Dental Management of Patients with a History of Substance Use Disorder

2019 NNOHA Conference

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Not since the HIV/AIDS epidemic has the United States faced as devastating and lethal a health problem as the current crisis of opioid misuse and overdose and opioid use disorder.
What's your experience, have you ever known someone (not just a patient) with opioid substance use disorder?

Yes, I know someone who has abuses opioid medications
Yes, I know someone who is addicted to opioids
Yes, I know someone who is in Rehab for an opioid addiction
Yes, I know someone who has died from an opioid overdose
“Of course we wanted to live with our mom, *it felt normal*”
America’s opioid epidemic just keeps getting worse…

And a health center dental program’s role is greater than you think!
The CDC has pronounced this "The Opioid Epidemic"

- 70,213 deaths in 2017 attributed to Opioid Use Disorder
  - More deaths than from MVA plus Gun Homicides
  - Affecting *all* ages, races and economic classes

CDC 2018
In 2017 “an estimated 134 Americans died everyday from an opioid overdose” or almost 4 deaths every hour leaving friends and family behind!

At this rate, by the year 2025, 500,000 deaths are projected!

CDC 2018
States with the highest numbers of drug overdose deaths

1. West Virginia
2. Ohio
3. Washington D.C.
4. New Hampshire
5. Maryland

https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state
Magnitude of the Problem

- U.S. makes up 5% of the world's population: Consumes 80% Oxycodone and 99% Hydrocodone.
- More than 11 million people used prescription opioids in 2016.
- Each day 1,000 people are treated in the emergency departments for opioid use disorder.
- Economic impact of opioid misuse is $78.5 BILLION a year.

CDC 2018
How did this epidemic begin?

• The Opioid epidemic began in the 1990s when pharmaceutical corporations did not fully address the threat of addiction when marketing these medicines with the medical community. This was the “first wave” of the Opioid epidemic.

• Pain = 5th Vital Sign

• By 2010, US doctors were writing over two hundred million Opioid analgesic prescriptions annually.
The second wave

- The second wave of the Opioid epidemic started in 2010 with a rapid rise in Heroin deaths as prescription painkiller deaths continued to climb. During this time, deaths from prescription Opioids overtook deaths from motor vehicle crashes.
- The rise in Heroin use, as an injection drug, also led to a rise in the spread of infectious diseases like HIV and Hepatitis C.

*From Delphi Behavioral Health Group*
Opioid Epidemic shifts from Prescription Opioids to Heroin
The third wave

- The third wave of the Opioid epidemic started only three years later with deaths involving highly potent, illicitly manufactured synthetic Opioids (like Fentanyl and Carfentanil).

Fentanyl is 25 x more potent than Heroin

From Delphi Behavioral Health Group
Fentanyl from China flows into the U.S. in several ways. (Photo: screenshot/Government Accountability Office)
3 Waves of the Rise in Opioid Overdose Deaths

- **Wave 1:** Rise in Prescription Opioid Overdose Deaths
- **Wave 2:** Rise in Heroin Overdose Deaths
- **Wave 3:** Rise in Synthetic Opioid Overdose Deaths

**Other Synthetic Opioids**
e.g., Tramadol and fentanyl, prescribed or illicitly manufactured

**Commonly Prescribed Opioids**
Natural & Semi-Synthetic Opioids and Methadone

**Heroin**

**Deaths per 100,000 population**

**SOURCE:** National Vital Statistics System Mortality File.
Where do people get these drugs?

• Bad Providers: A small number of high-volume, corrupt prescribers can provide a substantial supply.

• Diversion: Many people who use prescription analgesics non-medically obtain them for free from friends or family, and it is believed that in turn, most of those friends and family obtained those drugs from a single doctor.
12.5 Million People Aged 12 or Older Who Misused Pain Relievers in the Past Year

- Given by, Bought from, or Took from a Friend or Relative: 53.7%
- From Friend or Relative for Free: 40.5%
- Bought from Friend or Relative: 9.4%
- Took from Friend or Relative without Asking: 3.8%
- Got through Prescription(s) or Stole from a Health Care Provider: 36.4%
- Some Other Way: 4.9%
- Bought from Drug Dealer or Other Stranger: 4.9%
- Prescription from One Doctor: 34.0%
- Stole from Doctor's Office, Clinic, Hospital, or Pharmacy: 0.7%
- Prescriptions from More Than One Doctor: 1.7%
In one study, about 80 percent of current heroin users reported that they began with prescription opioids.
The pattern of opioids use varies widely around the world.

