HEALTH CENTERS AND HOSPITAL-BASED DENTISTRY

National Network for Oral Health Access

A White Paper

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1. INTRODUCTION

Health Centers are in a unique position to reach underserved populations suffering from a lack of consistent and affordable access to dental and health care. Increasing access to care, with subsequent identification, prevention and early intervention of dental disease, is the primary goal of a Health Center oral health program. However many patients have not received regular dental care and present with significant untreated pre-existing disease.

Although patients may have access to dental services through Health Center oral health programs, their age, dental condition and history and current health status may complicate treatment in the Health Center setting. Pre-cooperative children and individuals with complex medical, physical, and psychological conditions may require additional management skills and resources to treat pre-existing conditions. While Health Center dental providers have the training and skills to address the majority of their patient population's basic dental needs, some patients may require advanced techniques including sedation or general anesthesia in order to receive treatment. These cases often require resources that are not available in most Health Centers. Specialists performing these advanced techniques frequently do not participate in Medicaid or offer affordable options, such as a sliding fee scale based on income and family size. As a result, Health Center dentists may be unable to address the complex needs of all their patients within the Heath Center facility.

This white paper discusses options for providing oral health services for people with complex medical, physical, and psychological conditions and pre-cooperative children, including the development a hospital-based dental surgery program.

2. THE BURDEN OF DISEASE

Low income and minority groups continue to face significant hurdles in accessing preventive dental care and treatment. While federally subsidized dental care for adults has been curtailed, children and pregnant women remain eligible for care, but face systemic and individual barriers to obtaining services.[1]

Dental caries remains the most prevalent chronic childhood disease in the U.S. It is five times more common than asthma and seven times more common than hay fever.[2] The disease known as *early childhood caries* (ECC) (formerly termed *nursing bottle caries* or *baby bottle tooth decay*) is defined as the presence of one or more decayed (non-cavitated or cavitated lesions), missing (due to caries), or filled surfaces in any primary tooth in a child 6 years or younger.[3] ECC is prevalent among young children, particularly in underserved populations and racial/ethnic minorities.[4] Approximately 75% of ECC is found in approximately 8% of children age 2-5.[5] Compared to other age groups, where caries rates remain unchanged, the caries prevalence in pre-

schoolers has increased to 28%.[6]

In addition to low-income minority children, it has been established that people with chronic medical illnesses, developmental disabilities, and psychosocial issues experience more oral health care problems than others who do not suffer from these conditions. Advances in medicine have increased the likelihood that people today live longer with co-morbidities that would previously have shortened their lifespan.[7] Patients with special needs have also seen a gain in life expectancy. Thirty years ago, for example, the typical person with Down syndrome would have a life expectancy of roughly 12 years compared with 60 years today.[8] Because of these advances, the number of people with special needs who need oral health services is growing dramatically. According to United States Census 2000, roughly 50 million people, or almost 20% of the population, has a long-standing condition or disability.

How familiar is this scenario?

Mrs. X has 2 children under the age of 5. Both children already have dental decay that requires extensive treatment. The family lives far from an academic health center, does not have adequate transportation and is currently enrolled in Medicaid. Unfortunately, there are no dentists nearby who will accept new Medicaid patients or who feel comfortable performing restorative treatment on children less than 6 years old. There are no pediatric dental specialists participating in Medicaid in the region, so the family will have to travel hours for the specialty care they need.

The specifics of this scenario may be different but for many Health Center dental providers, this is a very common and difficult conundrum to resolve. Having dental insurance does not assure access to care.

In addition to those with chronic morbidities or disabilities, the aging population of America also has problems with obtaining basic oral health care services. 3.6% of non-institutionalized United States citizens over age 65 report needing care but are unable to obtain it.[9] The 2000 Surgeon General's Report on Oral Health indicates that people with developmental disabilities are at a significant disadvantage in obtaining hygiene services, have worse hygiene than their non-disabled counterparts, and have an increased need for periodontal treatment compared to the general population.[10] Many of the individuals described need techniques beyond customary dental practice in order to have needed dental work completed.

