NNOHA welcomes the 2013-2014 cohort of National Oral Health Learning Institute scholars!

Maria Smith, MPA, NNOHA Project Coordinator

NNOHA’s National Oral Health Learning Institute (NOHLI) is now in its second year, offering in-person and online trainings in leadership and practice management skills to Health Center Dental Directors and Dental Program Managers who have been in their positions for five years or less.


As the first-year cohort is getting ready to graduate at the 2013 National Primary Oral Health Conference (NPOHC), NNOHA has recently accepted a new cohort, for the 2013-2014 program year, of 16 Dental Directors from Health Centers across the country:

- **Julie Angellotti, DDS**, Marana Health Center, Marana, AZ
- **Jeri Bullock, DDS**, Community Health Centers of the Rutland Region, Rutland, VT
- **Lucia Covato, DMD**, North Side Christian Health Center, Pittsburgh, PA
- **Jennifer Hunter-Riley, DDS**, C. W. Williams Community Health Center, Charlotte, NC
- **Ashley Johnson, DMD**, Cedar Riverside People’s Center, Minneapolis, MN
- **Connie Kadera, DDS**, Marin Community Clinics, San Rafael, CA
- **John Kestranek, DDS**, Lorain County Health and Dentistry, Lorain, OH
- **Michael Kim, DDS**, HealthWorks for Northern Virginia, Leesburg, VA
- **Aine Malone, DDS**, Las Clínicas del Norte, El Rito, NM

The first-year cohort of the National Oral Health Learning Institute will be graduating at the 2013 National Primary Oral Health Conference in Denver, Colo.
Dejerneria Marshall, DDS, Inland Behavioral and Health Services, San Bernardino, CA
Ernest Meshack-Hart, DDS, FAGD, Partnership Health Center, Missoula, MT
James Millward, DDS, PC, Canyonlands Healthcare, Beaver Dam, AZ
Jared Parkinson, DDS, Spring Branch Community Health Center, Houston, TX
Ghazal Ringler, DMD, Anchorage Neighborhood Health Center, Anchorage, AK
Moira Sinnott, DMD, MA, United Community Health Center, Green Valley, AZ
Ryan Tuscher, DDS, PCC Community Wellness Center, Chicago, IL

Scholars have already begun their online coursework on the first two topics, Leadership and Health Center Fundamentals. They will meet for the first time at the 2013 NPOHC for in-person, hands-on workshops and networking. Scholars will meet again in January 2014, where NOHLI faculty will lead scholars through an intensive two-day boot camp focusing on role playing and case studies on topics including change management and personnel management.

In between in-person meetings they will work on online coursework and meet via webinar to review the coursework with faculty members. In addition, scholars are assigned to learning pods, each led by a more experienced Dental Director known as a “pod advisor,” that provides advice and guidance on coursework materials. Scholars will close out the program year at the NPOHC in Orlando, FL in August 2014.

NNOHA continues to partner with Paul Glassman, DDS, MA, MBA at the University of the Pacific Arthur A. Dugoni School of Dentistry, our consultant Amanda Stangis, MPH, the NOHLI Advisory Board, and NOHLI faculty to support our scholars. We thank them for their continued dedication to the program.

The next edition of NNOHA News, February 2014, will include an article about the newly graduated scholars from the pilot year of the program, including their experiences and leadership development in the NOHLI.

NNOHA will accept applications for the 2014-2015 NOHLI class during the summer of 2014. Learn more about the NOHLI at: http://www.nnoha.org/programs-initiatives/nohli/.

The NOHLI is funded under a cooperative agreement with the Health Resources and Services Administration.
WANTED: Advocates for community water fluoridation

Hollis Russinof, MUPP, American Academy of Pediatrics

Many people take for granted that community water fluoridation (CWF) in the US is a widespread, safe, and well-accepted public health practice. So it can come as a surprise to health advocates and concerned citizens alike when fluoride opponents seek to remove it from the local water supply.

CWF has become surprisingly controversial. It is not because the intervention lacks merit. On the contrary, it remains one of the safest and most effective methods of reducing dental disease in the general population. Changing ideological beliefs and, in many instances, outright misinformation pose the greatest threats to what has been heralded as “one of the 10 great public health achievements of the 20th century.”

In early 2013, the American Academy of Pediatrics (AAP) became the administering organization for the Campaign for Dental Health, a movement to protect children and all Americans from the unnecessary pain and costs associated with tooth decay. The Campaign for Dental Health is a volunteer network of local, state and national organizations that provides reliable, scientific information about oral health and community water fluoridation.

