Most states are failing to enact policies that ensure low-income children receive sealants, according to a new study released by the Pew Children’s Dental Campaign. **States Stalled on Dental Sealants: A 50 State Report**, grades states on their performance in sealing children’s teeth. Nearly three-quarters of states receive a grade of C or worse.

At one-third the cost of a filling,1 sealants have been found to reduce decay by 80 percent two years after placement, and continue to be effective for an average of nearly five years.2 Yet in 2010, fewer than 1/3 of 5 to 19-year-olds, and only 25 percent of children at or below the federal poverty level, had sealants on any of their teeth.3 The low rate of sealant placement for low income children is particularly concerning because they are more likely to have tooth decay, and less likely to see a dentist than their peers living above the federal poverty level, making sealants a critical prevention service for these children.

Pew’s report used four benchmarks to grade states on their sealant placement rates: (1) success in reaching high-need schools (serving large numbers of low-income children) with sealant programs; (2) state

1 American Dental Association Health Policy Institute, “2013 Survey of Dental Fees,” 2014.

NOTE: The NNOHA newsletter is for information sharing & discussion purposes. NNOHA does not endorse all included viewpoints or authors.
Practice acts requiring a dentist to see a child before a dental hygienist can place a sealant at school; (3) meeting the national goal of sealing the permanent molars of at least 50 percent of 3rd graders; and (4) reporting sealant data to the National Oral Health Surveillance System.

The report’s major findings included:

- Thirty-nine states and the District of Columbia lack sealant programs in most of their high-need schools.
- For school-based programs in thirteen states and the District of Columbia, children must see a dentist before a dental hygienist can seal their teeth. This rule runs counter to the evidence that a visual assessment is adequate before placing a sealant, and to the experience in dozens of states where a dental hygienist can independently assess which teeth to seal.
- Only thirteen states have met the Healthy People 2010 goal of sealing permanent molars in at least 50 percent of 3rd graders.
- In a number of states, Medicaid policies are creating roadblocks for school sealant programs. For instance, dental hygienists in Oklahoma and Vermont are not allowed to bill Medicaid for sealants provided in schools; Arkansas’ Medicaid program does not reimburse for portable dentistry; and Medicaid managed care organizations in Oregon do not yet reimburse for sealants provided in schools.


---

Utilizing a Public Health Dental Hygiene Practitioner (PHDHP) to Increase Access and Strengthen Interprofessional Collaborative Care

Lucia S. Covato, DMD, Dental Director, North Side Christian Health Center (Pittsburgh, Pa.)

The North Side Christian Health Center, a faith-based FQHC operating out of two locations in Pittsburgh, Pennsylvania, opened a small dental clinic in 2011 to address the unmet oral health needs of its underserved urban community. With limited clinical space, staff, and funding we creatively maximized our departmental budget by employing a Public Health Dental Hygiene Practitioner to provide services at both of our locations. Our PHDHP works independently one day a week at our satellite clinic, where she collaborates with our pediatricians to coordinate care for our young patients and, ultimately, improve health outcomes.

When NSCHC opened its dental clinic four years ago the dental, medical and behavioral health departments were co-located at its primary site, however only medical services were offered at our small satellite clinic, located in a local Section 8 housing development. Many of the patients utilizing the satellite clinic had challenges securing

---

transportation and childcare which prevented them from accessing the dental clinic. Through a small capital funding grant, we were able to secure portable dental equipment (including a portable dental unit, Nomad, and laptop) to maximize the space we already occupied in the apartment complex.

