Recently released! An analysis of 2013 health center oral health provider recruitment, retention, and job satisfaction

Kenneth Bolin, DDS, MPH, Medical Director, Sammons Cancer Center Dental Clinic, Baylor University Medical Center
Maria Smith, MPA, Project Director, National Network for Oral Health Access

Delivering quality oral health care services requires well-trained providers and support staff who are dedicated and motivated to supporting the mission of the program. While often challenging, taking time to carefully screen and select appropriate dental team candidates provides long-term benefits for the oral health program. These benefits include building support and collaboration among partners, patients, board members, the community, and current team members, as well as reducing turnover and recruitment costs.

To help Health Centers better understand and improve oral health provider satisfaction, and recruitment and retention strategies, the National Network for Oral Health Access, as part of a Cooperative Agreement with the Health Resources and Services Administration, worked with Baylor College of Dentistry in 2013 to develop and administer a survey of Health Center oral health providers and executive directors. This survey builds upon and updates results from the 2009 survey also conducted by NNOHA. The 2013 survey was mailed to all Health Centers in the United States and was completed by 457 dentists, 144 dental hygienists, and 246 executive directors.

Highlights of key findings are as follows:

- The majority of Health Center oral health providers are satisfied with their careers. Eighty four percent of dentists and 94 percent of dental hygienists indicated intent to remain employed at Health Centers.
The number one reason for choosing Health Center careers indicated among dentists and dental hygienists was that they “felt a mission to the dentally underserved population.”

A significant group of dental directors (39.8 percent) and dentists (26.3 percent) indicated that their salaries were greater than $140,000 per year (excluding benefits). While the most common salary range for dental hygienists was within the $50,001–$60,000 range, 24 percent indicated that their salaries were greater than $70,000 per year (excluding benefits).

Many oral health providers rotated through a Health Center oral health program before working at a Health Center, including 40.6 percent of dental directors, 51.7 percent of dentists, and 60.1 percent of dental hygienists.

Almost half of the respondents worked in private practices before working at Health Centers.

Providers with more years of experience or who had been employed by Health Centers longer were more likely to indicate intent to remain employed at Health Centers.

Providers who came to Health Centers because they felt a sense of mission; who perceived adequate interaction with Health Center medical colleagues; and who felt they had adequate administrative support, clerical support, and facilities and equipment were more likely to indicate intent to remain employed at Health Centers.

Survey results suggest that salary alone is not the main reason that oral health providers choose to leave or remain at Health Centers.

Survey results suggest that salary alone is not the main reason that oral health providers choose to leave or remain at Health Centers. Other factors also affect providers’ satisfaction with their careers. Health Centers may use these survey findings in efforts to recruit and retain personnel in the era of the Affordable Care Act and trends of interprofessional practice emerging throughout the country.

First, executive directors may find that the best recruits for dentists and dental hygienists will be those who may have rotated through a Health Center or safety-net dental clinic when the dentists and dental hygienists were completing their professional education. These rotations may have occurred years prior to the professional wishing to enter a new phase of practice, and after some amount of time spent in other professional activity or employment. In addition to advertisements directed towards students in professional school, Health Centers should advertise in state and local professional journals or with dental professional organizations. Advertisements could also be placed in non-profit publications and their corresponding website sections of career opportunities, such as the NNOHA Job Bank or the state and local components of the National Association of Community Health Centers.

Secondly, executive directors and management teams can also take note of the survey results that, while salary alone is not significantly associated with desires to remain in Health Center practices, a competitive starting salary and emphasis on increasingly generous fringe benefits that non-profits seem to be offering may tip the scales in favor of a dentist or dental hygienist accepting a job offer in a Health Center practice. The survey showed that most Health Center providers that had a high job satisfaction level were those with longer work experience in private practice. These providers may have had no retirement plan, may have had to self-fund any vacation or sick leave, and were likely saddled with paying their own malpractice premiums—all factors which, in a Health Center, add a 25-30 percent value to the offered salary.

