

**Ryan White CARE Act 2006 Grantee Conference**  
**Meeting Notes**  
**Weds. Aug. 30, 2006 Session for Community-Based Dental Partnership Grantees**

**Introduction and Program Overviews**

Barry Waterman welcomed the participants to the meeting. Barry noted that the session was intended for community-based dental partnership grantees and their partners. He noted that the session was intended to allow grantees to share experiences and generate ideas for their programs. A presentation was scheduled on the results of a SPNS (Special Projects of National Significance) 5-year outreach initiative to get people living with HIV/AIDS (PLWH/A) into primary care.

Barry noted that project officers (PO) would be showing up throughout the day, offering an opportunity for grantees to meet with their PO. Additionally, Dr. Deborah Parham Hopson and Dr. Rafi Morales would greet grantees.

Barry noted that it was the 4<sup>th</sup> year of the program. He congratulated the grantees on their efforts, and noted that the session would provide the time and safe space to brainstorm and share experiences with challenges. Each grantee is in a different stage, but all encounter the same issues to varying degrees.

The goals of the session are to address challenges, share successes/innovation, develop networks, and engage in problem solving.

Dr. Karen Yoder, the facilitator of the session here as a member of the CCPH Consultant Network, introduced herself. She noted that she has seen how dynamic the programs are, the ways in which they have fostered the involvement of dental students in your goals of increasing care for PLWH/A. Karen stressed the importance of taking home an action item from the session and accomplishing it once the grantees return to their programs.

Barry introduced Dr. Parham Hopson, the Associate Administrator of the HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA). Dr. Parham Hopson welcomed the opportunity to meet the grantees of the community-based dental partnerships program. She said that when she worked in Title III, Barry explained the importance of oral health care to providing comprehensive services to PLWH/A. As head of Title III, then as head of DCBP, and finally, as head of the Bureau, Dr. Parham Hopson has stressed the importance of providing oral health to PLWH/A. She referenced Dr. Duke's opening address at the conference as indication that she too is aware of the importance of oral health care. Dr. Parham Hopson recognized the quality of work within the dental partnership programs, and thanked both the grantees and Dr. Waterman for their roles in carrying out this program.

Barry responded that good ideas do not see fruition without support from above, and he stated that it was a pleasure to work for Rafi and Deborah.

Karen reviewed the agenda with the group. The first part of the session focused on presentations of one success and one challenge from each grantee, followed by a discussion of the lists.

George Clifford—Two years ago, we were lead applicant with a dental residency program; since then we lost our residency program, which made us ineligible to serve as the grant recipient. Then (Ft. Lauderdale) Nova took over as lead applicant (we are in upstate New York). In addition to the challenge of distance, we have faced a turnover of key staff. We lost our dentist, but we have been successful in recruiting a full-time bilingual dentist. We're still in the learning period. We're negotiating with dean from NOVA's dental school, and our dean in the medical college for a long distance residency program. One significant success—we went to the legislature (we were facing capacity restraint) and the legislature funded a new dental sweep, a state-of-the-art facility. We have only one dentist, but we have 3 dental chairs, so there is capacity for the residency program with NOVA. Regarding where we hope to go—there's a disconnect between being able to prove that oral health care has a positive effect on health outcomes. Since we use an interdisciplinary team approach, we're going to see if the patients active in dental care will have better viral load and CD4 counts.

Comment: I had an NIH RO1 grant to study that same thing. The results were looking positive, and then HAART came along, which masked much of the benefits from the dental program. We also studied the impact of doing a root canal for PLWH/A on CD4 and viral load. Root canals are every bit as likely to be successful in someone with diminished CD4 count and high viral load as someone without.

