

# A Manual for Addressing Oral Health in Substance Use Care on a Limited Budget

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## Introduction

### Why Oral Health Efforts Are Needed for Patients Being Treated for SUD

Maintaining good oral health is a major challenge for people experiencing a substance use disorder (SUD). Oral diseases, such as dental caries and periodontal disease, are the most prominent chronic diseases in the US and have profound implications for populations that are vulnerable (Global Oral Health Status Report, 2022). Caries is a process of demineralization of the teeth that leads to a cavity. Caries are caused by certain oral bacteria, turning sugar into an acidic state in the mouth. Periodontitis is an inflammatory process that affects the gingiva (gums), ligaments, and bone that surround the teeth. People with SUD experience significantly more chronic oral diseases, caries, loss of teeth, and periodontitis. However, this population is less likely to receive dental care (Baghaie, 2017). The causes of poor oral health are multifactorial. Many people with SUD have numerous social determinants of health (SDOH) barriers affecting access to care, including financial, transportation, and housing issues (Allukian, 1995; Mago, 2018). As a result, oral health is usually a lower priority in hierarchy of needs and becomes neglected. This leads to dental complications; often one's oral health needs are only addressed out of necessity. There are other barriers as well. Many people in this situation often have Medicaid or no dental insurance; it can be challenging to find a dentist accepting one's insurance and carrying through with the care prescribed, not to mention the necessary secondary preventive care (Paisi, 2019). The result is a vicious cycle, oral health affecting overall health and vice versa.

Often people experiencing SUD are also facing housing insecurity. Homeless individuals are twelve times more likely to face dental issues than their stably housed counterparts. For housing insecure individuals who live in hotels/motels or with relatives/friends, dental problems are six times more likely (Ferenchick, 1992). Compounding these oral health risks of homelessness and SDOH barriers are the direct effects of substances on oral health including dry mouth, vascular changes, and cravings for sugary food and drinks, all of which worsen oral health. When one is using substances, oral care is often forgotten or becomes less prioritized. Concurrently, the medications that we use to treat SUDs, buprenorphine and methadone, also have side effects that affect oral health (lower saliva production, increased mouth acidity)(Etminan, 2022). Untreated caries can cause local and systemic infections, lead to hospitalizations, and even death. Furthermore, the loss of teeth can lower self-esteem, make employment challenging, and affect proper nutrition (Moore, 2020). Likewise, periodontitis is associated with heart disease, uncontrolled diabetes, and other inflammatory systemic conditions (Liccardo, 2019).

Efforts are needed to offer low barrier oral health education, supplies, and referrals or direct dental care in practical settings such as where SUD treatment is being offered. The number of people who are homeless or housing insecure is approximately 750 000 to 1.5 million (U.S. Department of Housing and Urban Development, 2024). Concurrently, the population with opioid SUD is at epidemic levels affecting approximately 4% of the entire adult population (~10 million people)(Dowell, 2024).

## The Purpose of this Manual

This Manual was designed to help programs addressing SUD create a system-level approach to addressing the oral health needs of their patients. The manual is created for low resource programs that cannot afford to have dental professionals on site. We describe a four-tiered approach so that programs can adopt an approach that fits their budget and personnel level.

It should be noted that getting people into Medication Assisted Treatment (MAT) and Office-based Addiction Treatment (OBAT) programs that offer Medication for Opioid Use Disorder (MOUD) in itself does not improve the oral health of individuals. In a study by Simon et al, based in Massachusetts assessing >50,000 individuals receiving medication for opioid use disorder (MOUD) and dental care utilization found that initiating MOUD did not substantially result in increased dental access or substantial changes in dental procedures received (Simon 2022). It appears that patients receiving treatment for SUD likely require additional support to access dental care beyond MOUD alone. At the same time, when people do engage in improving their oral health while in treatment for SUD, they have better SUD outcomes. One study showed significant outcomes of hazard ratio (95% confidence interval [CI]) 3.24 (2.35 to 4.46) increase for completion of SUD treatment, and odds ratios (95% CI) at discharge were 2.44 (1.66 to 3.59) increase for employment, 2.19 (1.44 to 3.33) increase in drug abstinence, and 0.27 (0.11 to 0.68) reduction in homelessness (Hanson 2019).

In our program where we have a designated Community Health Worker (CHW) who offers oral health resources, education, and dental referral support (making appointments, transportation, reminders), we have found that 82.8% of patients who reported needing a dental appointment were scheduled and 31.8 (unpublished). In a survey of a sample of the same patients, respondents agreed or strongly agreed that oral health kits (94.3%) and oral health educational handouts (93.0%) were helpful. Patients also agreed or strongly agreed that the CHW was helpful (98.3%). The survey further explored self-reported improvements in increased teeth brushing frequency (57%) and improved flossing frequency (31%).

### The Four Tier Model of Offering Oral Health Resources to People with SUD

Oral health efforts can be offered in varying degrees depending on the resources available to the Office-Based Addiction Treatment (OBAT) program.

We call this a tiered approach which can build upon itself as a program acquires more resources. See table below.

