Medicaid and the Supreme Court’s Decision on Health Care Reform

Marija Osborn, MSW
NNOHA Policy Analyst

June brought the long awaited Supreme Court decision on the Affordable Care Act, which declared the controversial individual mandate to be within Congress’ constitutional power to tax. While that piece of the decision had garnered the most interest leading up to the decision, it is their ruling on Medicaid expansion which may impact your clinic most in the coming years.

As part of the effort to provide health care coverage to more Americans, the Affordable Care Act includes an expansion of Medicaid to cover nearly all people under age 65 whose household income is at or below 133% Federal Poverty Level (FPL). This expansion is to begin in 2014 and is to be 100% federally funded for the first two years and at 90% thereafter. The expansion component included a provision stating that if a state did not expand Medicaid then the HHS Secretary could withhold their Medicaid funding. This expansion was also ruled on by the Supreme Court.

In the Court’s ruling, the majority found that this was not just an expansion, but the creation of a new program because it went beyond the scope of the original program. Since the expansion was deemed to be the creation of a new program, predicating state’s funding for the existing program on their

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participation in the expansion was found to be unconstitutionally coercive. More simply, while Congress can provide funding for states to expand Medicaid, they cannot pull a state’s funding if states choose not to expand the program.\(^1\)

This decision gives states a new flexibility to choose if they will participate in expanding coverage to newly eligible individuals in their state. As of the end of July, five states had declared that they will not participate in the expansion, ten had declared they will participate in the expansion, and the remainder have not declared their decision yet. To see an updated map of each state's decision and learn where your state stands, refer to: [http://leanforward.msnbc.com/news/2012/07/24/12707197-so-where-do-states-stand-on-the-medicaid-expansion-lite](http://leanforward.msnbc.com/news/2012/07/24/12707197-so-where-do-states-stand-on-the-medicaid-expansion-lite).

While the ACA decision and implementation will have a large effect on safety-net health clinics, what impact will it have on the oral health side? Unfortunately the answer is not much.

The ACA requires that health plans offered both in the individual and group markets, including the expansion of Medicaid, must cover ten categories known as “essential health benefits.” The only place that oral care is included in this list is under pediatric services. The impact of this is that thousands of children will now have access to care, but their parents are not as lucky.

For every adult in the US who is without health insurance, it is estimated that three lack dental coverage.\(^2\) While the Affordable Care Act is projected to dramatically decrease the number of people without health insurance, it will not have the same impact on the number without oral health coverage because of its limited inclusion.

Comprehensive and preventative care needs to include oral health, and this is a battle to be fought at both the state and federal levels. At the state level you can be the voice of your clients in encouraging the state to include oral health under Medicaid, which is a state’s option. On the federal level, promising legislation has been introduced by Senator Sanders in the Comprehensive Dental Reform Act of 2012, which would incorporate oral health into Medicare, Medicaid, VA benefits, and the ACA.

As the country begins to implement the ACA, we can celebrate the expanded access to health care for millions, but we must keep oral health in the discussion.

References:
\(^1\) For further information on how the Medicaid expansion will impact individual states, refer to: [http://www.kff.org/healthreform/8076.cfm](http://www.kff.org/healthreform/8076.cfm)
\(^2\) [http://www.kff.org/uninsured/8324.cfm](http://www.kff.org/uninsured/8324.cfm)

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**NNOHA Welcomes Its New Policy Analyst**

In June, NNOHA welcomed a new Policy Analyst, Marija Osborn. Marija is excited to join NNOHA. Previously, Marija worked for United Way of Larimer County facilitating and coordinating multiple community groups to address a diversity of poverty related issues and barriers. These committees worked to develop and advocate solutions based in programing and policy. Marija’s work was central to the establishment of a community goal to cut poverty in half by 2025 and the development of the initial plan to achieve this goal. Marija has also worked with several Colorado policy organizations, including The Bell Policy Center where she worked on issues of fiscal policy and education access. Marija received her Masters of Social Work from the University of Denver with a concentration in facilitating community and policy change. Marija is an avid knitter and loves skiing, biking, and spending time with her dogs. Teddy King, NNOHA’s former Policy Analyst, continues to assist NNOHA in her new role as Policy Consultant.
NNOHA Launches the National Oral Health Learning Institute!

Maria Smith, MPA
NNOHA Project Coordinator

The National Oral Health Learning Institute (NOHLI) is an exciting new program for Health Center Dental Directors and Dental Program Managers. This year-long, in-person and online training program provides core knowledge and competencies that Health Center Dental Directors and Dental Program Managers need to work as effective managers, leaders, and advocates for oral health and their communities.

