Dear NNOHA Members,

It is a sincere honor to be writing to you as the new President of NNOHA and certainly an honor to follow our Founder and President of our first 20 years, Dr. John McFarland. His vision, dedication and passion are the best examples we can have moving forward.

We are coming off a highly successful conference in National Harbor, MD. NNOHA staff and our Conference Planner seem to outdo themselves every year. If you were able to be in attendance this year, you saw what I mean. If you were not able to be in attendance, mark your calendars for September 30 – November 3, 2012 in La Jolla, CA, near San Diego.

Some of the NPOHC highlights were the Fundamentals of Leading a Health Center Oral Health Program, the encouragement given to us by NACHC President and CEO, Tom Van Coverden, and the visit from Kathy O’Loughlin, Executive Director of the ADA. The Fundamentals session, which was geared mainly toward new Dental Directors, was the best-attended New Dental Director orientations we have had so far. The panelists did a great job of providing an incredible amount of information for new AND seasoned Directors. It was exciting to see that so many new programs are starting, and that there are a number of providers looking to NNOHA for direction. Tom Van Coverden spoke passionately about the current climate in Washington concerning Health Centers and placed emphasis on the power and clout that our movement and our mission have with lawmakers. He related several stories directly from lawmakers proving the power of our collective voice and the importance that communication is with our delegations in Washington to preserve Health Centers not only for the benefit of our patients, but also for the value and economic benefit that Health Centers bring to our communities. Lastly, it was very refreshing to hear the tone and encouragement from Kathy O’Loughlin.

(Continued on page 2)
A Letter from the New NNOHA President
(Continued from Page 1)

It is clear that many at the ADA recognize the contribution that Health Centers make to the oral health of the nation, the profession and our communities. She encouraged us— and I encourage you to follow her advice—to reach out to our private practice colleagues, “adopt a dentist,” and open the dialogue that will lead to a better understanding of what we do and how we can work together.

A bit about myself. I graduated from Oregon Health and Sciences University Dental School in 1993 and completed an AEGD at the University of Utah Hospital, followed by an Associateship in a private practice for about a year. I then had the opportunity to re-open a small Urban Indian Clinic in Salt Lake City during which time I became a National Health Service Corps (NHSC) Loan Repayor and began a Master’s Program in Anatomy at the University of Utah School of Medicine. In 1997, I became the Dental Director for Community Health Centers in Salt Lake City and worked with that organization to grow the program from one clinic to 3 clinics and one mobile clinic. The following year I completed my Master’s Degree and began teaching at the Medical School. Later in 2003, I had the opportunity to help launch the Arizona School of Dentistry & Oral Health, whose mission is to recruit, train and produce graduates who go into community and public health. I am currently the Associate Dean for Community Partnerships, teach Head and Neck Anatomy, and am a contract dentist providing care ½ day a week at the Phoenix Indian Medical Center.

I credit my longevity with Health Centers to two things: my NHSC Loan Repayment and NNOHA. Early on in my career, I attended the NPOHC, sponsored at that time by HRSA. It changed my outlook on my profession and made me realize that there were many other wonderful people doing what I was trying to do. It gave me a base for support and networking that made all the difference to me in my clinic. Learning from people like Jay Anderson, John McFarland, David Rosenstein, and many others, made me want to come back again and again. Indeed I have missed only one NPOHC since 1996.

NNOHA has been extremely important and relevant to me in my development and career.

NNOHA has grown tremendously since I first joined. We have a larger membership to represent and, as a consequence, are being asked to participate in and contribute to many more initiatives and to lend YOUR voice to many of the struggles we are facing now in oral health care for the vulnerable populations. It is my goal during the next two years to continue to make NNOHA as relevant in your careers as it has been in mine. We are, at the core, a membership organization and we need to hear from and serve you. That is my commitment to you for the next two years.

If there is anything you would like me, NNOHA or your Board of Directors to hear, please do not hesitate to contact us at our contact information listed on the NNOHA website— www.nnoha.org.

Thank you for your membership, thank you for your dedication to your Health Centers and thank you most of all for your service to the underserved.