David Rosenstein—We were the primary site for PLWH/A dental care for many years, and I didn't think that role was going to change from the grant. Starting in 1995, our patients were quite well, much more so than the early years. I've been talking to the Title III program, and I didn't understand why we weren't getting a lot of really sick patients. Working with a CBO and a Title III program formally made an enormous difference. Our patient count increased from 250 to 550 with the grant. Having outreach workers on the payroll was a large part of this increase. We reached out to 3 hygiene schools. The discrimination factor was high in Oregon. It was tough to get students from the hygiene schools through our clinic. What we're having no success in measuring is student perception toward PLWH/A (complications with institutional review boards, or IRBs). Measuring a change in attitudes is a challenge.

Comment: Our IRB must be better. We have anonymous survey—it's done in a classroom setting and we're close to getting everybody [to respond]. The surveys can't be traced back to individuals.

Comment: Part of our evaluation includes consent to talk to us at a later date, to see if their attitudes have changed. We have consent to call them to get data.

Carolyn Gray—We also face the challenge of distance between partners. Brooklyn and Tucson are where we are located. The original grant was awarded to a hospital in Tucson, AZ. Medical departments between the Lutheran Medical Center and El Rio Health Center worked with HRSA to save the grant. Our successes at this point: for the first time, patients receive care at El Rio — patients from HIV centers are getting referred for dental services. We have been able to get the

medical records on the medical side and the dental side coordinated. The medical coordinator is able to view dental health records. We have created a dental home for HIV-positive patients in Tucson. We've had a stable staff. A challenge we face is to strengthen relationships with community, to see what kind of outreach we can do to find patients.

Tom Rogers—In our area, there was a dental clinic in an Air Force base that closed down; the community-based dental clinic moved in to fill this gap. The same providers have been working with the population, some since 1992. We are working with a dental school. We have some didactic training, some role playing. The first day, we have a patient come in and talk about what it's like to have the disease. There is a discussion of legal requirements and professional duty to serve the patients. After four years of doing this, the most consistent comment we get from students is that they want more patient contact. Our biggest challenges are limited funding, and trying to work around academic scheduling. One fun aspect for me is our partnerships internationally (Nicaragua); we'd like to expand this.

Question (Karen): Has problem-based learning been used by any of these programs? If you give people a case, is the school willing to give you more time for patient contact? [Some participants answered yes, they have problem-based learning.]

Question (David): [Regarding hygienist unwillingness to treat PLWH/A] If the hygiene student would have been afraid to treat an African-American patient, would your reaction be the same?

Answer (Tom): I'm not sure. I've never had a student say they didn't want to treat anyone because of ethnicity, the institution is pretty diverse.

Comment (David): I don't know why some of the dental schools allow people to not treat HIV patients. It shouldn't be allowed the way you can't deny care to ethnic groups.

Comment (Tom): The hygiene schools seem to be more scared of treating PLWH/A. The hygiene textbooks and instructors are teaching false information (such as the risk of ultrasonic use with HIV-positive patients). I had a student that didn't want to work on a patient; I partnered her with another student, and after seeing treatment, she was more comfortable. Having didactic instruction first is good to get them ready.

Comment (Karen): This issue is something this group can have an impact on.

Tanya Darlington—We have very similar successes and challenges. I had the unique experience being a resident when this program first began. Our biggest success is the actual partnership between the Columbia University dental school and Harlem United. We are a 3 chair facility in the health center. There's still a large fear of treating our clients. In developing our CD-ROM, providing students with the most updated information, we still face much fear. Our students, however, love rotation to the site. They're recognizing that it's not only HIV status, but it's other issues (homelessness, etc.), that play into treatment. We are trying to pin down how the residents feel about treating PLWH/A on the rotation. At our dental school, a lot of the residents are frightened about being in the neighborhood of Harlem. Once they get there, the experience tends to be better. On the administration level, it's very frustrating to see people not wanting to

serve our patients. We're struggling as a program to accept this, because nowhere else in Harlem United can someone be scared to or refuse to serve a patient. We had a very good meeting with Columbia University on this issue; we're getting close to making a stand.

