National Primary Oral Health Conference 2014: Reflections from your new Executive Director

Phillip Thompson
NNOHA Executive Director

On behalf of the NNOHA Board of Directors, staff, and Conference Planning Committee, I want to thank everyone who participated in the 2014 National Primary Oral Health Conference (NPOHC).

The word that best captures the impressions of my first NPOHC is “warmth.” I heard the warmth in the laughter and stories told by colleagues from across the country, colleagues whose experiences span decades of commitment to the cause of oral health access. I saw the warmth in the presence and participation of NNOHA’s partners and supporters who believe in our vision and mission.

I tasted the warmth in the Coffee House, which was the go-to place for conversation and caffeine all meeting long. I heard the warmth again in the passion of our keynote speaker, Dr. Claude Earl Fox, and in the enthusiasm of our moderators, presenters, and exhibitors (If you heard Dr. Bob Russell speak you know what I’m talking about). I witnessed the warm introductions of new colleagues attending their first NPOHC as they were welcomed into the community of like-minded oral health professionals and supporters.

I was touched by the warm regard for this conference from returning attendees who told me they keep coming back because this conference gives them the information they use every day in their health centers. I was inspired by a new generation of oral health leaders represented by our 2014 graduating cohort of the National Oral Health Learning Institute who promised to keep in touch and keep the flame alive.
The word that best captures the impressions of my first NPOHC is ‘warmth.’

And, of course, we all felt the warmth every time we stepped outside the building. Ahh, Central Florida in August!

Those are my impressions. How about some statistics?

- Attendees registered for the conference: 572
- Number of speakers: 72
- Educational sessions: 37
- Plenary sessions: 2
- Networking breakfasts: 4
- Pre-session meetings: 6
- NNOHA committee and board meetings: 6
- Exhibitors: 71 (thank you all)
- Community Health Center Tours: 1 (thank you Community Health Centers Winter Garden)
- Guest appearances by a world famous cartoon character: 1

Obviously there was far more activity than any one person could attend. So let me thank everyone who took the time to present their expertise and experience at our NNOHA conference. I especially want to recognize our plenary speakers:

- Huong Le, DDS, MA, NNOHA President, who reminded us of NNOHA’s commitment to honor those who have gone before us and our vision 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.

- Mary Wakefield, RN, PhD, HRSA Administrator, who told us the 9,200 service sites of the nation’s community health centers represent our country’s greatest potential for developing truly integrated primary care.

- Claude Earl Fox, MD, MPH, former HRSA Administrator and public health leader, who urged the NNOHA community to get involved, “It’s great to have generals, but we have to have troops! It’s time to turn off the spigot of oral disease.”

- William Bailey, DDS, MPH, University of Colorado School of Dental Medicine, who reminded us that our jobs are about people and enabling people to live optimal lives. He told us to fully serve people we will have to use both our left brains and our right brains. We need all of our brain power as individuals and as a community. He concluded, “Individually we are a drop, together we are an ocean.”

- Gary Wiltz, MD, NACHC Board Chair, who after expressing his regret that oral health does not get the respect it deserves, promised to continue to work to ensure that primary health care also means oral health care. He concluded with these words, “It is no accident you are here today. There is no greater reward than to help someone smile. This is a great conference. You do great work. Hang in there. It will end well.”

In closing let me say we all owe a huge debt of gratitude to Dr. Daniel Brody and our Conference Planning Committee for a wonderful conference and a splendid opportunity to network together while building the oral health foundation for primary care.

See you next year in Indianapolis!

Save the date for the 2015 NPOHC: November 15-18, 2015 at the Indianapolis Marriott Downtown, Indianapolis, IN.
Many people take for granted that community water fluoridation (CWF) in the U.S. is a widespread, safe, and well accepted public health practice. Therefore, it can come as a surprise when fluoride opponents initiate efforts to remove it from the local water supply.