- Dentists in the United States write 37 times more opioid prescriptions than dentists in England

JAMA Network, May 24, 2019


Katie J. Suda, PharmD, MS1,2; Michael J. Durkin, MD, MPH3; Gregory S. Calip, PharmD, MPH, PhD2; et al Walid F. Gellad, MD, MPH4,5; Hajwa Kim, MS6; Peter B. Lockhart, DDS, FDS RCSED, FDS RCPS7; Susan A. Rowan, DDS8; Martin H. Thornhill, MBBS, BDS, PhD, MSc, FDSRCS(Edin), FDSRCSI, FDSRCS(Eng)7,9
If YOU are a prescribing provider, why would you say you might prescribe an opioid analgesic for your patient?

A. From my training, this is the most effective analgesic for acute severe pain - I stay with what I know and trust

B. Since opioids are schedule II drugs, they are much more potent than other options

C. I can not predict how much pain my patient may experience and want them to be comfortable in the worst case scenario

D. I am worried that a patient may post a poor rating for my care on social media if I do not prescribe what they expect or prefer

E. None of the above, I avoid prescribing opioid analgesics
Some states have more painkiller prescriptions per person than others.

Number of painkiller prescriptions per 100 people

- 52-71
- 72-82.1
- 82.2-95
- 96-143

SOURCE: IMS, National Prescription Audit (NPA™), 2012.
Statement on the Use of Opioids in the Treatment of Dental Pain

(2016)

1. When considering prescribing opioids, dentists should conduct a medical and dental history to determine current medications, potential drug interactions and history of substance abuse.

2. Dentists should follow and continually review Centers for Disease Control and state licensing board recommendations for safe opioid prescribing.

3. Dentists should register with and utilize prescription drug monitoring programs (PDMP) to promote the appropriate use of controlled substances for legitimate medical purposes, while deterring the misuse, abuse and diversion of these substances.

4. Dentists should have a discussion with patients regarding their responsibilities for preventing misuse, abuse, storage and disposal of prescription opioids.

5. Dentists should consider treatment options that utilize best practices to prevent exacerbation of or relapse of opioid misuse.

6. Dentists should consider nonsteroidal anti-inflammatory analgesics as the first-line therapy for acute pain management.

7. Dentists should recognize multimodal pain strategies for management for acute postoperative pain as a means for sparing the need for opioid analgesics.

8. Dentists should consider coordination with other treating doctors, including pain specialists when prescribing opioids for management of chronic orofacial pain.

9. Dentists who are practicing in good faith and who use professional judgment regarding the prescription of opioids for the treatment of pain should not be held responsible for the willful and deceptive behavior of patients who successfully obtain opioids for non-dental purposes.

10. Dental students, residents and practicing dentists are encouraged to seek continuing education in addictive disease and pain management as related to opioid prescribing.

Policy on Opioid Prescribing

(2018)

Resolved, that the ADA supports mandatory continuing education (CE) in prescribing opioids and other controlled substances, with an emphasis on preventing drug overdoses, chemical dependency, and diversion. Any such mandatory CE requirements should:

1. Provide for continuing education credit that will be acceptable for both DEA registration and state dental board requirements.

2. Provide for coursework tailored to the specific needs of dentists and dental practice.

3. Include a phase-in period to allow affected dentists a reasonable period of time to reach compliance, and be it further

Resolved, that the ADA supports statutory limits on opioid dosage and duration of no more than seven days for the treatment of acute pain, consistent with Centers for Disease Control and Prevention (CDC) evidence-based guidelines, and be it further

Resolved, that the ADA supports improving the quality, integrity, and interoperability of state prescription drug monitoring programs.

