

**Community-Based Dental Partnership Program
Technical Assistance Conference Call
March 11, 2004**

These notes were prepared by Annika Robbins, Administrative Coordinator, Community-Campus Partnerships for Health. If you see any corrections that need to be made, please email them to annikalr@u.washington.edu

INTRODUCTION

Barry Waterman, Chief Dental Officer, HIV/AIDS Bureau, Health Resources and Services Administration

Hello everyone. I'm joined by Dr. Jose Morales, Medical Director of our division of community based programs along with Dr. Gail Cherry-Peppers and several of our staff who serve as your program project officers and Lesley Swan sitting in for Margie DeGraw who is our new grants management specialist who will also be working with us on your dental grant programs. For grant administration issues Margie can be reached at 301-443-1868 or MDegraw@hrsa.gov. Also joining us by phone are some of our HRSA field office dental consultants and Dr. Sarena Seifer, director of Community-Campus Partnerships for Health. This call is being recorded for transcription purposes.

We have several things we wanted to accomplish with this call, including providing you with some program updates and discussing your preferences regarding topic content and frequency of future conference calls. But primarily we wanted to provide you with an opportunity to share some of your program successes and challenges to this point now half way through your grants 3-year project period. In the past year some of you have encountered unanticipated circumstances within your own institutions that have challenged your ability to manage this grant program. This is really an opportunity for us to collectively catch up on progress to date at this point in your programs. Our project officers and field office colleagues are on the call today to learn from your updates and listen to your concerns. So let me begin by sharing a few program items of interest.

Non-Competing Continuation Applications

For more information, visit

<http://www.hrsa.gov/grants/preview/guidancehab/cfda93924.htm>

As you know a non-competing continuation application is required toward the end of each grant year. The program and application guidance for your non-competing continuation application for year 3 funding is about to be released. A hard copy will be mailed to you by the HRSA grants application center and I'll email you an electronic copy. Your applications are due back not later than May 27, 2004, a couple of months earlier than last year. This non-competing application is essentially a report on your progress toward achieving your objectives in your current budget period (beginning September 1, 2003). And it presents your proposed budget and work plan notes on progress and additions for year 3. You'll notice the guidance appearance and format is different from last years. HRSA is undergoing much restructuring and this is one example. The new standardized HRSA guidance format which we now must follow did not allow us to include sample budget and work plan forms which were included in last year's guidance. But for ease of use and consistency I encourage you to submit your budgets and work plans for year 3 following the same formats you used last year. The new guidance format also uses new standardized language taking your applications to a maximum of 80 pages. Don't panic! We don't expect 80 pages, just submit only as many as you need to provide the information that the guidance requires. But as you follow

the sequence of the new format you'll notice language that differs from last year's guidance. If you have questions or need any assistance with this process please contact your program project officer.

Required Annual Reports

Another reminder, the guidance mentions the requirement to submit an annual report. That's a data report for the purposes of this grant. We are in the process now of modifying the application form used for the dental reimbursement program so it will serve as a single CARE Act dental service form. It will be used both as an application for dental reimbursement funding and as an annual data report form for community-based dental partnerships. Until we get OMB clearance for this I urge to follow the dental reimbursement application form as a guide to what data you should be collecting now for this program. The dental reimbursement application form for 2004 will be posted on our bureau website in the next few weeks and I'll email you the URL where you can access that as you proceed in your data collection efforts. I'll also mention briefly that our hope to do site visits to your programs within the next several months. We're not sure yet how the site review process will work or how our office and the field offices will jointly participate in them, but we'll keep you informed as plans unfold.

Ryan White Grantee Meeting in August 2004 – Your Participation and Ideas Requested ***For more information, visit: <http://www.psava.com/rwca2004/general.asp>***

Next, you all should've received notification on the Ryan White Grantee meeting this August 23-26 in Washington, DC. The purpose of the meeting is to provide technical assistance opportunities for all CARE Act grant recipients. The registration fee increases after April 30 by \$100 per person so we encourage you to register early. We're told that space limitations in the hotel restrict number of participants who can attend. And the letter of invitation sent out by our bureau director suggested one participant from each dental grant program. But we encourage you and one of your community-based program partners to register for this meeting as representatives of your community-based dental partnership program.

As in past year's, during the meeting there will likely be a couple of workshops of dental content which may be scheduled on the same day. *Please email me or your project officer and let us know what topics you are most interested in.* Also, if possible, we will try to schedule an opportunity for all of your programs to meet together as a group. This could be an open type format where all of you could discuss or brainstorm around issues of common concern about which you might want to engage in more in-depth conversation. Or it could be more structured, such as an in-service focus on a priority topic of mutual interest such as service-learning curricula, or various other things like 'how do we do this or that in our program.' *Now is the time to express your preferences on the technical assistance topics you'd like to see offered at this meeting. Please let us hear from you within the next couple of weeks as the workshop schedule for the August meeting is being developed.*

OVERVIEW OF TECHNICAL ASSISTANCE ASSESSMENT REPORT

Sarena D. Seifer, Executive Director, Community-Campus Partnerships for Health

It's really a pleasure to have an opportunity to talk to you all as a group. What I'm going to do is give a brief overview of the technical assistance assessment report that we prepared for Barry Waterman and his office. Some of you may be familiar with the name Stacy Holmes, she was on our staff as a program coordinator when this work was done. She was the one who conducted most of the interviews with principal investigators and with partners in your programs and this report is a summary of what we found out. You should've all received a copy when Barry sent out the agenda

so hopefully you've had a chance to take a look at it. It's not very long, it's only six pages, but I thought I would just cover some of the highlights. [The report is available on the CCPH website at: <http://depts.washington.edu/ccph/dentalpartnership.html>]