Thirdly, once the provider is hired, retention of the best providers becomes an issue. Although the survey indicated that only 16 percent of dentists and 6 percent of dental hygienists responding plan to leave Health Center practice, almost one in three Health Centers (29 percent) currently had a vacancy for a dentist position. It is interesting to note that those providers who did not feel there was sufficient interaction with the medical component of the Health Center practice were 2.86 times more likely, statistically, to have an intention to leave the
Advocacy

Will you be ready when the fluoridation rollback campaign comes to your community?

Barbara E Bailey, RDH, PhD, Senior Consultant, Ray & Associates; Member, NNOHA Advocacy and Strategic Partnerships Committee

Recently there have been numerous attempts to remove fluoride from community water systems. Why, you ask? Fluoridation of community water systems has been around since 1945, and became almost common place in the 1970s. What has happened in the last 40 years to make us revisit fluoridation? For one thing, a cultural shift has occurred. According to a study in the Journal of Personality and Social Psychology there has been a decline in civic interest, such as political participation and trust in government, as well as in concern for others. Generation Xers (1965-1980) and Millennials (1980-2000) have been greatly shaped by technology. The use of social media sites is the norm, and the main source of where many get most their information. Unfortunately, there is no requirement for accuracy, and misleading, inaccurate and emotionally charged information can be posted. As a result of these shifts, it is suggested that basic public health practices such as fluoridation and immunizations are under-valued, or even under attack, simply due to a lessened value placed on the common good and a heightened value on personal rights.

In preparing this article, I contacted several people who have had personal experience with rollback attempts. I asked two questions: 1) what surprised you most about the rollback effort; 2) what advice would you give those who might be facing rollback attempts.

Cathy Taylor-Osborne, DDS, MA, Director, Bureau of Oral Health, Kansas Department of Health and Environment is engaged in battles in her state, and as this newsletter goes to press, the city of Salina just voted to retain fluoride in the water. This occurs on the heels of the removal of fluoride from the water in Wichita in 2012. Dr. Taylor-Osborne shared articles (October 5) with me from the Salina Journal that discussed the effort and some of the scare tactics, including the idea that the fluoride being added to the water is industrial waste from China. A surprise was the wording of the referendum that requires a “NO” vote to retain fluoride. In February, a bill was heard by the HHS Committee directing water departments that currently fluoridate to include a notice in water bills saying that water fluoridation lowers IQ in children. This bill did not make it out of Committee, but served as a wake-up call.

Carol Hanson, RDH, BSDH, MPH, Coordinator, New Mexico Department of Health/Office of Primary Care & Rural Health was surprised to learn that there are so many well educated people who are misguided by what they read on the internet, and noted that the anti-community water fluoridation pages far outnumber the pro community water fluoridation supporters in Portland, Oregon.

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Tom Taylor, Primary Care Integration Coordinator, Alaska Primary Care Association shared that the extent of connection of local opponents to national opponents and outside organizations surprised him. Juneau, Fairbanks and Bethel dynamics were all linked into national opponents that speak against fluoridation. He was also surprised by the broad array of issues that were raised: effectiveness, health concerns and legal challenges to mass medication without consent. Tom also indicated that the time and energy spent by opponents, going to each local government meeting to speak against fluoridation during public testimony, organizing protests, writing letters to local newspapers and blogs across the country to influence other communities was amazing.

Lori Henderson, DDS in Columbia, MO reported that the 2013 community water fluoridation challenge was led by an engineer, a PhD in philosophy, and a biochemist. She was stunned by how easily these professionals abandoned critical thinking to advance the anti-fluoridation agenda. Beliefs trumped science, and any tactic was acceptable to achieve the discontinuation of fluoridation. Dr. Henderson watched in disbelief as the opposition distorted peer-reviewed scientific research, imagined conspiracies between organized dentistry, the CDC, and the fertilizer industry, and fabricated data to scare the public. Dr. Henderson stated, “I was surprised that presenting best evidence about the safety, efficacy, and affordability of water fluoridation was not enough to reason some people that optimal fluoridation is sound public health policy.” Again, emotion, not fact took center stage.