American Dental Association
October 2018
Rx

- Until recently, there were 0 hours of training on prescribing narcotics or chronic pain management in both dental and medical schools.

- Although prescription opioid involved death rates were stable from 2016 to 2017, they remained high and more must be done!

Dentists are no longer the 2\textsuperscript{nd} largest group of prescribers of Opioids.

Dentists now rank 6\textsuperscript{th}!
Also contributing to the problem:

- As states cut adult dental Medicaid benefits in an attempt to reduce healthcare costs, these costs are simply shifted to the ER, most which only provide *palliative* care for preventable dental conditions.

- ED physicians often prescribe opioid medications to manage acute dental care until the patient can visit the dentist.
What you need to know...

- Most cases of dental pain, especially post-surgical, are acute.
- Most cases of postoperative dental pain include an inflammatory component.
- Avoid Opioids and prescribe NSAIDs

Many studies have proven that Acetaminophen + Ibuprofen is synergistically more effective at managing dental pain than Opioids
Theories of Addiction

• Addiction is defined as the need for and use of a habit-forming substance despite knowledge the substance is harmful.

• Addicted persons experience tolerance - more and more of the substance is required to achieve the same effect and in the absence of the drug, they experience withdrawal symptoms = “Dope Sick.”
Which do you believe Addiction is....

a. A moral failure
b. A learning disorder
c. A chronic disease
d. both b and c
While addiction has been viewed historically as a moral failing or lack of individual self-control, it is now recognized and treated as a chronic brain disease often associated with relapses.

From Dr. John Ogram, Addictions Virginia
Addiction is a Chronic Brain Disease

• Addiction is driven by neurochemical changes in the brain that occur as a result of substance exposure.

• Most addictive drugs directly or indirectly activate the brain’s reward system, creating the “high” associated with drug use by markedly increasing the release of dopamine.

• Dopamine is a neurotransmitter regulating emotion, cognition, movement, motivation and pleasure.

From Dr. John Ogram, Addictions Virginia
The addicted brain (is not broken, it) has “simply undergone a different course of development....addiction is what you might call a wiring difference, not necessarily a destruction of tissue.”

- “Unbroken Brain” by Maia Szalavitz
Risks for Addiction

- Biological – genetic/family history
- Social – availability and intentional misuse
- Physiological – Adverse Childhood Experiences (ACEs)
All of the following increase the likeliness of developing an Opioid Addiction, but which one is the GREATEST risk factor?

- Personal or family history of alcohol or drug misuse
- Presence of mental health disorders (i.e. anxiety, depression)
- More than 4 Adverse Childhood Experiences
- Adolescence, Availability and Intentional Misuse
- Prescription access
Biological – Genetics and Family History

• Substance use has been documented within multiple generations of some families, indicating genetic predisposition.

• Research has confirmed 40%-60% of the predisposition to addiction can be attributed to genetics.

NIDA 2008
Social Availability and Misuse

• Adolescents are more apt to engage in risk-taking behaviors, including experimenting with drugs, and thus experience increased risk for addiction.

• Teens who received an prescription for opioid medication before Grade 12 are at 33% increased risk of misusing an opioid between ages 19-25 years old.

Pediatrics Volume 136, Number 5, November 2015
Physiological

• Some substance use disorder patients exhibit pre-existing co-morbid traits such as novelty-seeking and/or antisocial behavior.

• Adverse Childhood Experiences (ACEs) are associated with impaired cognitive, emotional, and social development, including substance misuse.

• Compared with people who have zero ACEs, people with ACE scores are two to four times more likely to use alcohol or other drugs and to start using drugs at an earlier age. People with an ACE score of 5 or higher are seven to 10 times more likely to use illegal drugs, to report addiction and to inject illegal drugs.

SAMHSA 2015
Treatment for Addictions

Medically-Assisted Treatment (MAT) = Medicine + Cognitive behavior Therapy

• Methadone Maintenance – must be dispensed w/i opioid treatment facility
• Buprenorphine/Naloxone (Suboxone®) – can be dispensed in office-based practice
• Naltrexone (Vivitrol®) – implanted

MATs drugs are longer acting, less euphoric and reduce withdrawal symptoms, they eliminate illegal use, improve health and social productivity
How comfortable are you in caring for Substance Use Disorder or MAT patients?