Comment: Discrimination is the elephant in the room. It's enormous and no one's doing anything about it. It's frustrating for people who have been in this field since '81. We're taking a lot of sons and daughters of dentists into dental schools, and the culture of fear is passed on. It's not in the culture of dental schools to focus on the responsibilities of service as in medical schools. No medical schools would allow someone to refuse treatment to PLWH/A.

Comment (Tanya): The residents are the main target of our CD-ROM. I've had residents come on rotation and do nothing clinical the first day. I give them an overview of what they'll be doing. What I need to do is stop comparing them to me. Offering the additional didactic training, this is an ongoing challenge for us. We try to get a read on what their training has been.

Comment: We've done some previous work on this. We had a dinner roundtable discussion of leaders in the profession, and at each table were an HIV advocate and trainer. We made it very clear that this was to look at and address PLWH/A not getting dental care. We had everyone write down three things they were going to do to make a difference. People published papers; people changed their organization. It seemed to make an impact at the time. We need to replicate this again. Another thing that we did is to make a videotape of people that had occupational exposure—vignettes serving as an educational piece. None of them had seroconverted. We showed it at a national conference, and that videotape seemed to have a big impact.

Comment: Regarding this problem of people that don't want to treat PLWH/A—I think it's across the board for any special needs patient. To rectify this, we've identified the residents that don't have stigma, then have them work with the others. We have 2<sup>nd</sup> year residents come back into our program and assist to alleviate fear.

Comment: We are making efforts to get residents to reflect on their experiences. We're using a website for them to work through to identify what their goals are for the academic year, and log what they're meeting. We're helping them in naming what their fears are.

[At this point, Barry introduced Dr. Rafi Morales, Director of HAB's Division of Community-Based Programs.

Rafi Morales—The Community-Based Dental Partnership program is one of the youngest programs. The program itself and oral health care are very important to us; the Administrator indicated the importance of oral health in her address, and we stress linkages to oral health services and your projects specifically in our Title III programs. Thank you for all of your work and dedication.]

Robert Trombly—We have been able to create an infrastructure for providing dental care through the grant. We have geographic challenges between the dental school and the clinic; getting students to the other side of the state is difficult. Other challenges we face include

communication, coordinating housing for the rural-based rotations, and meeting the data requirements for multiple funding sources. Our program is based on a blend of methods, including didactic and problem-based learning. We lost the Dental Director at Grand Junction, which caused the loss of a couple of rotation opportunities. We've been through the HRSA Office of Performance Review (OPR) process; it was a positive experience. We want to increase capacity somehow with flat funding. One of the strategies this year—we are based on 5 month cycle for our students, but there will be a pilot program to make it year-round to build capacity. One of the successes we've had is that the sites that were chosen were Title III clinics in the state, so there was already an identified patient load. Incorporating oral health in a primary care exam has been going wonderfully. We take some of the education onsite. With clinicians, we go out into the communities onsite at the partner clinics, and do education with everybody there (assistants, administrative staff, etc., as well as dentists). We're pioneering the use of portable equipment.

Michelle Henshaw—We have been working with the Holyoke Health Center; we looked over their experience for the past three years. Patients weren't really making it to the dental clinic. One of our successes was to comprehensively evaluate that whole process. We conducted interviews with staff, providers, and patients to see what was going on, why the link wasn't as strong as it could have been. We brought specialty services to the health center. Each student has to do a public health piece, doing projects to overcome the barriers we found. They provided tools to medical providers for the patient education to the importance of health care (CD-ROM). Data tracking is a problem—there are different systems, different information, so it is tough to make this information usable.