3. INDICATIONS FOR SEDATION, GENERAL ANESTHESIA AND ALTERNATIVE TECHNIQUES

A number of organizations have developed guidelines for the use of anesthesia and sedation in the dental setting. These are often referred to as guidelines for controlling "pain or anxiety," although anesthesia and sedation may be used for other reasons. The existing guidelines tend to be focused on the use of medications, and most have specific recommendations for

training, techniques of administration, and necessary equipment for the delivery of anesthesia and sedation in conjunction with dental treatment.[11]

As opposed to guidelines produced by organizations that focus on training and technique for delivering sedation and anesthesia, the Special Care Dentistry Association (SCDA) produced guidelines that focus on the indications and alternatives for using these modalities.[12] These guidelines recommend analyzing the risks and benefits of anesthesia, sedation or alternative techniques based on multiple individual factors and making a decision for which technique to recommend based on a thorough review of the patient's individual medical, physical, psychological, and social condition. According to the SCDA guidelines, some of the characteristics of people who can benefit from sedation, anesthesia or alternative techniques include:

- Individuals with cognitive impairment or emotional conditions who have difficulty understanding what is expected in a dental treatment situation.
- Patients whose fear about receiving dental treatment prevents them from receiving the needed treatment.
- Patients who are unable to sit in a dental chair or remain still enough to have dental procedures performed.
- Patients who have extensive dental needs that would require extended dental treatment over a prolonged period of time.
- Patients who require dental procedures that cannot easily be performed with local anesthesia because of an inability to achieve adequate local anesthesia for that procedure.
- Individuals with complex medical problems who require intra- and peri-operative monitoring.
- Individuals with complex medical problems (e.g., severe hypertension and cardiac or respiratory disease) whose physiologic state will be more safely controlled in a sedated or anesthetized state.

In addition to characteristics of people who can benefit from sedation, anesthesia or alternative techniques, the SCDA guidelines list several categories of techniques that can be used to provide dental treatment and improve the oral health of these individuals. These categories are:

- **General anesthesia delivered in hospitals, surgical centers, and dental offices** — This is the most complex and expensive mode of treatment listed and the one that carries the most risk. However, in some patients with complex medical, physical, and psychological conditions it may be the best and safest way to complete a course of dental treatment.
- **Sedation** — Ranging from minimal sedation to deep sedation. At one end of the spectrum, minimal sedation may be administered in outpatient settings and may be effective for people needing a little pharmacological assistance completing a dental procedure. At the other end of the spectrum deep sedation requires similar training and monitoring equipment

to certain general anesthesia techniques and carries concomitant risk.

- **Behavior support** — There are many behavior support techniques that can be used to help people complete a course of dental treatment.[13] They range from "tell-show-do" to sophisticated applied behavior analysis using behavioral analysis and reward systems. The most successful providers use a variety of techniques and a combination of techniques for different individuals and at different times. These techniques carry less risk than pharmacological methods.
- **Physical support** — Some people can be helped to complete a course of dental treatment using some form of physical support. This can involve positioning the patient to be more comfortable in the dental chair to have a member of the dental team or a caregiver hold the patient in some way to prevent them from interfering with treatment procedures. These techniques can be used alone or in conjunction with behavioral supports.
- **Psychological support** — Most people, up to 75%, have some nervousness about receiving dental treatment. There are a number of techniques for reducing people's fears and helping them receive dental treatment in a more normal manner.[14] These techniques range can overlap with behavioral supports and include "voice control" and relaxation techniques. They can also include aspects of cognitive therapy and systematic desensitization.
- **Social support and prevention strategies** — There are many people who can be helped to receive dental treatment without needing sedation or general anesthesia if their social support system can be enlisted.[15] This system can include parents or direct caregivers, employees of social or advocacy agencies, and general and social or educational professionals who work with that individual. People in the social support system can help prepare the individual for dental visits through a variety of techniques like role-playing and the use of "social stories". In addition if the individual and/or their social support system can effectively employ modern preventive techniques they can reduce the amount of dental treatment needed.

As is evident from the considerations above, there are numerous techniques for working with people with complex medical, physical, and psychological conditions. It is in the best interest of individuals in these categories if Health Center dentists, allied professionals and staff are familiar with and trained in all the techniques described here. By mastering the supportive techniques dental providers are able to reduce the number of people for whom they recommend using sedation and general anesthesia, and are in a much better position to recommend the most appropriate treatment for an individual patient.

