
Huong Le, DDS
NNOHA Conference Planning Committee Chair

What an exciting conference for NNOHA and our supporters! We set a record with more than 560 registered attendees. It was so nice to see so many new and familiar faces in La Jolla, CA.

Sunday’s pre-conference sessions included Fundamentals of Leading a Health Center Oral Health Program, with over 200 attendees, and Introduction to Diagnosis and Management of Orofacial Pain and TMD for the General Dentist. The kick off meeting for the pilot year of the National Oral Health Learning Institute (NOHLI) was also held that day. All ten NOHLI scholars met their individual mentors, who will assist them in their year of learning. It is our hope that these scholar-mentor relationships will grow even beyond the year of the NOHLI. Another special program, the Strengthening Oral Health Safety Net (SOHSN) initiative, also conducted an in-person meeting on Sunday, attended by representatives of participating Health Centers, as well as partners including the Dent-aQuest Foundation and the National Association of Community Health Centers.

Wayne Cottam, DMD, MS, NNOHA President, opened the conference Monday with an energetic presentation on NNOHA’s mission and stated that we as safety-net dental providers represent 1% of the overall dental profession. We are proud to be that 1%! Following Dr. Cottam was CAPT Angel Rodriguez-Espada, DMD, Chief Dental Officer for HRSA, with an update from the Bureau of Primary Health Care and our keynote speaker, John Featherstone, MSc, PhD.

(Continued on page 2)
2012 NPOHC (Cont’d from page 1)

Dean of the University of California, San Francisco School of Dentistry, speaking on the “Future of Dentistry.”

That same day, we held a NNOHA membership lunch meeting, led by our executive officers and staff, who gave members a quick overview of the work that NNOHA is doing on behalf of its members. We ended the day with the John Rosetti Centers of Excellence Awards Welcome Reception. After the awards ceremony, conference attendees enjoyed an evening outdoors with dinner and jazz music!

On Tuesday, NNOHA was honored to have Bill Calnon, DDS, ADA President at the time of the conference, and Don Weaver, MD, NACHC Chief Medical Officer, as our plenary speakers. Both talked about collaboration between dental providers, both public and private, and across disciplines with medical providers. Partnerships such as these will help strengthen the integration of dental into the bigger picture of primary health care nationally. Furthermore, we held NNOHA’s Annual Awards Luncheon, where we honored four award recipients who were so deserving of recognition. Tuesday evening ended with trips to downtown La Jolla, where conference attendees had the opportunity to go shopping and eat dinner—a great networking opportunity!

We opened Wednesday, the last day of the conference, with Dr. Paul Glassman’s presentation titled, “Oral Health Quality Improvement in the Era of Accountability: Implications for Health Centers.” A small group of conference attendees visited San Ysidro Health Center for a tour led by San Ysidro’s Dental Director, Sergio Cuevas, DDS. In between all of these great events and plenary sessions, our speakers gave compelling presentations on clinical topics, operations trainings and innovative practices.

Thank you for attending the 2012 NPOHC! Your attendance and support contributed to the success of our meeting and we would like to share our gratitude and appreciation with attendees, sponsors, exhibitors, speakers and staff who traveled near and far for this special event. We hope you left the conference with valuable information from experts in a variety of fields, new professional relationships, and an experience that left you feeling motivated, appreciated, and more confident in your work as a leader in oral health care! We would also like to sincerely thank the speakers, sponsors, and all the exhibitors for making this conference a great success.

Please feel free to contact us at info@nnoha.org or 303-957-0635 with any suggestions on how we can improve our annual conference to better serve your needs. We hope you will join us next year at the 2013 National Primary Oral Health Conference November 10 - 13, 2013 at the Hyatt Regency in Denver, Colorado.

Thank you again for your support of NNOHA and for the work that you do every day to improve the overall health of the underserved through increased access to quality oral health services.

Congratulations again to the 2012 NNOHA Outstanding Contribution Award winners!

Outstanding Leadership Award
Anna D’Emilio, DDS, Lutheran Medical Center

Outstanding Clinician Award
Mark Koday, DDS, Yakima Valley Farm Workers Clinic

Oral Health Champion Award
Mary Ann Andrew, RDH, Health Care Center for the Homeless

NNOHA Presidential Award
Donald L. Weaver, MD, National Association of Community Health Centers
Technology is not only changing the way that Health Centers do business, but it is changing the environment in which elected officials are making public health decisions. These changes are very apparent in conversations around Community Water Fluoridation (CWF) nationwide. Successful implementation and protection of CWF require our advocacy tactics to respond accordingly to these changes.

Water fluoridation has been in the news quite a bit across the country because of conversations in communities to both start and stop CWF. Additionally, the CDC is preparing to release the final policies and guidelines for the new lower fluoride level recommendation, so it is a conversation that will be continuing. Misinformation and misunderstanding are driving the opposition in these efforts, and they are heavily utilizing the internet to spread their message.

In 2011, Pew Research Center released a study which found that 59% of adults in the United States have looked online for health information (The Social Life of Health Information, 2011). While the survey points to the changing way that people access information about health conditions, it also found that doctors, nurses, and other health professionals continue to be the first choice for health related information. This means that in the midst of this information age, you still play a vital role in helping people understand issues like CWF.

At the 2012 National Primary Oral Health Conference, three speakers talked about different pieces of...
RADM Bailey addressed the reasons behind the change in the CDC’s recommendation for fluoridation levels. The original recommended range was made in 1962, and as RADM Bailey pointed out, a lot has changed since then. Fluoride is now more readily available in other sources, such as toothpaste. Additionally, the original recommendation was based on a study which showed children who lived in warmer climates drank more water than those in colder climates, creating the range of levels to fluoridate for optimal exposure. A study of data from 1999-2004 showed that this is no longer the case. These two findings led to the change in recommendation to eliminate the range of levels.