Assessment Report Findings

Well, as I said, we had telephone interviews with principal investigators and with partners. We spoke with 25 people altogether from each of the grantee sites. These conversations took place, they ended in the fall of 2003. We were looking at a number of topics, we had structured questions that looked at an overview of what you all are doing in your grant program. How the program compliments or not, the mission and goals of your institution; some of your strategic issues and challenges. We were interested in finding out how you were developing partnerships and how partners were involved in your programs. Ways that you're changing the curriculum in dental education, what your strengths and challenges and preferred types of technical assistance and training were. I realize in presenting this that this was a snapshot in time and that really covered the summer/fall period of last year and all of you are moving forward in your programs so some of these findings may not be absolutely accurate as of the moment and that's why we wanted to present them at least to get a starting point out for discussion and then have an opportunity for you to really tell what your successes and challenges are right now and going into the future by building on what we found in this report.

So we found a number of strengths that you all bring to this program. And it wasn't surprising to see these strengths because obviously you were competing for this program and you were all awarded the grant and had submitted very high quality proposals and some of what we found in terms of what strengths you're bringing to this effort is that many of you, most of you have partnerships that build on past relationships. There was already a lot of collaboration and partnering going on between the HIV/AIDS community and the dental institutions involved in your program and so it was natural to build on that for the purposes of this program.

We also found that in most cases what really led to a successful beginning of this program was having a principal investigator who has leadership, commitment and passion. And that that person is the key to mobilizing resources, getting people onboard, having a vision for where this program can go. And we were very impressed with that. We also found that you were all trying to take some honest attempts at new ways of doing business. That this program really challenged relationships, challenged decision-making structures, challenged the curriculum and the way dental residents and students are taught. And that you were coming into this really trying to develop some new ways of addressing community-academic relationships and community-based learning.

We also found that another strength was that in many cases the institutions that you're located in support and have a culture that facilitates this kind of work in the community. There's obviously a continuum and it varies from grantee to grantee but overall we found that a number of the grants were at places where there was a strong institutional support and mission and that seemed to be very much a success factor.

In terms of challenges we have identified a number of challenges to having a successful program. One whole area was around environmental issues, environmental concerns that were largely external influences. Many of which are very difficult for any individual grantee to have any control over. Budget cuts, local politics, there were personnel changes, you know, Barry mentioned earlier the issue of transferring a grant to another institution. And then also, in some communities, in some

institutions, some continued stigma and prejudice around HIV/AIDS care and people with HIV/AIDS. So those were all environmental challenges.

We also found another big challenge is the whole issue of time and bureaucracy. Everyone pretty much complained that there's not enough time to do everything that needs to be done in this work. There were also some challenges in the bureaucracies of the institutions and county government agencies that some of you are partnering with. We found that none of you expressed dissatisfaction with the Bureau of HIV/AIDS office or the reporting requirements pre se, but just expressing some anxiety about the process and about the continuation process and having information in a timely manner and to be able to respond and so forth.

Another challenge was around specifically the curriculum change issues. Trying to negotiate the schedules, working in academic institutions to change the curriculum content. And there were a whole set of other issues that came out of the discussion around bringing partners together and developing successful partnerships which are such an essential part of what this program is about. And some of the things in this area included, just, some of it's coordination and logistics. Being able to get the right people together frequently enough to really talk through the work. Some of you expressed the need to include students and residents in the discussions and in the deliberations and that was not always easy.

Among all of you there was a real variation in the concept of the term 'partnership' and we found that all of you have a variety of community organizations involved in some role but there's quite a continuum across what a partnership really entails.

Training, Technical Assistance, Online Resources

And then in terms of recommendations for technical assistance and training, these largely come from what you had to say to us when we asked directly about what you'd like to see. And then we added some of our own thoughts from the staff perspective, having reviewed the interviews across all the different sites. One was taking advantage of a website and really trying to get information distributed from your programs. One of the things we observed when talking to you is that nearly every single one of you is developing products and curriculum and training materials and partnerships agreements and all kinds of resources that could be helpful for you to share with each other. And prevent people from having to recreate the wheel.

And we also found that you were interested in having updated grantee profiles on the web so that you could see what each other was doing and also effectively communicate it to the outside world. I will say as a little side note that we do have a website, there's a web page on the CCPH website that's already constructed for this program, at <http://depts.washington.edu/ccph/dentalpartnership.html> *We could use your guidance to what you'd like to see on the website, what would be helpful and what kinds of products you have possibly that we could start putting up.*

Another area for technical assistance and training was providing opportunities and forums for sharing. This conference call will hopefully be one starting point for that. Barry mentioned the Ryan White meeting in August as another possible venue. But we thought, and heard from you that there was an interest in opportunities and forums for sharing, you know, do we need an active listserv, do we need more teleconferences like this, are there other meetings that many of you attend that we could tack on technical assistance sessions, those kinds of things we want to ask you about today also.

And then lastly, the last area was around educational resources on priority topics, and if you're looking at this document on page 6 we have a bunch of bullet points on different kinds of topics that you identified as being of interest. Some of them have to do with developing partnerships with developing interdisciplinary health professional education. There were questions about the HRSA grant application and reporting. You brought up issues of clinical, oral health needs of different populations that you're working with, like people who are homeless or different racial and ethnic groups and so forth. And then there was some interest in "how to" primers on different kinds of topics like "how do you coordinate with partner clinics," "how do you change the curriculum in a dental school," but we haven't committed to doing any of these things other than the website being king of the shell of the website because we really wanted to have this opportunity to talk to you about what your current strengths, challenges and needs are to move forward.

