THE ADVANTAGE

The Advantage Community Newsletter

NEW AGENDA!

Join us for this year's

2016 SUMMER MEETING

JULY 29TH, 30TH & 31ST

GROWTH

A Mission with Integrity

To provide dental leadership, service and access to care to our communities in an entrepreneurial, sustainable and professional manner.

INSIDE THIS ISSUE:

From Where I Sit

BY Mike Shirtcliff, DMD,
PRESIDENT, FOUNDER, INTERIM CEO

As many of you may have heard, Tom Tucker has been ill and is on medical leave. In the interim, I have resumed the president duties until his return. Thank you for bearing with me as my schedule is updated to reflect this change.

DentaQuest

Some of you may be curious about the status and meaning of the Advantage Dental/DentaQuest transaction. Advantage has been looking for a capital partner for several years. The need for this is due to current owners getting older and wanting to take their equity out and the need for capital to grow. Advantage Consolidated, LLC, (the owner group) is selling apart of the Holding Company to meet this need.

Looking at what assets Advantage has that would interest a capital partner, the Medicaid Managed Care Program has value in the new Affordable Care Act healthcare environment, as does the ownership model. DentaQuest is interested because the federal government and the states are looking for alternative solutions for the Medicaid marketplace, especially those like the Oregon program.

Advantage signed an agreement with DentaQuest at the end of last year with several contingencies. The major ones being governmental approvals, namely from the Oregon Health Authority (OHA), the Federal Anti-Trust Act, and the Oregon Insurance Division. The OHA and Federal Anti-Trust approvals have been received; more complicated is the Insurance Division approval. It required a public hearing, a 14 day public commentary period, time for the Commissioner to approve the transaction and once approved, a 60 day mandatory waiting period. We are hoping for approval by the end of June, which should set the closing date for the transaction to be late August, early September.

The Future

I was asked to give a 5-7 minute talk on the future of dentistry and what we could expect. Here are some of my reflections. The ADA has been discussing the current market and how the public is not buying what dentistry is selling, so we need to figure out other things to do. Figures point to the fact that dentists are seeing more patients, at an earlier age than physicians do, so dentists could be taking blood pressure, doing diabetic screenings and immunizations, etc. in the face of the current primary care physician shortage.

Baby boomers are retiring and buying less dentistry and the millennials don't have as much decay. The people who have dental problems are those on Medicaid, the working poor, the elderly poor and the disabled populations. The problem is in the traditional way of dealing with decay, seeing the dentist on a regular basis and catching problems when they are small does not work well for this population. This population traditionally does not have small problems, so they end up with dentures.

Those in charge of healthcare at the government level believe that 30% of what is getting done is not necessary and 50% of what they want done is not getting done. They are not happy that the price goes up 10-15% per year. As a result, they are working on transforming the healthcare delivery system including dentistry. They are trying to do so by creating patient-centered health homes and accountable care organizations (ACOs), pushing all providers into electronic health records, performance measures for hospitals and others, and the integration of behavioral, physical and oral health. They are moving away from hospital-centric specialty care to patient-centered health home.

What these leaders want is a group of providers, hospitals, physicians, mental health providers, oral health providers, physical therapists, durable medical equipment and non-medical transportation, etc. formed into an ACO. This is defined as a group of providers taking care of a group of patients to

From Where I Sit Continued:

produce certain outcomes tied to a global budget. They are starting with Medicaid and Medicare patients because 10% of the recipients spend 70% of the medicaid budget and 80% of healthcare costs are spent in the last two years of a patient's life mostly through medicare.

A huge contradiction in the healthcare industry is taking place. The small fish are getting swallowed up by the large fish and the large fish are getting swallowed by the giant fish. We are seeing many mergers between insurance companies and hospital systems, with PacificSource/Legacy Health and Trillium Health Net/Centene an example and physicians are going to work for larger healthcare systems and group practices.

Commercial control in dentistry is being taken over by retail companies like Aspen Dental, Smiles Dental and Affordable Dental etc. Dental student debt is averaging close to $300,000 per year with $400,000 not uncommon. Younger dentists are going to work for dental service organizations and older dentists are retiring when they can, rather than change to adapt to the new system. Rural communities are having a harder time finding dentists willing to locate to their areas so Federally Qualified Health Centers are putting in dental clinics.

States are beginning to realize that contracting with managed care companies (MCOs) makes more sense because it is easier to achieve compliance through them than to try to get organized dentistry and its individual members to change. It is more efficient to get to get the MCOs to produce the outcomes they are looking for. If the individual dentist is not willing to do what the MCO needs to maintain its contract then they find another provider who is or they put in one of their own clinics. The government is interested in healthier people as much as they are in repaired people. Individual fee for service dentists are not able to do this. Remember in the new world a cavity and filling is a failed outcome. Oral disease impacts the overall community healthcare dollars spent. Hospital emergency care costs an average of $1,000 a visit and the total US cost is over $3 billion. The average cost for a hospital treatment for dental restorative work can be $4,000-$6,000 per case for the OR, anesthesia and supportive OR costs. The dental costs can be $2,000-$4,000 per case. No one knows for sure what the medication costs, let alone lost time for school, work and physician and pharmacy costs are.

The future is going to be prevention, affiliation and integration to accomplish the triple aim of better overall health, a better patient experience at a better cost.

NEW AGENDA!

This year's Summer Meeting includes the following new events:

- Friday and Saturday CE classes
- Friday night Social
- Saturday morning 5K fun run
- Saturday evening ASK Raffle/Auction
- Sunday wrap up with golf scramble at The Ridge course

Register Here:

www.AdvantageDental.com/summermeeting2016

This year's selection of CE courses includes:

Nitrous
CPR
Risk Management
Pharmacology
Medical Emergencies
Record Keeping
Digital Impressions
Silver Fluoride
HR Laws
Compliance
Composites and Bonding
Updates from the BOD
Posterior Composites
Sealant Certification for EFDAs
Privacy & Security
Bone Grafting & Advanced Implants
Trauma Informed Care
OSHA & Infection Control
And More!

Oregon Health Plan (Medicaid) Provider News

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

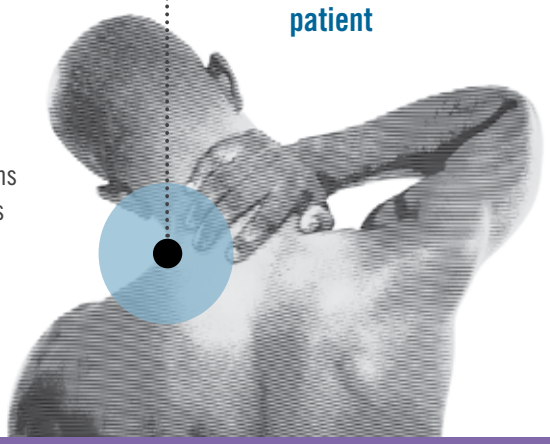
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- **Opioids are not first-line or routine therapy for chronic pain**
- **Establish and measure goals for pain and function**
- **Discuss benefits and risks and availability of nonopioid therapies with patient**



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

Oregon Health Plan (Medicaid) Provider News

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7 Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

Recommended Opioid Policy for Dentists

Pain management is routinely required for some dental procedures. Patients must receive respectful care and appropriate management of dental pain. Most often, dental pain management is for acute or episodic situations, requiring short-term prescribing. For many conditions, ibuprofen, acetaminophen, or a combination of the two will suffice for dental pain. In other circumstances, a very small amount of narcotic medications followed by OTCs will provide appropriate pain relief.

