and show progress therefore 600 centers to develop same protocal.

68. Mary **Callen**
Milwaukee Indian Health Center
WIC Program
2631 West State Street
Milwaukee, WI 53233
414-931-8606

She was not available. I will call back.

1/6/92

69. Kim Louis
Cheyenne River Head Start
P.O. Box 590
Eagle Butte, SD 57625
(605) 964-8710

She called requesting BBTD materials for her classrooms. She is the parent coordinator. This program has 14 classrooms with 251 students. She sees a lot of BBTD and would like to have new materials to counsel parents and send home to parents. I sent her a copy of the Moccasin Telegraph, a summary of the report, and a resource manual.

70. Jeddie Russell
(403) 668-7289

71. Chris Smith
Alaska Native Health Center
3289 Tongass Ave.

Ketchikan, AK 99901

She is fairly new, trying to set up awareness, not necessarily a program. Only one person in the WIC program is somewhat supportive, Head Start is not. She has information for parents, they did a health fair using a flip chart. They have no data collection, there is not a lot of BBTD seen in town, only 15% native population in town. She doesn't travel outside of town. The tribes are not together, she has heard of no support from them.

1/15/91

72. **Ruggles Stahn**
3200 Canyon Lake Drive
Rapid City, SD 57701

Involved with the diabetes program, obesity prevention, Head Start/WIC. The complete evaluation report was sent to him, 1/15/92.

73. **Steve Geierman**
Peoples Health Center
5701 Delmar
PO Box 11937
St. Louis, MO 63112-0937
(314) 367-7848

Requested HM/HB Prevention book, resource list, copy of order form-CDC. Sent 1/21/92, also added to mailing list.

74. **Delores Starr**
PHS Indian Health Center
Pine Ridge, SD 57770

Requested an order form for CDC. I also sent her a copy of the five year evaluation report summary.

119192

75. **Linda Butterfield**
Stanislaus County
Office of Education
Resource and Referral
801 County Center
3 court
Modesto, CA 95355
(209) 525-4900

76. **P. Joyce, MD**
Mt. Sinai.UConn OPS
80 Coventry Street
Hartford, CT 06112

(203) 242-0046

77. P.M. Schnider, MD
2335 Church St.
Zachary, LA 70791
78. John Murphy
735 25th Street
Cleveland, TN 37311

1/13/92

79. Dr. Vepel
Bristol Bay Health Center
Box 130
Bellingham, WA 99576
(907) 842-5245

Requested to be put on mailing list.

80. Keith Heller
520 Venture Ct.
Ann Arbor, MI 46103

A pediatric dentist writing a literature review on BBTD and writing a "fake" grant proposal for a training tape. He has a very strong interest in BBTD, also plans on doing his doctoral thesis on some area of BBTD. He was referred to us by Chris Delecki. Sent him 5 year report, resource manual, transferability information. He sent a thank you note to MBK for her help.

1/14/92

81. Marsha Holloway
IHS Dental Center
Southwestern Indian Polytechnic Institute
PO Box 25927
Albuquerque, NM 67125
(505) 897-5306

Pediatric dentist on duty for 5 months. She expressed interest in BBTD, wished to be on mailing list.

1/30/91

82. James Vesbach
Billings Area Office-IHS
711 Central Ave
PO Box 2143
Billings, MT 59103

83. **Roger Wayman**
PHS Indian Hospital
Browning, MT 59417
84. **Becky Smith-Thomas**
Miccosukee Health Center
PO Box 440021
Tamiami Station
Miami, FL 33144
85. **Jeff Hagen**
California Area Office-IHS
1825 Bell St., Suite 200
Sacramento, CA 95825
86. **Jeffery Carolla, DDS**
Washoe Tribe Health Clinic
919 Highway 395 South
Gardnerville, NV 89410
87. **Robert Collins**
IHS Headquarters; HSA, PHS
Room 6A-30, Parklawn Bldg.
5600 Fishers Lane
Rockville, MD 20857
88. **Gary Gritzbaugh**
IHS, Dental Services Branch
300 San Mateo Blvd. NE, Suite 600
Albuquerque, NM 87108

2/6/92

89. **Jan Lenell**
Southern Indian Health Council, INC
4058 Willows Rd
Alpine, CA 91901
(619) 445-1 188

Added to mailing list per request through mail

2/7/92

90. **Dr. Hetrick, DDS**
IHS Area Dental Branch
215 Dean A. McGee NW
Oklahoma City, OK 73102
(405) 945-6875

He called requesting to be on the mailing list. Also suggested Eric Bruce, who is already on it, and Dr. Woody Crow. No materials needed at this time.

91. Dr. Woody Crow
PHS Indian Hospital
Claremore, OK 74017

2/21/92

92. Els Fullford
Tanana Chiefs WIC Program
122 First Ave,
Fairbanks, AK 99701
(907) 452-8251

Sent info especially interested in weaning child off the bottle.

2/24/92

93. Arlan Andrews, DMD
PHS/IHS
Taos, NM 87571

Add Taos Pueblo Headstart, PO Box 1846, Taos, NM 87571 to mailing list.

2/27/92

94. Michelle Muller
South Central Child Development, INC
PO Box 1020
Wagner, SD 57380-1020

I sent her a letter saying RSG is out of print.

2/28/92

95. Kathy Nelson
USD Head Start
Univ. of South Dakota
414 East Clark Street
336 Julian Hall
Vermillion, SD 57069

I received a letter requesting "Ready! Set! Got". I sent letter telling her we are out of stock and they are out of print.

3/11/92

96. Sheila Buschette

White Earth, MN

She called requesting information on any grants or funds available for their BBTD program. Things wanted for purchase or materials for volunteers to make: Teddy bears/blankets for teddy bear exchange for bottle program, dinner or banquet to honor parents and present awards, possibly casino/bingo packets including coupons to be given when bottle traded in. I asked her to send a letter outline use for money if it were to be given to her program.

4/6/92

97. Karen Kopriva
(501) 208-1 028

Called for info on BBTD. I called and left messages, never heard back. Initially did not leave an address.

4/16/92

98. Dr. George Angelos
Brownsville Community Center
2137 East 22nd Ave
Brownsville, TX 78521

Sent 5 yr. report, Parents Helping Parents, materials order forms.

5/14/92

99. Susan
Puyallup Tribal Health
(206) 593-0232

Concerned about who **tippee** cups were sent to and if they were recieved. Should she pay the bill to Gerber-\$1 900.05

Order date **1/31/92** with shipping date **2/12/92**.

I called all of the service units, four did not receive the cups-Lummi, Wellpinit, Muckleshoot, Neah Bay.

I called Paula Rottman (1-800-336-5571) many times. She believes that the cups were all shipped to Puyallup with one purchase order. I told her Puyallup only recieved their 2 cases and did not distribute to any service units.

5/15/92

Paula Rottman placed a tracer to find the shipment (UPS) .

Dr. Vauhgn from Warm Springs called to confirm Linda Tolar as a back-up in his clinic June **15-19**. Also radiology certification questions.

5/21/92

I called Ms. Rottman regarding **tippee** cups shipment tracers, she will fax me a copy of the "shipment recieved" receipts from these locations. The tracer confirmed that the -boxes were

signed for at each of the service units in question.

6/29/92

100. Mr. Mortazazi
CRST Dental Clinic
PO Box 590
Eagle Butte, SD 57625

Sent him materials and added to mailing list.

6/30/92

101. Marge Statko
Pope County Public Health
Pope County Courthouse
Glenwood, MN 56334

I sent her BBTD Slide Series 1 and 2, Oral Disease Prevention slides. This is MBK's only copy, we need to get it back when she is finished. 9/1/92 these were returned.

7/1/92

102. Pat Golding
Blue Cross
PO Box 4137
Woodland Hills, CA 91365

Low income in LA Area. Sent her materials and added to mailing list.

7/14/92

103. Erika Brown
PHS Indian Health Center
Dental Clinic
PO Box 280
St. Ignatius, MT 59865

Flathead health fair in early August, Women and wellness clinic. Sent her materials and added to mailing list. She was very interested on more info on breastfeeding, she has heard conflicting info.

104. Mano a Mano
Mr. Conteras
Salem, OR

Migrant work with Mexican families.

7/13/92

105. **Margo** Quiriconi
Kauffman Foundation
4900 Oak St.
Kansas City, MO 64110

Adress change.

106. Vivian Swallow
Health Services Department
Shoshone & Arapahoe Tribes
Box 217
Fort Washakie, WY 82514

Tribal Health Planner requesting info. Info sent.

10 7. Candace Han&r
Kyle Health Center
Box 540
Kyle, SD 57752
(605) 455-2451 x207

Interested in funding and/or grants, HS curriculum, grade school level. She is a hygienist. Info sent.

108. Pat Christen
Inter-Tribal Council of Nevada
806 Holman Way
Sparks, NV 89431
(702) 355-0600

Requested Info. Info sent.

10 9. Susan A. Luly
Chippewa Health Center
450 Old Abe Road
Lac Du Flambeau, WI 54538
(715) 588-3371

Hygeinist requesting info and mailing list. Info sent.

110. Jane Fouste
Washington County WIC Program
155 North First Ave.,
Hillsboro, Or 97124
(503) 648-8881 x61 13

Wants to set up a program! Called her **9/3/92** She has received her materials, with no time to look at them.

111. Linda Stone, MPH
Dental Health Educator
Child Health and Disability Prevention Program
7601 East Imperial Highway
Office Building 307
Downey, CA 90242-3496
(310) 940-7985

Interested in **educational** materials for use in very low income LA County. For use in 2-3 **pow-
wows** and other outreach programs each year. Sent her all info .

7/24/92

1 12. Clarice Hill
CHDP Program
976 Lenzen Ave.
San Jose, CA 95126

Is interested in setting up a BBTD site. Sent info, training programs, resource **manuals**, etc.

7/28/92

113. Robin Stratton, RDH
Bristol Bay Area Health Corp.
Dental Clinic
PO Box 130
Dillingham, AK 99576
(907) 8425245

Info sent.

8/6/92

114. Laura Kollar
Tuba City Indian Med Ctr
OB Dept
Tuba City, AZ 86045

Sent all materials. Not necessarily interested in setting up a program.

8/20/92

1 15. Kelley Kershisnik
(507) 282-9099

Left message. I called twice with messages, no response.

8/24/92

116. Steven J. Hood, DMD
Reno/Sparks Tribal Health Center
34 Reservation Rd.
Reno, NV 69502

Request to be put on mailing list only.

8/26/92

117. Kris Crusoe
Coquille Indian Tribe Community Health Dept.
PO Box 1435
Coos Bay, OR 97420

Sent a list of **resources** available she could use for school projects/study.

8/31/92

116. Lou Jorden
Polk County Health Dept.
3241 **Lakeland** Hills Blvd.
Lakeland, FL 33605

Sent list of all resources materials available, Moccasin telegraph, summary of evaluation report.