Theresa Mayfield—One of our greatest accomplishment is getting a rural clinic up and running where no services were being provided. During this time, one Title II program merged with a Title III. There's a lot of traveling in serving this population. What we've done is collaborate with Title II and Title III programs to work with our site. The Title II program provides transportation. We've gotten integrated into the community. We've worked with the community dentists to let them know what we're doing. The community dentists got together to do *pro bono* work in the evenings for the working poor. We have been working with hygiene schools. The hygiene school administrators were our primary adversaries; we have a lot of education to do in the community with our colleagues. The successes we've had include two of our residents joining us after residency. We've been raising awareness slowly but surely. I've tried to put myself in the clinic as a resource. I continue to make an impact in the profession.

Question (Karen): Does anyone want to share about working with local dentists?

Comment: We have done site visits. We identified a need for education of dentists in the community. We worked on providing a session for continuing education for the local providers.

Comment: We started to give continuing education courses at the school and the local dental society.

Comment: We've been having preliminary discussions with the regional AETC.

Comment: We should focus on this, because the students will be going out and working with dentists operating in the field now, it's important to have them reinforce education and training.

Comment: Our AETC has had a longstanding oral health conference every year. By using the University's continuing education office, we got a whole new cadre that didn't attend in the past.

Comment: Regarding the rural to urban dentist to population ratio—there are huge geographic disparities.

Jill York—Our challenges are recruitment and tracking between funding sources and programs. Our successes: We've increased access to care. We've doubled our patient visits. We've coordinated forms and data collected to make sure all components of service management are more seamless. We're getting an eprofile to see how we can reflect the impact of the disease in our patient profile. We do pre- and post-testing on student beliefs, skills, and knowledge. We've seen remarkable attitude changes.

Alicia Hathorn—Our program was inherited. The initial challenge was with health department for the physical site of the clinic. It took 3.5 years to build. Until this there was no physical facility for the clinic. Finding enough space, going through architect were challenges. Our major success is that we're seeing patients now. We face geographic challenges. We're trying to contact all the hygiene schools to do a rotation through the clinic. One out of five is working with us now. It was a very positive rotation. I give didactic lectures to professional organizations, to see if others can help us do community partnerships. It's important to understand that every patient that sits down may be HIV-positive. Sometimes they will open up to you and it will touch your heart. We're an old program in a new facility.

Linda Kaste—We're an original grantee. We've encountered a number of challenges. One of our successes is that we're getting our students to talk more about their experiences working with PLWH/A. The faculty are more confident and able to help the students to talk about their feelings in working in this setting. A strength of our programs is that the preceptors allow students to figure out what they're good at and to build their patient load around that. We're trying to integrate our different grant programs to take a community focus. Right now we only have 32 hours of student time, and there is a period of 3 months per year when we don't have students; we want to increase that. This is difficult for the community. Our AETC works closely with the university, holding orientations and trainings. Before this CBDP program started, I wasn't sure what HIV education people are getting. That was a struggle we had early on.

Comment: As a dental school, one challenge is that we don't have enough money to pay preceptors. One challenge is to find a person at the clinic site that can serve as adjunct faculty.

Comment: The community needs to convince the schools that serving PLWH/A in the community is a rewarding, useful experience.

Comment: Our community site has really bought into teaching.

Question: How do you orient a student? Answer: Principles of Oral Health Management for the HIV/AIDS Patient, which is a HRSA-funded publication. There's also a lecture.

Debbie Fitch—I'm new to the dental clinic, but not new to HIV care at our site. A challenge we've had is that nobody wants to go to New Orleans for care from the surrounding areas. Our patient education material is lacking. In New Orleans, the dental school was flooded. The staff are living in Baton Rouge and commuting. A success we've had is that we're housed in the same building as the Title IV clinic, so patient recruitment and retention is easier. The longstanding patient relationship with me makes it important for them to make their dental appointments. Our future direction is a focus on data collection.

Question (Karen): How many of us have displaced Louisiana patients? [A majority responded yes.]

Comment: Trying to get information on where displaced patients are and on their status and situation has been a problem.