Tier 1	Tier 2	Tier 3	Tier 4
<p>Train all staff in proper oral health (OH) education</p> <p>Modify workflow to discuss OH with all</p> <p>Provide handouts about OH self-care and side effects of MOUD on mouth</p> <p>Provide a list of local dentists that accept Medicaid</p> <p>Clinicians get trained in proper oral exams, oral lesions, early management</p>	<p>All aspects of Tier 1 and</p> <p>Offer OH self-care kits</p> <p>Case management is utilized to help with dental appointments, logistics including transportation, address barriers, and give reminders</p>	<p>All aspects of Tier 2 and</p> <p>Offer on-site preventive and early management dental care including fluoride varnish and/or silver diamine fluoride</p>	<p>All aspects of Tier 3 and</p> <p>Offer on-site advanced dental care with dental professionals including cleanings and x-rays with dental hygienist; offer on-site dental care with dentist or dental therapist</p>

# Approaches to Addressing Oral Health in Substance Use Care Using a Tier System

## Tier 1

*Train all staff in proper oral health (OH) education.* Evidence informed, patient-centered advice is important for everyone. See the Resources section for more information. We advise that all staff become trained so that advice is consistent and accurate. *Smiles for Life* is a national curriculum that has modules on oral-systemic relationships, adult, pediatric and geriatric oral health, and more (see Resources).

*Modify workflow to discuss OH with all.* Each patient should be asked about their oral health, including symptoms, oral hygiene habits, and goals. Each patient should be educated about the importance of oral health, the effects of substances on oral health, and the side effects of SUD treatment on oral health. Each person should also be taught how to brush and floss properly and the importance of regular preventive and acute care. Handouts can be helpful.

*Provide handouts about OH self-care, side effects of MOUD on the mouth, and proper technique for self-care.* There are many handouts available, so creating new handouts is not necessary. Be sure to use handouts that are at an appropriate literacy level and ideally have images. Handouts are available in multiple languages. See the Resources section. Handouts can be included in self-care kits and even laminated to last longer.

*Provide a list of local dentists that accept Medicaid.* Patients often have difficulty finding a dentist that accepts their insurance, and this is especially true for patients with Medicaid. States often have an online resource for finding dentists that accept Medicaid and other resources for searching for dentists that accept private insurance. Creating a list that can be handed to patients is very helpful. Our list includes information such as dental office name, phone number, address, fax number, and insurances accepted. You can also add information about accessibility, languages spoken, if any restrictions such as age or pregnancy status. Dental specialists can be more challenging to find for patients with Medicaid. We recommend calling each office to verify information. Know that federally qualified health centers (FQHCs) may have additional resources such as state funding for dental care for underserved populations and graduated payments based on a person's income. Note Medicare does not have a dental benefit. Dental care, in rare situations, is covered if the dental issue is caused by a medical condition. Some patients are dual-eligible and have both Medicare and Medicaid. Others will need free dental care options or lower cost options. Some Medicare Advantage plans include basic dental coverage. AARP has low-cost dental insurance options. Some dentists provide pro bono care especially for Veterans.

There are other national, state, and local programs for Veterans, people with Cancer, and people who are elderly and have disabilities (see Resources). Dental schools, dental hygiene schools, mobile dental vans, and FQHCs may all have graduated payment programs for older adults or even free preventive care. There are also periodic one-time events such as Mission of Mercy where free care is offered by volunteer dentists and dental teams.

*All clinicians should be trained in basic oral health history taking and exam skills.* Patients should be asked about their oral health, oral symptoms and lesions, and an exam should be done periodically on each patient. Clinicians should be comfortable doing an oral cancer screening, treating dental infections, assessing oral lesions, applying fluoride varnish (FV), and making referrals based on urgency. There are online resources for these training courses. (See Resources).

## **Tier 2**

*All aspects of Tier 1, and:*

*Offer OH self-care kits.* Every patient should be given a toothbrush, fluoridated toothpaste, and floss. Ideally, this should be given in a plastic carrying case to keep the items together and clean, especially for people who are sleeping outside or need to be mobile. Other items can include handouts (see above and resources), fluoride rinse, sugar free gum and lozenges, and denture cleaning supplies (as needed). Supplies in the kit will need to be replenished as needed for each patient. These can be purchased in bulk, or donations can be sought from local dentists or dental hygiene distributors and companies.

*Case management is utilized to help with dental appointments, logistics, barriers, and reminders.* We use a community health worker; this can also be a case worker, social worker, navigator, promotora, or other allied health professional with training in oral health education. This case manager should be trained to teach about oral health basics and answer basic oral health questions. See Resources section for training. (Note *Smiles for Life* has a specific training module for front line workers.) Having someone who is bilingual or multilingual is helpful. This person should be prepared to get to know local dental resources by calling and possibly meeting with local dental offices. This position requires someone who is very patient-centered and creative in working out logistics for appointments. This may include explaining the bus schedule and routes or setting up a ride for a specific time. Written instructions for appointments including details of time, location, phone number are ideal. Patients can also take photos on their phones of the written instructions or add them to their phone calendar. We provide small pocket calendars for our patients. Note – when

booking a dental appointment, the office will usually require insurance information at the time of booking. Therefore, the case manager should have access to the patient's insurance information in the electronic health record and ideally access to the state Medicaid website to verify health insurance numbers and status. If resources are available, the CHW can also arrange for taxi or ride-share service to appointments or help patients learn about the bus system.

