
Irene Hilton, DDS, MPH, Dental Consultant, National Network for Oral Health Access

NNOHA is excited and pleased to announce the release of A User’s Guide for Implementation of Interprofessional Oral Health Core Clinical Competencies: Results of a Pilot Project. This guide is the result of an 18-month project in which NNOHA served as the coordinator and technical assistance provider.

The 2011 Institute of Medicine (IOM) report, Improving Access to Oral Health Care for Vulnerable and Underserved Populations, recommended that the Health Resources and Services Administration (HRSA) convene key stakeholders to develop a core set of interprofessional oral health core clinical competencies (IPOHCCCs) for non-oral-health professionals with the aim of increasing access to oral health care.¹

Following publication of the IOM report, HRSA convened a series of meetings to develop a standardized set of IPOHCCCs, develop strategies to enhance oral health primary care team approaches to patient care, and develop strategies for adoption and implementation of the oral health competencies in safety-net settings.

The oral health core clinical competencies include five domains: risk assessment, oral evaluation, preventive interventions, communication and education, and interprofessional collaborative practice.

In 2013, HRSA awarded NNOHA supplemental funding to pilot the implementation of the oral health competencies in three Health Centers across the country: Bronx Community Health Network, Inc. (New York, NY), Family HealthCare (Fargo, ND, and Moorhead, MN), and Health Partners of Western Ohio project team.
Ohio (Lima, OH). The goal of the IPOHCCC Pilot Project was to adopt and implement the core clinical competencies using a sustainable-systems approach that resulted in integrating oral health and primary care through interprofessional collaborative practice, and, ultimately, to increase integration of oral health care into primary health care.

The results of the IPOHCCC pilot and the experiences and findings from the three IPOHCCC pilot project teams are contained in the user’s guide. The guide includes sections on assessing organizational readiness before embarking on a project to integrate oral health into primary care practice, the planning process, developing training systems, updating health information systems, modifying clinical care systems, developing evaluation systems and addressing challenges.

The pilot teams encountered varied challenges throughout the pilot period, including covering expenses associated with modifying electronic medical records, providing training to primary care providers and support staff, determining how to integrate the oral health competencies into primary care visit flow, overcoming initial resistance to system changes, and addressing competing Health Center priorities.

The user’s guide is full of strategies, ideas, tools and tips for addressing implementation challenges. The teams developed many resources, which are shared in the publication including screenshots of EMR modifications that facilitated performing of the core clinical competencies. NNOHA assisted the teams in many ways including locating training materials and educational resources, developing evaluation measures for the project and facilitating knowledge sharing among the teams.

This guide provides a structure, options, and suggestions to help Health Centers and other safety net organizations develop programs that implement the oral health core clinical competencies for the purpose of integrating oral health care into primary health care, increasing access to oral health care, and improving the oral health status of the populations the Health Centers serve.

**Editor’s note:** Want to learn more about key findings from the user’s guide and how Health Centers can implement the competencies and incorporate oral health into primary care practice? **Join NNOHA for a webinar on Monday, February 23, 2015 at 3:00 pm EST/12:00 pm PST. Register today!**

Tooth decay is the most common chronic disease of childhood. By mid childhood, over 50 percent of children have caries and by late adolescence about 80 percent have acquired this preventable infectious disease. The epidemic affects disproportionately children in low-income families, and it is estimated that roughly 80 percent of untreated caries are found in 25 percent of children that are 5-17 years old. These statistics suggest that school sites present a good opportunity for healthcare providers to address this, and other healthcare issues during the school day, allowing children to remain in school.

The idea of providing healthcare services in public school sites is not new; in fact, the first school site health program was initiated in 1894. The first school-based dental program in the U.S. started in Connecticut in 1914. In the 1970s, with the advent of topical fluoride, many publicly funded programs institutionalized the delivery of topical fluoride (school-based fluoride mouth rinse program or FMRP). In the 1980s, some programs expanded to deliver pit-and-fissure sealants. The development, over the last 30 years, of portable dental equipment has helped expand the delivery of dental care at school sites.

One of the biggest challenges faced by school-based programs is financial viability. The enactment in 1965 of the Medicaid program created an opportunity to serve millions of children of low-income families and provided a funding stream to support healthcare programs for the underserved.