4. OPTIONS FOR HOSPITAL DENTISTRY OR DENTAL CARE WITH SEDATION OR ANESTHESIA

If, after consideration of the circumstances and alternatives listed above, a Health Center dentist has decided a patient would benefit from having his or her dental treatment performed in a hospital, the dentist will need to either establish a source to

refer that patient to or join the staff of a hospital where they can treat the patient themselves. There are a number of options Health Centers can consider for accessing hospital based dental care for their patients:

- **Develop a list of referral sources:** Some Health Centers may conclude that it is easiest to develop a list of dentists unconnected to the Health Center where patients can be referred. In some cases this option is necessary because the dentists who work at the Health Center are not trained or could not be credentialed to join the hospital staff. In other cases this is the best option because of the encounter-based billing system, which could result in a dentist spending many hours arranging and performing a hospital case and only being able to bill for a single encounter.

- **Integrate sedation or general anesthesia services within the Health Center:** In many communities there are medical or dental anesthesiologists who will bring portable equipment into the Health Center and provide sedation or anesthesia services on-site. The financial challenges described above may apply to this option as well since the Health Center may only be able to get reimbursed for a single encounter no matter how long the procedure takes.
- **Set up an affiliated non-encounter-based dental practice:** The Health Center could set up or contract with another dental practice that can use fee-for-service billing when performing hospital cases. It may also be necessary to train one or more dentists to be credentialed and join the hospital staff and perform hospital cases. Some dental schools have sedation capacity at the faculty teaching clinics. If the health center is affiliated with a dental school, for example as a rotation site, then it may refer the patient out to the faculty clinic for sedation-required dental procedure. Fee schedule needs to be discussed and planned out between the health center and the teaching clinic.
- **Establish a hospital-based dentistry program:** Under this option a Health Center dentist would have or obtain the necessary training to join a hospital staff and become credentialed to perform dental procedures on health center patients in the hospital operating room with a patient under sedation or general anesthesia.

Note that, depending on how they are structured, any of these options may require the health center to apply for a "Change in Scope". (See Section 6)

5. DEVELOPING A HEALTH CENTER HOSPITAL BASED DENTISTRY PROGRAM

There are resources available to guide a dental program in setting up a hospital operating room and performing dental work in a hospital.[16] A Dental Director should first ask if a hospital-based program is indicated. Can the needs of that segment of

the Health Center population that would benefit from having their dental treatment performed in a hospital be met by one of the previously listed options? Conducting a community needs assessment creates an accurate picture of available resources. Appendix A provides the steps Health Centers may take in considering this approach.

Once a need for a hospital-based program has been established, the fiscal viability of the program must be determined. It is important to create an operation and capital expense budget, and identify the cost for staffing, supplies, and capital equipment. A business plan will forecast if the project can be profitable or at least self-sustaining. It is important to predict the payer mix and how this may affect the bottom line. How the state Medicaid agency pays the Health Center for hospital-based dental services critically affects the program sustainability. Hospital-based programs reimbursed using the cost-based PPS reimbursement may not be as sustainable compared to those programs reimbursed using a fee-for service methodology.

6. SCOPE OF PROJECT/CHANGE IN SCOPE

Health Centers funded by the Health Resources and Services Administration (HRSA) under Section 330 of the Public Health Service Act receive grant funds to provide a certain range of primary health care services to a target population in a specific service area. Collectively, these characteristics comprise the Health Center's scope of project. Health Centers can obtain federal approval to provide "supplemental health services" which can include "dental services other than those provided as primary health services" through a "Change in Scope" request. It should be noted that as part of this request, the health center must demonstrate that the request will not require any additional section 330 funding in order to be accomplished. If additional federal funds are needed to implement the change, a request for additional grant funds may be submitted as part of a competitive grant application to expand services. Once a service is within the federal scope of project that it must be accessible to all patients, regardless of payer source, and available on the health center's sliding fee scale.