General Guidelines

1 Prescribe opioids cautiously to those with a substance abuse history.

2 Ask if patients are getting medications from other doctors, and use the PDMP prior to prescribing opioids whenever possible.

3 Do not prescribe opioids to patients in substance abuse treatment programs without consulting the program's medical staff.

4 Do not offer prescriptions with refills. Use caution if replacing prescriptions that were lost, destroyed, or stolen.

5 Prescribing over the phone is discouraged, especially with patients you have not met, except in rare cases involving known invasive surgery.

6 The use of non-combination opioids is discouraged.

7 If prescribing opioids, prescribe pills only in small dosages, which in most cases should not exceed 16 tablets.

8 When prescribing an antibiotic with the opioids, stipulate that the narcotic must be filled with the antibiotics at the pharmacy.

9 Inform patients how to secure medication against diversion and how to dispose of leftover medication.

10 Narcotics should not be prescribed more than seven days after the last appointment. It is strongly recommended that the patient be assessed in the clinic prior to providing narcotic (same or different narcotic) refills.

11 A second refill (same or different narcotic) request should require that the patient be assessed in the dental clinic and only be provided once a supporting diagnosis to continue with narcotic pain management is established.

12 Third refills are strongly discouraged (except in unusual clinical circumstances that are well documented, such as osteonecrosis management); consider need for chronic pain management by physician.

13 Prolonged pain management (while awaiting specialty care) should be managed by and/or coordinated with the patient's primary care provider.

JAMA Article: Cannabis use associated with periodontal disease

From the ADA News, June 01, 2016

People who use cannabis for up to 20 years may be more likely to have periodontal disease, according to research published in June in The Journal of the American Medical Association Psychiatry.

Using self-reported data on cannabis and tobacco use, the longitudinal study compared health outcomes in persistent cannabis users versus tobacco users and found cannabis usage associated with poorer periodontal health at age 38, and within-individual decline in periodontal health from ages 26 to 38 years. Cannabis use was not, however, found to be associated with other physical problems in early midlife, according to the open access article.

The authors conclude that the study results imply that "(1) cannabis use for up to 20 years is not associated with a specific set of physical health problems in early midlife. The sole exception is that cannabis use is associated with periodontal disease; (2) cannabis use for up to 20 years is not associated with net metabolic benefits (i.e., lower rates of metabolic syndrome); and (3) the results should be interpreted in the context of prior research showing that cannabis use is associated with accidents and injuries, bronchitis, acute cardiovascular events, and, possibly, infectious diseases and cancer, as well as poor psychosocial and mental health outcomes."

Relatedly, a case report in the May issue of The Journal of the American Dental Association about a patient who sought treatment five hours after using cannabis provides some background about the history of cannabis use. It highlights the need for specific guidance for oral health care professionals regarding cannabis use as it relates to dentists. The authors note that a greater number of Americans may use marijuana as state legislatures legalize the drug to some degree.

Drug resistance 'could kill 10 million people annually'

From Medical News Today, May 19, 2016

Antimicrobial resistance could kill 10 million people every year by 2050 - or one person every 3 seconds - unless global action is taken to tackle the problem. This is the conclusion of a final international review chaired by British economist Lord Jim O'Neill, which sets out 10 areas that need to be addressed to combat the threat of "super-bugs."

Antimicrobial resistance (AMR), or antibiotic resistance, occurs when microorganisms develop resistance to antimicrobial agents that once had the ability to kill them.

In the United States alone, these so-called super-bugs are responsible for more than 2 million infections and 23,000 deaths every year.

Clostridium difficile, carbapenem-resistant Enterobacteriaceae (CRE), and methicillin-resistant Staphylococcus aureus (MRSA) are among the biggest threats for drug-resistant infections in the U.S.

Oregon Health Plan (Medicaid) Provider News

Advantage Dental Services, LLC
The Advantage Community

To: Advantage Dental Services, LLC, Oregon Health Plan (OHP) Providers

From: Kyle House, DDS; Tom Tucker, DMD; Mike Shirtcliff, DMD

Date: May 18, 2016

Subject: State of Oregon Prescription Drug Monitoring Program (PDMP)

Enclosed is a memo sent to all Oregon licensed dentists regarding the PDMP for the State of Oregon. Currently this is a voluntary program, but it could soon become mandatory if we as OHP providers do not start participating in the program.

Many of us have noted and reported OHP patients who appeared to be abusing opioids for quite some time. Recently the federal government, through the DEA, and the state have been making efforts to do a better job regarding opioid control. Part of this process has been the drug monitoring program. The current protocol is that if you are going to write an opioid (narcotic) prescription, you should check the PDMP system. If the patient has a history that is similar to the example listed in the memo, or if anything appears out of the normal, you should determine what is best to be done in the given situation.

An important change that was made to facilitate use of this system is to allow delegates to check information on behalf of the provider. Below is from the **Frequently Asked Questions** section of the PDMP website: http://www.orpdmp.com/health-care-provider/

Who can access information in the system?
Healthcare providers and their authorized staff can access the system, but only for information regarding their own patients. Pharmacists and their authorized staff can access the system, but only for information regarding their own customers.

Please include a check of the PDMP into your prescription writing protocol. If you are unable to navigate the system, please contact the PMDP Helpdesk at 866-205-1222 or email orpdmp-info@hidesigns.com. If you have any trouble signing up or contacting PDMP, please contact Advantage Dental's Provider Relations at providerrelations@advantagedental.com or by phone at 888-480-4478 / Option 4, and they will assist you in getting connected. We have arranged for a representative from the Prescription Drug Monitoring Program office to be at our Summer Meeting to answer questions and assist providers in signing up for the program.

kh/tt/rms/cb

442 SW Umatilla Ave., Suite 200 • Redmond, OR 97756 • p 866.268.9631 • f 866.268.9618

Please welcome the newest providers to the Advantage Dental Community (January 2016 - April 2016)

Sayij Makkattil, DMD	Portland, OR
Abigial Borman, DDS	Payette, ID
Paul Concidine, DDS	Ontario, OR
Nina Kapur, DDS	Portland, OR
Susan Armstrong, DDS	Kennewick, WA
Abigail Borman, DDS	Ontario, OR
Stephanie Brown, DDS	Payette, ID
Paul Concidine, DDS	Nyssa, OR
Jeremiah Hawkins, DMD	Kennewick, WA
T Michael Hall, DDS	Lebanon, OR
Quinn Martin, DMD	Roseburg, OR
Stephen Shoemaker,DMD	Eugene, OR
Mitch Driscoll, DMD	Pocatello, ID
Kyle Isaacs, RDH, EPP	Monroe, OR
Benjamin Whitted, DDS	Molalla, OR
Reid Ketcher, DMD	The Dalles, OR
R Joseph Temple, DDS	Bend, OR
Justin Rader, DDS	Coeur d Alene, ID
Michael Scholes, DMD	Coeur d Alene, ID
David Anderson, DDS	Keizer, OR
Dain Paxton, DMD	Salem, OR
Thomas Snarr, DDS	Rexburg, ID
Steven Elkhal, DMD	Camas , WA
Ben Sutter IV, DMD	Eugene, OR
Daniel Egbert, DMD	Twin Falls, ID
Steven Elkhal, DMD	Portland, OR
William Grieve, DDS	Eugene, OR
Stephen Stanley, DMD	Grants Pass, OR
Lon Jensen, DDS	Redmond, OR
Timothy B Welch, DDS	Eugene, OR
Sarah Enright, DMD	Boise, ID
Justin Madsen, DDS	Boise, ID
Diana Pothier, DMD	Boise, ID
Michael Kim, DDS	Silverton, OR
Jessica Kloenne, DMD	Wilsonville, OR
Bradley Mortenson, DMD	Klamath Falls, OR
Larry Bybee, DDS	Pocatello, ID
Lori Killen Aus, RDH, EPP	West Linn, OR
Karli Herzog, DDS	Portland, OR

PacificSource Dental Sales Building on Momentum

By Dr. Jim Gimarelli, Director of Dental Business, Commercial Sales

I'm pleased to report that PacificSource has had some very positive growth in our dental business over the last several months. Overall commercial and government dental membership is just under 135,000 members, with commercial dental increasing over 11 percent in the last 10 months. This growth can be attributed to strong retention of business and new large group sales during this time period.