September 9, 1992

119. Mike **Arfsten**
245 E. 6th St.
St. Paul, MN 55101

Sent him complete 5 year report, resource manual, newsletter.

9/21/92

120. **Marti** Hall
Greater Lakes Intertribal Council (GLITC)
PO Box 9
Lac du Flambeau, WI 54533

Interested in "Parents Helping Parents" , will probably order 12, one for each tribe. These will be used for nurses in clinics, MCH workers, outreach workers in the Rural Infant Health Project. Sent **9/21/92**.

12 1. Samantha Stephen
1525 Silver Ave.
San francisco, CA 94134

Requested copy of the five year report. Sent **9/22/92**.

9/24/92

122. Dr. **Johanna** M. Douglass
Department of Pediatric Dentistry and Orthodontics
Univ. of Connecticut Health Center
Farmington, CT 06030-1610
(203) 679-2180

Received a letter, she is trying to set up a site in CT WIC program. Requested educational materials, training manuals for volunteers and any counseling information. I sent her 5 year evaluation report, resource manual and a "Parents Helping Parents" booklet, as well as the most recent copy of telegraph.



THE MOCCASIN TELEGRAPH

Volume I - September 1991

In this issue:

Information

..... 1

Spotlight on Cherokee, Oklahoma

..... 2

Beyond BBTD

..... 2

What will they think of next?

..... 3

Final Report Summary

..... 3

Editor: Dr. Bonnie Bruerd

Publisher: R. Berg-Johansen

This project is funded by the Indian Health Service, OPEL.

This is the first edition of The Moccasin Telegraph. The purpose of this newsletter is to serve as a communication network among those communities involved in the prevention of Baby Bottle Tooth Decay. This newsletter will be published quarterly.

You will not automatically receive this newsletter. If you want to be added to the mailing list for future editions, contact The Moccasin Telegraph at **503/399-5931**. Ask for Ann Hesketh.

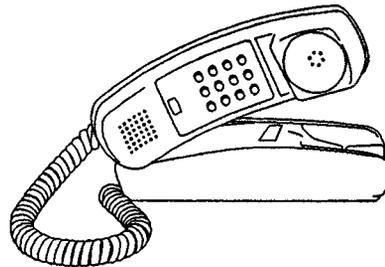
Also, The **Moccasin** Telegraph will rely on input from BBTD program sites for information to share in the newsletter. Call us with your suggestions, **frustrations**, and successes. If you don't call us, we may even call you to gather newsletter information.

Need technical assistance, BBTD materials, or program information?

The Moccasin Telegraph is both a newsletter and a BBTD telephone hotline. By **telephoning 503/399-5931** you can receive technical assistance, order BBTD materials, or get information about setting up a BBTD program in your community. Established sites can also use the hotline to raise concerns, share frustrations, and pass on effective strategies and education materials,

The mailing address is:

Attention: **Ann Hesketh**
The Moccasin Telegraph
PHS Indian Health Center
3750 Chemawa Rd, **NE**
Salem, OR 97305



(503) 399-5931

Spotlight on Cherokee, Oklahoma

Each edition, the newsletter will feature a BBTD program site. This edition's feature is on Cherokee, Oklahoma.

This community was one of the four original BBTD pilot sites.

Over a five-year period, this community reduced the prevalence of BBTD from 63 to 14 percent.

This represents a 78 percent reduction in BBTD!!!

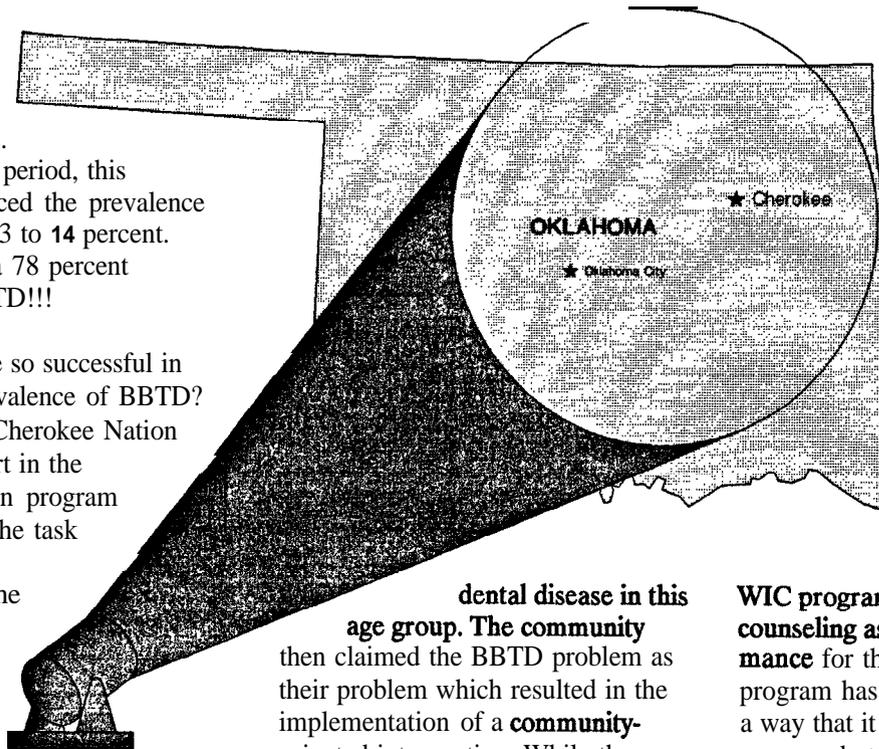
Why was this site so successful in reducing the prevalence of BBTD?

First of all, the Cherokee Nation had an active part in the BBTD prevention program from the start. The task force included members from the Tribal Council, Head Start, WIC, Indian Health Service, and **parents**. The community was educated about the high prevalence of BBTD

among their preschool children and then they were convinced of the many resulting problems of

oped their own strategies and materials as the program progressed.

This site had a strong site coordinator who stayed with the program and continued to motivate the community and health professionals to remain involved in the BBTD program. The site also claims that the involvement of **WIC** is critical to their continued success. The Cherokee Nation



WIC program now has BBTD counseling as a standard of performance for their employees. The program has been institutionalized in a way that it is no longer a new program but rather an everyday way of operating. This should be the goal of every BBTD program.

dental disease in this age group. The community then claimed the BBTD problem as their problem which resulted in the implementation of a **community-oriented** intervention. While the BBTD program materials were widely used, Cherokee also **devel-**

WIC program now has BBTD counseling as a standard of performance for their employees. The program has been institutionalized in a way that it is no longer a new program but rather an everyday way of operating. This should be the goal of every BBTD program.

Beyond Baby Bottle Tooth Decay (BBTD?)

On August 19-20, a group of dental public health professionals and other interested people met in Sedona, Arizona to discuss the high dental decay rate among Native American preschool children. Some of the professionals are concerned about the occurrence of high dental decay rates among preschoolers who have not been exposed to the inappro-

priate use of the baby bottle. There are many possible reasons for this dental decay but it is likely related to a combination of genetics, bacteria, and sugar exposure. Many research questions were identified and a clear need for some future epidemiologic and behavioral surveys was **identi-**lied. The conclusion was that BBTD is only one piece of a complex puzzle

of dental decay among preschool children. As a result of this meeting, it is likely that you will see some additions to the BBTD program education materials. New components will focus on oral hygiene and sugars in the diet. If you have any ideas about this topic, contact the Moccasin Telegraph.

What Will They Think of Next?

While reading a parenting magazine, one of our contributors saw this advertisement. Products like these promote the feeding of dental decay-causing liquids over extended periods during the day. Whatever happened to sitting down for a few minutes to feed the baby? Are we really in that **much of a hurry? If so, our children are probably suffering from even worse things**



than BBTD. The child in this ad is also much too old to be on a bottle at all. Have you seen any other products like these that we should be concerned about? If so, call the Moccasin Telegraph or better yet, send the advertisement to us so we can share it in the next newsletter.

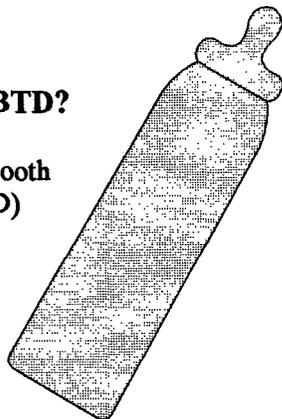
Final Report Summary

For those of you who may not be familiar with the **BBTD** project, we have included the following information from the **BBTD Final Report**.

What is BBTD?

Baby bottle tooth decay (BBTD) is a preventable dental disease that surveys have shown affects many preschool

children. BBTD is caused by inappropriate feeding practices, such



as giving a child a bottle at nap or bedtime or letting a child walk around or sit with a bottle during the day.

Any liquid with fermentable sugar can cause BBTD. The liquid in the bottle might be juice, soda pop, milk, or formula, but the resulting damage is the same. The fragile baby teeth decay rapidly and may cause pain. The problems resulting from BBTD include many cavities, crooked permanent teeth, ear and speech problems, orthodontic problems, and possible psychosocial problems. The cost of treatment is between **\$700-\$1,200** for a moderate to severe case of **BBTD**. If hospitalization is necessary, the cost is approximately doubled.

How many children have BBTD?

In 198384, an Indian Health Service (II-IS) survey of **1,321** children O-4 years old documented that approximately 52 percent of the children had BBTD. In 1985, a survey of 514 Native American children in Oklahoma and Alaska reported 53 percent prevalence of BBTD with a range of 17 to 85 percent prevalence in the 18 communities surveyed. In a survey of 1,607 Cherokee and Navajo Head Start students, 70 percent of the children were affected by BBTD.

What is the BBTD Program?