PROGRAM HIGHLIGHTS

University of Mississippi – George Davis

I'm a faculty member in the school of dentistry. My general disciplines are oral medicine and dental radiology. What we've done down here is, actually one of the successes could be and we turned an obstacle also in the clinic that we're developing in an underserved area and the medical center is heavily involved in this small operation and at this [mall] we have a collaborative medical/dental clinic that's being put together with the assistance of the state board of health in dentistry. The good news is the medical and the dental treatment will be in one facility for our HIV population. The negative with this is we're held hostage by the construction schedule of this operation and what seems to have happened is we were told it was going to be 90 days from start of construction to occupation and so far they've compressed a 3-month evolution into 6-9 months pending, so we're being held hostage by that operation but once we're operational you know, I'm really excited about what we can do and the population we can serve. So that's sort of the good news/bad news on the clinic itself. From the standpoint of education at the school of dentistry, curriculum changes do not move quickly and we have no formal course in the presentation of immuno-compromised patients but what I've done, I'm course director for three courses, so I'm including this in my course schedule and it's sort of like getting around the system, rather than wait 18-24 months to get a formal program approved in the curriculum in the school, I'm just including it in my three courses. You know, 6-10 hours and within those courses, I'm including individuals from infectious disease that actually are operating the HIV clinic at the Jackson Mall. From the standpoint of student's participation, this is most effective on a one to one basis and that's what I'm trying to accomplish. When the students are working with HIV patients and treating them, working with them on a one to one basis, I think is the most effective approach in the management of that population. And that's what were accomplishing here.

Albany Medical College Dental Program – David Drohan

I'm the chairman of the division of HIV dentistry at Albany Medical Center, I'm also the director of the Ryan White dental clinic there. Basically our program continues as it has, the core of it or the number of efforts we provide, we provide direct comprehensive patient care at the medical center in the Ryan White clinic for HIV positive patients. We're graciously supported by the division of HIV medicine which has an administration and a clinical staff that make my job very, very easy.

In the course of our program, in cooperation with the grant, there's been a sharing of experience in the form of training both didactic and clinical with our partners in the community, local dentists, local dental residents and all the auxiliary staff that are in the area. Currently we're also, we're kind of excited about, well, if any of you have practiced with out a hygienist, we're in the first year right now of an HIV dental hygiene fellowship in conjunction with the dental hygiene program in the area at Hudson Valley Community College and it's gone very well. We have a unique candidate who is very, very enthusiastic and does a great job in helping motivate the periodontal aspects I'm sure that we all struggle with the advent of our patients living longer and the advent of some of the side effects of these highly active anti-retroviral treatments that they all seem to be taking now. The aspect of perio- I wish I listened to my sainted perio- professors at Columbia University when I was a student there a little better than I did, but basically this has been a great find for us and in our second year we've also begun to help fund our partners in need initiatives in some of the neighborhood health centers, to help the expend staff and access for to the purpose of care to HIV positive patients. If I had to outline one success I would say that our ability to continue to provide comprehensive dental care to over 600 HIV-positive patients in a 23 county area in Northern upstate New York is probably the one success. And that we've been able to do this in spite of our challenge, and our challenge which was alluded to in the CCPH report is our ability, if we can control costs and ensure a revenue stream to keep these services funded at the current level they are is a very, very difficult thing in the local political arena that we live in here in New York state is as you may or may not know, currently private Medicaid, private dental Medicaid is one of the pending cuts in our coming state budget. And any institutional environment that we practice into is, of course, there are bureaucratic challenges. To my colleague in Mississippi, if you think dental schools move there, I've been trying to get a chart changed at Albany Medical Center for 2 years, just a chart and I think they're going to hold me hostage until we've used all the old ones first though. Basically that's what we've been up to.

Question: On the fellowship you mentioned, the dental hygiene fellowship, was stimulated as a part of this grant program and what exactly does the fellowship entail then?

Answer: The fellowship entails that the fellow will be treating patients in our Ryan White clinic. There's a lecture scheduled that she attends, she also rotates though the offices of HIV medicine over there, learns something about the medical treatments that are done, she does things on the billing, she's in the process of doing some research on (intra gingival) medications for some patients that she's currently doing a kind of a paper on, and it's basically something that the hygiene program approached us about and with the advent of the grant, it's a wonderful training place for her to learn more and she's actually gone out to some of the lectures I've given and been an adjunct and has just been a great, great find for us.

Q: How does your rotation schedule work out there? Do you rotate all your students, is it a volunteer basis, is it mandatory, and for how many days?

A: The residents, we do them, they do mini-residencies for the ones in the area. Previously the residency program at Albany Medical Center, which closed last year, at that point the residents would rotate through, but now our partners, there's a large group practice that has their residents rotate through our clinic. For many residencies, a week, and the other local residents in the area do about the same thing. They do training at their sites and then off site also at this point in time. As for the provision of care, the provision of care is done basically by myself.