The Campaign for Dental Health, a volunteer network of local and national organizations, was created to provide reliable information on community water fluoridation with a web-based presence, IlikeMyTeeth.org. Our mission is to support health professionals, advocates, scientists, and policy makers who recognize that CWF is a cost-effective way to prevent tooth decay.

Why talk about community water fluoridation?
Health professionals are a trusted source of information on children’s oral health. The Campaign has developed five new tools for health professionals with information and resources on fluoride, fluorosis, and community water fluoridation. These include two handouts specifically designed to share with patients, parents, and caregivers. The tools include:

1. Fluoride Safety: A Guide for Health Professionals is a concise explanation of the regulation and safety of fluoride additives and fluoridated water. Common concerns, including daily intake and use in preparing infant formula, are
addressed. Links to valuable resources are provided.

2. **Fluorosis Facts: A Guide for Health Professionals** gives health professionals a quick, thorough understanding of dental fluorosis and includes photos, follow-up resources, and suggestions for counseling on prevention.

3. **Say This, Not That: Tips for Talking about Community Water Fluoridation** is designed to help health professionals address technical, challenging questions with comfort and ease. Addressing many of the most common concerns, this tool offers discussion-friendly responses in a clever graphic format.

4. **Common Questions about Fluoride: A Resource for Parents and Caregivers** explains the importance and safety of fluoride in a question and answer format. A companion to Fluoride Safety: A Guide for Health Professionals, this handout lets your patients leave the office with accurate fluoride information in hand.


### Get Involved!
As oral health professionals, we have a responsibility to not only advance evidence-based preventive practices, such as fluoridation, but also to speak out when critics attack these practices. Here are 4 ways you can slow the erosion of sound public policy and promote evidence-based discussions about CWF.

1. Electronically-oriented? Join our Rapid Response Team and receive daily e-digests of online articles that need either correction or support. Follow us on [Facebook](https://www.facebook.com) and [Twitter](https://twitter.com), and add your voice to the discussion.

2. People person? Let us know that you are willing to volunteer to testify at local hearings should they arise in your area.


4. Want to increase the comfort zone? Your patients’ families will benefit from your reassurances that fluoridated water is safe for their children. See our [Health Professionals](https://www.aap.org) page for tools that can help you engage in an informed and comfortable discussion.

For more information or to be connected to local advocates, please contact [fluoride@aap.org](mailto:fluoride@aap.org).
Traditionally, dentistry evolved within a system of delivery completely separate from the rest of medicine. However, the ability of the dental profession to remain a casual acquaintance to the health care system is changing. Dentistry will have to become more involved as evidence of improved outcomes through increased dental-medical integration mounts.

**The importance of dental-medical integration**

The impact that oral health can have on systemic outcomes overlaps many disciplines and disease processes. Recognition of the oral health-systemic disease link continues to increase as research advances. Studies have resulted in a deeper understanding of the role of periodontal therapy in improving glycated hemoglobin; the association of periodontal disease with cardiovascular and stroke patients; and improvement in quality of life for AIDS patients through simple tooth brushing, to name a few.

**Levels of integration**

Integrating medical and dental care is especially important in safety-net settings, where patients often present complex health issues. The depth of integration an organization can achieve will depend on: the ability of the organization to consolidate and arrange efforts, leadership quality, capacity to provide care, and the willingness of management, staff, and providers to participate. Four levels of integration are suggested: basic, moderate, high and creative. Characteristics of each integration level are proposed in the following paragraphs as ‘includes but not limited to’:

**Basic Level Integration:** A bi-directional cross-referral process supporting referrals from dental to medical and vice-versa; consistent appointment queries during patient encounters for follow-up appointment due dates; use of cross-promotional educational materials; BMI, blood pressure, and heart rate measurements obtained in the dental setting and routinely shared with medical.

**Moderate Level Integration:** All providers possess a basic understanding of complementary disease processes; appropriate application of medical and dental interventions; target population identification and understanding; achieving or nearing meaningful use; partnerships facilitating community outreach; topical fluoride application in the medical setting.