The BBTD program is an experimental program, implemented in 12 Native American communities, aimed at the prevention of BBTD. The BBTD prevention project represents a cooperative effort by three Department of Health and Human Service agencies:

Administration for Children, Youth, and Families, Head Start Bureau

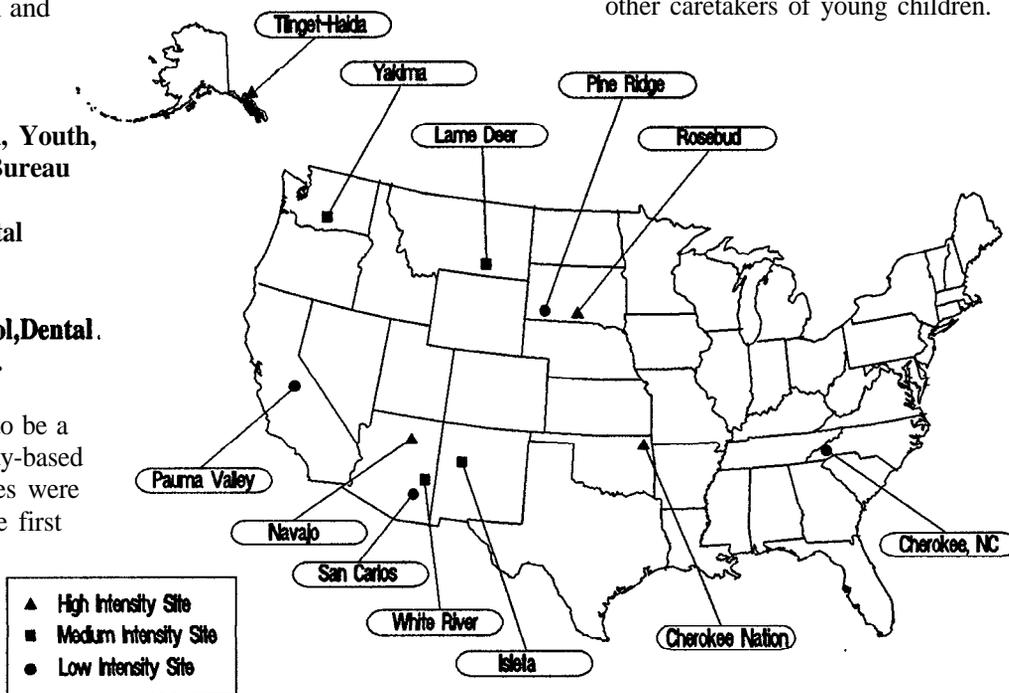
Indian Health Service, Dental Program

Centers for Disease Control, Dental Disease Prevention Activity.

The program was designed to be a multidisciplinary, community-based intervention. Two approaches were chosen as interventions. The first approach was **one-to-one** counseling with the caretakers of young children. Health professionals, parents, and tribal employees were trained to counsel parents both individually and through group meetings. As a result, physicians, nurses, nutritionists, Foster **Grandparent** groups, Community Health Representative programs (tribal health employees), health educators,

and WIC (Women, Infant, and Children supplemental food program) staff became involved in counseling and group presentations. The second major approach **con-**

announcements, and newspaper articles were released quarterly over a **3-year** period. The messages changed with each release, and the target population varied to include parents, grandparents, siblings, and other caretakers of young children.

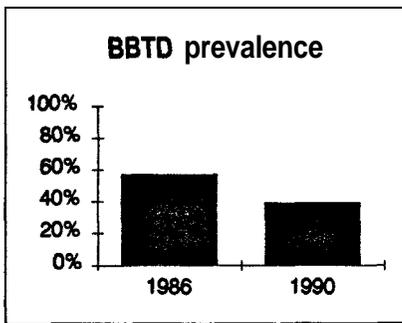


sisted of a media campaign designed to raise awareness and knowledge about BBTD community-wide. Its intent was to make prolonged bottle feeding less socially acceptable in Native American communities. A series of posters, public service

The planning group was especially proud of western singer, Crystal Gayle, who was photographed for three BBTD posters. In addition to the core groups strategies, people at the BBTD pilot sites came up with several strategies as they became more involved in the project.

The Program Works!

The BBTD program was successful in reducing the prevalence of BBTD at the pilot sites. Overall, prevalence decreased from 57 to 39 percent, resulting in a 32 percent reduction of BBTD. Not only is this decrease



statistically significant ($p < .001$), it also represents a significant **cost-savings** in dental treatment, trauma, pain, and other related health problems.

Keys to success

- A multi-strategy approach
- A multi-disciplinary approach
- Effective site coordinator
- Development of a task force
- Involvement of WIC or MCH agencies
- 100 percent contact with caretakers of infants
- Use of the complete package of education materials
- Repetition and Consistency

Steps to getting started

All of the effective sites followed these steps



1. Establish local baseline prevalence of BBTD
2. Select a site coordinator
3. Obtain support contracts from local agencies
4. Assemble a task force
5. Design a program plan
6. Develop an evaluation plan
7. Build in a reward or support system for the staff involved in the program

EDUCATION MATERIALS

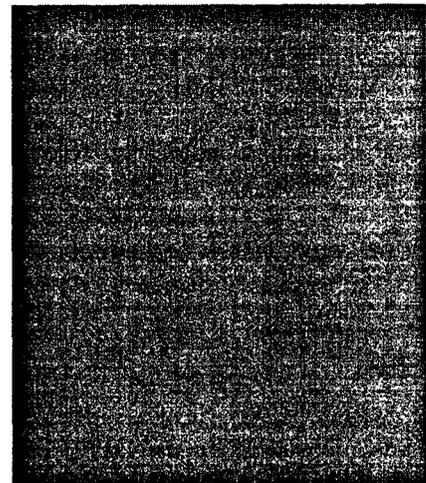
- How to Organize a BBTD Program manual
- Training Manual
- Counseling Books and Slides
- Cups . . . Balloons . . . Photo Hold
- Sewing Cards . . . Stickers . . . flyers
- Posters . . . PSAs . . . News Article

Show and Tell

You will **find** a pamphlet called "Keep Your Baby Smiling..." attached to your newsletter. This is a **well-**done pamphlet that you might want to add to your BBTD education materials. Contact The Moccasin Telegraph if you want the artwork to publish this pamphlet. If you know of other good materials to add to our resources, send us a copy and we'll feature it in "Show and Tell" .

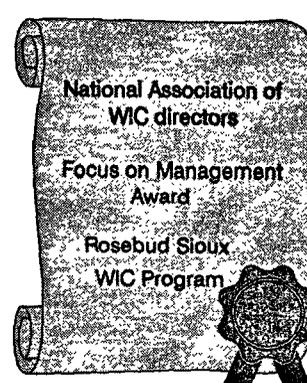
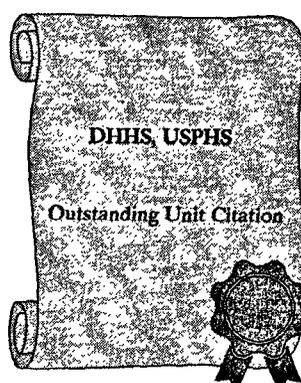
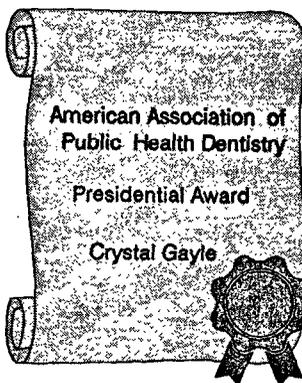
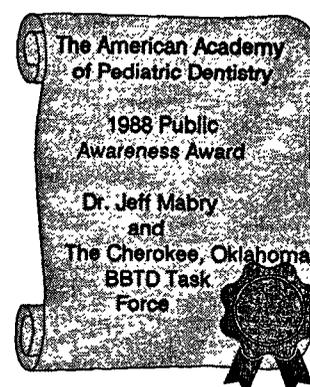
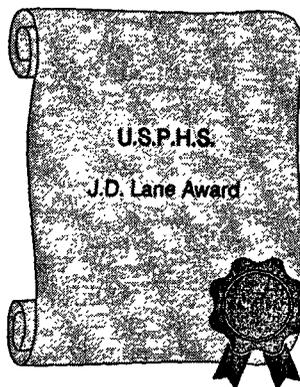
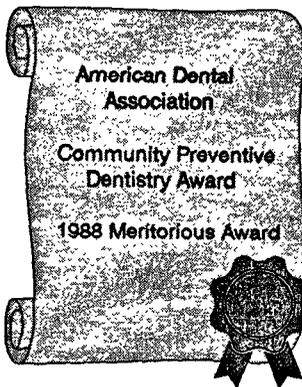
Calling New Sites

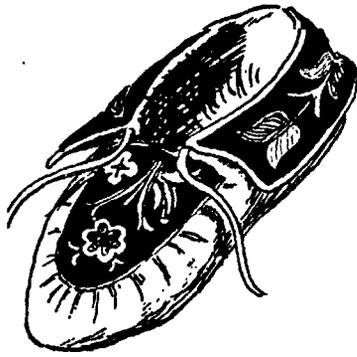
We will be training two new sites this year. Two trainers will travel to your community to train **20-30** health workers. The training is two days long. If you want to organize a BBTD program in your community, call The Moccasin Telegraph.



The Moccasin Telegraph
Attention: Ann Heskeith
PHS Indian Health Center
3750 Chemawa Rd., NE
Salem, OR 97305

BBTD PROGRAM AWARDS





THE MOCCASIN TELEGRAPH

Volume II - January 1992

In this issue:

Information

..... 1

Spotlight on White Earth, Minnesota

..... 2

Around the world

..... 3

Other news

..... 3

Parents helping parents

..... 4

Editor: Dr. Bonnie Bruerd

Publisher: R. Berg-Johansen

This project is funded by the Indian Health Service, OPEL.

This is the second edition of The Moccasin Telegraph. The purpose of this newsletter is to serve as a communication network among those communities involved in the prevention of Baby Bottle Tooth Decay. This newsletter is published quarterly.

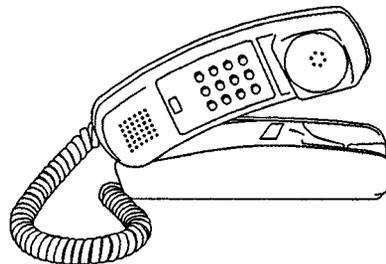
After the first newsletter was distributed, The Moccasin Telegraph received communications from across the country. The response was wide and varied. We heard from staff at IHS dental clinics, WIC programs, Head Start programs, State Health Departments, Dental Schools, and many other health professionals. Some of the contacts involved requests for education materials, some wanted more information about the original research, and some just wanted to share their own efforts at preventing BBTD with us. Sherry Scott from the American Indian Health Care Association in Minnesota is working on a **HP/DP** newsletter that will reach 2700 people. She will publish our name and telephone number as a reference. There seems to be a growing interest in the prevention of BBTD that extends beyond Native American communities.

Need technical assistance, BBTD materials, or program information?

The Moccasin Telegraph is both a newsletter and a BBTD telephone hotline. By telephoning **503/399-5931** you can receive technical assistance, order BBTD materials, or get information about setting up a BBTD program in your community. Established sites can also use the hotline to raise concerns, share frustrations, and pass on effective strategies and education materials.