Understanding the science behind CWF was highlighted by Dr. Lewis in his efforts to work with the Boulder Valley School Board. Dr. Lewis was contacted because the School Board was considering taking a position against CWF, and his first appeal to them was that they not make a decision based on bad science. Utilizing the principles of EBD, he helped them to identify information coming from faulty science, and was able to keep the School Board from taking action.

In depth opportunities to communicate about the science behind CWF are great, but not always possible, so Mr. Jacob’s presentation addressed how to message CWF to a larger audience. In the presentation framing was highlighted as central to successful campaigns. The key to framing fluoridation correctly is to focus on the need and on the impact that healthy teeth have on individuals. The messaging wheel developed from his research can be seen in the image below.

The recent success of fluoridation efforts in Portland, OR did not come quickly or easily, and was the result of a coalition putting in the time to have both the long conversations and use the right framing that led to the victory. Your community can see the same success in defending or starting water fluoridation, but they need you to be a part of it. If you need information or resources, start with the ADA’s website (www.ada.org/fluoride) and also look at www.ilikemyteeth.org. Then make sure you and your staff are having conversations with your patients, your partners, and your elected officials about the importance of CWF to public health.
Minimum Intervention or Minimally Invasive Dentistry (MI) is a philosophy based on the medical model of disease control. The MI philosophy embraces three ideals; identify, prevent and restore. The dental professional should be able to identify and assess risk factors early. Risk factors should be eliminated or minimized in order to prevent disease. If surgical intervention is required, the goal should be to preserve and conserve as much tooth tissue, bone or soft tissue as possible.

It used to be that diagnosis of cavities was solely based upon the tip of the explorer and the cavitation of the lesion. “Curing” caries involved simply the process of “drill, fill and bill.” Caries prevention was generalized for an entire population and consisted of brush more, floss more and use more fluoride. In defense of our profession, we simply did not have the risk assessment tools or the understanding of caries as a multifactorial disease that we now hold.

There are many more diagnostic tools available today than ever before to assess risk factors. In today’s paradigm, we have laser decay detection devices (DIAGNOdent, Kavo Corp) that are able to “see into occlusal pits and fissures” and detect pathological changes in the enamel. With this tool, we cannot only detect lesions earlier, but we can treat them earlier when remineralization is still a possibility, therefore preserving tooth tissue.

Saliva testing is another tool for risk assessment that is just now coming into the forefront of dentistry. Many practitioners are at minimum incorporating saliva testing into comprehensive exams. Saliva is the natural defense of the oral environment against decay. The quantity or flow of saliva is important. The quality or chemistry of saliva can cause an oral imbalance that quickly results in caries as well. There are two different saliva tests on the market today that offer quick results: Saliva Check™ (GC America) and CRT buffer™ (Ivoclar Vivadent). There is also a test available specific to the number of caries causing bacteria, CRT bacteria™ (Ivoclar Vivadent). This test requires purchase of an incubator and requires two days of incubation before results are available.

Every dental practitioner has come into contact with that patient that has unexplainable reoccurring decay. The patient’s homecare is pristine, there are minimal dietary concerns, there seems to be plenty of saliva flow and the patient is religiously using the prescription fluoride toothpaste you recommended. Stumped? Today, dental professionals can simply test and evaluate the health of that patient’s saliva. The results from a saliva test for the “unexplained” patient could reveal a poor buffering capacity (little or no calcium and phosphate), a flow issue (quantity) or simply a low pH. That patient lives with little to no protection from plaque acid attacks throughout the entire day and night.

What about the fluoride treatments you ask? Here is the thing about fluoride you might be forgetting; the fluoride ion requires the calcium ion to be present to “drive” it into the tooth surface for remineralization. The fluoride ion is less effective if the patient has inadequate saliva flow or if your patient’s saliva is without calcium and phosphate (the buffering components). Dental practitioners should consider this phenomenon when developing preventive care strategies for xerostomic and oncology patients as well.

There is also an amazing paradigm shift in the world of remineralization. Dental professionals no longer have to rely on fluoride alone for remineralization. The science is available today to utilize other necessary minerals that are essential to creating fluorapatite enamel such as calcium and phosphate.

Recaldent™ (CPP-ACP) is a breakthrough in science that has the ability to keep calcium and phosphate stable and maintained in a state of supersaturation within the biofilm. Recaldent has the ability to prevent demineralization/decay by being a buffering agent to plaque and dietary acids. The fluoride from over the counter toothpaste will adhere to the sticky milk protein (CPP) portion of Recaldent, allowing all three minerals, calcium, phosphate and fluoride to be available for remineralization. The CPP

(Continued on page 6)
MI Dentistry (Cont’d from page 5)

A portion of Recaldent is also the stabilizing factor; ACP alone is not stable for effective remineralization. Recaldent also offers a 3-hour half-life, making it one of the most therapeutic adjuncts to home care available for xerostomic and high-risk caries patients. Recaldent can be found in two products. MI Paste® (GC America) has a 10% dose of Recaldent and Trident® White Chewing Gum (Cadbury Adams) has a dose of 0.6% Recaldent.

New science has also given dental professionals a way to eliminate or minimize the risk of caries in partially erupted molars. Within the last few years manufactures have developed glass ionomer sealants. As a material, glass ionomer is moisture friendly, requires no etching, is self curing and best of all, there is a rechargeable fluoride release that incorporates with calcium and phosphate ions from the saliva to build fluorapatite enamel. Because it is moisture friendly, it can be expressed under tissue of partially erupted molars and stay where it is placed. Partially erupted molars are the most vulnerable to decay. All dental professionals have seen a case of the 12-year-old molars that are partially erupted for 12-24 months, hard to reach, with little access for cleaning. These patients often come back with the molars bombed out! Most of them need the professional protection a “caries therapist,” otherwise known as a Registered Dental Hygienist, can deliver.