- Very comfortable
- Somewhat comfortable
- Not comfortable
WE may be fueling the black market...

- The management of substance use disorder patients is challenging!
- Providers are unsure about the medical necessity of opiates to treat pain >7 for patients with addiction
- Patients fear that their provider does not believe them because the assessment of pain is most dependent on self-reporting

SUD patients feel mistreated. They can perceive physician/dentist inconsistency and avoidance, we kick patients out instead of addressing the problem
Connecting Patients for Treatment
A Strong Referral is Key

When your patient is ready:

• Know your local resources
• Make a plan with the patient
• Decide on follow up support strategies that you will use
• Direct warm handoff whenever possible
Have you ever witnessed or responded to a medical emergency related to an Opioid overdose?

No, I have been fortunate to never have witnessed an overdose

Yes, I witnessed someone with a suspected overdosed

Yes, I responded to a medical emergency where someone had overdosed
Treating the Overdosed Patient

- Naloxone – synthetic opioid antagonist
- Reverses respiratory distress
- May cause withdrawal symptoms (confusion, headache, nausea or vomiting, aggressiveness, tachycardia, sweating, and tremor)
- Although naloxone has not attained OTC status, many states have greatly expanded access to naloxone through pharmacies, emergency departments, community-based organizations, and first responders using various implementation models.
27 Year Old Male Referred From ER
Role of the Oral Health Team

• Oral health professionals must learn to recognize when a patient might have a substance use disorder. We should all know how to briefly counsel these patients and refer them for appropriate treatment.

• Oral health care has positive effects in recovery from substance use disorder patients’ need for pain control, destigmatization, and employability. Our health care systems deliver services for substance use disorder, but most lack oral health care programs. Our CHC goal is to deliver substance use disorder services focusing on the treatment, prevention, and awareness of opioid abuse, and their integration into primary care. ORAL HEALTH IS PRIMARY CARE.
Screening, Brief Intervention, and Referral to Treatment (SBIRT)

• SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

• SBIRT is an approach to the delivery of early intervention and treatment to people with substance use disorders and those at risk of developing these disorders.
Screening, Brief Intervention, and Referral to Treatment (SBIRT)

- **Screening** — the oral healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting.
Screening, Brief Intervention, and Referral to Treatment (SBIRT)

• **Brief Intervention** — the oral healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice.

• **Brief Intervention Steps:**
  - Raise the subject
  - Provide feedback
  - Enhance motivation
  - Negotiate a plan
Screening, Brief Intervention, and Referral to Treatment (SBIRT)

- **Referral to Treatment** — the oral health professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services
SBIRT Resources

• SAMHSA – HRSA Center for Integrated Health Solutions:
  • https://www.integration.samhsa.gov/clinical-practice/sbirt

• Arizona State University:
  • https://courses.cpe.asu.edu/browse/cabhp/courses/dentistry-sbirt-model

• University of Utah School of Dentistry:
  • https://umarket.utah.edu/um2/dentistrycde/product.php?product=41&store cookie=1
Medication Assisted Treatment MAT

• Medication assisted treatment (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorder. A combination of medication and behavioral therapies is effective in the treatment of substance use and can help some people to sustain recovery.

• The inclusion of oral health services can provide a great benefit by restoring function and improving self perception.
Dental Treatment Considerations for the Medication Assisted Therapy (MAT) Patient
MAT Medications

• Suboxone: (Buprenorphine and Naloxone) sublingual oral film, sublingual oral tablets
• Subutex: (Buprenorphine) sublingual oral tablets
• Sublocade: (Buprenorphine) extended release injection for subcutaneous injection in the abdominal region
• Vivitrol: (Naltrexone) extended release injection for intramuscular injection
Suboxone

- SUBOXONE® (buprenorphine and naloxone) is a prescription medicine indicated for treatment of opioid dependence and should be used as part of a complete treatment plan to include counseling and psychosocial support. Buprenorphine is an opioid that fills the cravings for opioids without the high produced by other opioid substances, while naloxone, which also is given to patients suffering opioid overdose, helps protect against misuse of the product.
Suboxone (buprenorphine and naloxone) sublingual film
How is Suboxone taken?