I don't know if our situation is somewhat unique but, in the early days of HIV, like most places, dentists were refusing to treat people who were HIV positive. It was a little worse in Oregon, I think, we had members of the board who weren't and we had people in positions of authority that weren't, so that lent credence to not providing care to this population, despite the fact that early on that was made clear that that was a requirement. What happened that may make this a little bit unique in this community as a result when Ryan White Title I funds became available, what we tried to do was to allow those funds to be expended at any office, any private office. We desperately tried to get private offices involved, none were willing, not a one. Not one single place. The result of that was that all of the Ryan White Title I funds came to a clinic that I direct for low-income patients. Which didn't transform completely but is now about a 1/3 people who are HIV-positive, a 1/3 people who are low-income, not that the HIV/AIDS patients are high-income, although some certainly are. The result of that was that unlike other communities where dental schools, as an example, were a site where patients would receive Title I funding, in our community, you had to come to the Ruffle Street clinic. What that means is that training programs, and there are three hygiene training programs, as well as the dental school program really were not seeing people who were HIV-positive. I think that that may make this community a little bit different than other communities, I think most dental schools had a significant number of people who were HIV-positive coming in as patients and we didn't, and that limited the experience that students were receiving.

So we had several objectives, one of which was to increase our patient load and a confusing thing for us was that our patients had shifted from being extraordinarily sick and extraordinarily poor to being extraordinarily healthy and relatively well-off. It was a situation that was not found in the Title III program so we really were at a loss to figure that one out. So our goal was to provide training for the dental students which is relatively easy to do as I'm a department chairman. We couldn't establish a course, but we did establish, during the week-long clinic orientation, I have half a day, so that's certainly not enough, but it's certainly more than we had before. The problem we had was working with the hygiene program. You know, with all due respect it's like herding cats, you have each program, three separate distinct programs, all of whom are telling us that only on Tuesdays from 9am-11am are we available to have our students come out. And we don't have that kind of flexibility with patient care and we don't have that kind of flexibility with staffing and it became, really a semi-nightmare coupled with the fact that one of the schools is 10 miles away, but across the border which means that there can be no clinical experience, it's observational. That's actually gone a whole bunch better than I would've expected. If I were a student, I would find it boring, but students are not finding it boring yet, they may well in the future. We were able to work out the problems with the scheduling and I was very pleased about that and in terms of a huge surprise, is that working with our partners, whom we've been working with forever, these are not strangers, these are people that I've been dealing with everyday, I've been treating patients who are HIV positive exclusively now for 24 years, and I've been dealing with them for 20 years, some of the same people, but you give them some funding and you put it in the context of a program and all of a sudden our patients are shifting from patients who were pretty sick and we're getting the low-income patients that we were trying to reach and we're also increasing the number of patients we're seeing in absolutely huge numbers. Once we started to work with these partners they actually were doing case management, they were bringing many patients to the clinic and in return, although we had been doing this before, we had been sending patients to them, it seems as though those numbers have increased. It seems as though we're sending patients to them in larger numbers than

we ever did before, patients who didn't have access to a physician or perhaps they were new in town.

Q: You've mentioned a number of challenges you've overcome, like the scheduling issue with the dental hygiene, and the success of increasing patients, is there a challenge that you might highlight that you're facing now and into the future that we could throw out into the discussion?

A: It is disappointing to me to have students come into me all the time with patients who somehow did get to the dental school, who are HIV-positive, with treatment plans that I certainly would never develop. They don't understand that if you're taking prophylactic drugs for or if you're taking anti-viral drugs that you're not in good shape. And that maybe crowning every tooth in the mouth after you do root canals on everyone is not maybe the best thing for the patient or to have the students do. It's always disappointing when you deal with faculty and you go over a health history and say, you know, a student brought this to me and I know you probably are aware of this drug and it indicates that this patient is in terrible shape, you now, life expectancy may be very markedly reduced, do you really think this should be done and they look at you like you're on the planet Mars because they have no concept of what the health implications are and you're thinking to yourself, this is a dental school, this is where we actually are providing the training for people who are going to be doing this in the future. And that's a challenge that is very discouraging, I don't have the patience to really talk to the faculty in a manner where they would listen. I can't look at them, like you're paid to do this and you don't really know how to do this. Doesn't this embarrass you? And that goes a long way as you might imagine in making friends and influencing people.

Q: I'm on the dental school faculty and, you know, I can personally relate to your frustrations with the way the patients are managed and, I think for my concern is my disciplines are all medicine and my focus is on treating the patient and that the mouth is part of the rest of the body and there's no separation. Unfortunately when we get to treatment arenas they focus on treatment that could be rendered in a laboratory on plastic teeth and the health histories and the medications are hurdles to doing the requirement for graduation. And I think that the biggest hurdle is that we're treating the entire patient, we're not accomplishing requirements on an a la carte approach. Another weakness is faculty in other areas don't really appreciate, at the level they should, the health history, what it means with medications, how they work, and why the patient is taking the medications. Unfortunately their lack of expertise in that area is treated as though it's not important, this isn't what you'll do in the real world.

A: On the other hand, there is one huge plus. And it's huge, I'm not an oral medicine expert, although because of the epidemic I end up doing biopsies and a number of procedures that I hadn't thought that I would be doing, but one of the things that happens is that a public health dentist is that I think those of you on the line who are public health dentists know that we're viewed as non-clinical and people who are paper-dentists, and there's a sneering attitude that people have. One of the things that the epidemic has done, since I do treat patients, and I only treat patients who are HIV-positive, it's done a few things, number one, on the positive side, it's to have our clinic stopped being attacked by the private sector because they recognize that we are a safety valve for them. Because of our presence, they don't have to deal with this patient population and they do appreciate that. And that's been a positive thing. And the other positive thing is that students see that we actually are clinicians and we know what we're doing when we treat patients and we know what a complex health history is and perhaps know more about it than some of the faculty at the schools, not perhaps. And that's a plus because then it puts us in a situation where they're more inclined to

listen when we try and talk to them about the social context in which dentistry is and should be practiced. So they give us more credence because they know that we treat patients, we treat difficult patients, we're doing (third molar bony) extractions and getting them out and showing the students how to do it while they're here. And that's been a real plus. I also wanted to also add that faculty development through AIDS Education and Training Centers (AETCs) is enormously helpful. It's always very good to get your faculty trained as a group, with some in-service training.