One does not know what they are missing if they have not placed a glass ionomer sealant yet. The technique is simple. The material is dynamic. Glass ionomer helps mature the enamel into fluorapatite. One thing to keep in mind when placing glass ionomer sealants is that this material is NOT resin. Glass ionomer does not handle like resin or look like resin. If the tooth surface is desiccated, the material will fall out. Dental care providers should prepare for a change in mindset on sealant placement. GC Fuji Triage® (GC America) and Riva Protect™ (SDI) are manufactures of glass ionomer sealants. Manufacturers’ directions should be followed. Assuming glass ionomer sealants can be placed like traditional sealants will only lead to frustration.

Even the world of surgical intervention (fillings) is changing. Many doctors are using a less invasive technique called the “sandwich technique.” This is a technique where glass ionomer restorative material (Fuji IX®, Fuji II LC® from GC America and Ketac Molar® from 3M Espee) replaces dentin and composite resin replaces enamel. By replacing dentin with glass ionomer the cavity preparation is more conservative, less tooth tissue is removed when compared to a preparation for amalgam or composite resin. Because of the fluoride release of the glass ionomer, any hard decay will remineralize, preserving tooth tissue. With cavity preparations for composite resin and amalgam restorations, all discolored dentin must be removed because there is not a remineralization component to these materials.

Another benefit of using glass ionomer as a base or dentin substitute is that dentin and glass ionomer have the same CTE (co-efficient thermal expansion) or bio-compatibility. Therefore, when the patient eats or drinks hot or cold things, tooth and material are expanding and contracting at the same time. This is very harmonious to maintaining a marginal seal adding years of life to the restoration, conserving tooth tissue.

Another MI movement in restorative dentistry is utilizing the Atraumatic Restorative Technique (A.R.T.) more within the U.S. The ART technique was developed for the World Health Organization and utilized in undeveloped countries when doctors became tired of continually pulling teeth. The ART technique consists of using glass ionomer as the final restorative material. Doctors literally, spoon excavate out the soft decay and pack in the glass ionomer material. What they found was that the fluoride release from the glass ionomer stabilized the tooth, stopped the decay process and allowed many more years of use to a tooth that would have either been pulled or left to decay further.

Dental professionals have an ethical obligation to apply the knowledge we gain from advancing sciences. With the many advances in research and development within academia as well as the dental manufactures, patients will greatly benefit from the treatment options of MI Dentistry. Dental hygienists should endeavor to become not only periodontal therapists, but caries therapists as well. By incorporating the MI philosophy into practice, dental hygienists will raise the bar for our profession as well as treatment options for patients.
At Last! Oral Health Care During Pregnancy: A National Consensus Statement

Irene Hilton, DDS, MPH, NNOHA Dental Consultant

Both perinatal and dental providers, as well as pregnant women, have expressed a desire for guidelines to direct and advise clinical care. In the last five years several clinical guidelines addressing perinatal oral health have been developed and released in New York, California, Washington and South Carolina as well as by the American Academy of Pediatric Dentistry.

In 2008, the Health Resources and Services Administration (HRSA), through its Maternal and Child Health (MCH) Bureau, convened an expert panel on perinatal oral health. The panel developed several recommendations on increasing access to oral health care for pregnant women. One key recommendation urged convening the American Dental Association (ADA) and the American College of Obstetricians & Gynecologists (ACOG) to develop one set of national guidelines, instead of multiple individual state and organizational guidelines.

The Oral Health Care During Pregnancy Consensus Development Expert Workgroup Meeting was convened by HRSA in collaboration with ACOG and ADA in October, 2011. Participants reviewed policies from federal agencies and national organizations, recent literature, and existing guidelines on oral health care during pregnancy. The participants identified common ground and the evidence-based science, which resulted in Oral Health Care During Pregnancy: A National Consensus Statement—Summary of an Expert Workgroup Meeting. The document provides guidance on oral health care for pregnant women for both prenatal care health professionals and oral health professionals, and guidance for health professionals to share with pregnant women.

The purpose of the national consensus statement is to respond to the need for improvements in the provision of oral health services to women during pregnancy, bring about changes in the health-care-delivery system, and improve the overall standard of care.

Prenatal care health professionals can assess a pregnant woman’s oral health status by taking an oral health history, checking the mouth for problems and documenting findings in the woman’s medical record. Prenatal care health professionals can advise women about oral health care by reassuring them that oral health care is safe throughout pregnancy; advising them about scheduling an appointment with a dentist; providing a referral to an oral health professional, if needed; encouraging them to seek oral health care, practice good oral hygiene, eat healthy foods, and follow oral health professionals’ recommendations.

Oral health professionals can assess a pregnant woman’s oral health status by reviewing her medical and dietary histories, including use of tobacco, alcohol, and recreational drugs, consulting with prenatal health care professionals, as necessary; performing a comprehensive oral examination; and taking radiographs when clinically indicated. Oral health professionals can provide oral disease management and treatment to a pregnant woman by providing emergency or acute care at any time during her pregnancy, as indicated by the condition; developing, discussing and providing a comprehensive care plan; using standard practice when placing restorative materials; using a rubber dam during endodontic procedures and restorative procedures; and positioning pregnant women appropriately during care. The vast majority of pharmacological agents that are prescribed by dentists in routine practice can be used for pregnant women include analgesics, antibiotics, anesthetics, and over-the-counter antimicrobials. There are a few exceptions such as tetracycline, the estolate form of erythromycin and NSAIDS during the 1st & 3rd trimester, and there are many other acceptable options to these specific medications.

Implementing the guidance in the consensus statement will help to foster change by improving health professionals’ awareness of the importance of oral health during pregnancy and their understanding that it is safe to provide oral health care to pregnant women; in turn, the oral health of pregnant women and, ultimately, of their children, will improve. The document and information on how to order single or multiple print copies, and implementation resources are available at http://www.mchoralhealth.org/materials/consensus_statement.html.
On August 23, 2012, the U.S. Department of Health & Human Services released its final regulations for Stage 2 of the Meaningful Use incentive program for EHRs. The Stage 2 Final Rule is complex and several of the measures have sub-requirements; however, there is more time for providers to meet the requirements. A provider that attested to Stage 1 of Meaningful Use in 2011 could attest to Stage 2 in 2014, instead of in 2013. Therefore, eligible professionals (EPs) are not required to meet Stage 2 Meaningful Use before 2014.