Sincerely,
Wayne W. Cottam, DMD, MS
NNOHA President

Mark Your Calendars!
2012 National Primary Oral Health Conference
September 30-October 3, 2012
Hilton Torrey Pines, La Jolla, CA
http://www.nnoha.org/conference/npohc.html
The NNOHA Advocacy and Strategic Partnerships Committee Conduct a 2-Day Washington, DC Seminar

Teddy Gray King, NNOHA Policy Analyst

NNOHA Advocacy and Strategic Partnership Committee Co-chairs, Dr. Pat Mason-Dozier and Dr. Janet Bozzone led their committee on a two-day intensive series of meetings at the end of September.

Graciously hosted by the Pew Children’s Dental Campaign, the committee met with an array of influential national advocates. The meeting kicked off with an in-depth session on the recent Institute of Medicine (IOM) report on oral health access, presented by Pew’s Shelly Gehshan. Shelly, a member of the IOM committee that drafted the report provided NNOHA members with outstanding insight to the IOM findings.

Other sessions included a presentation from Kaitlin McColgan from NACHC on the federal budget process. Elizabeth Moeller, a Washington, DC based lobbyist provided some best practices suggestions for how NNOHA advocates can stay in the government advocacy loop, and Meg Booth with the Children’s Dental Health Project, discussed a number of issues including the Department of Health and Human Services proposed regulations for pediatric dental benefits in Health Care exchanges.

“I thought the meetings were great — interesting with lots of concrete ideas of how to raise NNOHA’s public profile,” said Dr. Pat Mason-Dozier.

Perhaps a highlight of the two-day trip was a visit to the White House, with an early morning meeting with White House staff member, Ellie Schafer. Ms. Schafer brought NNOHA committee members into the White House through a staff entrance and met with the group. Among the topics discussed were oral health access and the critical role of Community Health Centers. Ms. Schafer indicated that she is happy to forward material promoting NNOHA and the mission to the White House domestic policy team — particularly as oral health may fit in with the First Lady’s Healthy Child initiative.

Dr. Janet Bozzone expressed, “We are so grateful to Pew for hosting our meeting in DC. These in-person meetings provide an invaluable opportunity for our committee to exchange ideas and develop our advocacy agenda. Besides, they can be much more fun than a conference call!”

One committee member said this trip was “life-changing” because it clearly showed him what steps he needs to take to affect policy changes.

Truly, this was a great learning experience for NNOHA policy advocates.

NNOHA Members Make a Difference at Recent ADA Annual Meeting

Irene Hilton, DDS, MPH, NNOHA Dental Consultant, and Teddy Gray King, NNOHA Policy Analyst

The recent ADA convention in Las Vegas demonstrated how the presence of Health Center dentists in organized dentistry, can be critical. Our last workforce survey revealed that 70% of the Health Center dentists that responded were also members of organized dentistry. This presents an opportunity for both increased collaboration between private practice and safety-net dental providers, but also provides an opportunity for educating private practice dentists about Health Center oral health programs.

At this year’s ADA House of Delegates two NNOHA members who are also ADA delegates, Jane Gillette and Ariane Terlet, spotted two proposed resolutions that, if passed, could have undermined the fiscal stability of FQHC dental programs. Dr. Terlet was able to contact two other NNOHA members attending the ADA meeting, Dr. Huong Le and Dr. Irene Hilton, and together all four NNOHA/ADA members were able to provide testimony against the two resolutions at the reference.

Visit the Policy & Advocacy section of the NNOHA website at http://www.nnoha.org/advocacy.html for more updates!
A Letter from the New NNOHA President
(Continued from Page 3)

committee, proving the importance of representing safety net oral health programs within the larger dental community.

The resolutions, supported by two state dental associations, sought to alter the Prospective Payment System (PPS) for reimbursement of services, including dental, in FQHC’s. Each sought to change the reimbursement system that currently keeps Health Center oral health programs sustainable. The reference committee pulled both resolutions from consideration and a substitute resolution to study the matter was passed instead. It is important to note that ADA Government Affairs staff opposed the two original resolutions as well.

Listening to the testimony and comments from dentists in the states supporting the resolutions, NNOHA members heard private practice providers who were not familiar with the financing of Health Center oral health programs in their local areas and felt that Health Centers had some kind of fiscal advantage. These dentists could benefit from personal education and site visits to well-functioning oral health programs in their states.

