NC Child

The Voice for North Carolina's Children

2025 LISTENING TOUR FINAL REPORT

Strengthening Smiles

CHILD ORAL HEALTH BARRIERS AND OPPORTUNITIES IN NORTH CAROLINA

Executive Summary

Challenges around provider availability and insurance coverage often play a factor in children's ability to access oral health care. Despite oral health playing a key role in children's overall health and quality of life, these challenges make it harder for parents and caregivers to prioritize, often resulting in dental care being sought at the pediatrician's office. Left untreated, tooth decay can cause abscesses in children and lead to infection in other parts of the body. Children with tooth pain may also find it difficult to eat, resulting in poor nutrition that hinders growth and development. Chronic pain can also lead to school absences, difficulty paying attention in the classroom, and lower academic performance. Oral health also has important social implications for children, as poor oral hygiene can lead to bullying, anxiety, and social withdrawal.

Despite its vital importance, children's oral health outcomes in North Carolina are not improving. Children still experience high levels of untreated tooth decay and often cannot access the preventive care that catches and treats decay early.

Too many families are unable to access oral health care; for children with Medicaid coverage, accessing care becomes more difficult as there are too few oral health providers throughout the state that accept Medicaid and see pediatric patients. This leads to oral health access gaps that can significantly delay care and allow decay to progress to severe levels. School-based oral health services play a key role in bridging these access gaps, but access to these school-based services is inconsistent across North Carolina.

This report builds on lessons learned from NC Child's 2024 Oral Health Listening Tour. This research more narrowly centers the experiences of four populations imperative to understanding the scope of children's oral health in North Carolina: parents of children with Medicaid coverage, school district personnel, oral health providers, and children themselves. We collected qualitative data from these key groups across the state to understand the current challenges, perceptions, and opportunities around oral health.

Through interviews and focus groups, this research seeks to understand crucial factors affecting current children's oral health outcomes, including access barriers, policy gaps, and complications in innovative service delivery.

KEY TAKEAWAYS

- Parents of children with Medicaid coverage reported that one of the main barriers they encounter when trying to access care is simply finding a dentist that accepts their insurance, forcing many families to travel across the state for a preventive visit.
- Dentists across the state spoke on the need for increased Medicaid reimbursement rates for oral health services that will enable them to meet the needs of children and improve access to care for families.
- School personnel highlighted that poor oral health outcomes among children hinders children's ability to focus in the classroom and perform well in school, while recognizing the vital role school-based oral health services play in improving access and outcomes.
- Finally, high-school age children discussed oral health's impact on self-esteem and confidence and expressed the need for schools to prioritize oral health education and services.

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Background

Despite its importance to positive overall health outcomes, oral health is often treated as an optional or a luxury service. Especially early in life, poor oral health outcomes can severely impact children's overall health. Tooth decay can lead to painful infections, trouble eating nutritious meals, and negatively affect the development of children's mouths and permanent teeth.

These impacts extend far beyond physical health; many children miss school due to severe oral pain and suffer significant self-esteem and confidence issues. Negative child oral health outcomes in North Carolina continue to persist across the state, with access to oral health providers, especially for children insured through Medicaid, remaining scarce.

CHILDHOOD ORAL HEALTH OUTCOMES STILL FALLING BELOW PRE-PANDEMIC RATES

Even before the impacts of COVID-19, North Carolina fared poorly in children's oral health outcomes. In the 2023, 2021, and 2019 Child Health Report Cards, published by NC Child and the North Carolina Institute of Medicine, North Carolina received a C grade in oral health. However, oral health outcomes slipped as families grappled with public health concerns during COVID-19 and many likely avoided the dentist or could not access oral health services. Pandemic-related concerns contributed to worsening oral health outcomes among children and resulted in North Carolina receiving a D grade for children's oral health in the 2025 Child Health Report Card.[i]

As North Carolina and the country came out of the pandemic, oral health outcomes have struggled to improve. Rates of untreated tooth decay among kindergartners in North Carolina still remain at elevated levels. In the 2023-24 school year, 19.1% of kindergarten students had untreated tooth decay.[ii] The most recent data represents a minimal decline from the prior school year's 19.9% of children with untreated decay but is markedly above the 15% of kindergarteners with untreated decay in the 2019-20 school year, just before the COVID-19 pandemic.

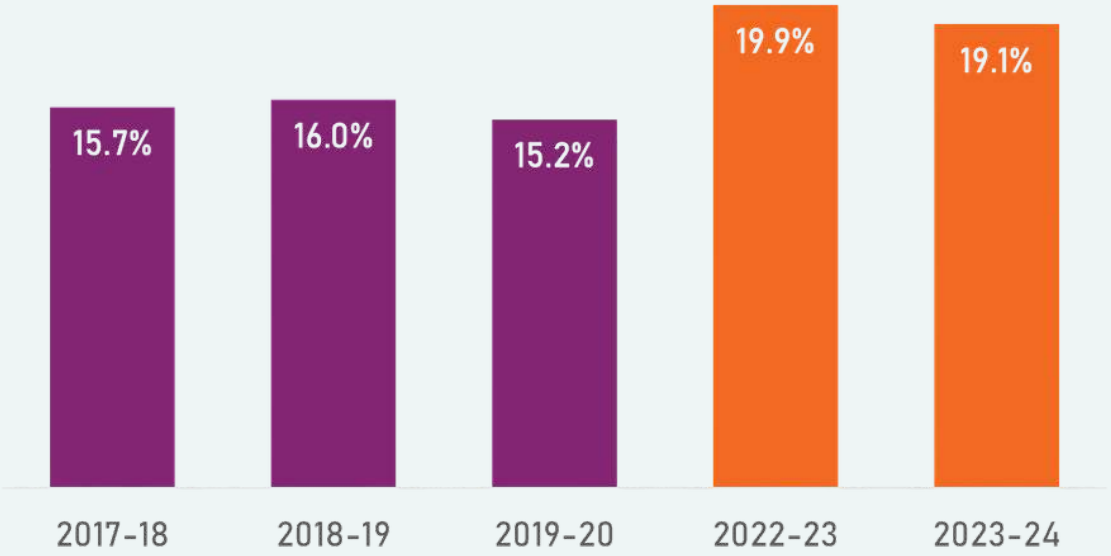
The number of kindergarteners identified with urgent dental needs has improved slightly but still remains above pre-pandemic levels. In the North Carolina Oral Health Section's screening data, "urgent dental needs" mean children show signs or symptoms of severe pain, infection, or gum swelling. In the 2023-24 school year, 2.9% of kindergartners had urgent dental needs, compared to 3.6% in 2022-23. Before the pandemic, 2.4% of kindergarteners showed symptoms of urgent dental health needs.

To gather data on child oral health outcomes, the NC Oral Health Section selects a random sample of elementary schools throughout the state to screen kindergarteners for treated decay, untreated decay, urgent dental needs, and other indicators of oral health. However, recent legislation has complicated parent, student, and school participation in this data collection. The number of oral screenings is

dependent on participation rates, so the true number of children with untreated tooth decay or urgent dental needs might be undercounted and/or the sample size might be too small to reliably estimate numbers at the population level.

ABOUT 1 IN 5 NC KINDERGARTENERS HAVE UNTREATED TOOTH DECAY

Percentage of kindergartners with untreated tooth decay



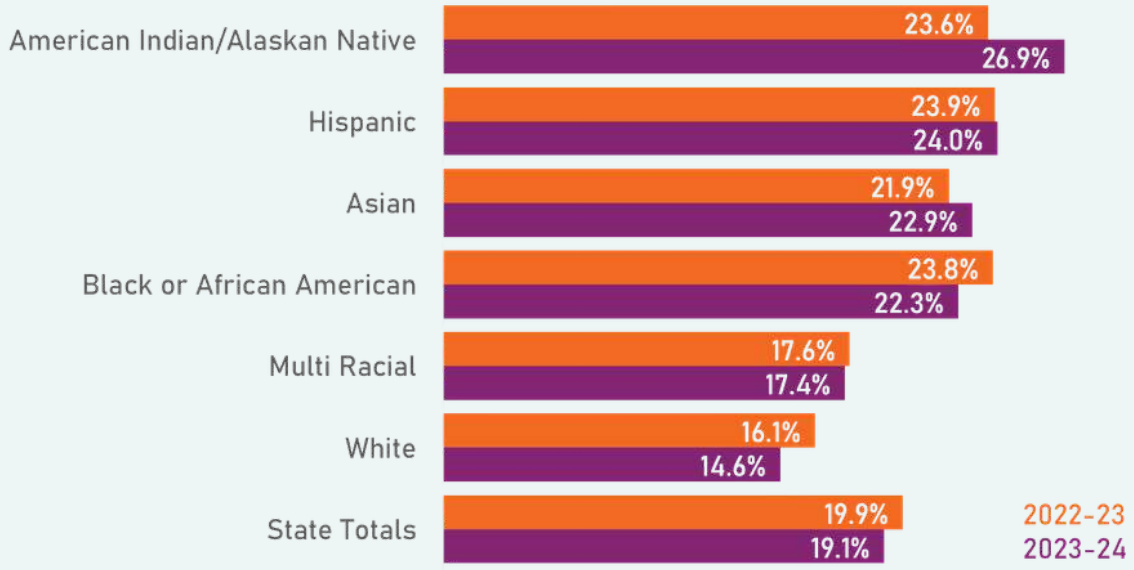
Source: NC Department of Health and Human Services, Oral Health Section (2026)
Note: The NC DHHS Oral Health Section did not publish data during the 2020-21 and 2021-22 school years due to the impact of COVID-19.

Disparities in oral health outcomes by race and ethnicity have similarly not improved in North Carolina. The rate of untreated decay among American Indian/Alaska Native, Asian, and Unknown/Other demographic groups has increased at least one percentage point in the course of one school year.[1] Meanwhile, the rate of decay among Black or African American and white kindergarteners has decreased by 1.5 percentage points. Across the state oral health outcomes are still stark across all demographic groups, with non-White children more likely to have higher rates of untreated tooth decay.

1. NOTE: While untreated decay among American Indian/Alaska Native, Asian, and Unknown/Other children have increased, the number of screenings conducted among children from these demographic groups is relatively low. Therefore, year-to-year increases should be interpreted with caution.