The scope of project defines the service sites, providers, services, target population, and service area for which section 330 grant funds and related project income may be used. In addition, inclusion in the scope of project is important because it:

- Determines the maximum potential scope of coverage for the Health Center Federal Torts Claim Act (FTCA) Program, which provides medical malpractice coverage for Health Centers and its providers/employees.
- Defines the approved service sites and services necessary for State Medicaid Offices to calculate payment rates.
- Defines the approved service sites and services necessary for the Centers for Medicare and Medicaid Services (CMS) to

determine a Health Center's eligibility for Medicare cost-based reimbursement. Currently there are no dental benefits from Medicare.[17]

While inclusion in the scope of project is necessary for participation in FTCA and FQHC payment rate programs, it does not guarantee that the health center will be able to participate in these programs. These programs have their own specific application processes and requirements, of which inclusion in the scope of project is only one.

Whenever there is a significant change in the scope or nature of project activities, a Health Center must request a change in scope.[18] To implement hospital based dentistry a Health Center may need to submit multiple "Change-in-Scope" requests to add sites and services, as applicable. Please see HRSA/BPHC Scope of Project Policies on the HRSA website: http://bphc.hrsa.gov/policiesregulations/policies/managefinance.html.

7. ENGAGING PARTNERS

Successful development of a hospital-based dental program depends on support by community dental providers and provides an opportunity for collaboration with organized dentistry. In addition, non-dental advocates in the community (i.e. school nurses, teachers, medical providers) should be engaged to increase the probability of success.

Many smaller hospitals may be unfamiliar with dental practice. During the community needs assessment phase of planning, the opinions of key hospital administrators should be solicited and educational outreach about the benefits of a hospital-based dental program implemented if needed.

Hospital capacity is also a factor in how a potential dental program might be viewed by administrators. If the hospital has available operating room (OR) capacity, i.e., they do not have a full OR schedule for their anesthesiologists, then it is more likely to be supportive of a proposal to utilize OR capacity for a dental program. In other facilities, dental providers may find it difficult to gain equal opportunity in scheduling OR time.

8. RECRUITMENT, CREDENTIALING AND PRIVILEGING OF STAFF

Although the first choice for providing care in a hospital setting may be a dentist on the Health Center staff, there are creative ways to procure dental providers. Aside from hiring or contracting with community dentists, by partnering with dental

schools, pediatric dental residents/fellows and/or Advanced Education in General Dentistry / General Practice Residency (AEGD/GPR) residents can be contracted to provide these specialty services. The American Academy of Pediatric Dentistry (AAPD) contains a list of pediatric training and fellowship programs with which to consider collaborating at: http://www.aapd.org/training/. The American Dental Association (ADA) maintains a listing of advanced education programs including AEGD and GPR programs at: http://www.ada.org/5502.aspx.

Obtaining hospital privileges may take several weeks or months. Each hospital has its own credentialing requirements. Some hospitals desire the dental provider to be Board Eligible or Certified in an appropriate specialty, but there is local variability. Many dentists applying for hospital privileges find it advantageous to have a sponsor facilitate the credentialing process. This may be a physician from the Health Center that is on the medical staff of the hospital, a local oral surgeon on staff at the hospital, or other local health official. Additionally, the Health Center will want to credential experienced dental assistants to assist in the OR as most surgical nurses are not familiar with dental techniques and materials.

9. EQUIPMENT NEEDS

Building a hospital-based program requires specific equipment for the operating room. There is a diverse range of equipment, from very high-tech and expensive machinery to simple devices that help provide care to patients. What each program can put together is dependent on the budget and the anticipated needs of the patients.

Equipment necessary in the OR includes:

- Self-contained, portable treatment unit (compressor, vacuum unit)
- Dental Handpieces
- Light curing unit
- Amalgamator
- Supply cabinet for hand instruments, dental materials and all other disposables
- Portable X-ray unit
- X-ray processor if Digital Film Sensor is not used
- Laptop computer if electronic chart and digital X-Ray system is used for images and charting. This is in addition to the hospital chart.

10. INSURANCE PRE-AUTHORIZATION/CASE MANAGEMENT

Prior to the delivery of dental care under general anesthesia, insurance companies will require appropriate documentation for reimbursement of general anesthesia services. In addition informed consent must be acquired; instructions must be provided to the parent/guardian or patient including dietary precautions. The patient's primary care provider must also perform a pre-operative health evaluation.