Large group retention has averaged about 90 percent over the last rolling 12 months. In addition, we sold 12 large group dental clients in 2015 -- each with more than 100 employees.

As of June 2016, we have an additional 12 new large group dental clients, eight of which have more than 100 employees.

Our Sales team has really begun to embrace our dental product, and PacificSource is in the process of transitioning our internal thinking about dental from "ancillary" to "core."

Our dental marketing message continues to focus on prevention, strong network, in-depth product portfolio, coverage for the entire family, and superior claims and customer service. We look forward to more growth as the momentum for our dental product continues to climb, both internally and externally.

The PacificSource Legacy partnership is expected to be finalized in August.

Things to Know about this Partnership

- We will maintain all our provider partnerships. We will continue to work with all our existing provider partners throughout Oregon, Idaho, and Montana. We will also continue to pursue future relationships with other healthcare providers.
- No change to existing provider contracts, processes, policies, programs, or staff. Please be assured that our processes, such as preauthorization and claims payment, will continue as usual. In addition, our name and brand will remain the same.
- For members, nothing has changed. Members will continue to receive the same outstanding benefits and unmatched customer service that have been hallmarks of PacificSource since 1933.
- As we move forward, the partnership will provide the foundation for improvements and enhancements. This includes increased access to care for communities, the creation of new and unique health plan offerings, and industry-leading stability in a volatile health insurance market.

For More Information visit:
https://pacificsource.com/media-newsroom-2015-12-23/

PacificSource HEALTH PLANS

NEW MEMBER BENEFIT PROGRAMS!

Advantage Dental is excited to announce 3 new member benefit vendors

elevate ORAL CARE

Staff Meeting

Make sure your entire staff is up to date on the latest therapies and protocols with an online Staff Meeting from Elevate Oral Care. Free CE Courses available.

Call 877-866-9113 or visit elevateoralcare.com for details.

The management team of Elevate Oral Care (EOC) has more than 100 collective years in oral health product development, most of that in the field of prevention. The Managing Members of EOC sold their prevention-based business called OMNII Oral Pharmaceuticals to 3M Corporation in 2006. OMNII was responsible for many first in dentistry including the first stannous fluoride gels and oral rinse concentrates, the first unit-dosed fluoride varnishes and the first tooth whitener. EOC is continuing this track record of industry firsts with Just Right® meter-dosed children's toothpaste, the first 2.5% fluoride varnish called FluoriMax® and the first silver diamine fluoride 38% product called Advantage Arrest®, among others.

The Program

- Discounted Platinum Pricing Plan
- Free Shipping with First and Online Ordering
- Free Educationally Based CE

Elevate Oral Care extends our Platinum Pricing Plan for our growing product line to all offices contracted with Advantage Dental*. Platinum Plan discounts provide savings of 5% to 20% off of our retail pricing. As a direct seller of products our products are already well positioned in price against distribution-based options.

An included benefit for Advantage contracted offices is FREE SHIPPING on all first orders, and for all orders placed through our on-line ordering system.

In addition, our dental industry market model is based on office education of the latest prevention science, protocols and best practices. Managing Members of EOC are active in the dental research and oral health policy communities nationwide. We help develop new prevention products, and contribute to best practices like CAMBRA. We extend to Advantage contracted offices the offer to conduct timely web-based, interactive educational staff meetings from our team of Prevention Specialists, which could include lunch. Go to www.elevateoralcare.com and click on the staff meeting button to request. We look forward to playing a part in the oral health improvement for your practices and the patients you serve.

*Owners of Advantage will receive a steeper discount on the Advantage Arrest product.

For more information contact:

Kevin Thomas

346 Pike Road, Suite 5 West Palm Beach, FL 33411

HIPAA PRIVACY AND SECURITY COMPLIANCE SUBSCRIPTION FOR INDEPENDENT DENTAL PRACTICES

Apgar & Associates provides expert privacy, information security, HIPAA, regulatory and electronic health information exchange consulting services. Our comprehensive and practical effective solutions help you protect the privacy of your clients and customers, comply with complex regulatory requirements,and expand your use of health information technology.

The subscription is ideal for dental offices with one or two providers that have neither the time nor resources needed to devote to HIPAA compliance. The subscription-based package allows for expert, personalized service from Apgar and Associates, as well as:

- An initial privacy and breach compliance assessment and security risk analysis
- A remediation plan and timeline specifc to our findings with supporting expert remediation assistance
- Secure, cloud-based compliance documentation

New Member Benefit Programs cont.

and action management technology
- Customized, current policies and procedures- privacy, security and breach
- Webinar-based workforce training and testing on HIPAA and state-specic laws
- Monthly check-in calls to review remediation progress, troubleshoot and discuss HIPAA challenges
- End-year follow up privacy compliance assessment, security risk analysis
- Updated remediation plan

We are happy to offer this model to offices contracted with Advantage Dental for $275 per month - almost a 7% savings from our customary small provider cost of $295 per month. Please note that a 12 month subscription is required; payments are debited monthly.
For every annual subscription that a contracted office decides to make, Apgar will donate $10 to the Advantage Smiles for Kids (ASK) program.

For more information contact:
Julia Huddleston (503) 384-2538
jhuddleston@apgarandassoc.com
www.apgarandassoc.com

ADVANTAGE DENTAL AND BENT ERICKSEN & ASSOCIATES NEW MEMBER BENEFIT PROGRAM

Eugene, OR—Advantage Dental and Bent Ericksen & Associates are pleased to provide a partnership that will bring Human Resources and Employment Compliance support and resources to Advantage Dental contracted providers.

Bent Ericksen & Associates, the #1 provider of human resources and employment compliance products to the healthcare field, will provide their proven "HR Director Package" in partnership with Advantage Dental members and practice owners.

Advantage Dental contracted providers will benefit by having a comprehensive, web-based, HR tool-set that ensures compliance with ever-changing federal and state laws. With the HR Director, human resource solutions become a click away. The HR Director includes all of the tools to help effectively manage personnel issues and employment compliance needs. The Personnel Policy Manual alone contains over 80 pertinent and comprehensive policies that are state-based and employee threshold specific, required by law, make good common business sense, as well as discretionary policies unique to each business.

In addition, the HR Director includes job descriptions, personnel forms, and resource guides on hiring, staff management and wage & hour compliance. HR Experts are a phone call or email away to guide dentists and office managers step-by-step through the legal minefield of HR topics such as Terminations, Pregnancy Leave, Performance Reviews, and Continuing Education Pay.

A message from Alan Twigg, Vice President of Bent Ericksen & Associates:
"We are thrilled to partner with Advantage Dental. Today, the trends do not bode well for employers: labor-related lawsuits are more common than malpractice claims; in He-Said-She-Said cases, employers lose over 85% of the time; and the average out-of-court settlement in dentistry is $25,000. Our goal is Prevention, and we know from experience that when a practice's "HR House is in order" the results are time saved, reduced stress, less employee turnover, higher production, and peace of mind."