### **Tier 3**

*All aspects of Tier 2, and:*

*Offer on-site preventive and early management of dental care including FV and/or silver diamine fluoride (SDF).* This tier requires additional training for clinicians. The basics of this training can be taken online with *Smiles for Life* or another resource. It is ideal to get some practical training from a health professional who has experience with these procedures. Clinicians can shadow in a dental setting or invite a dental educator to join your clinic for a session. Fluoride varnish is inexpensive and easy to apply with rare complications. There is not good evidence for caries prevention in adults (unlike children). However, FV can still be applied to teeth for prevention and early treatment. For patients who are experiencing homelessness and/or SUD, they are in a higher risk category, and the FV can offer some benefit. If a caries is in the very early stage (a white lesion or demineralization state), FV can reverse the damage. At later stages, such as a brown lesion affecting the dentin, FV can slow the disease process, buying the patient some time to see the dentist. FV can't be billed currently for adults. The average cost per unit is ~\$1. It can be applied every 6 months.

Silver diamine fluoride can be used to treat certain caries and arrest the disease process. This is also an inexpensive, effective treatment that medical providers can learn and now has a billable CPT code on the medical side (0792T). This procedure has an important side effect to discuss with patients – it leaves the treated aspect of the tooth with a black stain that is permanent. This procedure also needs to be repeated every 6-12 months to maintain the arresting effect of the caries. This procedure also can help patients buy time for definitive treatment by a dental provider. It is not a definitive treatment.

Both in-office treatments should be done in conjunction with definitive care by a dental professional eventually.

Other advanced training can be obtained through continuing education conferences or by shadowing dentists and oral surgeons including oral biopsies and regional blocks to perform drainage of dental abscesses.

## **Tier 4**

*All aspects of Tier 3, and:*

*Offer on-site advanced dental care with dental professionals including cleanings and x-rays with dental hygienist; offer on-site dental care with dentist or dental therapist. We do not offer these services. We partner with a mobile dental clinic and co-locate our mobile services on certain days of the month.*

## **For all tiers**

The use of other partners is essential. Recovery coaches, peer support workers, navigators, behavioral therapists, and others are all important allies in this work. Each can play a role in addressing fears, motivating an individual to seek this important care, and sharing personal stories as needed. In recovery work, different team members can have a big impact – reach out to others when a patient is having trouble moving along the continuum of care.

## Costs Associated with Addressing Oral Health in Substance Use Disorder Care

Integrating oral health into SUD care requires thoughtful consideration of resources and operational costs. Because implementation contexts vary across organizations, this section outlines the primary categories of costs and practical considerations rather than providing fixed budget estimates. Costs include salaries, training time, capacity building, supplies, handouts, transportation for the Community Health Worker (CHW) and clients, and data infrastructure. See Table 1 in Appendix for estimated costs by program tier.

### I. Personnel

Personnel costs typically represent the largest expense in the program. Costs vary by tier and depend on whether new staff are hired, or existing staff time is reallocated.

**Staff training.** All staff require training on oral health basics, data protocols, and their specific role in the program. Training costs include trainer time or fees, staff time away from clinical duties, and materials. Free online training modules are available (e.g. *Smiles for Life*) and can significantly reduce training costs at lower tiers. Clinical training at Tier 3 and above may require an external trainer or supervised practice.

**Clinical staff time.** Clinicians at all tiers should be prepared to add oral health screening and assessment to patient workflows. At Tier 3 and above, additional time is required for fluoride varnish and silver diamine fluoride application.

**Part-time CHW (0.5 FTE).** The CHW is the core patient-facing role - responsible for oral health education, kit distribution, appointment scheduling, follow-up, and care coordination. This is the largest single recurring personnel cost.

**Program coordinator/administrator.** Handles supply ordering and inventory, printing and preparation of materials, staff training coordination, and ongoing administrative tasks. At lower tiers this role can be absorbed by existing staff. Time requirements grow with program complexity; at Tier 2 or if trying to track data for research or other purposes, a dedicated research person is needed for IRB consultation and renewals, data tracking, and reporting responsibilities.

**\*Data analyst,** optional. See Section IV and Table 2 for guidance when this role becomes necessary.

## II. Materials and Clinical Resources

Material costs vary by tier and patient volume. Many items can potentially be offset through donations from dental supply companies, local dentists, or hospital systems.

- **Educational handouts.** Many high-quality handouts are available for free online in multiple languages. Printing costs are minimal. See Resources section for recommended sources.
- **Dental provider list.** A list of local dentists accepting Medicaid and other insurance types. Requires periodic updates. Printing costs are minimal.
- **Oral health kits.** Every patient should receive a kit containing at minimum a toothbrush, fluoridated toothpaste, floss, and a carrying case. Additional optional items include mouthwash, sugar-free xylitol gum or lozenges, denture cleaning tablets, pocket calendars for tracking appointments, and pens. Kit costs depend on patient volume and can be significantly reduced through donations.
- **Clinical supplies.** Required at Tier 3 and above. Includes exam gloves and application supplies for fluoride varnish and silver diamine fluoride. Fluoride varnish costs approximately \$1 per application. Silver diamine fluoride is also inexpensive and is billable under code 0792T. There are many distributors of fluoride varnish; silver diamine fluoride is usually obtained through Elevate Oral Care.
- **CHW equipment.** The CHW requires an iPad with case and stylus for field work, a laptop for office-based work, a mobile phone, and a wheeled bag or backpack for supplies. A mobile data plan is highly recommended when wifi access is unstable. Device needs depend on the clinical setting and evaluation requirements of the program. Field-based CHWs working outside the clinic typically rely on an iPad, while office-based or mobile-unit-based CHWs may find a laptop more practical. Programs with more intensive data collection may require both. Equipment costs are one-time purchases but should be budgeted for periodic replacement, updates, and repairs. Equipment may be donated by hospital systems or partner organizations.

