Survey of School-Based Oral Health Programs Operated by Health Centers:

Descriptive Findings
## Table of Contents

- Glossary of Terms  
- Executive Summary  
- Introduction  
- Methods  
- Survey Results  
- Focus Group Results  
- Recommendations  
- Conclusion  
- Links  
- Resources for Starting a School-Based Dental Sealant Program  
- Appendices  
- Credits  

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Glossary of Terms

**Fixed site**—In contrast to mobile and portable programs, fixed sites are school-based health centers (SBHCs) located in school buildings or on school grounds. (See also mobile and portable program, school-based health center.)

**Health Center**—Health Centers are public or private not-for-profit organizations that provide preventive and primary health services to populations with limited access to health services. The Health Center designation is available only to programs that meet certain federal requirements and that receive federal grant funds under Section 330 of the Public Health Service Act. Many Health Centers serve as sponsoring organizations of SBHCs. (See also school-based health center.)

**Mobile and portable program**—In contrast to fixed sites, mobile and portable programs (also known as travelling programs), use mobile vans and/or portable equipment to deliver services in schools. (See also fixed site, mobile van, portable equipment.)

**Mobile van**—Mobile vans are recreational vehicle–style vans that health professionals use to bring health services to schools. The vans are equipped with exam rooms and medical equipment.

**Portable equipment**—Portable equipment is equipment that health professionals use to bring health services to schools. They set up exam rooms in classrooms or other available spaces.

**School-based health center (SBHC)**—SBHCs are health clinics that (i) are located in or near school facilities of school districts or boards or of Indian tribes or tribal organizations; (ii) are organized through school, community, and health professional relationships; (iii) are administered by sponsoring facilities; (iv) use health professionals to provide primary care services to children in accordance with state and local laws, including laws relating to licensure and certification; and (v) satisfy such other requirements as states may establish for the operation of such clinics.

**School-based oral health program**—School-based oral health programs are oral health components of SBHCs. (See also school-based health center.)

**Uniform Data System**—The Uniform Data System (UDS) is a core set of information appropriate for reviewing the operation and performance of Health Centers. UDS data are collected from Health Center programs which include Program Grantees and Look-Alikes as defined in Section 330 of the Public Health Service Act.
Executive Summary

This paper presents the results of a national online survey of Health Centers that National Network for Oral Health Access (NNOHA) conducted in June 2013 to obtain information about school-based oral health programs located in school-based health centers (SBHCs) and operated by Health Centers. Survey respondents were dental directors from Health Centers that currently have school-based oral health programs. Sixty-two Health Centers from 29 states that provided school-based oral health programs completed the survey.

The paper also presents results from two follow-up focus groups held in August 2013 with dental directors or school-based program managers from 10 Health Centers with large school-based oral health programs.

Survey results indicate that:

The average Health Center had SBHCs in 12.4 schools (range 1–74) and provided oral health services to 1,910 students per year (range 5 to 15,000). In most Health Centers, one of the following school-based oral health care delivery models predominated: portable equipment (46.7%), fixed clinics (30.6%), and mobile vans (8.1%). Fourteen Health Centers (22.6%) used a combination of the three models. Most school-based oral health programs operated during school hours, 5 days per week, and 9 or 10 months per year. Some saw students before and after school hours, on Saturdays, and during summer months. Participating students were in elementary (50%), middle (18%), and high (19%) school; 13% were in preschool. Only nine programs served students from other schools or adults.

Almost all school-based oral health programs offered basic diagnostic services (e.g., examinations, radiographs) and preventive services (e.g., prophylaxes, dental sealants, fluoride varnishes/rinses). About half provided restorative services, and a small percentage (14%) also provided some specialty services (e.g., root canals). All programs referred students to the Health Center or to outside health professionals for oral health treatment or specialty services that the school-based oral health program did not offer. Few SBHCs had formal tracking systems to determine the percentage of referred students that actually receive needed services.

Most Health Centers billed for services provided in SBHCs and received quarterly or monthly reports on SBHC revenues and expenses. Primary payers were Medicaid/CHIP (82.4%), 330 grant (8.4%), private insurers (9%), self-pay (3%), and other (5%). For students enrolled in Medicaid/CHIP, Health Centers received their usual per-visit rate.

Some key focus group findings include:

- Most Health Centers took over existing SBHCs in the 1990s when other community organizations were unable to secure adequate financial and management support to continue running the SBHCs.
- To fund new equipment, construction, and supplies, Health Centers depend on federal funding from the Health Resources and Services Administration, as well as on grants from a variety of sources.
Most Health Centers offer both primary care services and oral health services in their SBHCs, and there are strong working relationships among oral health professionals, other health professionals, and administrative staff.

Enrolling students in SBHCs is a challenge; on average only 25% to 50% of eligible students are enrolled. To enroll students in SBHCs, program staff need to work closely with school staff to disseminate information. Streamlining the consent process can help ensure that more parents provide consent for their child’s treatment.

The majority of Health Centers use integrated electronic dental records and billing systems in their SBHCs. Those still using paper recordkeeping expect to have electronic systems operating within the next year or so.

Focus group participants reported strong support for SBHCs within their Health Center, schools, and community. They also noted that the SBHCs were financially stable.

All SBHCs were in the process of expanding to accommodate additional schools and more students.

While the results described here are based on a small survey sample and therefore have limitations, many findings have relevance and immediate applicability for school-based oral health programs.
Introduction

Health Centers are public or private not-for-profit organizations that provide preventive and primary care health services to populations with limited access to such services. The Health Center designation is available only to programs that meet certain federal requirements and that receive federal grant funds under Section 330 of the Public Health Service Act. In 2012, Health Centers nationwide served more than 4 million dental patients.¹

For many Health Centers, providing services through school-based health centers (SBHCs) is an important strategy to increase access to health services for children and adolescents who are underserved. SBHCs serve as excellent vehicles to reach additional patients and to address unmet primary care services and oral health services needs in communities. To underscore the strategic importance of SBHCs in reducing health disparities, the Affordable Care Act (ACA) appropriated $200 million during 2010–2013 to improve and expand health services provided in schools.