Today, using mobile equipment, our PHDHP accompanies a pediatrician to NSCHC’s satellite site and offers dental hygiene services to patients and families scheduled for well-child medical visits. Most of these patients typically would not travel to our primary site for services. The pediatrician and PHDHP maintain separate schedules, but work collaboratively to introduce patients to NSCHC dental services, and to provide access to dental care for our at-risk population. While working at the satellite clinic, the PHDHP screens the pediatric patient, provides preventive and hygiene services, counsels pregnant women and new parents on nutritional and hygiene recommendations, screens emergency patients, and takes indicated radiographs which are delivered to the dentist electronically for immediate treatment planning. She also verifies dental insurance coverage for patients, and schedules patients for treatment at our primary site. A small treatment room that was previously not utilized by the medical team serves as a dental operatory. Front office staff is shared by both providers. All dental records are kept in an integrated EHR (eClinicalWorks and Open Dental), and are immediately accessible by both the dental and medical teams, as well as the billing department. When it is necessary to refer a patient to our primary dental site for treatment, the PHDHP offers the patient a familiar face and a “warm hand-off” for their first visit.

The Public Health Dental Hygiene Practitioner has offered NSCHC cost-effective means to increase oral health care access for our most vulnerable, underserved population within the confines of a small dental department and limited budget. Additionally, the interprofessional collaborative care system coordinated by the PHDHP has improved provider and patient understanding of oral health, and contributed toward the Center’s Level 3 Patient Centered Medical Home accreditation.

Editor’s Note: Dr. Covato won the 2014 NNOHA Contribution Award for Outstanding Clinician! She is also a graduate of NNOHA’s National Oral Health Learning Institute.
Safety and Efficiency in Instrument Management

Mary Govoni, CDA, RDA, RDH, MBA

Management of dental instruments is a critical factor in successful and productive patient treatment. It has become even more important in the last several years, with media reports of infection control breaches that involve improper processing and sterilization of dental instruments in various practices around the country.

In community health settings, productivity and efficiency become even more important due to the high number of patients needing care. Reprocessing of instruments needs to be fast and effective, but also safe for the dental health care professionals, keeping them in compliance with Occupational Safety and Health Administration safety regulations and Centers for Disease Control & Prevention guidelines. Health centers are also required to comply with Joint Commission on Accreditation of Healthcare Organizations standards for infection control and prevention. All of these standards and guidelines address the critical steps in instrument management and reprocessing, which include transporting, cleaning, drying, packaging, sterilizing and storing.

According to OSHA, contaminated instruments must be transported from treatment to sterilization area in a covered, puncture-resistant container in order to avoid injury to the health care professionals. Instrument cassettes assist the facility in meeting this requirement, and protect health care professionals from injury not only while instruments are being transported, but also while they are being cleaned. After each instrument is used, it is placed back on the silicone rail in the cassette (Image 1). When the procedure is completed, the cassette is closed and locked for transport and can be placed directly into an ultrasonic cleaner or instrument washer. No additional handling of the instruments is needed. Once the cleaning process is completed, the cassette is opened to confirm that the instruments are free of debris, and the instruments can be rinsed and dried while in...

INTRODUCING HU-FRIEDY'S INFINITY SERIES™ CASSETTES

The Most Sophisticated Solution for Instrument Management

Clinica’s dental call center

Launching a Dental Call Center

Lisa Lafflam, MBA, Dental Operations Director, Clinica Family Health Services (Metro Denver, Colo.)

Clinica Family Health Services has a well-trained and efficient communications center that handles telephone traffic for the entire organization. However, not long after arriving to the dental department, I heard a lot of rumbling about our telephone customer service. Daily, patients would complain that they could not talk with a receptionist and that staff took too long to return their calls. Due to the complexity of making dental appointments, dental calls were being transferred out of the communications center to the dental front desk. If staff were busy, the call would go to voicemail. Staff tried to return calls in a timely fashion, but it was not always possible. In an organization striving for open access and hospitality, we were failing our patients.