All of the respondents were adamant that communities and health care professionals cannot wait until a threat is eminent, but must be proactive in educating not only patients, but community leaders, neighbors, family and friends. Dr. Henderson said, “We live in a society where professional organizations and government agencies are suspect and expert opinion often has less influence than ideas found on social media. The anti-fluoridation message resonates with people who prefer natural remedies, fear chemicals, believe in government and corporate conspiracies, and who place individual rights before the public good.” Among the interviewees, there was also agreement that a diverse coalition must be built – not just oral health professionals. The group must include community leaders across the board that have credibility and can speak persuasively for the cause.

Remember, water fluoridation prevents tooth decay in both children and adults. The U.S. Task Force on Community Preventive Services examined 21 studies and concluded that fluoridated water reduces tooth decay by a median rate of 29 percent among children of ages 4 to 17. A meta-analysis in the Journal of Dental Research estimated water fluoridation’s impact on adult teeth. The report concluded that fluoridation reduced decay by 27 percent.

Do not wait. Prepare now; develop your positive message for fluoridation, and practice on your staff, family and patients. Many resources are available to assist you:

- [www.cdc.gov/fluoridation/faqs/index.htm](http://www.cdc.gov/fluoridation/faqs/index.htm)
- [www.ilikemyteeth.org](http://www.ilikemyteeth.org)
- [www.ada.org/fluoride](http://www.ada.org/fluoride)
- [http://apps.nccd.cdc.gov/MWF/Index.asp](http://apps.nccd.cdc.gov/MWF/Index.asp)
- [www.cdhp.org/](http://www.cdhp.org/)

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3 Carol Hanson, RDH, BSDH, MPH, Coordinator, New Mexico Department of Health/Office of Primary Care & Rural Health. Personal Communication, October 2014.
4 Tom Taylor, Primary Care Integration Coordinator, Alaska Primary Care Association. Personal Communication, October 2014.
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Establishing dental treatment guidelines to help build patient centered health homes

Scott Brian Wolpin, DMD, Chief Dental Officer, Eastern Shore Rural Health System, Inc.

While we, as safety net oral health providers, are all passionate messengers that overall health requires good oral health, how many of us have unintentionally frustrated our medical colleagues because we were unable to accommodate their referrals in a timely manner? It is a simple fact that many more patients are treated by Health Center medical programs than dental programs. Subsequently, many populations with poor health are underserved by the current oral health system. Further, these individuals often have acute dental care needs that not only impair function and cause suffering but also exacerbate their chronic medical illnesses. These hurting, tired, huddled masses compete for the limited access our dental safety net is able to provide.

Similar to many Health Centers, our dental program at Eastern Shore Rural Health System, Inc. (serving Northampton and Accomack Counties on the Eastern Shore of Virginia) experiences numerous individuals attending emergency visits each day due to barriers in accessing preventive oral health care. We have discovered that a large portion of adult patients that present as emergency patients to our offices, whether as walk-ins or referrals from the local hospital emergency rooms, may not be medical users of our health system. Some patients do not even have a medical home. Additionally, we have learned that our dentists have been uncertain on how to best manage high risk patients with uncontrolled systemic disease. Associated with health literacy and access challenges, as many as 20 percent of our emergency dental patients are medically unstable individuals. This makes providing definitive care in a timely manner more difficult for these patients.

During the dental assessment, and part of our triage process, we take the patient’s vitals. Not surprisingly, the dental emergency which brought the patient to the office is more of a worry than an untreated medical condition, such as hypertension. By establishing dental treatment guidelines for these patients, we have assured the treatment we provide is safe. In addition, we have greatly enhanced our relationship with the medical team. This outcome is aligned with the transformation of health care leading to patient centered health homes.