A recent report from the National School-Based Health Alliance, the national voice for SBHCs,² indicates that SBHCs are typically sponsored by local health care organizations, including Health Centers (33.4%), hospitals (26.4%), and local health departments (13.3%). The report states that over the past 10 years, the trend is toward more Health-Center-sponsored SBHCs. For SBHCs, Health Centers provide a sustainable foundation of operations and clinician support. This, coupled with their overlapping missions, provides a rationale for many Health Centers to take over existing SBHCs or start new ones.

A large number of SBHCs provide comprehensive services, including oral health services. Yet little is known about the characteristics and operations of school-based oral health programs operated by Health Centers. Many Health Centers and other organizations have contacted the National Network for Oral Health Access (NNOHA) seeking information about the establishment and operations of school-based oral health programs operated by Health Centers.

This paper presents the results of a national online survey of Health Centers that NNOHA conducted in June 2013 to obtain information about school-based oral health programs located in SBHCs and operated by Health Centers. The paper also presents results from two follow-up focus groups held in August 2013.

Survey respondents were dental directors from Health Centers that currently have school-based oral health programs. Focus group participants were dental directors or school-based program managers from Health Centers with large school-based oral health programs. The paper discusses school-based oral health program history, financing, practices, and future directions; recommendations and conclusions are also presented.

While the results described here are based on a small survey sample and therefore cannot be universally applied, NNOHA hopes the information provided will inform efforts to enhance or expand existing school-based oral health programs and help those wishing to establish new programs—ultimately improving access to oral health services and thereby oral health and overall health outcomes for the populations we serve.

Methods

To obtain information about school-based oral health programs operated by Health Centers, NNOHA staff developed and tested a survey instrument. In June 2013, NNOHA electronically disseminated the survey to 282 Health Centers that reported having patients that received services in an SBHC and having an oral health program (defined as employing more than 0.5 full-time equivalent (FTE) dentists or delivering more than 500 dental visits per year) in their 2011 UDS report to the Health Resources and Services Administration (HRSA). However, the UDS data does not specify what services were provided in the school-based setting, meaning that the dental visits could have been in the SBHC or at the Health Center. Health Centers that did not respond within 2 weeks of receiving the survey were contacted via follow-up phone calls or e-mails and were asked to complete the survey. The survey instrument is found in Appendix A.

Data were first screened to identify Health Centers with illogical and outlier responses. Health Centers that provided such responses were contacted and asked to correct any misinformation. Then, for each variable, descriptive statistics were generated using a spreadsheet. In a few cases, chi-square statistical tests were used to test associations among variables. Because this was a preliminary survey with a small sample size, no multivariate statistical methods were used.

In addition, in August 2013 two focus group conference calls were held with dental directors or school-based oral health program managers from 10 Health Centers with large school-based oral health programs. The purpose of the focus groups was to collect qualitative data on several issues not addressed in the survey and to obtain more detailed follow-up information about other topics that the survey addressed. Focus group participants received interview guides before the conference calls took place. Focus group discussions were recorded and are analyzed in this paper (see the Focus Group Results section). The focus group interview guide can be found in Appendix B.

Survey results are based on a limited survey sample, not a representative sample, and therefore caution should be exercised in using them to draw conclusions about SBHCs and school-based oral health programs in general.

Survey Results

Response Rate and Responder Locations

Of the 282 Health Centers contacted, 64 responded to the survey. Of the 64 surveys received, two were incomplete and could not be used, leaving 62 usable surveys (22% response rate). However, since the UDS captures only self-reported data that the Health Center provides and does not detail types of services offered, it is not known what percentage of the 282 Health Centers that received the online survey offered oral health services in their SBHC. In that sense, we are unsure of the true value of the denominator.

Completed surveys were obtained from Health Centers in 29 states. The states with the largest number of reporting Health Centers were California (7) and New York (6). As seen in Table 1, the Health Centers represent the following HRSA regions and states:

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iii Bureau of Primary Health Care, Health Resources and Services Administration, Health Center Data. [http://bphc.hrsa.gov/healthcenterdatastatistics](http://bphc.hrsa.gov/healthcenterdatastatistics).
Table 1: Number of Participating Health Centers by HRSA Region and State

<table>
<thead>
<tr>
<th>Region 1</th>
<th># Health Centers</th>
<th>Region 6</th>
<th># Health Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maine</td>
<td>3</td>
<td>Louisiana</td>
<td>2</td>
</tr>
<tr>
<td>Vermont</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connecticut</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
<td><strong>Total</strong></td>
<td><strong>2</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Region 2</td>
<td></td>
<td>Region 7</td>
<td></td>
</tr>
<tr>
<td>New York</td>
<td>6</td>
<td>Missouri</td>
<td>1</td>
</tr>
<tr>
<td>New Jersey</td>
<td>3</td>
<td>Iowa</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
<td><strong>Total</strong></td>
<td><strong>3</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Region 3</td>
<td></td>
<td>Region 8</td>
<td></td>
</tr>
<tr>
<td>Maryland</td>
<td>1</td>
<td>North Dakota</td>
<td>1</td>
</tr>
<tr>
<td>Virginia</td>
<td>1</td>
<td>Colorado</td>
<td>3</td>
</tr>
<tr>
<td>West Virginia</td>
<td>1</td>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Region 4</td>
<td></td>
<td>Region 9</td>
<td></td>
</tr>
<tr>
<td>Kentucky</td>
<td>2</td>
<td>California</td>
<td>7</td>
</tr>
<tr>
<td>North Carolina</td>
<td>1</td>
<td>Arizona</td>
<td>1</td>
</tr>
<tr>
<td>Mississippi</td>
<td>3</td>
<td>Hawaii</td>
<td>2</td>
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<tr>
<td>South Carolina</td>
<td>3</td>
<td><strong>Total</strong></td>
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<tr>
<td>Florida</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>Georgia</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
<td></td>
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<tr>
<td>Region 5</td>
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</tr>
<tr>
<td>Wisconsin</td>
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<td>Washington</td>
<td>2</td>
</tr>
<tr>
<td>Illinois</td>
<td>1</td>
<td>Oregon</td>
<td>3</td>
</tr>
<tr>
<td>Michigan</td>
<td>2</td>
<td><strong>Total</strong></td>
<td><strong>5</strong></td>
</tr>
<tr>
<td>Ohio</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Integrated Services
Among the 62 respondents, 47 (75.8%) provided both primary care services and oral health services within an SBHC in at least one school. The remaining 15 respondents had stand-alone oral health programs.