Stage 1 established a core and menu structure for objectives and measures that EPs had to achieve in order to demonstrate Meaningful Use. The basic framework for Stage 2 is the same as Stage 1; however, there are several key important changes in the rules for EPs. The Stage 2 measures can be grouped into the following four categories:

1. New measures,
2. Measures made more rigorous without threshold % increase,
3. Measures with Increased % thresholds, and
4. Measures that do not change across stages (though may move from menu to core).

The Medicaid Electronic Health Record (EHR) incentive program has grown significantly in interest and the Meaningful Use funding has accelerated the transition to a fully integrated health record for many healthcare providers, including Health Centers. Highlights of the program follow:

- Managed by your State Medicaid Agency,
- EHR incentive amount is $63,750 for eligible professionals (dentists),
- Payments over six years, does not have to be consecutive,
- No Medicaid payment adjustments, and
- In the first year providers can receive an incentive payment for adopting, implementing, or upgrading (AIU) EHR technology. Providers must demonstrate Meaningful Use in the remaining years to receive incentive payments.1, 2

HRSA has stated, “Simply put, "meaningful use" means providers need to show they’re using certified EHR technology in ways that can be measured significantly in quality and in quantity.”3 The timeframe and stages of Meaningful Use is shown in the table below. Since the EHR Incentive Programs began in January 2011, more than 6,121 dentists have registered, 3,049 dentists have received payment totaling $64,583,000 for achieving Stage 1 objectives. This is excellent news; however, Stage 2 Meaningful Use has important changes to the Clinical Quality Measures reporting requirements.

On August 23, 2012, the U.S. Department of Health & Human Services released its final regulations for Stage 2 of the Meaningful Use incentive program for EHRs.3 The Stage 2 Final Rule is complex and several of the measures have sub-requirements; however, there is more time for providers to meet the requirements. A provider that attested to Stage 1 of Meaningful Use in 2011 could attest to Stage 2 in 2014, instead of in 2013. Therefore, eligible professionals (EPs) are not required to meet Stage 2 Meaningful Use before 2014.

Stage 1 established a core and menu structure for objectives and measures that EPs had to achieve in order to demonstrate Meaningful Use. The basic framework for Stage 2 is the same as Stage 1; however, there are several key important changes in the rules for EPs. The Stage 2 measures can be grouped into the following four categories:

1. New measures,
2. Measures made more rigorous without threshold % increase,
3. Measures with Increased % thresholds, and
4. Measures that do not change across stages (though may move from menu to core).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>2012</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>2013</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>2014</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>2015</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>2016</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>2017</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>

* Dentists who attest to successfully demonstrating Meaningful Use in 2011 will stay in Stage 1 for three years; all others will participate in Stage 1 for two years. (Source: Stage 2 Tip Sheet: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2Overview_Tipsheet.pdf)
Under Stage 2, EPs have to meet 17 core objectives and 3 of 6 menu set objectives. Objectives like patient engagement and health information exchange will be a challenge for several Health Centers. The “exchange of key clinical information” core objectives from Stage 1 was eliminated in favor of a more robust “transitions of care” core objective in Stage 2, and the “provide patients with an electronic copy of their health information” objective was eliminated because it has been replaced by an “electronic/online access” core objective. The Summary of Care documents, clinical summaries and online patient information have new required data fields. There are also multiple Stage 1 objectives that have been combined into more unified Stage 2 objectives, with a rise in the measure threshold that providers must achieve for each objective that has been retained from Stage 1.

NNOHA’s HIT work group proposed several clinical quality metrics for oral health and beginning in 2014 two oral health measures below are included in Stage 2.

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1335</td>
<td>Children who have dental decay or cavities</td>
</tr>
<tr>
<td>1419</td>
<td>Primary caries prevention intervention of part of well/ill child care as offered by primary care medical providers</td>
</tr>
</tbody>
</table>

Several Electronic Dental Record (EDR) vendors have moved forward with product upgrades to improve the interface with electronic health record systems that will eventually achieve the goals of improving the patient experience and lowering healthcare costs. EPs should verify if the EDR/EHR vendor solution has been certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) and reported to ONC. 4 Visit this website for details: http://onchpl.force.com/ehrcert?q=chpl.

Additional information can be found on CMS’s website regarding Stage 2 measures. 5 A complete list of 2014 CQMs and their associated National Quality Strategy domains will be posted on the CMS EHR Incentive Programs website (www.cms.gov/ EHRIncentivePrograms) in the future. NNOHA will continue to help guide safety-net oral health programs through Health IT decisions and challenges as they emerge. Additional information, guidelines and tools can also be found on the NNOHA’s website that can assist Health Centers move forward with EHR Implementation and achieving Meaningful Use objectives. 6

We recommend that every provider visit the CMS website and NNOHA website for regular updates since rules and regulations continue to change as well as the list of certified products. Reach out to national and state entities, such as NNOHA and PCAs, if you have questions or need further guidance.

Steven Russell served as a consultant for the NNOHA HIT White Paper recently released. To read the White Paper, visit: http://www.nnoha.org/practicemanagement/hit.html

References:
2 HRSA HIT Adoption Toolbox: http://www.hrsa.gov/healthit/toolbox/healthitadoptiontoolbox/meaningfuluse/whatismeaningfuluse.html
3 HRSA—What is “Meaningful Use”?: http://www.hrsa.gov/healthit/meaningfuluse/mu%20Stage1%20CQM/mu.html
4 Office of the National Coordinator (ONC) for Health Information Technology: http://onchpl.force.com/ehrcert?q=chpl
6 NNOHA HIT Webpage: http://www.nnoha.org/practicemanagement/hit.html
Clinica Family Health Services (known as Clinica), a Federally Qualified Health Center (FQHC), provides a full spectrum of primary care services, including medical, dental, behavioral health therapy, pharmaceutical services, case management services, and more. For this article, NNOHA interviewed An Nguyen, DDS, MPH, Vice-President of Dental Services at Clinica. Clinica’s mission is to be the medical and dental care provider of choice for low-income and other underserved people in southeastern Boulder, Broomfield and western Adams counties. Clinica’s care aims to be culturally appropriate and prevention focused.