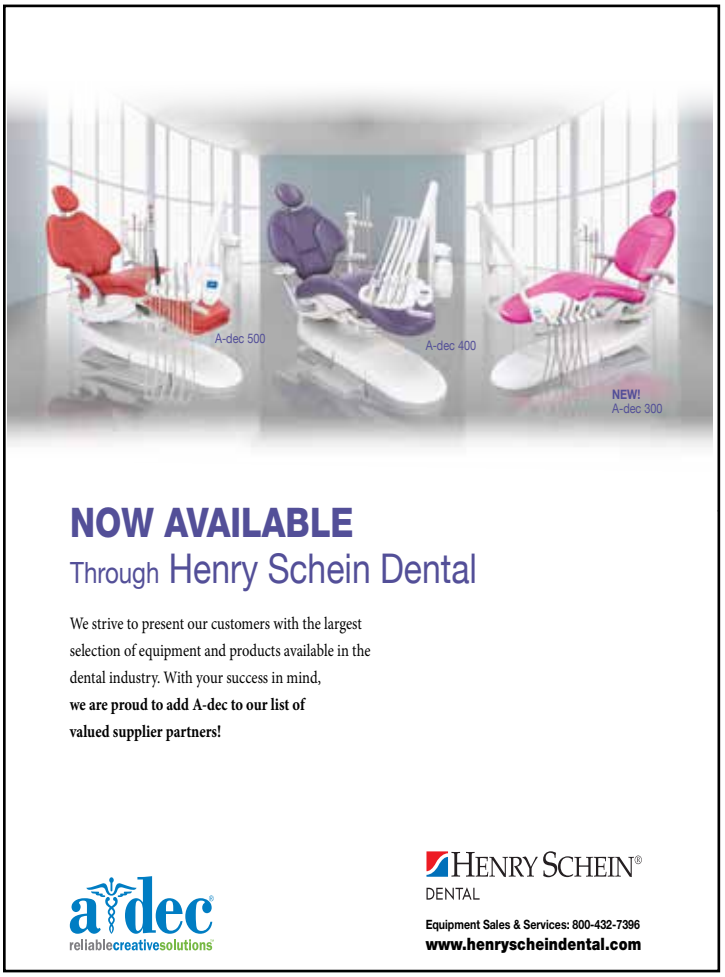
For over 30 years, Bent Ericksen & Associates has distinguished itself as the leader in employment compliance and human resources for healthcare professionals. Focusing exclusively in the areas of human resources, staffing issues, employment compliance—a critical element for all dental practices—Bent Ericksen & Associates' products and support services are an essential resource in preventing trouble and financial hardship.

For more information contact:
Bent Ericksen and Associates
800/679-2760 or 541/685-9003
info@bentericksen.com
P.O. Box 10542, Eugene, OR 97440.
www.bentericksen.com.

Member Benefit Vendors

All members of Advantage Dental ARE ELIGIBLE TO RECEIVE THE FOLLOWING DENTAL BENEFITS FROM HENRY SCHEIN:

- 10% Cash Rebate on qualifying Merchandise and Small Equipment
  - Rebate will be paid quarterly in the form of a check if quarterly purchases reach or exceed $5,000.00 from our catalog of over 90,000 products
- Privileges Status
  - Labor discounts, special promotions, extended warranty and Privileges Points for electronic ordering at the applicable Privileges level
- Guaranteed Service Response
  - Privileges Customers receive a 4 hour response time for in-office emergency repairs or we pay the labor (some geographical restrictions apply)
- Access to Exclusive Products
  - Henry Schein is the exclusive distributor for Dentrix, Dexis, i-Cat, Camlog, Colgate, Arestin, DemandForce, Ortho Organizers and E4D as well as many other products from more than 175 vendor partners
- And many more - Speak with your Henry Schein Representative for all the details



Henry Schein is the world's largest distributor to office based practitioners with over 800,000 total customers. Henry Schein is number 296 on Fortune's Top 500 companies, as well as one of Fortune's Top 100 most admired companies.

If you would like to learn more about how Henry Schein can help you achieve greater success in your practice, please contact Regional Manager, Steve Gunson at robert.gunson@henryschein.com or call 503.682.2609

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coriant
Workflow Solutions

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Coriant is a sales and marketing team specializing in print, marketing, branding and print-to-mail solutions. We look forward to applying our expertise, technology and a powerful distribution network to help customers do business faster, smarter and more cost efficient.
Contracted offices can save from 2-8% on their purchases depending on the purchase amount. You can save on printing solutions, marketing materials & services, promotional & branded products and giveaways, business documents, scrubs and much more. For more information contact Gale Slaughter at gale@e-coriant.com.

Member Benefit Vendors

Local Fresh Marketing is a leading designer and online marketer of dental websites. In addition to eye-catching, dynamic and multi-functional website applications, Local Fresh offers connectivity solutions to the Internet in order to improve search rankings, and to drive traffic to the practice. Local Fresh programs also help dentists build their reputation and patient loyalty online.

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Local Fresh extends a 10% discount to Advantage Members off its published 2016 rate sheets, including any ongoing marketing services to help promote the practice online.

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Simply call Ian Johnstone at 971-244-4466 or email at ianj@enviroshrednw.com
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*Contact Ian Johnstone for specific price details, as some outlying locations may have additional costs for pickup.

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The firm's flat-fee services, before discount, are:

- Entity Formation.
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- Retirement Plans. Our fee for establishment of most retirement plans is $1,250 for a new or restated plan.
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Contact Derek D. Simmons or B. Kevin Burgess at Watkinson Laird Rubenstein, P.C., at (541) 484-2277 in Eugene, (541) 673-5528 in Roseburg, (541) 295-3218 in Grants Pass, or (541) 923-8767 in Redmond for further information.

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Patterson Dental
Patterson Dental offers Advantage Dental Members a no-obligation complimentary upgrade in the Patterson Advantage program. Silver Level customers are upgraded to Gold Level, Gold Level customers are upgraded to Platinum Level, and Platinum Level customers are upgraded to Diamond Level.

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Advantage Credit Services manages accounts receivable, helps the practice to provide patient financing and offers assistance for the front office team.

Tesia
Advantage Dental providers receive three months of FREE unlimited claims submission (including paper claims printed and mailed). Following that, you will only pay $39.95 per month for unlimited claims submissions.

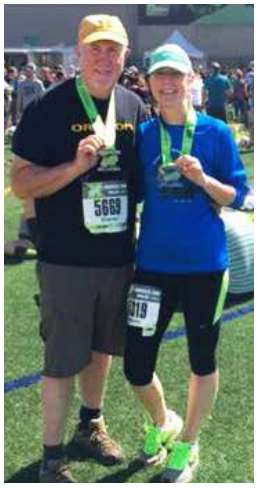
Computer Habits
Computer Habits offers Advantage Dental members a 10% discount off of their hourly rate for IT Services.

If you would like further information about these programs or other member benefits please email: marketing@advantagedental.com

Caring Professionals Providing Orthodontics for At-Risk Youth Throughout Oregon

ASK Facts:

- The estimated high school graduation rate of children in the ASK program is 95%.
- The 2014 graduation rate for Oregon is to 72%.
- Marion County has the highest number of children in the ASK program followed by Klamath and Jackson County.