## III. Transportation

Transportation needs vary significantly by geographic setting. Programs serving patients in urban areas with public transit may have minimal transportation costs, while rural programs may face substantially higher expenses.

- **Patient transportation** — Many patients lack access to personal transportation. Options include taxi or ride-share vouchers, bus passes, and CHW-accompanied trips. Grants can be pursued to fund patient transportation. Where possible,

scheduling dental appointments on the same day as OBAT appointments can reduce transportation barriers. Medicaid in some states has a benefit for transportation if booked a certain number of days in advance. This benefit may not help patients who are homeless due to the need for a specific address.

- **CHW transportation** — Mileage reimbursement for the CHW to meet patients or accompany them to dental appointments. Requirements depend on program geography and model.

#### IV. Data Infrastructure and Evaluation

Evaluation costs are often underestimated, and building a functional data infrastructure takes time. Even basic tracking requires dedicated time and tools, and costs can grow with program complexity. It is important to recognize that the evaluation level a program can realistically achieve depends not only on resources but also on the program model. Programs without a CHW can start with a simple patient-level tracking system managed by the coordinator. However, a CHW is added and conducting active case management, a more structured system is required to support follow-up, referral tracking, and insurance management. A simple spreadsheet is usually no longer sufficient. As a general guide, Tier 1 programs without a CHW are most likely to start at the Basic evaluation level, while programs at Tier 2 and above with a CHW will need Intermediate infrastructure from the outset. Advanced evaluation, including formal outcomes analysis and publication, is a realistic goal but typically requires two or more years of infrastructure development. Programs should not be discouraged by starting simple; a system that is consistently maintained and grows with the program is more valuable than a complex system that is underused or poorly maintained. Organizations should factor evaluation costs into program budgets from the outset.

##### Evaluation levels

- **Basic activity tracking:** *For programs without a CHW.* No patient-level data is collected. Tracks aggregate program activity only: number of kits distributed, handouts given, and referral lists provided. A simple daily tally maintained by existing clinical or administrative staff is sufficient or check boxes built into the EHR. No dedicated tracking system or additional personnel are required, but consistent documentation habits are recommended from the outset.
- **Intermediate:** *For programs with a CHW.* Required for active case management regardless of evaluation goals. Each patient contact is logged and linked to the patient over time, supporting referral tracking, follow-up scheduling, insurance management, and appointment status. Requires REDCap or a structured database.

CHW handles data entry with coordinator oversight. This level is driven primarily by operational necessity, not evaluation intent.

- **Advanced:** *For programs pursuing formal evaluation, grant reporting, or publication.* Builds on Intermediate infrastructure with added rigor, validation protocols, and dedicated analyst support. Includes longitudinal outcome tracking, formal analysis, and publication-ready reporting. Typically requires at least a year of infrastructure development.

#### **Cost considerations:**

- **Institutional Review Board (IRB) consultation.** Mandatory for all programs regardless of tier. Includes staff time to obtain a written exemption letter confirming the work qualifies as program evaluation rather than human subjects research, as well as annual renewals and modifications as the program evolves.
- **Data security.** Technical safeguards including access controls, encryption, and secure storage, as well as procedural protocols for handling protected health information. In many cases, this is provided by the host institution (if the program is affiliated with an academic institution) through existing infrastructure such as a Microsoft environment protected by an institutional firewall.
- **Data collection platform.** At Basic level, a simple Excel spreadsheet managed by the coordinator is sufficient. At Intermediate level, a structured platform such as REDCap or Qualtrics is required to support visit-level logging and case management. Any platform containing protected health information must comply with organizational and regulatory requirements. Consult with your organization's IT department regarding platform selection, licensing, setup, and ongoing maintenance costs.
- **EHR adaptation.** Configuring existing EHR fields or building new documentation templates for oral health data. Often handled by institutional IT and may carry no direct program cost.
- **Data analyst time.** For data cleaning, management, and reporting, beyond the data entry effort of the CHW. Not required at Basic or Intermediate levels for routine reporting. Becomes essential at Advanced level. See Personnel section for FTE guidance.
- **Training on data protocols.** Orienting the CHW and staff to data collection tools, documentation standards, and privacy requirements. This is distinct from clinical training and should be budgeted separately. Training requirements increase with evaluation level and should be repeated with staff turnover.

See Appendix Table 2 for a detailed breakdown of data and evaluation costs by level.

## **Strategies to Reduce Costs**

Reducing program costs often requires proactive outreach and relationship-building as the program grows. Many of the expenses outlined above can be offset through donations, partnerships, and creative reallocation of existing resources.

