

2022 (S4486) and was referred to the Committee on Finance in June 2022. One critical aspect in the House bill refers to including a process for measuring outcomes and effectiveness, although specific metrics have not been identified. The impending over-arching legislation provides fuel to speed up the decision on how best to measure OHL and oral health outcomes. On a broader scale, the Senate bill incorporates the recently updated Quintuple Aim of Healthcare. In addition to striving toward improving outcomes, lower costs, better health, and clinician well-being included in the Quadruple Aim, increasing health equity is part of the vision to optimize US healthcare. As oral health literacy is encompassed within the realm of health equity as a determinant of health, systems engaged in improving health equity must coordinate general health and oral health care to meet this goal.⁶

While this may seem a daunting task, there are steps that dental hygienists can take in our daily practice as we interact with individual patients. As is often the case, change often begins at the grassroots level. Implementing strategies to increase the ability of patients to navigate and access care need not be difficult nor expensive. We can assist patients by using plain language in our clinical conversations. We can work within our practices to assure that adequate signage and parking at the point-of-care facilitates patients who may struggle with finding our offices. When possible, provide sliding fee scales for patients who are under- or uninsured to reduce the financial burden for potential patients. Having a “real person” answer the phone, an interpreter service available for patients requiring language assistance, written materials written at a 6th grade reading level and available in the predominate languages spoken in your geographic area can make a difference.

When you are ready for a larger commitment, establish a monthly screening program at community sites to reach the most vulnerable and least likely to self-initiate care. Private practices initiating a relationship with a collaborative dental hygienist can facilitate preventive care in community settings and create both the trust and resources needed to refer patients for restorative treatment. For more details, toolkits are readily available online that provide oral health literacy best-practices.⁷

In conclusion, the frameworks that integrate general and oral health care are promising. Yet much work is left to be done at the grassroots and systems levels that begins with agreeing on process and outcome measures. The many moving parts that comprise healthcare in the US make change slow and cumbersome. Yet, change only occurs when those with similar goals put forth the coordinated efforts required to move the dial. Be the change you want to see!

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Erratum

Correction to Bosma, ML, et al. (2022)

In the article “Efficacy of Flossing and Mouthrinsing Regimens on Plaque and Gingivitis: A randomized clinical trial, by Bosma, ML, McGuire, JA, Sunkara, A, et al. *J Dent Hyg*. 2022 Jun; 96(3):8-20. PMID: 35654568 <https://jdh.adha.org/content/96/3/8>, there was an error in Table V, page 17, sample sizes for “Week 12.” The correct sample size (n) for the 4EO mouthrinse group should read 40, the correct sample size for the Professional flossing (FBH) group should read 35, and the correct sample size for the Supervised flossing (FUS) should read 38.