**Diversity in school-based models**

Not all school-based oral health care delivery models are alike. They tend to respond to the nature and needs of the delivery agency. In a symposium organized by Center for Oral Health in the fall of 2013 we found a continuum that goes from screenings to comprehensive dental care (see Figure #1).
These models have their own unique strengths and weaknesses. The high prevalence of caries demonstrated by some oral health assessments suggests that school-aged children in underserved communities would benefit from comprehensive models.

**Challenges to Implementing a School-Based Oral Health Care Program**

Participants at Center for Oral Health’s symposium identified the following challenges and areas for improvement, which reflect personal and institutional level barriers.

- **Cultivating Relationships with Schools:** Developing relationships takes time but is considered critical to ensure success.
- **Sustainability:** Schools have learned that, in absence of a sustainability plan, grant-funded programs tend not to last long.
- **Sharing and Tracking Data:** More effective systems are needed to share information about a child’s dental history between schools, insurance carriers, and dental professionals. Success stories shared in these networking sessions demonstrate that while challenging, it is possible.
- **Changing Cultural Norms:** Changing cultural norms associated with cavities, dental visits and the importance of oral health and challenging parents’ fears, myths and misinformation is critical to successful implementing school-based programs.
- **Workforce:** Programs that rely on volunteer dentists sometimes find that they have difficulty recruiting dentists. Coordinating volunteer dentists requires staff time and resources.
- **Follow up Care:** Many treatment referrals are not followed up for reasons that may include few low cost clinics, transportation, dentists who do not take Medicaid, or parents who cannot take time off work.
- **Medicaid:** Medicaid is an underutilized resource, participants noted it can be challenging, intimidating, and frustrating to work with Medicaid, as a provider and a patient, and it requires perseverance and patience in the very best of circumstances.

- **Child Abuse/Neglect Reporting:** Providers require better guidance about whether and when to report extreme dental decay as evidence of child abuse and neglect.
- **Special Needs Children:** Providers and administrators have noted “were it not for the heart of a few dentists, these kids would not get any care.”

**Sustaining school-based models**

The biggest challenge is sustaining efforts beyond seed or grant funding. Sustainability is a complex dimension that requires more than financial resources (see figure #2). Participants at the Center for Oral Health symposium identified the following elements to ensure successful delivery of school-based oral care:

1. Community Collaborative Practice Model
2. “Comprehensive” on-site care
3. Multidisciplinary Teams
4. Multisite Model (Optimization of resources)
5. Portable Clinic Model
6. Supportive School Oral Health Policies
7. Supportive State Medicaid Policies
8. Presence of a solid business plan
9. Presence of a quality dashboard

![Sustainable School-based Oral Health Model](image.png)

*Figure 2: School-based oral health care sustainability model*
Comprehensive school-based programs offer the promise of improving access to prevention, diagnosis of, and treatment of dental disease highly prevalent in children and adolescents in public schools. Pediatric health care professionals, educators, and mental health specialists should work in collaboration to develop and implement effective and sustainable school-based oral health services.

Clinical Excellence

Managing the Emergency Walk-in Patient

Daniel Brody, DMD, Chief of Oral Health, Valley Health Systems, Inc. and Member, NNOHA Board of Directors

The emergency walk-in dental patient, aka “the schedule buster,” can strike fear in the hearts of the dental team. Nothing is more stressful and lowers staff morale more than falling behind on the schedule and having to leave late. I would like to share some strategies for managing walk-in patients efficiently, using the common situation of an emergency dental patient that requires a tooth extraction.

1) *Deal with the problem once:* Treatment is always the best option. In this case, “the best way to get rid of an infection is to get rid of the source of the infection.” Delaying treatment through the use of antibiotics and analgesics simply creates a second incident of chaos because an appointment time has to be found the following week, which is usually double booked. You are also inviting the patient to become a “no-show” only to present again somewhere down the line with the same problem and have the cycle repeat itself until they end up in a hospital emergency room.

2) *Know the answer before asking the question:* There are key determinants that can impact your treatment plan. Your dental assistants can help you and save significant time by triaging the patient, which will assist you in determining a course of action and feasibility of immediate treatment. Medical history responses including blood thinners; prosthetic joints, hypertension, diabetes, heart conditions, and allergies require follow-up. Ideally, the pertinent medical information can be accessed through a shared EHR. If not, you should develop a plan for emergency consultation with your medical department. Also, consider having a standing order for radiographs for emergency patients. This allows diagnostic information to be available and waiting for you when you enter the operatory allowing you to make a timely diagnosis and treatment plan.

