

Oral Health Resources Inventory 2011

1. Oregon's Oral Health Resources Inventory 2011

The purpose of this survey is to document current available oral health resources in Oregon. It is designed to identify and assess current resources being used for oral health in each county, such as service delivery, promotion and prevention activities, and programs addressing oral health and dental care.

The results of this survey will help identify local areas of need and determine how best to maximize the use of resources to improve access to oral health services and reduce rates of oral health disease. Survey results will be included along with other relevant data at the county level to create county profiles that will be available online for easy access.

You may receive a follow-up phone call to clarify or gather more information about your organization.

This survey will take approximately 30 minutes to finish. Thank you for spending your time and assisting our efforts to improve the oral health of all Oregonians!

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2. Survey Respondent Information

Please provide your contact information so that we may follow-up with you if we have any questions or need additional information.

Survey Respondent Information

Name:

Position/Title:

Organization:

Email Address:

Phone Number:

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3. Secondary Contact

In case you are not available for follow-up, please provide contact information for a secondary contact person.

Additional Contact Information

Name:

Position/Title:

Organization:

Email Address:

Phone Number:

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4. Organization Information

The next set of questions is about your organization.

Please indicate among the choices below, the practice setting types that best describe your organization. Check all that apply.

- Safety Net Clinic
 - FQHC - Federally Qualified Health Center
 - RHC - Rural Health Center
 - IHS - Indian Health Service Clinic
 - Tribal Clinic
 - VA Hospital or Military
 - Head Start
 - Advocacy/Service Group
 - School-Based Health Center
 - School-Based Program
 - County Health Department
 - Other (please specify)
- County Health Department with Clinic(s)
 - Migrant Health Center
 - Community-Based Program
 - Homeless Health Center
 - Nursing Home/Assisted Living
 - General Medical-Surgical Hospital
 - Dental Care Organization
 - Academic Institution
 - Limited Access Settings (LAP work site)
 - Volunteer Agency (e.g. Rotary)

Organization Information

Name of Organization:

Address:

Address 2:

City/Town:

State:

ZIP/Postal Code:

County:

Website:

Main Phone Number:

Additional Phone Numbers

Dental/Oral Health Clinic:

Other:

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Do you have more than one facility?

Yes

No

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5. Additional Facilities Information

Organization Information

Name of Other Facility:

Address:

Address 2:

City/Town:

State:

ZIP/Postal Code:

County:

Website:

Main Phone Number:

Additional Phone Numbers

Dental/Oral Health Clinic:

Other:

Do you have another facility to add?

Yes

No

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6. Additional Facilities Information

Organization Information

Name of Other Facility:

Address:

Address 2:

City/Town:

State:

ZIP/Postal Code:

County:

Website:

Main Phone Number:

Additional Phone Numbers

Dental/Oral Health Clinic:

Other:

Do you have another facility to add?

Yes

No

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7. Additional Facilities Information

Organization Information

Name of Other Facility:

Address:

Address 2:

City/Town:

State:

ZIP/Postal Code:

County:

Website:

Main Phone Number:

Additional Phone Numbers

Dental/Oral Health Clinic:

Other:

Do you have another facility to add?

Yes

No

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8. Additional Facilities Information

Organization Information

Name of Other Facility:

Address:

Address 2:

City/Town:

State:

ZIP/Postal Code:

County:

Website:

Main Phone Number:

Additional Phone Numbers

Dental/Oral Health Clinic:

Other:

Do you have another facility to add?

Yes

No

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9. Additional Facilities Information

Organization Information

Name of Other Facility:

Address:

Address 2:

City/Town:

State:

ZIP/Postal Code:

County:

Website:

Main Phone Number:

Additional Phone Numbers

Dental/Oral Health Clinic:

Other:

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10. Organizational Practice

The next set of questions is designed to understand how your organization and/or facility(s) provide oral health services.

Does your organization provide dental/oral health services directly?

Yes

No

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11. On-site Dental/Oral Health Services

On-site services mean a fixed dental operator (a working space with equipment) within your facility or a dental professional providing preventive dental/oral health services within your facility.

Do you provide on-site dental/oral health services?

