NEEDED – HEALTH CENTER DENTAL CLINICS – TO EDUCATE DENTAL STUDENTS

Wayne Cottam DMD, MS, Associate Dean for Community Partnerships at the Arizona School of Dentistry & Oral Health

As Associate Dean for Community Partnerships at the Arizona School of Dentistry & Oral Health (ASDOH), I have the privilege of administering one of the most far reaching and comprehensive Community Based External Rotation programs of any dental school in the country. The parent university – A.T. Still University - and the founding Dean – Dr. Jack Dillenberg – were very far sighted when they planned the school with the idea that the students could obtain a large portion of their clinical education in community and public health settings. Accordingly, ASDOH sends students to over 70 different community based sites around the country for over half of their 4th year. These sites include Health Centers, VA’s, Indian Health Services (IHS) and other public health clinics. This idea was extremely radical when first suggested and many came forth with predictions of gloom and disaster purporting that a good educational setting could not be provided in these “Public Health” clinics. One critic went so far as to say that the community based setting was a concern because he wanted to see a dental school “graduate quality dentists, not a bunch of Public Health dentists.”

As the person charged with setting up this visionary program, I could not understand the concerns. As a Health Center Dentist and Dental Director for over 10 years, as a member of NNOHA for almost that long, and having attended the National Primary Care Oral Health Conference in Sedona and many other cities for many years, I had firsthand knowledge of the excellence that pervaded the Health Center movement and was personally acquainted with many of the dentists and dental directors. I knew them to be caring, competent, compassionate, hard working dentists as well as excellent human beings. In other words, exactly the kind of person I would want participating in the education of our students. Our program has been very successful thus far in getting students into Health Centers, providing them with an excellent clinical education and graduating excellent clinicians, over 35% of which returned to work in Health Centers or other Public Health agencies.

The real story here however is how the rest of the dental education establishment has come to realize what others knew years ago. Many schools are now seeking to place their students into community settings for more and more of their clinical education. The Robert Wood John-
The benefits of community based dental education are numerous. For the student, the benefits include:

- Exposure to a variety of community and public health based clinical environments and situations.
- An opportunity to be taught and mentored by excellent clinicians.

For the training site the benefits include:

- The dental staff has the opportunity to share their expertise and experience.
- The experience that the student receives at the site can be a very effective recruiting tool.
- The organization has the opportunity to be a partner with schools in educating future dental professionals about cultural, societal and health issues unique to the community they serve.

The take home message is that you, as Health Center dentists, are in increasing demand, not only as caring providers delivering care to those in need, but as a resource for quality clinical education for the future of our profession. We should be proud of this.

For more information, contact:
Wayne Cottam DMD, MS
Associate Dean for Community Partnerships
Arizona School of Dentistry & Oral Health
AT Still University of Health Sciences
5850 East Still Circle Mesa, AZ  85206
Phone: 480-248-8154
Cell: 480-600-5890
wcottam@atsu.edu

GIVING POLICY SOME TEETH

“Health Affairs,” the policy journal of the health sphere, recently published an article on oral health policy. It offers examples of discrepancies between policy and needs and examples of successful interventions that integrate oral health care with informed policy. To read the full article, visit:
http://content.healthaffairs.org/cgi/content/abstract/27/2/404

ASDOH Student Rotations continued...

The Robert Wood Johnson Foundation (RWJ) Pipeline project provided grants to ten dental schools in 2003 and those schools have developed partnerships with Health Centers to have their students in those clinics for up to 12 weeks. The second phase of the RWJ pipeline project will begin soon, providing more funds for other dental schools to explore these partnerships. Lastly, a comprehensive study on reforming dental education conducted by the Macy Foundation between 2004 – 2007 stated that in order to survive the challenging fiscal times ahead, dental schools should increasingly consider community based clinical education and concluded that Health Centers and other sites are very appropriate venues for quality clinical education.