Columbia University - Marcia Irving Ray

I actually kind of wear 2 hats. Faculty member but I'm also the dental director for the community partnership of Harlem United. We opened the dental clinic here at Harlem United in August. I hate to say this, but it's actually been going pretty well. We've got 4 residents rotating through as well as 3 undergrad dental students that rotate through once a week. Thus far we've had about 600 visits with about 200 patients from within the facility as well as community-wide. I guess the residents weren't really expecting this to be part of their residency but thus far we've had a pretty good experience with them. I had experience prior to coming to Harlem United working with HIV/AIDS patients at a community-based organization. I was a little bit more opened minded than some of the faculty, but so far we've had a pretty good experience.

Currently we're working on getting our lecture series, the residents had to take part in a lecture series last semester. It was 8 or 9 lectures that they went through once a week and each of the faculty gave a lecture, as well as myself. The students responded pretty well to that and the lecture material has come in pretty handy, dental patient management and so forth.

The doctor that went prior expressed one of the problems that I do have here. The residents want to get a lot of hands-on experience in terms of crowns and implants, all those things that our patients can't really handle right now. So I think that's been our only draw back, clinically. We're trying to work on a website. And we're trying to put our lectures on CD's so we can have some distribution.

We really have overcome the prejudice to being in Harlem. For those of you that don't know, Columbia is kind of on the border. We did have a little bit of an issue with some of the residents wanting to come to Harlem, and we've kind of overcome that talking to them directly. I think we've just gotten a pretty good pool of residents that came here, I think we got lucky with them. And they've been pretty perceptive. We had 4 residents the first semester, that was August to December and 3 of them have returned. One ended up going on to some post-doc work that she wanted to do and she wanted to come back but she couldn't and we had no problem replacing the other two, getting the other two spots filled. The undergrad students have just seemed to be really excited to be here. We're really giving them a real realistic view of what it's like to treat our patients. The majority of our patients have clinically diagnosed AIDS so they're really getting some hands-on experience with a population that they may have been a little fearful to treat before. So that definitely is one of our strengths here with our program.

Q: When you talk about that CD-Rom with the lectures, is that intended for wide distribution to any dental program?

A: Any dental program.

Comment: Our local AETC are actually very good at doing cultural sensitivity training for residents. I strongly suggest that if anybody else is having problems with cultural competency issues that they talk to the AETC and maybe the AETC can help. [Note: To find an AETC in your area, visit <http://www.aids-etc.org/>]

Louisiana State University - Janet Lee

Basically we were very lucky and I think our greatest strength was that the LSU Dental School identified some years ago, about 4-5 years ago now, that there was a need for dental care in rural Louisiana. So with the help of a local health authority developed a dental clinic within a hospital setting in Alexandria which is literally bang, smack in the middle of the state four hours north of New Orleans. Every single one of our senior dental students, and in fact, second year dental hygiene students, rotates through this clinic for one week during their final years. This is a perfect site, it's extremely poor site, an extremely poor area, the 3rd highest rate of HIV within Louisiana itself. We decided that we'd rotate a GPR, we have a 2 year GPR program located down at Charity Hospital in New Orleans, up in that clinic for a 2 month rotation so that they would actually handle the HIV patients. But one of our goals was that every single student, dental student and hygiene student, would actually have some hands-on care.

Now quite frankly, we've been a bit disappointed at the patient no-show rate, because one of our great barriers to care is obviously transportation and we developed a partnership with a health enterprise network to see if they would facilitate transportation. That's been a little bit tricky, it's been a long time coming, in fact, one of the things I'd like to bring up is that when we put in for our roll-over funds we actually wanted to increase the budget because there were certain things like insurance for the church vans that this patient group is using and because there was a delay to actually get those budget roll-over funds approved, now that we've got them approved, we'll obviously get moving. But that is sort of 6 months after September, so we've cut into half the year.

One of our strengths was the existence of something that the school puts a high priority on. I feel sorry for the people who have trouble with actually changing their curriculum, because in fact LSU had done all that before I even developed this site for the HIV.

One of the greatest disadvantages that we have is that last year Louisiana cut \$70 million off its health care budget through the charity system. Currently all those dental clinics in a medical facility where there is a Title III medical clinic that treats HIV positive patients which has been a good collaboration, the hospital actually wants them out of that facility, because, of course, as you know, dentistry doesn't generate any money for them.

So we're currently looking at different sites to move our program to which is causing some difficulty, but I think that the school is very committed to this so I think that we're going to find something and I think it'll work. It's going to cause a major hiccup for us when we've just got things nicely situated. So there are some very strong positives in Louisiana. The budget issues for us are just hellish and I don't know how that's going to go, except that I keep a fairly positive, up-beat attitude.

As far as educating the local dentists is concerned, we actually had a request from the local dentists that we give an all day symposium on HIV. We've actually set this up for later this spring/early summer. We have tremendous partnerships with the Title III clinic, also with a Title II funded Central Louisiana AIDS support service that have been tremendously helpful to us. It's been helpful

to the patients. We actually had patients who were traveling 4-5 hours to come down for dental care to New Orleans, prior to the opening of this clinic. Now we find that for routine maintenance, the hygiene appointments and also sort of routine restoral care they can actually access care in Alexandria. I've had some feedback from old patients of mine who really appreciate the fact that we've had this move.