HIGHER RATES OF UNTREATED TOOTH DECAY AMONG NON-WHITE KINDERGARTENERS OVER TIME

Percentage of kindergarteners with untreated tooth decay by race/ethnicity, 2022-23 and 2023-24 school years

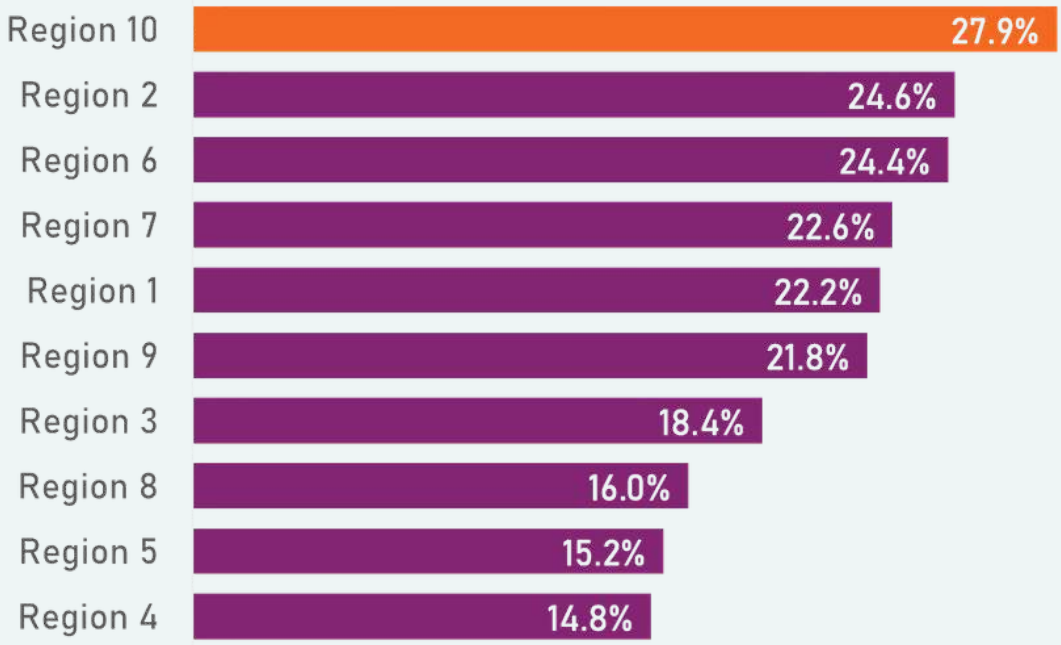


Source: NC Department of Health and Human Services, Oral Health Section (2026)

Kindergarteners' oral health outcomes at the statewide level do show slight improvements over last year's data, but trends vary based on region. Children in local health Region 10 (Eastern North Carolina) have poorer outcomes than the prior school year, with 27.9% of kindergarten students screened for untreated tooth decay in the 2023-24 school year compared to 26.1% in 2022-23. Similarly, Region 2 (Western North Carolina) and Region 6 (Sandhills) face higher rates of untreated decay than the rest of the state. Notably, these are primarily rural regions of North Carolina where access to dental care is sparse.

OVER A QUARTER OF KINDERGARTENERS IN RURAL REGION 10 HAVE UNTREATED TOOTH DECAY

Percentage of kindergarteners with untreated tooth decay by local health region, 2023-24 school year



Source: NC Department of Health and Human Services, Oral Health Section (2026)

The North Carolina Association of Local Health Directors groups counties according to the following regions:

- Region 1: Cherokee, Clay, Graham, Haywood, Jackson, Macon, Swain, and Transylvania
- Region 2: Buncombe, Burke, Caldwell, Henderson, Madison, Polk, Rutherford-McDowell, Mitchell-Avery, and Yancey
- Region 3: Davidson, Davie, Forsyth, Stokes, Surry, Watauga-Ashe-Alleghany, Wilkes, and Yadkin
- Region 4: Alexander, Cabarrus, Catawba, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, and Union
- Region 5: Alamance, Caswell, Chatham, Durham, Guilford, Orange, Person, Randolph, and Rockingham
- Region 6: Anson, Cumberland, Harnett, Hoke, Lee, Montgomery, Moore, Richmond, and Scotland
- Region 7: Franklin, Granville-Vance, Johnston, Nash, Wake, Warren, and Wilson
- Region 8: Bladen, Brunswick, Columbus, Duplin, New Hanover, Onslow, Pender, Robeson, and Sampson
- Region 9: Bertie-Camden-Chowan-Currituck-Gates-Pasquotank-Perquimans-Hertford, Dare, Edgecombe, Halifax, Hyde, Martin-Tyrrell-Washington, and Northampton
- Region 10: Beaufort, Carteret, Craven, Greene, Jones, Lenoir, Pamlico, Pitt, and Wayne

ORAL HEALTH CARE IS INACCESSIBLE FOR MANY FAMILIES

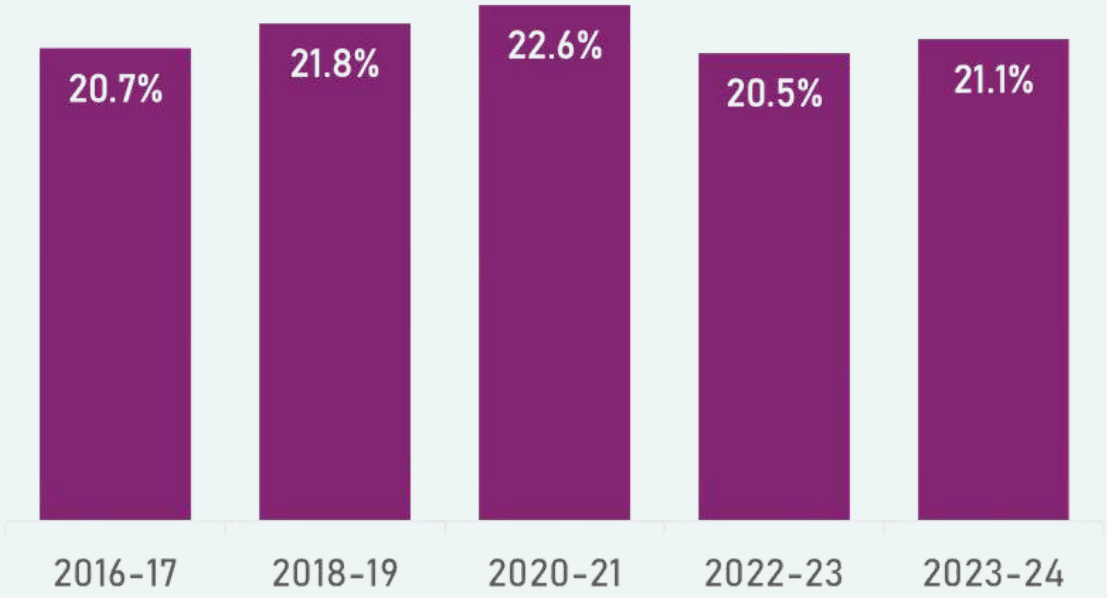
Access to preventive dental care is essential for maintaining healthy teeth and preventing disease. Regular dental visits do more than keep teeth clean; they allow dentists to detect cavities and decay early, before they become serious problems. When left untreated, tooth decay can lead to broader health complications, including difficulty eating nutritious foods, increased risk of heart disease, and even life-threatening infections such as sepsis.

However, children and families across North Carolina grapple with an oral health system that is too difficult to access. According to data from the National Survey of Children's Health, more than 1 in 5

children ages 1-17 in North Carolina went without a preventive dental visit in 2024.[iii] The percentage of children without preventative dental visits in 2024 ticked up slightly from 2023's data and has shown little improvement since 2017.

MORE THAN 1 IN 5 CHILDREN WENT WITHOUT A SINGLE PREVENTIVE DENTAL VISIT IN THE LAST YEAR

Percentage of children ages 1-17 with no preventive dental visit (check-ups, dental cleanings, dental sealants, or fluoride treatments) in the last year

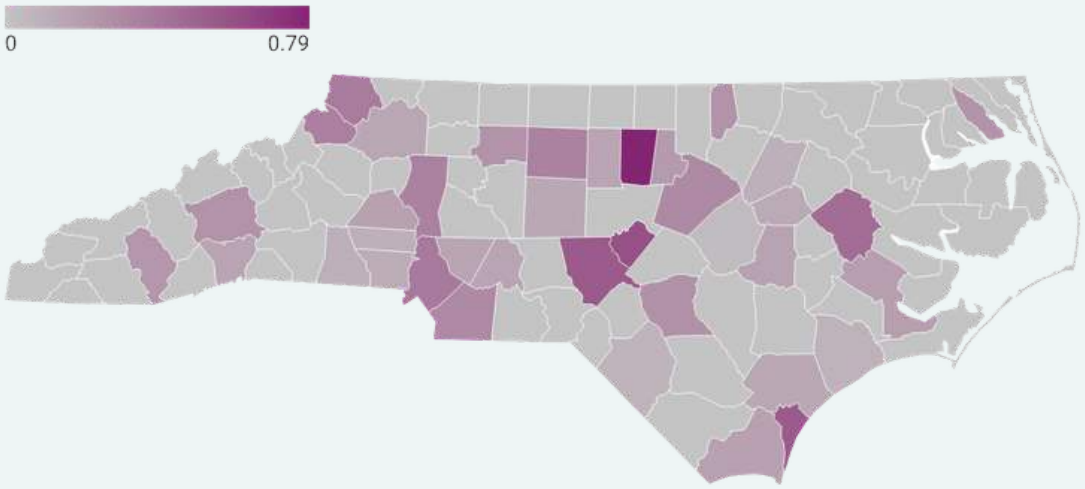


Source: National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau.

Several factors can contribute to access problems. Chief among them is an insufficient supply of dentists across the state. In 2025, there were only seven counties that did not qualify as a Health Profession Shortage Area (HPSA) for dental health in North Carolina, indicating that the number of providers throughout most of the state are insufficient to meet the oral health care needs of the population.[iv]

Additionally, there are even fewer oral health providers who specialize in pediatrics. Oftentimes, a general dentist might not see children or might not accept new pediatric patients. In 2024, there were 62 North Carolina counties that did not have a single pediatric dentist.[v] Dental workforce shortages prevent families from accessing quality oral healthcare for their child, forcing families to travel several hours to reach the nearest pediatric provider. Lack of access to pediatric dentistry in most North Carolina counties also places pressure on the supply of dentists that are available, creating long wait times for children to see an oral health provider.

PEDIATRIC DENTISTS PER 10,000 POPULATION (2024).



Source: North Carolina Health Professions Data System, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

Children with insurance coverage through Medicaid face greater challenges to accessing oral health care. Roughly half of North Carolina children are enrolled in Medicaid, with rates often higher in rural counties in the state.[vi] The number of oral health providers accepting Medicaid in the state is insufficient to meet the demand for services among families with children. Only about 40% of dentists in North Carolina accept Medicaid for dental services at any volume, and only 28% of North Carolina dentists accept a meaningful volume of Medicaid patients.[vii] As discussed in the qualitative findings of this report, one of the primary reasons for a lack of dental care options among children with Medicaid coverage is reimbursement rates for oral health services that still remain at 2008 levels. Very few providers can sustain their practice on Medicaid patients alone, so many either do not accept new Medicaid patients, or significantly limit the number of patients they can accept. Community health centers and safety net dental clinics help to fill these gaps in many communities, but these providers can also be challenging to access.

OVERVIEW OF FINDINGS FROM NC CHILD'S 2024 LISTENING TOUR

In 2024, NC Child conducted 20 focus groups about child oral health outcomes with key stakeholders across North Carolina. Conversations included parents, county health officials, school district personnel, community advocates, oral health providers, and more. Focus group participants discussed the factors impacting children's oral health outcomes in their community, access barriers, and potential solutions. Below are some key findings that informed this year's iteration of the Listening Tour:

TOP BARRIERS TO IMPROVING CHILDREN'S ORAL HEALTH OUTCOMES:

1. **Provider availability:** There are too few providers, especially pediatric providers, to meet the oral health needs of children in communities across the state, especially in rural areas or for services for children with special healthcare needs.
2. **Access for Medicaid patients:** Families with Medicaid coverage consistently struggle to find oral health providers that will accept their insurance, often leading to a delay in crucial care.
3. **Inconsistent insurance coverage:** The cost prohibitive nature of oral health care prevents families from accessing care.
4. **Parental knowledge gaps:** Many parents are unsure what milestones to look for in their child's mouth, including when to take them to the dentist for the first time.
5. **Social determinants of health:** When a family is struggling to afford basic needs for their family like food or housing, oral health care quickly becomes less of a priority.