For the student, the benefits include:

- A deeper understanding of the unique oral health challenges faced by many communities, and the opportunity to learn firsthand how to address those challenges.

The benefits of community based dental education are numerous. For the student, the benefits include:

- Exposure to a variety of community and public health based clinical environments and situations.
- An opportunity to be taught and mentored by excellent clinicians.

The Robert Wood Johnson Foundation (RWJ) Pipeline project provided grants to ten dental schools in 2003 and those schools have developed partnerships with Health Centers to have their students in those clinics for up to 12 weeks. The second phase of the RWJ pipeline project will begin soon, providing more funds for other dental schools to explore these partnerships. Lastly, a comprehensive study on reforming dental education conducted by the Macy Foundation between 2004 – 2007 stated that in order to survive the challenging fiscal times ahead, dental schools should increasingly consider community based clinical education and concluded that Health Centers and other sites are very appropriate venues for quality clinical education.

For the student, the benefits include:

- A deeper understanding of the unique oral health challenges faced by many communities, and the opportunity to learn firsthand how to address those challenges.

For the training site the benefits include:

- The dental staff has the opportunity to share their expertise and experience.
- The experience that the student receives at the site can be a very effective recruiting tool.
- The organization has the opportunity to be a partner with schools in educating future dental professionals about cultural, societal and health issues unique to the community they serve.

The take home message is that you, as Health Center dentists, are in increasing demand, not only as caring providers delivering care to those in need, but as a resource for quality clinical education for the future of our profession. We should be proud of this.

For more information, contact:
Wayne Cottam DMD, MS
Associate Dean for Community Partnerships
Arizona School of Dentistry & Oral Health
AT Still University of Health Sciences
5850 East Still Circle Mesa, AZ  85206
Phone: 480-248-8154
Cell: 480-600-5890
wcottam@atsu.edu

GIVING POLICY SOME TEETH

“Health Affairs,” the policy journal of the health sphere, recently published an article on oral health policy. It offers examples of discrepancies between policy and needs and examples of successful interventions that integrate oral health care with informed policy. To read the full article, visit:
http://content.healthaffairs.org/cgi/content/abstract/27/2/404

ASDOH’s Dental Clinic

“[STUDENTS GAIN] A DEEPER UNDERSTANDING OF THE UNIQUE ORAL HEALTH CHALLENGES FACED BY MANY COMMUNITIES, AND THE OPPORTUNITY TO LEARN FIRSTHAND HOW TO ADDRESS THOSE CHALLENGES.”
The Health Center model of health care presents a unique and valuable opportunity for medical/dental collaboration. In most Health Centers the medical and dental services are co-located in the same building, providing an opportunity for patients to develop a comprehensive health care home. In the recent Oral Health Collaborative Pilot, Health Center dental teams worked closely with their medical counterparts to encourage preventive oral health education for pregnant women and very young children. The pilot teams learned that patients were much more likely to schedule a dental appointment if their medical provider reinforced the importance of dental care, than if the dental clinic called medical patients and invited them to get dental care.

The Oral Health Collaborative focused on the prevention and treatment of caries and periodontal disease in pregnant women and the prevention and treatment of early childhood caries. Four health center teams piloted this model to efficiently identify interventions that yielded the greatest improvements in outcomes, with the ultimate goal of achieving a disease-free mouth for underserved patients.

Prior to the start of this pilot, there was general resistance in the dental community to provide oral health services to pregnant women and young children under the age of 3. The American Dental Association, American Academy of Pediatrics, and American Academy of Pediatric Dentistry all recommend that children have their first dental visit by age 1. Despite this recommendation, the majority of dentists will not see a child until age 3. The Oral Health Collaborative applied quality improvement methodologies to teach dental providers how to work with very young children, offering a valuable dental experience to young children and their caregivers.