Yes

No

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12. On-site Dental/Oral Health Services

On-site services mean a fixed dental clinic space (a working space with equipment) within your facility or a dental professional providing preventive dental/oral health services within your facility.

How many fixed dental facilities (clinics) do you have?

of Fixed Dental Facilities

Number

What dental/oral health service(s) do you provide at your on-site facility(s)? Please check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Educational Programs | <input type="checkbox"/> Endodontic |
| <input type="checkbox"/> Screenings | <input type="checkbox"/> Periodontic |
| <input type="checkbox"/> Diagnostic | <input type="checkbox"/> Orthodontic |
| <input type="checkbox"/> Emergency Care | <input type="checkbox"/> Prosthodontic - Removable |
| <input type="checkbox"/> Preventive | <input type="checkbox"/> Oral & Maxillofacial Surgery |
| <input type="checkbox"/> Restorative | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> General Dentistry | <input type="checkbox"/> Prosthetics - Fixed |
| <input type="checkbox"/> Pediatric Dentistry | <input type="checkbox"/> Referrals |
| <input type="checkbox"/> Other (please specify) | |

How many dental units or operatories do you have at your facility(s)?

of Dental Units

Number

How many days each week are the dental units or operatories used?

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What preventive services are you providing at your on-site facility(s)? Please check all that apply.

- Cleanings
- Dental Sealants
- Fluoride Varnish
- Other Fluoride Therapies (gels, foams, rinses)
- Sports/Mouth Guards
- Night Guards
- Oral Health Prevention Education
- Caries Risk Assessment
- Other (please specify)

Approximately how many patients do you provide dental/oral health services for each week at your on-site facility(s)?

Number

What are the hours of operation of your facility(s)?

Does your on-site facility(s) exclude any dental/oral health services?
Please list the specific services and explain why they are excluded.

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Which dental/oral health services does your facility(s) refer patients out to? Please check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Educational Programs | <input type="checkbox"/> Endodontic |
| <input type="checkbox"/> Screenings | <input type="checkbox"/> Periodontic |
| <input type="checkbox"/> Diagnostic | <input type="checkbox"/> Orthodontic |
| <input type="checkbox"/> Emergency Care | <input type="checkbox"/> Prosthodontic - Removable |
| <input type="checkbox"/> Preventive | <input type="checkbox"/> Oral & Maxillofacial Surgery |
| <input type="checkbox"/> Restorative | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> General Dentistry | <input type="checkbox"/> Oral Pathology |
| <input type="checkbox"/> Pediatric Dentistry | <input type="checkbox"/> Prosthetics - Fixed |
| <input type="checkbox"/> Other (please specify) | |

Please identify any specific providers you provide referrals to.

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13. Portable Dental Units

A portable dental unit is a unit designed to provide preventive dental/oral health services, such as dental sealants, and may be moved to another location in a vehicle.

Do you have any portable dental units?

Yes

No

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14. Portable Dental Units

A portable dental unit is a unit designed to provide preventive dental/oral health services, such as dental sealants, and may be moved to another location in a vehicle.

How many portable dental units do you have?

	# of Units
Number	<input type="text" value="6"/>

What dental/oral health service(s) do you provide with your portable dental unit(s)? Please check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Educational Programs | <input type="checkbox"/> Endodontic |
| <input type="checkbox"/> Screenings | <input type="checkbox"/> Periodontic |
| <input type="checkbox"/> Diagnostic | <input type="checkbox"/> Orthodontic |
| <input type="checkbox"/> Emergency Care | <input type="checkbox"/> Prosthodontic - Removable |
| <input type="checkbox"/> Preventive | <input type="checkbox"/> Oral & Maxillofacial Surgery |
| <input type="checkbox"/> Restorative | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> General Dentistry | <input type="checkbox"/> Prosthetics - Fixed |
| <input type="checkbox"/> Pediatric Dentistry | |
| <input type="checkbox"/> Other (please specify) | |

How often do you provide the above services with your portable dental unit(s)? For example, 3 days per month, twice a week, etc.

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15. Off-Site Mobile/Van Services

A mobile dental van means a vehicle that houses a dental operatory or more. Your organization may own the van or it may be provided through an agreement with another organization.

Does your organization provide off-site dental/oral health services utilizing a mobile vehicle such as a van or trailer?