SCHOOL-BASED ORAL HEALTH SERVICES PROVIDE A VITAL LINK TO UNDERSERVED CHILDREN BY MEETING THEM WHERE THEY ARE.

- School-based oral health programs can improve access to oral health services and instill the importance of oral health in students.
- Mobile dental units (MDUs) serve as a critical source of oral health care in schools. They remove access barriers for children and co-locate services where students spend much of their time.

FAMILIES ARE MUCH MORE LIKELY TO ACCESS PRIMARY CARE THAN ORAL HEALTH CARE.

- Primary care is much more accessible than oral health care, especially for Medicaid patients. Despite its increased accessibility, pediatricians often do not discuss oral health in well-child visits.
- Families reported inconsistent dental care provision at pediatric primary care visits, with some pediatricians simply asking if a child has a dentist, others applying fluoride varnish, and some not discussing oral health at all.

RECOMMENDATIONS FOR IMPROVING CHILDREN'S ORAL HEALTH OUTCOMES

1. Expand school-based oral health programs
2. Increase access for Medicaid patients
3. Improve parent education around oral health

Research Goals and Methodology

NC Child's 2024 Listening Tour engaged a wide variety of stakeholders in children's oral health throughout the state. In 2025, we sought to narrow the focus to four specific groups of stakeholders: parents of children with Medicaid coverage, school district personnel, oral health providers, and children themselves. Our key research questions for this qualitative project were:

1. *What factors impact a provider's ability to accept Medicaid patients?*
2. *What factors limit parents of children with Medicaid coverage from accessing oral health care for their children? What does quality of care look like?*
3. *What role do schools play in expanding access to oral health care? What barriers do schools face in implementing school-based oral health services?*
4. *How do children view their own oral health and that of their peers? How do they see it impact their daily lives?*

NC Child conducted six focus groups with parents of children with Medicaid coverage, five with school district representatives, and five with high school-aged children. Parental focus groups sought to remedy a limitation we found in 2024. In those larger focus groups with more and a wider variety of stakeholders, parents of children with Medicaid coverage could be reticent to share their perspectives in larger groups. Thus, in 2025 NC Child held focus groups solely with parents to gain a deeper understanding of the challenges they face. We held focus groups with parents in Cherokee, Ashe, Union, Lee, Wake, and Pitt counties. Each group had approximately 7-12 parents and lasted for a duration of 60-75 minutes.

School district focus groups sought to more deeply understand oral health service delivery in schools across the state, the implementation challenges schools face, and utilization of school-based services among students. In Mitchell, Cherokee, Union, Pitt, and Wake counties, we held focus groups with key school district personnel, including student health directors, school nursing staff, student support personnel, and external dental partners responsible for providing care to students. Each focus group included about 6-10 school personnel and lasted for a duration of 60-75 minutes.

NC Child's last set of focus groups included discussions with high school students ages 14-18, aiming to understand their perceptions of oral health and their understanding of the impacts oral health has on other aspects of their lives. We held five focus groups with youth in Durham, Harnett, Lee, Mitchell, and Union counties. Focus groups included about 7-12 participants and lasted roughly 45 minutes.

NC Child then conducted nine key informant interviews with dentists, predominantly pediatric dentists, throughout the state, including providers that worked in private practice and community health organizations. NC Child discussed with providers a wide range of topics, including trends in and current perceptions of children's oral health outcomes, their experience serving children with Medicaid coverage, interactions with the NC Medicaid program, and parental involvement in children's oral health. Interviews lasted 30-45 minutes each.

After gaining written informed consent from all participants and parents, NC Child recorded each focus group and interview and transcribed conversations using an online transcription service. NC Child then cleaned transcripts for accuracy based on audio recordings and uploaded the transcripts into the qualitative analysis software Dedoose.

NC Child developed an initial qualitative codebook based on past research and current research goals and revised the codebook as we collected new qualitative data. Codes were grouped into six focus areas: the current landscape of oral health and overall health practices, community resources and increasing access, social determinants of health, Medicaid, barriers to access, and codes specific to youth focus groups. NC Child coded these transcripts in batches during the qualitative data collection phase. After coding all transcripts for a participant group (i.e., providers, parents, school personnel, students), we conducted a thematic analysis based on coded excerpts to observe trends across focus groups and interviews.

Parent Focus Group Findings

During the 2024 Listening Tour, NC Child recognized the need to create spaces solely for parents of children with Medicaid coverage to share their children's oral health care experiences. In these focus groups, parents of children with Medicaid coverage discussed the adequacy of current community resources, quality of care their children receive, and how access challenges impact their children's oral health. Parents lifted up access to dental providers that accept Medicaid as a prominent barrier to positive oral health outcomes for children. Parents also proposed that incorporating oral health services outside of a dental office, such as in schools or in primary care settings, would improve oral health outcomes for children.

MEDICAID ENABLES REGULAR PREVENTATIVE DENTAL VISITS, BUT PRIORITIZING ORAL HEALTH ABOVE OTHER NECESSITIES CAN BE DIFFICULT FOR FAMILIES IN FINANCIALLY STRAINED HOUSEHOLDS.

When asked how often parents can take their children to the dentist, a vast majority of parents affirmed that they take their child twice a year for regular cleanings and exams since it is covered through Medicaid. A few parents reported that they need to take their child more often if there is an issue or if their child needs orthodontic work. Participants also reported that cancelling appointments due to other demands can make it difficult to reschedule due to limited availability among Medicaid providers.

Some parents remarked that they were not accustomed to going to the dentist regularly when they were a child if their parent did not have dental insurance or did not prioritize oral health, leading to oral health issues as an adult and trust issues with the dentist. One parent emphasized, however, that they wanted to break that generational cycle for their children and help them recognize the importance of oral health.

“Well, I know, like, my experience as an adult and how I didn't go as a kid, my parents didn't take me. So now I have a lot of issue[s]...with my teeth, and I don't want [my children] to have those same issues.” - Union County parent

Parents reported that other family priorities often take precedent over oral health. Dental visits take a backseat to accessing food, housing, and other necessities among financially strained households. Given that untreated oral health issues can manifest as larger health problems for children, this stresses the importance of meeting the needs of the whole family to foster positive oral and overall health outcomes for children.

"Your decision is going to be based upon what's most important to you. Across the board. If I'm trying to get a house for my family, everything else becomes secondary." - Wake County parent

Parents discussed how even insurance and health systems often do not prioritize oral health as a crucial component of overall health. This suggests that how systems treat oral health care compared to other aspects of child health influences, implicitly or explicitly, affects parents’ perceptions of the importance of dental care. By separating overall health insurance and dental insurance, some parents automatically view dental services as luxury or add-on services.

"Dental and vision are second tier items. They need to be first tier. They need to be on an equal plane. but vision and dental are second tier items." - Wake County parent

Good oral hygiene, along with regular visits to a dentist, are imperative measures to take to ensure good oral health outcomes. Parents in focus group conversations understand this reality but expressed difficulties in ensuring they brush and floss every night if they work multiple jobs or if they have other challenges in their home. Others remarked that some children might not even have someone making sure that they are brushing, especially in split households, where one parent might not be making sure that their child is maintaining those habits.

“Every child has a different dynamic or different struggle...one might be housed. One might be living with grandparents. One might be living with aunts and uncles. One might be living with older siblings... So, every child might not have that exposure to health, like brushing their teeth and making sure somebody is teaching them how to brush their teeth properly.” - Lee County parent

Many parents understand that oral health impacts overall health, eating habits, and tooth decay, leading to more serious illnesses like heart disease. They also know that unmet oral health needs impact children's social habits and mental health, as they have observed oral health issues manifest into confidence and self-esteem challenges. One parent from Wake County noted that their daughter "suffered from bullying at school because her teeth got overcrowded." Dental problems like missing teeth or overcrowded teeth can lead to significant self-esteem and mental health problems in children in addition to the physical ramifications of tooth decay.[viii]

"I mean, dental health can affect your heart. It can affect everything. It's really, really necessary, and then it's not something that's accessible for most people, despite being one of the most necessary." - Union County parent

EXPANDING ORAL HEALTH SERVICES IN SCHOOLS WOULD BE A GREAT WAY TO IMPROVE ACCESS TO CARE, PARENTS SAY.

School-based health services are a key strategy to increasing access among underserved children. However, many of the children of parents in NC Child's focus groups attend schools that lack school-based services, or their parents do not have complete information on school-based offerings. Only two counties we spoke with, Ashe and Union, reported that their child's school had a mobile dental unit (MDU) visit during the school year to provide cleanings, exams, and sealants. Parents expressed frustration with the lack of communication and inconsistent scheduling with school-based oral health services; many said they are never notified when the MDU is coming to the school.

For parents with children that do not have MDUs providing care to students, parents remarked that their students receive dental screenings at school, but that these are also inconsistent. Most parents reported that increasing the prevalence of school-based oral health services would be a great way to improve their child's access to oral health care, removing barriers like transportation or the inability to take off work to take their child to appointments.

"I wish they would come to the schools, because sometimes you just can't- Parents either are working, or they don't have transportation, or the appointment is so far. I wish they had... a mobile dental bus that came, pulled up, kind of like the Scholastics used to do. And, you know, just get the kids excited about oral hygiene." - Lee County parent

Parents expressed a desire for more emphasis on oral health care and hygiene in their child's health education. Devoted health education instructional time to discuss oral health would help reinforce good oral health habits to children and the importance of oral health to overall health. During the 2024

Listening Tour, participants often reflected on the fluoride mouthrinse program that they participated in when they were children and the key role the program played in fostering good oral health habits. Parents in these focus groups reported similar sentiments, but also acknowledged that most of their children do not receive that service in school.

"I think that if kids would have like, some sort of, like a presentation and make them more aware of how important [oral] hygiene is, and send that information to the parents at home, then it will help a lot. Because, you know, the parents will reinforce that information, and kids will be more conscious about it." - Wake County parent

While community-based oral health resources like Give Kids a Smile Day or other free or low-cost dental clinics do exist, parents face issues accessing these services due to transportation, work schedules, and cost. By expanding access and consistency with school-based oral health services, providers can meet children where they are and make crucial preventive care accessible.

PARENTS WANT MORE INTEGRATION OF ORAL HEALTH INTO PRIMARY CARE SETTINGS.

Parents reinforced NC Child's 2024 Listening Tour recommendation to integrate oral health touchpoints into primary care settings. Parents NC Child spoke with in the 2025 Listening Tour indicated that oral health is barely brought up in their children's well-child visits. Most pediatricians will ask if the child has seen a dentist, but parents reported that this feels like the provider is just "checking a box." Some providers might check in the child's mouth or apply fluoride varnish, but this was the exception, not the norm. Parents view well-child visits as an opportunity to provide oral health education or connect them to resources to find a dentist that accepts Medicaid.

Parents reported that pediatricians are much easier to access than oral health providers, especially for families with Medicaid coverage, which could make meaningful integration of oral health care into primary care effective. According to data from the UNC Sheps Center, there are 0.21 pediatric dentists per 10,000 people in North Carolina, and most counties do not have a pediatric dentist. Alternatively, there are 1.58 pediatric physicians per 10,000 people across the state, and nearly every county has a pediatrician. Parents also reported that well-child visits are often a requirement for many aspects of a child's life, such as enrollment in child care centers or participation in sports. One participant in Ashe County reported that after delivering their child, "they will not let you leave the hospital without a primary care physician." Parents feel that oral health care does not receive the same level of priority in health systems as primary care.