3) *Be prepared:* Instrumentation to anesthetize should be ready and waiting when you enter the operatory. Utilize your team members to the top of their license capabilities. If licensed to do so in your state, dental hygienists can provide local anesthesia. I also order the necessary instruments I will need to complete the extraction when anesthetizing and then proceed to my regularly scheduled patient. In my absence, the assistant prepares the instruments, completes the necessary consents and reviews post-op instructions.

4) *Expect the best but prepare for the worst:* Have all the necessary instrumentation and medicaments at your immediate disposal. Package your instruments in a fashion that groups the instruments into level of need progressing from routine to surgical and have them at your immediate disposal. Nothing wastes valuable chair time and detracts from other team members completing their duties more than someone constantly calling out to staff to bring additional instruments.
5) **Failure to plan is planning to fail:** Study the radiograph and develop your plan of attack based on the tooth root morphology. In Photo 1, know you are dealing with a three rooted lower molar before you begin.

6) **Be aggressive-divide and conquer:** Lay a flap and section a tooth from the start, not after 30 minutes of trying to remove the tooth intact, and finally fracturing the root which will then will take another 30 minutes to retrieve. If a root fracture occurs, make your flap large enough to have good access to retrieve the root. In Photo 3, the radiograph shows the need to immediately remove the crown of the tooth and section the tooth.

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**Editor’s note:** Sessions on oral surgery for general dentists will be presented at the 2015 NNOHA Conference, November 15-18th at the Indianapolis Marriott Downtown, Indianapolis, Indiana. Mark your calendars and plan to attend. Preliminary conference information will be available in the near future on the NNOHA website.

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**Corporate Advisory**

**NNOHA Welcomes New Corporate Advisory Committee Member, Kuraray Noritake Dental**

Kuraray is an international specialty polymer manufacturer with a dental division providing a full line of adhesive restorative materials. The Kuraray dental division is noted as developing many key new technologies in the dental industry the past 37 years:

- 1st Total-Etch Dentin Bonding Agent (1978)
- 1st Caries Detecting Dye (1978)
- 1st Universal Adhesive Monomer MDP
- 1st Successful, Self-Etching Bonding System (1993)
- 1st Self-Adhering Resin Cement **(PANA-VIA 1983)**
- The “Gold Standard Bonding System” **CLEARFIL SE BOND**

In 2012 Kuraray acquired the dental ceramics division of Noritake and now provides a full line of ceramic and zirconia restorative materials. To contact Kuraray please visit: [www.kuraraydental.com](http://www.kuraraydental.com) and for free live and on-demand CE please visit: [www.kuraraydentallearning.com](http://www.kuraraydentallearning.com).
In my opinion, to make the most comprehensive diagnosis of caries, I want to see and verify using as many technology tools as possible. My methods of caries detection have evolved over the years. Years ago, I used an explorer to catch the cavity along with film radiography; then we moved on from the explorer to digital radiography. Eventually, I added the intraoral camera and a fluorescence caries detector (KaVo DIAGNOdent™) to that armamentarium. In 2014, my practice took caries detection to an even higher level, and I switched my caries detection to one that uses transillumination technology.

Caries detection methods have varied over time. Quantitative light-induced fluorescence (QLF) detects caries by visible light system. With this type of system, the light causes the teeth to fluoresce in green (or red) with a contrast resulting on the demineralized tooth tissue. Another caries system, one that I have used in the office in the past, is DIAGNOdent’s laser fluorescence which, instead of producing a colored image of the tooth, displayed a numerical value.

Transillumination technology bathes the tooth in safe, near-infrared light and yields an image in which the enamel appears transparent, while the porous lesions trap and absorb the light. As a result, the images appear similar to X-ray images: healthy tooth is light, caries is dark. This technology can be used to detect interproximal, occlusal, and recurrent caries, even in the early stages. Unlike a radiograph, the transilluminated image is not affected by interproximal overlap on routine bitewings. And these images offer the ability to see around restorations that can in some cases be blocked out on the X-rays. Of special note are the statistics on the accuracy of this technology — case studies show a 99% accuracy rate.¹

The only system with transillumination technology currently offered in North America is DEXIS™ CariVu™. The unit works with DEXIS™ imaging software either as a stand-alone item or with the DEXIS™ digital X-ray sensor.