The following process is common protocol that must be completed, but it may vary locally. The process typically includes:

- A physical exam scheduled within 7 days before the posted OR date. This could vary with different hospitals. Check with the hospital OR protocol.
- Two insurance pre-authorizations – one for the patient's medical insurance to cover the hospital's fees (facility and anesthesia costs) and one for the patient's dental insurance to cover the proposed treatment plan (pre-authorization request).
- A completed ADA Pre-authorization claim form, which must specify Hospital as the place of treatment on line item #38. Link to the ADA claim form: http://www.ada.org/prof/resources/topics/topics_claimform.pdf

One of the most effective strategies is to budget the position of a case manager into the proposal for developing hospital-based dental services. Specifically, a case manager for a hospital-based dental program may:

- Optimize OR utilization (i.e. posting a "stand-by" case in the event of a cancellation and looking for any additional available OR time);
- Obtain all prior authorizations required by insurers;
- Assure all official procedures/forms are complete prior to surgery;
- Interpret all patient information forms for non-English speaking patients (i.e. discharge instructions, may populate patient demographics on hospital forms);
- Be available for interpretation on site (i.e. pre-op and recovery rooms) as needed;
- Discuss the patient's and/or caregiver's concerns, questions about surgery, sedation, (i.e. explains what to expect and how to navigate the hospital, calls patient/family day before and day after surgery);
- Confirm surgery dates with the hospital, providers and family;
- Facilitate the transportation needs of the patient/family;

- Coordinate and prepare the surgery calendar for hospital dentists;
- Share data for reporting purposes;
- Work with Social Services, Child Protective Services and other agencies (i.e. Head Start) to assure access to needed care;
- Work with the billing office, and Health Center's medical and dental providers as a liaison to improve communication; and
- Work with the Dental Director to develop tools that facilitate referrals, to prioritize cases and determine length of surgery times to improve scheduling.

Parent education brochures that address many of the questions parents and caregivers have regarding dental care for their young children and sedation can be found at the following American Academy of Pediatric Dentistry site: http://www.aapd.org/pediatricinformation/brochurelist.asp

11. QUALITY ASSURANCE

Understanding and awareness of the importance of quality in the hospital setting and the external hospital accrediting organizations, and national, state and local health standards that insure quality, are critical for dental providers practicing in the hospital setting. The two most well known accrediting organizations are:

- The Joint Commission: http://www.jointcommission.org
- Accreditation Association for Ambulatory Health Care: www.aaahc.org

Even though all hospitals are accredited by The Joint Commission and have quality improvement programs in place, any Health Center with a hospital-based program should conduct specific quality improvement activities on patients seen in the hospital setting, such as assuring hospital notes are transferred into the Health Center patient record and using the existing dental clinic quality improvement system to follow up and address poor clinical outcomes.

12. PROGRAM EVALUATION

An ongoing evaluation process allows the Health Center to determine if a particular program has been successful. Evaluation accomplishes several important tasks, including:

- Builds accountability into programs; assuring good value for money invested;

- Helps program planners and administrators learn from mistakes, and make midcourse corrections;
- Helps over-burdened communities avoid unsuccessful reproduction of programs that are not suited for their needs, and conversely, helps communities tailor successful programs to meet their circumstances;
- Documents successful outcomes that provide a factual foundation upon which leaders in the oral health community can then build further financial, programmatic, and policy support; and
- Builds recognition for programs.

13. SUMMARY

Health Center patients generally have a large burden of oral disease and can be complex to treat. Ideally, their needs would be addressed through prevention or routine treatment. In some cases additional techniques such as behavior and physical or psychological support can be useful. In those circumstances where sedation or general anesthesia is needed outside resources can be enlisted such as contracting with providers or pursuing academic collaborations.

In other circumstances, the best solution may be to for a Health Center dentist to join a hospital staff and bring Health Center patients to the hospital. The local factors and challenges will differ from one Health Center to another. While understanding that prevention should be the primary focus of Health Center oral health programs, Health Centers should consider developing new programs, such as hospital-based dentistry, if appropriate to better serve the needs of their patients and their community.

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18. HRSA – "The Health Center Program: Change in Scope": http://bphc.hrsa.gov/scope/

FREQUENTLY ASKED QUESTIONS

Q: I have a child with extensive dental needs that requires general anesthesia but is not insured and has limited resources, how can I assure that that this care is compensated (for both the hospital and our Health Center)?