### **Presentation: SPNS Outreach Initiative**

Carol Tobias, Serena Rajabiun, Moses Pounds

Carol—Let's have a conversation about our outreach initiative—lessons learned from the SPNS Outreach Project to Engage and Retain People in HIV Medical Care. How many of you have struggled to get people into your clinics? Has anyone not struggled with retaining people in oral health care? [One person responded.]

Major findings of the initiative: There are 3 at-risk populations—those not in care at all, those tenuously connected, and those at high risk of dropping out of care. Does anyone have a guess about what percentage of PLWH/A are not in care at all? [30% was suggested.] The initiative had an impact on getting people engaged in care.

Patients were asked what health care needs they had and which of these needs were unmet. For most primary care areas, unmet needs reported were a fraction of the needs identified. Dental care was different; everyone that identified it as a need identified it as unmet.

The area of health beliefs as a barrier to care needs to be explored. People at times do not believe they are sick enough to seek care.

Systems that worked to bring and retain PLWH/A in care include the following: health system navigation; visit accompaniment; and peer advocates. Anytime support is needed...for language barriers, housing barriers, cultural barriers...these systems work. [It was noted that even onsite at the same location, moving patients from where they received care to the next building without accompaniment resulted in patient falloff.]

Comment: We try to educate support people (such as visit coaches) to give information to help the patients out.

Comment: That's a good point; a lot of case managers don't get HIV Oral Health 101.

Comment: To save time with big patient loads, I ask the patient what it is that they expect I can do for them. If their expectations are reasonable, I don't waste time with education they probably already know.

Comment: I think that we need to go through patient education every time, with every patient. I explain our expectations of how things will progress each time.

Comment: I use CAESY education software. It's an excellent way to provide patient information about a procedure. It has been a tremendous tool for us.

Carol—Case management was another model to keep people in care. There are an awful lot of people with HIV that don't have case manager. For some populations intensive case management services in complex situations can be really good.

Comment: We're working with one agency that provides case management; it's of utmost importance.

Question: Has anyone gotten information on how to connect homeless people and homeless teens specifically? Answer: You may not have resources through the dental program, but if you can connect with an already existing case management system as an extension of their efforts, you may be able to reach this population.

Carol—Peer advocacy models were the third type of effective model. This can work in primary care, and it may be transferable to oral health care.

Comment: I've been explaining to people that they own their care. It's a role reversal from the traditional approach. We spent a lot of time making them a part of their own treatment plan.

Comment: What helps us is that we have a day program; in the daily support group, you get support for your fears about dental care.

Carol—Interventions that worked include tracking missed appointments for outreach interventions. This reduced the no-show rate. Motivational interviewing... this is a behavioral change intervention technique. Programs specifically used this to look at retention in health care. Increasing not only health literacy, but basic life skills training (budgeting, etc.), increased retention. Many agencies, to get people in care, would find their clients at other agencies. Forming personal connections seems effective (as it's the individual that often links clients to other agencies).

Primarily, we learned that **having care coordination** is very important. A lot of people reported that the most important thing keeping them in care is having that individual reach out, remind them, help them, and support them through care.

[Carol describes a study done that showed interventions by peers to be as effective as interventions by master's degree-prepared experts.]

## **Breakout Group Discussions**

Four groups formed to discuss one or two of the following topics:

1. How to disseminate information amongst ourselves, public and profession;
2. What community partners need from the school and vice versa;
3. How to track pre- and post-program student attitudes and knowledge;
4. Dealing with students' fear of treating PLWH/A;
5. Using case management.

Group 1—We discussed cultural competence. There is a need for education and experience. By giving individuals (staff, students, outside people, faculty members in the center) information, tools, and experience, it will result in a change of attitudes towards the HIV-positive patient. Regarding partnerships: the easiest way to partner with someone is if they're an AIDS Service Organization (ASO) or an Area Health Education Center (AHEC). Basically, if they're dealing with HIV-positive populations already, it's easy to partner with them, whether or not they get RWCA funding.