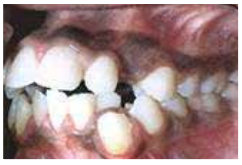
Dr. Dane Smith and his wife Boni Smith

May 1, 2016 2016 EUGENE MARATHON EUGENE, OR

The ASK Team completed the Half Marathon and raised over **$5,000** for Advantage Smiles for Kids.

Thank you to all of the generous donors/supporters.

ASK CHILD UPDATE - MEET RAMLA



Before Braces

Ramla is being treated by Dr. Darcy Cruikshank in Hillsboro, Oregon.

Ramla is described as being sweet and compassionate. She is volunteering at a community food bank.

Thank you for the donated and discounted services for ASK Kids!

Donated and Discounted Services for ASK Kids:

Dr. Alleman, The Dalles Clinic

Dr. Mike Harper, Neighborhood Health Center Dental

Dr. Jeff Burstein, Summit Oral Surgery & Implants

Dr. William Johansen, Gentle Dental

Dr. Brian Humble, Pacific Oral Surgery & Implants

Dr. T Blair Smith

Silver Falls Family Dental

Dr. Travis Schuller, Madras Advantage Clinic

Dr. Juliana Panchura, Smile Central Oregon

Dr. Todd Schock, Facial & Oral Surgery

Indian Health Services

Klamath Tribal Health

Dr. Walle, Klamath Falls Dental Specialists

Dr. James Savage, Associates for Oral and Maxillofacial Surgery

Dr. Tyler Mack, SmileKeepers

Dr. Loman, Smile Keepers

In memoriam of Dr. Dane Smith's father Edward L. Smith, members of Advantage Consolidated, Inc. donated more than **$12,000** to ASK and the Denny Turner Endowment Fund.

Annual ASK Auction & Reception

Music, Hors d'oeuvres & Open Bar

Saturday Evening July 30th

Sponsored by Elevate Oral Care

elevate ORAL CARE

5:00 pm
Eagle Crest Conference Center

Event features guest artist **Bill Hamilton**, accomplished Latin musician **Miguel de Alonso** and tastings from **Stave & Stone Wine Estates** and **Bend Distillery**. Winners of the 2016 ASK Raffle will be drawn at 8PM.

Live & Silent Auction Items Include:

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Corvallis Civil War Package with Tickets, Lodging & Dining Included

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The evening will end with the raffle drawing for the 3 trips described below.

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SANTA FE, NEW MEXICO LUXURY GETAWAY
3 Nights at Fairmont Heritage Place, $100 Dining Gift Card to La Casa Sena, Admission to Georgia O'Keeffe Museum, Airfare

WIN A TRIP FOR FOUR
DISNEY WORLD FAMILY ADVENTURE
4 Night Stay at the Hyatt Regency Grand Cypress, Airfare, $1,050 Disney Gift card

WIN A TRIP FOR TWO
CLASSIC WRIGLEY FIELD ROOFTOP EXPERIENCE
Rooftop Bleachers & Dining at Chicago Cubs Game, 3 night stay at luxury Chicago hotel, Airfare

Also New to this Year's Conference Agenda:

- **Friday Night Social** - July 29th @ 5:00 pm
  *Drink Tickets will be provided by DA Davidson
- **Saturday Morning 5k Fun Run** - July 30th @ 7:00 am - 8:30 am
  *Proceeds go to ASK
- **Sunday Golf Scramble at the Ridge Golf Course** - July 31st Tee Off @ 8:30 am

Raffles sponsored by:
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To Purchase Raffle Tickets & to Register for the 5k Fun Run visit: www.AdvantageSmilesforKids.org

Advantage Dental

Advantage Smiles for Kids

Article from Northwest Dentistry July/August 2015

THE FOLLOWING ARTICLE CAME FROM

NORTHWEST DENTISTRY

JOURNAL OF THE MINNESOTA DENTAL ASSOCATION
VOLUME 94, NUMBER 4
JULY- AUGUST 2015

Coming Clear - Patients, Poverty and Perspective

Outreach, Prevention and the "Urgent Chair"

by Cindy Shirtcliff, M.S.W.
and
Terie Dreussi-Smith, M.A.Ed.

Outreach, Prevention, and the "Urgent Chair"

Cindy Shirtcliff, M.S.W.* and Terie Dreussi-Smith, M.A.Ed.**

Each member of *Northwest Dentistry*'s Editorial Advisory Board brings his or her individual experience and interest to the journal, and our brainstorming is a pretty lively and heartfelt process. When one of our members told us about the topic "Understanding Poverty", the discussion ignited, and it was decided to invite representatives† from the "Bridges Out of Poverty" movement to share their insights and constructs with *NWD*'s readers. If "understanding poverty" feels like a rather elevated, even arrogant, viewpoint to adopt, well, we shared that discomfort. Then we got over it, put our hearts in the right place, picked a place to start, and presto (and hopefully change-o), we went ahead on that splendid "need-to-know" basis. So here is something scratch-practical we all need to know: One way or another, we are all in this together, and if we don't find a way to make that work, life, as the saying goes, will.

The Editors

Meet Our Source: The "Bridges" Perspective

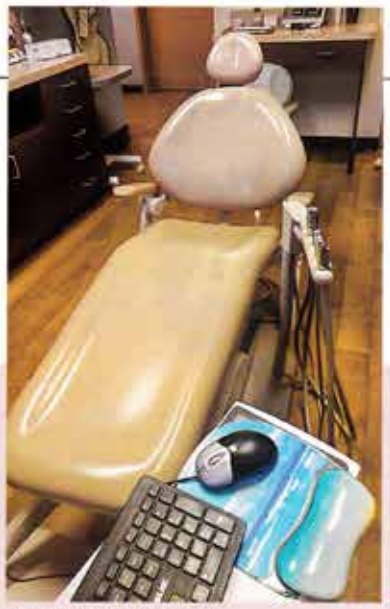
The Bridges Out of Poverty movement has grown considerably beyond the content of the 1999 book from which it draws its name.[1] This growth has stemmed in large part from the people championing and applying its tools and strategies. Bridges is not a program *per se*, but rather a continuous learning process featuring a set of constructs, tools, and strategies that has spread across 40 U.S. states and six other countries to date. It is an active, evolving, grassroots response to poverty that uses the "Triple Lens" of change through individuals, institutions, and the community. It has led to follow-up programs which engage people living in poverty, bringing all economic classes to the problem-solving and decision-making tables. In short, Bridges involves innovations that have resulted in new thinking, creative programming, and an increasingly comprehensive approach to addressing issues surrounding poverty.

The Ten "Bridges" Constructs

Basic to the Bridges philosophy are its "Primary Constructs of the Bridges Out of Poverty Lens".

1. Use the lens of economic class to understand and take responsibility for one's own societal experience while being open to the experiences of others.
2. Address inequalities in access to resources at the intersections of poverty with other social disparities (race, gender, physical ability, age, etc.).
3. Define poverty as the extent to which a person, institution, or community does without resources.

Continued on page 15



Expecting the unexpected.

About Advantage Dental

Advantage Dental (AD), headquartered in Redmond, Oregon, has developed innovative dentistry practices to build dental health equity throughout the state. Two of the models it used to define and design its practices are *Bridges Out of Poverty: Strategies for Professionals and Communities* (1999, 2009) and the later book *Bridges to Health and Healthcare* (2014).