Additionally, there is a widely held myth in the dental community that pregnant women should only receive dental care in the 2nd trimester of pregnancy, and then only very limited services. Preventive and restorative treatment to optimize a woman’s oral health prior to the birth of her baby decreases the chance of the mother passing cavity-causing bacteria to her child and may lower risk for negative birth outcomes resulting from chronic periodontal disease. The oral health collaborative pilot brought together dental and medical professionals and provided clinical tools and support to make systematic changes that enabled delivery of oral health care to pregnant women in all phases of pregnancy.

As a result of the Oral Health Collaborative, we realized two things were critical to creating real change: one is to bridge the gap between medical and dental care by ensuring that physicians understand the role of oral health in good primary care and engaging them in the referral of all their pregnant and very young patients to the dental clinic. The other was training of dental staff to increase comfort levels and skill in providing preventive and restorative treatment to pregnant women and very young children.

"Patients were much more likely to schedule a dental appointment if their medical provider reinforced the importance of dental care."
A COMPREHENSIVE APPROACH TO WASTE MANAGEMENT FOR THE DENTAL PROFESSION:
Practicing environmentally conscious dentistry and complying with new amalgam disposal and recycling regulations

By Marc M. Sussman, Dental Recycling of North America

There are new and emerging environmental regulations that will impact your work in the future (if they have not already). Specifically, the focus of the proper disposal and recycling of amalgam waste is the driving force behind the new regulatory focus. The concern about mercury pollution is now a top priority of state and federal environmental officials.

The disposal of toxic metals, and in particular silver and mercury, is an important environmental concern. In many communities new laws and regulations are being passed to ensure that silver and mercury discharges from dental offices are properly collected and recycled. The focus on dental practices is due to the fact that amalgam, which has a 50% mercury content, was being released in the environment from these practices.

In many European countries the installation of amalgam separators has been mandated and requires that the contents of the separators be recycled on an ongoing basis (mostly within a 12-month period). The experience from Europe is that widespread compliance has substantially reduced the amount of mercury emitted from dental practices and entering the environment.

Approximately ten years after amalgam separators were made mandatory in parts of Europe, the issue arose in the United States. Seattle, Washington was the first to see this issue emerge. The local, publicly owned treatment works (POTW) discovered that dental offices were emitting mercury to its facility. As a result of the Clean Water Act, POTWs were under greater pressure to ensure that heavy metals like mercury did not end up in the waste sludge. The local POTW in Seattle decided on a voluntary program regarding the use of amalgam separators and recycling. Following this voluntary program several other POTWs in the U.S. released data showing the extent of mercury from dental offices entering their systems.

Most of the initial focus on these dental practices started in the mid 1990s. Ten years later, many of the municipalities that were concerned about this issue and had instituted voluntary programs, moved to institute formal regulation regarding mercury waste. Thus, Seattle, which has had a voluntary program for some 10 years, became the first locale to require amalgam separators and proper recycling in dental practices.

States that have mandatory requirements or have future compliance dates set in place are:

- Connecticut
- Massachusetts
- Maine
- New Hampshire
- New Jersey
- New York
- Rhode Island
- Vermont
- Washington (state)
- Oregon

The states of Michigan, Pennsylvania and Ohio are looking seriously at regulatory action as well.
Waste Management Continued...

Finally, Congresswoman Tammy Baldwin of Wisconsin is planning to introduce a bill in the House of Representatives addressing this issue on a federal level. In summary, for public sector clinics, whether funded wholly or in part with local, state, and/or federal dollars, complying with new amalgam disposal and recycling requirements will be a required practice in short order. Regardless of these requirements, addressing this issue is the Right Thing to Do and is part and parcel or being a socially responsible corporate citizen. Your patients and the community will thank you for these environmental efforts!!

AMALGAM RECYCLING & THE ADA

The American Dental Association has taken positions encouraging amalgam recycling as well. Excerpts below are from the October 2007 document “BEST MANAGEMENT PRACTICES FOR AMALGAM WASTE” from the ada.org website.