It should be acknowledged that some NNOHA members are involved in organized dentistry and have served as presidents of their local dental components, and on committees at the state and national level. Five years ago a Health Center Dental Director from Michigan, Dr. Jane Grover, was elected ADA Vice-President. However, if more members are present in meetings or casual discussions when concerns relating to Health Centers are first brought up locally, proactive education can take place so that, hopefully, issues do not misguided escalate to the national level.

“We need to leverage this into a learning moment for NNOHA members,” said Dr. Irene Hilton, after testifying at the ADA reference committee. “We are always saying people should get more involved in organized dentistry, and now we have a concrete example of how being there, at the ADA House, we were able to make a difference.”

Asher Community Health Center (Oregon)

Mitsuko Ikeda
NNOHA Project Director

Asher Community Health Center is the only medical and dental provider in a frontier Oregon county. Asher CHC started in January 2005 and has gradually opened a dental clinic in each of the county’s 3 small towns to complement primary care services, as resources have permitted. For this issue, NNOHA interviewed Dr. John Frachella, Dental Director of the Asher CHC.

What is your community like?

Wheeler County is 1700 square miles with only 1,440 residents. It has 3 small towns: Fossil 470 people, Spray 170 and Mitchell 130. The remaining population lives in scattered ranches and rural home sites. Initially, dental services were provided in a dental van, which parked in each town and could only serve low-income people for free. Funds were limited for the van so dental care was sporadic and minimal, focusing on emergency and urgent services. In August 2008, we were awarded a Bureau of Primary Health Care (BPHC) service expansion grant for dental services. Using private foundation grants, a small primary care and 2-chair dental operatory was built with donated equipment, and opened in Mitchell in February 2009. A 1-chair operatory was opened a year later in a back room of the primary care clinic in Spray. Funds were obtained through a congressional earmark to construct a 2-chair operatory in the main clinic in Fossil, scheduled to open in October 2011. This completes a 4-year strategic plan of the Board of Asher CHC, which prioritized dental services.

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

The challenges in providing care are primarily economic. An FQHC must reduce barriers to care to the absolute minimum for those at or below 200% of the Federal Poverty Level. Fully 50% of patients get
subsidized care at a sliding fee scale, which goes as low as $35 per visit with an additional $15 per procedure. When insured and sliding fee patients are averaged, the cost per visit is about $250, while collections average $100. Without subsidies as an FQHC and from local property tax, the clinics could not exist. Even with subsidy, it must limit the number of visits per year to balance operating cost and resource.

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

We work in collaboration with Advantage Dental, a Medicaid dental care organization that serves this area. Our philosophy matches that of Advantage, that there is no way to restore ourselves out of the problem, because, funds are too limited. We have acquired an excellent team of dentists, who have a combined 120 years’ experience from exams to endodontics. Our dental program provides comprehensive dental care to a rural county where dental services have never existed before. There is an aggressive prevention program with annual visits to each school for a free oral health exam for all students with parental permission. Fluoride varnish is applied at these visits and at other visits during the year as needed. When combined with restorations rampant caries has been brought under control for many children and adults.

Do you have any strong partnerships in the community?

The Mitchell Clinic is located on the grounds of the Mitchell School. It is a school-based health center. Students can receive both primary care and dental care without leaving school grounds. This provides more timely care and reduces days lost to sickness. There are also strong partnerships with the county’s other 2 schools to ensure the annual oral health examination and to secure parental approval.

How do you interface with the medical de-

partment?

Asher CHC is unique in that it combines in one organization all the health services for an entire area, including primary care, dental care, home health services, and the public health program. Because the number of staff is small and they share common facilities, referral flows easily. Most coordination can be done informally and on a case-by-case basis.

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

When Asher CHC started, it could not find any other dental clinics with a similar operating and fee structure. Our first budget was a “guess.” Since then we have developed a history on both care and reimbursement that we would be glad to share with other providers.

What would you like the decision makers in DC to know about Health Center dental programs? What is your wish list?

Programs can be started on a tight budget, but it would be good for federal regulations to require all FQHC’s to use donated and refurbished equipment so that more money can go towards more patient care.