Founded in 1994 by a group of Oregon dentists concerned with the lack of access to dental care in rural Oregon, the model AD created addressed this concern, as well as the need for affordable and effective dental insurance to groups of all sizes throughout Oregon. AD's clinics are located strategically throughout Oregon to serve the uninsured and underinsured populations. It is geographically the largest and numerically the second largest dental care organization in the state of Oregon. Advantage Dental has always been an advocate for local communities. Recently there has been a campaign to promote the medical management of caries, helping to change the traditional paradigm from "drill and fill" to one of caries prevention. ■

***Cindy Shirtcliff** is a Licensed Clinical Social Worker and the regional manager community liaison for Advantage Dental. She is adjunct faculty at Umpqua Community College, and a certified trainer in the Bridges Out of Poverty material.*

****Terie Dreussi-Smith**, M.A.Ed., is co-author of Bridges Out of Poverty: Strategies for Professionals and Communities and Bridges to Health and Healthcare: New Solutions for Improving Access and Services, and has been a national public speaker and consultant with aha! Process, Inc. since 2000.*

†Please see sidebar this page.

Cover Feature

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4. Build relationships of mutual respect.
5. Base plans on the premise that people in all classes, sectors, and political persuasions are problem solvers and need to be at the decision-making table.
6. Base plans on accurate mental models of poverty, middle class, and wealth.
7. Stabilize the environment, remove barriers to transition, and build resources at the individual, institutional, and community/policy levels.
8. Address all causes of poverty. Four areas of current research are at-risk children and youth populations; vulnerable adults; standard patients; and integrated health practice.
9. Build long-term support for individual, institutional, and community/policy transition.
10. Build economically sustainable communities in which everyone can live well.

The Tools: Motivational Interviewing

Developed by William R. Miller and Stephen Rollnick, Motivational Interviewing (MI) is an approach to counseling relationships.[2] The strategy uses non-judgmental, non-confrontational dialogue to increase patient awareness of potential problems caused, consequences experienced, and risks faced as a result of a behavior. The process helps patients envision a healthier future story, develop their own argument for change, and access increased motivation to achieve the change. The interaction is warm, neutral, and respectful of the patient's perspective.

Because MI focuses on the present and entails working with clients to access their *own motivation to change*, it can be particularly useful for individuals who live in environments of poverty centered on the "tyranny of the moment". It is a fresh approach for patients in at-risk populations because it allows the voice and thinking of the patient to be the primary change agent. In contrast, the tendency of many professional organizations is to directly educate people regarding what they need to change, why they need to change, and how they need to change, virtually regardless of patients' perceptions or contexts.

Once relationships are established, individuals tend to weigh the pros and cons of their behavior throughout the dialogue. Originally used for addictions counseling, MI is now used in smoking cessation and other health and wellness sectors to address lifestyle-related health issues.

The First Big Idea

The Bridges initiative was not the first foray into innovative practices by Advantage Dental (AD). In 2004, Klamath County Public Health launched the Klamath County Early Childhood Cavities Prevention program, based on the community's desire to more effectively address oral health. The common goal was two-year-olds with no decay. The target populations were low-income expectant mothers, and the thinking was that treating the mother-and-child dyad would have better oral health outcomes than treating one or the other separately. A dental hygienist was the case manager for the project, and she collaborated with public health officials, WIC (federal Women, Infants and Children program), dental care organizations, and local dentists.

The result after five years was that 85% of the two-year-olds were cavity-free, compared with 58.9% in other Oregon counties. The study showed a strong correlation between poor oral health and a lack of resources available to those low-income mothers living in poverty. A cluster of poverty-related risk factors, including relationship issues, mental health and emotional well-being, lack of dependable transportation, little money for gas, child care difficulties, time constraints, and other stressors, interfered with the expectant mothers' ability to get oral health care.

The lack of external resources impacting access and availability of care was a great part of the problem. The "nowness" or immediacy of poverty over a period of time when groups and families remain in deep poverty affects how many individuals view their future story, how they are motivated, and how they look at preventive health and dental care. The phrase "Dentists are for rich people" is heard in lower income neighborhoods, a powerful illustration of how marginalized, at-risk groups often feel about dental resources.

Bridges defines poverty as "the extent to which an individual does without resources". The day-to-day lives of individuals living in poverty make engagement with dental care difficult. Individuals living in poverty environments tend to be busy doing "agency time", seeking resources, and trying to meet basic needs. This makes life difficult and chaotic. The "tyranny of the moment" keeps them focused on the crisis of the now, with little time or energy to focus on tomorrow, next week, or next month. Survival needs of food, housing, utilities, and transportation often take priority over dental appointments.

AD's involvement with the Klamath study resulted in a change in thinking about how dental services are delivered to those in poverty. AD serves the Oregon Health Plan population (Medicaid), those who qualify by their low income. The Klamath Project[3] taught the team that to be the most effective they would need to learn more about the day-to-day lives of those in poverty.

One quote in particular resonated with one of our authors: "The

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Cover Feature

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healthier you are psychologically, or the less you may seem to need to change, the more you can change"[4]. She realized that dentistry asks patients with the lowest and fewest resources to make significant changes in order to fit dental health into their already chaotic lives. We want them to call ahead, schedule appointments, show up on time, fill out pages of medical history, value their teeth, brush, floss, change their diet, and care for their children's teeth, without ever considering the lack of resources in their environments. What could be done to meet these patients "where they were"? One of the Bridges constructs emphasizes the importance of stabilizing the environment and removing barriers. How would we do that in dentistry?

Knowing the value in community collaborations and non-traditional dental outreach via the Klamath Project, AD began by looking at vulnerable populations: pregnant women, young children, school-age children, mental health patients, adults with disabilities, and geriatric patients. We looked at the intersection of poverty with other social disparities in order to address inequalities in relation to accessing resources. We developed collaborations with community partners to help deliver the messages of oral health and dental health equity.

Constructs changed how we planned, how we viewed our patients, and how we came to understand how we use our own "economic class lens" to communicate with patients who have a very different experience and focus.

As we looked at the mental models Bridges uses to illustrate the concrete experience of economic class, we realized that at all levels organizations tend to design and plan from a middle-class perspective. We had always collaborated with our "community": The international Bridges community involves brilliant people from all socioeconomic classes across the U.S. and beyond to come together to forge systemic change at the institutional and community levels, giving us the opportunity to talk with people who use Bridges in health and healthcare, as well as in building sustainable communities. What we needed to add was a lens of understanding of the population we were serving: those living in poverty.

At-Risk Children and Youth Populations

In the WIC program, parents (primarily mothers) bring their young children to get recertified for benefits. AD works with WIC to place expanded-practice dental hygienists at the WIC office to perform free oral health screenings and fluoride varnish treatments on the young children from birth to age five. These screenings allow us to provide preventive services and detect problems early. We can then triage the children to their primary care dentist. Data from the assessment are entered into an electronic system, which generates an e-mail to the dentist of record and AD's case management system. This allows the case managers to help those with the highest urgency get appointments in a timely manner. When indicated, we will help the parent call from the WIC site to set up the appointment with the dentist.

We find less than one percent of these patients have urgencies of infection, pain, or rampant decay, and hope the preventive services will decrease that even more. Mothers are receptive to the screenings in this environment, where they already have trusted relationships. They almost universally express that "I don't want my child to have bad teeth like me" or to suffer from tooth pain.

Our hygienists are trained to use MI skills to promote relationship building for patient engagement. In the prenatal and/or preschool outreach setting, solicitation of what a mother does or does not know about taking care of her child's teeth begins a reciprocal conversation and avoids the paternalistic approach of "talking to" as opposed to "talking with". Here a parent may be asked, "Would you like your daughter to keep her teeth for her lifetime?" And asking a parent "When is the best time of the day to brush your child's teeth?" sets the expectation that it can happen in the future. It gives the message a future focus and helps the parent plan for the upcoming event of cleaning the child's teeth. Once a relationship is established, "change talk" can be elicited by asking someone waiting for an emergency dental procedure, "Would you like to hear some ideas about how to avoid being in the pain you're in today?" or "How does constant tooth pain interfere with things you would like to do?"