The coursework of the NOHLI covers the topics from NNOHA’s Operations Manual for Health Center Oral Health Programs, including Leadership, Health Center Fundamentals, Financials, Risk Management, Workforce and Quality. For example, NOHLI scholars will learn how to develop relationships with members of the Executive Team, better develop and manage the dental department’s budget, effective recruitment and retention strategies, and how to develop a quality improvement plan. NOHLI scholars will learn via online modules, assignments, live webinars and in-person trainings. NNOHA is proud to work with the University of the Pacific Arthur A. Dugoni School of Dentistry, our technical partner, who hosts the platform for all online learning. 2012-2013 NOHLI scholars will meet for the first time at the 2012 National Primary Oral Health Conference in La Jolla, CA, for an orientation and in-person training.

NNOHA is proud to announce the 2012-2013 NOHLI scholars:

- Remedios Amigon, DDS, Comprehensive Community Health Centers, Inc., Glendale, CA
- Lisa Bozzetti, DDS, Virginia Garcia Memorial Health Center, Hillsboro, OR
- Stephen Chadwick, DDS, West County Health Center, Guerneville, CA
- Tena Geis, RDH, MA, Primary Health Care, Inc., Des Moines, IA
- Lisa Kearney, DDS, Erie Family Health Center, Chicago, IL
- Ginger Melton, RDH, Hampton Roads Community Health Center d/b/a Portsmouth Community Health Center, Portsmouth, VA
- Miriam Parker Adams, DDS, Hamilton Community Health Network, Flint, MI
- Kelley Purvis Johnson, DMD, Healthcare Network of Southwest Florida, Immokalee, FL
- Yogita Thakur, DDS, MS, Ravenswood Family Health Center, East Palo Alto, CA
- Arthur Unruh, DDS, Community Health Center of Southeast Kansas, Iola, KS

The NOHLI is funded under a cooperative agreement with the Health Resources and Services Administration.

Editor’s Note:
NNOHA received an overwhelming number of applications for the first year of this initiative.

We thank you for your interest! The applications for the 2013-2014 NOHLI will be available in the summer of 2013. Please check http://www.nnoha.org/nohli.html for more updates in the future.
This is the clinical topic at the moment and has some people, most of them not dentally inclined, very nervous. Some of these people are your patients. This article serves as a quick reference on the facts about dental x-rays and the risk of meningioma and gives information that could assist dental providers in answering some of the questions that may be slightly beyond our recollection from dental school radiography.

The article “Dental X-Rays and Risk of Meningioma,” April 10, 2012, Cancer is definitely an eye opener, showing an association between dental x-rays and meningioma, a type of brain tumor. As we shall address later, it certainly needs to be heeded in terms of our practice, and how we as practitioners of dentistry need to use x-rays prudently. However, the article has inadvertently caused a panic in the general public.

According to the United States Department of Health and Human Services, there are four levels of research studies. The hierarchy is as follows from highest to lowest level of validity:

**Chart 1: Hierarchy of Study Designs**

- **Level 1:** Randomized controlled trials (highest validity) - includes quasi-randomized processes such as alternate allocation.
- **Level 2:** Non-randomized controlled trial - a prospective (pre-planned) study, with predetermined eligibility criteria and outcome measures.
- **Level 3:** Observational studies with controls - includes retrospective, interrupted time series (a change in trend attributable to the intervention), case-control studies, cohort studies with controls, and health services research that includes adjustment for likely confounding variables.
- **Level 4:** Observational studies without controls (e.g., cohort studies without controls and case series)

The study conducted for the published article is at best a Level 3 study, “observational study with controls,” because while the selection of the control group was random, the study relied on patients recalling the number of times that they had visited the dentist since they were a child and the number of x-rays received during those visits. It is not clear how or if different types bias in the research design were reduced. Were the interviewers blinded? Is it possible that study participants who had had surgery for Meningioma could over-report exposure because they knew that the study was about risk of dental x-rays?

In addition, the method of using a questionnaire may not have been appropriate or the most reliable in this situation. It is conceivable that 70-79 year old individuals did not accurately remember the type or number of x-rays they had when they were 8 years old. The authors point out the difficulty of getting medical records; however, in a sample of the cases, they could have corroborated the data found in the questionnaires with systematic analysis of medical/dental records to validate the self-reported x-ray exposure. The article does recognize this as a potential fault but this was not adjusted for in the results. The study did not attempt to retrieve patient records. The authors state that this was difficult because records for most dental patients are not centralized and that most patients will average 6.1 to 6.6 dentists over a lifetime. This makes the data in the article less valid as room for error is high.

Other commentaries have also questioned the results of this study. A missing piece is the association of dental x-rays with tumors in other organs that are close to the mouth. This includes the eye, thyroid, and oral epithelium. DrBicuspid.com interviewed Arthur Goren, past director of radiology at SUNY Stony Brook School of Dental Medicine and currently clinical associate professor in the department of cardiology and comprehensive care at New York University College of Dentistry. He mentioned that dosimetry studies of cone-beam CT exposures to the head and neck of adult male and female and juvenile phan-
toms that show that these other facial structures received more scatter radiation than the brain and cranium. Yet there has been no association shown between dental x-rays and increased tumors in these sites.