"I think there should be more of a connection between, like, the pediatrician and the dentist... when we take them into their doctor, there should be a connection there. Like, 'Oh, we're gonna check out on this problem and then if there's problems, I'm sending you over here to the to the dentist.'" - Union County parent

OVERALL, PARENTS ARE NOT SATISFIED WITH THE VOLUME OF ORAL HEALTH PROVIDERS THAT ACCEPT MEDICAID, OFTEN TRAVELING HOURS TO REACH THE NEAREST PROVIDER.

Parents' most prominent barrier to their children's oral health care access is a lack of providers that accept Medicaid. As discussed in our interviews with providers, many limit the volume of Medicaid patients they serve due to low reimbursement rates, which restricts access for children with Medicaid coverage. Parents reported often having to call several offices before they find a provider that accepts Medicaid, and they usually cannot get an appointment until several months later. If a child has an emergency dental problem, lack of access and long wait times can have serious implications.

"If you do have a cavity, you get your cleaning, and then they'll say, 'Well, we'll make an appointment,' and that appointment might be six to eight months down the road, and then you've got more cavities because of that." - Cherokee County parent

"There [are] no places up here that take children. And if they do take children, they do not take Medicaid." - Ashe County parent

If a dental visit cannot wait and a parent is unable to find a provider that accepts Medicaid, this can often result in out-of-pocket costs for families. Even with insurance coverage, some services or procedures might not be 100% covered and/or require co-pays, reinforcing the cost-prohibitive nature of oral health care and its reputation as luxury service, especially among lower income families.

"The bills are excessive... if you're already barely making ends meet, adding the extra expense of dental procedures that you're just like, 'Well, we're going to lose that baby tooth anyway. Why do anything to it?' You know, a lot of people in this area don't see the need for that or can't afford it." - Ashe County parent

The lack of adequate providers in rural communities especially forces families to travel significant distances to find a provider that accepts pediatric patients and Medicaid. Cherokee County parents noted that they often must travel as far as Asheville, Hendersonville, or even Charlotte to access dental care for their children. That means one dental appointment requires a parent to take an entire day off work and

have their child miss an entire day of school. Parents whose children have special or complex health care needs, such as needing sedation care for regular cleanings, often must travel even farther to find a dentist that provides the services they need.

"After that I'm not sure where I'm going to take [name redacted] because it's hard to find somebody that will take a blind, autistic child." - Cherokee County parent

"One of my coworkers, her daughter is handicapped...She's said, 'You know, we have to take our daughter all the way to Charlotte for her dental work, because there's nobody here that would handle, like, handicapped children's dental work.'" - Ashe County parent

PARENTS ARE NOT HAPPY WITH THE QUALITY OF CARE THEIR CHILDREN RECEIVE AND FEEL BURDENED WITH THE RESPONSIBILITY TO ADVOCATE FOR THEIR CHILD'S NEEDS.

In the 2024 Listening Tour, some parents anecdotally mentioned that the quality of care their children receive at dentists that accept Medicaid is often inadequate. Parents in these focus groups reaffirmed the sentiment that some Medicaid providers often do not take the time to ensure their child has a positive experience at the dentist.

One Wake County parent reported that they feel like they are in an "assembly line" at the dentist, and that their child is rushed in and out of appointments. Parents feel as though Medicaid providers do not take adequate time to explain the services they are providing or why they are needed, leaving parents feeling the need to go above and beyond to advocate for their child. One parent in Union County reported that it seems like pulling teeth is often the only option providers give them if their child is having recurring issues without providing any additional care options. Another parent in Pitt County said that their daughter had her front teeth pulled at only seven years old.

"I feel like it's so invasive. Like everything is like, 'Oh, we need to pull this'... they're going under and having these major, like, things happen...to me, it just feels so excessive, and it feels so invasive for these little ones to go through these, like, major procedures that, I mean, they're painful, they hurt, and then it takes a while to recover." - Union County parent

These experiences, if not handled with care, can cause long-lasting trauma that discourages children from seeking care as adults. Many parents remarked that they personally do not go to the dentist regularly due to past negative experiences that eroded their trust in oral health systems. Parents' past trauma can

impact their approach to their children's oral health care. For example, some parents noted that they avoid clinics that accept a high volume of Medicaid patients. Of course, quality of care concerns do not apply to all Medicaid providers, but a few negative experiences can sow distrust in the community, creating additional barriers to overcome.

"I remember being a kid, mom would take us to, like, Charlotte or Salisbury or somewhere. And they were Medicaid dentists. They had offices that were cram-packed, and we had dentists that just didn't give a crap. They were rough, they were mean, and it made me terrified." - Ashe County parent

PARENTAL KNOWLEDGE GAPS REGARDING ORAL HEALTH CAN UNWITTINGLY LEAD TO A DELAY IN ORAL HEALTH CARE.

Another prominent barrier to positive oral health outcomes in children is parental knowledge gaps, even if unintentional. A lack of understanding of oral hygiene, symptoms of teeth decay in children's teeth, and appropriate timing of dental care, can have serious implications for their child's oral health. Knowledge gaps are often generational. Parents who did not grow up with good oral hygiene habits are often less likely to instill them in their children. Some parents remarked that they initially did not understand the importance of taking care of baby teeth since their child was going to lose those teeth regardless.

"Just in the area we live in, like, nothing against anybody that lives here, but a lot of people didn't grow up with access to do this, so they don't see the importance of going to the dentist. So, like, it's just hereditary through the years, like, nobody's breaking the cycle." - Ashe County parent

Parents also expressed a desire to receive more information on what to expect at the dentist and/or feedback on their child's oral health. One parent in Lee County reported that their child had several teeth removed at 9 years old and this affected her confidence and self-esteem, stating that, "if I would've known then what I know now, I wouldn't have let them take all her teeth out like that. Because it took forever for them to grow back, and she was insecure about that."

"Before I feel like they used to give out pamphlets or information or even just like a paper that said, 'This is what we did today.' Now, I don't know what they did other than the cleaning." - Lee County parent

Parents also feel like they lack knowledge regarding Medicaid covered services, community oral health resources, and availability of Medicaid providers. Parents are advocating for their children both in and out of appointments, often not knowing where to start in finding a provider that accepts Medicaid, leaving them to call multiple offices and often without success. Parent focus group participants expressed that

better knowledge of the types of services Medicaid covers, why these are important for their child's health, appointment timing for different services, and where they can access providers would help them better care for their children's oral health.

Oral Health Provider Interview Findings

NC Child's interviews with dentists sought to understand the experiences of a workforce with critical gaps in North Carolina that limit access for families. Provider interviews covered a wide array of topics, including the state of children's oral health, changes in rates of decay over time, parental involvement, and community resources. However, conversations mainly centered on providing care to children covered by Medicaid and barriers that prevent providers from accepting a higher volume of children with Medicaid.

About 60% of dentists in North Carolina do not accept Medicaid patients, and those that do often place a cap on the volume of Medicaid patients they can see.[ix] Low Medicaid reimbursement rates for dental services in North Carolina represent a key limiting factor to Medicaid participation among private providers. In a survey from the American Dental Association (ADA), 79.6% of providers surveyed indicated that reimbursement rates from Medicaid were an extremely important factor in keeping them from treating more Medicaid patients.[x] As such, we sought to understand from providers how reimbursement rates affect their decisions to see Medicaid patients and discuss other challenges like administrative barriers that might preclude them or other providers from accepting Medicaid patients.

PROVIDERS OBSERVE HIGH RATES OF TREATABLE TOOTH DECAY AMONG CHILDREN, ESPECIALLY CHILDREN WITH MEDICAID COVERAGE WHO LACK ACCESS TO CARE.

Providers reported high rates of preventable tooth decay as one of the most common oral health concerns they see in children. According to dentists interviewed, overconsumption of sugary snacks and drinks are largely to blame for this type of decay. Many providers expressed frustration at the lack of understanding that sugar causes decay and the use of candy as a reward in schools. Providers also noted that most of the tooth decay that they treat can be prevented with proper oral hygiene like brushing and flossing daily.

"At schools, they're handing out candy rewards for treats... if you're talking about school-based oral health things, please, whatever you can do to promote non-food rewards would be a huge reduction in cavities."
- Durham County oral health provider

While decay resulting from poor hygiene is a "disease that transcends socioeconomic levels," according to one provider, severe oral pain is often exacerbated in uninsured or underinsured populations. One provider considers children with Medicaid as underinsured due to the limited availability of providers that accept Medicaid. When families cannot access preventative dental care like routine cleanings, good oral hygiene serves as the only defense to decay, which often is not enough. Oftentimes, that leaves families with Medicaid to seek out oral health care only when oral health problems become unignorable. Providers expressed that patients with Medicaid are then forced to turn to hospital emergency departments to receive care, overwhelming an already strained hospital system. Overreliance on emergency department visits drives up public health spending in Medicaid programs, even as many of the issues leading to emergency dental care use could have been resolved with proper preventative services.[xi]

"We know that [children with severe decay] have, potentially, more visits to the emergency room because they're hurting and it's the middle of the night and parent doesn't know what to do, and they don't have a dentist, so they go to the emergency room." - Guilford County oral health provider

Severe oral pain from untreated decay can affect children's long-term health, school performance, and overall quality of life. Children in need of significant restorative dental care often require several appointments which means they must miss multiple school days, especially if the family needs to travel long distances to access care. One study of 6- to 17-year-olds found that children with at least one dental problem were 50% more likely to miss at least one school day and that children with poor or fair oral health status were 60% and 90% more likely to miss more than three or six school days, respectively.[xii] Our interviews with providers reaffirmed this trend.

"And I see children that are, you know, affected every day by pain and discomfort, and inability to chew, inability to concentrate, inability to go to school because they have [oral] health problems. And, you know, that's kind of an acute thing with children, but it sets the tenor for what's going to happen in the rest of their lives." - Halifax County oral health provider

Providers also noted that poor oral health outcomes translate to negative impacts on children's overall health and wellbeing. Decay and infection in baby teeth might lead to damage to permanent teeth. Pain from dental caries can prevent children from eating healthy foods, leading to potential malnutrition and developmental impacts.[xiii] Research has also linked dental caries to poor physical and mental health and self-esteem issues among children, finding connections between dental issues and feelings of unhappiness and worthlessness, especially among older teens.[xiv]

"Certainly, some of these kids that, you know, have... decay on their front teeth, self-esteem then becomes an issue as we get into, like, the adolescent years." - Durham County oral health provider

PROVIDERS ACKNOWLEDGE PARENTS NEED MORE EDUCATION ON CHILDREN'S ORAL HEALTH TO FOSTER BETTER OUTCOMES.

Providers reinforced that a lack of parental involvement and understanding of the importance of dental health stands as one of the most prominent barriers to positive child oral health outcomes, as this can lead to increased rates of decay among children. While providers emphasized that oral hygiene at home is imperative to stop decay, they noted that many parents often overlook fostering good dental habits in their children and some delay seeking out oral health care until it is impossible to ignore. Providers had mixed reactions on whether this might be due to knowledge gaps or simply an inability to access oral health care. However, providers we interviewed did more uniformly recognize that it can be difficult for parents who work multiple jobs or struggle to afford basic needs to prioritize dental care for their children.