> Different environments in which we live will provide us with different insights and motivations.

The Bridges context can teach us to be aware that different environments in which we live will provide us with different insights and motivations. Not everyone is motivated by choice and future story; some are motivated by survival, entertainment, connections, and relationships. The dialogue begins with AD staff "seeking first to understand"[5]. Additionally, we have trained home-visiting nurses to apply fluoride varnish on young children's teeth while in the home

setting, reducing the barrier of scheduling a dental office visit. The hygienist also teaches oral hygiene and nutrition to pregnant mothers, offering a free dental assessment, giving out kits with toothbrush, floss, and toothpaste while triaging to care in the Prenatal Nutrition class of WIC. We promote our dental offices being able to get a pregnant woman in for an appointment within 10 to 14 days of her initial call.

Hygienists perform dental screenings on children kindergarten through sixth grade in the school setting. The school-based programs offer education to students about oral health care as well as assessments, fluoride varnish, dental sealants on permanent molars, along with kits that include toothbrush, toothpaste with fluoride, and floss. A "report card" goes home with the child telling the parent the level of urgency. We also reach out to screen Head Start children and relief nurseries.

One Head Start hosts a health fair at the beginning of the school year that includes a physical, vision screening, and oral health screening. If a child is reluctant to participate, we have him or her watch peers receive assessment and fluoride. Of the approximately one percent of these children who have urgencies of pain or infection, with the electronic data system, some can get triaged to care the same day.

Language and Relationship Building

We know there is little significant learning without significant relationships, and we continually assess the language registers, non-verbals, and communication styles that we use, while appreciating that not everyone will use and understand formal language registers. The Bridges language and communication concepts help us improve patient engagement while improving outcomes. This may seem like more time and funding are being used, but in the long term money is saved, or it is a budget-neutral strategy.

We need to be aware that in poverty and related environments, information may be mainly communicated within an 800-word vocabulary called "casual register". This is accompanied by a circular story structure that may not have information sequenced in terms of beginning, middle, and end. Casual register and story structure allow for good relationship building, but if one of our staff should glance at her watch, we know the relationship with that patient probably is broken. It may take longer to communicate with patients who don't use the middle-class formal register and sequenced two-minute "get to the point" discourse pattern. Therefore, it is vital to structure services with time flexibility to ensure that all patients know they are both "seen" and heard.

We know there is little significant learning without significant relationships.

The Hidden Rules of Poverty

Many living in poverty have their own "hidden rules" about oral health. Examples include:

- "I only go to the dentist if I have a toothache."
- "I expect to lose my teeth someday."
- "It's just their baby teeth."
- "Going to the dentist costs too much."
- "Dentists are for rich people."

Most of the women in the Klamath Project appeared to believe they must be lucky or rich to have good teeth.

One aspect of Bridges that helped us here was the understanding that even though doing "agency time" - going to various organizations for help - assists under-resourced individuals in gaining access to services, there tends to be considerable distrust of organizations and "authority". We understood the environment and the "hidden rules" of poverty enough to respect the story and experience of each person we encountered.

Reasons parents were not accessing care ranged from transportation issues to substance abuse treatment to doing agency time to domestic violence. The most common reason for not taking the child to the dentist was the parent's own fear of the dentist. One mother stated, "Well, she isn't complaining that it hurts", offering an opportunity to help her understand our main message, that her child could keep her teeth for the rest of her life. The pain and embarrassment of missing teeth and gum disease have been experienced from generation to generation for many in poverty.

Our goal is to keep interventions from being punitive. Our concern is that if it becomes punitive, some parents would stop consenting to the school preventive services. That said, as mandatory reporters, we will report to Child Welfare when appropriate and as necessary.

Integrated Health

Oregon launched coordinated care organizations across the state in 2012 to integrate physical health, oral health, and mental health. The goal of this integration was to meet the triple aim of improving patient experience of care, improving population health, and reducing costs of care. The rural poverty population in Oregon is not very diverse ethnically in most areas, but there is a high rate of poverty.

Vulnerable Adults. Our Coordinated Care Organization (CCO) team developed an expanded

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care clinic for individuals with co-morbid conditions of diabetes and severe and persistent mental illness. We integrated a hygienist to work alongside the physician to do oral health screenings and education.

At an Integrative Administrative Workgroup of the CCO meeting, the Executive Director of Mental Health and one of the authors brainstormed the idea of doing oral health screenings in the mental health setting. On the first day of screenings in this setting, they discovered two patients with abscessed teeth. Now, if we find patients whose mental health diagnosis interferes with their ability to access care, the mental health organization will assign a case manager to help them get into their dental home.

A local brokerage case-manages 250 adults with disabilities. We ask that caregivers of the patient come to the screenings so we can help educate them about oral health care for the patient, and we distribute toothbrush kits and triage to care as needed. Many of these patients are more comfortable with the screening outside of the traditional dental office.

The Urgent Chair

Understanding that many in poverty have difficulty doing future planning, knowing that most have had limited dental care/coverage, and being aware of their hidden rules about their teeth, we realize that every day there will be a certain number of patients who will have unexpected emergencies. In each of our 35 clinics, we plan for such urgencies by having a third chair and emergency time set aside for patients in pain. During one week this past spring, in 18 clinics we handled 327 emergencies. We also have a special fee and financing for anyone with an urgent situation who is uninsured. Our policy of turning away no one in pain due to inability to pay allows us to treat patients in the appropriate setting instead of having them end up in the hospital emergency room.

A tool we use every day is the Bridges resources model that reminds us that each patient has strengths and is a problem solver. This includes assessing financial resources, of course, but goes beyond this to looking for strengths in cognition, coping skills, spiritual and cultural strengths, physical health, and the extent to which the patient has bonding social capital (our inner circle of friends and family) and bridging capital (those beyond our circle who support our health, wellness, and other areas of sustainability). As individuals, institutions, and communities, we seek to build more than dental health; we are building critical resources together with our patients.

Conclusion

Author Robert Sapolsky[6] tells us "human relationship is a sledgehammer that obliterates every societal difference". The Bridges Out of Poverty concepts are helping us to not just remove barriers, but cut them down at their roots. Rapport-building with organizations and engaging them to help spread the message that decay has a bacterial cause that is generally transferred from the primary caregiver (usually the mother) to the child through saliva is paramount to the outreach model being successful. We want to help spread the word about oral health across the lifespan from prenatal to end of life.

Finally, we have found that taking oral health science to the people in their own particular locations allows us to touch more lives outside of the traditional oral health care setting. ■

References

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3. Journal of Public Health Dentistry, Summer 2008.
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"Of all the preposterous assumptions of humanity over humanity, nothing exceeds most of the criticisms made on the habits of the poor by the well-housed, well-warmed, and well-fed."