The other thing is that in other areas such as Monroe, which again is another very rural, very impoverished area, the Title II people have asked if they send their patients down to access this sort of dental care, if they paid, would they be able to do this, and we decided, that yes, that would be acceptable. Especially if the Title II consortia funded the transportation so that we aren't funding the transportation for people out of our catchments area, but other groups are. So those people are able to come down and it means sort of a 2 hour drive instead of a 6 hour drive down to New Orleans. So that's been pretty useful.

Tufts University and Holyoke Health Center – Trish from Holyoke Health Center

We sound like a very unique program, after listening to everyone else. My name is Trish and I'm the development director at the Holyoke Health Center and we are the partners with Tufts University. Actually, we're very unique in the sense that we're about 100 miles west of Tufts University and we actually have students that come out and live with us on a five week rotational period. And Stan Wilk (who I was hoping was going to be on the call) is new to the project. He began in the fall of last year, so we had some transition there but it's been great to get him in.

And one of the things that I think that has been so positive in this is the Holyoke Health Center is a community health center and for a number of years we've held one of the largest Ryan White III partnership grants. So onsite we have HIV specialty care as well as HIV primary care going on all the time. We just finished last year an enormous reconstruction of our dental unit and we now have 11 new laboratories. We just recently brought in some oral surgeons to work with us and it's just a few floors above primary care. So dental care, primary care, and HIV care are all in one building and have really become integrated. I think this contributes to a really unique opportunity for the students because they're able to come out on a five week rotation and we usually have three and sometimes six students that come and live in downtown Holyoke. And for those of you who aren't familiar with Holyoke, it's a predominately downtown Latino community, one of the poorest communities within the commonwealth of Massachusetts, one of the highest HIV rates and certainly an urban experience. Very different from Boston, from where they're coming from, because it's so contained.

So as a result of this project we were able to rent some apartments right in the downtown where the students actually live. So not only are they getting an experience of caring for HIV patients in the clinical setting, they're also really beginning to understand the public health implications of what poverty has to do with HIV, which what drug use is connected and living within the community of people that they're serving I think is a very different experience for many of them and has opened up their eyes in a lot of ways.

We've structured the 5-week program for them to come in on as employees per se. So they go through a formal staff orientation which I think really connects them to the health center and that they can see someday that this dental care is linked to everything else that's going on. I think they clearly understand the mission of what a community health center is all about and also get connected

to our health disparities collaborative works where we have asthma, diabetes, depression and HIV. And really understand that the whole comprehensive care is linked in this philosophy.

I think some of the successes have been that they've truly been integrated into our programs there, in our schedule, they have great working relationships with our staff dentists, dental hygienists, our dental assistants. But our new twist for this year is letting the students have an experience to treat and work with our HIV patients at our local jail where we also hold a contract. So they're able to start care there and then hopefully as these patients come out back into the community they're picked up again with other Tufts students as well as Holyoke Health Center staff so the care is comprehensive.

We've also started another project with, we've hired a person who we're calling a Dental Liaison with our HIV team. So when they come in for the routine or specialty HIV care and they haven't had a dental visit, this person actually provides an escort service up to the dental floors so we're really implying a no-missed opportunity approach that when you come in for any of your care. And this person actually walks up with them, introduces them to the staff, and gives them a tour and if there's an opportunity for space they can come in and get an x-ray. And then subsequent appointments are booked. So people are really getting a level of familiarity, understanding who we are and I think no-shows especially will decrease as a result because of this small relationship has already been established.

Q: Are there some challenges that you might want to highlight that you anticipate or are facing now?

A: Well, I think one of the major challenges last year was that Adult Medicaid eliminated dental coverage so not only were straight Medicaid patients losing their care, free dental coverage, HIV patients were as well so we've been working with that. I think the ongoing challenge is to continue to really work with our teams to integrate this dental visit and not lost patients when they come in and make sure that they do get up to dental. From the student perspective we haven't had any challenges. I think they come in and they may have been a little apprehensive about living in the community initially but it's really been an extraordinary experience for them to get connected to public health, primary care, and living in a community that's serving the patients that are right there.

Q: Is this a mandatory rotation for the students or is it voluntary?

A: In past years it has been. In the 4th year they go in an internship in Tufts sites all around the country so the students were able to select where they were interested in whether it was a migrant camp or an HIV focused or a dental office. This coming year there will be some mandatory rotations stuff that will be coming through.

Q: That's an interesting point. It would be interesting to get feedback from the students as to (A) why they picked your site, what it was that sort of attracted them and (B) what the reaction was once they'd been there compared to the reactions of other places, such as migrant worker sites and stuff, because I think that might help us with this students perception or barriers to care from the students point of view. But I think that's a super place to look.

A: I think you're absolutely right. When they finish their rotation they fill out sort of a customer satisfaction form or an evaluation for us as well as for Tufts. We can go back and review that. I think one of the strengths that has come out is that the students actually get an extremely broad-based

experience in the community health center setting and that's been very different than other places where they've just been, in some ways, almost stuck at doing very low-level procedures and experiences. Here they've really been exposed to the whole range of care.

Q: I'd be interested to know why they chose that rotation over another one. What was they saw as being attractive before they even got there? They might be people that maybe we want to be pulling in or recruiting in the future, you know, they sound as though they might be people that we should be targeting.

University of Louisville- Teresa Mayfield

Actually, I'm new to this. My predecessor retired in December. I have around the table with me a number of people: Lou Barr, associate dean for business and finance, involved in the original grant proposal; John Torrent. director of dental services for the Kentucky Department of Corrections; Susan King. clinical director for dental services for the grant; and Jennifer LaRey, program coordinator for the grant. It has been my pleasure to be a part of this grant and I've learned a lot in the last couple of months. What I'll talk about is just a little bit of the challenges and then I've asked Dr. Torrent to go over what we're doing with the prison system because I think that is a unique thing that we have going on here.