The primary mission of the Campaign is to support advocates, scientists, policy makers, and others who recognize that CWF is a valued, cost effective way to prevent tooth decay. The Campaign’s web presence, ILikeMyTeeth.org, helps counter misinformation purported by fluoride opponents. This is critically important because 61% of Americans regularly seek information on health and medical issues online.

Is it safe to go into that water?

If you’ve ever waded into the comments section of an online article or blog, especially if the topic is at all controversial, you’ve likely experienced the fierce exchange of accusations and rejoinders that follows. Like opponents of childhood vaccines, anti-fluoride activists are becoming increasingly successful at influencing public opinion and changing local public health practices.

The good news is that your patients trust you and the information you give them on their oral health. That’s also why you make such powerful advocates when speaking in support of local efforts to maintain or implement fluoridated water systems.

NNOHA’s new website contains a page devoted to resources for supporting Community Water Fluoridation efforts (http://www.nnoha.org/resources/advocacy/cwf/). Additionally, NNOHA has developed several member only resources including “Say This, Not That,” a one page document to help you avoid common mistakes, and sample letters to the editor. These resources will be available to members soon.

The Campaign’s Web site offers registered users a variety of multimedia resources, photos, and language on community water fluoridation. You can even develop customized sites that will be hosted on the Local Campaigns section of the ILikeMyTeeth.org. Information about setting up a site is just a click away: fluoride@aap.org.

You want me to do WHAT?!!

Here are 4 different ways you can slow the erosion of sound public policy and promote evidence-based considerations on this hot-button issue.

• Electronically-oriented? Join the Campaign for Dental Health’s Rapid Response Team and receive daily e-digests of online articles in need of correction or support. Follow us on Facebook and Twitter.

• People person? Volunteer to testify at local hearings should they arise in your area. Contact Marija Osborn, NNOHA’s Policy Analyst, at maria@nnoha.org.

• Like to write? Pen a blog post on children’s oral health for ILikeMyTeeth.org.

• Comfort zone: Your patients’ families will benefit from your reassurances that fluoridated water is safe for their children.

For more information on the Campaign for Dental Health or to be connected to local advocates, please contact Heather Stob, hstob@aap.org or 847/434.7918, Hollis Russinof, hrussinof@aap.org or 847/434.4983, Lauren Barone, lbarone@aap.org or 847/434.4779, or fluoride@aap.org.
As dental providers are increasingly required to meet standards of care and demonstrate improved outcomes, many organizations have engaged themselves in developing oral health measures. The Dental Quality Alliance (DQA) is one such organization. DQA is a forum of major stakeholders in oral health care delivery that uses a collaborative approach to develop oral health care measures. Its mission is to advance performance measurement as a means to improve oral health, patient care and safety through a consensus-building process.

The Objectives of DQA are:

1. To identify and develop evidence-based oral health care performance measures and measurement resources.
2. To advance the effectiveness and scientific basis of clinical performance measurement and improvement.
3. To foster and support professional accountability, transparency, and value in oral health care through the development, implementation and evaluation of performance measurement.

The DQA is comprised of many major dental professional societies, payers, educators and a member from the general public that have come together as an alliance to further the mission. Several federal agencies under the Department of Health and Human Services (HHS) also serve as technical advisors to the DQA. The American Dental Association (ADA) took the lead in establishing the DQA at the request of the Centers for Medicare and Medicaid Services (CMS) and continues to serve as its convener.

There are currently 25 contributing members, 4 technical advisors and a public member. Understanding the important work of DQA, the NNOHA Board of Directors decided to join as a member of the Alliance in 2012. At this time, Dr. Margaret Drozdowski-Maule and I represent NNOHA at the table. Shortly after joining, I was asked to chair the EHR workgroup that worked to develop a set of pediatric oral health measures for Meaningful Use consideration. Dr. Marty Lieberman has also been invited to serve on the adult workgroup whose charge is to define oral health measures for the adult population.

At this time, two oral health measures have been accepted as clinical quality measures by CMS: (a) Percentage of children, ages 0-20 years, who have had tooth decay or cavities during the measurement period; and (b) Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period (dental & medical setting). Additionally, DQA is working on testing more measures. Among these are sealants in children age 6-9 and care continuity. For more details about DQA measure activities, visit: http://www.ada.org/7503.aspx.

It has been a great collaboration with ADA, other specialty organizations and government agencies to develop clinical quality measures. NNOHA is proud to be part of the Alliance. More information on the DQA is available at http://www.ada.org/5105.aspx.

Evaluating oral health improvement activities on a shoestring budget

Thomas Keifer & Theresa Anselmo, Thomas Keifer Consulting

In this era of increasing accountability, evaluation is used not only to document responsible stewardship of financial resources, but also to justify the use of those resources through demonstrating the benefits of how the resources are utilized. Evaluation plays an important role securing and keeping resources, as well as in many aspects of organizational planning, management, and decision-making. Yet many oral health programs face a number of significant challenges in implementing evaluation activities. Lack of evaluation knowledge and experience, lack
of organizational support, difficulties in follow-up with subjects, and the list goes on. Maybe the biggest challenge is lack of resources (e.g., dollars, staff time, evaluation expertise).

As health clinics are increasingly asked to do more work with fewer resources, the activities seen as contributing less to the frontline operation may get shifted down the priority list, and funding dedicated exclusively for evaluation may be limited or unavailable. Evaluation on a shoestring is not a new concept. We hope that, after reading this article, safety-net programs will see opportunities to integrate evaluation activities into daily oral health improvement programs, and will use evaluation to illustrate the value of their programs to various stakeholders.

An evaluation can be initiated for a number of purposes, including:

- Monitoring what you’ve done
- Tracking who has been served
- Determining what your stakeholders think
- Demonstrating the impact you have made

The question is how to demonstrate each of these on a tight budget and within a limited timeframe.

While understanding the gold standard for evaluation is a randomized control trial, effective evaluations do not need to be as complicated, or as time consuming, as you may think. The most important thing you can do when conducting an evaluation on a shoestring is to plan your evaluation early and plan well. This will help focus your attention on the most important questions you want answered, and will increase the likelihood that the results you get will provide those answers.

Here are some things to think about when conducting evaluation on a shoestring:

- Begin at the beginning – When planning a new oral health improvement program, hone in on what you really need to know to evaluate your oral health improvement program or project. Use evaluation principles to determine your goals and objectives, and give thought to what data might help assess your achievement of those goals and objectives.

- Integrate evaluation into programming and activities you already do – Continuous Quality Improvement efforts, satisfaction surveys, and monthly production reports are some examples of information you may already regularly collect. Figure out how these data sources can be utilized in your evaluation.

- Institutionalize evaluation – Request dedicated evaluation funds for each project, integrating them into every grant application or budget request.

- Leverage and maximize evaluation funding – If you implement cross-discipline/cross-department programs or collaborate with external groups or partners, ask them to invest resources (e.g., financial, personnel etc.) in the evaluation. If you have graduate students or residents, they may be willing to contribute to the evaluation for publication rights or course credit.

- Consider building your own internal evaluation capacity – Skills such as database development, data collection, organization and entry, participant recruitment or surveying, may be...
Dental therapists providing cost-effective routine and preventive care to underserved communities in Alaska and Minnesota

David Jordan, Project Director, Dental Access Project, Community Catalyst

In May, Community Catalyst released a report assessing the economic viability of services provided by practicing midlevel dental providers in the U.S. The report shows that midlevels are expanding preventive dental care to people who need it most: children and those who can’t afford care. At the same time, midlevels are providing that care at a reduced cost to the dental practice. The report determined that dental therapists, midlevel dental providers that are currently practicing in Alaska and Minnesota, cost their employers 27 and 29 percent respectively of the revenue they generate.

The report is the first to analyze the economic viability of practicing midlevel dental providers in the U.S. It comes at a time when more than a dozen states are exploring using midlevel dental providers as a way to greatly expand access to dental care. According to the federal government, approximately 45 million people in the U.S. live in areas where there are not enough dentists to serve the population.

“For the first time we have a real picture of what it means to employ a midlevel dental provider,” said Frances Kim, DDS, DrPH, who authored the report. “What we are seeing is that midlevel providers are providing mostly preventive care to the most economically-challenged patients and are still able to generate enough revenue to ensure that dental practices that employ them can care for the poor.”

Midlevel dental providers are fairly new in the United States, with Alaska and Minnesota being the first two states authorizing dental therapists as a provider model. Eight states have put forward legislation seeking to authorize dental therapists and several other states have called for studying the model further. Outside of the U.S. dental therapists have been practicing successfully in close to 50 other countries for the better part of a century.

In the two states studied, dental therapists work as part of a dental care team, helping expand the reach of a dentist — in much the same way as nurse practitioners, physician assistants and other medical personnel have been able to expand what the medical...
As a result of dental therapists, dentists are spending more time on more complex procedures and leading the dental team.

The report, *Economic Viability of Dental Therapists*, assessed dental therapists in practice between August 2011 and December 2012. Key findings include:

- The majority of services dental therapists provided (32.8 percent) were preventive; sealants (44 percent) and fluoride varnishes (43 percent) were the most common preventive services.

- Less than a quarter (23.7 percent) of the care dental therapists provided was restorative care, and extractions represented just a fraction of care (3.8 percent).

- Restorative procedures represent the majority of revenue (46.7 percent) dental therapists generate. Preventive procedures account for 20.5 percent of revenue despite the fact that they are the most commonly performed procedures.

Dental therapists primarily treat children, low-income adults, Native Americans and those who would not otherwise have access to dental care. Seventy-eight percent of dental therapists’ patients in Minnesota were publicly insured and the majority were under 21. In Alaska, 66 percent of patients served by dental therapists were under 21.

This report underscores just how critical dental therapists could be to fighting what has become the number one chronic but preventable disease affecting children. Children and families with Medicaid often struggle to find a dentist willing to treat them. With the implementation of the Affordable Care Act, in 2014, as many as 5.3 million kids could be eligible for services, but they need providers to treat them.

Dr. Kim Frances, author of the report, will be presenting Tuesday, November 12 at the National Primary Oral Health Conference and we invite you to join us and ask your questions about these models and the findings of this report.

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**DENTSPLY Caulk is simplifying Class II restorations**

Jason H. Goodchild, DMD

Jawaharlal Nehru once said that the highest type of efficiency is utilizing existing material to the best advantage. This is especially true of Class II composite resin restorations. With an estimated mean annual failure rate of 2.3%, the prudent practitioner must leverage clinical precision and the best materials to provide consistent positive outcomes.¹

There are many factors that can influence the prognosis of Class II composite restorations, including: adhesive system used, isolation, material, and operator skill. With Class II’s making up almost half of the direct restorations done in the United States annually, they can become an important factor in patient experience, retention, and referrals — and ultimately the health of your practice.

We also know there are a number of variables that can cause premature restoration failures and potentially unhappy patients. That is why dentists need to have supreme confidence in the materials they choose so that coupled with operator skill; Class II composite restorations are predictable and consistently successful.

To avoid issues such as fractures, food traps, and gingival inflammation, restoring natural contact and contour is essential. To ensure tight, accurate contacts on all your Class II restorations, take a strong first step with the Palodent® Plus Sectional Matrix System.

Depending on preparation size, depth, and available enamel, the type of etching method used can influence bond strength and post-operative sensitivity levels. When using Prime&Bond Elect™ Universal Dental Adhesive, you can elect to total-etch, self-etch, or selective etch to match your preference for the situation. Built on the clinically proven chemistry of Prime & Bond® NT™ adhesive, Prime&Bond Elect™ delivers consistent, high bond strengths and virtually no post-op sensitivity.

Minimizing the potential for polymerization shrinkage and maximizing adaptation of the restorative material helps mitigate the potential for sensitivity.
and recurrent caries. Once the optimal form and surface for restorative material placement is prepared, consider SureFil® SDR® flow for the first restorative layer. SureFil® SDR® flow is a low-stress, bulk-fill flowable composite resin with excellent matrix and cavity adaptation, and a 4mm depth of cure. These attributes simplify placement, making SureFil® SDR® flow an ideal flowable resin for Class I’s and II’s, even in the maxillary because of its self-leveling handling.

For the final occlusal layer, take advantage of simple shading, proven durability, and easy handling with TPH® Spectra Universal Composite. DENTSPLY Caulk’s TPH® Spectra restorative combines nanotechnology with proprietary, synergistic fillers in a patented resin matrix for optimal durability and esthetics. With excellent translucency and a refractive index almost identical to enamel and dentin, dentists can expect a pleasing blending effect to make restorations virtually indistinguishable from natural tooth structure. TPH® Spectra also contains hybrid and nano-fillers which have been shown to resist chipping, fractures, and marginal staining.

TPH® Spectra comes in two handling choices: a creamy light-viscosity formulation, and a packable high-viscosity formulation. For both viscosities the physical properties are similar. Because handling preference is subjective and highly individualized, practitioners are now able to select the right viscosity for all clinical situations.

References:

Early start to flu season
Shannon Pace Brinker, CDA, Kavo Kerr Group

It is that time of the year – flu season. As dental providers, it is good to know the trends for the year and be prepared.

Each year, one flu virus of each kind is used to produce seasonal influenza vaccine. During 2011-2012, 132.8 million doses of flu vaccine were distributed in the United States according to the Centers for Disease Control and Prevention.

The CDC recommends a yearly flu vaccine for everyone 6 months of age and older to protect against this potentially serious disease. Flu vaccines are designed to protect against three influenza viruses that experts predict will be the most common during the upcoming season.

Types of Flu

Not all types of flu are the same. Some can cause mild symptoms while others can make you very sick. Influenza is a contagious respiratory infection caused by a number of flu viruses, which enters your body through mucus membranes through your nose, mouth and eyes. Every time you touch your face you could be infecting yourself with a virus.

Type A viruses are capable of infecting people as well as animals; it is more common for people to suffer the ailments associated with this type of flu. Wild birds act as the hosts for this flu virus. Type A virus is constantly changing and is generally responsible for the large flu epidemics.

Type B virus is found only in humans. Type B flu may cause a less severe reaction than type A flu virus. However, type B flu occasionally can be very harmful. This type of flu is not classified by subtype and do not cause pandemics.
Type C viruses are also found in humans. Type C is milder than either type A or B. People generally do not become very ill from the influenza type C viruses, and it does not cause epidemics.

Cold or Flu?

Common colds and flu have similar symptoms, but flu symptoms are more severe. Flu symptoms may include cough or sore throat, runny nose, head or body aches, chills and fatigue, fever of 100 degrees or higher and nausea, vomiting or diarrhea.

Prevention

Here are a few helpful tips to keep your home or office sanitized during the flu season to help prevent the spread of germs:

1. If you are sick with flu-like symptoms, stay home for at least 24 hours after your fever is gone without the use of fever-reducing medicine.

2. Cover mouths when coughing and sneezing. Use your sleeves or bury your nose into your elbow. Cover your nose and mouth with a tissue when you cough or sneeze and throw the tissue in the trash immediately after using. VioNex Antiseptic Skin Wipe Towelettes can also be used for easy hand cleaning when soap and water are not available.

3. Tell everyone in your home and office to wash his or her hands several times per day, especially after using the bathroom and before eating. Liquid soap needed to wash hands should be about the size of a quarter, and warm water works better than cold. VioNex Antimicrobial Liquid Soap is gentle and non-irritating liquid soap that helps reduce bacteria that can cause disease.

4. Door handles, phones, and keyboards in particular are some of the biggest culprits in transferring germs. An intermediate disinfectant such as, CaviWipes1 by Kerr TotalCare, is perfect for cleaning, disinfecting and decontaminating clinical and environmental surfaces.

5. Don’t share mugs, cups, pens, lip balm, and other items that are often shared with family members.

6. Give your children sanitizing solutions to keep in their backpack at school. VioNex No rinse Gel Antiseptic Hand wash provides a convenient and economical way to cleanse and kill germs on your hands when soap and water are not available.

Since 1977, the flu has been linked to a range of 3,000 to 49,000 deaths in a season. Additionally, the flu is responsible for up to 200,000 hospitalizations each year in the United States. The seasonal flu vaccine was created to try to avert these epidemics. Recommend flu shots to your patients, and follow the tips above!

References:

2. Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases (NCIRD) 2012-2013 Influenza Season Week 51 ending December 22, 2012
4. Centers for Disease Control and Prevention. MMWR, Vol. 59, No.33, CDC Atlanta
Dental Aid (Louisville, Colo.)
Dennis Lewis, DDS, President & CEO

Maria Smith, MPA, NNOHA Project Coordinator

Dental Aid is a non-profit dental clinic serving low-income and uninsured residents of the Front Range in Colorado. Dental Aid’s mission is to improve the quality of life of children and adults struggling to afford health care by providing compassionate, affordable, quality dental care and education, while advocating to ensure access to care. For this article, NNOHA interviewed Dental Aid’s President & CEO, Dennis Lewis, DDS.

When did your dental clinic start?