As with all reacting articles and comments written, a pause for caution is warranted. The strength of this study is the large number of participants \( n \), an \( n \) of 1433 tumor cases and an \( n \) of 1350 controls. This suggests reliability in the findings and sets the stage for studies better data collection (perhaps using insurance data) or higher level study design.

The American Dental Association website contains a wealth of information on the amount of radiation we encounter on a daily basis. It is well known among most dental professionals that the amount of radiation we administer is very low compared to the daily exposure from sources such as cosmic radiation and naturally-occurring radioactive elements (for example, those producing radon).

According to the ADA website, it would take almost 100 bitewings to match the amount of background radiation that people are subjected to on a yearly basis. Due to the use of faster films and digital radiography, the amount of radiation has been reduced even further. Care is always needed, and the acceptable ADA guidelines for recommended x-rays still need to be followed. These can be found on the ADA website and a quote from the ADA is prudent here, “The recommendations [in the] chart are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after reviewing the patient’s health history and completing a clinical examination. Because every precaution should be taken to minimize radiation exposure, protective thyroid collars and aprons should be used whenever possible.”

In conclusion, although sensational as these results are, remember the issues with the study design and that the results show an association between a variable and an outcome, not causation. As presented by the media however, the results have elicited some panic. Providers need to educate their patients; practice prudence with radiograph prescription and procedures.

References
   Department of Epidemiology and Public Health, Yale University School of Medicine, 60 College Street, PO Box 208034, New Haven, CT 06520-8034
4. American Dental Association: www.ADA.org

HIV Screening in Health Center Dental Practices

Clifford Hames, DDS, VP/Chief Dental Officer/Chief Infection Control Officer, Hudson River HealthCare
Ann Hinson, MT(ASCP), CLS(H), NCA, HRHCare Infection Preventionist, HRHCare Manager of Laboratory Services

On July 3, 2012, the FDA approved the OraQuick In-Home HIV Test, the first over-the-counter, self-administered HIV kit to detect the presence of antibodies to human immunodeficiency virus type 1 (HIV-1) and type 2 (HIV-2). In 2004, Orasure Technologies created a version of this same test for use by trained technicians in clinical settings. As a result of this minimally invasive test that uses a sample of oral fluid cellular exudates, people who might not have known they are infected with HIV have been able to seek proper care in the early stages of this chronic illness.

Four years ago, I was approached by Doug Capasso, Director of HIV Services at Hudson River HealthCare (HRHCare), to see if I would join him in a significant paradigm shift from the usual scope of services we provided as Health Center dentists and

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The HRHCare Integrated Rapid HIV Testing Model in our Dental services is the same as the Medical model except that the test when administered by a dental assistant is directly supervised by a dental hygienist or dentist. Both reactive and non-reactive results are given by the dental hygienist or dentist. If the results are found to be reactive, a Genesis Case Manager or Social Worker comes down to Dental before the patient is informed of the result so counseling services are immediately available.

For the next year, we were able to meet or exceed our monthly goals. More than 120 screening tests were performed. Initially medical and dental staff were skeptical about the number of new cases that would be identified in the dental clinic. During that time one asymptomatic adolescent was discovered with a reactive screening result which was confirmed with a blood test to be HIV(+). In 2010, we added our Poughkeepsie dental practice as the second site to offer this service.

By 2011, HIV screening was routinely being offered in all of our medical service areas so the demand for HIV screening in the dental department dropped off sharply. To date, we still offer patients the option to have an HIV screening as part of their dental visit but patients usually decline since they are being screened in other clinical areas of our organization. Throughout the organization 29,455 patients have been tested from June 2008 to date, with 40 confirmed positives for HIV/AIDS.

In summary, dentistry has always placed a strong focus on prevention. Our comfort level working in the oral cavity alongside oral fluids has made screening for HIV a natural extension of the preventive services we offer to our patients. Early detection through HIV screening not only improves the quality of life for patients who may not know they are infected, but also helps prevent the spread of this incurable virus to others who may not know their partners are infected.”
The Nations’ Network:
The National Institute of Dental and Craniofacial Research (NIDCR) awards a $67 million, seven-year grant that consolidates its Practice-Based Research Network initiative into a single national coordinated effort

Sonia K. Makhija, DDS MPH, Director of Communications and Dissemination, National Dental PBRN

NIDCR first launched three regional dental Practice-Based Research Networks (PBRN) in 2005 to provide practitioners with an opportunity to propose and participate in research studies addressing oral health care. Intended to expand the profession’s evidence base, the studies are conducted in dental offices with consenting patients. Hundreds of practitioners and thousands of patients have benefited by participating in the first PBRN phase during 2005-2012. NIDCR, part of the National Institutes of Health, has provided the nation an unprecedented, historic opportunity by funding the next phase – a single national network. This is “the nation’s network.”