An integrated care approach calls for a collaborative effort that may not come easy at all Health Centers. However, if you explain how establishing dental treatment guidelines can positively affect other clinical outcomes, it is easier to get buy-in. For example, for one patient, we extracted two chronically infected molars and his H1AC improved drastically, by 2 points. The outcomes of this dental visit illustrated the benefits of good oral health for a diabetic patient to the primary care provider. At a quarterly provider meeting, the same primary care provider reported that “…even after motivational interviewing with my patient, he did not
change any of his risk behaviors. He did not eat any better, he did not exercise. Yet he is remarkably healthier after his dental surgery.” This testimony went far in setting the stage for our Health Center’s clinical leadership group, which includes both medical and dental program providers, to collaboratively develop the dental treatment guidelines outlined in Figure 2 for hypertensive patients.

It is easy to see how this shared effort strengthens the interface and mutual understanding between medical and dental programs. Not only are we seeing many more dental referrals from our medical colleagues, but our medical colleagues are also starting to understand our dental capacity crisis, and our need to focus on the most vulnerable, high risk patients. Their referrals reflect that new understanding. Some medical providers have even expressed an interest in learning how they can address acute oral conditions they see in their daily practice. Related to this experience, our medical and dental teams are now providing same day, dual service appointments for our youngest patients to initiate prevention activities. Our dental team is learning to treat dental disease using a chronic disease management model. Perhaps the biggest lesson learned is that there are no longer medical or dental patients, only Health Center patients.

Figure 2. Dental Treatment Guidelines for Hypertensive Patients

<table>
<thead>
<tr>
<th>Stage</th>
<th>Health Center Medical User</th>
<th>Non-Health Center Medical User</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal D/C &lt; 80 S/C &lt; 120</td>
<td>No modifications required</td>
<td>No modifications required</td>
</tr>
<tr>
<td>Pre-Hypertension D/C 80-89 S/C 120-139</td>
<td>Provide care Recheck at end of treatment</td>
<td>Provide care Recheck at end of treatment</td>
</tr>
<tr>
<td>Stage 1 Hypertension D/C 90-99 S/C 140-159</td>
<td>Emergency care only Make entry in EHR</td>
<td>Emergency Care only Refer to current physician or Health Center as new medical patient</td>
</tr>
<tr>
<td>Stage 2 Hypertension D/C &gt;100 S/C &gt; 160</td>
<td>No treatment Consult with patient’s physician</td>
<td>No treatment Refer to local hospital ER</td>
</tr>
<tr>
<td>Hypertensive Crisis D/C &gt;110 S/C &gt; 180</td>
<td>Call for immediate medical attention, 911 needed?</td>
<td>Call for immediate medical attention, 911 needed?</td>
</tr>
</tbody>
</table>

“...our medical colleagues are also starting to understand our dental capacity crisis, and our need to focus on the most vulnerable, high risk patients.”
NNOHA Welcomes New Corporate Advisory Committee Member, Crosstex

A division of Cantel Medical Corp., Crosstex manufactures a wide array of infection prevention and control products for the healthcare industry. Crosstex was founded in 1953 and is headquartered in Hauppauge, New York. The company sells more than 25 types of face masks, all of which are manufactured in its FDA-registered New York facility. With sales in more than 100 countries, Crosstex products include sterilization pouches, biological monitoring and accessories, patient towels and bibs, surface disinfectants and deodorizers, germicidal wipes, hand sanitizers, gloves, sponges, cotton products, saliva ejectors and evacuator tips. Crosstex is a company living its brand promise: Crosstex Protects. To contact Crosstex please visit www.crosstex.com or email crosstex@crosstex.com.

Watch, wait, and...WORRY!

Jill G. Hutchinson, RDH, Clinical Educator and Special Markets Account Manager, GC America

It is October 1980, and I am in my first year of dental hygiene school. Today we are learning to chart, and my clinic partner, Linda, picks up a shepherd’s hook explorer and begins to probe the pits and fissures of my molars in an attempt to get that “stick” indicating potential caries. Remember that 34 years ago, we were NOT taught to be “sharp with our eyes, not our instruments,” as students now learn.