I think one of our biggest strengths is that we have a direct referral system from our patient care clinic that is right next door in the hospital. What we've done over the past few months is that we have actually let them schedule the patients into our clinic. So, as another person said, when the patient comes down and has finished their primary care appointment they're immediately given a dental care appointment and they come for screening and they actually are indoctrinated or told about the program and given the opportunity to receive dental care. We are now booked out through May with those appointments so we're just delighted to have that opportunity to serve the population.

We have a clinic right there next to our primary care clinic in which the (AEZD) and the (GPR) are available for treatment. They go ahead and incorporate the patient's treatment in with all the other patients that come to that clinic. So they get care and make appointments just like any other patient in the system. That has seemed to work out well.

In addition to that Dr. King is operating an indigent care clinic in one of our rural areas. That has been wonderful, we have patients that are driving from all over the state to come and see her and seek care because they cannot seek care in any other areas. We also have a liaison with the prison system. In which, like one of the other sites, working with prisoners to get them in good shape before they go out into the community and have a basis for having some supportive care once they go back out into the community.

John Torrent: This is actually a new partnership between the Department of Corrections and the University of Louisville. It's been a very exciting relationship. I think that there's been many positive facets to this. One has been the patient care where the University of Louisville has been bringing clinicians into our clinics and been providing additional services. I think educating our population to the importance of dental services as it relates to their particular disease/condition.

The other thing that has just been an incredible success has been in providing that bridge to the community so that they're able to develop a relationship with this individual while they're housed in our facilities and then as they serve out or parole out, that individual is easily connected to a community-based clinic that can just continue their care. And that has prevented many people from just falling between the cracks and leaving and not knowing where to go or what to do. So I think it's provided a wonderful continuation of care which is something that we're seeking, not just on a dental level, but on a medical level. In fact, this has been a tremendous model for us which we're going to want to explore continuing it on into the medical side.

I think the other thing that we've gained from it, from the Department of Corrections standpoint is a better understanding of our partner and other opportunities that we might be able to work together both with this population as well as with other populations. It's truly been a win-win for all parties.

University of Illinois-Chicago - Michael Olesandt

I'm joined by Larry Salzman. We have been having a great time putting this program together, but basically we keep running into a space problem at the different community clinics we see. Chicago and Chicago Land is set up where there are quite a few smaller community HIV dental clinics that have 1-3 chairs and really can't afford the space to have students man them. So we've been trying to come up with different ways to partner with these clinics, not necessarily providing clinical services but teaming up for health education or trying to give them patient take home materials, things like that. There is one clinic that we do have students being rotated through currently and there are two more that are caught up in bureaucracy that we hope to have them go through next year. But we keep running into a space problem.

Q: I have a question about this business about space. Where are you getting the students from? Are they supposed to be on a rotation? And if they're supposed to be on a rotation, what is the rotation supposed to be doing? In other words, before you start these HIV services were they providing clinical care and where were they doing that?

A: We modified the special patient's needs rotation. As many of you know adding to a curriculum is virtually impossible but tweaking an existing curriculum is relatively easy. We took the special patients needs course, which Dr. Salzman is, luckily, the director of and instead of rotating them through the hospital for 2 full days, we siphoned off some of the 4th year students and we told them that their rotation would be one of these community HIV clinics. In fact, we're having some problems with that because we can't fit all the 4th year students into the one clinic that we have already. So a handful of them are upset that they get the bad rotation, and their friend gets to go to the nice hospital that's close to the campus and in presumably a better neighborhood. It's not fair, it's not fair.

Loma Linda University – Tom Rogers

We had an advantage here in that we had a 12 year sort of partnership between the school of dentistry, a community outreach program called SACCHS, from our medical center and the County Department of Public Health. There's been a dental clinic associated with the medical clinic in the department of public health for 12 years. Eight years ago we moved into a nearby air force base, that was closed and the university purchased a large medical/dental clinic from them, you know, the

building, for a nominal fee and that's where the dental clinic has been operated. It's been a 24 operatories, most of which is a community clinic for a quite depressed, largely Hispanic area on one side and then on the other side we have 6 operatories devoted to the HIV care and we have about a 1,000 active patients there. A very loyal clientele actually. The volunteer to come in and interact with the students. They've been very supportive of this whole program. This academic year we do weekly rotations with 4-5 dental students and 1-2 hygiene students every week. They spend 8 hours over there and we have a program that's a mixture of didactics, role-playing, you know, how do you deal as a dentist or hygienist when you look on the chart and someone says their HIV positive, how do you talk to them. Or you start to see signs of symptoms that someone's HIV positive and they haven't indicated that they are, they may not even know that they are, how do you talk to them.

The first day the students come in, the patients volunteer to be interviewed, to sit and just talk with the students. The second day we have some didactics and it's mostly around patient care which, since they're only there for a couple of hours, maybe 3 hours at the most doing this, we don't get them involved in complex things, mostly exams, prophylactics and simple fillings. Most of the dental care under the (Part F?) grant is administered by Dr. Turner who's the community dentist who's been running that clinic for the entire 12 years it's been in operation.

We survey the students when their juniors, these are all senior dental students and senior hygiene students, we surveyed them when they were juniors and then we're surveying them again at the end of their rotations. We're just now finishing up, we've just about ran all 130 dental students and hygiene students through it so we're going to be reviewing our outcomes and presenting it to our faculty at our end of the quarter faculty meeting next Friday. And then we're going to be going back to our advisory council with the outcomes and how we want to change the program for next year. We're mainly going to be tweaking, it really ran pretty well.