The national network is made up of members, including private practices, group practices, Health Centers, etc. who investigate research questions with practical impact that will improve the quality of dental care. The goals of the PBRN are to conduct national oral health studies on topics of importance to a diverse range of practitioners and their patients, to provide evidence to improve routine dental care, and to facilitate movement of the latest evidence into routine clinical practice. A key objective is to conduct studies that will improve the knowledge base for clinical decision-making, with the long-range goal of improving the health of the nation.

The National Dental PBRN is headquartered at the University of Alabama at Birmingham (UAB) School of Dentistry and is led by Dr. Gregg Gilbert, the National Network Director and the Chair of the Department of General Dental Sciences. “This can become a precious national resource for our profession and our patients. We aim to improve the nation’s oral health by improving the knowledge base for clinical decision-making and moving the latest evidence into routine care. We are so fortunate that NIDCR has invested in our profession and its scientific basis.”

Under Dr. Gilbert, UAB will serve as the national administrative base for six smaller regional nodes. In addition to Birmingham, there are nodes in Rochester, NY; Gainesville, Fl; Minneapolis, MN; San Antonio, TX; and Portland, OR.

The National Dental PBRN is now enrolling practitioners and actively encourages Health Center dental programs to participate. The PBRN has reached out to NNOHA to ask members, especially those involved in the previous PBRNs, to enroll and participate in developing the evidence base for the clinical care we provide our patients. You can enroll online by going to www.NationalDentalPBRN.org, and following directions from there. You need to have a functioning email address to enroll. If you previously participated in another network such as the DentalPBRN, PEARL or PRECEDENT, you will need to re-enroll because of revised enrollment questions and the need to update information.

For more information on the nation’s network, refer to http://www.dentalpbrn.org/uploadeddocs/NDPBRN%20Overview_Newsletter_Format_042612.pdf.

If you have any questions, please contact Dr. Sonia K. Makhija, Network Director of Communications and Dissemination at dentalpbrn@uab.edu.

Editor’s Note:
Dr. Gilbert will be presenting a session on the PBRN and how your involvement can benefit your patients at the 2012 National Primary Oral Health Conference (NPOHC). If you are interested, please join us at 4:30pm on Tuesday, October 2.
Patient communication, eliminating loss of an x-ray falling out of a chart, having a complete electronic dental record integrated with your patient management system, being able to see your patient records from any secure and encrypted internet connection, and the ability to keep current traditional film x-ray equipment if selecting a digital phosphor plate instead of film. Pick a reason and you will be happy that you are not using traditional film once you have adopted digital technology into your practice.

Which Digital Equipment is Right for My Practice?

There are two type of digital radiography commonly used, indirect and direct. Indirect or phosphor technology is the use of a phosphor plate instead of film and scanning the plate in a low light area laser processor. Direct or sensor technology is the use of an encapsulated chipset in the patient’s mouth providing instant viewable x-rays on the computer monitor. In today’s market, direct technology is the most commonly purchased digital x-ray equipment. However, if one of the main requirements is affordability and wanting to use your current PAN and CEPH machine, then phosphor technology is a good option. For pediatric offices, I have always recommended both types of digital radiography. There are many children that cannot tolerate anything placed in their mouth. Phosphor is a great option when digital sensors are just not an option and NOT taking an x-ray is not an option.

All phosphorous scanners can take a size 0, 1, and 2 digital x-ray phosphor plates and there are units that can process a size 4, occlusal x-ray, and all PAN sizes, and CEPH.

Key to Successful Digital Transition

Training, training, and more training. Yes it is true, more and more dental students are being exposed to digital radiography in dental school (no pun in-
tended), but that does not make them experts on all systems and the use of an integrated practice management system. Sensor, plate, and cone positioning is the key to a clear and quality diagnostic image and that takes time and clinical practice with a certified trainer. This is the most important aspect of your digital radiography equipment. Too many times digital radiography is purchased and patients complain about the sensors. This is commonly due to the staff not feeling confident in how to use the equipment properly. Make sure the trainer is certified in the equipment from the manufacture and has a clinical background to understand the basics of patient care and needs during the image acquisition procedure.

Selecting the right imaging software is just as important. Today’s imaging software markets the ability to integrate and/or bridge to your practice management systems. Though this is key to a total Electronic Dental Record (EDR) solution, if you ever want to switch software platforms, it is often impossible to convert the images to another imaging software platform. A key to a true agnostic imaging system is to ensure the software has the capability of storing the image in a DICOM format. DICOM is a standard image format compared to the JPEG format, which is found in most digital home cameras. DICOM is a medical format standard being adopted in the dental market. DICOM is being lobbied to become the dental image standard. More information on DICOM can be found at: [http://medical.nema.org/](http://medical.nema.org/)

Mary Kelly, RDH, BS, Iowa Dental Board

Iowa has developed several innovative methods to increase access to preventive oral health services. Three key programs: Public Health Supervision Agreements, School Screening Certificates and the I-Smile™ Dental Home Program interact to create successful approaches to increasing access to dental homes.