Patients get to see directly how transillumination technology benefits their dental care. My patients can watch the image on the operatory monitors as we use the unit. Due to the capacity for integration, I can show the CariVu image side-by-side with the intraoral camera image and with digital radiographs. With these easy to understand images, they can better understand the need for preventive or restorative care. This technology also helps clinicians cater to patients’ diverse needs. Some patients are anti-radiation and refuse to allow X-rays. Other dental patients have a severe gag reflex, and there are also those who have had radiation therapy for cancer, or patients on whom it is too difficult to use any sensor (or film) such as small patients or those with large tori. With this system, I can get much of the information needed to formulate a diagnosis and then proceed with preventive or restorative treatment.

A face mask is an important medical device used to protect both patients and healthcare professionals from the exchange of microorganisms, bodily fluids, aerosols, and particulate matter. Based on the average rate of respiration at 16 breaths per minute, a clinician has the potential for 7,680 exposures in a workday. Therefore, selecting the appropriate face mask is a key component to minimize the spread of potentially infectious diseases.

Dental professionals are exposed to a variety of potentially hazardous substances on a daily basis. It has been well documented that the most likely mode of transmission in dentistry is through inhalation of bacterial aerosols or splatters containing a plethora of potentially infectious micro-organisms.

Aerosols generated during treatment are the most dense in a semicircle about 36” surrounding the patient’s face, and considering that the optimal operating distance is 14 – 18” from the patient’s face, the clinician’s potential risk of exposure is high. Research has shown the most contaminated area on the dental clinician’s face following treatment is around the nose and inner corner of the eyes.

The key to choosing the right mask for the task lies in three areas: quality of material and manufacturing, design with custom fit, and compliance with proper use.

In April 2011, ASTM International released a new version of the standard specifying performance of face masks, ASTM F2100-11. Face mask material performance is based on testing for fluid resistance, bacterial filtration efficiency, particulate filtration efficiency, breathability (P-Δ), and flammability.

**Fluid Resistance:** Face masks are tested on a pass/fail basis at three velocities corresponding to the range of human blood pressure (80, 120, 160 mm Hg). The higher the pressure withstood, the greater the fluid spray and splash resistance.

**Bacterial and Particle Filtration Efficiency:** The effectiveness of a material to prevent passage of bacteria or particles. A higher percentage indicates higher filtration efficiency; i.e., 95% filter efficiency indicates 5% of the aerosolized bacteria or particles used in testing passed through the mask material.

**Delta P/Differential Pressure:** Measures the resistance of mask materials to air flow which relates to the ‘breathability’ of the mask. The values are expressed from 1 to 5; the higher the number, the lesser the air flow, and, therefore, the less breathable the material.

**Flammability:** The rate at which the material burns determines the level of flammability; a minimum of a 3.5 second burn rate is required to pass with a Class 1 rating.

An appropriate barrier level of mask must be selected based on the anticipated level of exposure to infectious materials during a given procedure and ASTM levels 1, 2, and 3 provide that guidance. Protection is about form, function AND fit.

Even if a surgical mask has a high level filter, the lack of a close seal to the face will negate filter performance because particles will follow the path of least resistance and travel through the gaps between the surgical mask and the face.

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Most regulatory and professional organizations recognize the inherent fit issues of surgical masks showing gaps along the cheeks and chin. A secure fit along the entire periphery of the mask is critical. A recent study evaluating the total leakage through a surgical mask indicated five to eight percent came from filter leakage with 25-38 percent from face seal leakage.²

Crosstex has revolutionized face masks by applying scientific knowledge to the design and manufacturing of these everyday medical devices. The Secure Fit® technology mask line — developed after extensive research at Stony Brook University Hospital in New York — provides up to three times more protection from exposure to infectious particulates (splatter/aerosols) than the standard earloop face mask. The increased protection is achieved through a patent-pending design which eliminates gapping along the top, bottom and sides of the mask.

Selecting the appropriate face mask is a key component to minimizing the spread of potentially infectious diseases. Consideration must be given to breathability, face coverage and peripheral fit, as well as ease of removal without self-contamination — ultimately ensuring adequate bacterial filtration and fluid resistance is critical. Remember, a face mask is only as good as it fits.