As Linda begins to poke around with her explorer under the gum tissue flap covering the distal one-third of the occlusal surface of my erupting third molar, #32, she gets the dreaded “stick!” I could feel it catch, and I was horrified. A cavity on a tooth that had not even fully erupted! I was embarrassed and ashamed that I, an aspiring dental hygienist, had allowed this to happen. I had to wait until the holiday break to return home and have #32 filled by my dentist.

How could this happen? The idea of watching and waiting until the tooth fully erupted with a high probability of decay, as well as the inability to place a resin sealant until then, was worrisome to me. I began to see more and more of this in clinical practice over the next several years. Concerned parents would ask, “Isn’t there some type of treatment you can do now [to protect partially erupted caries prone molars]?” It has become one of my personal crusades as a practicing dental hygienist and a clinical educator to find a solution to this question, and here is why:

- The operculum covering the distal one-half of molar teeth during the eruption process allows for the retention of plaque and the initiation of the carious process before complete eruption has occurred.
- The location of the permanent molars in the posterior region of the child’s mouth also complicates his or her ability to properly clean these areas and remove debris. As long as an erupting tooth has no antagonist contact, plaque accumulation and caries are promoted.
Almost every young patient 6-18 years of age will have a partially erupted molar in some stage of development. Indications are that up to 50 percent of every partially erupted molar exhibits signs of an incipient lesion – deep pits, fissures and hypomineralized areas are very common.

The operculum acts as a bacteria trap, and moisture and saliva contamination prohibit the ability to place a resin sealant. This becomes a treatment planning nightmare for the clinician. Moreover, the “watch and wait” option provides no treatment for the patient.

One solution is to place a glass ionomer sealant underneath the operculum and on the partially erupted occlusal surface to protect the tooth throughout the eruption process. How is this possible? Glass ionomers are hydrophilic and love moisture. Since glass ionomers work in a wet field, no isolation, etching or bonding is required. They are self-adhesive and chemically bond to the enamel as opposed to a resin sealant that relies on a mechanical bond, which can fail if contamination and microleakage occur. Best of all, a glass ionomer sealant is self-curing and self-occluding, so no light curing or bite adjustment is necessary once it is placed.

Since fewer steps are required, placing glass ionomer sealants saves valuable chairtime. Glass ionomer sealants are simple and fast. A clinician can place 4 to 8 sealants using one capsule in only 3 to 5 minutes.

Oftentimes, in practice, I seal partially erupted molar(s) at the prophy appointment eliminating the need for a return visit. This makes both the parent and child very happy. As a dental hygienist, I know I am providing a treatment that helps the developing molar and continually release fluoride (rechargeable fluoride) over the next 24 months.

The glass ionomer sealant that I use is GC Fuji TRIAGE, a hydrophilic, self-cure, self-adhesive, high fluoride-releasing sealant that allows you to effectively and efficiently seal partially erupted molars.

During my 32 years as a dental hygienist, dentistry and preventive dental products have continually changed and evolved with more biocompatible dental materials and the practice of minimally invasive dentistry. We now have a new treatment option, a “healthy solution” for patients with caries-prone partially erupted molars. This is important because dental caries is still the number one childhood disease.

For more information on GC Fuji TRIAGE, contact Jill at jill_hutchinson@gcamerica.com or visit http://gcamerica.com/.

This article was sponsored by GC America.
Under the Clean Water Act, in September 2014, the Environmental Protection Agency proposed new technology-based pretreatment standards that would affect all dental offices across the country. According to the Agency:

EPA is proposing technology-based pretreatment standards under the Clean Water Act (CWA) for discharges of pollutants into publicly owned treatment works (POTWs) from existing and new dental practices that discharge dental amalgam. Dental amalgam contains mercury in a highly concentrated form that is relatively easy to collect and recycle. Dental offices are the main source of mercury discharges to POTWs. Mercury is a persistent and bioaccumulative pollutant in the environment with well-documented neurotoxic effects on humans.¹

In other words, the new Proposed Rule aims to ensure that dentists who either place or remove amalgam properly collect and recycle the wastes generated from those activities. The Proposed Rule emphasizes compliance, documentation AND enforcement. Previous mandatory programs (in some states) emphasized only equipment purchases and did not provide for inspection of offices or mandate other types of enforcement. This Proposed Rule is far more extensive as it demands both compliance with proper recycling and documentation, as well as establishing mechanisms to inspect those offices suspected of non-compliance.