When did your Health Center start?
Clinica was founded in 1977 to serve the needs of migrant farmworkers in the northern suburbs of Denver, Colorado. At that time, it began as a one-room clinic with a curtain drawn down the middle, separating the exam room from the reception desk. Since then, Clinica has grown significantly to better meet the needs of the community and is now composed of five sites spread across two counties (including the addition of a dental program about 11 years ago), with nearly 400 employees and a $30 million budget, serving 40,000 patients in total of three counties last year.

What is your community like?
Clinica is located on the front range of the Rocky Mountains, just north of Denver. Its location is ideal for easy access to outdoor adventures for which Colorado is known and because of this the area is attractive to families and healthcare providers looking to relocate. While there are a plethora of services and service providers located within our area, our patients (45% of whom are Spanish-speaking and underserved new immigrants) can be described to live in a “glass box” within our community, where the services are often visible, yet are unobtainable due to a variety of access barriers. Clinica has been the health care provider of choice for these patients for over 30 years.

What challenges do you face that might be different from other Health Centers?
Hispanics in our community, composing 75% of our patient population, experience a 70% prevalence of decay, which is 15% higher than for non-Hispanics. In addition to the fact that this decay is two times more likely to go untreated, this represents one of the most significant health disparities in our community, yet, with the relatively small size of Clinica’s dental program (with the capacity to serve only 15% of all active patients), we have minimal ability to treat decay once it has occurred. Though our struggles to meet the oral health needs of those patients in our service area are not unique to Clinica, the breadth of disease that we see in our community is staggering.

What are you doing well that you would like to share with us?
Clinica is nationally renowned for developing and implementing successful innovations in primary care that are patient-centered, evidence-based, and outcomes-oriented. Because of this environment, we are able to try new ideas and apply new concepts to our dental program. We are evaluating and implementing advanced access principles, panel management, and quality improvement measures in the dental setting. We also have a small cohort of mission-oriented dental providers who are engaged in applying evidenced-based clinical guidelines towards care that is quality driven in a measurable way.

Do you have any strong partnerships in the community?
Community partnerships are an integral part of Clinica’s strategic plan to meet our mission. There are a multitude of organizations within the community with which Clinica partners, but one of the most wide-reaching partnerships for the organization is based on the sharing of our electronic health record with other providers in the community. Through this partnership, patients have a comprehensive health record that is accessible not only when they are receiving primary care at Clinica but is also viewable by private referral specialists and hospitals for patients that require care with other health professionals in our community. This partnership has helped ensure that the patient receives health care that is more accurate with fewer redundancies.
How do you interface with the medical department? (Meetings, EHR, special programs?)

The ability to integrate with the medical team is one of the most unique and clinically important features of community health dental programs. At Clinica, all of the dental clinics are co-located with medical, facilitating interdisciplinary communications and consultations on patient care. There are also systems in place to help track referrals from a medical provider to a dentist, and the dental providers can access patient medical charts through the EHR. However, our most successful integration endeavor has been around making oral health an extension of the traditional medical visit. At the time of a patient’s routine visit with his or her primary care provider, a hygienist provides oral health education, anticipatory guidance, and fluoride varnishes for children, parents, and expectant mothers. This program is offered in one-on-one visits as well as in the group visit model, where cohorts of new or expectant moms can share their experiences caring for their children’s oral health, ask questions, and learn in a communal environment. In this way, these families provide each other with social support and motivation to succeed at maintaining self-management goals. Not only are we seeing better dental care-seeking for all our patients and earlier establishment of a dental home for our pediatric patients, but it has also put oral health higher on our medical providers’ radar and increased their awareness and knowledge. These integration endeavors reflect our mission to provide prevention-focused care in a patient centered way that also supports our whole body health through all the cycles of life.

Has NNOHA been helpful to you in some way?

We represent a small but growing minority in the dental profession because of the type of work we do and it can feel isolating. NNOHA gives us a community of other oral health professionals for support and guidance in a way that many other dental professional organizations may not.

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

As a dental leader for a Health Center, it is important that the program you represent has a strong, equal voice and representation within the organization. I have found that the strongest, most effective Health Center dental programs make their Dental Directors an integral part of the executive or leadership teams. While this representation ensures that dental receives equal attention compared to other services, it also facilitates honest communication and integration with other leaders within the organization. Energy and support should be given to help Health Centers organize in a way that gives all their leaders effective partnership to best meet their patients’ needs.

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

Because of the complex nature of the work, given the significant barriers our patients face and the amount of disease they experience, Health Center dental programs are among the most resourceful and collaborative models of dental care in our country. Out of the adversity that our dental providers face in providing care to some of our country’s neediest populations, the greatest potential for some of the best, most effective innovations in quality-based dental service provision is likely to be found in a Health Center.

What is on your wish list for the future?

Nearly universally-speaking, access to dental care represents one of the greatest unmet needs for underserved populations in America. I would love to see more dedicated funding to help Health Center dental programs grow to better meet the oral health needs of the communities they serve. Though this is a lofty goal, parity with medical services would be an amazing intermediate outcome. It would be a tremendous success to ensure that every Health Center patient also has the advantage to access comprehensive and prevention-focused oral health services.