Group 2—We decided to talk about tracking and documenting patient outcomes, cultural competence, quality of life, etc. The conversation went to data forms and reports, including the CARE Act Data Report (CADR) and the Dental Services Report (DSR). They're both resource-intensive reports. There are duplications of effort; the patients find it cumbersome and the institutions find it cumbersome. At this point, most organizations still do hand counts—it's wasted time and energy. The community-based organizations are much farther along than the universities in terms of collaborations and data reporting.

We talked about electronic medical records (EMR), and merging dental and medical information. Different programs are building EMR systems to share information between multiple health care agencies and between disciplines, completely integrating dental, medical, and mental health services as well as the billing system. There are capacity building grants for building EMR systems.

We talked about institutional change at dental schools. Theresa (Mayfield) gave us insight on the university perspective. As universities participate in the CBDP rotations, the students are not generating money for the school. The universities are more likely to use a research grant than us. But the universities represented here are nevertheless committed to the program. When students won't touch HIV-positive patients, the productivity in our clinic is down.

When chances arise to come to the table with other medical groups to discuss EMR, we need to be at the table and be integrated as a medical provider. Oral health should be an integral part of the patient's overall care. EMR is a good way to bridge the gap. We're going to have a wealth of medical outcome data as a result of dental health. We should not connect to an EMR, we should be part of an EHR (electronic health record) from the beginning.

Group 3—We discussed cultural competence and overcoming fear as a barrier to care. Some providers had medical staff come in and present information to deal with fears. The biggest impact for students is in the shift between being a student to being a resident—that’s where the caring is lost.

One suggestion is to have a psychotherapist come in and talk about fears and barriers. Having an HIV-positive patient come in and share their personal story is also helpful. Another strategy is to begin working with younger students (such as David Rosenstein’s high school outreach program). These efforts should be targeted at overcoming the stigma of HIV and avoiding blaming the victim. Encourage active patient involvement in treatment; students should understand that this improves the process. Existing dentists and hygienists can be harder to work with, as the prejudices are already set. However, it should be an expectation for the providers that work with us that it’s not an option to decide whether or not to treat a person—we don’t discriminate against anyone. We give staff support with any help they need, but it’s the reality that patients are not to be turned down. You can’t decide to not treat sick people. It’s part of the career. Present it as a win-win—students are learning complex cases, and they’re helping people in need in return.

Group 4—We talked about cultural competence and funding constraints. We identified many issues, one of which is that our students and faculty are not a diverse group nationally. We’re all trying to put students in clinical service opportunities that teach cultural competence. We haven’t come up with a great model yet. We would love to get more information on how you measure if someone is gaining cultural competence. We know it when we see it, but it’s tough to quantify and document. We discussed what medical schools are doing out there, and whether their approaches are better than the dental schools. If anyone has wonderful programs, we’d love to implement them.

We need a new definition of what it is to be a dental health care provider. There’s disconnect between the systems we’re working in and what students are being taught. There is a need for depth and breadth on cultural competency training, including the assurance that oral health is an understood part of the medical system. Few RWCA grants address oral health. We need to influence policy makers. Fear mitigating education needs to be linked to visualization of risk assessment and risk management. Stats of seroconversion could be presented and compared to the risk of injury and death in regular activities (flying, driving on highway) of day-to-day life.

### **Office of Performance Review (OPR) Site Visit Overview**

Barry—It used to be that every grantee had a site visit every Project Period (once every 3 years). Since 2002, HRSA has been consolidating site reviews, creating the OPR. OPR plans to visit each program funded by HRSA grants every 10 years. They’re looking at fiscal accountability and grantee-selected measures of performance.. HAB program reviews are different. We’re focused on the quality of care being provided, so we can report to Congress what is done in terms of clinical quality that might not be possible without CARE Act programs. Because your programs have different areas of focus, we also want to hear about the different models that are successful. We’re trying to learn from you on these site visits as well as provide technical assistance.