"I mean, [parents are] overwhelmed with a lot of things... when you ask a family who's, you know, struggling to put food on the table...'Are you brushing your child's teeth?' And they roll their eyes, and I can understand. I probably would roll my eyes, too." - Orange County oral health provider

One of the most common barriers expressed by providers is the sheer amount of information parents do not have or do not understand about oral health, often at no fault of their own. Multiple providers remarked on the common misconception that some parents have that "baby teeth don't matter" since a permanent set will grow soon after, even though problems with baby teeth can affect how a child's mouth develops. Baby teeth that are lost or that need to be pulled early can misalign permanent teeth and result in jaw or bite issues later in life.[xv]

"You know, sometimes parents say to me, 'Oh, well, I don't brush their teeth because they're baby teeth and they're going to fall out.' Or, you know, having kids go to bed at night with milk bottles or juice or whatever it may be, just having no idea the damage that that can do to their teeth at that young of an age." - Alamance County oral health provider

Providers also reported that some parents might not understand the leading causes of decay. Some parents attribute oral health issues to genetics or their child "inheriting their bad teeth," when the more likely culprit is decay caused by overconsumption of sugar and contact with bacteria. Many parents also do not know at what age they should start taking their child to the dentist, inadvertently leading to a delay in care. The American Association of Pediatric Dentistry recommends that parents take their child to the dentist for the first time when their first tooth erupts or by their first birthday. Providers we spoke with emphasized that they try to reserve time in appointments to discuss oral health habits and hygiene with parents, since oftentimes parents either receive misinformation or no information on healthy dental habits.

"It's kind of disheartening in that, you know, we've got so much oral disease in North Carolina, and if you look at it from, you know, from 40,000 feet, you say, 'This could be prevented if we got people the right information.'" - Halifax County oral health provider

SOCIAL DETERMINANTS OF HEALTH ARE ALSO BARRIERS TO POSITIVE ORAL HEALTH OUTCOMES FOR CHILDREN.

The impact of social factors like food insecurity, poverty, and geography on children's oral health outcomes has been well documented, and providers intimately understand these dynamics. To dental providers, access to healthy foods stands as one of the top determinant factors of children's oral health. Healthy foods are often more expensive and less accessible than highly processed foods that contain ingredients that deteriorate teeth. In some parts of North Carolina, many families do not have healthy food options at all. Across interviews, providers repeatedly brought up that the prevalence of sugary snacks and drinks, even in schools, makes it difficult for children and families to choose healthy options. Some providers also reiterated what parents expressed in separate focus groups: when families experience food insecurity, oral health drops down on the priority list.

"Refined sugars, they lead to more cavities, and I think they also actually lead to more secondary caries, you know. Like, let's say I come in and do a beautiful restoration, everything's all good. If you just go and wash that in refined sugars every day for the next month or so, it's going to come back and it's going to fail." - Alamance County oral health provider

Geography and transportation to appointments also arose as a barrier to children accessing oral health care in provider interviews. Providers in urban areas like Orange and Durham counties noted that they are among the few pediatric dentists that accept Medicaid patients in the region. They often see patients from surrounding rural counties who travel significant distances for appointments. One Durham County provider remarked that the average distance their patients travel to their office is approximately 90 miles. A provider in Orange County has patients that will travel three hours to see them. Additionally, families that need to utilize public transportation are often unable to access dental offices with a bus system alone. Providers noted that some patients utilize Medicaid transportation for appointments, but these services are often unreliable.

PROVIDING CARE TO PEDIATRIC MEDICAID PATIENTS CAN PRESENT BARRIERS TO DENTAL OFFICES.

Most of our interviews with oral health providers revolved around their experience with North Carolina's Medicaid program. A key finding of NC Child's 2024 Listening Tour Report was that access to care for children with Medicaid coverage is a major barrier to positive oral health outcomes at the population level. Simply put, there are not nearly enough oral health providers, especially dentists with a specialty in pediatrics and accepting Medicaid, to fulfill the demand from children and families that need dental services. For providers we spoke with, the share of their patients that have Medicaid coverage ranged from 30% to up to 75%. Providers practicing in community health centers and public health clinics represent the high end of this range. Interviews with providers sought to understand the factors limiting dental practices from serving more children with Medicaid coverage.

DENTISTS REPORT THAT NC MEDICAID DOES COVER MANY COMPREHENSIVE PROCEDURES.

In the American Dental Association's provider survey across eight states, 70.8% of respondents indicated that Medicaid's failure to cover more comprehensive procedures represented either an extremely important or very important barrier to them treating more Medicaid patients.[xvi] North Carolina providers interviewed in this study indicated that NC Medicaid does actually cover more comprehensive dental procedures, suggesting a positive divergence from Medicaid practices in other states. Most providers interviewed reported that they have not had many issues with procedures or treatment not being covered through Medicaid or received denial for service reimbursement.

However, some providers noted that the process of getting approved for services for children with special health care needs can be cumbersome. One provider noted that they first have to prove a failed attempt at providing care without sedation before a child can be approved for sedation for a cleaning or exam. Rendering care without sedation for a child who might struggle with the intrusiveness of dental care can have traumatic impacts on children with special or complex health care needs. Requiring a failed attempt at providing care without sedation first can also waste both staff time and resources when the provider, and sometimes the family, already knows that sedation care is needed.

"But if they're six and up, and I say that they need sedation, I have to see them in the chair first, let it be a failed attempt, and then Medicaid will cover it. But it wastes so much time." - Alamance County oral health provider

LOW MEDICAID REIMBURSEMENT RATES ARE THE PRIMARY BARRIER PREVENTING PROVIDERS FROM ACCEPTING MEDICAID PATIENTS.

While Medicaid might cover comprehensive services well, low reimbursement rates for dental services can prevent providers from accepting Medicaid insurance. This stood as the most prominent and frequently discussed barrier to treating more children with Medicaid coverage. After coding provider interview transcripts, 28% of qualitative codes for Medicaid-related discussions pertained to reimbursement rates, the highest single code category across all interviews with providers.

In 2025, Medicaid reimbursement rates for child dental services in North Carolina were only 50.8% of private insurance payments and 33.9% of average dental charges.[xvii] The reimbursement rate that dentists receive from NC Medicaid has remained largely the same since 2008.[2] As providers noted, reimbursement rates have failed to keep pace with the rising cost of equipment, staff salaries, and other dental office overhead. This often forces providers to place a cap on the number of patients with Medicaid coverage they can see, if any at all. As noted previously, some providers we spoke with cap the number of children with Medicaid they see at 30% and are not often able to accept new patients.

"Right now, we are being paid the same fee that we got in 2008... Would you work a job that you had gone 17 years and never gotten a raise? Probably not." - Guilford County oral health provider

Due to low reimbursement rates, many pediatric providers often accept Medicaid patients out of a sense of duty, equating it to pro bono work since they receive very little payment from Medicaid reimbursement. Providers often spoke of their moral obligation to provide care for the Medicaid population. However, providers are often frustrated that they are among a relatively small portion of dentists that are providing care to such a large share of children and families with Medicaid coverage. This trend, as noted by a provider in Durham County, is "...unsustainable. And you have practices that are having to close because of it."

"I would say [reimbursement rates] have never been sufficient. I think people [accept Medicaid patients] out of the goodness of their heart. Depending on what the procedure is, it could be, you know, 30 or 40%...it may cover costs in some settings, but it may not cover costs of delivering the care itself." - Orange County oral health provider

Low reimbursement rates can also lead to a low quality of care. Providers we spoke with that have a lower volume of Medicaid patients often cap this number so that they can maintain a high quality of care for

2. NOTE: Albeit rates have been temporarily increased since 2008. For example, NC Medicaid increased dental rates during the COVID-19 pandemic using federal relief dollars; however, those funds have since expired and rates have reverted back to 2008 levels.

their patients. Higher volumes of Medicaid patients for some offices can mean shorter appointment times, which can frustrate parents and can often exacerbate children's fear of dentists if providers have to rush through exams or fillings.

"I think that, unfortunately, you know, we all know about those 'drill and fill' clinics who are high Medicaid volume, and you know, they're just seeing kids in and out the door, and it's so quick. Sometimes, those kids are treated, but it always is not in the best circumstances" - Alamance County oral health provider

MEDICAID ADMINISTRATIVE BARRIERS

Across the country, administrative barriers in Medicaid programs often prevent providers from becoming Medicaid-certified. These can take many forms, including prior authorization for services, complex billing, and onerous enrollment documentation. North Carolina providers interviewed in this study had mixed perspectives on administrative barriers like this in NC Medicaid. Most providers expressed that initially becoming certified as an NC Medicaid provider can be cumbersome but generally did not have many complaints about remaining certified. Many reported that the administrative barriers they encounter in NC Medicaid are not dissimilar to private insurance. However, multiple providers noted that if a doctor drops out of the Medicaid program, recertification can be difficult.

"When I got in practice, you could fill out one page, send it to Medicaid, and in two weeks, they sent you a number, and then you could start seeing patients. Now, there's a lot more hoops you got to jump through, but there's the same number of hoops for private insurance." - Guilford County oral health provider

Beyond certification, some providers expressed positive attitudes about NC Medicaid's reimbursement processes, noting that reimbursements are generally submitted in a timely manner and that the system is straightforward. However, if an office sees a higher volume of Medicaid patients or if their practice gets audited by Medicaid, the administrative burden can often exceed their staff's capacity. One provider we spoke with had a dedicated staff member in their office that oversees Medicaid administrative work, but not every office can hire staff specifically for their Medicaid patients.

School District Personnel Focus Group Findings

Schools provide a vital link to oral health care for underserved children that might not have a dental home. Integrating oral health screenings and dental services in schools can effectively identify and treat tooth decay early and expand access to oral health care. NC Child's focus groups with school personnel centered around school personnel's concerns regarding student oral health, poor oral health's impact on student achievement, and the scope of current school-based oral health services and barriers to implementation.

ORAL HEALTH OUTCOMES IN SCHOOL

BY THE TIME SCHOOL PERSONNEL SEE A STUDENT WITH TOOTH PAIN, IT IS OFTEN SEVERE AND IMPACTING THEIR DAY-TO-DAY WELLBEING.

Most school personnel told us that they are not seeing overwhelming numbers of students complaining about tooth problems, but when they do, it is often so significant that it cannot be ignored. Participants also noted that, most of the time, if the tooth pain is severe, nothing can be done that day and the student is sent home, missing the rest of the school day and putting students behind. School district personnel said they identify students with dental needs, but many never actually receive care. Schools will refer children to dental clinics, but uninsurance or a lack of Medicaid providers can delay or prevent care delivery, prolong tooth pain, and risk decay becoming more severe.

"I think too, by the time we see them, [their teeth] are so bad. I mean, we don't see it when it's just starting. I mean, I think of a kid we saw last year. He never, hardly, came to school. And by the time somebody had me look at his teeth, like, literally every tooth was black against the gum." - Cherokee County school personnel

"I get kids that come in with just raging, huge cavities, nerves exposed, and stuff like that. And if they are undocumented or underinsured or not insured, it is very hard to get somebody in to somewhere for care before they have, like, an abscess. It's heartbreaking." - Union County school personnel

School personnel routinely recognized the connection between oral health and overall health, acknowledging the increased risks of infection from untreated decay and the impacts on children's dietary practices. They also conveyed that students experiencing tooth pain during the school day struggle to focus in class, and many often stay home if pain is severe. In areas like Mitchell County, school districts reiterated some of the same concerns parents expressed, specifically that students often miss entire days

of school for one dental visit due to minimal access to providers in the area. This issue is compounded for students who require multiple dental visits to take care of severe oral health problems, setting them further back in school.