**High Level Integration:** A high percentage of patients having seen both medical and dental providers on a regular basis; population health care coordination; implementation of an integrated quality assurance plan; sharing of systemic disease benchmarks; high level medical and dental screenings.

**Creative Level Integration:** A ‘wide-open’ level that encourages innovation, allows creativity, and facilitates professional and patient development.

**Implementation of integrated care**

The initial process of integrated care management should include the development of a strategic plan with a realistic timeline of planned graduation through the levels of integration. The strategic plan should also highlight the training procedures that will be used. Within the medical setting, training related to oral health should focus on its importance to systemic well-being, as well as basic information on oral health issues, treatment, and outcomes. The Smiles for Life education program is a comprehensive oral health curriculum that can be used for
While dentists possess general knowledge of systemic disease processes, their knowledge base is limited as it relates to comprehensive treatment of disease; common medical language; and treatment outcome, assessment and goals. Dental provider and staff training should include: systemic health prevention, common prescribing practices of physicians and basic information on goal-oriented systemic treatments. Currently, there is not a universally accepted curriculum for the enhancement of medical knowledge for practicing dentists. This should be a focus of integration supporting organizations in the immediate future.

**Conclusion**

Meaningful dental-medical integration has been shown to improve patient outcomes and patient satisfaction. In addition, closed claims analyses of integrated care have also demonstrated a reduction in per capita cost to the health system. As the American health care system undergoes significant changes in patient treatment, the role of dentistry will continue to prove vital to a successful paradigm shift.

**References:**


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**Clinical Excellence**

**Minimizing the stress of restoring children’s teeth: for the child and the provider**

Gloriana Nana Lopez, DDS, MPH
Dentist, Community Health of South Florida-Marathon (Fla.)

There are still many instances when children come into our clinics with dental caries and we are the only providers who can help them. This can be due to the cost of restorative care, lack of insurance, lack of access to specialty care, geography resulting in long distances to travel for care, etc.

At our clinic we have developed methods that allow teeth with early to moderate decay to be restored with minimal trauma. Our method allows the child to work in collaboration with us by giving the child control of the pain factor and the way treatment is carried out.

Typically no injectable anesthesia is used and early to moderately decayed molars or anterior teeth with Class I, II or V caries can be restored. This methodology began in response to the reactions of children to having the “shot”. Not many kids liked this part of the visit. It seemed to be one of the reasons that parents did not return for further care.

For this approach to be successful, case selection is critical. The child must be able to understand directions in order to be a partner in completing treatment, and the caries should be in the early to moderate stage.
Ideally, less invasive procedures should be performed first to gain the confidence of the child and to introduce the tools, sounds and routine of the dental visit. We perform a rubber cup prophylaxis so we can introduce the “Super soaker” (air/water syringe), “Mr. Thirsty” (saliva ejector) and “Mr. Bumpity Bump” (the slow speed). The child gets to hold Mr. Thirsty and put it in their mouth themselves.

The children also learn to use their left hand as a signal to stop. We encourage them to keep their left hand on their chest (ideally on the edge of the towel/bib). This way they can communicate if they need us to stop. It is imperative that you do stop if the hand goes up – we actually have them demonstrate to us what they need to do to get us to stop. It is essential that the child and provider understand the expectations before beginning restorative treatment.

The next visit is for restorations to get the “sugar bugs” out and put in a “white star”. We begin doing restorations using only the slow speed round bur if there is direct access to the lesion. The high speed is used only if the marginal ridge needs to be removed to reach the lesion and the child is cooperative. At this visit the child is reminded of the instruments we will use and introduced to the high speed (Whistling Charlie).

All peripheral caries are removed first. All efforts are made to remove all caries and if a matrix band is needed, topical anesthetic is placed and the child is shown the band (tooth ring) and told their tooth will be wearing a ring (or get a hug) while we put in their white star. We rinse vigorously and use glass ionomer restorative material.

We have had good results with these techniques, providing hundreds of restorations. Anecdotally, we believe these fillings are lasting as long as similar restorations that are placed using anesthesia.

This method is similar to the Atraumatic or Interim Restorative Technique (ART/IRT) and we can say from experience that children return and do not have the fears about “getting a shot”. They know they can trust us and return regularly and cooperate as needed. Patients feel better about avoiding “the shot” and we feel better about giving relatively pain free dental care.

Sometimes the child will not tolerate the high speed to get through the marginal ridge. When this is the case, we then let them know we will need to make their tooth go to sleep for a while so it won’t hurt. We explain that they will be feeling a “mosquito bite” for 3 seconds, during this time they are encouraged to wiggle their toes, as it helps distract the brain and makes it more tolerable.

With proper case selection, we believe this method of caring for early to moderate occlusal and proximal caries is an improvement on the traditional method of using anesthesia. It is simple, involves the child in their care, builds trust and can have lasting positive impacts on the patients we serve.
Outfitting your operatory ergonomically

Timothy J. Caruso, PT, MBA, MS, Cert. MDT, CEAS

On a daily basis, dental professionals encounter a wide variety of patients, problems and tools that require modified, if not extraordinarily awkward postures in order to deliver effective treatments. What is the price of these physical acrobatics in the operatory? The awkward postures, repetitive motion and forceful exertions necessary to do your job can strain your musculoskeletal system, which inhibits the body’s natural repair processes. This often results in pain, limited mobility, headaches, fatigue, numbness, tingling and potential injury. Many of you reading this may experience one or more of these problems. Dentists are one of the few professions, besides professional football and ultimate fighting, which accept pain as part of their working day.

Let’s start with the patient chair: what is its purpose? Patient comfort, support, positioning, esthetics? The main function of the patient chair should be facilitating access to the oral cavity for the practitioner. The design of the patient chair that allows for this is a thin, narrow back at the patient’s torso and head. This allows easy access to the oral cavity while allowing the practitioner to maintain a balanced, upright posture.

While patient comfort is important, it should not be at the cost of limiting access to the oral cavity. A wide, thick padded patient chair will often require practitioners to place their legs under the back of the chair. While this allows the practitioner to get closer to the oral cavity, it also requires raising the patient in order to gain access, and in doing so, elevating their shoulders into an unnatural position of abduction (See Photo 1). A wide back rest also causes dental professionals to bend forward, twisting their spines in order to access the oral cavity (See Photo 1). Neither of these positions allows one to maintain a properly balanced working posture.

Another important chair feature to look for is an adjustable headrest that will support the patient’s head and neck and allow the dental professional to correctly position the patient for efficient treatment. Last, can the chair be easily adjusted for the left to right handed operator, or to allow for improved access when working with an anxious patient?

Next to the patient chair, the most important consideration is the operator stool. The operator stool should be given as much consideration as the patient chair and not be an afterthought. The characteristics of the operator stool should provide the operator with support and comfort while in the numerous working postures required to perform oral health care. The seat pan should be large enough to support the buttocks and upper thighs.

The seat should adjust up and down as well as tilt slightly forward to allow the operator’s hips to be slightly higher than the knees. This position places the pelvis into a slight anterior tilt, better balancing the natural curves of the spine (See Photo 2). The height of the hydraulic cylinder should meet the need of the operator to assume the previously described position. Taller individuals should consider a taller cylinder. When in doubt, ask your vendor for a trial period with the taller cylinder stool.

The back of the operator chair should adjust up and down as well as anteriorly and posteriorly to provide support and tactile cueing for the operator throughout the working day to help maintain a balanced sitting position.