While not comprehensive, this brief article cites the KEY aspects of the Proposed Rule which will impact your practice.

1. The Proposed Rule will apply to anyone who places OR removes amalgam.
2. It includes permanent and temporary dental offices, hospitals, schools, clinics, mobile units and facilities owned by federal, state or local governments.
3. Requires both the installation, maintenance, monitoring and recycling of an amalgam separator plus requires compliance with ADA Best Management Practices regarding the recycling of “scrap amalgam” (excess mix or carvings, empty capsules from pre-capsulated alloy, extracted teeth containing amalgam, in line disposable traps and vacuum traps from wet vac systems).²

Amalgam separators must:

1. Be 2008 ISO 11143 certified to operate at a minimum of 99% efficiency.
2. Be inspected at least monthly for proper operation [some communities require more frequent inspections].
3. Be properly sized to incorporate all the wastewater that may pass through it.
4. Have canisters, cartridges or units changed when full, as recommended by the manufacturer, or annually - whichever comes first.
5. As cited in # 4, changes MUST be done AT LEAST ANNUALLY.
6. Be maintained so as not to allow for unprocessed wastewater to bypass the system and enter a drain.³


Scrap amalgam handling, collection and recycling:

1. Must include all items considered to be "scrap amalgam" (see previous list).
2. Requires use of non-chlorinated line cleaners in the pH range of 6 to 8.
3. This waste must never be placed in with regular trash or bio-hazardous (red bag) waste.4

Monitoring, reporting and record keeping:

Monitoring and enforcement will be conducted by the wastewater treatment facilities. Dentists will be categorized as Dental Industrial Users, a less stringent category than Significant Industrial User.5 To maintain this Dental Industrial Users status, the office must certify, among other things, that:

1. It has installed and is properly maintaining, inspecting and recycling an amalgam separator meeting the ISO certification standard previously noted.
2. It adheres to all ADA Best Management Practices and recycles all scrap amalgam (as previously described).
3. It maintains a written log of separator inspections (conducted at least monthly), as well as all notes related to the unit’s servicing.
4. Canisters, cartridges or separator units are being recycled at least annually.6

Failure to comply with the above may result in loss of the Dental Industrial User status and reversion to more intense inspections as a Significant Industrial User.

Baseline reports, containing a significant amount of information about the practice including the names of all dentists practicing there, along with their Dental License Numbers, must be filed within 180 days of the effective date of the Rule in order to establish a Dental Industrial User status.

Other reports including 90 day compliance reports and periodic monitoring reports will also need to be filed as things move forward.7

All reports listed above, along with service, maintenance and inspection logs, plus dates of canister or cartridge changes, etc., must be kept on file for at least 3 years.

What are the costs? The Environmental Protection Agency calculated costs based on the number of treatment chairs in various configurations from 1 up to 7+ chairs. When calculating a simple average across all groups, the initial cost to purchase and install an amalgam separator equals approximately $1,172.50 per office (this is exclusive of scrap amalgam recycling). The average annualized recurring costs to maintain and recycle the separator were estimated to be $588.75.8

This proposed rule is expected to be published in the federal register very shortly and interested parties can contact me for further information at AFrost@drna.com or visit www.drna.com.

New Benefit for NNOHA Organizational Members

NNOHA is very pleased to announce that Dental Recycling of North America is offering a 40% discount to all NNOHA organizational members on DRNA's amalgam separator equipment and the BMP chair-side amalgam recycling program. Please review the accompanying article carefully for more information on the proposed new regulations that will affect your practice. Deadlines for compliance vary according to your location. In addition, DRNA will make a donation to NNOHA for every BU amalgam separator sold and on all DRNA contracts for amalgam separator services through December 31, 2016.