The mailing address is:

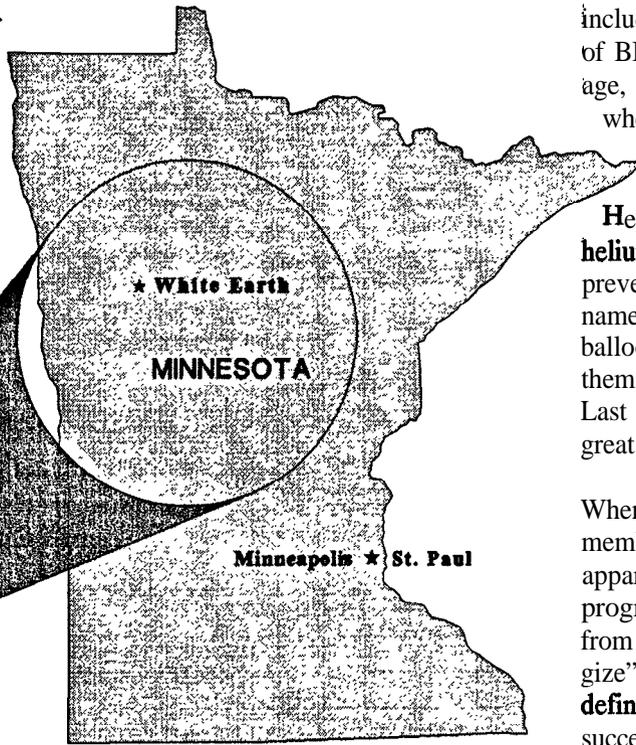
Attention: Ann Hesketh
The Moccasin Telegraph
PHS Indian Health Center
3750 Chemawa Rd, NE
Salem, OR 97305



(503) 399-5931

Spotlight on White Earth, Minnesota

This edition of the newsletter puts the spotlight on White Earth, Minnesota. The project coordinator is Sheila Buschette. Sheila is also the Health Handicap Coordinator for Head Start. White Earth has had a BBTD task force for four years now. They cover a five county area which includes the White Earth Reservation. The task force is made up of trained parents, Head Start staff,



included local radio station coverage of BBTD events, newspaper coverage, school newsletters, and "anywhere we can get free publicity".

White Earth sponsors a yearly balloon lift-off where the Head Start children "lift-off" helium-filled balloons with a BBTD prevention message and the child's name attached. Those who find the balloons contact the children to tell them how far their balloons went. Last year, balloons traveled some great distances!

When communicating with task force members from White Earth, it is apparent that this is a "high energy" program. The enthusiasm projected from the task force seems to "energize" the community. Enthusiasm is **definitely** one of the keys to a successful BBTD program. Good Luck to White Earth!

IHS personnel, WIC staff, Social Service staff, CHR personnel, a nutritionist, a dentist, and nurses. The task force sets goals and objectives, organizes the strategies, orders supplies, and establishes a budget. They do their own fundraising to support the BBTD program. Letters were sent to area organizations to enlist donations and contributions. A follow-up visit and presentation from a BBTD task force member was given to each organization. White Earth trains their local professional groups over dinner meetings.

BBTD prevalence data is gathered each year. Children are screened at **WIC sites, Sunday schools**, public schools, Head Start classrooms, and community events in the five county area. Results are used to enlist the concern of local organizations and

parents. Prevalence over the **first** three years dropped from **38** to 25 percent. This represents a 34 percent decrease in BBTD!

The strategies employed by the BBTD prevention program include distributing dental packets to day care, preschool programs, and school districts. BBTD cups are filled with flowers and distributed to OB units, hospitals, and dental offices. This year, they plan to make teddy bears and exchange them for bottles. A booth was built to use at Pow-Wows and other community events. BBTD educational materials are distributed at these events, along with prizes and balloons. Trained parent volunteers work at the community events.

The White Earth BBTD program uses media campaigns to reach a wide audience. Strategies have

Youngsters are getting ready for the balloon lift-off in White Earth, Minnesota.

Around the world

On November 14, 1991 the Daily News ran an article titled "Rotting baby teeth in Germany brings ruling against food maker". The ruling was one of the **first** major product liability claims won by ordinary consumers. Germany's federal high court ruled that the Milupa baby food maker must pay damages to children whose teeth were harmed by its highly sugared teas. This could prompt a rash of claims against other firms, the lawyers and industry sources said.



According to medical studies, an estimated 100,000 German children suffered damage to their teeth from the teas and many had to have their baby teeth extracted. Milupa encouraged parents to give babies the teas to help them sleep, marketing the products together with a bottle as a "Good-Night Drink".

New Name and Address

To order BBTD materials from CDC, you now direct your orders to the following address:

Centers for Disease Control
Division of Oral Health
Mailstop F10
1600 Clifton Road
Atlanta, GA 30333

BBTD bibs for infants

BBTB programs in the Alaska and Bemidji Areas are purchasing bibs to give to infants. The bibs can be imprinted with a BBTD prevention message of your choice. The bibs are white vinyl with blue or pink lettering. The price varies from \$1.70 to \$2.01 depending on the quantity you order. You can get further information from Health Impressions, 1-800-299-3366



are as cariogenic (cavity-causing) as candy? Highly refined carbohydrates are generally cavity-causing. As for sugar-filled pop, it's best not to get young children started at all. Parents should be offering fruit, popcorn, sandwiches, **veggies**, sugar-free drinks, milk, and cheese for snacks. If a sweet snack is given, "gummy" animals are a good choice because research has shown that they do not cause cavities like other candy.

Eating Between Meals

Most dentists agree that it's not what you eat at meals that causes **cavities...it's** what you eat between meals that counts. Most parents know that sugary foods cause cavities but do they know that crackers

BBTD Cups

Cups now cost \$65.55 a case (115 cups). To order cups, contact:

Gerber Products Division -
Baby Care
P.O. Box 120
Reedsburg, WI 53959

(608) 524-4343
FAX (608)524-6779

News from the States

Several States are interested in the prevention of BBTD. Minnesota and California both have special initiatives for the prevention of BBTD. The State of Oregon is networking with Healthy Mothers/ Healthy Babies to organize a BBTD program.

David Rollason, a physician assistant at the Isabel Community Clinic in South Dakota, contacted the Moccasin Telegraph to obtain information on establishing a BBTD prevention program. Community health centers now have as part of their funding requirement to develop protocols to prevent and detect early stages of BBTD. This policy will affect 600 community health centers across the country. This is good news for those of us who are concerned about BBTD. It is crucial that BBTD not be seen as a "dental problem" because by the time the dentists see the children, it is too late to prevent the disease. We'd like to hear from more State programs!

The Moccasin Telegraph
Attention: Ann Hesketh
PHS Indian Health Center
3750 Chemawa Rd, NE
Salem, OR 97305

Parents Helping Parents



This column is designed to answer parents' questions about preventing BBTB and problems related to feeding and sleeping. For those of you who work with parents routinely, let us know which questions have really "stumped" you. Since we believe that parents are the best experts, we will ask other Indian parents to respond to the questions. The following question was raised at a BBTB training session.

Question: I **almost** had my 18 month old baby weaned, but she got sick . I gave her the bottle again to comfort her and now I have to start all over. What will I do if this keeps **happen-**ing?

Answers from Parents:

"Try a different comfort habit like a new teddy bear."

"Your baby might be getting sick because of the bottle causing ear

infections. You need to be strong."

"You can give her lots of love by rocking and holding her when she's sick instead of comforting her with a bottle.

"**As soon** as your baby is well again, take the bottle away and if she gets sick again, don't give in. She'll be OK She doesn't need the bottle to get well.

Program Questions:

A dentist from **California** IHS wants to know if other BBTB programs are distributing pacifiers as alternatives to bottles? If so, where are they getting them and what do they cost? **Can** they be purchased at special bulk prices? How do other programs feel about this idea?



THE MOCCASIN TELEGRAPH

Volume III - May 1992

In this issue:

Information
..... 1

Spotlight on Browning, Montana
..... 2

Helpful Ideas for Supporting Parents
..... 3

Welcome Acoma-Laguna
..... 3

P&rents Helping Parents
..... 4

Editor: Dr. Bonnie Bruerd

Publisher: R. Berg-Johansen

This project is funded by the Indian Health Service, OPEL.

This is the third edition of The Moccasin Telegraph. The purpose of this newsletter is to serve as a communication network among those communities involved in the prevention of Baby Bottle Tooth Decay. This newsletter is published quarterly.

The Moccasin Telegraph has received communications from across the country. The response has been wide and varied. There seems to be a growing interest in the prevention of BBTD that extends beyond Native American communities.

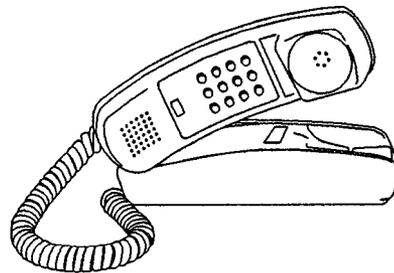
This edition of the newsletter shares information about an award-winning BBTD site, highlights a newly-trained site, and has various other bits of information for those involved in the prevention of BBTD.

Need technical assistance, BBTD materials, or program information?

The Moccasin Telegraph is both a newsletter and a BBTD telephone hotline. By telephoning **503/399-5931** you can receive technical assistance, order BBTD materials, or get information about setting up a BBTD program in your community. Established sites can also use the hotline to raise concerns, share frustrations, and pass on effective strategies and education materials.

The mailing address is:

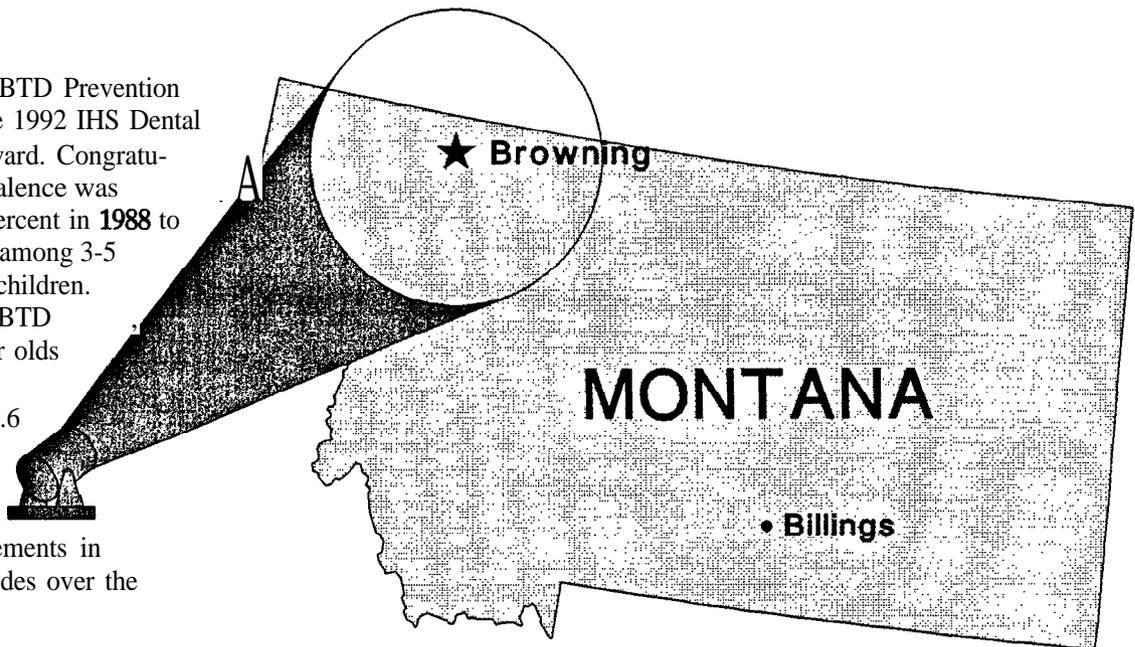
Attention: AM Hesketh
The Moccasin Telegraph
PHS Indian Health Center
3750 Chemawa Rd, NE
Salem, OR 97305



(503) 399-5931

Spotlight on Browning, Montana

The Blackfeet BBTD Prevention Project won the 1992 IHS Dental Program **HP/DP** award. Congratulations! BBTD prevalence was reduced from 65.9 percent in 1988 to 22.4 percent in 1991 among 3-5 year old Head Start children. The prevalence of BBTD among the three year olds dropped from 61.6 percent in 1988 to 15.6 percent in 1991. The BBTD Prevention Project also documented improvements in knowledge and attitudes over the four year period.