When OPR reviews a grantee, they may do a review of all HRSA-funded programs that grantee administers. So an OPR review can examine either an individual program or multiple HRSA grant programs managed by the parent institution. OPR will negotiate with the site what they're going to look at, but they typically examine a couple of items of national focus. Aside from these baseline items, you can ask them to evaluate and suggest improvements to other parts of your program. Members of the review team include Federal staff and outside consultants.

The point of this overview is that there are two parallel site visit processes, one from the HRSA OPR and one from the HAB program office.

### **Report of two Community-Based Dental Partnership Programmatic Technical Assistance Visits**

Theresa Mayfield—I learned a lot from the review process. I understand that the spirit and intent of the visit was to help us improve our program. One of the things I learned is how HRSA could advocate for us. You will be scrutinized in some ways, but in the spirit of strengthening your organization.

To establish the format for the site visit, we had a conference call with Barry, Victor, and Lolita to talk about what they would be looking at. Barry was still deciding what he was going to do, he sent me a form he was working on, the fiscal review module used for Title III projects. There was an administrative model as well.

Onsite, the visit was composed of three parts. Barry provided an overall analysis, Victor looked at clinical aspects, and Lolita conducted the financial review. I had a chance to tell my story, then we split up. We did fine on the financial review; if you're keeping your records and there's an audit trail, it won't be a problem. Barry, Victor, and I went to one of the clinical sites. We looked at what was happening at the clinic, and looked at patient records (all of the things you do to review how your programs are coming along and how your patients are doing). Collaborations are a little tricky. The community-based clinics have a lot more emergent care, and one of the things we need to change is that when we make a referral, we need to track if they showed up, what happened, etc. Everyone has to keep that data now. We got insight on the interaction between entities from a clinician with many HIV-positive patients. We're also beefing up our patient education.

The second day we went to a rural site. Before that, Barry, Victor and Lolita met with a group of consumers. The intent is to get patients' perceptions of what we're doing. With grants you envision something, sometimes without feedback. You need to step back and say, "Are we meeting the needs of the consumers?" What you're doing will speak for itself, but you'll have to have consumer input, so think about that.

Barry and his team are there to advocate for you. I didn't write the grant, I don't control the budget, and I'm not a dean. They advocated for me to the university, without making the administration feel threatened. They helped me get things straight.

Michelle Henshaw—What was challenging is that we hadn't before had a HRSA site visit. We've had some from the National Institutes of Health and foundations that fund us. A site visit from them was basically an overview. An in-depth look like this was new for us. It was culture shock for the dental school. I recommend starting the dialogue with your administration early. That was a barrier I ran into. The site visit was really a give and take. We only have one partner that is over an hour away, and Barry had the foresight to meet and do almost everything at one site. That speaks to the flexibility that the site visit team has in making this work for you. The emphasis is on making your program better. Preparation for the visit was stressful, but the visit itself was not.

Barry—I tried not to schedule visits too early in your grants. I wanted to give everyone sufficient time to get into working mode. Our visits have to follow a format similar to site visits for other programs. There are certain things I can advocate for, but there are some things we can't. It has to follow a similar format to Titles III and IV visits, covering administrative, clinical, and fiscal areas. It's a learning experience, rather than merely documenting nuts and bolts. Thanks to the pilot site visits, the administrative and fiscal modules are being shortened to be more pertinent to your programs, especially those housed in dental schools.

Theresa—I filled in the modules with what I was going to say ahead of time. Having the review documents gives you a heads up of what they'll be looking at. You can think about what your deficits are and you can pick the site review team's brains about what to do. It's done in the spirit of making you better.

Question: What is the length of time of the visit.

Answer: Ours was two days because there are two sites. There is an onsite debriefing that is very valuable. We brought in many key players. You're one of the best advocates for patient care, and it's important to the community. The universities love to use what we're doing as evidence of helping the community.