Our wish list includes two new Piezo Electric Scalers, expanding the number of dental days per month, to be more self-sufficient, and to be recognized nationally for providing top quality dental care on a shoestring budget. Starting on a shoestring made it necessary to purchase and restore used dental equipment. The delivery arms of chairs acquired for the new Fossil clinic even had old ceramic cuspidors—remember those? Then A-dec came to the rescue and donated new chairs, delivery units and cabinets. Burkhart Dental donated the installation. As equipment wears out and is retired, we hope to be able to purchase up-to-date equipment from these two excellent companies.
No Time for EBD?
Hope Saltmarsh, RDH
NNOHA Membership Resources Committee Member

You are certainly not alone if you feel like evidence-based dentistry is something you should be investigating, but you just haven’t found the time for it. The ADA’s Evidence-Based Dentistry website has been set up to make it as quick and easy as possible for clinicians to incorporate practices that are supported by the highest level of evidence.

For anyone interested in finding good evidence quickly, this is a great first place to look: http://ebd.ada.org. The website was supported by a grant from the National Library of Medicine and the National Institute for Dental and Craniofacial Research (Grant Number G08 LM008956) and is open to dentists, dental hygienists and anyone else with an interest in finding answers – including our patients.

Do you want to discover if your practice is following the evidence-based clinical recommendations of the ADA? Click on “Clinical Recommendations” (http://ebd.ada.org/ClinicalRecommendations.aspx). You will see a list of recommendations for the following topics:

- Non-Fluoride Caries Preventive Agents
- Fluoride Supplements
- Reconstituting Infant Formula
- Screening for Oral Cancer
- Sealants
- Topical Fluoride
- Infective Endocarditis: Guidelines from AHA
- Tobacco: guidelines from USDHHS

You will be able to view or download the full article or report on the topic along with a colorful chairside guide.

Perhaps you need an answer to a specific clinical question that is not addressed by the recommendations. Click on “Systematic Reviews” (http://ebd.ada.org/SystematicReviews.aspx). You will see a list of 27 topic headings to help you efficiently find your answer. Find the topic that fits best and click to see a subtopic list on the left. Use this to jump through the listing of systematic reviews or just scroll through the titles until you find what you’re looking for, as well as many interesting topics you didn’t set out to find.

There are lots of different study designs – randomized controlled trials, case-control studies, cohort studies, etc. Why only systematic reviews (SRs)? Clinical practice should be supported by the best available evidence. Certainly, sometimes there is little or no evidence and practitioners use expert opinion and their own experience. However, when there is evidence, the highest level is the systematic review that may or may not include a meta-analysis.

A systematic review is a comprehensive and unbiased review process that locates, appraises and synthesizes evidence from the scientific studies to obtain a reliable overview. When a specific statistical strategy for combining the results of studies included in a systematic review is conducted this is termed a meta-analysis.

It is important to understand that not all SRs are conducted equally well. If you do not have the knowledge necessary to determine how well a SR was conducted, you will be glad to see the growing number of SRs that have brief critical summaries available beside them. You can scan the reviews based on the overview of each critical summary. If you find a SR that seems to answer your question, read the critical summary and SR in order to decide what the implications are for your own practice. Pay attention to the description of the population studied. Consider how similar that population is to your patient(s).

References:

ADA’s EBD website enables busy providers to find clinical evidence quickly.
How Can Accreditation Enhance Your Future Practice?

Geoffrey Charlton-Perrin
Director of Marketing and Communications
The Accreditation Association for Ambulatory Health Care (AAAHC)

With the cooperative agreement between HRSA and NNOHA to work together to provide, expand and improve oral health services in federally sponsored community health centers, oral health care providers may begin to consider the advantage of becoming part of an accredited community health center or medical home.

What is required for accreditation of these health centers, and how can it affect your practice in the future?

This question is increasingly affecting the quality assessment of ambulatory organizations, as many state legislatures begin to require accreditation, and patients, the public, insurers and others look to accreditation as a mark of quality. HRSA encourages accreditation, and has a contract with the Accreditation Association for Ambulatory Health Care (AAAHC) as well as with other accrediting bodies, to accredit federally funded community health centers as a means to promote continuous quality assessment and improvement. Increasingly, these health centers also are looking to be accredited as a medical home – which is emerging as a widely accepted approach that has the potential to both improve health care and close down costs.

About Accreditation

It's not a rubber-stamp process. The accreditation process is not something you can take lightly. You have to be truly committed to raising the bar on the care you deliver to your patients. Accreditation involves a review of all your procedures, your staff, and the physical environment – everything from the way your governing body sets policy to your out-of-office-hours phone message. It’s certainly not a rubber-stamp process - you have to earn it.

But it’s worth it. Instead of dwelling on why you shouldn’t go through the accreditation process, let’s pause for a minute and think of all the reasons why you should.

1. **Your Patients:** First, there are your patients. Sometimes we forget that patients facing health problems are anxious and looking for reassurance wherever they can find it. Accreditation gives them that reassurance – especially for first-time patients. Accreditation is an instant signal that your organization maintains nationally-recognized standards of quality patient care.

2. **Your Organization:** It’s also reassuring for you that your organization has been surveyed by experienced health care professionals and confirmed to be practicing at or above nationally-recognized standards.

3. **Your Staff:** Because one aspect of high quality often leads to another, accreditation can be that extra incentive that attracts the best and the brightest to join your organization.

4. **Your Third Party Recognition:** Accreditation is recognized by third-party payers and state and government agencies.

Accreditation brings with it the cachet of independent endorsement by your peers. It gives you the security to know that you and your organization have undergone a thoughtful, professional scrutiny by experts that confirms that you are delivering patient care at nationally-recognized standards.

From the Author: If you have been considering accreditation for your organization, I would recommend that you visit our web site, www.aaahc.org, and learn more about the process. You can also call 312-853-6060 and ask to speak with an accreditations services member, or email us at info@aaahc.org. We will be glad to assist you in any way we can.

NNOHA Technical Assistance Survey Reveals a Strong Need for Practice Management Consulting

Aimee Bernard, PhD and Robin Koenigsberg, PhD
Think2 Consulting

NNOHA Technical Assistance (TA) Survey

Community health centers struggle to meet the growing need for safety net dental services while maintaining the long-term financial viability of their clinics, particularly in the current climate of economic and regulatory uncertainty. An increasing number of dental programs are turning to practice management experts that offer technical assistance in overcoming this challenge.

(Continued on page 8)
NNOHA Technical Assistance Survey
(Continued from Page 7)

In order to learn more about the Technical Assistance needs of health center oral health programs, NNOHA commissioned a study of its members, conducted in May 2011, to assess:

- the most pressing problems confronting dental programs
- common roadblocks to progress
- preferences for the various types of technical assistance
- the effectiveness of outside technical assistance services

One-hundred-and-thirty-five NNOHA members, representing dental programs at FHQCs in over 38 states and the District of Columbia, responded to NNOHA’s TA Survey. The findings from this national survey provide the most complete picture to date of the need for technical assistance and the effectiveness of such services in safety net dental clinics.

Most Common Problems

The results of the survey suggest the most common operational problems impacting the efficiency, effectiveness and long-term sustainability of dental clinics are:

- no-show or cancellation rates
- billing and collections issues
- unsustainable patient payer mix

The results of the survey suggest the most prevalent clinical problems are:

- inability to complete patient treatment plans and, as a result, improve oral health outcomes
- lack of clinical protocols
- suboptimal balance of preventive, restorative, and surgical procedures

Technical Assistance Preferences

Regarding technical assistance consulting services, respondents favored, two-to-one, technical assistance consultation related to practice-level factors (patient policies, scheduling, and billing procedures) over organizational-level factors (executive leadership and support). Other types of practice management consulting services of interest to a majority of the respondents were:

- individualized improvement plans
- on-site diagnostic assessments
- documented do-it-yourself materials (sample policies, best practices, and on-line interactive materials).

According to the study, roughly 60 percent of survey respondents felt technical assistance would offer significant benefits; another 34 percent indicated it would provide at least some benefits. This suggests a strong need for technical assistance.

Previous Experience

One-third of the responding clinics had received technical assistance services between the years 2008-2011. Greater than 75 percent of survey respondents whose clinics had received practice management consultation experienced at least some improvement in:

- net revenues
- operational efficiency and management decision making
- patient access to dental care
- improved quality of care and oral health

This evidence preliminarily suggests that technical assistance has made inroads to meeting the complex set of objectives necessary to address a wide variety of short- and long-term operational and clinical challenges confronting safety net dental programs.

These results of the survey are reported in a broader study undertaken by Think2 Consulting in collaboration with NNOHA’s Dental Consultant and Practice Management Committee. The report, entitled, “Evaluation of the DentaQuest Institute Safety Net Solutions’ Practice Management Technical Assistance Program and Dental Clinic Technical Assistance Needs Among NNOHA Membership,” will be available in its entirety on NNOHA’s website.

Be sure to check the NNOHA website for a technical assistance self-assessment tool, which was created to allow the NNOHA membership to self-assess the need for practice management consulting services.
**Sabbatical: A Retention Tool**

Huong Le, D.D.S., Dental Director, Asian Health Services Community Health Center
NNOHA President-Elect

**Sabbatical** (from Latin sabbaticus, from Greek sabattikos, from Arabic Sobat, from Hebrew shabbat i.e., Sabbath, literally a "ceasing") is defined as a rest from work, or a hiatus, often lasting from two months to a year. Many companies and organizations, such as universities, as well as big high-tech companies like Intel and Genentech, offer a sabbatical provision in their benefit package as a recruitment or maybe more of a retention tool for valued long term employees.

For non-profit organizations like Health Centers, it is a rarity. Some Health Centers actually do have the provision of “leave of absence,” which can be treated like a sabbatical. For example, one Health Center allows the employees to take a one-year unpaid sabbatical to go back to school to receive a master’s degree or other education training without losing seniority or benefits. I just happen to work for a Health Center that embraces the idea of giving the employees a “rest” from their service. Our Health Center believes that a sabbatical not only rewards the employees for their great service over the years, but also allows the employees time to reflect on their accomplishments. The policy started quite some years ago, and it allows a 3-month “sabbatical” or paid leave for all employees who have completed their 20 years of service and a 6-week sabbatical leave after 10 years of service at the center.

Some of the employees have used this time to do projects that they have wanted to do for a long time but have not been able to because of work obligations. Volunteer for medical missions, lecturing at nearby colleges, writing memoirs are some examples of what our employees have done on their paid leave. Many have traveled back to their native countries. Whatever the employees choose to do, it is a great reward for their hard work over a number of long years of service.

Some of the challenges of administering a sabbatical program have to do with financing the program and managing the work load. Our policy allows some flexibility as far as when the employees can arrange the sabbatical. This helps the managers of the department to work on personnel assistance, such as hiring on-call or temporary help or schedule workload appropriately. The other challenge is the cost of sabbatical. It needs to be worked into the budget carefully.

The program has resulted in a very positive effect and increased morale level at the Health Center. Sabbatical is just one extra benefit that our employees happen to like and choose over monetary incentive bonuses. With our busy work and family obligations, we sometimes forget to take a break to reflect, and this program would force us to do just that. I myself can’t wait to take my own sabbatical, soon!

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**Development and validation of a measure of pediatric oral health-related quality of life: POQL**

Noelle L. Huntington, PhD; Dante Spetter, PhD; Judith A. Jones, DDS; et al

The authors adapted the measure of Pediatric Oral Health-related Quality of Life (POQL) measures to pediatric populations. The POQL was tested for reliability and validity in diverse populations. The children were placed into three categories by age: preschool, school age, and pre-teen. Both the child and their parents answered the initial 20-item assessment to compare the results for consistency. The POQL was tested with a variety of statistical analysis and found to be both valid and reliable. The POQL measured physical results of oral health disease with questions in areas such as pain, ability to chew and if the child cried from any thing associated with their mouth or surrounding areas. It also focuses on social and emotional scales with measures around smiling, laughing, worrying about being attractive and if they are unhappy with their looks. The POQL has potential utility for both clinical assessments and large-scale population studies. The POQL could be useful to dentists practicing in safety-net clinics to gain a better understanding of the ramifications of oral health diseases on their specific patient populations. The POQL could also be useful when seeking support for their dental program.