How did the Blackfeet BBTD Prevention Project achieve this success? For one thing, they had an enthusiastic and well-organized site coordinator, **Julieann Rattler**, a dental hygienist. Her first step was to conduct a training session for **CHRs**, WIC staff, IHS Discharge Planner, **CHNs**, and Screening/Ward nursing staff. Each department agreed to begin counseling parents about BBTD. The dental program supplied them with pamphlets and **tippee** cups. Similar to other successful sites, WIC and prenatal/well-child clinics provided most of the counseling with other departments reinforcing the prevention messages. Training sessions were held on an annual basis to update information.

Funding for this program was originally provided through a Head Start Supplemental Grant for **\$12,325**. Most of the educational materials were received from CDC at no cost. Follow-up funding was

obtained through Head Start PA-26. This was used to obtain additional supplies, provide dental treatment by a private dentist, and to fund a dental hygienist's salary one day per week as the site coordinator. (We think it is exciting to see a site with a budget and assigned staff to work on the BBTD problem. This shows a high level of commitment from the Blackfeet Tribe!)

An on-going media campaign was implemented in 1988. Some of the **PSAs** were recorded by the students of the Browning High School's Young Mother's Program. A float was designed by the dental staff and toothbrushes, **tippee** cups, BBTD logo balloons, and sugar-free gum were "pitched" from the float. Presentations were given to Head Start staff, Head Start parents, and the **Browning High School** Young Mother's Program. Head Start children received toothbrushes

imprinted with "brush your teeth" and parents received brushes with a similar message printed in the native Blackfeet language. Baby bibs and infant T-shirts with BBTD prevention logos were distributed to children during their immunization appointments. **T-shirts**, toothbrushes, **tippee** cups, coloring books, storybooks, and other "give aways" appear to be an important part of the Blackfeet program. These items keep BBTD at the forefront of people's minds and conversations. Various information booths were set up during local community events including the lunch program at the Eagle Shields Senior Citizen's Center.

The site coordinator, Ms. Rattler, states "The best and most exciting part of this project is how the many departments/agencies have worked together to impact the BBTD problem."

Helpful Ideas for Supporting Parents

Written by: Gwen Alexander, Ph.D.

As health workers, we are counting on those we work with to make daily decisions that support healthful life-styles and reduce risk of threats to health. The prevention of BBTB involves working with parents and other caregivers to support appropriate use of the baby bottle and promote positive **parenting techniques in** general. These healthy decisions can be strengthened if the parents' intentions to follow the new procedures are firmly in place.

"On a scale of one to ten, to what extent do you intend to follow my recommendations during the next week?"

Behavioral intention is believed to be an important and immediate precursor to adopting and continuing behavior. As adults, we tend to learn better when we have goal-directed learning experiences—that is, when we specify an achievable goal ahead of time, and work to achieve our determined end point. Similarly, research has demonstrated that stating one's intention to engage in an ongoing behavior is the strongest predictor of actual behavior.

The Theory of Reasoned Action by Fishbein and Ajzen suggests that the strength of intention is influenced by one's own beliefs and attitudes. Personal attitudes and beliefs about the effectiveness, value, and ability for performing a behavior must be in place before a person will voluntarily continue involvement in a new skill. The strength of intention is also influenced by the attitudes of those in one's social or ethnic **group**—"social norms". Social norms or standards, determined by modeling or the advice of influential people in one's social or ethnic group, can have

an important effect on an individual's decision-making.

Social **influence** can provide support **or** create barriers. The importance of assessing the influence of social norms should not be underestimated when behavior change is recommended. As we all know in our work with BBTB, it is **difficult** to change the attitudes and values of parents when prolonged use of the baby bottle is prevalent throughout the community. We have also learned that with a high level of community intervention, **social**

norms and attitudes begin to work **for** us as informed persons spread the word about BBTB and influence other community members.

So, how can all of this research and discussion about intentions help us in our daily work with the caregivers of parents? During a contact, participants may be asked, **"On a scale of one to ten, to what extent do you intend to follow my recommendations during the next week?"** You could also ask caregivers, **"Are you ready to establish a weaning schedule and sign a contract stating that you will wean your child this week?"** Similarly, questions about social influence may be included. You might ask **"Is there someone who might not support your efforts to wean your child?"** or **"Are there people or places that you might want to avoid while you are weaning your child?"** For those whose response indicates weaker intention or less support, follow-up questions to assist in problem solving may reduce barriers to adopting the new behavior. You might ask, **"Can you think of at least one person who could**

support you in your efforts to wean your child?"

The goal of health education is to incorporate behavior modifications into one's life-style. Attention to parents' intentions and the influence of social norms will improve our efforts to prevent BBTB.

Welcome Acoma-Laguna!

In February 1992, a new site was added to the growing list of BBTB prevention programs across the country. This site is **Acoma-Laguna** in New Mexico. They "kicked off" their program with a two-day training for twenty health professionals. The group consisted of nurses, a nutritionist, WIC, Head Start, and



dental staff. The training included an overview of the BBTB project, counseling skills, presentation skills, and a planning session. One of the more difficult challenges for this site will be to reach some of the isolated communities in the service area. When we last saw these folks, they were diligently listing all of the activities they wanted to start with and assigning responsibility among their staff. This was a creative and well-organized group. Good Luck!

The Moccasin Telegraph
Attention: Ann Heskeith
PHS Indian Health Center
3750 Chemawa Rd., NE
Salem, OR 97305

Parents Helping Parents



This column is designed to answer parents' questions about preventing BBTB and problems related to feeding and sleeping. For those of you who work with parents routinely, let us know which questions have really "stumped" you. Since we believe that parents are the best experts, we will ask other Indian parents to respond to the questions. The following question was raised at a BBTB training session.

Question:

How can I wean my child when the baby-sitter continues to give him a bottle?

Answers from Parents:

"Wean your child during a vacation or even a weekend. When you take your son to the sitter, tell her that your son is no longer using a bottle. Take a **tippee** cup and leave it at the sitters."

"You may need to tell your sitter about BBTB and the importance of weaning your son."

"You can't expect the sitter to do this job for you. You need to do it yourself when you have a few days off work."

Program Questions/Answers
In response to the dentist interested in distributing pacifiers:

Gerber Baby Products offers NUK pacifiers at a reduced rate. A minimum order of **\$150.00** plus shipping costs is required. To order these products contact Paula Rottman at **1-800-336-5571**.

#2516 NUK Toddler \$12.64/doz.

#2508 NUK Basic \$21.64/ 2doz.

#2591 NUK Toddler \$10.80/doz.

(The 800 telephone number can also be used to order BBTB cups.)



THE MOCCASIN TELEGRAPH

Volume IV - September 1992

In this issue:

Information

..... 1

Spotlight on The State of Washington

..... 2

In the research corner

..... 3

Welcome Coeur D'Alene!

..... 3

Bright Smiles, Bright Futures

..... 3

Parents helping parents

..... 4

Editor: Dr. Bonnie Bruerd

Publisher: R. Berg-Johansen

This project is funded by the Indian Health Service, OPEL.

This is the fourth edition of The Moccasin Telegraph. The purpose of this newsletter is to serve as a communication network among those communities involved in the prevention of Baby Bottle Tooth Decay. This newsletter has been published quarterly this past year. In the future, the newsletter will likely be published twice a year.

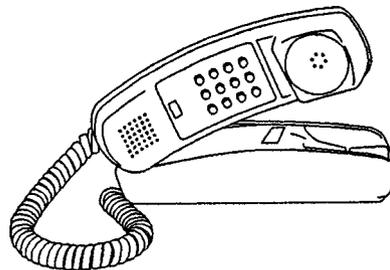
The Moccasin Telegraph continues to receive communications from across the country. The prevention of BBTD has created links between many Native American and non-Native organizations and communities. This edition of the newsletter shares information from the State of Washington, highlights a newly-trained site, and has various other information for those involved in the prevention of BBTD.

Need technical assistance, BBTD materials, or program information?

The Moccasin Telegraph is both a newsletter and a BBTD telephone hotline. By telephoning **503/399-5931** you can receive technical assistance, order BBTD materials, or get information about setting up a BBTD program in your community. Established sites can also use the hotline to raise concerns, share frustrations, and pass on effective strategies and education materials.

The mailing address is:

Attention: Ann Amett
(previously Ann Hesketh)
The Moccasin Telegraph
PHS Indian Health Center
3750 Chemawa Rd, NE
Salem, OR 97305



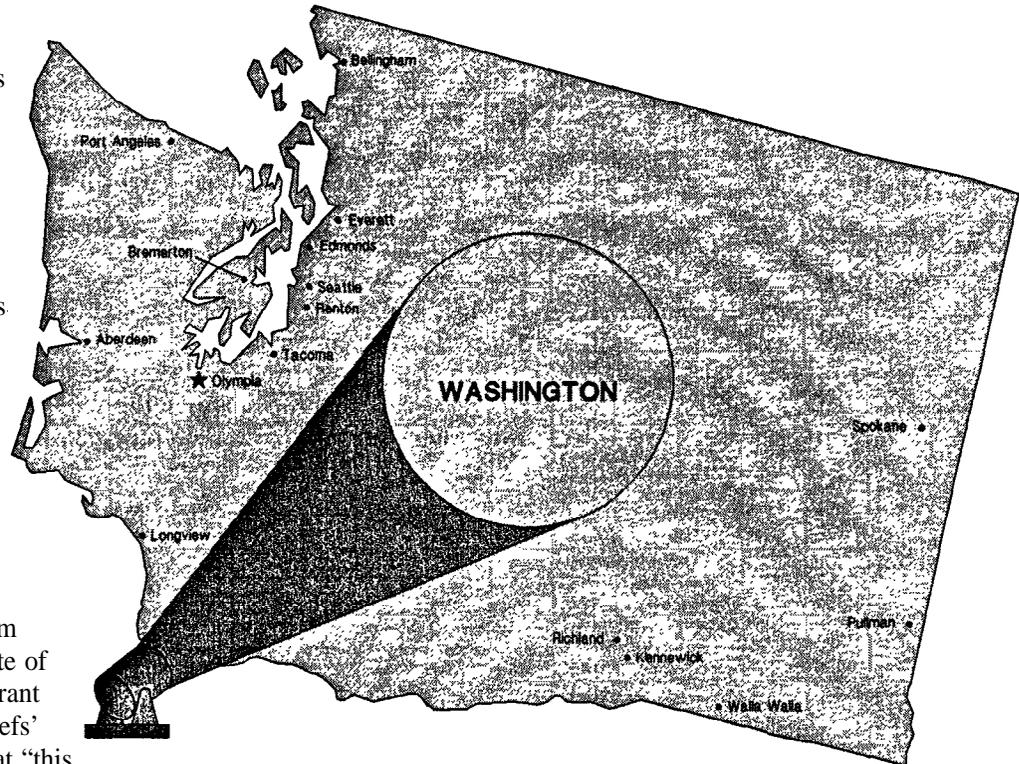
(503) 399-5931

Spotlight on The State of Washington

The state of Washington is launching a state-wide effort aimed at the prevention of BBTD. We became aware of this effort when we were asked to review their client survey form. We have since shared our education materials and resources with this program. We interviewed the coordinator, Donna Oberg, a registered **dietician** with a masters degree in public health. Donna works for the King County Health Department in Seattle.