Sublingual

Buccal
What is the Direct Oral Effect of Suboxone Use?

• Suboxone is acidic with a pH of 3.4 when dissolved in water
• Suboxone has a poor oral bioavailability and therefore patients are specifically instructed to keep the strip and accumulating saliva in their mouth as long as possible as long as possible to maximize absorption of the medication through the oral mucosal surfaces.
What are the Common Oral Side Effects of Suboxone?

- Xerostomia (dry mouth)
- Painful tongue
- Redness of the mouth
- Numb mouth
- “Mountain Dew” effect
Xerostomia (dry mouth)

• Saliva has a buffering capacity and is the primary defense against dental caries (decay). Saliva is anticarogenic and maintains the health of the soft (gums) and hard (teeth) tissues of the mouth by neutralizing acidity in the mouth.

• Saliva has remineralization properties
Restorative Treatment is Doomed to Fail Without Treatment for Xerostomia (Dry Mouth)

- Drink plenty of water
- Use of commercially available lubricating agents
- Use of Xylitol products
- Apply Fluoride varnish / Silver Diamine Fluoride
- Home Fluoride application with custom trays
- Bicarbonate mouth rinse
Dental Treatment Considerations for MAT Patients

- Comorbidity / Infection Control
- Polypharmacy
- Anxiety / Dental Phobia
- Low Threshold to Pain
- Staffing
- Extent of Disease
- Treatment Time Considerations / Productivity
- Cost / Sustainability
Comorbidity / Infection control

- Hepatitis C
- Hepatitis A
- HIV
- Increased Incidence of Infective Bacterial Endocarditis (Methicillin Sensitive Staphylococcus Aureus (MSSA))
- Increased Risk of Stroke Associated with Infective Bacterial Endocarditis
- History of Heart Valve Replacement (Tricuspid)
- Increased Incidence of Spinal Abscess
Polypharmacy

- Antidepressants (SSRI: Selective Serotonin Reuptake Inhibitors) Lexapro, Prozac, Paxil, Zoloft
- Antidepressants (SSNI: Selective Serotonin & Norepinephrine Reuptake Inhibitors) Effexor
- Tetracyclic Antidepressants: Remeron
- Antidepressant and Sedative: Trazodone
- Anti-Anxiety drugs: Buspar, Ativan (Lorazepam)
- Antipsychotic drugs: Seroquel, Risperdal
- Muscle Relaxers: Baclofen, Flexeril
- Antihistamines: Vistaril, Loratadine (Claritin)
- Colace, Miralax
Polypharmacy

PLEASE LIST ALL MEDICATIONS, INCLUDING OVER THE COUNTER MEDICINES. IT IS VERY IMPORTANT WE KNOW ALL MEDICATIONS AS THEY CAN INTERFERE WITH YOUR ORAL HEALTH CARE.

DENTAL ANESTHETICS (NUMBING MEDICATION)

Subutex 2mg
Prozac 20mg
Busepar 10mg
Frenazel 100mg

Gabapentin 3mg
Monase
Protonix
Zantac
Zofran 4mg
Dental Anxiety/Dental Phobia
Dental Anxiety/Dental Phobia

• Trauma Informed Care in Dentistry
• Patients who have experienced trauma are more likely to have chronic health conditions and engage in risky health behaviors. They may be especially wary of dental exams and procedures that place them in vulnerable positions in close physical proximity to a dental professional.
• Practice “Trauma Informed Approach to Dental Care”
Dental Anxiety/Dental Phobia

• Through Medical and Dental History
• Manage Expectations
• Staffing
• Tell, Show, Do
Low Threshold To Pain / Pain Management

• The amide local anesthetics including lidocaine, bupivacaine (Marcaine) and articaine (Septocaine) when given as single or limited injections have not been convincingly linked to instances of clinically apparent liver injury and liver toxicity but when given as constant infusions or repeated injections have been mentioned as possible causes of clinically apparent liver injury.

• Pre-operative loading dose of ibuprofen. Ibuprofen and other NSAIDS rarely affect the **liver**. Unlike acetaminophen (Tylenol) most NSAIDs are absorbed completely and have negligible first-pass *hepatic* (**liver**) metabolism.

• Stay ahead of post-operative pain.
Technique = Pain Management
Technique = Pain Management
Post Operative Pain Management

• NSAIDS are potent inhibitors of prostaglandin synthesis and target the inflammatory pain encountered with acute infections, tissue injury and surgical trauma.

• Set Expectations: “some soreness and discomfort is normal”

• The most effective pain management is combining ibuprofen and acetaminophen
Post Operative Pain Management

• Ibuprofen, nonsteroidal anti-inflammatory drugs (NSAIDs), are safe in hepatitis patients but no more than 3,200mg in a 24 hour period (one 800mg tablet every 6 hours at most). However, NSAIDS can be harmful if patient has cirrhosis. They are safe in hepatitis patients who do not have cirrhosis. If a patient has cirrhosis, then NSAIDs cannot be taken at all.

• If necessary, Acetaminophen (Tylenol) can be used in hepatitis patients but no more than 2,000 mg (2 grams) total over 24 hours (one 500mg tablet every 6 hours at most). In general, Tylenol is safe to use in cirrhosis at above frequency.
Post Operative Pain Management

- 2% Viscous Lidocaine, 100c, Swish with 2 teaspoons for 2 minutes q2h prn, spit out, do not swallow, no refills
- Medrol Dose Pack
### Controlling Dental Pain

#### Stepwise guidelines for acute postoperative pain management in dentistry.

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<thead>
<tr>
<th>PAIN SEVERITY</th>
<th>ANALGESIC RECOMMENDATION*</th>
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<tbody>
<tr>
<td>Mild</td>
<td>Ibuprofen (200-400 milligrams) q† 4-6 hours: prn‡ for pain</td>
</tr>
<tr>
<td>Mild to Moderate</td>
<td>Ibuprofen (400-600 mg) q 6 hours: fixed interval for 24 hours</td>
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<tr>
<td></td>
<td>Then ibuprofen (400 mg) q 4-6 hours: prn for pain</td>
</tr>
<tr>
<td>Moderate to Severe</td>
<td>Ibuprofen (400-600 mg) with APAP (500 mg) q 6 hours: fixed</td>
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<td></td>
<td>interval for 24 hours</td>
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<td></td>
<td>Then ibuprofen (400 mg) with APAP (500 mg) q 6 hours: prn for</td>
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<tr>
<td>Severe</td>
<td>Ibuprofen (400-600) with APAP (650 mg) with hydrocodone (10 mg)</td>
</tr>
<tr>
<td></td>
<td>q 6 hours: fixed interval for 24-48 hours</td>
</tr>
<tr>
<td></td>
<td>Then ibuprofen (400-600 mg) with APAP (500 mg) q 6 hours: prn</td>
</tr>
<tr>
<td></td>
<td>for pain</td>
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Moore, PA, Hersh, EV, Combination Ibuprofen and acetaminophen for acute pain management after third–molar extractions. JADA 2013; 144(8):898-908
• Exparel is a long-acting, sustained-release formulation of bupivacaine HCL, a local anesthetic widely used for treating postoperative pain. Exparel was formulated using the DepoFoam lipid-based delivery system. DepoFoam technology encapsulates the drug in multivesicular liposomal particles which then release the drug over a desired period of time without altering the drug molecule.

• Exparel is specifically indicated for administration into the surgical site to produce postsurgical analgesia.

• The average wholesale price (AWP) of a 20-mL vial is $285
New Dental Reimbursement Code

D9613
MAT Oral Health Program Considerations

• Productivity considerations – extent of disease
• Staffing
• Reimbursement
• Provider burnout
• Sustainability
Establishing Your MAT Oral Health Program

- Integration through communication.
- Emergency seen ASAP
- 90 day compliance
- Set your limitations
- Patient motivation and compliance
- Labs: HIV, Hepatitis, Liver function
- Established scheduling and regular updates
Contact Us!

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