Number of Schools and Students Served
The average number of schools in which Health Centers provided oral health services was 12.4; the range was 1 to 74 schools. Figure 1 shows variations among Health Centers providing
oral health services in 10 or fewer schools; Figure 2 shows variations among Health Centers providing oral health services in 11 or more schools.

Figure 1: Number of Health Centers Providing Oral Health Services in 10 or Fewer Schools by Number of Schools (n = 39)

![Figure 1](chart1.png)

Figure 2: Number of Health Centers Providing Oral Health Services in 11 or More Schools By Number of Schools (n = 22)

![Figure 2](chart2.png)

Among the 61 respondents that supplied data on the number of schools in which they provided oral health services, 39 (63.9%) provided services in 10 or fewer schools. Within this group, 22 Health Centers provided services in 2 or fewer schools. For the 22 that provided services in 11 or more schools, over half (15) provided services in 11 to 30 schools. Only 2 provided services in more than 60 schools.

There was also substantial variation in the number of students served annually. The average number of students receiving oral health services annually was 1,910. The range was very large, spanning from 5 to 15,000 students, illustrating the extreme differences in the states of development of school-based oral health programs. Figure 3 shows the distribution for Health Centers providing oral health services to 1,000 or fewer students annually. Figure 4 shows the distribution for Health Centers providing services to 1,001 or more students annually.
Among the 51 respondents that supplied data on number of students served, 31 (60.7%) provided oral health services to 1,000 or fewer students. Within this group, 10 (32.3%) respondents provided services to 200 or fewer students. Among the 20 Health Centers providing services to 1,001 or more students, over half (13) provided services to 3,000 or fewer students. Only 2 Health Centers provided services to more than 9,001 students.

**Delivery Model**

Health Centers provided oral health services to students in schools via three delivery models: (1) fixed clinics located in schools, (2) mobile vans parked on school property, and (3) portable equipment carried into schools and located in temporary spaces. The survey shows that 41.9% of services were delivered using portable equipment and temporary spaces. Another 27.4% were delivered in fixed clinics, and 8.1% in mobile vans. Fourteen Health Centers (22.6%) used multiple delivery models.
Most school-based oral health programs serving 500 or fewer students annually used portable equipment. However, a chi-square test showed no statistically significant relationship between number of students served annually and clinic model.

**Number of Students Served per Day per School**
The number of students served per day per school is an important measure of Health Center productivity. Among the 42 respondents that supplied this information, the average number of students served per day per school was 16.5. The range was 3 to 60 students per day per school. Figure 6 shows the distribution of the number of students served per day per school.

The majority of respondents (30 of the 42 that supplied this information) served between 6 and 20 students per day per school.
Months and Days of Operation

Most schools are not in session 12 months a year or 7 days a week. Consequently, it is important to know how school-based oral health programs accommodate school schedules. Figure 7 shows the number of Health Centers operating school-based oral health programs by month among the 58 respondents that supplied this information.

Figure 7: Number of Health Centers Operating Oral Health Programs by Month (n = 58)

![Chart showing the number of Health Centers operating oral health programs by month.]

Figure 8 shows another perspective: the variation in the total number of months that Health Centers operated their school-based oral health programs.

Figure 8: Number of Months of School-Based Oral Health Program Operations (n = 58)

![Chart showing the number of months Health Centers operated their school-based oral health programs.]

The data indicate that most programs operated for only 9 or 10 months per year. However, a surprising number of programs (16) continued operating during July. The programs that visited schools only 1 month per year performed oral health screenings.

Figure 9 shows the number of days per week that Health Centers operated school-based oral health programs, among the 60 respondents that supplied this information.

The majority provided services 5 days per week. Fourteen Health Centers provided oral health services before and after normal school hours (data not shown).
School-Based Oral Health Program Services

Table 2 lists the numbers and percentages of Health Centers (among the 61 respondents that supplied this information) offering each type of clinical service. The descriptions of the clinical services used are the same as those in the periodic National School-Based Health Alliance survey of SBHCs, available at [http://www.sbh4all.org/site/c.ckLQKbOVLyK6E/b.7742441/k.E71F/SBHC_Data.htm](http://www.sbh4all.org/site/c.ckLQKbOVLyK6E/b.7742441/k.E71F/SBHC_Data.htm).

Table 2: Percentage of Health Centers that Provide Each Type of Oral Health Service in Program (n=61)

<table>
<thead>
<tr>
<th>Oral Health Service</th>
<th>% of Health Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Health Education</td>
<td>95.1</td>
</tr>
<tr>
<td>Fluoride Varnish</td>
<td>88.7</td>
</tr>
<tr>
<td>Dentist Examination</td>
<td>80.6</td>
</tr>
<tr>
<td>Sealants</td>
<td>80.6</td>
</tr>
<tr>
<td>Prophylaxes</td>
<td>79.0</td>
</tr>
<tr>
<td>Radiographs</td>
<td>64.5</td>
</tr>
<tr>
<td>Hygienist Screening Examination</td>
<td>53.2</td>
</tr>
<tr>
<td>General Dental Care</td>
<td>53.2</td>
</tr>
<tr>
<td>Fluoride Rinse</td>
<td>41.9</td>
</tr>
<tr>
<td>Hygienist Examination</td>
<td>27.4</td>
</tr>
<tr>
<td>Fluoride Supplements</td>
<td>20.9</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>14.5</td>
</tr>
</tbody>
</table>

Most school-based oral health programs operated by Health Centers provided basic diagnostic and preventive services. Dentists rather than dental hygienists tended to perform clinical examinations. In 53.2% of programs, dental hygienists performed oral health screenings. It is important to note that 53.2% of the programs provided general oral health services (e.g., restorations, extractions) while few (14.5%) provided specialty oral health services (e.g., orthodontics, oral surgery).
Referrals
Eighteen Health Centers referred students that their school-based oral health programs served to the Health Center or to outside health professionals for oral health treatment or specialty services that the school-based oral health program did not offer. The percentage of referred students is highly variable (between 10% and 100%), suggesting that the survey question may have been misunderstood. The percentage of referred students that actually received services in school-based oral health programs also varied greatly. However, it is important to note that most Health Centers did not collect data on these two survey items in a standardized manner.