An important part of Iowa’s oral health system is the I-Smile™ Dental Home Program. The I-Smile™ initiative was created to ensure that Medicaid-enrolled children in Iowa have a dental home. The Title V agencies within Iowa employ registered dental hygienists who serve as I-Smile™ coordinators with many roles that are primarily non-clinical. These same agencies many times also employ dental hygienists for clinical work in outreach programs.

A key part of I-Smile™ is partnering with the dental and medical community. Some programs are designed with a nurse, physician or physician assistant to perform a screening and fluoride varnish. Schools, hospitals, community health centers, safety-net clinics, nursing facilities, Head Starts and WIC programs all can serve as initial access points to oral health care. I-Smile™ coordinators provide technical assistance and training for medical personnel on how to complete a dental screening and how to apply fluoride varnish and when to refer children to establish a dental home. Referrals are followed up by the I-Smile™ coordinator, who works within the dental community to recruit dentists to accept clients for dental services.

Multiple Approaches to Access: Iowa’s Response to Improving the Oral Health Status of Its People

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Referrals to the I-Smile™ coordinator come from many sources even those not connected with the area Title V agency. The coordinators are the point person in the community for all oral health referrals.

More than one and a half times as many Medicaid-enrolled children ages 0-12 saw a dentist for care in 2011 than in 2005 through the I-Smile™ program coordinated by 24 dental hygienists.

The Iowa Dental Board passed the Public Health Supervision (PHS) rules effective January 2004. A dental hygienist in a written agreement with a dentist may provide services in defined public health settings, prior to the patient seeing a dentist for an exam. A key provision in these rules is to provide to the patient, parent, or guardian a written plan for referral to a dentist and assessment of further dental treatment needs.

PHS dental hygienists are working in the county health department’s medically compromised adult programs, walk-in clinics, flu clinics, back to school health fairs, well baby visits, school based sealant programs and nursing facilities. With the PHS sites involving other health related settings there are many opportunities for the medical and dental professionals to interact and improve overall health. Sources of funding can be through Title V funds, Medicaid, Hawk-I (a program that provides free or low-cost health care coverage for Iowa children in families with limited incomes), private pay, and insurance. Over 61,000 open mouth screenings took place in 2011 through PHS. There were 76 registered dental hygienists with PHS agreements with 47 dentists.

In 2008, Iowa began a dental screening mandate for students entering kindergarten and 9th grades. Nurses, physicians, physician assistants, dental hygienists and dentists can screen children entering kindergarten while only the dental professionals can screen the 9th graders for the mandated school certificate. In the 2010-2011 school screening program, over 54,000 children were screened with over 7,000 referred for dental treatment and an additional 1,100 referred for urgent dental care. Many of these screenings are done in private dental practices while nurses or dental hygienists provide screenings in school settings for those who have not accessed traditional private practice. The I-Smile™ Coordinator serves as the contact person for those children who have identified needs to assist with care-coordination.

While Iowa still has many barriers to accessing oral health care, these programs are successfully bringing together the medical and dental community to create several pathways to the dental office.

For resources on the statistics above or for further information, please visit:

- [http://www.idph.state.ia.us/hpcdp/oral_health_reports.asp](http://www.idph.state.ia.us/hpcdp/oral_health_reports.asp)
- [http://www.state.ia.us/dentalboard/PHsupervision.html](http://www.state.ia.us/dentalboard/PHsupervision.html)

Flint Hills Community Health Center (Emporia, Kansas)

Maria Smith, MPA, NNOHA Project Coordinator

Located in Emporia, Kansas, Flint Hills Community Health Center (FHCHC) is a community health agency providing leadership so that all individuals have healthy choices available to them and thus creating a safe, healthy community and environment. FHCHC provides comprehensive public and personal health services, including medical, dental and behavioral health care. For this issue, NNOHA interviewed Erin Reece, Public Information Officer, at Flint Hills Community Health Center.

When did your Health Center start?

We started as Lyon County Health Department in 1923. Since that time, we have continued to grow from providing home visits and immunizations to offering more comprehensive public and personal health services. In 1997, the Health Department became a Federally Qualified Health Center. At that time, we expanded our services to everyone including patients with insurance, Medicare, Medicaid, as well as the uninsured. Flint Hills Community Health Center is dedicated to providing professional services for everyone.

What is your community like?

Our community is the true portrait of Americana; it is the founding city of Veteran’s Day. Emporia is a center for diverse manufacturing, trade, education, health care and tourism. Our primary industries include food products, automotive components, fabricators, electronics, telecommunications and distribu-
tions. We are home to both a university and a technical college.