For more information contact DRNA at 800-360-1001 ext 17. Remember to mention that you are a NNOHA organizational member to receive the discount. If you are not sure if your organization is an organizational member, contact NNOHA at 303-957-0635.
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Member Spotlight: Community Care, Inc. (Milwaukee, Wis.)

Van Anh Le, DDS, Dental Director, Community Care, Inc.
Maria Smith, MPA, Project Director, National Network for Oral Health Access

For this article, NNOHA interviewed the Dental Director at Community Care, Inc., Van Anh Le, DDS. Community Care, Inc.’s mission is to develop and demonstrate innovative, flexible, community-based approaches to care for at-risk adults, in order to optimize their quality of life and optimize the allocation of community resources.

When did your organization start?
Community Care began in 1977 when founder Kirby Shoaf created an organization to design, develop and operate a comprehensive, coordinated system of in-home, community-based services for the functionally disabled and the frail elderly. Since then, Community Care has established and operated more than a dozen programs. Each of these programs was designed to provide quality care and enhanced opportunity for quality of life to eligible seniors and disabled adults while preserving their dignity and autonomy. In the early days, dental care was contracted to outside providers, but in 2003, it was brought in-house. Currently we employ two part-time dentists and one part-time hygienist, working out of two sites. Each site has one operatory.

What is your community like?
Community Care has services in 11 counties in Wisconsin including urban and rural areas. The dental department serves members in four counties with the majority in Milwaukee County.

What challenges do you face that might be different from other Health Centers and safety-net clinics?
Since we are not a fee-for-service provider, we have to be resourceful in providing services, especially in regards to dental care. Our funding is capitated from Medicare and Medicaid. Moreover, since we have members with moderate to severe developmental disabilities, sometimes their dental care is only possible with hospital out-patient procedures. Therefore, we need dental specialists that accept Medicare and have hospital privileges, which are often a challenge to recruit.

What are you doing well that you would like to share with us?
Community Care has been integrating health care even before it was fashionable, with the team meeting model. A single team sees participants through assessments and care delivery and coordination, and the result is that participants enjoy comprehensive, continuous care that addresses their changing needs. Dental is used both as a consultant and a provider for the team. As a consultant, we help determine whether dental treatment is necessary or appropriate. As a provider, we treat the patient as part of the care team.

Do you have any strong partnerships in the community?
As part-time faculty at Marquette School of Dentistry, I sometimes ask for informal consults for difficult cases from specialty departments at the school. Currently, D2 students visit us to attend our team meetings. We would like to arrange D4 externships in the near future.

How do you interface with the medical department?
While our Electronic Medical Record has been in place for several years, we just implemented our Electronic Dental Record this year. We chose Mediadent since we use the same company for our Electronic Medical Record. Even though we have experienced some growing pains with the transition, the support received from the leadership team has been extremely helpful.
Why did you join NNOHA?
I first joined NNOHA in 2007 as a new dental director of a FQHC. Even though I no longer work at a Health Center, I continue my membership because of the values and support I receive from NNOHA through the annual conference and online. In 2012-2013, I volunteered as a mentor to a National Oral Health Learning Institute scholar. It was an honor to donate my time and support the next generation of dental directors. I was also glad to see that the scholars' Health Centers were supportive of their dental directors participating in the program.

What do you “know now that you wish you knew then” or what advice would you give to a new Dental Director?
While the dental care we provide every day to the underserved is crucial, some days can be more overwhelming than others. Stay strong and remember how rewarding and worthwhile your commitment is. When you feel alone or frustrated, remember that your fellow NNOHA members are available to support you. Attend an annual conference and you will be sure to find a comrade in your cause!