An interesting thing from the comments of the students who go through is, the post session comments, they wanted more patient care, more patient interaction, which we found really encouraging.

As far as our frustrations, the biggest frustration and I almost hate to tell you this, but it's been with HRSA over our roll-over request which still seems to be stalled even though we initiated it last September. I hope some progress can be made on that because we want to put that back into more patient care.

Response from HRSA staff: We've been working on that and without grant reorganization it was originally lost, now located and they're working on it. That's the progress. We'll continue to bird-dog it, but part of the problem is that many, many pieces of HRSA are being restructured, reorganized, and it's not just one process and so we've got new people involved in it, new ways of doing things. We're stymied by it too, and you know, the piece in Sarena's report about you all dealing with institutions and bureaucratic frustrations, it's true in the public sector, too!

Janet Lee: I'd like to make a comment, that Captain Wainwright came down to New Orleans to meet with various grantees and I found that extremely useful on a couple of levels. First of all, there were actually some grantees in New Orleans that I didn't even know about in some community clinics and I'm more involved in a central group so that was extremely useful and it was also very good to actually have time to sit down with him and pick his brain on how to better do things so we could

facilitate things moving forward. It certainly didn't facilitate the roll-over funds, I'm with you on that one, but I did find that his coming down was exceedingly useful.

Q: I would also like to know if anybody else has a problem with scheduling student rotations around board exams and working with students to schedule into their extramural rotations.

A: That's always a problem and during finals, during board exams, we just can't have them. It makes a logistic problem in terms of scheduling and fortunately I've had quite a bit of help here in the clinical dean's office in doing that. But it is an ongoing problem.

New Jersey Dental School - Andrew Youngblood

Basically we have good things to report. And with us is our partner from Access One, Sylvania Landau. And we're calling from our brand new beautiful facility which was put together with the Title III funding that we received. We have two broad missions with our funding, one is educational and the other is patient care services.

The educational component began last year with the rotation of 6 general dentistry residents and 5 CODE students, which are community-based dental educational students outside of the dental school where they spend their entire clinical year treating patients in the community as well as rotations through the HIV clinics. We put together a 10 hour didactic course for all 11 participants and we also put together a pre and post course evaluation piece which we just implemented this year. We initiated the pre-course evaluation and we're going to be instituting the post-course evaluation very soon and hopefully we'll get some publishable results from that.

The second component is the patient care aspect and we had an existing facility, which was inadequate, it was a very small facility in Atlantic City, which is also an epicenter of HIV infection, and we took the funding and we've expanded and basically got up and running a brand new beautiful facility which just opened last month on a limited basis and we're adding more days of the week to this facility. And I can tell you that you're all invited and we'll send out notices of our open house and I hope that people can come out and take a look at this facility. We'll just begin treatment of patients here, we were treating patients in the interim at another sister facility which is only a few miles away.

Sylvania Landau: I'm the executive director of Access One and I think the first to speak from a social service AIDS community-based organization. We partnered with Dr. Youngblood's organization in that all of our case-managed Ryan White clients from a tri-county area were currently not seeking dental care. Close to 400 case managed clients come through our case managers and are identified through them then forwarded to, as with any type of specialty care they see a primary care physician, an infectious disease doctor and then that doctor then turns that around and we have over 50 specialty care doctors within our network and we saw the need for dentistry as just being one of those specialties. So all of those patients then are forwarded to the community-based dental partnership here with New Jersey Dental School.

My coordinator and the case managers coordinate transportation to the clinic. They either give out bus tickets or coordinate with other social service agencies within the tri-county area and get them on the vans or the buses to get them out here and that has worked really well within our community because it is, even though you would think of Atlantic City as being a very urban area, these three

counties are very, very rural in nature. And so getting them from sometimes an hour or two hours away to the center can be trying but the coordinator does do that very well and she works for Access One and partners with New Jersey Dental School.

IDEAS FOR THE FUTURE

Topics for In-Person Meeting

“For an in-person group meeting, I would like to see anybody’s and everybody’s feedback for, if they have any evaluations from students or partners, I’d like to see (A) the format and (B) the content.”

Resources

“What I’d like to see is a list of partners and maybe some contacts that we could get in touch with so that we could develop some of the partnerships in our area. It would help me get a good idea on how to proceed and how to solidify maybe some of the partnerships that we do have.

Future conference calls and listserv discussions

“I certainly think that when I listen to all these suggestions, having a place where you can actually put up a problem that you’ve bumped into...I think too often we’re trying to reinvent the wheel, in fact, the information is out there, it’s just that it hasn’t struck us. But having a place or a site that we can go to post questions, post concerns, or even boast a little bit about our successes, it will allow us to more readily focus or identify people that we can contact.”

RELEVANT WEBSITES

AIDS Education and Training Centers

<http://www.aids-etc.org/>

Bureau of HIV/AIDS, Health Resources and Services Administration

<http://hab.hrsa.gov/aboutus.htm>

HRSA’s Community-Based Dental Partnership Program Webpage

<http://hab.hrsa.gov/programs/factsheets/comdenfact.htm>

Non-Competing Continuation Applications for the Community-Based Dental Partnership Program

For more information, visit <http://www.hrsa.gov/grants/preview/guidancehab/cfda93924.htm>

Community-Campus Partnerships for Health

<http://www.ccph.info>

CCPH’s Community-Based Dental Partnership Program Webpage

<http://depts.washington.edu/ccph/dentalpartnership.html>