### **Supplies and Materials**

Dental hygiene supply companies such as Colgate Palmolive routinely donate supplies to community health programs. A formal request written on organizational letterhead is often sufficient. Local dentists, dental hygiene schools, and dental schools may also donate fluoride varnish, toothbrushes, toothpaste, and floss, particularly if they have an existing relationship with your organization or serve a shared patient population. Reaching out to local dental societies can help identify willing donors. Bulk purchasing through group purchasing organizations or hospital supply systems can also reduce per-unit costs significantly.

### **Equipment**

Hospital systems and academic medical centers are potential sources for equipment such as laptops, iPads, and mobile phones, especially if the program is affiliated with or serves patients from those institutions. Many institutions have surplus equipment available for reallocation. It is worth contacting your IT department or administrative leadership before purchasing new devices.

### **Personnel**

At lower tiers, personnel costs can be reduced by reallocating existing staff time rather than hiring new staff. A social worker, navigator, case manager, or peer support worker already employed by the organization may be able to absorb CHW responsibilities with appropriate training. Volunteer dental students, dental hygiene students, and health or public health students can also provide meaningful support for education and outreach activities. Some universities actively seek community placement sites for students and may provide supervision at no cost to the program.

### **Training**

Free online training modules such as *Smiles for Life* provide high quality oral health education for clinical and non-clinical staff at no cost. Supplementing online training with a single in-person session led by an internal clinician (if they have the expertise) can further reduce reliance on paid external trainers. Partnering with a local dental school or dental

hygiene program for clinical training at Tier 3 and above may also reduce costs while providing students with valuable hands-on experience.

### **Transportation**

Transportation needs depend significantly on program location. Costs can be minimized by helping patients find dental providers located close to where they live or receive OBAT treatment. Scheduling dental appointments on the same day as OBAT appointments reduces the number of separate trips required (and no-show rates). Some municipalities offer free or reduced-cost bus services, and having a team member familiar with local transit options can eliminate the need for taxi or ride-share vouchers in many cases. Medicaid in some states covers transportation costs to health appointments.

### **Funding and Grants**

Grant funding through state oral health coalitions, federally qualified health center networks, substance use disorder focused foundations, and state and federal health departments can offset personnel and supply costs. Some states have specific funding streams for oral health integration in SUD treatment settings. Partnering with a local FQHC, dental school, or academic medical center may open access to funding sources not available to standalone programs. It is worth consulting with your organization's grants office early in program planning to identify relevant opportunities.

### **Data and Evaluation**

Many data infrastructure costs are absorbed by the host institution and significantly reduce direct program costs. REDCap licensing, data security infrastructure, and EHR access are often available through institutional systems at no additional charge. Where a dedicated data analyst is not feasible, starting with a simple Excel-based tracking system maintained by the program coordinator is a practical and cost-effective alternative. As the program grows and data needs become more complex, analyst support can be phased in gradually. Some universities may have students looking for projects to incorporate into the practical element of their studies.

## **Barriers, Challenges and Solutions**

### **Insurance considerations and access to state Medicaid gateway (Gateway.gov)**

Many patients do not have their insurance cards or member number readily available, yet dental offices require insurance information at the time of booking. It is essential for the CHW to have access to the state Medicaid gateway (Gateway.gov) to look up Medicaid numbers directly. Insurance information in the EHR can serve as a backup but is sometimes outdated and should be verified before booking an appointment. Having this access in place before the program launches will prevent delays and failed appointment attempts.

### **Patients who don't have dental insurance**

Dental hygiene schools will often do cleanings for free. Dental schools do not offer free care, but costs can be reduced based on income. This is also true for FQHCs that offer dental care. Some dental offices will offer pro-bono work on occasion.

### **Preparing patients for dental appointments**

Explain to patients that no-showing an appointment may result in the dental office not allowing the patient to make another appointment with that dental office. It is better to call and cancel. Explain the nature of appointments. The first dental appointment may be more for assessment and teeth cleaning, and definitive work may only be planned at that visit. Explain about the length of appointments, especially if a patient is going to a dental office that runs behind or dental and dental hygiene schools where appointments are very long.

### **Addressing mental health issues**

Many patients' experiencing homelessness and/or SUD suffer from mental health issues. For more serious issues, these should be addressed by skilled providers before a patient engages with the dental team if they are thought to be a threat to the care being carried out. If the issue is fear of the dentist or past trauma to the head and neck area, patients can work with a therapist to address these concerns and work on techniques that might help. A note can be sent with the patient to explain to the dental team about these issues. If a patient needs medication to reduce anxiety during the visit, this is something the medical team can provide to make the dental visit easier.

**Addressing active substance use**

Some patients may not be ready to see the dental team due to active use of substances. Efforts may need to focus on oral health self-care for now. The OBAT team can offer other services (e.g. peer support) or high doses of MOUD to help a patient move along the continuum of sobriety. When the patient is ready to visit the dental team, if they are still using substances, a conversation should be had about timing of substance use to avoid withdrawal or heavy sedation during the dental visit. The OBAT team can provide a letter, with the patient's permission, about the issues the patient is facing. The OBAT team can offer to provide pain management to avoid the dental team accusing the patient of drug seeking behavior.

**Addressing transportation**

Many patients will not have access to personal transportation. Inquire if they have a friend that can take them to their dental appointment. Be careful however since some favors have to be re-paid with money or other exploitive favors. Some municipalities have free bus services. Having a person on the OBAT team who understands this system and has copies of schedules as handouts can be helpful. Some bus systems have training navigators that patients can access. To reduce this burden, try to help patients find a dentist that is closest to where they are staying or living. Lastly, if resources permit, provide transportation with a taxi or ride-share voucher and set up the pickup with the patient.