We started by collecting data: number of complaints received, nature of the complaints, number of messages being left, and
In addition to improving wait times for patients, we have seen improvements in team morale.

how long it took us to return calls. Data confirmed that we took days, sometimes weeks, to return voicemails. Dental staff met with Clinica’s vice president of operations and the call center director to discuss possible solutions. We identified two options: we could train the existing 20 communications center staff on how to schedule dental appointments so that the communications center could handle calls, or, alternatively, we could create a dedicated dental call center using existing dental staff. We decided to try the latter, which required less training and could be implemented more quickly.

During the three-month planning phase, we identified how incoming dental calls would be routed. To qualify for dental services, patients must be active medical patients at Clinica. We opted to have all dental calls routed through the communications center to confirm that status, and then transferred calls to the dental call center to make the actual appointment. This flow ensured that the dental call center was receiving an appropriate call volume, while assuring that dental patients met enrollment qualifications. We also had to determine staffing ratios for the call center, despite not knowing the exact call volume. We decided to use the same equation used by Clinica’s communications center: one attendant for every 3.5 providers. For our dental team, that meant we needed 2.5 attendants. This ratio has provided adequate coverage. However, given the small team size, we decided to cross-train the front desk staff so they could cover the call center when an attendant is sick or on vacation.

One of the benefits of having a dental call center is that we can now collect accurate customer service data. We track call volume, wait times, dropped calls, etc. The dental call center averages 1,000 calls per month. The average time a patient waits to speak with an attendant is one minute. Only four percent of incoming calls are dropped due to patients hanging up. This is a remarkable improvement over our previous service level.

In addition to improving wait times for patients, we have seen improvements in team morale. According to Operations Technician Gisele Jara, “Before we launched the call center, it was a frustrating game of tug-of-war for my full attention between the patient in front of me and the patient calling in. After the launch, we experienced overdue calm and clarity. We were able to give patients the one-on-one time that they deserve. We make fewer mistakes because we don’t feel rushed by the phones. Patients have mentioned that they appreciate the undivided attention we’re giving them, and they notice that it doesn’t feel as chaotic as before.”

The days of Clinica’s dental patients waiting weeks to schedule an appointment are long gone, which is very satisfying to both patients and staff.

Figure 2: Comparison of dropped vs. answered calls at Clinica’s new dental call center, January-March 2015.
For this article, NNOHA’s Project Director, Maria Smith, interviewed Dr. Ghazal Ringler, Dental Director at Anchorage Neighborhood Health Center. The organization’s mission is to improve wellness by providing high-quality, compassionate healthcare regardless of ability to pay.

**When & how did your health center oral health program start?**
Anchorage Neighborhood Health Center was Alaska’s first community health center and remains the state’s largest, serving over 14,000 individual patients with over 40,000 visits per year. ANHC began service to Anchorage with a handful of clinicians in a trailer in 1974. The center was then moved to a facility constructed in 1982. The ANHC dental program came about in the late 1980s with the leadership of our board of directors and our local municipality. Initially, the dental clinic only housed two chairs and was located in a corner of the building basement. It began primarily as an emergency clinic with a daily line up of patients for tooth extractions. In the early 1990s, the dental clinic closed due to a lack of funds. Dr. Edward Graves, a public health dentist, helped to re-open the clinic a couple of years later. ANHC operated a satellite medical and dental clinic in the neighboring Mountain View for 10 years which was closed in 2008. In 2012, the entire Anchorage Neighborhood Health Center moved to our new $30 million building. Our dental clinic increased to a total of 10 chairs, two of which are dedicated hygiene rooms.

**What is your community like?**
Anchorage is statistically younger and has more uninsured than other comparable cities. We are also one of the most ethnically diverse cities in the country with patients from Asia, American Samoa, Africa, as well as Europe and the Middle East. Anchorage is isolated due to our distance from mainland United States. Most of our patients are middle-aged adults who are uninsured. They are seeking both emergency services as well as comprehensive care.

**What challenges do you face that might be different from other Health Centers?**
Since Medicaid is a preferred payer source in Alaska and there are an abundance of pediatric dentists in Anchorage, our entire health center has fewer children and families than other comparable centers. We find it challenging to attract families with children to our practice. Other challenges include lack of resources to fully treat patients, which must be a struggle for other centers as well.
What are you doing well that you would like to share with us?
We are proud to share that we have moved from emergent care to comprehensive dental care. Since moving into our new building, we are focusing on growing the dental program, and developing and retaining team members.

Do you have any strong partnerships in the community?
For the last six years, we have partnered with our state’s oral health program to provide sealants in elementary schools and study the retention rates. In 2014, we participated in Mission of Mercy, the very first in Alaska. We are in the process of starting a “pay it forward” dental treatment program with our local dental society and other community partners to help our underserved population and to reduce dental related ER visits.

Why did you join NNOHA?
I attended a NNOHA conference after hearing about it from one of our vendors a few years ago. That was my introduction to NNOHA and the rest is history! I also participated in Cohort 2 of the National Oral Health Learning Institute.

What do you “know now that you wish you knew then” or what advice would you give to a new oral health program?
I would encourage new dental directors to get involved with NNOHA. The opportunity to network with other health center dental providers is invaluable. NOHLI is a great experience because I learned skills that were not covered in dental school, such as leadership skills and health center dental program financials.

What would you like decision makers in DC to know about Health Centers?
Dental services in Alaska are especially expensive and inaccessible. The need for affordable care is great. Policy makers need to acknowledge the connection between oral and overall health and provide more access to care.

What is on your wish list for the future?
We would like to expand services in our community with a mobile dental unit and expand our school-based sealant programs.

Did You NNOHA?

News Alert and Updates

Take advantage of opportunities to join NNOHA’s Advocacy & Strategic Partnerships Committee! This Committee discusses current policy issues related to oral health and actively advocates for safety net providers and the oral health of underserved communities. If you are an advocate for oral health and want to make a difference in your community then join us. If interested, please contact Jodi Padilla at jodi@nnoha.org.

National Oral Health Learning Institute (NOHLI) Update: This month, NNOHA is hosting NOHLI scholars in Denver for a 2 1/2 day intensive hands-on training. Topics to be covered include change management, quality improvement, financials, and more! For more information on NOHLI, visit: http://www.nnoha.org/programs-initatives/nohli/.
Le family participates in CDA Cares Volunteer Dental Program: Dr. Huong Le, Dental Director at Asian Health Services in California and NNOHA Board President volunteered at the CDA Cares event last March in Sacramento. It turned out to be a family affair, with Dr. Le’s husband, Dr. Chi Le, a physician, working in medical triage, and their son, Curtis, currently a college student, working in patient routing. The event provided dental services at no charge to more than 2,000 patients. NNOHA encourages its members to volunteer at similar events and to share those stories with NNOHA!

Editor’s Note: Do you have an announcement to share with other NNOHA members, such as a successful volunteer event or local win for community water fluoridation? Send your news to maria@nnoha.org to share in the next newsletter. NNOHA will try its best to honor all requests.

2015 ANNUAL CONFERENCE

The NNOHA Annual Conference, November 15-18, 2015, in Indianapolis, IN, offers several special sessions and networking opportunities that require pre-registration. The titles below will take you to a description of the session and a full listing of all sessions requiring pre-registration.

- Clinical Intensive Learning Session: Oral Health of the Aged and Aging: Effective Treatments for Common Conditions
- Fundamentals of Leading a Health Center Oral Health Program
- Reframing Leadership: A Framework for Organizational Change (a Digging Deeper session)
- Using Health Center Dental Dashboards for Tracking, Measuring, and Improvement (a Digging Deeper session)

http://www.nnoha.org/events/annual-conference/
Upcoming Conferences & Events

**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

**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

**2015 Community Health Institute & Expo**
Hosted by National Association of Community Health Centers (NACHC)
August 23-25, 2015
Orlando, FL

“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.”