What challenges do you face that might be different from other Health Centers?

We do not think we are unique in this, however, Kansas has a serious problem when it comes to access to dental care, especially in rural areas of the state. According to the Kansas Dental Project, with the average dentist in Kansas approaching retirement age, this problem will only get worse.

In Kansas, 93 of our 105 counties (86%) do not have enough dentists to serve their population, 13 of which have no dentist. All or a portion of each of these 93 counties have received a federal designation as a workforce shortage area. A new federal report determined it would take a minimum of 94 new dentists in Kansas to eliminate the shortage areas. Even in counties with enough dentists, vulnerable populations consistently have trouble finding care.

What are you doing well that you would like to share with us?

We were fortunate to receive a grant from the Kansas Association for the Medically Underserved (KAMU) that enabled us to receive funding from DentaQuest Foundation’s Strengthening the Oral Health Safety Net Initiative. Safety Net Solutions visited our site and explored ways to improve the effectiveness of care and support efforts to raise awareness on the importance of oral health. DentaQuest looked at all aspects of our services from the way we schedule patients to the way our operators are set up. Their feedback will help us make positive changes in our dental clinic. Also as part of this initiative, NNOHA has been providing us with technical support and resources for medical-dental integration.

Do you have any strong partnerships in the community?

We do have very strong partnerships in our community, primarily with our local school districts. We have a program called, “Future Smiles” where a registered dental hygienist with their extended care permit outreaches to surrounding schools to do screenings, sealants, prophylaxis and fluoride varnish treatments.

How do you interface with the medical department?

We are currently working on becoming licensed as a medical home. We interact monthly with the manager and conduct full staff meetings. The fact that we have a full medical clinic, a public health department and a WIC department under one roof is superb. We had a dental patient once who did not know she was pregnant. When the hygienist was working on her teeth, they asked her how far along she was in her pregnancy. The patient told the hygienist she was not pregnant, but the hygienist saw the baby kick. After her dental appointment, she was able to find out, through our medical clinic, that she was indeed pregnant. Overall, being alongside so many other departments helps our patients receive the best care possible.

What do you “know now that you wish you knew then” or what advice would you give to a new Health Center Dental Director?

Patient care and satisfaction is by far the most important piece to being in any industry. This is especially true when people have a fear of visiting the dentist. According to Colgate, it has been estimated that 9 to 15% of Americans avoid seeing the dentist because of anxiety and fear. It is important to put yourself in the role of the patient and make their experience as pleasant as possible.

What would you like decision makers in DC to know about Health Center dental programs?

We would like decision makers to understand that dental care is just as important as medical care in an individual’s overall health. Some people avoid the dentist because of anxiety and fear, while others avoid the dentist because of their inability to pay. Decision makers in DC need to understand the barriers to dental care that families across the country face every day.

What is on your wish list for the future?

Our wish list for the future is to take the suggestions we learned from the Strengthening the Oral Health Safety Net Initiative and turn them into a reality.
Did You NNOHA?

NNOHA's New Resources!

- **HIT White Paper**: NNOHA’s HIT Workgroup just released "Guide to the Future: A Strategic Roadmap to Achieving Meaningful Use Objectives and Selecting an Integrated Electronic Dental Record (EDR)-Electronic Health Record (EHR) System to Improve Oral Health Access and Outcomes." Visit the HIT webpage on NNOHA’s website to download the document: [http://www.nnoha.org/practicemanagement/hit.html](http://www.nnoha.org/practicemanagement/hit.html)

- **Promising Practices**: NNOHA released an exciting new resource, the Promising Practices webpage, in July 2012. Explore the promising practices by visiting: [http://www.nnoha.org/practicemanagement/promisingpractices.html](http://www.nnoha.org/practicemanagement/promisingpractices.html)

**ACU Health IT and the Underserved Conference Abstracts Due September 1**: To help clinical leaders further their understanding of and adoption of health IT tools, ACU is convening its first conference on **Health IT and the Underserved** on March 7-8, 2013, at the Poughkeepsie Grand Hotel ([http://www.pokgrand.com/index.html](http://www.pokgrand.com/index.html)) in Poughkeepsie, NY. ACU is seeking presentations on the use of health IT to improve patient care and outcomes, including: health technology tools, workforce training, patient engagement, team-based technology, patient-centered medical homes (PCMH) and meaningful use (MU), mobile technology, tele-health, and programs for special populations, such as migrant, homeless, or those living in public housing. You can submit your abstract at: [http://conta.cc/KofsjS](http://conta.cc/KofsjS). The deadline for abstract submissions is **September 1, 2012**.