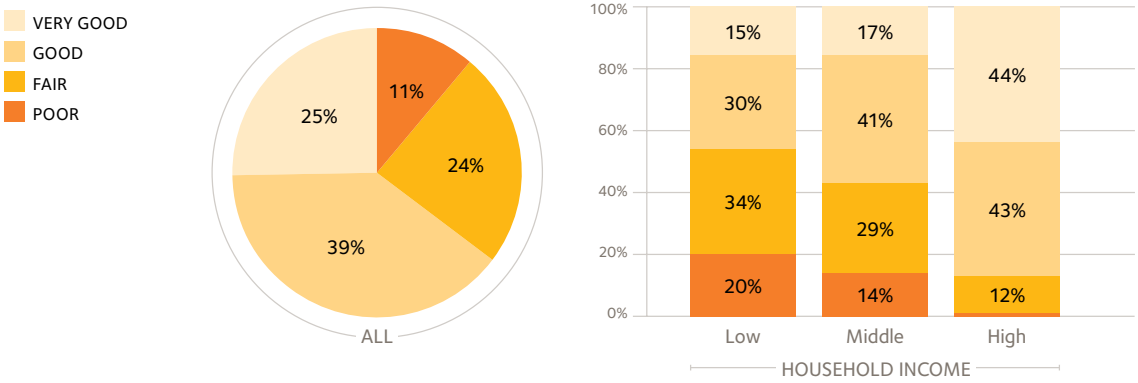
Herman Mellville

Oral Health in Oregon

Oral Health and Well-Being in Oregon

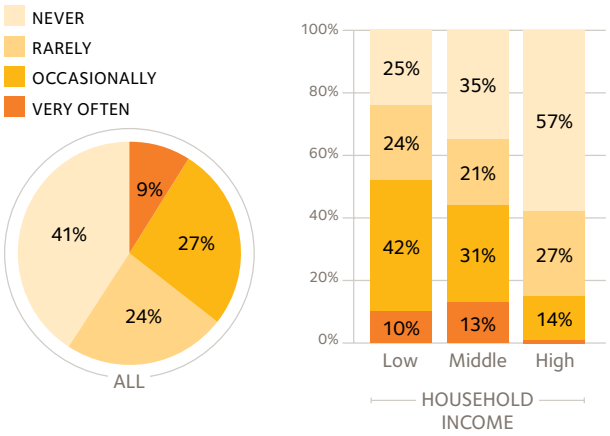
How do adults in Oregon view their oral health? This fact sheet summarizes select data on self-reported oral health status, attitudes and dental care utilization among Oregon adults as of 2015, by income level, based on an innovative household survey. For methods and sources, visit ADA.org/statefacts. For more information on the ADA Health Policy Institute, visit ADA.org/HPI.

Overall Condition of Mouth and Teeth

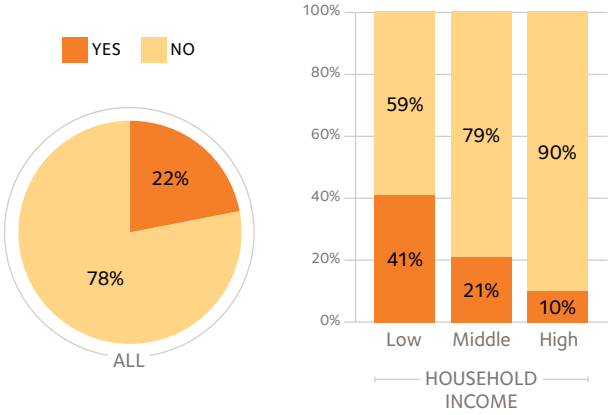


1 in 5 low income adults say their mouth and teeth are in poor condition.

Life in General is Less Satisfying Due to Condition of Mouth and Teeth

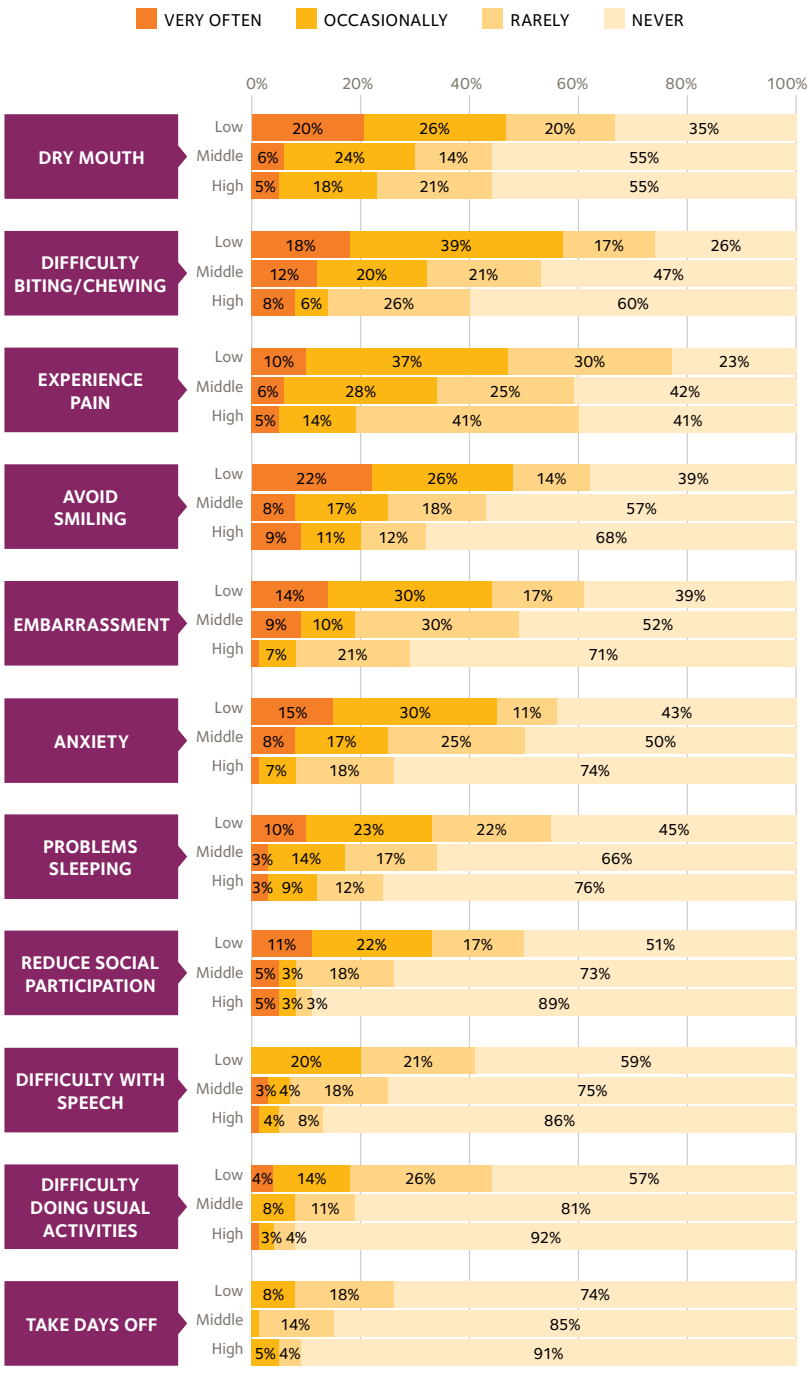


Appearance of Mouth and Teeth Affects Ability to Interview for a Job



Oral Health and Well-Being in Oregon

Problems Due to Condition of Mouth and Teeth, by Household Income



Low income adults are most likely to report having problems due to the condition of their mouth and teeth.

The top oral health problem for low income adults is **difficulty biting and chewing.**

48% of low income adults avoid smiling due to the condition of their mouth and teeth.

19% of high income adults experience pain due to the condition of their mouth and teeth.

19% of middle income adults feel embarrassment due to the condition of their mouth and teeth.

33% of low income adults reduce participation in social activities due to the condition of their mouth and teeth.

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