“Concern about the effects of mercury in the environment has increased over the years. Mercury in the environment is bioaccumulative, which means that it can build up in fish and cause health problems in humans and other animals that eat fish. Many state health professionals recommend limiting fish consumption, especially for children and pregnant women.

Mercury is a naturally occurring metal; however, about half of the mercury released to the environment comes from human activity. Of that amount, 53% is emitted from combustion of fuels for energy production and 34% is from the combustion of waste. Sources associated with manufacturers and consumers make up the remaining 13%, with dentistry contributing less than one percent.

Although mercury in the form of dental amalgam is stable, amalgam should not be disposed of in the garbage, infectious waste “red bag,” or sharps container. Amalgam also should not be rinsed down the drain. These cautions are important because some communities incinerate municipal garbage, medical waste, and sludge from wastewater treatment plants. If amalgam waste ends up in one of these incinerated waste streams, the mercury can be released to the environment due to the high temperatures used in the incineration process. Increasingly, local communities are enacting restrictions on the incineration of wastes containing mercury. The good news is that amalgam waste, kept separate from other waste, can be safely recycled. The mercury can be recovered from amalgam wastes through a distillation process and reused in new products. The ADA strongly recommends recycling as a best management practice for dental offices.”

To read the complete “BEST MANAGEMENT PRACTICES FOR AMALGAM WASTE” from the ADA, visit

http://ada.org/prof/resources/topics/topics_amalgamwaste.pdf
The science of remineralization is a developing arena of dentistry that is improving oral health. Fluoride has long been a mainstay of prevention and fighting the destructive forces of demineralization. However, in the words of Dr. Douglas Young, an associate professor in the Department of Restorative Dentistry at the University of the Pacific School of Dentistry, “Fluoride alone in many patients is usually not enough to tip the caries balance towards health.”(1) MI paste is one tool available to providers to support the remineralization process. It is part of a growing trend of “minimally invasive dentistry” that favors finding just the right solutions of chemicals to rebuild decayed teeth, rather than merely patching their holes.

MI Paste (CPP-ACP) is Amorphous Calcium Phosphate (ACP) and Casein Phosphopeptide (CPP). ACP is calcium and phosphate in its reactive form – the minerals that are in healthy saliva. The CPP is a sticky milk protein that acts as the delivery vehicle for the ACP into the plaque/biofilm. It comes in a tube, like toothpaste, although it is more like a cream than a paste.

MI Paste is both a preventive product as well as a reparative or remineralization tool. MI Paste prevents demineralization by loading itself into the biofilm and neutralizing plaque and dietary acids for over three hours: it buffers the acid attack on teeth. It is also reparative, allowing the uptake of all three necessary minerals; calcium, phosphate and fluoride during the remineralization process.

Any patient that presents with active caries is a candidate for remineralization products like MI Paste. Caries is an acid driven disease and an active lesion is a mineral imbalance. Other patient indications would include high-risk caries individuals such as orthodontic patients, geriatric patients with multiple medications causing dry mouth or dexterity challenges, pregnancy patients and special needs individuals. No special equipment is needed to apply the paste; it can be done with just an index finger. Remineralization is an encouraging option for high-risk patients because it is minimally invasive, easy-to-use, and focuses on prevention and reparation instead of more involved procedures.

Professionally supplied dental products such as MI Paste (CPP-ACP) and MI Paste Plus (CPP-ACPF) from GC America are available from dental dealers like Henry Schein, Inc. The amount of active ingredient in MI Paste and MI Paste Plus is 10%. It costs about $12 per tube which could last a year for patients that are using the technology to aid with sensitive teeth, or would last about a month for patients with more severe needs. Recaldentä (CPP-ACP) technology can also be found in Trident White Chewing gums made by Cadbury Schweps. The gum is commercially available in various grocery, convenience, and department stores across America. The amount of the active ingredient Recaldentä (CPP-ACP) in the chewing gum is .6%. The gum would need to be used 4 -5 times a day for 15 minutes at a time to get a therapeutic level. The way the Recaldent is delivered makes it available for general sensitivity or improvement of oral balance. The paste with the higher level and direct application on white spots is more effective treating a specific site.