Yes

No

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16. Off-Site Mobile/Van Services

A mobile dental van means a vehicle that houses a dental operatory or more. Your organization may own the van or it may be provided through an agreement with another organization.

What oral health service(s) do you provide through a mobile dental van? Please check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Educational Programs | <input type="checkbox"/> ITR - Interim Therapeutic Restorations |
| <input type="checkbox"/> Screenings | <input type="checkbox"/> Endodontic |
| <input type="checkbox"/> Diagnostic | <input type="checkbox"/> Periodontic |
| <input type="checkbox"/> Emergency Care | <input type="checkbox"/> Orthodontic |
| <input type="checkbox"/> Preventive | <input type="checkbox"/> Prosthodontic - Removable |
| <input type="checkbox"/> Restorative | <input type="checkbox"/> Oral & Maxillofacial Surgery |
| <input type="checkbox"/> General Dentistry | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Pediatric Dentistry | <input type="checkbox"/> Prosthetics - Fixed |
| <input type="checkbox"/> Other (please specify) | |

How often do you provide services through the mobile dental van? For example, twice a month, 10 patients each week, etc.

What preventive dental/oral health service(s) are you providing in the mobile dental van? Please check all that apply.

- Cleanings
- Dental Sealants
- Fluoride Varnish
- Other Fluoride Therapies (gels, foams, rinses)
- Sports/Mouth Guards
- Night Guards
- Oral Health Prevention Education
- Caries Risk Assessment
- Other (please specify)

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Approximately how many patients do you provide dental/oral health services for in the mobile dental van per year?

Number

Does your mobile dental van exclude any dental/oral health services?
Please list the specific services and explain why they are excluded.

Which dental/oral health services does your mobile dental van refer patients out to? Please check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Educational Programs | <input type="checkbox"/> Endodontic |
| <input type="checkbox"/> Screenings | <input type="checkbox"/> Periodontic |
| <input type="checkbox"/> Diagnostic | <input type="checkbox"/> Orthodontic |
| <input type="checkbox"/> Emergency Care | <input type="checkbox"/> Prosthodontic - Removable |
| <input type="checkbox"/> Preventive | <input type="checkbox"/> Oral & Maxillofacial Surgery |
| <input type="checkbox"/> Restorative | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> General Dentistry | <input type="checkbox"/> Oral Pathology |
| <input type="checkbox"/> Pediatric Dentistry | <input type="checkbox"/> Prosthetics - Fixed |
| <input type="checkbox"/> Other (please specify) | |

Please identify any specific providers you provide referrals to.

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17. Contracted Dental/Oral Health Services

A contracted dental provider means a dentist who provides dental services to your organization's patients at his or her private office, another organization with a dental clinic, or a Limited Access Permit (LAP) dental hygienist who provides services in the field.

Does your organization provide any dental/oral health service(s) through a contracted dental provider?

Yes

No

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18. Contracted Dental/Oral Health Services

A contracted dental provider means a dentist who provides dental services to your organization's patients at his or her private office, another organization with a dental clinic, or a Limited Access Permit (LAP) dental hygienist who provides services in the field.

Approximately how many patients does your organization refer out to a contracted dental provider(s)? For example, 5 patients each week, 20 per month, etc.

What dental/oral health service(s) does your organization provide through a contracted dental provider(s)? Please check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Educational Programs | <input type="checkbox"/> Periodontic |
| <input type="checkbox"/> Screenings | <input type="checkbox"/> Orthodontic |
| <input type="checkbox"/> Diagnostic | <input type="checkbox"/> Prosthodontic - Removable |
| <input type="checkbox"/> Emergency Care | <input type="checkbox"/> Oral & Maxillofacial Surgery |
| <input type="checkbox"/> Preventive | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Restorative | <input type="checkbox"/> Oral Medicine |
| <input type="checkbox"/> General Dentistry | <input type="checkbox"/> Oral Pathology |
| <input type="checkbox"/> Pediatric Dentistry | <input type="checkbox"/> Prosthetics - Fixed |
| <input type="checkbox"/> Endodontic | |
| <input type="checkbox"/> Other (please specify) | |

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What preventive dental/oral health service(s) are provided through a contracted LAP dental hygienist? Please check all that apply.