Although masks may look similar, each mask has notable differences affecting the quality and level of filtration. Understanding the ASTM performance level of each mask can help make the selection based on the procedural needs easier and ensure your mask will provide the appropriate protection. Crosstex makes the selection process a breeze with the MaskEnomics rating system, designed from minimum to maximum performance criteria. Table 1 below can help you in your mask selection. For additional information, visit: http://crosstex.com/play-video/maskenomics.html.

This article is sponsored by Crosstex International.

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<td>Low amounts of fluid, spray and/or aerosols are produced</td>
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Table 1: Face Mask Material Requirements by Performance LEVEL

“I believe surgical mask failures are largely or entirely due to their lack of fit.”
Lise M. Brosseau, Sc.D., CIH Director, Industrial Hygiene Program, University of Minnesota, School of Public Health; Division of Environmental and Occupational Health.

Member Spotlight: Health Partners of Western Ohio (Lima, Ohio)

Beth West, LISW-S, Chief Operations Officer, Health Partners of Western Ohio
Kym Taflinger, Chief Analytics Officer, Health Partners of Western Ohio

For this article, NNOHA’s Project Director, Maria Smith, interviewed Dr. Beth West and Kym Taflinger. Health Partners of Western Ohio’s mission is to eliminate gaps in health outcomes for all members of our community by providing access to quality, affordable, preventive and primary health care.

When did your Health Center start?
Health Partners of Western Ohio was formed by a group of community residents and health professionals in Lima, Ohio. The impetus for the formation of Health Partners came from the activities of the Healthy People 2000 in partnership with the City of Lima. Healthy People 2000 identified access to primary care services as a top priority and out of this program grew the formation of the Southside Health Center Development
Committee and MUA/HPSA designations were obtained for five census tracks in south Lima. Health Partners was originally formed as Allen County Health Partners in October 2002 and applied to become a “New Access Point” in December 2003, receiving funding December 1, 2004.

We started our oral health program in 2005 at our very first Health Center site, the Dr. Gene Wright Community Health Center. The oral health program started out of a great need within our community for oral health care. The CEO, Janis Sunderhaus (nurse) and the Director of Behavioral Health, Jolene Joseph (social worker) attended a number of dental conferences and trainings and started the program from the ground up. We have since expanded oral health services to three of our other health centers. We are also in 30 schools with our sealant program.

What is your community like?
We currently provide oral health services at four of our health centers, two of which are in Lima, Ohio. Lima mostly serves a low income African American population. One of the health centers in Lima is located inside the city’s largest high school and serves students, teachers, faculty, and families of the school district. The Kenton Community Health Center serves a very rural population coming from Appalachian roots. Most of our patients in this area receive Medicaid and some are from the Amish community. The New Carlisle Community Health Center serves many migrant and seasonal farm workers. More than half of our patients, as well as our staff, are Spanish speaking.

What challenges do you face that might be different from other Health Centers?
One of our challenges is that we are in communities that are very different from one another. These differences require us to be innovative and unique to the needs of each patient population that we serve. Two of these unique populations are the Amish and the Migrants. Both of these populations need targeted health education with an emphasis on the importance of prevention.

What are you doing well that you would like to share with us?
In the last two years, we have expanded oral health services to two additional sites with one more coming in 2015. We are also providing dental services in 30 different schools with our sealant program. We provide care out of a mobile van and complete screenings, cleanings, and sealants to eligible students. In 2014, we completed approximately 3,500 visits through this program. The biggest allies to our sealant program are the school nurses for sure!

How do you interface with the medical department (meetings, integrated EDR/EMR, special programs)?
We have an integrated model of care at all of our health centers which includes medical, dental, pharmacy, chiropractic, and behavioral health. We facilitate monthly provider meetings to include all disciplines listed. Our EHR, PrimeSUITE from Greenway, is fully integrated across our system of care. All of our children receive fluoride varnish and a dentist comes over and does a quick visual exam during their medical visit.

Why did you join NNOHA?
Health Partners was chosen to participate in NNOHA’s Oral Health Core Clinical Competency Pilot Project in 2013. The goal of the project was to adopt and implement HRSA’s oral health competencies using a sustainable-systems approach that results in integrating oral health and primary care through interprofessional collaborative practice, and, ultimately, to increase integration of oral health care into primary health care. Through our membership and participation in the pilot, we have received invaluable technical assistance, education, and attended conferences to enhance our learning.