Treating caries chemically can be part of a new paradigm shift in oral health care, where treating the infection and preventing further decay decreases the need for end-stage surgical interventions. For more information, visit www.gcamerica.com (product information and free continuing education courses) or www.mi-paste.com (consumer website). To order, contact your local Henry Schein supplier, or contact Kathleen Titus at (916) 772-0424 or kathleen.titus@henryschein.com.

References:
Chalmers, The Evolving Technology of Amorphous Calcium Phosphate. Dimensions of Dental Hygiene CE
CONGRATULATIONS TO THE MEMBERSHIP DRIVE WINNERS!

Each NNOHA member who referred at least 5 of their colleagues for NNOHA membership prior to March 31, 2008 were entered in a drawing to win 2 new Kerr DEMI curing lights valued at $1,000. Congratulations to the winners: Juris Svarcbergs of CAMcare Health Corporation in New Jersey and Marty Lieberman of the Georgetown Dental Clinic in Seattle. Thank you to Kerr Corporation for contribution of the 2 curing lights for the drawing as well as their ongoing support of NNOHA.

NNOHA BOARD OF DIRECTORS OPENINGS

NNOHA is committed to having wide-ranging representation from all ten HRSA regions on the Board of Directors. Board members must be a provider at a Federally Qualified Health Center, a current NNOHA member, must commit to participation in 4 NNOHA Board of Directors meetings each year (2 in person, and 2 via conference call) & participate in at least one NNOHA committee. This is an excellent opportunity to guide the activities of the network and connect with your colleagues. Interested members may self-nominate for board positions or may be nominated by a member in good standing. Nominees will be voted on by the current board. Interested candidates should contact Colleen Lampron at colleenlampron@gmail.com for more information.

FREE SEALANT BROCHURES

Pulpdent Corp. offers free sealant brochures in English & Spanish for any public health providers. Call the company direct to order some brochures: 1.800.343.4342.

ADVISORY COMMITTEE RECOGNITION

NNOHA’s Advisory Committee is comprised of representatives from major dental manufacturers in the country. This group recognizes the importance of providing care for the underserved and has committed funding, resources, and expertise to NNOHA to help us achieve our mission. We are grateful for the contributions from these corporate supporters:

- 3M
- Dentsply
- GC America
- Mydent
- Henry Schein, Inc
- Independent Dental
- Kerr
GOLD CIRCLE ORGANIZATIONAL MEMBERS

These organizations have contributed at least $250.00 to become organizational members of NNOHA:

- Arizona School of Dentistry & Oral Health, Mesa, AZ (Director of Integrated Community Clinics - Wayne Cottam)
- Camcare Health Corp., Camden, NJ (Dental Director - Juris Svarcbergs)
- Community Health Center of the Black Hills, Inc., Rapid City, SD (CEO - Crystal Jordan)
- Fort Gay Family Health Center, Fort Gay, WV (Dental Director - Dan Brody)
- Hudson River Healthcare, Peekskill, NY (Chief Dental Officer - Clifford Hames)
- Jordan Valley Community Health Dental Clinic, Springfield, MO (William Thousand)
- La Clinica Del Carino, Hood River, OR (Elizabeth Aughney)
- Missouri Primary Care Association, Jefferson City, MO (CEO - Joseph Pierle)
- Wyoming Primary Care Association, Cheyenne, WY (Operations Coordinator - Donna Anderson)

MEMBER RECOGNITION

The following people have recently initiated or renewed their NNOHA membership and we recognize them for their commitment:

MEMBER BENEFITS REMINDER

Take advantage of the benefits available to you within NNOHA’s community:

• **Communicate with Your Colleagues:** NNOHA’s listserv is for those who appreciate daily communication among their peers and want to post questions and give feedback. It requires a separate sign-up from the newsletter. If you would like to be subscribed to NNOHA’s listserv, send an e-mail to MAJORDOMO@ohsu.edu with the text “Subscribe NNOHA” in the body of the e-mail. All of this text needs to be in plain text format.