Dental Aid started in 1974 and to the best of our knowledge, we are the oldest, non-profit standalone safety-net oral health clinic in Colorado. Dental Aid has three clinics, in Boulder, Longmont and Louisville, serving about 8,000 individuals per year with over 27,000 visits per year.

What is your community like?

Boulder County is a socially diverse area due to employers such as the University of Colorado in Boulder, and technology companies such as IBM and Qualcomm. These organizations have the ability to draw employees from all over the world. In spite of these high-end earners, Boulder County has a monthly Medicaid workload of over 23,500 visits. The county currently has about 14,000 individuals enrolled in Medicaid with another 5,000 eligible but not enrolled. The County is estimating that Affordable Care Act Medicaid expansion will add another 12,500 individuals to Medicaid. Estimates for total number of individuals below 250% of poverty is just under 40,000.

What challenges do you face that might be different from other safety-net clinics?

We do not receive Federal or State dollars but rather receive fee-based Medicaid reimbursement, which is significantly less than cost-based reimbursement. This results in an extremely tight business model.

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

We measure behavioral change. We use anticipatory guidance, motivational interviewing and patient goal setting as tools to request and measure changes in behavior. We then reinforce this behavioral change with clinical observations such as decreased biofilm, changes in bacterial load and gingival health.

Moreover, we are especially proud of our Bright Smiles for Bright Futures program, a pre-birth intervention aimed at lowering severe early childhood caries. The program began in 2002 as a three-year pilot designed to provide oral health care and education for low-income pregnant women to avert premature and low birth weight deliveries. It has since developed into a mechanism for behavioral change and disease elimination in women and an important part of decreasing caries transmission from mother to infant, ultimately improving children’s oral health.

Bright Smiles is a central component in our continuing work to change the current oral health culture of pregnant women and their families. Dental Aid has learned that reinforced oral health education is necessary to create sustained change. All individuals involved in perinatal care must understand and be in agreement on the importance of oral health care during pregnancy and throughout early childhood.

Do you have any strong partnerships in the community?

As a stand-alone, Dental Aid depends on community partnerships. We work closely with local government, including city councils and county commissioners. In addition, we have formal Memorandums
How has NNOHA been helpful to you?

NNOHA provides a source of promising practices in clinics similar to ours, serving patient populations similar to ours. NNOHA also provides a professional development avenue through their annual conference and a voice of advocacy for our patients and us. I personally enjoyed co-chairing the Membership Resources Committee in the past.

What do you “know now that you wished you knew then” or what advice would you give to new dental staff?

To practice in the safety-net, you have to like ALL facets of general dentistry. You have to be a good restorative dentist, as well as an oral surgeon, periodontist, prosthodontist and endodontist. The spectrum of dentistry provided in the safety-net is broad. It is a very demanding practice model.

What would you like the decision makers in DC to know about safety-net dental programs?

There are many successful safety-net models throughout the country and they need support from Washington. The safety net is weakened when stand-alone clinics close.

What is on your wish list for the future?

My wish is that all oral health clinics that qualify for federal loan repayment also qualify for cost-based Medicaid reimbursement. This change in the business model for stand-alone clinics would solidify their business model and create a stable and sustainable cash flow. In the end this would increase access to care and improve the health of our communities.

A special thank you to Dennis Lewis, DDS, President & CEO at Dental Aid for contributing to this article.

Are you interested in learning more about Bright Smiles for Bright Futures? Check out the promising practice that Dental Aid contributed to NNOHA that details this program at http://www.nnoha.org/programs-initiatives/promising-practices/clinical-excellence/.

Did You NNOHA?

NNOHA Website and Listserv Launched: NNOHA launched its new website and listserv in October 2013. The website highlights NNOHA’s various programs and initiatives; resources according to four key topic areas; new and improved Job Bank; and upcoming NNOHA events, including the National Primary Oral Health Conference and webinars. The NNOHA Listserv is intended to promote networking and learning among Health Center and safety-net dental directors, dentists, dental hygienists and other staff members working to improve access to quality oral health care. We hope that these two resources will be useful additions to the services we offer.

Fellowship Opportunity: Joseph L. Henry Oral Health Fellowship in Minority Health Policy – The Harvard School of Dental Medicine and Harvard Medical School seek applicants for the 2014-2015 Joseph L. Henry Oral Health Fellowship in Minority Health Policy. This fellowship is a one-year or two-year academic degree-granting program, designed to develop oral health leaders, particularly minority oral health leaders, who will pursue careers in health policy, public health practice and academia. The deadline for applications for the program starting in July 2014 is December 26, 2013.

HRSA Grant Opportunity: HRSA-14-060 Teaching Health Center Graduate Medical Education (THCGME) Program – This grant opportunity increases primary care medical and dental residency training in health centers and other settings by funding residents’ medical education expenses. For more information, visit: http://www.hrsa.gov/grants/index.html.
Upcoming Conferences & Events

Save the date for the 2014 National Primary Oral Health Conference, August 17-20, 2014 in Orlando, FL!

Association of Maternal & Child Health Programs (AMCHP) Annual Conference
January 25-28, 2014
Washington, DC

1st International Quintessence Symposium on Oral Health: The Oral-Systemic Connection
February 7-8, 2014
Sheraton San Diego Hotel & Marina
San Diego, CA

American Academy of Dental Practice Administration (AADPA) Annual Meeting
March 5-8, 2014
Hyatt Regency Indian Wells Resort & Spa, Palm Springs, CA

15th Annual International Summit on Improving Patient Care in the Office Practice and the Community
Hosted by the Institute for Healthcare Improvement
March 9-11, 2014
Washington, DC

American Dental Education Association (ADEA) Annual Session & Exhibition
March 15-18, 2014
San Antonio, TX

American Association for Dental Research (AADR)/ Canadian Association for Dental Research (CADR)
Annual Meeting & Exhibition
March 19-22, 2013
Charlotte, NC

Policy and Issues Forum (P&I)
Hosted by National Association of Community Health Centers (NACHC)
March 19-23, 2014
Marriott Wardman Park Hotel, Washington, DC

Special Care Dentistry Association (SCDA) 26th Annual Meeting on Special Care Dentistry
April 10-13, 2014
Westin Michigan Avenue, Chicago, IL

National Oral Health Conference
Hosted by Association of State and Territorial Dental Directors (ASTDD), American Association of Public Health Dentistry (AAPHD), and the Centers for Disease Control and Prevention (CDC)
April 28-30, 2014
Fort Worth, TX

Spring Primary Care Conference
Hosted by Northwest Regional Primary Care Association (NWRPCA)
May 17-20, 2014
Seattle Waterfront Marriott, Seattle, WA

2014 USPHS Scientific and Training Symposium
June 10-12, 2014
Raleigh, North Carolina
The Pay it Forward Promotion is a special offer from NNOHA that allows you to introduce the value of NNOHA to a colleague. By purchasing a 2014 NNOHA membership for a colleague who is a new NNOHA member you will receive:

20% OFF YOUR 2014 ANNUAL DUES AND
20% OFF A NEW MEMBERSHIP FOR A COLLEAGUE

We are sure you know someone that would like to join and a little nudge from you can make it happen, especially if you tell them: “you will pay their first year.” If you do not have a particular colleague in mind that you wish to sponsor but would like to help NNOHA grow its membership by participating in this membership promotion, simply write in “you pick” in the line designated for your colleague on the “Pay it Forward Promotion” membership form.

You receive 2 annual memberships for only $80.00 – a $20.00 savings!

To take advantage offer, sign up at:

http://www.nnoha.org/join/overview/

Contact Terri Means, Membership Services Coordinator, with any questions you may have.
Member Recognition:
ORGANIZATIONAL/UNIVERSITY & ASSOCIATION MEMBERS

The following have initiated or renewed their membership of NNOHA between August 1, 2013 and November 1, 2013. We recognize their commitment to supporting NNOHA and improving access to oral health services for the underserved.

- Adelante Healthcare, Inc.
- Albany Area Primary Health Care, Inc.
- Arizona Association of Community Health Centers
- Camcare Health Corp.
- Collier Health Services, Inc.
- Colorado Rural Health Center
- Community Dental Care
- Community Health Center, Inc
- Community Health Centers, Inc. (Winter Garden, FL)
- Cross Trails Medical Center
- Delta Dental of Colorado Foundation
- Heart of Texas Community Health Center, Inc.
- Jordan Valley Community Health Dental Clinic
- Metro Community Provider Network
- North County Health Project
- NorthLakes Community Health Center
- Quality Systems, Inc.
- Refuah Health Center
- San Ysidro Health Center
- Texas Association of Community Health Centers
- Three Lower Counties Community Services, Inc.

NNOHA’s mission 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.

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