What would you like decision makers in DC to know about Health Centers and safety-net clinics?
I believe that a person’s overall health is very much dependent on their oral health. When they can eat without pain, their nutrition intake can improve, resulting in being better able to fight off illness and reduce the need of prescription drugs. In other words, decision makers in DC need to understand the importance of increased funding for oral health services for the underserved given the oral systemic link.

What is on your wish list for the future?
I would like to offer dental services to the caregivers of our elderly and disabled patients.

Did you NNOHA?

Staff Update

NNOHA welcomes new policy analyst, Jodi Padilla
Jodi joined the NNOHA team in June 2014 as the Interim Office Support and Membership Services Coordinator, and transitioned into the Policy Analyst position in September. Previously, she worked at Children’s Hospital Colorado Foundation and Janus Capital Group. She has an MBA from National University and a Bachelor of Science in Psychology from San Diego State University. Outside of the office, she enjoys traveling and is always happy to check out new places. She is excited to continue working with NNOHA and its members.

NNOHA News and Updates

NNOHA participates in the Amazon Smile program!
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. To shop at AmazonSmile visit http://smile.amazon.com/. As the holiday shopping season approaches, shop and let Amazon donate to NNOHA!
Offer for complimentary copies of Bright Futures in Practice: Oral Health—Pocket Guide

The National Maternal and Child Oral Health Resource Center is able to provide complimentary printed copies of Bright Futures in Practice: Oral Health—Pocket Guide, 2nd edition. It was developed to assist health professionals promote oral health care for pregnant and postpartum women, infants, children, and adolescents. The guide was co-authored by Paul Casamassimo, DDS, and Katrina Holt, MPH, MS, RD, FAND, and supported by the Maternal and Child Health Bureau. An electronic copy of the pocket guide is available at http://www.mchoralhealth.org/pocket.html. The Resource Center is able to distribute boxes (1 box = 112 copies) of the pocket guide at no charge. If you are interested in receiving bulk copies for distribution to clinic staff and outreach efforts to health professionals and students, please complete the order form.

Colgate/American Dental Hygienists’ Association Community Outreach Award

Attention dental hygienists! Does your component have a great community program that brings access to oral healthcare and education to a community in need? Tell your story! The Colgate/ADHA Community Outreach Award recognizes ADHA components and individuals submitting on behalf of components that have implemented significant community outreach projects on preventive oral care. Applications are due February 2nd. Apply today to recognize your community service project and receive complimentary registration to Center for Lifelong Learning at the 92nd Annual Session in Nashville, Tennessee!

Health Center dentists, past and present, participate as ADA Delegates at the ADA 2014 America’s Dental Meeting in San Antonio, Texas in October

Did you know that almost 70% of dentists working in Health Centers are ADA members? At first glance there may not seem to be any connection between safety-net dental practice and organized dentistry, but there is tremendous potential for partnerships that benefit the patients we serve and expands our individual experience. Consider becoming a leader in organized dentistry!

Pictured from L to R: Dr. Brian Chui, Dr. Ariane Terlet, Dr. Irene Hilton, Dr. Jane Gillette
Save the Date!
2015 NNOHA Conference
November 15-18, 2015
Downtown Indianapolis Marriott
Indianapolis, Indiana

Revisit fun moments from the 2014 NNOHA Conference with this slide show!

2014 NNOHA Conference Slide Show

Upcoming Conferences & Events

Association of Maternal & Child Health Programs (AMCHP) Annual Conference
January 24-27, 2015
Washington, DC

Yankee Dental Congress
Presented by Massachusetts Dental Society
January 28-February 1, 2015
Boston, MA

American Dental Education Association (ADEA) Annual Session & Exhibition
March 7-10, 2015
Boston, MA

American Association for Dental Research (AADR)/ Canadian Association for Dental Research (CADR) Annual Meeting & Exhibition
March 11-14, 2015
Boston, MA

16th Annual International Summit on Improving Patient Care in the Office Practice and the Community
Hosted by the Institute for Healthcare Improvement
March 15-17, 2015
Dallas, TX
“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.”