- Screenings
- Cleanings
- Dental Sealants
- Fluoride Varnish
- Other Fluoride Therapies (gels, foams, rinses)
- Oral Health Prevention Education
- Caries Risk Assessment
- Periodontal Scaling
- Prosthetics - Temporary Soft Denture Relines
- Other (please specify)

Are there any dental/oral health services which are excluded through your contracted dental provider(s)?

Please list the specific services and explain why they are excluded.

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Which dental/oral health services does your organization refer patients out to beyond those provided by your contracted dental provider(s)? Please check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Educational Programs | <input type="checkbox"/> Periodontic |
| <input type="checkbox"/> Screenings | <input type="checkbox"/> Orthodontic |
| <input type="checkbox"/> Diagnostic | <input type="checkbox"/> Prosthodontic - Removable |
| <input type="checkbox"/> Emergency Care | <input type="checkbox"/> Oral & Maxillofacial Surgery |
| <input type="checkbox"/> Preventive | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Restorative | <input type="checkbox"/> Oral Medicine |
| <input type="checkbox"/> General Dentistry | <input type="checkbox"/> Oral Pathology |
| <input type="checkbox"/> Pediatric Dentistry | <input type="checkbox"/> Prosthetics - Fixed |
| <input type="checkbox"/> Endodontic | |
| <input type="checkbox"/> Other (please specify) | |

Please identify any specific providers you provide referrals to.

	5
	6

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19. Collaboration Within Organization

Some organizations coordinate care between dental/oral health services and other health programs. Please take a moment to tell us about health services your organization coordinates.

Is there collaboration between programs within your organization? For example, dental care and diabetes prevention program.