**Remembering the dental visit**

Many patients face challenges in remembering appointments due to other needs and challenges in their life. If patients have a phone that receives calls or texts, the dental team can send reminders. A member of the OBAT team can also send reminders and give reminders in person at OBAT appointments. One idea is to set up the dental visit on the same day as the OBAT appointment later in the day to create an opportunity for a reminder and checking in on other barriers such as fear, transportation, etc. If the dental appointment is soon after the OBAT appointment, and resources are available, the patient can be driven or sent via a taxi or ride-share directly to the appointment. Another idea is to provide patients with pocket-calendar books. This can be used for OBAT appointments and other medical and dental appointments. If the dental appointment is on the same day as the OBAT appointment and the patient is not ready or able to make the dental appointment, this gives OBAT staff an opportunity to cancel the appointment rather than it becoming a no-show visit.

## **Literacy, Health Literacy, Language, and Numeracy**

Remember that many of our patients have issues with reading abilities. Ask patients in a respectful manner about their ability to read. Use hand drawn or preprinted maps or diagrams if applicable. Explain the location based on well-known landmarks to the patient. Inquire if people can tell time or have a way to keep track of days. Explain in simple terms what dental self-care entails and provide pictures or videos or in-person demonstrations. Do the same to explain what a dental procedure or exam will entail. Use handouts in the patient's preferred language. There are many oral health handouts online and high-quality interpretive services. Be careful with numbers as some patients can read but get confused with numeracy. Use the teach-back technique to make sure the patient understands the lesson or plan; when done in a respectful manner, this can avoid confusion, frustration, and missed appointments.

## **Communication/Information Issues**

Our electronic health records often do not communicate with one another and especially between medical and dental. Be prepared to print out medication, allergy, and problem list records for patients to take to the dentist. If they are on a medication or have a condition that a dentist may want info on (e.g. diabetes – latest A1c, HIV – viral load, CD4 count) include that information too. Get written consent early to talk to other health providers. A phone call can go a long way in explaining to a dental colleague about the unique nature of a patient's life. Many of our patients do not have their insurance card or member number. Provide this information to the dental office directly and give the patient a copy if you can get that information from their chart or by contacting their insurer. It is important for at least one team member to have access to the Medicaid database for patient information and if the team has a navigator, this person should get access to avoid having to disturb other members of the team. This can be difficult to get permissions for as some states have specific requirements for what team members can have access to the state database. Most outreach OBAT teams also have challenges with power sources, wifi/mifi, cellular service, and other modern-day glitches. Take precautions to have backup systems for all team members.

## **Dental Team Frustrations**

Dental offices, whether they are private or FQHC-based, are busy places. Chair time is valuable. Missed appointments mean the chair is empty. This means someone else is missing a dental appointment. Anticipate barriers as outlined above and try to solve issues before they happen. Communicate with the dental team about patients that have trauma or mental health issues and give them tips on what works for your team with that patient. If

resources permit, have an OBAT team member or navigator go with the patient to at least their first dental visit. Help patients to understand that it is better to call and cancel if they can't make an appointment than not to show up. This is true even if it is at the same time as the appointment. To avoid the possibility of multiple no-shows at the same dental office (if your patients have a high no-show rate) book only one patient per day with a dental office and build relationships with multiple offices to spread out visits for patients who have many challenges with making appointments. Try to have meetings with the dental team, or a mixer, or send a gift once a year if resources permit – team building can lead to collective investment in the outcomes of our mutual patients.

## Summary

Oral health is inseparable from overall health and well-being. A healthy mouth contributes to confidence, employability, and proper nutrition, and recent research demonstrates that addressing oral health needs is associated with better substance use disorder treatment outcomes. People experiencing homelessness and SUD face disproportionately poor oral health, driven by factors largely beyond their control: social determinants of health, the direct effects of substances on the mouth, side effects of SUD medications, and significant barriers to accessing dental care.

Simply asking patients to see a dentist is not enough. This population requires active, sustained support to navigate the many obstacles between them and dental care. Waiting for patients to find their own way to the dentist will not work.

This manual offers a practical, tiered framework that any program can adapt regardless of budget or staffing level. From basic oral health education and kit distribution to on-site dental care, every tier represents a meaningful step forward for patients whose oral health needs have long gone unmet. The strategies outlined here are grounded in real program experience and designed to be actionable from day one.

Every program can do something. Many programs can do a great deal. The evidence, the framework, and the tools are now in hand - what remains is the will to act.

## Resources

### Training

#### Smiles for Life

National Oral Health Curriculum Free online modules covering adult oral health, geriatric oral health, oral health examination, the relationship between oral and systemic health, urgent dental care, silver diamine fluoride, and fluoride varnish application. Free continuing education credits available for clinical staff. Note there is a module specifically designed for front line workers as well. <https://www.smilesforlifeoralhealth.org/all-courses/>

#### HealthTeamWorks

CHW Oral Health Training. Free self-paced online training designed specifically for community health workers. Covers oral health basics, public health messaging, early identification of issues, and facilitating access to dental care.

<https://communityhealthworker.org/additional-chw-training/oral-health-training/>

#### Oral Health Resource Center

Digital Library (MCH Oral Health) Articles and resources on oral health and opioid use, health literacy, fluoride varnish, silver diamine fluoride, and more. Includes patient handouts in multiple languages. <https://www.mchoralhealth.org/materials/>

### Mental Health, Substance Use, and Oral Health

#### Oral Health, Mental Health and Substance Use Treatment Toolkit.

National Council for Mental Wellbeing. A practical toolkit for providers integrating oral health into behavioral health and SUD treatment settings. Includes frameworks for coordination, patient education models, screening and referral strategies, and real-world program examples. <https://www.thenationalcouncil.org/resources/oral-health-mental-health-substance-use-treatment-toolkit/>

#### Oral Health and Mental Health Connection.

CareQuest Institute for Oral Health. Overview of the bidirectional relationship between oral health and mental health, with resources for providers. <https://carequest.org/the-connection-between-oral-health-and-mental-health/>

## Handouts

**Adult How to Brush.** American Dental Association [https://www.mouthhealthy.org/-/media/project/ada-organization/ada/mouthhealthy/files/activity-sheets/adahowtobrush\\_eng.pdf](https://www.mouthhealthy.org/-/media/project/ada-organization/ada/mouthhealthy/files/activity-sheets/adahowtobrush_eng.pdf) Accompanying video: <https://www.mouthhealthy.org/all-topics-a-z/brushing-your-teeth>

**Adult How to Floss.** American Dental Association [https://www.mouthhealthy.org/-/media/project/ada-organization/ada/mouthhealthy/files/activity-sheets/adahowtofloss\\_eng.pdf](https://www.mouthhealthy.org/-/media/project/ada-organization/ada/mouthhealthy/files/activity-sheets/adahowtofloss_eng.pdf) Accompanying video: <https://www.youtube.com/watch?v=HhdoPXNKNm4>

**Brushing and Flossing Handout.** Health Resources and Services Administration (HRSA) Available in multiple languages. <https://www.hrsa.gov/sites/default/files/hrsa/oral-health/flossing-brushing.pdf>

## Multilingual Patient Resources

**Oral Health Resource Center.** MCH Oral Health Patient handouts available in multiple languages including Spanish, covering brushing, flossing, fluoride, and prenatal oral health. <https://www.mchoralhealth.org/materials/>

**MouthHealthy.** American Dental Association Patient education materials and videos available in Spanish. <https://www.mouthhealthy.org/en-us/spanish>

**HRSA Oral Health Resources** Brushing and flossing handouts available in multiple languages. <https://www.hrsa.gov/sites/default/files/hrsa/oral-health/flossing-brushing.pdf>

**Interpreter Services For patients with limited English proficiency.** Interpreter services are available through most hospital systems and federally qualified health centers at no cost to the patient under federal law. Programs should identify their institution's interpreter services contact info and make this information available to the CHW. Phone and video interpretation services such as Language Line are widely available and can be used during dental office calls on behalf of the patient.

## **Supplies**

Toothbrushes, toothpaste, floss, fluoride mouth rinse, fluoride varnish, and denture cleaning supplies can be ordered through dental supply companies or Amazon. Bulk donations can often be obtained from dental hygiene supply companies such as Colgate Palmolive, Proctor and Gamble, and Oral-B by submitting a formal written request on organizational letterhead.

## Insurance and Medicaid Resources

### MassHealth Dental Program.

Provider and Patient Lookup Patients and CHWs can look up MassHealth-enrolled dental providers and verify member eligibility. <https://www.masshealth-dental.org/>

MassHealth Dental Customer Service Center For help finding a dentist or verifying dental benefits. Phone: (866) 616-2699 | TDD/TTY: 711

### MassHealth Dental Benefits Information.

Mass.gov Overview of covered dental services and eligibility by plan type.

<https://www.mass.gov/info-details/learn-about-masshealth-dental-benefits>

MassHealth Provider Directory Member Eligibility:

<https://masshealth.ehs.state.ma.us/providerdirectory/>

For programs outside Massachusetts, check your state's Medicaid agency website for member eligibility lookup tools and lists of enrolled dental providers.

## People Without Dental Insurance

Dental hygiene schools frequently offer free or low-cost cleanings. Dental schools provide comprehensive services at reduced rates based on income. Federally qualified health centers (FQHCs) use sliding scale fees and are often the most accessible option for uninsured patients. Check the websites of your state dental association, state dental hygiene association, department of public health, and oral health coalitions for local options.

### One and Two-Day Free Dental Care Events America's Dentists Care Foundation.

Search for clinic events by location. <https://adcf.net/about-us/>

## Veterans

**Everyone for Veterans.** Dental care program for eligible veterans.

<https://www.everyoneforveterans.org/dental-program.html>

**Veterans Smile Day.** Annual free dental care events for veterans.

<http://veteransmileday.org/>

**VA Medical Centers.** Comprehensive dental care for eligible veterans. Contact the VA New England Health Care System at 781-687-2000 or your regional VA for eligibility information.

## **People Experiencing Cancer**

**Cancer Care.** Financial assistance for dental care and co-pays for people experiencing cancer. [https://www.cancercare.org/financial\\_assistance](https://www.cancercare.org/financial_assistance)

## Appendix

**Table 1. Program Cost Estimates by Tier.**

Cost Category	Tier 1	Tier 2	Tier 3	Tier 4	Notes
<b>PERSONNEL</b>					
<b>Staff training time</b>	\$0–\$500	\$0–\$500	\$0–\$1,500	\$0–\$1,500	Free if using online modules (e.g. Smiles for Life); higher if external trainer hired. Cost increases at Tier 3+ for clinical training
<b>Program coordinator / administrator</b>	~0.05 FTE	0.10–0.20 FTE	0.20–0.30 FTE	0.30–0.50 FTE	Handles IRB, ordering, printing, setup, and ongoing material updates and coordination. May be existing staff with reallocated time rather than a new hire. Higher in year 1 due to setup. May be absorbed by existing staff at Tier 1.
<b>Part-time CHW (0.5 FTE, salary + benefits)</b>	—	\$25,000–\$40,000	\$25,000–\$40,000	\$25,000–\$40,000	Largest recurring cost
<b>On-site, part-time dental hygienist</b>	—	—	—	\$30,000–\$50,000	May be contracted or volunteer
<b>On-site dentist / dental therapist</b>	—	—	—	Varies widely	Often via mobile clinic partnership
<b>MATERIALS</b>					
<b>Educational handouts (printing)</b>	\$0–\$100	\$0–\$100	\$0–\$100	\$0–\$100	Many free online
<b>Dental provider list (printing)</b>	\$0–\$50	\$0–\$50	\$0–\$50	\$0–\$50	Needs periodic updating
<b>Oral health kits (per patient/year)</b>	—	\$10–\$30 /per patient	\$10–\$30 /per patient	\$10–\$30 /per patient	Costs reducible via donations

<b>Fluoride varnish</b>	Optional	Optional	\$1 per application/patient	\$1 per application/patient	Tier 3 entry point
<b>Silver diamine fluoride</b>	—	—	<\$0.20 per application/lesion/patient	<\$0.50 per application/lesion/patient	Billable under code 0792T
<b>EQUIPMENT</b>					
<b>CHW equipment (iPad, phone, bag)</b>	—	\$2,200–\$3,500	\$2,200–\$3,500	\$2,200–\$3,500	iPad + case + stylus, laptop, mobile phone, wheeled bag or backpack. Mobile data plan (~\$360–600/yr) highly recommended, because wifi is often unstable. May be donated.
<b>Clinical supplies (exam gloves, mirrors)</b>	—	—	\$200–\$500	\$200–\$500	
<b>Mobile dental unit equipment</b>	—	—	—	Varies	Usually partner-owned
<b>TRANSPORTATION</b>					
<b>Patient transportation (taxi, bus passes)</b>	—	\$500–\$3,000	\$500–\$3,000	\$500–\$3,000	Higher in rural settings
<b>CHW mileage</b>	—	\$200–\$1,000	\$200–\$1,000	\$200–\$1,000	Depends on geography
<b>DATA &amp; EVALUATION * - see Table 2 for details</b>					
<p>Costs in this table reflect annual estimates unless otherwise noted. Equipment costs are one-time purchases but should be budgeted for periodic replacement, updates, and repairs. Personnel (the CHW, program coordinator, and data analyst where applicable) typically represent the largest cost drivers, though data analyst costs vary significantly and are addressed separately below. Total program costs vary significantly based on patient volume, local salary rates, institutional resources, and whether costs can be offset through donations or reallocation of existing staff time. Programs are encouraged to use this table as a framework for building a budget tailored to their specific context.</p>					

**Table 2. Data and Evaluation Cost Consideration**

<b>Cost Item</b>	<b>Basic distribution tracking</b>	<b>Intermediate</b>	<b>Advanced</b>	<b>Notes</b>
<b>IRB consultation &amp; exemption letter</b>	NA as no patient data involved.	✓	✓	Requires annual renewal and updates when program changes
<b>Data security infrastructure</b>	—	Institution-provided	Institution-provided	
<b>Tracking tool setup and maintenance</b>	Simple daily tally, Excel or paper log	REDCap or structured database	REDCap or equivalent	Ongoing adjustments expected as program evolves at all levels
<b>EHR adaptation</b>	—	Recommended	✓	
<b>Staff training on data protocols</b>	1 hr/person	2-4 hrs/person	4-8 hrs/person	Repeat as needed with staff turnover
<b>CHW time for data entry</b>	—	Per visit contact logging, referral and follow-up tracking	Full structured data entry per protocol	Scope and time burden increases significantly at Advanced
<b>Program coordinator time</b>	Periodic tallying of activity counts	Oversight of CHW data entry, data quality checks	Oversight of CHW data entry, analyst outputs and reporting.	
<b>Data analyst time</b>	—	—	20+ hrs/month	Essential at Advanced level
<b>Report types and outputs</b>	Aggregate counts only: kits distributed, handouts given, referral lists provided	Patient engagement summaries, demographic breakdowns, referral and follow-up rates, quarterly program reports	Longitudinal outcome analyses, appointment completion rates, publication-ready datasets, formal evaluation reports, grant progress reports	Appointment-level data such as completion rates requires Advanced infrastructure

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*Note - The introduction of this manual is a modified version of a paper currently in review in Journal of Substance Use and Addiction Treatment.*