Question: How much time was there between notification of the site visit and the visit itself?

Answer (Barry): Your Project Officer (P.O.) will ask you for dates in the next 9 months. We'll share review materials with you as early as we can. Most visits will last 2 days and will hit principal sites. We do an entrance briefing so you can tell us what you're doing, then visit the sites. We meet with a consumer panel confidentially so patients can open up. This paints a picture of how care is being delivered and the impact that care has on the community. It's good to document that our programs offer something meaningful in patients' lives.

### **Report of an OPR Site Visit**

Robert Trombly—I was notified about the OPR visit, but there's not necessarily communication with your PO. The reason we were chosen is that the OPR decided to review all HRSA grantees in our major metropolitan area. They can do it by state, by region, or by grantee. One of the OPR representatives in our region is a dentist, another was a nurse by training. The notification was 3-4 months before the visit. We had weekly conference calls to discuss the whole process.

We got an instructional videotape on the process. There was no mystery to what they were doing.

Compared to a HAB program review, the OPR review was much less detailed in terms of hands-on analysis. We spent a lot of time discussing thoughts about our program. You go through the calls and familiarize them with your program. Since the review was for metro Denver, we didn't focus on our sites outside of Denver. We then talked about developing performance measures. We came up with 2. How many unduplicated patients we serve, and how many students are getting hands-on clinical training. We also designed 3 developmental measures.

The site visit lasted 3 days. We focused on what's contributing to success, what's restricting success, how to do performance measures, and then creating an action plan. Because we were part of a bigger regional process, we went through a strategy process with other HRSA grantees. The focus of the strategy was addressing Healthy People 2010 national goals and how to provide access to primary care.

David Rosenstein—From the perspective of someone who conducts OPR reviews, I want to state that no one plays “Gotcha!” If they do, they won't review again. Also, confidentiality is paramount—it's never ever broken. These are not people who have been working for 2 years. The non-Federal dentists they use are very experienced; the shortest amount of experience is 20 years of being a dentist in a community health center.

I have never seen anyone pick on people. In OPR we don't even get to pick what we will look at. Some items are nationally mandated. One such item is how many patients were seen in a one year period.

If a weakness in a program is identified, we would work with an experienced consulting group; we would say “Their no show rate is high, can you help them?” Everyone wants to help, wants to make it a better program. The site visits do not aim to fix blame. About 25% of the programs are recommended for technical assistance. Most programs only receive advice on how to create a better product. We all know it's a nerve-wracking process.

The performance measures are designed by the type of area. For example, for patient completion rate, is it an episodic patient? Are you getting patients in without too much wait? It's tailored to the program; e.g., it is understood that a homeless-serving program will have a near-0% completion rate.

### **Ideas for Information Dissemination**

In addition to a listserv that Barry noted will be activated shortly after the conference, the group brainstormed about the following list of potential outlets to disseminate information about and from the programs.

Presentations:

- National Network on Oral Health Access
- National Oral Health Conference

- American Public Health Association
- American Dental Education Association
- American Association of Dental Research
- American Dental Association (ADA)
- Community-Campus Partnerships for Health
- HIV/AIDS Treatment Management Group.

Publications:

- Journal of the ADA
- Journal of Public Health Dentistry
- American Journal of Public Health
- ASDA.

What to Measure:

- Cultural competence (how should this be measured)
- Attitude and knowledge changes among students
- Changes in perception of the need for dental care among community partners
- Alumni knowledge and attitude
- Quality of life measures, and how to measure the impact of oral health care and improved oral health status on the lives of positive patients
- How we are transferring knowledge to other programs (shows impact across the community and integration with other HIV service providers).

Products:

- Materials to teach cultural competence/respect
- Grant program summaries (a quick summary of what programs are doing)
- All the products developed by grantees should be listed on the listserv and available through posting on the Community-Campus Partnerships for Health (CCPH) website.