The impacts of poor oral health extend beyond attendance and academics in schools. Some school personnel reported that they sometimes observe behavioral issues in students with severe oral pain. They also see poor oral health affect students socially, as students with visible tooth decay are often self-conscious of their smile or hesitant to speak and participate in class.

"If there [are] dental issues, a lot of times they don't want to participate in, like, big classroom discussion. They don't want to smile because, you know, their teeth may not look the same as their classmates... even if it's not the pain that's impacting them." - Wake County school personnel

LACK OF PARENT INVOLVEMENT CAN BE A SERIOUS BARRIER TO POSITIVE CHILD ORAL HEALTH OUTCOMES, SCHOOL PERSONNEL REPORT.

Across the board, school district personnel reported that many parents face barriers that can limit their involvement in their children's oral health care. One factor contributing to this is simply a general lack of knowledge around the importance of oral health care. School district personnel affirmed findings from the parent focus groups that oral health education and habits are often generational. If a parent did not grow up regularly going to the dentist and practicing good oral hygiene, their children are also less likely to do so. Participants also echoed the widespread misconception that "baby teeth don't matter" among some parents. Lack of education around good oral health hygiene leads to parents not knowing the signs of tooth decay in their children or when to start brushing their children's teeth and taking them to the dentist.

"Because you could you look at their parents and kind of see where the path they're going on. It's generational; how they take care of their mouth is generational, because if mom and dad aren't brushing their teeth, they're not making kids brush their teeth. They're not teaching that." - Mitchell County school personnel

School district staff also recognize that oral health care is often deprioritized when families struggle to provide other basic needs. Focus group participants reported that if families are struggling to afford necessities like food or safe housing, making sure that their children are brushing their teeth and going to the dentist regularly is not a top priority.

In other cases, school districts find that parents are simply disengaged in prioritizing their child's oral health. Pitt County Schools often hosts educational opportunities for parents regarding oral health, but it can be challenging to engage the parents that they need to reach. This also affects the ability to provide

school-based oral health services to students who need it, since school-based services require parental consent before treatment. Participants in Mitchell County noted that most of the time there is a lack of follow-up from parents when a child is sent home with a referral to a dental clinic. Despite the benefits of school-based care, no involvement from parents often leads to a delay in care or a recurrence of caries.

"I mean, obviously, when families are struggling with the most basic needs, you know, housing, shelter, food, they're not going to prioritize health, dental or, you know, or mental health. I mean, that's just, it's too far down. You know, they're going to prioritize what they need for the next day." - Pitt County school personnel

ORAL HEALTH DISCUSSIONS IN CLASSROOMS, EVEN IN HEALTH CURRICULA, ARE SCARCE.

Parent focus groups revealed a desire for oral health to be more broadly discussed in the classroom. But school district personnel reported that health curriculum only briefly discusses oral health topics, if at all. Oral health is typically only discussed in a single lesson in health classes or during February for dental hygiene awareness month and mostly just for younger grades. Some school districts recognized the need for more oral health education. School district personnel and their dental partners in Pitt County try to fill the gap in classroom-based oral health education through supplemental oral health education with providers and through the mobile dental unit. Expanding oral health education in schools for students, as well as their parents, can help instill the value of oral hygiene at a young age and establish lifelong positive habits.

SCHOOL-BASED ORAL HEALTH SERVICES CAN EXPAND ACCESS TO CARE FOR STUDENTS, BUT CHALLENGES REMAIN.

Participants in school district focus groups discussed various forms of school-based oral health services. But a few stood out as the most prominent: screenings for oral health needs, preventive care in the school building, and preventive care through mobile dental units. Screening usually only happens in kindergarten and typically consists of state dental hygienists' visits to schools where they check students for untreated tooth decay, treated tooth decay, and other urgent dental needs. If students need follow-up care for urgent dental needs, they typically refer them to a brick-and-mortar clinic. Some participants noted that kindergarteners, second graders, and fifth graders used to be screened in schools, but that now screenings are typically limited to kindergarteners in select schools in the county. Without the presence of comprehensive school-based services, students with oral health issues like severe pain are sometimes sent home, and the school will contact the parents to try and make a connection with a dentist. The success of referrals like these hinges upon provider availability in the community and parental follow-up on recommendations.

Beyond screenings, school-based oral health services typically include comprehensive care like cleanings,

fluoride varnish, and sealants. These are often in partnership with local Federally Qualified Health Centers (FQHCs or Community Health Centers) or other community clinics. Providers will typically receive a list of students from the school whose parents have consented to oral health care provision and will set up equipment in a classroom with water access. Depending on the school district, this could be once a year or multiple times throughout the school year. Participants did note that the demand for school-based dental services far exceeds current capacity. School personnel acknowledged that, for many students, school-based care might be the only dental services they receive, especially if they are uninsured or have Medicaid coverage.

One of the more increasingly common ways oral health services are provided in schools is through mobile dental units (MDUs). MDUs, which can range in size from a van with one or two dental chairs to a semi-truck with multiple chairs, are often operated through county health departments, FQHCs, or private clinics. Most MDUs provide comprehensive oral health care, including screenings, cleanings, sealants, extractions, and fillings. In select cases, MDUs may have the capacity to conduct X-rays on-site. All services are provided with parental consent, and students are often referred to a brick-and-mortar clinic if MDUs cannot perform a procedure. MDUs can be privately owned, funded through the health department and Medicaid, or financed through philanthropic funding. Temporary grant funding can create difficulties for school-based oral health services if they lose funding or if they have no way of meeting increasing demand with current funding streams.

Focus group participants noted care volume provided through MDUs often hinges on staffing capacity, and some counties struggle to retain dentists and hygienists to staff them. Ideally, an MDU will stay at a school until all treatment plans for students needing care are fulfilled. However, with staffing and provider shortages, MDU staff are fortunate if they provide care at schools once a year. Participants remarked that there are additional challenges in finding providers who can work with children and operate within the confines of a mobile clinic.

"And you know, then again, a provider has to have a heart for it. This is not for everyone. Working with children is not for everyone. Working in a mobile unit is not for everyone. Working for public health, you know?...you have to have a heart for it, and if you don't, then you'll get worn out, or, you know, you'll go elsewhere." - Pitt County school personnel

Pitt County school personnel remarked that they are seeing a lower response rate of parental consent forms recently and are serving fewer students as a result. They also noted that they typically get a much better response from elementary school students than middle school or high school students, so they are currently trying new marketing strategies to appeal to older students. Similarly, with the passage of SB 49, more commonly known as "The Parents' Bill of Rights," parents must now actively opt-in for oral health services as simple as screenings. School-based oral health providers cite this legislation as a barrier to providing care to students, which results in some students who might need significant care falling through the cracks.

"And now with the Parent Bill of Rights, parents... actually have to actively sign their child up for a health screening, correct? Which includes dental screening. So, if they don't have the initiative to send in the paperwork, then their child isn't going to get a dental screening or other health services." - Cherokee County school personnel

Youth Focus Group Findings

Children and teens' perspectives are often left out of discussions about oral health. The absence of children's experiences can limit the effectiveness of recommendations to improve oral health outcomes and expand services, as programs not designed with children's perspectives centered could be underutilized. NC Child sought to address this gap through focus groups with high school students. These conversations provided valuable insights into how they see oral health affecting themselves and their peers and point to a desire for more school-based services and better access to dental care.

HIGH SCHOOL STUDENTS KNOW THE IMPORTANCE OF GOOD ORAL HYGIENE BUT FAMILY CONVERSATIONS ABOUT ORAL HEALTH WANE AS CHILDREN GROW OLDER.

High school-age participants in oral health focus groups conveyed similar sentiments regarding prioritization of oral health care as parents, school-district personnel, and dental providers. Most older children report going to the dentist at least every six months, but the frequency and consistency of visits depend on their parents' attitude toward oral health, reflecting the generational influence that can affect children's experiences with oral health. One participant in Harnett County noted that, as they have gotten older, their visits to the dentist have dwindled.

"After I turned 10, no one really cared about my dental hygiene anymore, so I really have to go [to the dentist]." - Harnett County participant

Similarly, participants acknowledged that going to the dentist every six months can become difficult without adequate providers in the area, or if they need to reschedule an appointment. Without local dental care options, good oral hygiene becomes a necessity. Youth participants across all focus groups did understand the importance of avoiding sugary drinks and snacks to prevent decay, as well as brushing their teeth twice a day, and flossing. However, for children that do not have access to healthy foods or live in financially strained households that cannot afford nutritious foods, good oral hygiene alone may not be enough to maintain healthy teeth.

"I would go [to the dentist], but recently they closed. Well, they don't have anybody at here at Spruce Pine. That's where I used to go all the time. So, ever since that happened, I don't really go, but I just try to brush my teeth as much as I can and floss and everything." - Mitchell County participant

High school focus group participants noted that oral health conversations with their parents and adults waned as they grew older. Participants remarked that their parents talked more about the value of brushing and flossing their teeth when they were younger. Conversations that do happen usually center around dental appointments and scheduling and less on fostering and maintaining good oral health habits.

"I think it's a lot more prevalent when you're younger. I feel like at our age, none of our parents are really like, 'Did you brush your teeth?'" - Harnett County participant

While teens that NC Child spoke with in focus groups acknowledged the importance of regular dental visits, many feel as if the experience could be more positive. Some of this relates to the typical discomfort many people might have with the dentist, especially the sensory experience of cavity fillings and sitting for X-rays. However, discomfort at the dentist can be compounded by a lack of communication by providers. Just as parents expressed a desire for more information on the services provided at the dentist, high school participants felt the same sentiments. Teens remarked that they wished providers took more time to explain what they were doing and highlighted the difference that good communication can have on their experiences. These early experiences at the dentist in childhood and adolescence are critical, as they have important implications for children's relationship with oral health care as adults.

"I would say my experience at the dentist, my first dentist, she wouldn't explain what she was doing. So, it was scary at first. Then I changed dentists, and it was like a whole different experience, and I actually enjoyed it. It wasn't painful or anything. I knew everything that she was doing as she was going." -Lee County participant

TEENS UNDERSTAND BARRIERS TO ORAL HEALTH CARE ACCESS LIKE PROVIDER AVAILABILITY AND INCOME, WHILE ACKNOWLEDGING THAT POOR ORAL HEALTH OUTCOMES CAN HURT SCHOOL PERFORMANCE AND SOCIALIZATION.

Student focus group participants understand oral health as a vital component to overall health, but they also acknowledge the same barriers that their parents, school districts, and dental providers discussed. As reflected in the discussion above, high schoolers who live in communities with poor provider access are often forced to rely on hygiene alone to maintain the health of their teeth. They also discussed that families struggling to meet basic needs will deprioritize oral health care. One student in Harnett County explained that they live with their single mother and have issues with insurance coverage, so oral health care is not something that is a top priority for their family.