A special thank you to An Nguyen, DDS, MPH, Vice-President of Dental Services at Clinica Family Health Services for contributing to this article!
Retired Dentists: A Workforce Gold Mine for Health Centers

Jane Grover, DDS, Dental Director
Center for Family Health (Jackson, Michigan)

As the Dental Director of a busy Health Center for the past eleven years, I can appreciate how hard it can be to find skilled and personable dentists to render clinical care to the underserved population. The challenges of working in the Health Center environment can make the task seem even more daunting at times.

But for my Health Center, strong relationships with private practice colleagues built over the years have come in very handy. In my particular situation, being very involved with organized dentistry for the past 20 years has allowed me to establish a rolodex of experienced dentists who have come to our rescue on more than one occasion.

When we first opened the dental department eleven years ago, some of the local dentists were very skeptical. There was already a children’s dental clinic in our local health department, they argued, so why expand on something that was already working well?

Never mind that the definition of “working well” to the private practice community meant that they had somewhere to refer children patients with Medicaid (the truth actually was that yes, the clinic worked well, but had only 4 dental chairs, no transportation or translation services and formal community outreach efforts were very low).

One dentist in particular was very vocal about folding that children’s clinic into a Health Center dental department that would also serve adults as well as children. He came to many preliminary meetings and voiced his disapproval about the whole project. This dentist was very well respected in our community, knew many people and was an excellent clinician. I made it a point to sit with him at local dental society meetings to glean his perspective on treating difficult restorative cases.

When we began to have AEGD residents rotate through our new Health Center dental department, I made efforts to have him come to lunch with us and meet these wonderful young dentists. He began to see our dental department as a valuable training opportunity. Over the next two years, he looked forward to meeting the new group of residents. He shared his positive observations about our Health Center with our local dental society members and as a result, opposition to our newly established Health Center oral health program quickly died down.

Then one of the AEGD residents wanted to visit this dentist at his private practice. They developed a great relationship and that resident ended up buying the practice. The newly retired dentist asked me, “Jane, what can I do now?”

The logical answer was to use the expertise of this dentist, so my Health Center hired him. He has become our most valuable voice in the community, and has helped champion many fundraising efforts for our Health Center. His dental experience has been priceless, not only to our AEGD residents, but to all dental staff as well.

He is not the only example of finding “gold” help among the “silver” hair of the retired dental community. All the time that I was having the general dentist lunch with the AEGD residents, I was also lunching with our local “rock-star” oral surgeon, who is deeply respected in our community.

All I did was gently remind him that “someday” he would retire, and we would love to have him work with us. Just doing that three or four times per year, while asking his oral surgery advice on several cases, built a great relationship that we enjoy to this day. And, of course, when he retired, he came over to work with us, and has been a tremendous help. It only took me eight years of lunches, but time flies when you are looking forward to having an oral surgeon help you out once per week!
What is interesting about retired dentists is that they have great energy and a network of other dentists whom are retired but are so “type A personality” that they need to do “something.” That “something” is invaluable in helping train new dental hires who are fresh out of school and select equipment and supplies that make fiscal sense, and being a solid sounding board for addressing the complex issues of delivering dental care to an underserved population.

Retired dentists help spread the message in the community about Health Centers and the dramatic disease of a population who does not receive regular care. The retired oral surgeon once told me, “Jane, I can’t believe the bizarre stuff you folks see here.” We photograph the “bizarre stuff” and those cases are used (with patient permission) to educate our Health Center Board, our local dental community and many service clubs. In fact, after showing some PowerPoint slides of before and after cases, many service club members reach for their checkbooks and ask, “Jane, how can we help?”

Retired dentists can be a key to a better relationship between your Health Center and the local dental community. They can be your best friends, valuable providers to a grateful population and mentors for our new dentists. Their presence can significantly reduce the risk of “burnout” that some Health Centers experience. Cultivate this wonderful group and watch your world become a better place!

Members of NNOHA’s Membership Resources Committee have volunteered their time to review articles and studies that may be valuable to safety-net oral health programs. One of these reviews is listed below. To read more literature reviews, including a new review on “Effect of periodontal treatment on glycemic control of diabetic patients: a systematic review and meta-analysis,” by Teeuw WJ, et. al., visit http://www.nnoha.org/litreview.html. Please note that some of the full articles may require subscriptions or payment to view.

**Obstetric outcomes after treatment of periodontal disease during pregnancy: systematic review and meta-analysis**

Nikolaos P Polyzo, et. al.

This article outlined the results of the authors’ systemic review and meta-analysis of a number of randomized controlled trials of birth outcomes of pregnant women with documented periodontal disease that were randomized to periodontal treatment (scaling and root planning) or no periodontal treatment. The authors evaluated each trial and assigned it as either high quality or low quality utilizing the Cochrane’s risk of bias tool. Low quality trials supported a beneficial effect of treatment while high quality trials provided clear evidence that no such effect exists. The authors concluded that while treatment of periodontal disease in pregnant women is beneficial, it cannot be considered as an effective way of reducing the incidence of preterm birth.

The value of this article to safety net clinics is that it gives insight into performing a systemic review and meta-analysis to evaluate conflicting study results. This study clearly displays the importance of evaluating the quality of a study so that our treatment and expected outcomes are evidence based from the findings of high quality studies.


Read the full article at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3011371/

A special thank you to Dr. Dan Brody for contributing this literature review.
Dental Pipeline National Learning Institute’s Inaugural Class Prepares to Launch

Maysa Namakian, MPH, Paul Glassman, DDS, MA, MBA, and Kim D’Abreu, MPH
University of the Pacific

PARTNER HIGHLIGHTS

The University of the Pacific Arthur A. Dugoni School of Dentistry (Pacific) in partnership with American Dental Education Association (ADEA) is launching the Dental Pipeline National Learning Institute (NLI). Supported by the Robert Wood Johnson Foundation, the NLI is a new training program dedicated to increasing recruitment and retention among low-income and underrepresented minority students at dental schools. It is an effort to create a diverse workforce of dentists who understand the oral healthcare needs of patients from underserved populations.