A: The Hospital Survey and Construction Act, also known as the **Hill-Burton Act**, is a United States federal law passed in 1946. Facilities that received federal funding to add beds to their hospital were also required to provide a 'reasonable volume' of free care each year for those residents in the facility's area who needed care but could not afford to pay. In 1975, the Act was amended and became Title XVI of the Public Health Service Act. Working with the finance office of the hospital, your patient may be qualified to receive these funds. Title V funding can also be used for outpatient surgery charges in some states that dedicate a portion of these funds for oral health services. Uninsured children without other resources are candidates.

Q: I want to add a dental service that's not currently in the health center's federally approved scope of project, such as hospital-based dental services, to our Health Center's dental program, how far in advance will I need to request a Change in Scope when adding these services to our Health Center's project scope?

A: Health Centers should request approval for changes in scope **at least 60-90 days before the planned date of implementation of the program. Note that the health center may need to submit multiple Change in Scope requests.** Please see HRSA/BPHC Scope of Project Policies on the HRSA website: http://bphc.hrsa.gov/policiesregulations/policies/managefinance.html

Q: Our state Medicaid program wishes to compensate the care we provide in the operating room on a cost-based reimbursement rate (determined by the cost of our office-based dental care), how can we afford to provide comprehensive care in the hospital setting under this arrangement?

A: It is unlikely that the program can sustain itself on cost-based reimbursement so other partnership opportunities must be explored that would afford your hospital provider to be reimbursed fee-for-service. Partnering with a dental school, local health office or other organizations are options that may need to be considered. Or perhaps you can work with your State Dental Director and Medicaid administrators for a special carve-out agreement. Regardless of how you get there, you will need to pull together all of the various stakeholders to work out a solution.

Q: What competencies or proficiencies should a dentist providing hospital-based care have? Do I need to be a pediatric dentist? I am a GP—can I be the OR provider?

A: Many hospitals require advanced training for credentialing such as hospital-based post-doctoral training programs (General Practice Residency or Advance Education in General Dentistry Residency, pediatric residency). Additionally, experience and comfort in providing common pediatric dental procedures (i.e. pulpal therapies, space maintenance and stainless steel and composite crowns) is necessary if you will be treating children. This is why sponsors/proctors/mentors are required initially for the first few OR cases. Ability to work with electronic medical records and hospital-based documentation is also necessary.