"It's in the recent years that I haven't been to [the dentist] as, like, the past like, two years... And it's just like, I have a single mom, and she works all the time, so it's hard for us to get off school, and then I've had problems with insurance and all of that. So, it's not something that's at the top of our list." - Harnett County participant

Despite barriers that exist for some children and their families, most are acutely aware that oral health has an immense impact on their health and overall well-being. Participants remarked that intense tooth pain or decay leading to tooth extraction impedes their ability to eat nutritious foods, which can cascade into other health problems. Similarly, they recognize that tooth decay can lead to serious infections that can spread elsewhere in the body. Most teens we spoke with were not directly experiencing significant tooth pain, but they do note discomfort when they periodically need to have braces tightened which contributes to temporary impacts on their daily lives.

"If you had, if you had, like, severe tooth pain, it would probably, like, influence, like what you're eating. You'd probably be eating less, which isn't, like, healthy." - Union County participant

Students also discussed oral health issues' impact on school performance. Research shows that students with toothaches in the last six months are about four times more likely to have GPAs lower than the median compared to students without recent toothaches.[xviii] In focus groups, students reported difficulties concentrating in class when they experience tooth pain, after having cavities filled, or while dealing with severe headaches or migraines resulting from tooth pain. Other students noted that they often miss entire days of school to go to the dentist if their community lacks access to adequate oral health providers.

"Yeah, concentration would be low. Because, like, whenever I got my filling, it was kind of hard to pay attention, because...some part of my mouth was still numb and then... it was still hurting, so it was kind of hard to concentrate." - Lee County participant

Student discussions of how oral health affects self-confidence and peer perceptions were similarly concerning. In multiple focus groups, students mentioned that someone's teeth or smile are often the first thing they notice, understanding that people make judgements based on these physical characteristics. One high school participant commented that yellow or crooked teeth can have a negative impact on employment prospects, for both part-time jobs during school and long-term careers as adults. Some focus group participants have witnessed students bullying their peers for the appearance of their teeth, which can lead to feelings of self-consciousness and discourage socialization. One student from Harnett County noted that "there's definitely, like, people who are bullies, not nice people who will go and point out people who don't have super nice teeth, just to be mean."

"Yeah, I think a lot of it is, like, when you see somebody with, like, dirty teeth, or, like, just not the regular teeth that you see all the time... people will already make up ideas about them, like, 'Oh, they're probably lazy, or they don't brush their teeth, or like, X, Y and Z,' all this about them, when in reality, like that could just be how their teeth looks." -Harnett County participant

STUDENTS ARE EAGER TO SEE SCHOOLS STEP UP AND MAKE ORAL HEALTH A PRIORITY.

While school-based oral health services bridge gaps in access and provide comprehensive care to children, student focus groups revealed mixed experiences with school-based cleanings and dental exams. High schoolers reported receiving school-based oral health care either in school or through MDUs in elementary and middle school, but services tapered off when they reached high school. Most said that they would take advantage of school-based services if provided, as they could reduce access barriers related to provider availability and the challenges for families finding time to go to the dentist. Interestingly, this diverges from conversations with school personnel, who reported that they receive the lowest interest in school-based dental services from high schoolers. High school students that do use school-based services suggested that additional privacy measures could help with uptake. Teeth cleanings and other preventative services are often conducted in open spaces, which can cause them to feel uncomfortable when other students pass by.

"Yeah, I transferred to the school sophomore year, but at my old school, they did have [dental services], and I think it helped a lot of people, because almost every student showed up and they really, like, benefited from that service." - Harnett County participant

Participants also noted that oral health is not often prioritized in classroom instruction, and schools could better address oral health disparities by providing supplies to students. Even health classes do not meaningfully cover oral health, sometimes only bringing it up as a potential career pathway. Lee County students suggested that it might be beneficial for schools to bring in dentists or dental assistants to detail how the services they provide improve students' oral and overall health. Students also expressed that their schools should offer oral health supplies for them or their peers who may not have the means to buy toothbrushes, toothpaste, dental floss, and other resources. Discussing oral health in a classroom setting can also reinforce the importance of maintaining good oral health habits and allow students to have productive conversations among themselves about oral health.

"I think if maybe every now and then they had, like, a little assembly where they talked about oral health and talked about the things you could do and gave out, like, contacts to like, 'Oh, if you have this, you can contact this person,' or 'oh, if you're having these issues, you can come talk to this nurse,' or whatever. So, it'd be beneficial, and people would know what to do specifically if they had those problems. Because maybe it's not even that we're not talking about [oral health] enough, but maybe it's just that people don't know specifically what to do." - Mitchell County participant

Beyond school-based improvements, high schoolers also emphasized the common theme throughout our focus groups that oral health is cost prohibitive. Especially for uninsured families, out-of-pocket costs can price people out of oral health care. Some participants also noted that their Medicaid coverage consistently makes it difficult to access a provider that will accept their insurance, echoing themes heard across all focus groups. When we asked how access to oral health care could be improved, most focus groups discussed that cost should not preclude someone from being able to access crucial dental care. Participants proposed that offering oral health, whether in schools or communities, at little to no cost would help improve oral health outcomes.

"So, I feel like a lot of times, if people don't go to the dentist... it's not because they don't want to, more that they can't afford to." - Mitchell County participant

Policy Recommendations

I. INCREASE REIMBURSEMENT RATES FOR DENTAL SERVICES

Reimbursement rates are the most prominent barrier to existing providers accepting a higher volume of pediatric Medicaid patients. Dental providers can simply bring in much more revenue from charging private insurance than Medicaid. By increasing reimbursement rates to be more competitive with private insurance, North Carolina can incentivize providers to expand the number of Medicaid patients they see by making reimbursements more financially viable for their businesses. Studies have shown a positive relationship between more generous Medicaid payment policies and improved oral health outcomes for children. A 2022 study indicated that a one percentage point increase in Medicaid fee ratio was associated with a significant increase in positive oral health, with results most significant for Hispanic children.[xix]

In North Carolina's 2025 legislative session, Representatives Brian Biggs, Donny Lambeth, Larry Potts, and Tricia Cotham introduced legislation to increase Medicaid reimbursement rates for dental services from 35% of the average dental charge in 2023 to 46%.[xx] This would have brought North Carolina's dental rates more in line with surrounding southern states. The bill also would appropriate $52 million in recurring funds in each of year of the biennium to the North Carolina Department of Health and Human Services to cover the cost of increased rates, which would also draw down $95 million in federal funds for Medicaid dental rate increases. In the 2026 legislative session, Senators Gayle Adcock, Jim Burgin, and Kevin Corbin filed another bill to increase Medicaid rates for dental services to 50% of the average dental charge, which included an $80 million appropriation. Additional funding for increased dental rates is critical to prevent funding shortfall in other Medicaid-covered services. However, both bills had little movement since their introduction.

Policymakers can ease access shortages for children and families with Medicaid coverage by passing this or similar legislation that increases dental rates. Doing so would incentivize provider participation in NC Medicaid and allow existing Medicaid-certified providers to accept a more meaningful volume of patients with Medicaid coverage.

"Medicaid reimbursement rates, just by increasing them, will help our bottom line...it may entice some private offices in rural areas where there's no other dentist who may choose to, you know, throw a few bones... a patient's way, and accept a few Medicaid folks into their practice. " - Buncombe County oral health provider

II. IMPROVE FUNDING STREAMS FOR SCHOOL-BASED ORAL HEALTH SERVICES

With increasing demand for school-based health services, current staff capacities often fall short. For many students, school-based oral health services are their only source of oral health care. The impact of programs like mobile dental units (MDUs) or school-based health centers (SBHCs) hinges upon consistent, widespread care, which is difficult to maintain without appropriate funding streams.

One of the biggest challenges to offering comprehensive school-based oral health services as some school districts in North Carolina have done is funding. Often times the upfront capital costs of purchasing vans or trailers that can serve as MDUs and outfitting them appropriately can be cost prohibitive. Dedicated grant funding for school districts or their county health department partners to create or expand school-based oral health services through MDUs can help fill this gap. Once established, programs like MDUs can often sustain themselves through Medicaid or private insurance billing or philanthropic funding. But the upfront capital and planning costs often stand as barriers to launching these programs. Legislative general appropriations or grants pulled down from the federal government and provided by DHHS can help districts and local communities get these programs off the ground.

Comprehensive school-based oral health services can also be expanded by prioritizing funding for school-based health centers (SBHCs). Select counties in North Carolina already have SBHCs that provide physical and mental health support for public school students, but they are not widespread. According to the North Carolina School-Based Health Alliance, there are more than 90 SBHCs serving 30,000 students in North Carolina that are funded through health systems, philanthropic organizations, or through local government. There are even fewer state-funded school-based health centers. In fiscal year 2025, there were only 30 state-funded SBHCs, serving about 8,100 students.[xxi] SBHCs offer a wide range of services, which can vary by site. Most provide primary and preventative medical care and wellness clinics, while others add behavioral and oral health care to their service array.

Oral health services are often less common among SBHCs. A national census of school-based health centers in 2022 found that only about 30% offer on-site oral health services, which was the second least common type of medical service offered.[xxii] More commonly, pediatric providers will perform dental screenings as part of well-child visits at SBHCs and refer children to community-providers if dental needs are identified. However, as discussed in this report, families struggle to access providers in their communities, especially if their children have Medicaid coverage and must navigate a limited workforce. Among state-funded SBHCs, only about half of students served (54%) had a dental home in FY2025.[xxiii] Expanding on-site oral health services at SBHCs would help remove barriers to oral health care for children who otherwise may not be able to access dental services.

Increased state funding for SBHCs could help facilitate new centers or expand existing SBHCs' service array to include comprehensive dental care. As with MDUs, the state's role could largely be limited to upfront capital and planning costs. This might take the form of initial funding to retrofit existing buildings or construct modular units for new SBHCs in schools that already have them, or, conversely, funding

existing SBHCs that do not have oral health services to purchase the necessary equipment to begin offering these services. Once started, SBHCs can often rely on Medicaid and private insurance billing to sustain services in schools.

Other states across the country have started to direct funding to expand SBHCs, and North Carolina can follow suit. In Georgia, Governor Brian Kemp's administration directed $125 million of COVID relief dollars to expand school-based health centers in the state.[xxiv] These funds were dedicated to starting new SBHCs in Georgia with each recipient receiving $1 million for local needs assessments, capital improvements, and initial staffing. SBHCs had three years to spend down the funds and, after that, needed to sustain operations through billing or private and philanthropic investments.

III. UPDATE STATUTES REGULATING ELIGIBILITY REQUIREMENTS OF PUBLIC HEALTH AND LIMITED SUPERVISION DENTAL HYGIENISTS TO IMPROVE WORKFORCE EFFICIENCY

North Carolina faces a shortage of dental providers, particularly dentists. While increasing Medicaid reimbursement rates can help ease some challenges for children and families with Medicaid coverage by incentivizing dentists to accept Medicaid, it does not ameliorate the existing oral health workforce shortage. North Carolina can ease some oral health access challenges by updating General Statutes with regulatory changes that improve efficiency in care settings across the state.

North Carolina statues identify a few different types of dental hygienists, including limited supervision and public health hygienists. These are hygienists that have more experience that allows them to operate outside of dental offices and therefore with less direct oversight from dentists. Limited supervision and public health dental hygienists conduct the same preventative care as regular dental hygienists. North Carolina's regulatory and statutory framework allows limited supervision and public health dental hygienists to provide care outside of a dental office and in community-based settings like public health departments and clinics, mobile dental units, and school-based settings, all with less direct oversight from dentists.