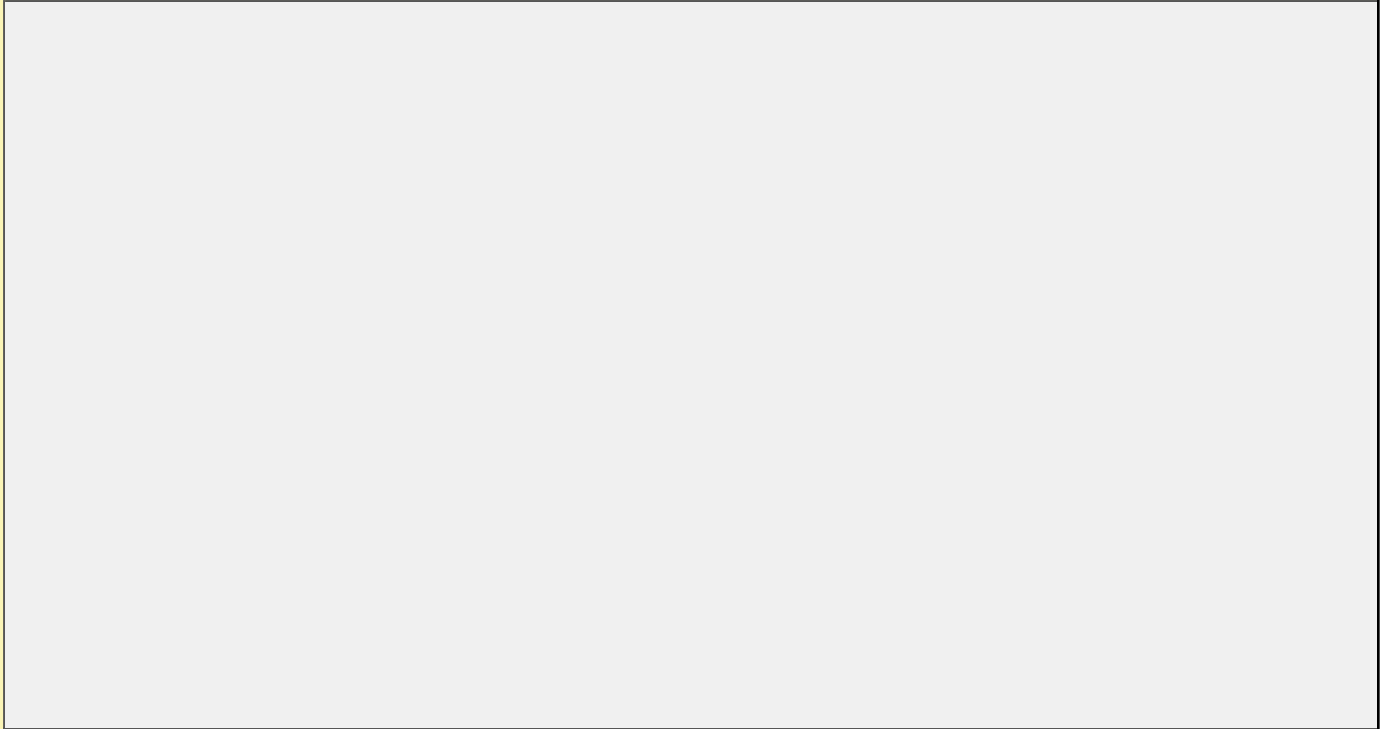
Yes

No

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20. Collaboration Within Organization

How do the programs collaborate on patient care? Please describe.



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21. Community Collaboration

Providing communities with effective dental/oral health services often involves working with other groups and organizations to improve outcomes and increase access to oral health care and preventive services. In this next set of questions, partnerships are defined as any group of two or more stakeholders working together on a common issue or goal.

Is your organization currently, or has your organization ever been involved in a collaboration or partnership?

Yes

No

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22. Community Collaboration

Partnerships are defined as any group of two or more stakeholders working together on a common issue or goal.

Who is your organization currently working with, or has worked with on a collaboration or partnership? Please list the organization(s).

Please describe the project, issue or goal that you are/were working on?

What are/were the outcomes for the collaboration or partnership?

Is there any organization(s) that you would like to partner with to work on increasing access to oral health care and preventive services? Please list the specific organization(s).

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If you have a strategic or action plan that you would like to share with us, please check yes and we will follow-up with you to receive a copy of it.

Yes

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23. Future Plans for Adding or Discontinuing Dental/Oral Health Services

Adding new services can also mean enhancing existing services. Discontinuing services can also mean decreasing existing services.

Do you have any future plans to add or discontinue any dental/oral health services or programs that your organization currently provides?

- Yes - add to current services
- Yes - discontinue some current services
- No

Other (please specify)

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24. Future Plans for Adding Dental/Oral Health Services

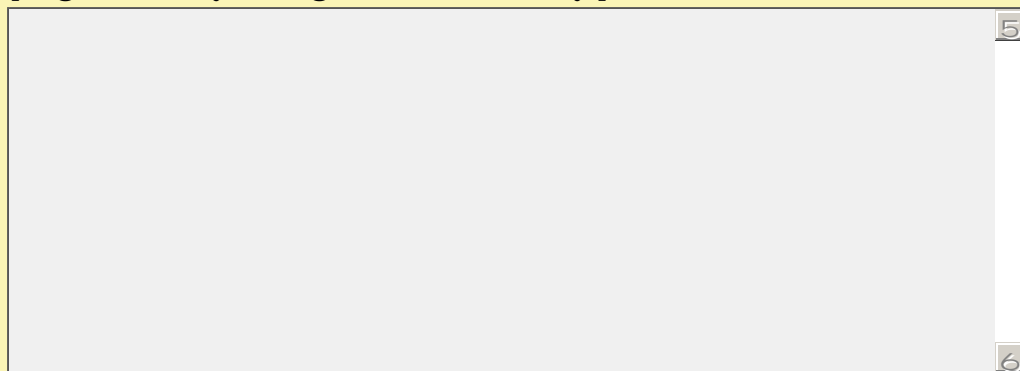
Please describe your plans for adding or enhancing dental/oral health services or programs at your organization.



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25. Future Plans for Discontinuing Dental/Oral Health Services

Please describe your plans for discontinuing or decreasing dental/oral health services or programs that your organization currently provides.



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26. Workforce

Please provide the number of and total full-time equivalents (FTE) for each position listed below. Information is only needed for those providers that you employ or contract with for services.

Licensed Dentists

Number of

Total FTE

General Dentists

Number of

Total FTE

Pediatric Dentists

Number of

Total FTE

Specialty Dentists

Number of

Total FTE

Registered Dental Hygienists (RDH's)

Number of

Total FTE

Limited Access Permit (LAP) RDH's

Number of

Total FTE

Dental Assistants

Number of

Total FTE

Administrative Personnel supporting dental/oral health services or programs. For example: office manager, claims processor, or receptionist.