Patient Sources
Almost all respondents indicated that 100% of the patients who received services in school-based oral health centers came from the school where the center was located. Only nine respondents indicated that students from other schools or adults received services in their programs.

Student Grades
Table 3 shows the percentages of students receiving services in school-based oral health program operated by Health Centers, by grade. Most students were in grades K–5. A smaller percentage were in other grades.

<table>
<thead>
<tr>
<th>Grade Range</th>
<th>% of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschool</td>
<td>12.9</td>
</tr>
<tr>
<td>Elementary (grades K-5 )</td>
<td>50.2</td>
</tr>
<tr>
<td>Middle (grades 6-8)</td>
<td>17.9</td>
</tr>
<tr>
<td>High (grades 9-12)</td>
<td>18.9</td>
</tr>
<tr>
<td>Other</td>
<td>0.1</td>
</tr>
</tbody>
</table>

School-Based Oral Health Program Staff
Table 4 shows the number of FTE staff that Health Centers employed to provide services in and administer school-based oral health programs. The average number of Health Center staff employed in school-based oral health programs was quite small. However, some Health Centers employed substantial numbers of school-based oral health program staff.

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Reporting Health Centers</th>
<th>Average Staff Number</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentists</td>
<td>47</td>
<td>1.0</td>
<td>0–4.5</td>
</tr>
<tr>
<td>Dental Hygienists</td>
<td>39</td>
<td>1.1</td>
<td>0–9.0</td>
</tr>
<tr>
<td>Dental Assistants</td>
<td>47</td>
<td>1.6</td>
<td>0–6.0</td>
</tr>
<tr>
<td>Other</td>
<td>29</td>
<td>1.4</td>
<td>0–8.0</td>
</tr>
</tbody>
</table>
Most Health Centers reported that schools did not have paid staff dedicated to operating school-based oral health programs. This does not include in-kind contributions of school administrators, teachers, and support personnel.

Financial Report Frequency
Among the 59 respondents that supplied this information, most (50) received reports on the financial operation of their school-based oral health programs at least annually. Some received reports quarterly or monthly.

Billing
Of the 58 respondents that supplied information about billing, all but 9 billed for services provided in their school-based oral health programs. For students enrolled in Medicaid/CHIP, all but 3 Health Centers charged Medicaid/CHIP their usual Health Center per-visit rate. A review of the 9 Health Centers that did not bill for services indicated that most served fewer than 300 students per year, used portable equipment, and provided mainly diagnostic and preventive services to elementary school students.

Payers
Figure 10 shows the percentage of school-based oral health program revenues generated from each payer source, for the 41 respondents that supplied this information. The combined Medicaid/CHIP programs and the 330 grant provided almost 90% of program revenues.
After receiving the completed surveys, NNOHA staff conducted focus groups with dental directors or school-based program managers from 10 Health Centers. Focus group participants were selected from Health Centers with large school-based oral health programs who indicated in the survey that they provided a wide range of oral health services using multiple delivery models and that they billed for services.

The 10 Health Centers represented in the focus groups were located in 10 states and 6 HRSA regions. They operated SBHCs at between 3 and 74 school-based sites and served from 1,000 to 15,000 students per year. All provided preventive oral health services, and over half also provided general oral health services at school-based sites.

The aims of the focus group were to gain an understanding of the history of school-based oral health programs, how they are funded, and how they remain sustainable and self-sufficient.

Starting a School-Based Oral Health Program

Many focus group participants’ school-based oral health programs have been in place since the late 1990s and early 2000s. At that time it was common for local charitable organizations, hospitals, and school districts to launch school-based oral health programs, but the programs tended to be grant-funded and were not fiscally sustainable. Focus group participants indicated that original sponsoring organizations (such as charitable organizations, hospitals, and school districts) asked Health Centers to take over the school-based oral health programs for two primary reasons: (1) Health Centers offered a stable source of program funding and could be reimbursed for services provided to students enrolled in Medicaid/CHIP and (2) Health Centers could supply experienced administrative and clinical staff to manage the programs.

Some focus group participants with newer school-based programs described being approached by school districts or individual schools with requests to provide oral health services at schools. Others said that the Health Centers initiated contact with schools to discuss partnering to provide oral health services, either as a stand-alone program or as part of a comprehensive SBHC offering primary care services, oral health services, and other services.

Funding Start-Up Capital Expenses

Covering capital expenses is a primary concern of Health Centers considering starting school-based oral health programs. Most of the Health Centers that assumed control of existing school-based oral health programs already had equipment and other operating resources in place. However, over time, it became necessary to replace much of this equipment. Also, once they had stabilized the existing school-based oral health program, many Health Centers expanded to more schools and had to buy additional equipment. In most cases, Health Centers use grant funds to cover start-up capital expenses such as portable equipment, mobile vans, and build-outs of fixed school-based clinics. Grant funding sources include HRSA, state...
offices of rural health, state or county programs targeting children’s needs, city or county health departments, local school districts, local foundations, and other private grants. Two focus group participants from the same Health Center said that as their program has become more profitable, it has been able to use profits to expand and buy more equipment. No Health Centers reported raising capital through debt financing.

Promising Practices

A. Interdisciplinary Practice
Most focus group participants’ SBHCs offered primary care services and other services such as behavioral health care services, vision care services, and social work services in addition to oral health services.

According to focus group participants, when primary care services and oral health services are offered in SBHCs with fixed clinics, there is a great deal of interaction among health professionals and other staff. These SBHCs offer comprehensive services with overlapping hours across the disciplines. Programs tend to share clerical and administrative staff, have integrated health information technology (HIT) systems, and share management of clinical operations.