What do you “know now that you wish you knew then” or what advice would you give to a new oral health program?
We have learned not to reinvent the wheel and to reach out for help when needed. Organizations must keep their mission in mind when providing oral health services. Dental services can be expensive and you must have a solid business plan that includes
comprehensive services, financial projections, and continual evaluation.

**What would you like decision makers in DC to know about Health Centers?**
Oral health care cannot be separated from primary or behavioral health. The whole person must be the focus of health care. Policy makers must keep this in mind when making decisions related to reimbursement policies.

**What is on your wish list for the future?**
On our wish list is to expand oral health services including new dental clinics, expanding our sealant program, and opening additional school based health centers that offer comprehensive dental services.

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**Did You NNOHA?**

**News Alert**

The [Campaign for Dental Health](http://www.campaignfordentalhealth.org) is pleased to announce that their fluoride tools/posters, developed by the American Academy of Pediatrics, with assistance from NNOHA and funded by the Pew Children’s Dental Campaign, are now available in Spanish. Everything is available for download online. For printed full size versions of the posters, please request them by emailing fluoride@aap.org. In your email, please include in the quantity requested.

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**Thank You to our 2015 National Oral Health Learning Institute Sponsors (so far)!!**

As we begin the new year, NNOHA is very pleased to announce that the National Oral Health Learning Institute (NOHLI) is under way with its third cohort of scholars. Fifteen dental leaders from ten different states have enrolled in a year-long development program to learn the core knowledge and competencies needed to develop as effective directors and advocates for oral health and their communities. This would not be possible without the financial support of corporate and foundation partners who share NNOHA’s vision of access to oral health care for everyone.

- **Washington Dental Service Foundation** (funded by Delta Dental of Washington) is supporting five NOHLI scholars from the state of Washington!!
- **Dentsply International** is supporting two NOHLI Scholars!
- The following friends of NNOHA are supporting one NOHLI Scholar each.
  - KaVo Kerr Group
  - Henry Schein Special Markets
  - Delta Dental of California Foundation
  - Delta Dental of Minnesota Foundation
  - NNOHA Board of Directors – personal contributions from members of NNOHA’s leadership
- NNOHA is also grateful to [Delta Dental of Colorado Foundation](http://www.ddcf.org) for supporting and hosting our 2015 NOHLI “Boot Camp.”

If your organization or company would like to sponsor a NOHLI scholar for 2015 there is still time. Contact Phillip Thompson at executivedirector@NNOHA.org for details. To learn more about NOHLI visit [http://www.nnoha.org/programs-initiatives/nohli/](http://www.nnoha.org/programs-initiatives/nohli/).
Save the Date!
2015 NNOHA Conference
November 15-18, 2015
Indianapolis Marriott Downtown
Indianapolis, Indiana

Upcoming Conferences & Events

**American Academy of Dental Practice Administration (AADPA) Annual Meeting**
March 4-7, 2015
Tucson, AZ

**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

**Policy and Issues Forum (P&I)**
Hosted by National Association of Community Health Centers (NACHC)
March 18-22, 2015
Washington, DC

**Special Care Dentistry Association (SCDA) 27th Annual Meeting on Special Care Dentistry**
March 27-29, 2015
Denver, CO

**National Oral Health Conference**
Hosted by Association of State and Territorial Dental Directors (ASTDD) and American Association of Public Health Dentistry (AAPHD)
April 27-29, 2015
Kansas City, MO
National Farmworkers Health Conference
Hosted by National Association of Community Health Centers (NACHC)
May 5-7, 2015
San Antonio, TX

Association of Clinicians for the Underserved (ACU) Annual Conference and Workforce Forum
June 1-3, 2015
Alexandria, VA

American Dental Hygienists’ Association’s 92nd Annual Session
June 17-23, 2015
Nashville, TN

Academy of General Dentistry (AGD) Annual Meeting & Exhibits
June 18-21, 2015
San Francisco, CA

National Dental Association (NDA) Convention
July 24-28, 2015
Chicago, IL

25th Hispanic Dental Association (HDA) Conference & Expo
August 14-16, 2015
San Antonio, 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.”