Number of

Total FTE

Other Health Professionals (e.g., nurse, dietitian, health educator)

Number of

Total FTE

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27. Funding Sources

The next set of questions will be used to group organizations by funding source(s). Your organization's specific budget will not be requested. Please consider specific funding sources targeted for dental/oral health services in your responses.

What type(s) of funding do you receive from the Federal Government? Please check all that apply.

- Budgeted Line Item through a Federal Agency
- Grants
- N/A
- Other (please specify)

What type(s) of funding do you receive at the State Level? Please check all that apply.

- Budgeted Line Item through a State Agency
- Grants
- General Funds from the Legislature
- N/A
- Other (please specify)

What type(s) of funding do you receive at the Local Level? Please check all that apply.

- Budgeted Line Item through the City or County
- Contracts
- Fee-for-Service Agreements
- Public Foundations
- Private Foundations
- Donations
- N/A
- Other (please specify)

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What type(s) of reimbursement do you accept for patient services provided? Please check all that apply.

- Self Pay - Sliding Scale
- Self Pay - Fixed Fee
- Private Insurance
- Medicaid/Oregon Health Plan
- Medicare Advantage Plan (part C)
- Donations
- N/A
- Other (please specify)

Approximately how much is your total dental/oral health budget annually?

Choose a Range

Please approximate the percentage (%) of the total number of patients served in each category.

Medicaid	<input type="text"/>
Self Pay	<input type="text"/>
Private Insurance	<input type="text"/>
Charity Care	<input type="text"/>
Medicare	<input type="text"/>

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28. Community Support & Future Sustainability

What type(s) of community support do you currently receive? Please check all that apply.

- Volunteer or Retired Health Care Professionals
- Community Volunteers
- Community Partners (i.e. local organizations, hospitals, service clubs)
- In-Kind Donations
- Financial Donations
- N/A

Other (please specify)

What support does your organization need to sustain their current service level or increase capacity to add additional dental/oral health services or programs?

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Based on the geographical area in which your organization carries out most of its services and/or programs, what do you believe are the most important barriers to overcome in order to increase access to dental/oral health services in your community?

Please rank the following barriers from 1 = most important to 7 = least important

	1	2	3	4	5	6	7
Funding Resources	ja	ja	ja	ja	ja	ja	ja
Low Medicaid Reimbursement Rates	ja	ja	ja	ja	ja	ja	ja
Shortage of Trained Professionals	ja	ja	ja	ja	ja	ja	ja
Lack of Cultural & Language Competent Health Professionals	ja	ja	ja	ja	ja	ja	ja
Inadequate dental equipment, supplies & facilities	ja	ja	ja	ja	ja	ja	ja
Lack of Educational Programs & Media Campaigns	ja	ja	ja	ja	ja	ja	ja
Poor Transportation Infrastructure	ja	ja	ja	ja	ja	ja	ja

Please describe briefly up to three of your organization's most important services or activities that improves oral health outcomes and increases access in your community?

Most important service/activity:

2nd most important service/activity:

3rd most important service/activity:

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29. Patient Profile

Please approximate the percentage (%) of the total number of patients served in each category.

Male

Female

Pregnant Women

Infant - Toddler (ages 0-3)

Preschool (ages 3-5)

Kindergarten - 6th Grade

7th Grade - 12th Grade

Ages 18 - 64

Ages 65 and Older

Which populations, if any, does your organization specifically target? Please check all that apply.

Early Childhood (0-4)

School-Age (5-17)

Adult (18 - 64)

Older Adult (65+)

Special Needs (all ages)

Maternal/Prenatal

Other (please specify)

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30. Other Survey Contacts

Are there any other organizations or contacts that this survey should be sent to? If so, please provide us with names and contact information.

31. Thank You!

Thank you for spending your valuable time providing us with information about your organization! This information will assist us in completing the Oregon Oral Health Resources Inventory project so that all current available oral health resources in Oregon are documented. It will help us determine local areas of need and identify opportunities for collaboration and sharing of resources.