LINKS

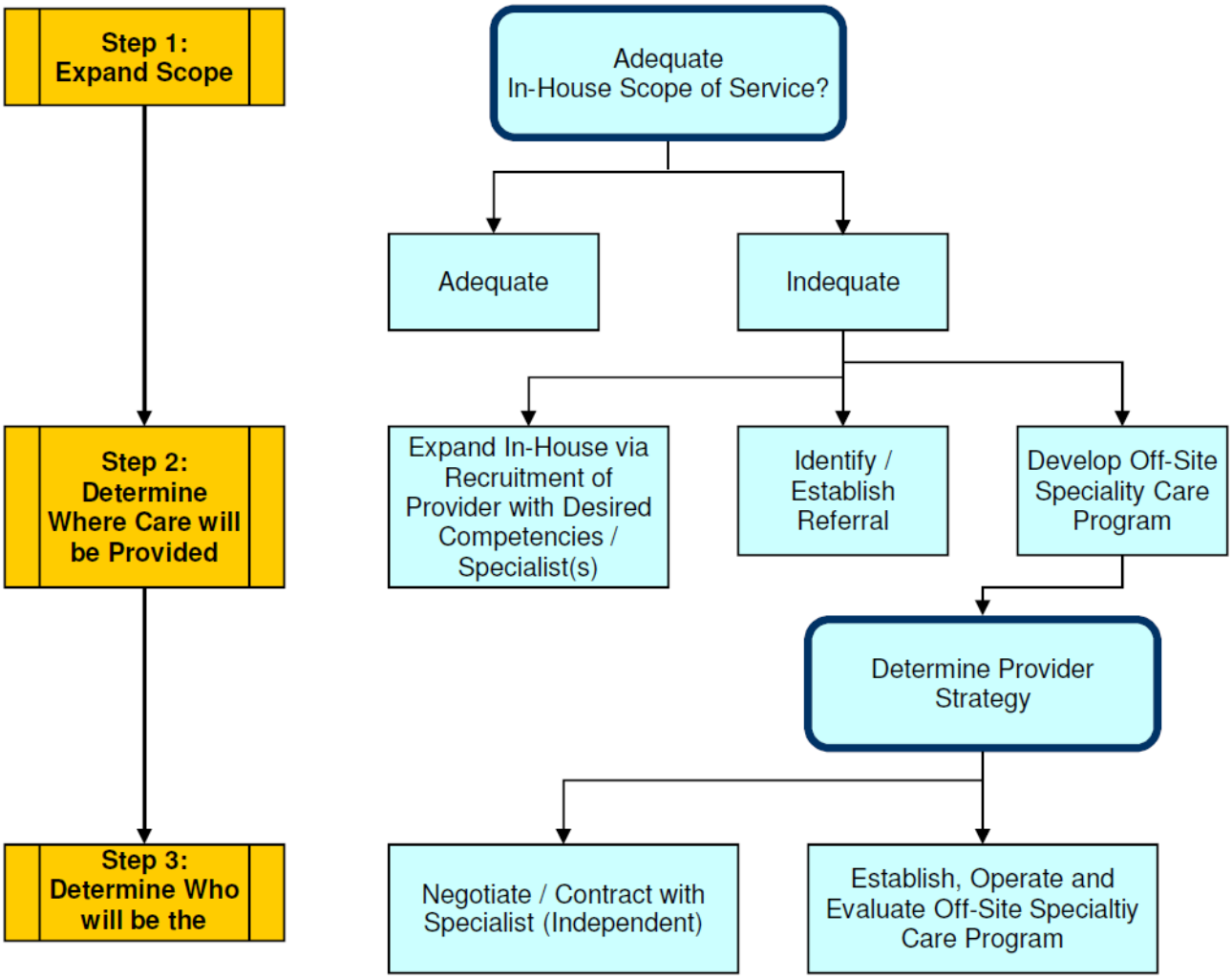
- Accreditation Association for Ambulatory Health Care: www.aaahc.org
- American Association for Community Dental Programs – *A Guide for Developing and Enhancing Community Oral Health Programs* designed to help Local Public Health Associations: http://www.aacdp.com/guide/execsummary.html.
- AACDP – *A Model Framework for Community Oral Health Programs: Based Upon the Ten Essential Public Health Services*: http://www.aacdp.com/docs/Framework.pdf.
- American Academy of Pediatric Dentistry: www.aapd.org
- Association of State and Territorial Dental Directors: http://www.astdd.orgASTDD – *Assessing Oral Health Needs: ASTDD Seven Step Model*: http://www.astdd.org/oral-health-assessment-7-step-model/.
- Children's Dental Health Project – *Increasing Access to Dental Care through Public/Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers*: http://cthealth.org/matriarch/documents/handbook.pdf
- The Joint Commission: http://www.jointcommission.org
- National Guideline Clearinghouse – Guideline on Behavior Guidance for the Pediatric Dental Patient: http://www.guideline.gov/summary/summary.aspx?doc_id=14224
- Special Care Dentistry Association: http://www.scdonline.org/

Portable Equipment :

- A-dec, Inc.: www.adec.com
- Aseptico: www.aseptico.com
- ASI Medical, Inc.: www.asimedical.net
- Bell Dental Products: www.belldental.com
- DNTLworks: www.DNTLworks.com
- I-Tec: www.itecusa.org
- M-DEC (Mobile Dental Equipment Corporation): www.portabledentistry.com
- Safari Dental: www.safaridental.com

Appendix A:

Decision Flow Chart of Necessary Steps to Integrate Specialty Care Services



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NNOHA
National Network for Oral Health Access

The **National Network for Oral Health Access** (NNOHA) is a nationwide network of dental providers who care for patients in safety-net systems. 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.

“The mission of the National Network for Oral Health Access (NNOHA) is to improve the oral health of underserved populations and contribute to overall health through leadership, advocacy, and support to oral health providers in safety-net systems.”

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