But right now, North Carolina has conflicting rules with differing eligibility requirements for limited supervision and public health dental hygienists, which creates ambiguity around the settings either of these hygienists can operate in, as well as who can qualify as a particular type of hygienist. These qualifications aren't mutually exclusive, and ambiguity around the classification limits and creates confusion around the care settings they can practice in.

Both limited supervision and public health dental hygienists provide similar services to their patients; the primary distinction simply relates to the settings in which these hygienists can provide care. Public health hygienists typically work in local health departments, state public health programs, and Federally Qualified Health Centers connected to public health systems. Limited supervision hygienists typically

hygienists typically work for private entities in wider community settings like schools. Updating General Statute 90-233 to better clarify and align eligibility requirements regulating public health and limited supervision dental hygienists would improve efficiency in community-based care by making it easier for both types of hygienists to move between care settings.

There are other changes that can be made to General Statute 90-233 to better address oral health workforce challenges. Increasing the number of dental assistants that limited supervision dental hygienists can supervise would further improve access in school and community settings. Currently, limited supervision dental hygienists can supervise just one dental assistant to assist in clinical procedures. Increasing this number to two dental assistants under the supervision of limited supervision hygienists (and public health hygienists) would effectively create a small care team and continue to improve workforce challenges and the efficiency of care. Hygienists could focus more on clinical care they are licensed for, while dental assistants handle prep work and logistics. In school-based settings like mobile dental units, this change would increase the number of students that hygienists could see and treat in the limited amount of time they are visiting schools.

Combined with investments in school-based oral health services, these statutory changes would enable more hygienists to work in school-based settings. Layering enhanced Medicaid reimbursement rates on top of these policy changes may also help to make school-based programs more sustainable while better serving children with Medicaid coverage in school settings. Increased investments in the upfront costs of comprehensive school-based oral health services like MDUs or SBHCs can jumpstart these programs in schools that do not have them. More streamlined regulatory frameworks around eligibility requirements for public health and limited supervision dental hygienists improves efficiency among the existing dental workforce and expands the number of hygienists that can work in schools. Coupled together, these interventions move toward a more sustainable school-based oral health system that will increase access to services for children and families who otherwise struggle to access care.

IV. PUBLIC HEALTH CAMPAIGNS ON THE IMPORTANCE OF ORAL HEALTH FOR OVERALL HEALTH

In all focus groups and interviews conducted through this research, participants uplifted a lack of knowledge about the importance of oral health and education around good oral hygiene as a common barrier to positive outcomes for children. State and local policymakers can invest in public health campaigns that educate parents about the critical role oral health plays in children's overall health and development. These campaigns should clearly communicate the importance of early preventive dental visits, daily oral hygiene, and healthy nutrition in preventing cavities and other oral diseases. Messaging should be culturally relevant, easy to understand, and distributed through trusted channels such as pediatricians' offices, schools, child care centers, and community organizations. By increasing parents' awareness of how oral health affects children's ability to eat, learn, and grow, public health campaigns can encourage preventive behaviors and help families seek timely dental care, ultimately improving long-term health outcomes for children.

V. INTEGRATE ORAL HEALTH CARE MORE INTENSIVELY INTO PRIMARY CARE

Pediatricians are much more accessible than oral health providers. Despite its importance to overall health, oral health is scarcely discussed in well- child visits. By incorporating more aspects of oral health in primary care visits—beyond simply glancing in children's mouths or asking parents if they have a dentist—families could be exposed to oral health education early in a child's life. Integration of oral health with primary care increases access to critical care for children by identifying severe tooth decay early, but it also signals that oral health is crucial to overall health.

North Carolina's 'Into the Mouths of Babes' program is designed to equip medical providers with oral health examination training and identification of dental issues. However, when we spoke with parents about their experiences in primary care settings, we found that any integration of oral health in well-child visits is inconsistent and often surface level, suggesting the program may not be widespread.

Some states have already implemented models in well-child visits that incorporate dental exams by oral health providers into primary care appointments. Wisconsin's Medical Dental Integration (WI-MDI) model embeds dental hygienists in prenatal and pediatric primary care teams at various Federally Qualified Health Centers, nonprofit clinics, and large health systems throughout the state. During a well-child visit, the hygienist performs a 10-minute oral health examination for caries, applies fluoride varnish and silver diamine fluoride as needed, provides education to families, and assists in making referrals to a dental clinic. In 2023, over 15,000 visits to a medical provider at these locations included an oral health examination by a dental hygienist.[xxv]

Conclusion

Improving oral health care access must be a primary policy consideration to improve the overall health and well-being of children in North Carolina. The two are inextricably linked, but too often that connection point is lost. Our health systems treat oral health as a "luxury" or "add-on" service, which deprioritizes its central role in better health outcomes for children. Even if families recognize oral health's importance, many struggle to access dental providers in their communities, especially families with children with Medicaid coverage. Poor oral health outcomes in children like untreated tooth decay or dental caries and severe dental pain can evolve into larger health issues, while also impacting their self-esteem, mental health, and academic performance. Improving rates of tooth decay and preventive dental care access will require oral health providers, schools, and families to work in tandem with one another. Improving access to community-based dental care, engaging families about the importance of oral health, and investing in school-based oral health services would all help address increasing needs among children and foster a more robust oral health system in North Carolina.

References

i. NC Child and North Carolina Institute of Medicine. North Carolina Child Health Report Card. 2025, 2023, 2021, and 2019. Accessed at: https://nciom.org/nc-health-data-archive/north-carolina-child-and-womens-health-report-cards/

ii. NC Department of Health and Human Services, Division of Public Health, Oral Health Section. Kindergarten Oral Health Status 2023-2024. Accessed at https://www.dph.ncdhhs.gov/programs/oral-health/stats-and-data#GeneralData-862.

iii. Child and Adolescent Health Measurement Initiative. 2023-2024 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 01/30/2026 from [www.childhealthdata.org].

iv. NC Department of Health and Human Services (2025). North Carolina Office of Rural Health, Dental Health- Health Professional Shortage Areas (HPSA). Accessed at https://www.ncdhhs.gov/dental-scores/download

v. North Carolina Health Professions Data System, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Created January 30, 2026 at https://nchealthworkforce.unc.edu/interactive/supply/.

vi. NC Child analysis of NC Department of Health and Human Services Medicaid enrollment data and US Census Bureau population estimates.

vii. North Carolina Institute of Medicine. (2024). Transforming Oral Health Care in North Carolina. Accessed at https://nciom.org/wp-content/uploads/2024/04/Oral-Health-Report-4-24.pdf.

American Dental Association Health Policy Institute. An ADA Health Policy Institute Analysis for the North Carolina Department of Health and Human Services, Division of Health Benefits. December 2020. Accessed at https://oralhealthnc.org/wp-content/uploads/2021/01/NC-HPI-report-final.pdf.

viii. Guarnizo-Herreño, C. C., & Wehby, G. L. (2012). Children's dental health, school performance, and psychosocial well-being. The Journal of pediatrics, 161(6), 1153–1159. https://doi.org/10.1016/j.jpeds.2012.05.025

ix. North Carolina Institute of Medicine. (2024). Transforming Oral Health Care in North Carolina. Accessed at https://nciom.org/wp-content/uploads/2024/04/Oral-Health-Report-4-24.pdf.

x. American Dental Association, Health Policy Institute. (2024). Survey of Medicaid Beneficiaries and Survey of Dentist Opinions on Medicaid Combined Results Report. Accessed at: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/Survey_Dentists_Medicaid_Beneficiaries_Eight_States.pdf

xi. CareQuest. (2022). Three Reasons Why Adults on Medicaid Need Dental Coverage. Accessed at https://www.carequest.org/about/blog-post/three-reasons-why-adults-medicaid-need-dental-coverage

xii. Guarnizo-Herreño, C. C., Lyu, W., & Wehby, G. L. (2019). Children's Oral Health and Academic Performance: Evidence of a Persisting Relationship Over the Last Decade in the United States. The Journal of pediatrics, 209, 183–189.e2. https://doi.org/10.1016/j.jpeds.2019.01.045

xiii. American Academy of Pediatric Dentistry. Policy on early childhood caries (ECC): Consequences and preventive strategies. The Reference Manual of Pediatric Dentistry. Chicago, IL: American Academy of Pediatric Dentistry; 2025:96-100.

xiv. Guarnizo-Herreño, C. C., & Wehby, G. L. (2012). Children's dental health, school performance, and psychosocial well-being. The Journal of pediatrics, 161(6), 1153–1159. https://doi.org/10.1016/j.jpeds.2012.05.025

xv. Consumer Guide to Dentistry. (2019). A Developing Smile: The Permanent Impact of Baby Teeth. https://www.yourdentistryguide.com/news/baby-teeth-permanent-teeth/#:~:text=If%20baby%20teeth%20are%20lost,address%20misalignment%20or%20spacing%20irregularities..

xvi. American Dental Association, Health Policy Institute. (2024). Survey of Medicaid Beneficiaries and Survey of Dentist Opinions on Medicaid Combined Results Report. Accessed at: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/Survey_Dentists_Medicaid_Beneficiaries_Eight_States.pdf

xvii. Analysis of American Dental Association, Health Policy Institute. (2025). Medicaid fee-for-service (FFS) reimbursement data. Accessed at https://www.ada.org/resources/research/health-policy-institute/coverage-access-outcomes/dental-care-in-medicaid-programs

xviii. Seirawan, H., Faust, S., & Mulligan, R. (2012). The impact of oral health on the academic performance of disadvantaged children. American journal of public health, 102(9), 1729–1734. https://doi.org/10.2105/AJPH.2011.300478

xix. Lipton BJ, Decker SL, Stitt B, Finlayson TL, Manski RJ. Association Between Medicaid Dental Payment Policies and Children's Dental Visits, Oral Health, and School Absences. JAMA Health Forum. 2022;3(9):e223041. doi:10.1001/jamahealthforum.2022.3041

xx. Act to Modernize Medicaid Dental Rates. H.B. 60. North Carolina General Assembly. (2025). Accessed at chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.ncleg.gov/Sessions/2025/Bills/House/PDF/H60v0.pdf

xxi. North Carolina Department of Health and Human Services. (FY 2025). NC School Health Center Annual Report. Accessed at: https://www.ncdhhs.gov/annual-report-school-health-centers-fy-24-25/open

xxii. National Center for School Based Health Care, School-Based Health Alliance. (2023). Findings from the 2022 National Census of School-Based Health Centers. Accessed at: https://sbh4all.org/wp-content/uploads/2023/10/FINDINGS-FROM-THE-2022-NATIONAL-CENSUS-OF-SCHOOL-BASED-HEALTH-CENTERS-09.20.23.pdf

xxiii. North Carolina Department of Health and Human Services. (FY 2025). NC School Health Center Annual Report. Accessed at: https://www.ncdhhs.gov/annual-report-school-health-centers-fy-24-25/open

xxiv. Associated Press. (August 24, 2022). Kemp allots $125M in federal money for school health centers. Georgia Public Radio. Accessed at: https://www.gpb.org/news/2022/08/24/kemp-allots-125m-in-federal-money-for-school-health-centers

xxv. Jenna E. Linden, Constance L.U. Gundacker, Lindsay Deinhammer, Matt Crespin. (June 2023). Medical Dental Integration in Wisconsin: Integrating dental hygienists into pediatric well child visits and prenatal care. American Dental Hygienists' Association, 97 (3) 13-20. Accessed at: https://jdh.adha.org/content/97/3/13#sec-4