• **List Your Openings:** NNOHA hosts an online job bank to list openings for dentists, dental hygienists, and other dental team support staff at Health Centers across the country. This service is free to NNOHA members. Members can post openings by completing the job description form from the website: http://www.nnoha.org/careers.htm.

• **Use the Discounts:** Henry Schein, Inc. offers a Health Center discount. To enroll in the Henry Schein, Inc. discount program, members may contact Kathleen Titus at (916) 772-0424 or kathleen.titus@henryschein.com. Dental Recycling of North America (DRNA) offers a discount to any NNOHA member of 10% - 15% (depending on the service purchased) for dental waste management and recycling. To enroll in DRNA’s discount program, or for more information, members may contact Crystal Ali at 1(800) 360-1001 x15.

• **Let us Know:** What could we do to increase the value of NNOHA membership? Contact NNOHA staff at NNOHAinfo@gmail.com.

UPCOMING CONFERENCES AND EDUCATIONAL OPPORTUNITIES

• **“Oral Health Basics for the Primary Care Provider”** webcast - The Community Health Association of Mountain/Plains States (CHAMPS) announced an upcoming clinical webcast on oral health basics presented by Michael E. Crutcher, DDS, of Community Health Center of the Black Hills in Rapid City, SD. The webcast will take place on Tuesday, June 24, 2008. For more information, visit www.champsonline.org/Events/Distance_Learning.asp.

• **Dental Management Coalition’s Annual Conference** will take place July 21-24 in Port St. Lucie, Florida. For more information, visit http://www.dentalmanagementcoalition.org/2007.html.


• The **National Summit of Clinicians for Healthcare Justice Conference** takes place October 23-25, 2008 in Washington, DC. Come network, learn, and rally for Health Justice. For more information, visit http://www.allclinicians.org/home.php.

• Information on the **National Primary Oral Health Conference** this fall coming soon!

CONNECT THE DOCS

Do you know of a new Health Center dental clinic or new Dental Director? Help us link up with them and share the resources available to them through NNOHA. Forward this newsletter or let a NNOHA staff member know who to contact: NNOHAinfo@gmail.com. Let’s stay connected!
Collaborative Update continued...

Many low-income women get their pre-natal care at Health Centers where, generally, both physicians and dentists are on staff. This can make referrals easier and it gives us the opportunity to alert pregnant women about the need to get dental care for themselves and their newborns. Physicians are asked to screen for obvious oral health problems and to provide initial oral health counseling, but the real key to success is making sure all patients are referred to dental practitioners for comprehensive care. Health Centers can be on the cutting edge in persuading busy physicians to take on responsibility for dental referrals.

Dentists also, have had to expand their horizons. “Dental training has come a long way but a lot of us learned in school that children under three were not candidates for care and that it was risky to treat pregnant women.” says collaborative faculty member Martin Lieberman, DDS. To counter professional resistance, says Lieberman, the Collaborative faculty provided the latest clinical information and support on how to use that information in daily practice. “We put the research literature in front of them, we trained them how to manage small children as patients and we explained treating pregnant women in the context of providing good pre-natal care.”

A national roll out of the Oral Health Collaborative has been stalled due to insufficient resources. However, NNOHA continues to seek funding and hosts periodic conference calls with interested teams and experienced pilot teams. In addition, the Oral Health Collaborative implementation manual is available on NNOHA’s website at http://www.nnoha.org/resources.htm.