Armrests are another option for the
operator stool that is often overlooked or not considered. Many practitioners have spent their entire careers working without arm support. Research has demonstrated that dental practitioners spend nearly half of their working day in poor seated postures (Marklin, R.W. (2005). Working Postures of Dentists and Dental Hygienists. CDA Journal, 33(2), 133-136), including forward tilted head with rounded shoulders, elevated arms, kyphotic upper backs and flexed lumbar spines (See Photo 1); the infamous “chicken wing” position. Poor working postures add additional stress to an already busy day. Arm support can be an invaluable stress reducer for the dental practitioner. It may add minutes, hours or even days of comfort and reduced stress. Experience has also shown that arm support can facilitate a more appropriate, balanced work position while alleviating stress on the upper quarter of the practitioner.

There are many options for armrests, so when considering which to choose, one must determine the ability of the armrest to comfortably support the upper extremity and provide adequate freedom of movement to allow the required actions of the practitioner. In other words, the armrest should not obligate the practitioner to move in a particular plane of movement, but should provide support for necessary movements. Armrests should comfortably support the arm and not place undue stress on the neuromuscular structures of the forearm. Additionally, the armrests should be able to be easily moved out of the way if they are not needed.

So when considering outfitting the operatory, the main question to be answered is not necessarily how comfortable is the patient, but rather how comfortable is the dental practitioner and can s/he get close enough to the patient to provide quality care while maintaining a healthy posture? Can they get to the target without harming themselves?

This article was sponsored by KaVo Kerr Group.

Member Spotlight

Community Health Centers, Inc. (Winter Garden, Fla.)

Catherine Jones, RN, BSN, NNOHA Interim Project Coordinator

Community Health Centers, Inc. provides comprehensive health care services including adult and pediatric dental services, family medicine, internal medicine, pediatric medicine, obstetrics, gynecology, laboratory, pharmacy, X-Ray, family planning, behavioral health, optometry and in the near future podiatry services. For this article, NNOHA interviewed Dr. Gregg Stewart, DMD, Vice President/Chief Dental Officer, with support from Ms. Jackie Burt McDonough, RDH, BASHD, Director, Dental Operations at Community Health Centers, Inc. Community Health Centers’ mission is to provide quality and compassionate primary and preventive medical, dental and pharmaceutical services to Central Florida’s economically and culturally diverse communities.

When did your Health Center start?
Community Health Centers, Inc. was originally founded as the West Orange Farmworkers Health Association in 1972. Several nuns, local farmworkers and consumer activists identified the need to assist the under-privileged in the area. The original facility in Apopka was a trailer that consisted of a team of one doctor, one nurse and one assistant.

In 1976 a satellite center was opened in Winter Garden that included dental, pharmacy and laboratory services. Two years later, the trailer was relocated to Groveland, which is approximately one hour southwest of the original site. By 1979, dental and childbirth services were initiated at the original site in Apopka. Through the generous contribu-
tions of patients and farm-working fundraisers, a new site was built in Groveland in 1983.

What is your community like?
Originally created for migrant farmworkers, Community Health Centers, Inc. now operates centers in nine low income, underserved communities with diverse cultural backgrounds. Young adults under 25 years of age represent 51% of the more than 53,000 patients served annually at Community Health Centers, Inc., and 5% are individuals who are over 65 years of age.

What challenges do you face that might be different from other Health Centers and safety-net clinics?
The various locations of each of our sites present distinct obstacles. Some sites are located in rural areas and others are in the metropolitan locale. Transportation, supportive neighborhood services, and adult versus pediatric services provided can enhance the challenges.

The Management Information System and Information Technology Departments have been proactive in developing our communications systems. They have stayed ahead of our usage needs, allowing Community Health Centers, Inc. to be one of the first to implement an integrated electronic health record system. Community Health Centers, Inc. was selected as one of the beta sites for eClinicalWorks’ integrated medical-dental record system.

Our centralized check-in/check-out process at some of our sites, and our centralized appointment call center challenge us to ensure our staff understand the complexity and uniqueness of both dental and medical services. In addition, the sheer size of our Winter Garden site (32,000 square feet) creates a substantial facility to manage.