Through the NLI, 11 dental schools have been selected to implement a year-long recruitment and retention campaign or engage community-based dental education partners. Each NLI institution will receive $12,000 along with other support and resources, including a three-day training course about Dental Pipeline best practices, advocacy, and leadership; peer mentor match-ups; access to various online courses; and fundraising and development tutorials.

“This is a great opportunity to extend the lessons of a decade of dental pipeline activities and foster new partnerships dedicated to improving oral health for underserved people” says Dr. Paul Glassman, Project Director of the Robert Wood Johnson Foundation (RWJF) grant (which is supporting this initiative) and Director of the Pacific Center for Special Care at the University of the Pacific Arthur A. Dugoni School of Dentistry. He expressed his gratitude to the RWJF for supporting this initiative.

Dental schools participating in the NLI include:

- Harvard School of Dental Medicine
- Indiana University School of Dentistry
- Southern Illinois University School of Dental Medicine
- Marquette University School of Dentistry
- Medical University of South Carolina College of Dental Medicine
- Oklahoma University College of Dentistry
- University of Detroit Mercy School of Dentistry
- University of Minnesota School of Dentistry
- University of Nevada, Las Vegas, School of Dental Medicine

“Our goal for the National Learning Institute is to create an environment that embraces differences so that future dentists can learn effectively,” says Kim D’Abreu, ADEA Senior Vice President for Access, Diversity, and Inclusion. “While working to forge better partnerships between dental schools and their respective communities, we also hope to sound a clarion call about the growing epidemic of oral disease-related deaths among underserved populations due to lack of the ‘right’ care.”

The Dental Pipeline effort is based on the concept that dental institutions can address the access to dental care crisis by recruiting and admitting more under-represented minority students, increasing cultural competency of all students and educating dental students through community rotations in Health Centers and other safety-net dental settings. These principles served as the basis of a decade-long nationwide effort among dental schools and community partners that has positively impacted dental education and access to care.

More information regarding the Dental Pipeline National Learning Institute can be found at http://www.adea.org/PipelineNLI.
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/)

---

Strengthening the Oral Health Safety Net Initiative: Expanding oral health capacity at the national, state and local level

Jaime Hirschfeld, M.Ed.
Director, Health Center Growth and Development, National Association of Community Health Centers

A strong safety net system is essential to address current and future demands for oral health prevention, education and treatment for underinsured and underserved children and adults. Despite Health Centers employing nearly 10,000 oral health providers and treating more than 3,750,000 dental patients (about 12% of all health center visits), many face challenges such as financial viability, recruitment and retention, and inadequate reimbursement.

The DentaQuest Foundation’s continued investment in the “Strengthening the Oral Health Safety Net Initiative” will not only allow the National Association of Community Health Centers (NACHC) and its partners, National Network for Oral Health Access (NNOHA) and the Massachusetts League of Community Health Centers (MLCHC), to confront these challenges, but also expand oral health capacity at the national, state and local level.

The first cohort of Strengthening the Oral Health Safety Net participants included 26 oral health programs and Primary Care Associations (PCAs) from five states – AZ, GA, IL, KS and PA. Now, the initiative is expanding to include 10 more Primary Care Associations grantees and their Health Centers, who will receive technical assistance from NACHC and its partners. The PCAs include:

1. Arizona*
2. Bi-State
3. Georgia*
4. Illinois*
5. Kansas*
6. Michigan
7. Mississippi
8. Ohio
9. Oregon
10. Pennsylvania*

These 10 PCA organizations will work with NACHC to promote oral health and develop programming on behalf of member Health Centers to promote interprofessional activities among dental and medical programs in Health Centers, elevate the importance of oral health within the PCA, develop executive leadership at Health Centers to promote optimal oral health, and promote safety net oral health needs at the state level.

At the community level, a number of FQHC-affiliated safety net dental programs within each PCA will receive individualized technical assistance from the DentaQuest Institute’s Safety Net Solutions program.

For more information on the Strengthening the Oral Health Safety Net Initiative, contact Jaime Hirschfeld, NACHC’s Director of Health Center Growth and Development at jhirschfeld@nachc.com or (301) 347-0460.

*Second year grantees
NNOHA Welcomes Special Projects Coordinator, Sonia Sheck, MS:
In September, NNOHA hired Sonia Sheck, MS, as its new Special Projects Coordinator. Previously, Sonia worked for Colorado Community Health Network where she provided project management, facilitation, and practice coaching to safety net clinics in the areas of the patient-centered health home model and oral health. Sonia also facilitated the Colorado Dental Health Network, a board-appointed committee of Colorado health center dental directors, by coordinating in-person meetings, creating new data analyses, and strengthening partnerships. Her experiences in the health care field also includes coordinating access to coverage and care for elementary school children in New York City, analyzing health care claims data for a large New York City-based health care worker’s union, and providing consulting and facilitation support to primary care associations throughout the country. Sonia has a Master of Science degree in health services management and policy from New School University in New York City and a Bachelor of Arts degree in psychology from Smith College in Northampton, MA. In her free time, Sonia enjoys hiking, snowshoeing and taking outdoor education classes.

NNOHA Partners with PBRN: NNOHA is currently collaborating with the National Dental Practice-Based Research Network to increase the participation of Health Center dental providers in the PBRN activities.

- To become more familiar with the National Dental PBRN, download the presentation Dr. Gregg Gilbert (National Network Director, National Dental PBRN) made at the 2012 NPOHC at http://bit.ly/VVxZ7K or watch the orientation video at http://youtu.be/M4jfl5F8Tt4.
- If you have any suggestions for research topics that may benefit Health Center dental patients, email Mitsuko Ikeda at Mitsuko@nnoha.org.
- To enroll in the network, visit: http://nationaldentalpbrn.org/enrollment.php.
Upcoming Conferences & Events

Here are some upcoming conferences in 2013. For a more detailed list, please visit: http://www.nnoha.org/conference/links.html:


- The 2013 American Academy of Dental Practice Administration (AADPA) Annual Meeting, “THE PATH- Passion, Purpose, Prosperity” will take place March 6-9, 2013 at The Cosmopolitan Hotel in Las Vegas, NV. For more information, visit http://aadpa.org/meetings-education/annual-meeting.