Focus group participants also reported that the design of the physical clinic space facilitates collaboration and communication. Clinicians are in daily contact. Some focus group respondents stated that in shared space, students can see health professionals in two or three areas (e.g., primary care services, oral health services, behavioral health services) in the same visit. Students are triaged in the same place, and staff use appointment scheduling and the HIT system to encourage use of multiple services during a single visit. This is an integrated process with bilateral referral between the multiple disciplines.

Many SBHCs hold monthly meetings of all clinical program staff in an effort to coordinate operations and student services, including referrals. All focus group participants reported that they had excellent working relationships with their professional colleagues at sites offering different types of health services.

B. Enrolling Students and Obtaining Consent for Treatment
Enrolling a large percentage of eligible students into school-based oral health programs and obtaining consent for treatment requires a great deal of effort. When asked to estimate the average percentage of eligible students who are enrolled in a school year, focus group participants reported a range of 25% to 50%. All reported that enrolling students presents a major challenge but also shared strategies that they have developed to meet the challenge.

SBHCs that most successfully met this challenge kept in mind that informing parents about the availability of oral health services in the school-based setting and obtaining consent for treatment is an ongoing process. The process begins with ensuring buy-in from the school district and superintendent and continues at each school by winning support from the principal and teachers. In planning the operations of a school-based oral health program, appropriate SBHC staff should meet with school district and school staff to develop both a plan to advertise the availability of oral health services in the school and strategies for obtaining consent for treatment.

Enrolling Students. All focus group participants agreed that the best time to implement enrollment efforts is at the beginning of the school year. Depending on the school, different strategies should be employed. Most programs include information about oral health services and consent forms with materials given to families when enrolling or registering students for the new school year. These materials can also be made available at back-to-school nights and parent
orientations. In one program, dental assistants and insurance-enrollment specialists are placed at a table near the school office during the first week of school. They offer parents oral health education, program information, and a chance to enroll students.

Other programs place packets in teachers’ mailboxes to distribute to students to take home on the first day of school. Along with other school information, the packets contain descriptions of available health programs at the school, including the oral health program, and consent forms. One focus group participant stated that because oral health program information is sent home with other important first-day paperwork from the school, parents seem to afford the oral health information greater importance.

During the school year, programs can continue to interact with parents and provide them with opportunities to enroll their child. Possible avenues include the registrar’s office, school sports events, major school events, and Parent-Teacher Association (PTA) meetings. Programs may also catch parents when they are dropping students off in the morning.

Some focus group participants mentioned the value of having outreach staff associated with their oral health programs. Some fixed-clinic programs have full-time care coordinators who are specifically charged with increasing program enrollment. These individuals can make a significant difference in enrolling students and managing relationships between oral health program staff and school staff, parents, and students. Another program hired an outreach coordinator to work with the school’s parent coordinators, who interact with parents inside the school. In yet another program, a school district employee, the family health liaison, partners with the SBHC. As a school employee, the liaison has access to all student records and information and can conduct outreach along with school nurses, whereas SBHC employees can access records only once students are enrolled in the SBHC. At schools served by mobile and portable programs, school nurses are invaluable when it comes to identifying students most in need of oral health services so they can be enrolled in the program.

At fixed sites, strategies for enhancing awareness of the SBHC in general and oral health services in particular include increasing signage and marketing presence at school so that parents are more likely to know that there is an SBHC that offers oral health services, mentioning that the SBHC offers oral health services on the school website and Facebook page, writing articles for the school newsletter about available oral health services, and disseminating information about services at local health fairs.

In schools with mobile and portable programs, methods for advertising the program’s upcoming presence at the school include raising a banner at the school 2 weeks before program arrival, sending out e-mail blasts, and setting up automated calls and text alerts to parents and caregivers.

Obtaining Consent for Treatment. Focus group participants indicated that streamlining the consent process can help ensure that more parents provide consent for their child’s treatment. Suggestions for streamlining the process for SBHCs offering a variety of services include placing consents for all types of services offered (e.g., primary care services, oral health services, behavioral health services, vision services) on one form or putting into place a protocol whereby when a student comes to the SBHC for any type of services, the follow-up process includes
targeting him or her for obtaining consent for all types of services offered, including oral health services.

The scenario of a student presenting for emergency services who does not have a signed consent form on file was discussed briefly during the focus groups. A few participants said that if a student presents with an oral health emergency, verbal consent is obtained from the parent for that one visit. Sometimes the best way to contact the parent is through the student’s cell phone. After receiving emergency treatment, the student is sent home with a consent form.

Mobile and portable programs that travel to different schools during the year implement various approaches to obtain consent for treatment. Some distribute consent forms at each school at the beginning of every school year, regardless of when the program will actually be on site, and then follow up with a second batch at schools scheduled for spring. At one program, consent forms go out at the beginning of the school year, and then school nurses start follow-up about 4 weeks before the mobile and portable program is scheduled to be at a particular school.

Other mobile and portable programs prefer to distribute consent forms just before the program is scheduled to be at the school. Forms are put in teachers’ mailboxes to be sent home with students via “backpack mail” once or twice, usually at 2, 4, and/or 6 weeks before the program is scheduled to be there. One program providing a full range of oral health services used a dual consent system—general consent for preventive oral health services and additional consent when restorative procedures are needed so that the information can be discussed with parents. If a student needs restorative services, the appropriate consent form is sent home with the student, and parents are asked to contact the program to discuss the treatment plan.

Another program developed an incentive system in the elementary schools it served. Before the program is scheduled to be at the school, program staff make a presentation to teachers, administrators, and staff, explaining program operations. At this time, consent forms are distributed to students. The class to return the most forms (whether yes or no consent) wins an ice cream party.

C. Operating Programs During Non-School Hours and Months

A few focus group participants with mobile and portable programs reported using winter and spring breaks and summer months to perform equipment maintenance, train staff, and do related tasks. Others said that during these periods, the program moves to other community locations to maintain productivity. Some of these locations include fixed SBHC sites that do not offer oral health services, Head Start sites, migrant worker facilities, homeless shelters, nursing homes, and state division of youth services residential facilities.

Most school-based oral health programs with fixed sites find it challenging to keep busy when school is not in session. Focus group participants’ strategies to address this challenge include advertising in the community to encourage parents whose children attend other schools to bring their children in during breaks and summers and printing the SBHC schedule in the local

iv Survey results indicate that most school-based oral health programs operated by Health Centers did not operate during the summer months when schools were not in session. However, several operated 11 to 12 months a year.
newspaper. Within schools, efforts include posting signs with program hours during summer break and other breaks, using outreach workers, implementing automated phone calls to parents, and asking coaches of school sports teams to encourage student athletes to visit the SBHC for sports physicals and oral health services during summer breaks and other breaks. Focus group participants noted that from mid- to late August, right before the start of the school year, there is a tremendous upswing in visits to SBHCs for sports physicals and checkups.

One focus group participant’s SBHC has developed a comprehensive non-school-hours program. This SBHC has been seeing adults at its school-based oral health program since 2003. Generally, after 2:30 p.m., when the school day ends, the program is open to children and adults with low incomes in the community and offers oral health services on a sliding fee scale. Attracting patients has not been a problem. In fact, the program has a constant flow of adult patients requiring extractions throughout the year, including during school breaks. Word has spread that oral health services are available at the school for the community at large. The dental director of this SBHC reported that during the summer months the program sees mostly adults, with students representing about 30% to 40% of the patient population, and estimated that about 20% of the adults are relatives of students who attend the school, while the rest are not. A challenge for this program arises from the fact that adults’ needs differ from students in certain clinical situations, and the physical set-up of the SBHC is not conducive to long procedures and complete patient privacy.

D. Referrals and Care Coordination

All focus group participants reported referring students for oral health services as needed, whether their SBHCs provide only diagnostic and preventive oral health services or comprehensive oral health services. While some SBHCs track all school-based referrals, most lack formal tracking systems to determine the percentage of referred students that actually receive needed services.

Programs that provide only preventive and diagnostic services have to develop strategies to ensure that students needing restorative and surgical services receive these services. The process for doing so varies among programs.

All school-based oral health programs operated by Health Centers refer students with acute oral health needs (e.g., pain, infection) to the Health Center or to other community facilities where students can obtain oral health services immediately. For example, for students in severe pain, one program makes same-day referrals for the student to be a drop-in patient at the Health Center. SBHC staff call the student’s parents to pick the student up at school and take him or her to the Health Center.

School-based oral health programs used different strategies for coordinating follow-up oral health services. At one program that offers only preventive and diagnostic services, all students are screened at the beginning of the school year. Program staff send letters home to parents of students who need restorative services. If by the time the student receives preventive services during the school year he or she has not received restorative services,
program staff send parents another letter, and either the school nurse or SBHC oral health staff make follow-up phone calls to parents to coordinate follow-up services.

Other programs that offer only preventive and diagnostic services coordinate services by directly scheduling students needing restorative services into the Health Center schedule through shared HIT systems. Program staff or Health Center staff can call parents to schedule appointments. Since clinical and billing data entered at the school can be accessed at the Health Center, staff can call parents directly to make appointments. One program determines whether students have dental homes as part of the consent process. For students with an existing dental home, a report is sent to their dental home stating that the student has tooth decay. For students needing follow-up services that do not have an identified dental home, program staff contact parents to schedule restorative services for students.

Another school-based oral health program with both a mobile and portable prevention program and a fixed school-based program reviews the list of students from the mobile and portable program that need follow-up restorative services and did not receive them and calls parents during the summer to see if they want their child to receive services at the Health Center or at another fixed school-based site that is open during the summer.

For programs offering comprehensive oral health services, the goal is to minimize referrals and provide most restorative services at the school. This is especially important in rural areas where the school-based oral health program may be 30 to 35 minutes from the Health Center. Focus group participants whose programs offer comprehensive oral health services estimate that between 10% and 15% of students require referral.

Focus group participants cited need for oral surgery, endodontics, and pediatric behavior management as the most common reasons that SBHCs refer students. Participants communicated that there was a very high noncompliance rate for root canal and oral surgery referrals.

One focus group participant described frustration over being unable to develop an adequate referral network for obtaining root canals for students. Despite compiling a list of dentists who will perform root canals at reduced cost, other Health Centers, safety-net providers, and other options, some students that needed root canals could not afford them and eventually returned to the SBHC with cellulitis for extraction.

E. Recordkeeping and Billing Systems

School-based oral health programs need to develop recordkeeping and billing systems that comply with Health Insurance Portability and Accountability Act (HIPAA) and other privacy regulations. This is a particular concern for school-based oral health programs using Wi-Fi networks.

Most focus group participants use HIT systems to document SBHC clinical data. The most common dental software system used is Dentrix; other systems mentioned include QSI and Open Dental. A few sites are still using paper charting but expect to convert to electronic charts soon. In rural areas where mobile and portable programs might visit schools, Wi-Fi networks are not always available, and encounter data cannot be uploaded until the units return to areas where Wi-Fi access is available.

All reimbursement information is entered and billed electronically; however, programs vary in how they manage clinical encounter data. In programs where the dental software and the billing system are integrated, billing takes place at the time of service, as procedures are easily entered into the software. In rural areas, on-site billing is, as previously mentioned, contingent on Wi-Fi
network availability. Some schools in areas with poor Wi-Fi access let dental program staff use the school’s fixed Internet for billing. Any billing not done on site at the school takes place at the Health Center.

Programs with dental software that does not interface with the Health Center billing system, as well as programs using paper recordkeeping, must transfer encounter data to the electronic billing system. These programs have clinicians complete a paper encounter form at the SBHC, and these forms are sent to the Health Center so that data can be manually entered into the billing system, or the data is sent electronically to the Health Center, where it is re-entered into the billing system.

Most programs verify eligibility and benefits before scheduled appointments using billing information obtained as part of the enrollment/consent process. A few programs verify eligibility at the appointment. One mobile and portable program sees so many students that it is most efficient to have a biller travel with the program to perform billing on site.

For students, programs bill commercial and government insurance plans as appropriate. Students without insurance either receive services based on a sliding fee scale, or services are subsidized by other revenue streams. Programs keep careful track of uncompensated services and charges, and this information is used to generate support from other sources, such as foundations.

The program serving adults provides services on a sliding fee scale. This program gives adults treatment plans listing services to be completed at each visit and the corresponding costs. Payment is expected at the time of the visit.

Future Directions
All focus group participants were positive about the future of their school-based oral health programs. They noted that the programs have strong internal support within their Health Centers. School-based oral health programs are also valued by school districts, individual schools, county public health officials, parents, students, and community leaders. One Health Center makes sure that the county council receives annual data on its school-based oral health programs. Focus group participants did report pushback from local dentists, but this does not appear to be a barrier to program functionality at the local level. One participant felt that private-sector dentists need education about the fact that school-based programs are targeted to students who currently do not receive services from private dental practices.

All focus group participants indicated that they anticipate growing their school-based oral health programs in the coming years. Several plan to double the number of schools they serve and increase the number of school districts in which they operate. Existing programs continue to receive requests from other school districts to provide oral health services for their students. One participant stated that her school-based oral health program data show that oral health professionals are as productive in the mobile van as they are in the fixed school-based oral health program. Others participants said that their programs plan to expand the scope of services offered in the schools they currently serve and/or to incorporate services for adults at some sites. As one participant put it, “the future is very bright.”
Recommendations

The recommendations presented in this section are based on focus group feedback and are designed to help those wishing to launch a school-based oral health program or to improve the operations of an existing program.

Starting a School-Based Oral Health Program

- Contact local schools or school districts to assess interest in partnering to develop the program.
- Assume management of existing school-based oral health programs run by local charities, hospitals, or school districts.

Funding Start-Up Capital Expenses

- When assuming control of an existing school-based oral health program, use equipment and other operating resources already present.
- Fund capital expenses such as portable equipment, mobile vans, and build-outs of fixed clinics with grants. Sources of grants include HRSA, state offices of rural health, state or county programs targeting children’s needs, city or county health departments, local school districts, local foundations, and other private grants.

Developing Interdisciplinary Practice

- Offer multiple types of health services (e.g., primary care services, oral health services, behavioral health services, vision services) in the same location.
- Overlap clinic schedules so that multiple health services are offered during the same hours.
- Share management of clinical operations and staffing.
- Hold monthly meetings of all clinical program staff to coordinate operations and student services, including referrals.
- Use an integrated HIT appointment-scheduling system and health record across disciplines.
- Triage students to receive multiple services in the same location and during the same visit.

Enrolling Students and Obtaining Consent for Treatment

- Obtain buy-in and support by meeting with school district and on-site school staff to develop both a plan to advertise the availability of oral health services in the school and strategies for enrolling students and obtaining consent for treatment.
Implement enrollment efforts at the beginning of the school year by including information about oral health services and consent forms with materials given to families when enrolling or registering students for the new school year, at back-to-school nights, and at parent orientations.

Continue enrollment efforts during the school year in situations and locations where program staff can interact with parents, such as in the registrar’s office, when parents are dropping students off in the morning, and at school sports events, major school events, PTA meetings, and back-to-school nights.

Streamline the consent process by combining consent for all types of services (e.g., primary care services, oral health services, vision services, behavioral health services) on one form.

For mobile and portable programs that visit different schools during the year, distribute consent packets at each school at the beginning of each school year, and then follow up with a second batch at schools scheduled for spring, and/or have program staff start follow-up about 4 weeks before the program is scheduled to be at a particular school.

Distribute consent forms just before the school visit, sending packets home with “backpack mail” once or twice, usually 2, 4, or 6 weeks before the mobile and portable program’s visit.

Use outreach coordinators to increase program enrollment and manage relationships between oral health program staff and school staff, parents, and students.

Develop incentive programs to increase program enrollment, such as rewarding the class that returns the most enrollment and consent forms.

Operating Programs During Non-School Hours or Months

Move mobile vans or portable equipment to other community locations to maintain productivity during non-school hours or months.

Use school outreach workers and automated phone calls to parents to encourage use of the school-based oral health program during non-school hours or months.

Ask coaches of school teams to encourage student athletes to visit the SBHC for sports physicals and oral health services during summer and other breaks.

Serve individuals from the community at large during non-school hours or months, and advertise in local media.

Referrals and Care Coordination

Track referrals to determine the percentage of referred students that actually receive follow-up services.

Refer students in severe pain the same day as drop-in patients to the Health Center, with a parent picking the student up at the school and taking the student to the Health Center.

Coordinate care in prevention-only school-based oral health programs by sending letters to parents of students who need restorative services, and follow up by having program staff call parents.

Schedule students in prevention-only programs who need restorative services into the Health Center oral health schedule through a shared HIT appointment system.

Send results of school-based oral health program screenings to students’ identified dental homes.
Develop referral networks of community safety-net oral health professionals, dental schools, contracted private oral health professionals, or other offices where students from SBHCs are welcome.

**Recordkeeping and Billing Systems**

- Recordkeeping and billing systems using Wi-Fi must comply with HIPAA and other privacy regulations.
- Bill at the time of service in programs where the school-based dental software and the Health Center billing system are integrated.
- Programs with dental software that is not integrated with the Health Center billing system should complete paper encounter forms at the visit and send these forms to the Health Center for manual entry or send the encounter data electronically to the Health Center for re-entry into the billing system.
- Keep track of uncompensated services and charges, and use this information to generate program support from other sources, such as grants and donations.

**Conclusion**

This paper presents the results of a national online survey that NNOHA conducted in June 2013 to obtain information about school-based oral health programs operated by Health Centers. The paper also presents results from two follow-up focus groups held in August 2013 with dental directors or school-based program managers from Health Centers with large school-based oral health programs.

While the results described here are based on a small survey sample and therefore have limitations, many findings have relevance and immediate applicability for school-based oral health programs.

Although only a small percentage of Health Centers currently operate school-based oral health programs, the number is increasing. Some well-established, successful programs have developed strategies to address issues unique to delivering oral health services in the school setting, such as securing funds for capital start-up costs or replacement equipment and developing a patient and financial base that allows program sustainability. Challenges include advertising, obtaining consent for treatment, recordkeeping, billing, referral, and follow-up-service coordination.

As the ACA and other initiatives look to bring oral health services to populations that have traditionally experienced access barriers, such as children and adolescents from families with low incomes, viable strategies for achieving this goal are needed. School-based oral health programs operated by Health Centers represent one strategy. Health Centers, with their long track record of serving the underserved, are logical candidates for expanding to encompass this delivery model.
Resources for Starting a School-Based Dental Sealant Program


School-Based Dental Program Survey Instrument

1. Health Center Contact Person (Staff completing this survey).

   Name __________________________
   Organization __________________________
   Title __________________________
   City/Town __________________________
   State __________________________
   Email Address __________________________
   Phone Number __________________________

2. Does your Health Center offer medical care in some or all of the same schools that the dental program operates?

   Yes ________ No _________

3. Program Size
   ■ In how many different schools do you provide dental services? _______
   ■ How many children receive services per year? _______
   ■ On average, how many patients are treated per day per school? _______
   ■ Check, if information on patient treated per day is not readily available/unknown _______

4. School Dental Delivery Model
   Please give the percentage of patients from each of these delivery models (the total must be 100%). Please use whole numbers.

   ■ Fixed clinics in a school building _______%
   ■ Mobile van(s) on school property _______%
   ■ Portable equipment/temporary space _______%

5. Time Program Operates
   Please give the months of the year and days of the week that the school dental program operates.

   ■ Months of the year (check months operate)

   |------|------|-------|------|------|------|------|------|-------|-------|-----|------|

   ■ Days of the week (check days operate)

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
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6. Services
What services are provided to children in school clinics? Please check all that apply.

<table>
<thead>
<tr>
<th>Services</th>
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<tbody>
<tr>
<td>Oral Health Education</td>
</tr>
<tr>
<td>Hygienist Screening Exams</td>
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<tr>
<td>Dental Examination by a Dentist</td>
</tr>
<tr>
<td>Dental Examination by a Hygienist</td>
</tr>
<tr>
<td>Radiographs</td>
</tr>
<tr>
<td>Dental Cleanings (e.g. prophies)</td>
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<tr>
<td>Dental Sealants</td>
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<tr>
<td>Fluoride Mouth Rinse</td>
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<tr>
<td>Fluoride Varnish</td>
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<tr>
<td>Fluoride Supplements</td>
</tr>
<tr>
<td>General Dental Care (e.g., fillings, extractions)</td>
</tr>
<tr>
<td>Specialty Care (e.g., orthodontics, oral surgery)</td>
</tr>
<tr>
<td>Other (please list)</td>
</tr>
</tbody>
</table>

7. Referrals
■ What percentage of children is referred to Health Center dental clinics for services?
   _______%
■ What percentage of referred children receives care in Health Center dental clinics?
   _______%
■ Check, if referral information is not readily available/unknown. _______

8. Target Population
■ Please estimate the percentage of different types of patients treated (the total must be 100%).
   Children from designated school _______%  
   Children bused from other K-12 schools _______%  
   Other children and adults _______%
■ Check, if this information is not readily available/unknown. _______

9. Children Grades
■ Please estimate the percentage of children in each grade group (the total must be 100%).
   Pre-school _______%  
   Elementary (grades K-5) _______%  
   Middle School (grades 6-8) _______%  
   High School (grades 9-12) _______%  
   TOTAL 100%

■ Does the program operate outside of regular school hours (e.g., before or after school hours)?
   Yes ________  No _________
10. Program Staffing in Schools
■ How many full-time equivalent (FTE) staff does the Health Center employ to deliver
  services in schools?
    Dentists  _______
    Dental Hygienists  _______
    Dental Assistants  _______
    Others  _______
■ Estimate how many FTE staff, if any, does the school system contribute to the school
dental program? _______
■ Check, if school staff information is not readily available/unknown. _______

11. Payments
Does the Health Center bill for any dental services provided in schools?

    Yes _____ No_______

12. Payments
Does the Health Center receive its usual per patient visit reimbursement rate for Medicaid/
CHIP eligible children treated in schools?

    Yes _____ No_______

13. Financial Reporting
■ Do you receive periodic reports on school program finances(i.e. revenues and
  expenses)?

    Yes _____ No_______
■ If you do receive financial reports, how often do you get them?(Check one)

    Quarterly _____  Annually _____  Other _____

14. Program Payers
■ What percentage of school program revenues is generated from these payers? (the
total must be 100%)
    Medicaid/Child Health Insurance Plan  _________%
    Other federal/state government programs  _________%
    Patient fees  _________%
    Private insurance  _________%
    Private foundations  _________%
    Health Center 330 grant  _________%
    Other  _________%
■ Check, if payer information is not readily available/unknown. _______

15. Can NNOHA staff contact you for follow-up questions?

    Yes _____ No_______
Appendix B

Focus Group Discussion Topics

History
1. What were the circumstances that led you to start the program? Who approached whom?
2. How have you funded the capital expenses of your program...for example buying the portable equipment for mobile or van programs and the build out and dental operatories for fixed clinics?

Operations
3. For those with both medical and dental programs in the schools, how much interaction is there between the medical and dental programs within your SBHCs?
4. What is the process for informing parents about the SBHC dental program and obtaining consent for services?
5. How do you resolve the challenges in obtaining consent?
6. For Health Centers operating their SBHCs in the summer months when schools are closed, how/where do you find adequate number of patients?
7. Most programs appear to refer patients from schools to the home Health Center. What is the actual referral process? Is there any follow-up or tracking of which children are referred and how many make it to the Health Center?
8. What is your clinical (chart) documentation process? Electronic or paper? If electronic, what is the system?
9. What is your billing (encounter) documentation process?

Future
10. How strong is the political and administrative support for the SBHC program within your Health Center and in the schools? Who are the advocates and detractors?
11. What is the relationship of your SBHC program with local dentists?
12. What you do think is the future of your program?
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- Jewish Renaissance Medical Center (Perth Amboy and Newark, NJ)
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The National Network for Oral Health Access (NNOHA) is a nationwide network of Health Center dental providers. These providers understand that oral disease can affect a person’s speech, appearance, health, and quality of life and that inadequate access to oral health services is a significant problem for low-income individuals. The members of NNOHA are committed to improving the overall health of the country’s underserved individuals through increased access to oral health services.

For more information on NNOHA, visit www.nnoha.org, send an email to info@nnoha.org, or call 303-957-0635.