What are you doing well that you would like to share with us?
A pivotal recognition for our centers occurred in 1989 when the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited Community Health Centers, Inc., which established Florida’s first and only accredited community health organization! Additional assistance was added to enhance a supportive and caring environment. County public health services such as teen pregnancy classes, drug treatment programs, early enrollment and outreach programs were integrated into Community Health Centers, Inc.

Over the next thirty years, Community Health Centers, Inc. would grow into an organization that includes nine sites, with seven of these providing dental services. By the end of 2014, another site will be opened. Team members comprise nearly 400 providers and staff colleagues. The departments include, but are not limited to, Management Information Systems / Information Technology, Compliance, Human Resources, Purchasing, Facilities, Accounting / Billing, and Managed Care / Insurances.

In 2010, the prestigious Accreditation Association for Ambulatory Health Care (AAAHC) also awarded accreditation status to Community Health Centers, Inc.

Furthermore, Community Health Centers, Inc. dedicates significant amount of time and resources to training staff. Our philosophy is to be proactive and provide team members the guidance to learn and implement processes to minimize errors. Additionally, we dedicate resources to identify and “grow” our future leaders by providing management training and other learning opportunities for our staff.

Our Director of Real Estate and Construction has implemented a “Green Philosophy” with our newest building projects. Energy efficient lighting (LED and natural) and upgraded insulation, along with low maintenance flooring cut utility and cleaning costs tremendously over the life of the building.

Do you have any strong partnerships in the community?
Collaboration and alliances have been formed with over a dozen entities, including
I leave each NPOHC feeling totally recharged and ready for the next challenge!

What would you like decision makers in DC to know about Health Centers and Safety-Net Clinics?

The Health Center model is THE most cost effective health delivery system for primary and preventive care.

What is on your wish list for the future?

My wish list would include a desire for all Health Centers to receive funding needed to ensure access to dental services for all underserved communities.

Additionally, we need to further collaborations between educational institutions and Health Centers. This will allow greater access for patient care and expose a wider segment of the general population to the positive presence of Health Centers.

A special thank you to Gregg Stewart DMD, Vice President/Chief Dental Officer and Jackie Burt McDonough, RDH, BASDH, Director, Dental Operations at CHC, Inc. for contributing to this article!
Did You NNOHA?

Welcome New Staff!

NNOHA is pleased to introduce the new members of our staff.

**Phillip Thompson, Executive Director:** Phil comes to NNOHA with more than twenty-five years’ experience in health care management, most recently as Chief Financial Officer of Sheridan Health Services, a federally qualified health center offering dental, behavioral, and primary care services operated by the University of Colorado College of Nursing. His past experiences include financial management of a pediatric psychiatric hospital, operational management of ambulatory clinics in a university hospital, and executive leadership of a large multi-site home health program in Alabama. He has served on the board of directors for a state-wide home health association, and currently serves as a Board president of Senior Homes of Colorado, a non-profit organization providing low-cost housing for seniors.

**Laura Brindle, Office Support and Membership Services Coordinator:** Laura joined the NNOHA team in August 2014 as the Office Support and Membership Services Coordinator. Prior to joining NNOHA, Laura marketed graduate-level special education and social work textbooks for Love Publishing. She also worked as an editor at McGraw-Hill. Laura is currently pursuing her master’s degree in Public Administration with a concentration in nonprofit management at University of Colorado Denver. Outside of the office, Laura enjoys hiking, reading, and traveling. She is excited to join the NNOHA team and looks forward to getting to know NNOHA’s members.

**Cathy Jones, Interim Project Coordinator:** Cathy worked for 13 years at Mountain Family Health Centers (MFHC), an FQHC in the central mountains of Colorado, in several positions including nursing and quality improvement. In 2013-14, she was responsible for four of the five MFHC sites receiving PCMH Level 3 recognition. She has 30 years of nursing experience in both acute and ambulatory settings, with patients of all ages. She received her Bachelor of Science in nursing degree from Regis University in 1991.