**Primary Health Care / Health Centers Funding Alert**: Applications are open for **HRSA-13-237 Affordable Care Act - Health Center Controlled Networks and Service Area Competition Grants**. For more information, visit: [http://www.hrsa.gov/grants/index.html](http://www.hrsa.gov/grants/index.html)

Upcoming Conferences & Events

Here are some upcoming conferences in 2012. For a more detailed list, please visit: [http://www.nnoha.org/conference/links.html](http://www.nnoha.org/conference/links.html):

- **NACHC’s 2012 Community Health Institute & EXPO** will take place at The Peabody Orlando in Orlando, Florida from September 7-11, 2012. For more information, visit [http://meetings.nachc.com/?page_id=83](http://meetings.nachc.com/?page_id=83).

- The annual **National Rural Recruitment and Retention Network** conference and membership meeting will take place in Tacoma, WA, September 18-20, 2012. For more information, visit [https://www.3rnet.org/](https://www.3rnet.org/).

- The 2012 **National Primary Oral Health Conference** will occur September 30-October 3, 2012 at the Hilton Torrey Pines Hotel in La Jolla, CA. Registration is available at: [http://www.nnoha.org/conference/npohc.html](http://www.nnoha.org/conference/npohc.html). Register by August 30 to receive the early bird rate!


- The 2012 **American Dental Association Annual Session** will take place October 19-20, 2012 in San Francisco, CA. Visit [www.ada.org](http://www.ada.org) for details.

- **AAP National Conference & Exhibition** will take place October 20-23, 2012 at the Ernest N. Morial Convention Center in New Orleans, LA. For more information, visit [http://www.aapexperience.org](http://www.aapexperience.org).

- The **American Public Health Association (APHA) Annual Meeting & Exposition** will occur in San Francisco, CA, October 27-21, 2012. For more information, visit [http://www.apha.org/meetings/AnnualMeeting/](http://www.apha.org/meetings/AnnualMeeting/)

- The **ADA/Forsyth Course on Evidence-Based Dentistry** will occur November 5-9, 2012 at the Forsyth Institute in Cambridge, Massachusetts. Visit [http://www.ada.org/forsythcourse.aspx](http://www.ada.org/forsythcourse.aspx) for more details.
Member Recognition

ORGANIZATIONAL AND ASSOCIATION MEMBERS

These organizations became 2012 Organizational or Association Members of NNOHA between May 1, 2012 and August 1, 2012. We recognize their commitment to supporting NNOHA and improving access to oral health services for the underserved.

- Access Community Health Centers - Errin Pfeifer
- Ajo Community Health Center – Jennifer Lim
- Arizona Association of Community Health Centers – Da-Nell Rogers
- Asian Health Services – Huong Le
- Cass County Health Department – Megan Swan
- Collier Health Services, Inc. – Kelley Johnson
- Community Health Association of Spokane – Jonathan Judd
- Community Health Centers, Inc. – Margaret Drozdowski-Maule
- Community Health Center of Southeast Kansas – Krista Postai
- Community Health Improvement Center – Barbara Dunn
- Dientes Community Dental Care – Laura Marcus
- El Rio Health Center – Gregory La Chance
- Family First Health – Jenny Englerth
- Family Health Centers, Inc. (Louisville) – Stephanie Poynter
- Family Health Services Corporation – Robyn Walker
- GraceMed Health Center, Inc. – David Sanford
- Health Care for the Homeless (Houston)- Teresa Grygo
- Heart of Texas Community Health Center, Inc. – Allen Patterson
- Howard Brown Health Center – Jamal Edwards
- Indiana University School of Dentistry – Karen Yoder
- Inland Behavioral & Health Services – Temetry Lindsey
- Lake County Health Department Community Health Center – Kim Wagenaar
- Lakewood Resource and Referral Center, Inc. – Chedva Werblowsky
- Lawndale Christian Health Center – Jonathan Wildt
- Lone Star Community Health Center – Jammie Tosevski
- Marana Health Center – Carol Field
- Montana Primary Care Association - Mary Beth Frideres
- Mountain Family Health Centers – Garry Millard
- North Country Health Care – Kimberly Williams-Barnes
- Open Cities Health Center – Brian Quinlan
- Sadler Health - Elaine Herstek
- Salina Family Healthcare Center – Ann Feil
- Salud Para La Gente, Inc. – Dennis Baluyut
- San Ysidro Health Center: Centro de Salud de la Comunidad San Ysidro – Sergio Cuevas
- Scranton Primary Health – Mary Czyzyk
- Shawnee Health Service – Di Riley
- Spring Branch Community Health Center – Jared Parkinson
- Summit Community Care Clinic – Zulma Fuller
- Valley Healthcare Systems, Inc. – Sarah Lang
- Washington Association of Community and Migrant Health Centers – Susan Bogni
- West End Medical Centers, Inc. – Michael Brooks
- Whitefoord Community Program – Yvette Hagins
- Yakima Valley Farm Workers Clinic – Mark Koday

Applications are being accepted for a new three year program at Temple University Kornberg School of Dentistry that combines an established second year AEGD Program with a Master’s Degree in Public Health.

The program may accept dentists without AEGD education into the AEGD 1; however, those who have completed an AEGD or GPR training would be preferred and accepted directly into the AEGD 2.

- **Year 1** – Second year AEGD Program with emphasis on advanced general restorative dentistry skills
- **Year 2 & 3** – MPH Program at Temple University plus practice in the school’s Community Dental Clinic (include a salary for practice, full tuition for the MPH Program)

For more information, visit: [http://www.nnoha.org/directory/108043/115758/](http://www.nnoha.org/directory/108043/115758/)
INDIVIDUAL MEMBERS

NNOHA currently has over 2,200 members. The following people have initiated or renewed their membership between May 1, 2012 and August 1, 2012, and we recognize them for their commitment.

The NPOHC is the largest gathering of safety-net oral health program staff in the country and the primary venue for Health Center Dental Directors and their support teams to share quality improvement best practices, obtain clinical continuing education, and attend sessions on emerging oral health issues.

Highlights of the conference include 18 units of CORE/Category I courses featuring outstanding national speakers including, Dr. Barbara Sheller, Dr. John Featherstone, Dr. Alan Budenz, Dr. William Carpenter, Dr. Charles Carpenter, Dr. Susan McCormick, Dr. Alan Felsenfeld....and many more. ADA president Dr. William Calnon will speak during the plenary session.

For the first time NNOHA is offering a pre-conference session: “Introduction to Diagnosis and Management of Orofacial Pain and TMD for the General Dentist” with Omar F. Suarez, DMD, MAGD on Sunday, September 30, 2012 from 8am – 5pm. This additional 8-hour course sponsored by Lutheran Medical Center focuses on the Diagnosis and Management of TMD. Upon completion of this course, participants will gain deeper knowledge as to the pathophysiology of TMD/OFP conditions, comprehensively evaluate a patient with orofacial complaints, arrive at a differential diagnosis and recommend a course of action or intervention. Dr. Suarez is a diplomat of the American Board of Orofacial Pain and has been awarded the prestigious Mastership Award from the American Academy of General Dentistry. Continental breakfast, AM/PM breaks, and lunch will be included. $150 additional fee required. (Pre-Registration Required)

Fundamentals of Leading a Health Center Oral Health Program session, on Sunday, September 30, 2012, 1pm – 5pm. A perfect training opportunity for Dental Directors (both new and those seeking to learn more) and Health Center executive teams, including CEOs, COOs and CFOs. NNOHA highly encourages you to attend this training if you are: (1) New Dental Director less than 5 years of experience; (2) First-time NPOHC attendee; or (3) Administrator trying to expand your oral health knowledge. (Pre-Registration Required)

Additional Sessions Include:

- **Rotary Endo Hands-On Session** with Diwakar Kinra, DDS, MS, Monday, October 1, 2012, 2pm – 3:30pm and 4pm – 5:30pm - sponsored by Dentsply. (Pre-Registration Required)

- **SonicFill Hands-On Session** with David Hornsbrook, DDS, Tuesday, October 2, 2012, 11am – 12:30pm - sponsored by Kerr. (Pre-Registration Required)

- **Perio/Laser Hands-On Session** with Michael Koceja, DDS, Wednesday, October 3, 2012, 1:30pm – 3:00pm - Sponsored by Henry Schein. (Pre-Registration Required)
The National Network for Oral Health Access (NNOHA) is a nationwide network of dental providers who care for patients in safety-net systems. These providers understand that oral disease can affect a person’s speech, appearance, health, and quality of life and that inadequate access to oral health services is a significant problem for low-income individuals. The members of NNOHA are committed to improving the overall health of the country’s underserved individuals through increased access to oral health services.

"Mission of NNOHA is to improve the oral health of underserved populations and contribute to overall health through leadership, advocacy, and support to oral health providers in safety-net systems."

2013 NNOHA MEMBERSHIP APPLICATION

October 1, 2012-September 30, 2013

Please complete the following information and mail to:

PMB: 329, 3700 Quebec Street, Unit 100,
Denver, CO 80207-1639

Select one:

____ Annual Individual membership $50.00
____ Dental Hygienists or Dental Assistants $30.00
____ Annual Organizational/University membership $350.00

(If you select organizational membership, please attach a separate sheet with names, titles, and E-mail address of those included.)

Contact Information:

Name ____________________________________________
Title ____________________________________________
Organization ______________________________________
Address _________________________________________
________________________________________
Phone __________________________________________
E-mail _________________________________________

Committees:

____ I am interested in receiving committee information.
____ I am not interested in participating on a committee at this time.

Method of Payment:

_____ Check
_____ Bill Me
_____ Credit Card

Credit Card # ____________________________________ Security Code Exp. Date

Signature _______________________________________

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