*Journal of Public Health Dentistry* 71(2011) 185-193

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**LITERATURE REVIEW**

http://www.nnoha.org/litreview.html
**NNOHA Seeking Two Staff Members:** NNOHA is currently seeking candidates for two open positions: Executive Director and Project Coordinator. Detailed announcements and job descriptions can be found at: [http://www.nnoha.org](http://www.nnoha.org) (see “What’s New” section). The deadline to apply is November 30, 2011. Please help us spread the words!

**...**

**New Resources Available:**


**...**

**NNOHA Job Bank Renewed:** NNOHA’s job bank now has a new look! Visit [http://www.nnoha.org/dentalcareers.html](http://www.nnoha.org/dentalcareers.html) to view dental vacancies in the safety-net or post openings at your program.

**...**

**Funding Opportunities:**

- For HRSA funding opportunities, visit: [http://www.hrsa.gov/grants/index.html](http://www.hrsa.gov/grants/index.html). Currently, service area competition opportunities are posted.

**Upcoming Conferences & Events**

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

- **The 2012 American Dental Education Association (ADEA) Annual Session & Exhibition** will take place March 17-21, 2012, in Orlando, FL. For more information visit: [http://www.adea.org/2012ANNUALSESSION/Pages/default.aspx](http://www.adea.org/2012ANNUALSESSION/Pages/default.aspx).
Member Recognition

These organizations became 2011 Organizational or Association Members of NNOHA between July 15 and November 1, 2011. We recognize their commitment to supporting NNOHA and improving access to oral health services for the underserved.

ORGANIZATIONAL MEMBERS

- Adelante Healthcare, Inc. – Avein Saaty-Tafoya
- Avenal Community Health Center – Joey Chen
- Care for the Homeless – G. Robert Watts
- Central Florida Family Health Center – John Foster
- Community Clinic at St. Francis House – Kathy Grisham
- Community Health Center of Fort Dodge – Jennifer Genniua-McDaniel
- Community Health Center of Snohomish County – Kishore Shetty
- Community Health Centers of Southern Iowa-Ronald W. Kemp
- Community Health Centers, Inc. – MidValle, UT-Daniel Baird
- Community Healthcare Network – Greggory Taddeo
- D.C. Primary Care Association – Gwendolyn Young
- Gaston Family Health Services, Inc. – Robert E. Spencer
- Genesis Financial Solutions – Janine Harris
- Health Access Washoe County-HAWC Inc. – Daniel Ahern
- HealthNet Inc. – Philip Woller
- Heart of Texas Community Health Center, Inc. – Allen Patterson
- Highland Medical Center – Debra Perdue
- Hurtt Family HealthClinic – Eriq Nguyen
- Institute for Family Health – Phillip Artenberg
- Keystone Rural Health Center – Joanne Cochran
- Kids Smiles – Cheryl Janssen
- Lutheran Family Health Center Network – Neal Demby
- One World Community Health Centers – Regan Mackintosh
- Open Cities Health Center – Dorii Gbolo
- Open Door Family Medical Center – Janet Bozzone
- San Benito Health Foundation – Rosa Vivian Fernandez
- San Francisco Community Clinic Consortium – John Gressman
- Shasta Community Health Center – Cheryl Russo
- Temple University, Komberg School of Dentistry – Frank Torrisi
- Tri-Town Community Action Agency – Stephen Thomas
- United Neighborhood Health Services –

INDIVIDUAL MEMBERS

NNOHA currently has over 1,800 members. The following people have initiated or renewed their NNOHA membership between July 15, 2011 and November 1, 2011, and we recognize them for their commitment.

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."

2012 NNOHA MEMBERSHIP APPLICATION
October 1, 2011-September 30, 2012
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 membership $350.00
(If you select organizational membership, please attach a separate sheet with names, titles, and E-mail address of those included.)

Committees:
_____ I am interested in receiving committee information.
_____ I am not interested in participating on a committee at this time.

Contact Information:
_______________________________________
Name
_______________________________________
Title
_______________________________________
Organization
_______________________________________
Address
_______________________________________
Phone
_______________________________________
E-mail

Method of Payment:
_____ Check
_____ Bill Me
_____ Credit Card

_________________________________________
Credit Card #
_________________________________________
Security Code
_________________________________________
Exp. Date

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Signature

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