News Alerts

**New resource – Survey of School-Based Oral Health Programs:** This new paper presents the results of a national online survey of Health Centers that NNOHA conducted in June 2013 to obtain information about school-based oral health programs located in SBHCs and operated by Health Centers. The paper also presents results from two follow-up focus groups held in August 2013. NNOHA hopes the information provided will inform efforts to enhance or expand existing school-based oral health programs and help those wishing to establish new programs—ultimately improving access to oral health services and thereby oral health and overall health outcomes for the populations we serve. To download the paper, visit: [http://www.nnoha.org/nnoha-content/uploads/2014/07/SBHC-Report-FINAL_2014-07-28.pdf](http://www.nnoha.org/nnoha-content/uploads/2014/07/SBHC-Report-FINAL_2014-07-28.pdf).

**2015 ADA Humanitarian Award deadline is September 15:** Nominations are now being accepted for the ADA HUMANITARIAN AWARD. Each year this prestigious award recognizes a dentist member who has distinguished themselves by outstanding, unselfish leadership and at least a ten year commitment to their fellow human beings in the field of dentistry, through the dedication of extraordinary time and professional skills to improve the oral health of underserved populations in the United States and abroad. To nominate an ADA member download the nomination packet at: [http://www.ada.org/1477.aspx](http://www.ada.org/1477.aspx) or contact the ADA Division of Global Affairs at 312.440.2726 or [international@ada.org](mailto:international@ada.org). Nomination materials must be received on or before September 15, 2014.
Did you know that NNOHA participates in the AmazonSmile program?

What is AmazonSmile?
AmazonSmile is a simple and automatic way to support NNOHA every time you make a purchase at Amazon, at no cost to you. When you shop at smile.amazon.com, you’ll find the same prices, selection and shopping experience as Amazon.com, with the added bonus that Amazon will donate a portion of the purchase price to NNOHA.

How do I shop at AmazonSmile?
To shop at AmazonSmile simply go to http://smile.amazon.com/ from the web browser on your computer or mobile device. You may also want to add a bookmark to AmazonSmile to make it even easier to return and shop at AmazonSmile.

Which products on AmazonSmile are eligible for charitable donations?
Tens of millions of products on AmazonSmile are eligible for donations. You will see eligible products marked “Eligible for AmazonSmile donation” on their product detail pages.

Can I use my existing Amazon.com account on AmazonSmile?
Yes, you use the same account on Amazon.com and AmazonSmile. Your shopping cart, Wish List, wedding or baby registry, and other account settings are also the same.

How do I select a charitable organization to support when shopping on AmazonSmile?
On your first visit to AmazonSmile, you need to select a charitable organization to receive donations from eligible purchases before you begin shopping. We trust that you will choose NNOHA! Amazon will remember your selection, and then every eligible purchase you make on AmazonSmile will result in a donation.

How much of my purchase does Amazon donate?
The AmazonSmile Foundation will donate 0.5% of the purchase price from your eligible AmazonSmile purchases. The purchase price is the amount paid for the item minus any rebates and excluding shipping & handling, gift-wrapping fees, taxes, or service charges.

This is a simple and easy way to support the National Network for Oral Health Access by purchasing items that you planned to purchase anyway. Be sure to start using it now for Back-to-School items and for your Holiday shopping.

How can I learn more about AmazonSmile?
Please see complete AmazonSmile program details.
Upcoming Conferences & Events

3RNet 2014 Annual Conference
September 16-18, 2014
Denver, CO

American Dental Association 2014 – America’s Dental Meeting
October 9-14, 2014
San Antonio, TX

American Academy of Pediatrics National Conference & Exhibition
October 11-14, 2014
San Diego, CA

National Organization of State Offices of Rural Health Annual Meeting 2014
October 28-29, 2014
Omaha, NE

American Public Health Association Annual Meeting
November 15-19, 2014
New Orleans, LA

“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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