The BBTD prevention program began two years ago in the state of Washington with a \$2500.00 grant from the Washington State Chefs' Association. **Donna** told us that "this is how it all started". The Chefs' Association has continued to support the program each year. This year, the program expanded with a grant from the Washington Dental Service Foundation. The King County Health Department, in conjunction with the Washington Dental Service Foundation, will purchase 30,000 Stop BBTD Baby Cups. This amounts to one cup for every **six**-month old baby, in the state of Washington, who is eligible for WIC this coming year. That's a lot of cups! That's a lot of babies!!!

The intervention strategies will be implemented through WIC programs. A cup will be given to the caretakers of infants during the **six**-month assessment. At two selected



infant visits, handouts **will** be given to the caregivers. The first handout is titled, "Put Your Child to Bed With a Teddy Bear...Not a Bottle" and the second handout is titled, "Baby's First Cup". Counseling will also be given when the cup and handouts are given out. The second phase of the intervention, which is scheduled to begin in April, will be the training of WIC certifiers and nutritionists to do oral screenings.

The BBTD intervention in Washington also has a research component. The University of Washington, School of Dentistry, is working with the King County Health Department to survey a sample of WIC clients. The survey will include questions to assess knowledge, attitudes, and

behaviors on the topic of BBTD and the importance of primary teeth. The research project is also planning to assess the impact of toothbrushing on BBTD. Toothbrushes will be distributed at three month intervals to 2000 WIC clients who have infants. Six thousand toothbrushes will be supplied through the efforts of the King County Dental Society in conjunction with local dental suppliers.

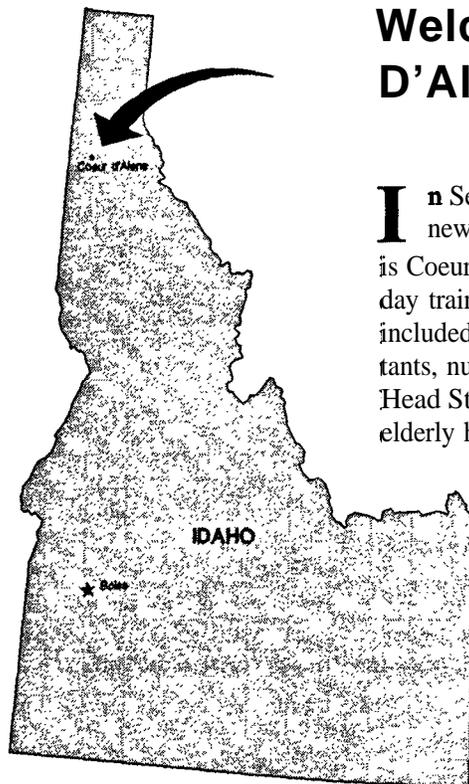
As you can see, this is a large program with multiple funding sources. We want to commend Donna Oberg and her colleagues for their efforts towards the prevention of BBTD in the state of Washington.

In the Research Corner

A recent article published in Public Health Reports by Barnes et al (March-April 1992, Vol107) compared BBTD among Head Start children who are members of four ethnic groups in five southwestern states. Age, residence, and fluoridation status were also compared for the total sample and ethnic categories. Data were collected on 1,230 children. Using the criterion of two decayed primary maxillary incisors, BBTD was detected among 22 percent of the white children, 21 percent of the black children, 24 percent of the Hispanic children, and 35 percent of the Native American children. Rural children had significantly higher prevalence of BBTD than nonrural children for all ethnic groups except whites. There were no significant differences based on fluoride status. The authors concluded that studies are needed to identify predisposing factors among the ethnic groups and residence status in order for more effective preventive regimens to be developed, implemented, and evaluated. (Maybe we should send them the BBTD Five Year Evaluation Report!)

Bright Smiles, Bright Futures Colgate

A new curriculum to prevent dental disease and promote oral health has been developed for preschool children and their families. This effort is being funded by Colgate. The curriculum has 23 activities which includes songs, posters, an oversized book, toothbrush kits, parent take-home materials, and much more. During one section of the curriculum, flyers about BBTD are sent home to parents. Many of the materials are available in both English and Spanish. The curriculum is still in the testing stages. The curriculum will be pilot-tested in several Native American Head Start programs. It will not be available upon request until next year. Stay Tuned!



Welcome Coeur D'Alene!

In September 1992, another new site was trained. This site is Coeur D'Alene in Idaho. The two-day training for fifteen people included one dentist, dental assistants, nurses, social workers, the Head Start Health Coordinator, an elderly health advocate, and day care staff. The training included an overview of the BBTD project, counseling skills, presentation skills, and a planning session. The Coeur D'Alene planning session was extremely productive. We can't wait to see the results. Good Luck!

The Moccasin Telegraph
Attention: Ann Arnett
PHS Indian Health Center
3750 Chenawa Rd., NE
Salem, OR 97305

Parents Helping Parents



This column is designed to answer parents' questions about preventing BBTD and problems related to feeding and sleeping. For those of you who work with parents routinely, let us know which questions have really "stumped" you. Since we believe that parents are the best experts, we will ask other Indian parents to respond to the questions. The following question was raised at a BBTD training session.

Question: My two year old spends many hours a week with his grandparents. His grandparents let him have too much candy and other sweets. I've tried to talk to the grandparents but they won't change. What should I do?

Answers from Parents:

Recommend snacks that are healthy. Take a bag of good snacks to their house.

Take one of your son's best **photo-**graphs and blacken the teeth with a pen. Show it to the grandparents and tell them that you don't want your son to look like that.

Tell the grandparents that your son can't go over there if they keep giving him sweets.

Editor's note: Whatever you decide, **be** gentle. Grandparents are one of our greatest resources. They provide

our children with a sense of history, an understanding of the elderly, unconditional love, and patience that we busy parents don't always have. When they overindulge our children, it is often out of love.

AGENDA

TRAINERS: Ric Bothwell/ Bonnie Bruerd/ Mary Beth Kinney/ Ann Hesketh

ACOMA-CANONCITO-LAGUNA

March 11, 1992

- 9:00 Welcome and Overview
- 9:15 Opening Exercise
- 9:45 Prevention of Oral Diseases
- 10:15 Break
- 10:30 What is BBTD?
- 11:00 Overview of the BBTD Program
- 12:00 Lunch
- 1:00 Brainstorm the Qualities of a Good Listener
- 1:15 Describe the Problem-Solving Model
- 2:00 Practice Counseling Interactions
- 3:00 Break
- 3:15 Brainstorm the Qualities of a Good Educator
- 3:30 Applications of Health Behavior/Health Education
- 4:15 Four Steps to Effective Presentations/Assignments
- 4:30 Values Clarification Exercise
- 5:00 Adjourn

March 12, 1992

- 9:00 Four-Step Presentations
- 10:00 Break
- 10:15 Planning and Evaluation Exercise
- 11:15 Strengths Exercise
- 11:45 Goal Setting Exercise
- 12:00 Lunch

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning future training programs. Please take a few moments to complete this evaluation form.

Please circle your response

low 1 2 3 4 5 high

1. Training objectives were clear. 1 2 3 4 (5)
2. Audiovisual materials were helpful. 1 2 3 (4) 5
3. The training manual and handouts were useful. 1 2 3 4 (5)
4. Instructor communicated clearly. 1 2 3 4 (5)
5. Instructor was attentive to group needs. 1 2 3 4 (5)
6. I feel adequately prepared to organize a BBTD program in my community. 1 2 3 (4) 5
7. I feel adequately prepared to train others to work with the BBTD program. 1 2 3 (4) 5

The most valuable portion of the course was:

group functions the "shoe", the

The least valuable portion of the course was:

nothing

Do you plan to implement a BBTD program when you get back to your community? Yes

If no, why?

What is your job title?

Acting Chief Basic Satellite /
Staff Dentist Basic clinic

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning future training programs. Please take a few moments to complete this evaluation form.

Please circle your response

low 1 2 3 4 5 high

1. Training objectives were clear. 1 2 3 4 5
2. Audiovisual materials were helpful. 1 2 3 4 5
3. The training manual and handouts were useful. 1 2 3 4 5
4. Instructor communicated clearly. 1 2 3 4 5
5. Instructor was attentive to group needs. 1 2 3 4 5
6. I feel adequately prepared to organize a BBTD program in my community. 1 2 3 4 5
7. I feel adequately prepared to train others to work with the BBTD program. 1 2 3 4 5

The most valuable portion of the course was:

How to educate

the students more

The least valuable portion of the course was:

reading from

the book

Do you plan to implement a BBTD program when you get back to your community? yes

If no, why?

What is your job title?

Dental Therapist

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning future **training programs**. Please take a few moments to complete this evaluation form.

Please circle your response

low 1 2 3 4 5 high

1. Training objectives were clear. 1 2 3 4 **5**
2. Audiovisual materials were helpful. 1 2 3 4 **5**
3. The training manual and handouts were useful. 1 2 3 4 **5**
4. Instructor communicated clearly. 1 2 3 4 **5**
5. Instructor was attentive to group needs. 1 2 3 4 **5**
6. I feel adequately prepared to organize a BBTD program in my community. 1 2 3 **4** 5
7. I feel adequately prepared to train others to work with the BBTD program. 1 2 3 **4** 5

The most valuable portion of the course was: _____

How to show it to the public

The least valuable portion of the course was: _____

the audio material

Do you plan to implement a BBTD **program** when you get back to your community? _____

If no, why? _____

What is your job title? _____

Recital Artist

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your **opinion is** important to us. Your comments are helpful in planning **future training programs**. Please take a few moments to complete this evaluation form.

- Please circle your response*
- | | low | 1 | 2 | 3 | 4 | 5 | high |
|--|-----|---|---|---|---|---|------|
| 1. Training objectives were clear. | | 1 | 2 | 3 | 4 | 5 | |
| 2. Audiovisual materials were helpful. | | 1 | 2 | 3 | 4 | 5 | |
| 3. The training manual and handouts were useful. | | 1 | 2 | 3 | 4 | 5 | |
| 4. Instructor communicated clearly. | | 1 | 2 | 3 | 4 | 5 | |
| 5. Instructor was attentive to group needs. | | 1 | 2 | 3 | 4 | 5 | |
| 6. I feel adequately prepared to organize a BBTD program in my community. | | 1 | 2 | 3 | 4 | 5 | |
| 7. I feel adequately prepared to train others to work with the BBTD program. | | 1 | 2 | 3 | 4 | 5 | |

The most valuable portion of the course was: Group settings
especially where we got a feedback & comments

The least valuable portion of the course was: _____

Do you plan to implement a BBTD program when you get back to your community? Yes

If no, why? _____

What is your job title? MCH/CHC

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning future training programs. Please take a few moments to complete this evaluation form.

Please circle your response

low 1 2 3 4 5 high

1. Training objectives were clear. 1 2 3 4 **5**
2. Audiovisual materials were helpful. 1 2 3 **4** 5
3. The training manual and handouts were useful. 1 2 3 4 **5**
4. Instructor communicated clearly. 1 2 3 4 **5**
5. Instructor was attentive to group needs. 1 2 3 4 **5**
6. I feel adequately prepared to organize a BBTD program in my community. 1 2 3 **4** 5
7. I feel adequately prepared to train others to work with the BBTD program. 1 2 3 **4** 5

The most valuable portion of the course was: getting involved in group activities during instruction.

The least valuable portion of the course was: _____

Do you plan to implement a BBTD program when you get back to your community? yes

If no, why? _____

What is your job title? Teachers Aides

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are **helpful** in planning future training programs. Please take a few moments to complete this evaluation form.

Please circle your response

low 1 2 3 4 5 high

- 1. Training objectives were clear. 1 2 3 4 **5**
- 2. Audiovisual materials were helpful. 1 2 3 4 **5**
- 3. The training manual and handouts were **useful**. 1 2 3 4 **5**
- 4. Instructor communicated clearly. 1 2 3 4 **5**
- 5. Instructor was attentive to group needs. 1 2 3 4 **5**
- 6. I feel adequately prepared to organize a BBTD program in my community. 1 2 **3** 4 5
- 7. I feel adequately prepared to train others to work with the BBTD program. 1 2 **3** 4 5

The most valuable portion of the course was:

The training manuals, order form for materials, interaction with other group members.

The least valuable portion of the course was: _____

Do you plan to implement a BBTD program when you get back to your community?

Yes ~~no~~ through the S.I.P.I. Prevention Committee + dental C.A.R.S.

If no, why? _____

What is your job title? _____

Registered Dental Hygienist

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning future training programs. Please take a few moments to complete this evaluation form.

Please circle your response

low 1 2 3 4 5 high

1. Training objectives were **clear**. 1 2 3 4 **5**
2. Audiovisual materials were helpful. 1 2 3 4 **5**
3. The training manual and handouts were **useful**. 1 2 3 4 **5**
4. Instructor communicated clearly. 1 2 3 4 **5**
5. Instructor was attentive to group needs. 1 2 3 4 **5**
6. I feel adequately prepared to organize a BBTD program in my community. 1 2 3 **4** 5
7. I feel adequately prepared to train others to work with the BBTD program. 1 2 3 **4** 5

The most valuable portion of the course was: How to present
BBTD

The least valuable portion of the course was: _____

Do you plan to implement a BBTD program when you get back to your community? yes

If no, why? _____

What is your job title? Health Coordinator

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning future training programs. Please take a few moments to complete this evaluation form.

Please circle your response

low 1 2 3 4 5 high

- 1. Training objectives were clear. 1 2 3 4 **5**
- 2. Audiovisual materials were helpful. 1 2 3 **4** 5
- 3. The training manual and handouts were useful. 1 **2** 3 4 **5**
- 4. Instructor communicated clearly. 1 **2** 3 4 **5**
- 5. **Instructor** was attentive to group needs. 1 2 3 4 **5**
- 6. **I feel** adequately prepared to organize a BBTD program in my community. 1 2 3 **4** 5
- 7. I feel adequately prepared to train others to work with the BBTD program. 1 2 3 4 5

The most valuable portion of the course was:

Everything I

liked the role play.

The least valuable portion of the course was:

The pictures

Just kidding!

Do you plan to implement a BBTD program when you get back to your community? yes

If no, why?

What is your job title?

Teacher Aide (Health Aide) Virginia Head Start Program

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning future training programs. Please take a few moments to complete this evaluation form.

Please circle your response

low 1 2 3 4 (5) high

1. Training objectives were clear.

1 2 3 4 (5)

2. Audiovisual materials were helpful.

1 2 3 4 (5) but I didn't like the cows

3. The training manual and handouts were useful.

1 2 3 4 (5)

4. Instructor communicated clearly.

1 2 3 4 5

5. Instructor was attentive to group needs.

1 2 3 4 (5)

6. I feel adequately prepared to organize a BBTD program in my community.

1 2 (3) 4 5

7. I feel adequately prepared to train others to work with the BBTD program.

1 2 3 (4) 5

The most valuable portion of the course was:

and communicating

being supportive

The least valuable portion of the course was:

can't think of any

Do you plan to implement a BBTD program when you get back to your community? yes

If no, why?

What is your job title?

Head Start Teacher/Health Aide

Thank you for completing this questionnaire!

Super wk shp - liked sharing + group activities also info

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning **future training** programs. Please take a few moments to complete this evaluation form.

Please circle your response

low 1 2 3 4 5 high

- | | |
|--|------------------------|
| 1. Training objectives were clear. | 1 2 3 4 5 |
| 2. Audiovisual materials were helpful. | 1 2 3 4 5 |
| 3. The training manual and handouts were useful . | 1 2 3 4 5 |
| 4. Instructor communicated clearly. | 1 2 3 4 5 |
| 5. Instructor was attentive to group needs. | 1 2 3 4 5 |
| 6. I feel adequately prepared to organize a BBTD program in my community. | 1 2 3 4 5 |
| 7. I feel adequately prepared to train others to work with the BBTD program. | 1 2 3 4 5 |

The most valuable portion of the course was: the skits

The least valuable portion of the course was: lunch

Do you plan to implement a BBTD program when you get back to your community? yes

If no, why? _____

What is your job title? Dental CTR - Generalist

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are **helpful** in planning future training programs. Please take a few moments to complete this evaluation form.

Please circle your response

low 1 2 3 4 5 high

1. Training objectives were **clear**. 1 2 3 4 5
2. Audiovisual materials were **helpful**. 1 2 3 4 5
3. The training manual and handouts were useful. 1 2 3 4 5
4. Instructor communicated clearly. 1 2 3 4 5
5. Instructor was attentive to group needs. 1 2 3 4 5
6. I **feel** adequately prepared to organize a **BBTD** program in my community. 1 2 3 4 5
7. I feel adequately prepared to train others to work with the BBTD program. 1 2 3 4 5

The most valuable portion of the course was:

Any and All

information on BBTD.

The least valuable portion of the course was:

Every bit of information was good to me and I would like to pass it on.

Do you plan to implement a BBTD program when you get back to your community? yes

If no, why?

What is your job title?

Teacher and Health Aides in Head Start Program.

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning **future training programs**. Please take a few moments to complete this evaluation form.

Please circle your response

low 1 2 3 4 5 high

- | | |
|--|------------------------|
| 1. Training objectives were clear. | 1 2 3 4 5 |
| 2. Audiovisual materials were helpful. | 1 2 3 4 5 |
| 3. The training manual and handouts were useful . | 1 2 3 4 5 |
| 4. Instructor communicated clearly. | 1 2 3 4 5 |
| 5. Instructor was attentive to group needs. | 1 2 3 4 5 |
| 6. I feel adequately prepared to organize a BBTD program in my community. | 1 2 3 4 5 |
| 7. I feel adequately prepared to train others to work with the BBTD program. | 1 2 3 4 5 |

The most valuable portion of the course was: _____

The main lesson on BBTD (pictures and what BBTD is)

The least valuable portion of the course was: _____

Group session

Do you plan to implement a BBTD program when you get back to your community? ?

If no, why? Dr. Bennis with Dental staff to back off till needed.

What is your job title? Dental Assistant

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are **helpful** in planning future training programs. Please take a few moments to complete this evaluation form.

Please circle your response

low 1 2 3 4 5 high

1. Training objectives were **clear**. 1 2 **3** 4 5
2. Audiovisual materials were helpful. 1 2 3 **4** 5
3. The training manual and handouts were useful. 1 2 3 **4** 5
4. Instructor communicated **clearly**. 1 2 3 **4** 5
5. Instructor was attentive to group needs. 1 2 **3** 4 5
6. **I feel** adequately prepared to organize a BBTD program in my community. 1 2 **3** 4 5
7. I feel adequately prepared to train others to work with the BBTD program. 1 **2** 3 4 5

The most valuable portion of the course was:

Sharing of ideas, experiences to give it more personal

The least valuable portion of the course was:

needed more time on problem-solving model

Do you plan to **implement** a BBTD program when you get back to your community?

yes with help of others/Task Force

If no, why?

What is your job title?

PT Nutritionist

Thank you for completing this questionnaire!

BBTD TRAINING

AGENDA

TRAINERS: Bonnie Bruerd/ Mary Beth Kinney/ Ann Hesketh

COEUR D'ALENE

September 14, 1992

- 9:00 Welcome and Overview
- 9:15 Opening Exercise
- 9:45 Prevention of Oral Diseases
- 10:15 Break
- 10:30 What is BBTD?
- 11:00 Overview of the BBTD Program
- 12:00 Lunch
- 1:00 Brainstorm the Qualities of a Good Listener
- 1:15 Describe the Problem-Solving Model
- 2:00 Practice Counseling Interactions
- 3:00 Break
- 3:15 Brainstorm the Qualities of a Good Educator
- 3:30 Applications of Health Behavior/Health Education
- 4:15 Four Steps to Effective Presentations/Assignments
- 4:30 Values Clarification Exercise
- 5:00 Adjourn

September 15, 1992

- 9:00 Four-Step Presentations
- 10:00 Break
- 10:15 Planning and Evaluation Exercise
- 11:15 Strengths Exercise
- 11:45 Goal Setting Exercise
- 12:00 Lunch

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning future training programs. Please take a few moments to complete this evaluation form.

Please circle your response

low 1 2 3 4 5 **high**

- 1. Training objectives were clear. 1 2 3 ④ 5
- 2. Audiovisual materials were helpful. 1 2 3 ④ 5
- 3. The training manual and handouts were useful. 1 2 3 4 ⑤
- 4. Instructor **communicated** clearly. 1 2 3 4 ⑤
- 5. Instructor was attentive to group needs. 1 2 3 ④ 5
- 6. I feel adequately prepared to organize a BBTD program in my **community**.
1 2 ③ 4 5
- 7. I feel adequately prepared to train others to work with the **BBTD** program.
1 2 ③ 4 5

The most valuable portion of the course was:

 I felt the
whole course was absolute an Very Important Issue

The least valuable portion of the course was:

Do you plan to implement a **BBTD** program when you get back to your community? yes

If no, why?

What is your job title?

 Dental Assistant

Thank you FOR completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning future training programs. Please take a few moments to complete this evaluation form.

Please circle your **response**

low' 1 2 3 4 5 high

1. Training objectives were clear. 1 2 3 **4** 5
2. Audiovisual materials were helpful. 1 2 3 **4** 5
3. The training manual and handouts were useful.. 1 2 3 **4** 5
4. Instructor communicated clearly. 1 2 3 **4** 5
5. Instructor was attentive to group needs. 1 **2** 3 4 **5**
6. I feel **adequately** prepared to organize a BBTD program in my community. 1 **2** 3 4 5
7. I feel adequately prepared to train others to work with the BBTD program. 1 **2** 3 4 5

The most valuable portion of the course was:

The inter action
between professions was good to see

The least valuable portion of the course was:

The running
down of any one program

Do you plan to implement a BBTD program when you get back to your community? es

If no, why?

What is your job title?

Child Care Liaison Jannette

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning future training programs. Please take a few moments to complete this evaluation form.

Please circle your response

low 1 2 3 4 5 high

1. Training objectives were clear. 1 2 3 4 5
2. Audiovisual materials were helpful. 1 2 3 4 **5**
3. The training manual and handouts were useful. **1** 2 **3** 4 5
4. Instructor **communicated** clearly. 1 2 3 4 **5**
5. Instructor was attentive to group needs. 1 2 3 4 **5**
6. I feel adequately prepared to organize a BBTD program in my community. **1** 2 **3** 4 5
7. I feel adequately prepared to train others to work with the BBTD program. **1** 2 3 4 5

The most valuable portion of the course was: Learning how not to tell patient their dad

The least valuable portion of the course was: The Tape

Do you plan to implement a BBTD program when you get back to your community? yes

If no, why? _____

What is your job title? Dental Assistant

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning future training programs. Please take a few moments to complete this evaluation form.

Please circle *your response*

low 1 2 3 4 5 high

1. Training objectives were clear. 1 2 3 4 (5)
2. Audiovisual materials were helpful. 1 2 3 4 (5)
3. The training manual and handouts were useful. 1 2 3 4 (5)
4. Instructor communicated clearly. 1 2 3 4 (5)
5. Instructor was attentive to group needs. 1 2 3 4 (5)
6. I feel adequately prepared to organize a BBTD program in my community. 1 2 3 4 (5)
7. I feel adequately prepared to train others to work with the BBTD program. 1 2 3 4 (5)

The most valuable portion of the course was: listen on response for communication was very helpful

The least valuable portion of the course was: _____

Do you plan to **implement** a BBTD program when you get back to your community? yes

If no, why? _____

What is your job title? Receptionist

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning future training programs. Please take a few moments to complete this evaluation form.

Please circle your response

low 1 2 3 4 5 high

1. Training objectives were clear. 1 2 3 4 **5**
2. Audiovisual materials were helpful. 1 **2** 3 4 **5**
3. The training manual and handouts were useful. 1 **2** 3 4 **5**
4. Instructor communicated clearly. 1 2 **3** 4 **5**
5. Instructor was attentive to group needs. 1 2 3 4 5 **5**
6. I feel adequately prepared to organize a BBTD program in my community. 1 2 3 4 **5** 5 1
7. I feel adequately prepared to train others to work with the BBTD program. 1 2 3 **4** 5

The most valuable portion of the course was:

delivered in a positive manner

The least valuable portion of the course was:

part about of

Do you plan to implement a BBTD program when you get back to your community? ?

If no, why?

I will discuss it with the media practitioners at our local clinic

What is your job title?

RAJ - BSW student

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning future training programs. Please take a few moments to complete this evaluation form.

Please circle your response

low 1 2 3 4 5 high

- | | |
|---|------------------------|
| 1. Training objectives were clear. | 1 2 3 4 5 |
| 2. Audiovisual materials were helpful. | 1 2 3 4 5 |
| 3. The training manual and handouts were useful. | 1 2 3 4 5 |
| 4. Instructor communicated clearly. | 1 2 3 4 5 |
| 5. Instructor was attentive to group needs. | 1 2 3 4 5 |
| 6. I feel adequately prepared to organize a BBTD program in my community. | 1 2 3 4 5 |
| 7. I feel adequately prepared to train others to work with the BBTD program. | 1 2 3 4 5 |

The most valuable portion of the course was: the presenters

knowledge / professionalism / dedication

The least valuable portion of the course was: _____

Do you plan to implement a **BBTD** program when you get back to your community? yes?

If no, why? _____

What is your job title? RN-BSN student - Oralem Carallone

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning future training programs. Please take a few moments to complete this evaluation form.

- Please circle your response*
- | | low | 1 | 2 | 3 | 4 | 5 | high |
|--|-----|---|---|---|---|---|------|
| 1. Training objectives were clear. | | 1 | 2 | 3 | 4 | 5 | |
| 2. Audiovisual materials were helpful. | | 1 | 2 | 3 | 4 | 5 | |
| 3. The training manual and handouts were useful. | | 1 | 2 | 3 | 4 | 5 | |
| 4. Instructor communicated clearly. | | 1 | 2 | 3 | 4 | 5 | |
| 5. Instructor was attentive group needs. | | 1 | 2 | 3 | 4 | 5 | |
| 6. I feel adequately prepared to organize a BBTD program in my community. | | 1 | 2 | 3 | 4 | 5 | |
| 7. I feel adequately prepared to train others to work with the BBTD program. | | 1 | 2 | 3 | 4 | 5 | |

The most valuable portion of the course was: The four steps to effective presentations

The least valuable portion of the course was: _____

Do you plan to implement a BBTD program when you get back to your community? Yes

If no, why? _____

What is your job title? Community Health Rep.

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning future training programs. Please take a few moments to complete this evaluation form.

Please circle response

low 1 2 3 4 5 high

- 1. Training objectives were clear. 1 2 3 4 **5**
- 2. Audiovisual materials were helpful. 1 2 3 4 **5**
- 3. The training manual and handouts were useful. 1 2 3 4 **5**
- 4. Instructor **communicated** clearly. 1 2 3 4 **5**
- 5. Instructor was attentive to group needs. 1 2 3 4 **5**
- 6. I feel adequately prepared to organize a BBTD program in my community. 1 2 **3 4** 5
- 7. I feel adequately prepared to train others to work with the BBTD program. 1 2 **3 4** 5

The most valuable portion of the course was: BECOMING CONNECTED AS AN ORGANIZING GROUP

The least valuable portion of the course was: _____

Do you plan to implement a BBTD program when you get back to your community? Yes

If no, why? _____

What is your job title? DENTIST

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning future training programs. Please take a few moments to complete this evaluation form.

Please circle your response

low 1 2 3 4 5 high

1. Training objectives were clear. 1 2 3 4 5 (5)
2. Audiovisual materials were helpful. 1 2 3 4 5 (5)
3. The training manual and handouts were useful. 1 2 3 4 5 (5)
4. Instructor **communicated** clearly. 1 2 3 4 5 (5)
5. Instructor was attentive to group needs. 1 2 (3) 4 5
6. I feel adequately prepared to organize a BBTD program in my community. 1 2 3 4 5
7. I feel adequately prepared to **train** others to work with the BBTD program. 1 2 (3) 4 5

The most valuable portion of the course was:

Participating in

the program

The least valuable portion of the course was:

Did not know

and the program materials

Do you plan to implement a BBTD program when you get back to your community? Same

If no, why?

What is your job title? Retired & active in Senior
Citizen Program

Thank you for completing this questionnaire!

BBTD WORKSHOP

Evaluation Form

Your opinion is important to us. Your comments are helpful in planning future training programs. Please take a few moments to complete this evaluation form.

Please circle your response

low 1 2 3 4 5 high

1. Training objectives were clear. 1 2 3 4 **5**
2. Audiovisual materials were helpful. **1** 2 3 4 **5**
3. The training manual and handouts were useful. 1 2 3 4 **5**
4. Instructor **communicated** clearly. **1** 2 3 4 **5**
5. Instructor was attentive to group needs. 1 2 3 4 **5**
6. I feel adequately Prepared to organize a BBTD program in my community. 1 2 3 4 **5**
7. I feel adequately prepared to train others to work with the BBTD program. 1 2 3 **4** 5

The most valuable portion of the course was: _____

The least valuable portion of the course was: _____

Do you plan to implement a BBTD program when you get back to your community? yes

If no, why? _____

What is your job title? Carpenter RW

Thank you for completing this questionnaire!

OPEL GRANT FY'91-FY92

SPENDING PLAN	BUDGET	VENDORS	COMPLETION DATE
Phase I			
Marketing Plan	3,050	Purchase Order -SSI	9/1/91
Policy and Procudures Manual	3,950	Purchase Order -SSI	7/1/91
Train Network Personnel	980	Purchase Order -Bonnie Bruerd	7/1/91
Materials	7,100	Purchase Order -GPO	7/15/91
Network Personnel	14,573	.5 FTE GS 4 Clerk Typist	9/30/92
Quarterly Newsletter	4,880	Purchase Order -SSI	10/1/92
Subtotal	34,533		
Phase II			
Development of Training Materials/Manuals	8,220	Purchase Order -SSI	10/15/91
Implementation of Training Workshops	5,520	Purchase Order -Bonnie Bruerd	9/14/92
Media/Materials	8,000	Purchase Order -GPO	7/15/91
Travel for Workshops	2,200	Travel Order -PAO	9/30/92
Parents Helping Parents/Books-Slides	1,425	Purchase Order -Barbara Holcomb	12/1/91
Subtotal	25,365		
Phase III			
Final Report Preparation	1,100	Purchase Order SSI	10/1/91
Process Evaluation	1,200	Purchase Order SSI	10/9/92
Evaluation of Network Support	2,000	Purchase Order SSI	10/9/92
Subtotal	4,300		
Total	64,198		