- The 2013 American Dental Education Association (ADEA) Annual Session & Exhibition will occur March 16-19, 2013, in Seattle, WA. For more information visit: http://www.adea.org/2012annualsession/Pages/atadea12.aspx.

- The 2013 American Dental Education Association (ADEA) Annual Session & Exhibition will occur March 16-19, 2013, in Seattle, WA. For more information visit: http://www.adea.org/2012annualsession/Pages/atadea12.aspx.

- The American Association for Dental Research (AADR)/IADR Annual Meeting will take place in Seattle, WA, March 20-23, 2013. For more information, visit http://www.aadronline.org/i4a/pages/index.cfm?pageid=3507#.UJwnXYZlndl.


- IHI’s 14th Annual International Summit on Improving Patient Care in the Office Practice & the Community will take place April 7-8, 2013 in Scottsdale, AZ. For more information, visit http://www.ihi.org/offerings/Conferences/Summit2013/Pages/default.aspx.

- The 25th Annual Meeting on Special Care Dentistry will occur April 18-21, 2013 in New Orleans, LA. For more information, visit http://www.scdaonline.org/?page=AnnualMeeting.

- The Annual Central Texas Dental Symposium will occur Friday, April 19, 2013 at the Dell Children’s Medical Center in Austin, TX. For more information, visit http://www.dellchildrens.net/services_and_programs/craniofacial_center/annual_central_texas_dental_symposium/.


- The ADA’s 2013 EBD Champions Conference will take place April 25-27th, 2013 at the ADA Headquarters in Chicago, IL. For more information, visit: http://www.ada.org/278.aspx.

- Western Clinicians Network is sponsoring the Annual Region IX Leadership Institute-20th Anniversary Celebration on April 28-May 1, 2013 in Kapolei, HI at the Aulani Resort. For more information, visit http://www.westerncliniciansnetwork.net/?page_id=194.


- The Northwest Regional Primary Care Association’s Spring Primary Care Conference will take place May 18-21, 2013 in Anchorage, AK. Visit http://www.nwrpca.org/conferences/spring-primary-care-conference.html for more details.

- Sponsored by The PHS Commissioned Officers Foundation for the Advancement of Public Health, the 2013 USPHS Scientific and Training Symposium will be held at the Renaissance Hotel in Glendale, AZ from May 21-23, 2013. The theme for the 2013 Symposium is “Public Health Prevention and Care: Bridging the Gaps.” For more details, visit http://symposium.phscof.org/.
Second Annual Henry Schein Cares Global Product Donation Program Awardees Announced

NNOHA and Henry Schein Cares are pleased to announce the following awardees of the 2nd Annual Henry Schein Cares Global Product Donation Program (GPDP):

- Asian Health Services
- Crescent Community Health Center
- Family Health Service Corporation
- Gaston Family Health Services, Inc.
- Healthcare For The Homeless - Houston
- Legacy Community Health Services
- Loudoun Community Health Center
- Piedmont Health Services, Inc.
- Refuah Health Center Inc.
- Spring Branch Community Health Center
- Treasure Coast Community Health Inc.

NNOHA and Henry Schein applaud the outstanding efforts to help bring health care access to underserved groups and are thrilled to be able to support the efforts of these organizations. Please visit [http://www.nnoha.org/henryschein.html](http://www.nnoha.org/henryschein.html) to learn more about this opportunity or check back in early 2013 for the full announcement regarding the 3rd annual GPDP.

Got Questions?

Visit NNOHA Forums:
A Message Board for NNOHA Members

The purpose of the Forums is to facilitate discussion among the NNOHA members and allow them to ask questions on various topics to their peers and NNOHA staff.

Visit [http://www.nnoha.org/forums.html](http://www.nnoha.org/forums.html) for instructions or to sign up today!

Need help?
Contact us at info@nnoha.org.
Member Recognition

ORGANIZATIONAL AND ASSOCIATION MEMBERS

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

- Albany Area Primary Health Care, Inc. - Clifton Bush
- Avenal Community Health Center - John Blaine
- California Dental Association - Gayle Mathe
- Community Dental Care - Vacharee Peterson
- Crescent Community Health Center - Sharon Mary Grisanti
- Eisner Pediatric & Family Medical Center - John Pham
- Family HealthCare Network - Henry Cisneros Jr.
- Frederiksted Health Care, Inc. - Talia Moses
- Institute for Oral Health - Mary Ellen Young
- Jordan Valley Community Health Center - Kecia Leary
- Loudoun Community Health Center - Jade Bernard
- North County Health Project, Inc. - Judy Mendez
- Sister Ann Community Dental - Donald Dobbs
- St. Joseph Health Sonoma County - Stacey Stirling
- The Lakes Community Health Center - Christina Sopiwnik
- Valley Health Systems, Inc.: Fort Gay - Dan Brody
- Wirt County Health Services Association - Merinda Birkett

INDIVIDUAL MEMBERS

NNOHA currently has over 2,300 members. The following people have initiated or renewed their membership between August 1, 2012 and November 1, 2012, and we recognize them for their commitment.


Important Change:
The NNOHA Board of Directors voted at the 2012 NPOHC Annual Board Meeting to update NNOHA’s membership year to a 12-month term. Therefore, you will have one year from date of activation to access NNOHA’s Forums, the Weekly Digest, mentoring and grant opportunities, NPOHC member discounts, and more! If you have any questions regarding how this change may affect your membership, please contact info@nnoha.org.
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.”

NNOHA MEMBERSHIP APPLICATION

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

This publication was supported by Grant/Cooperative Agreement No. #U30CS09745 from the Health Resources and Services Administration (HRSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA.