Grantee Meeting Minutes

May 6-7th , 2010

May 6th, 2010 9:00am – Local Evaluation Project CHC and HIV Alliance

<u>Local Evaluation Project CHC:</u>

1. Reasons for choosing a periodontal study:
    a. Enthusiasm for subject matter. Designed to still capture information around periodontal disease.
2. Initial Study Design and protocol
    a. Clinical attachment loss.
    b. All dentist and hygienist were calibrated.
3. Problems
    a. Examiners had difficulty using the BU database.
    b. A lot of time incomplete or inaccurate entries were not followed up. People moved on.
    c. Persons forgot to include information in charts at initial exam.
    d. Difficult to analyze periodontal data quantitatively.
4. Evaluation Modifications
    a. Reclassification of all patients on recoverable data
5. Case Definitions for the level of Periodontitis
    a. Level 1: No or mild periodontitis
    b. Level2: Moderate – clinical attachment loss (not on the same tooth)

c. Level3: Severe periodontitis

6. Clinical Data Collected

   a. First time patients come in, history of patient is collected. Nothing interesting seems to be popping out. Lower educational level appears to be associated with periodontal disease.

<u>Local Evaluation Project HIV Alliance:</u>

1. Quality Management Activities – how many clients are we serving, and are we serving enough?

2. Of the people they are serving, are they receiving quality care (The Appropriate care)?

3. Rates of Service table

   a. How many people in case management services, how many people are enrolled who are treated.

      i. In bad counties – issues is distance to clinics and main clinics (5-9) hours

      ii. Differential referrals strategies among Case Managers

      iii. Competing with a local health Center

   b. 600 Client survey questionnaires were mailed about confidentially, quality of service, etc.

      i. 56% felt decrease in mouth pain….example of things to take a look at and make changes/ come up with next steps for improvement

      ii. Strategies for increasing patient satisfaction and compliance among the counties.

   c. How/ what lessons have they learned to increase access to these groups.

      i. Satellite clinics, but still the closest is 5 hours away. They drive out to pick up patients

   d. What efforts have they made with dental societies?

      i. They have not done that yet. They only have 8 clients. Tag teaming patients to pick up and perform services. It takes a lot of organization and cost effectiveness to manage the distance patients have to travel to receive services

May 6th, 2010 9:45am – Multisite Data Discussion – Jane Fox & Serena Rajabiun

1. N=2494 patients in our final multisite data – largest ever
    a. Mean age of patient = 44yrs
    b. Mean years positive = 10yrs
    c. 40% black, 33% white, 21% Latino, 75% male
    d. 53% patients did not receive dental care in 2 or more yrs.
2. Symptoms in the past 12 months?
    a. Interesting correlations between people's symptoms and those dissatisfied with their appearance and avoiding going out.
    b. We are starting to see some changes in behavior with the sugar sodas and hard candy and sugar gum.
3. Getting to a complete final follow-up dataset
    a. We urge sites to learn from issues from baseline interviews, such as cleaning up the "others" categories.

Ancillary Services: update

1. Analyze what's been the impact in oral health outcomes by providing ancillary services?
    a. 87% of enrolled multisite patients have some form of ancillary service data
    b. Main staff providing ancillary services: Case Managers (Outreach workers, patient navigators), Administrative Staff, Dental assistants, Others (Van Drivers, Hygienist).
    c. Documenting these services because they are non-billable!
2. What can we do with this Multisite data, how can we use it?
    a. Frequencies in type of services provided and how does it improve oral health and retention in care.
    b. Mixed method paper on patient perspective on the role of dental case managers/patient navigators

3. The impact of dental case managers

    a. Idea to discuss with sites. Deadline for abstracts is May 12th. Sites should contact Jane if they want to work on this.

    b. Unless we get the smoking under control and plaque under control then we will be going in circles with treating periodontal disease.

    c. Persons can't get periodontal care, which is affecting their health and they can't get a job and also problems with their appearance.

Qualitative Study: update

1. 39 patients from 6 sites with initial & follow-up interviews.

    a. People may know about hygiene such as brushing or flossing, but are they actually doing it?

    b. What is it that the SPNS sites have done to impact client oral health care?

2. Did you learn something new about HIV oral health care?

    a. Good oral hygiene = good HIV health…showing awareness between HIV and oral health.

    b. Improvements in oral health care practices…patients are brushing and flossing more frequently.

    c. Biggest difference from receiving care: relief of pain, can eat, improved appearance, smile more, quality of care in dental staff and services are good, easier to access care.

    d. Changes to overall HIV health – ranges from no change to some changes (emotionally, pain reduction, etc)

    e. The role of the dental case manager: - had there not been a case manager, the patient may not have known about the service, comfort-ability, and reduction in fear resulting in better retention of care.

3. Advice to others?

    a. The awareness of oral health and its role that it plays in HIV health care.

        i. "Needing to keep up with physical, mental and oral are all connected"

        ii. Perception of oral health care affecting overall health in general, such as CD4 count increasing.

iii. Carol suggested people getting motivated to write articles qualitatively for the journal supplement to complement the quantitative analysis from the multisite study.

4. Analytical suggestion:

    a. Go into the clinical data and look at the disease outcomes and the impact these ancillary services had on it.

May 6th, 2010 10:30am – Utilization Data and Chart audits – Carol, Helene, and David

1. Problems

    a. We don't know most of the time whether or not the data we have is reliable, if it is correct, or accurate. This is a lot of money spent on resources and there's no excuse to have work not documented.

    b. Sites need to make sure data entered in charts and in ECHO are accurate, if not then the data is no good and is not reflecting how much work they are doing

    c. Many are clinical hygienists who need to get into a new research mode because they are letting down our work for HIV oral health.

    d. We need to know what services are being performed to individual vulnerable populations. If the info is not accurate then we are reporting nothing (20% inaccuracy is not GOOD).

    e. Do audit before audits visits, and don't lie about audits when it really hasn't been done.

    f. Helene has visited over ½ the sites for chart audits. Sites are doing an incredible amount of work that reflects increase in access to care. But the lack of complete are not showing these results, so it's important to accurately reflect the results in the data.

    g. To demonstrate increase in services, need to demonstrate by entering the data

    h. Under reporting of data – such as patient education. Personnel are reporting in charts but not in ECHO thus consistency and accuracy is a problem.

    i. Over reporting of chart /chart errors – in addition to codes, we need reporting of all services actually done. For example, some just report services but had other services done.

    j. Coding errors – we have seen duplications of patients and services. We need sites to go back and audit these glitches to make sure data is accurate.

k. Need to resolve basic issues like reporting "teeth cleaning".

l. It was pretty surprising after warning sites to audit their charts, and when ECHO visited they were not complete.

2. Reasons/Lessons learned

a. CHC - Thinking that billing code equals utilization data, when in reality they do not add up. Clinicians need to have the mentality that each service daily needs to be documented.

b. Some sites can hardly bill. So sometimes just mark off office visit. The person doing the data entry into ECHO did not know what to look for. The training of the data person into dental coding was an issue. Avi corrected this by repeatedly training the new person over and over by whoever arrived on the scene.

c. Started putting the exact procedure and start printing the actually billing code and procedure so that the data entry personnel can clearly document what services were actually done.

d. One site had inaccuracy of codes. Dr. Davis actually wrote down the codes so that the data entry person can write down the correct information.

e. **IMPORTANT TO HAVE A DENTAL CLINICIAN OR SOMEONE WITH DENTAL EXPERIENCE WORKING ALONGSIDE WITH THE DATA ENTRY PERSONNEL SO THAT THE DATA IS ACCURATE.**

f. Some other issues – getting students and faculty on board to enter data has been difficult to control.

g. ECHO has created an actual report by site, by patient ID, by pulling chart and making comparison between ECHO data and Chart DATA…**PLEASE CONTACT ECHO IF SITES NEED ANY HELP HAVING BETTER ABILITY TO ENTER DATA.**

3. Where do we go from here

a. St. Luke's has done an amazing job with their chart data and are almost perfect…Likely due to from the beginning having a dental director working well with them and Clinicians taking an active role.

b. Karl – in beginning they were repeating codes and never had a billing system. So instead they got an encounter form by putting everything that was said in the Note section in codes.

c. **When sites are being asked to do a chart audit, we want them to download their data from the ECHO data base and match it up with their charts and check the dental codes and make sure a dental director or clinician is there to monitor the consistency.

d. ALL SITES NEED TO HAVE EVERY SINGLE CHART AUDITED BY JUNE 15TH . We want to make sure every single patient has been checked. Asking site to plan now, shutting down clinical operations and do nothing but enter all data.

e. August is the last date for data collection. And then we will ask sites to enter all their data in that first week in August. If someone comes in for care Sept 1st it will not get entered in the multisite data.

f. Sites can continue to track patients after multisite site study but the main thing is to focus on getting the information in of the services that were provided over the 4 years.

g. How do we make the case that oral health service should be on the priority list? This is what sites should think about as motivation for funding for continued services etc…

GOAL: Have a complete and final database by October 15th.

May 6th, 2010 11:00am LESSON LEARNED Introduction – Jane Fox

1. If you open up an HIV clinic, here are some things you want to know?
    a. What are the main similarities and differences in programs to increase awareness in HIV
    b. What kind of structural policies are needed?
2. Categories: regulatory issues, recruiting and training staff, connections with schools, dental case management, patient centered care, transportation, mobility, levels of dental services, integrating medical and dental care, and sustainability.
3. Are there any categories that sites feel we have missed?
    a. Amanda – a lot of the clinicians are used to private practice setting. What are the supports that they need to have in place to make the environment better for clinicians?
    b. Using private practice clinicians and integrating them into the public health model. Because the practice in private health practice is very different compared to the public health setting.
    c. Sometimes certain dentist would want things that are outside site funds.
4. Is there a patient piece?

a. Not too widely because the access clients have had is very limited – Amanda

b. Nancy had similar experience – the expectation of self-care is not feasibly done on a consistent basis.

c. Limited resources in patient education.

d. Long-term-payment for services – depending on the setting, there is an underlying presumption that there is a lot of funding for services is there and it's not. It would be helpful to have a serious conversation to have long-term financing for the HIV community.

e. If the care isn't going to be paid for by somebody then not sure what's going to happen when we are done.

1. Helene asks: How many sites are affiliated with a dental institution – 4

2. Helene asks: How many are affiliated with a dental program – 3

    a. 1 program has talked to coordinators of dental reimbursement. There are certain ways to convince part A to cover some funds.

May 6th, 2010 12:30pm Lessons Learned – Jane Fox

Other questions for Lessons Learned:

- Orienting/training clinicians and support staff in the differences between public health dentistry and private practices – e.g. re requesting supplies; who pays for what, what you do when certain things are not available. (HIV Alliance and SHRT) Also around self-care expectations.
- Long term payment for services (Lutheran).

1. ACG – keeping an open door for patients, but still many don't come back for preventive care. Irshad – want to look at why and why not. What happened to the 80% who didn't come back? People have a greater level of need than they expected. There is a lot of work needed to do to get people through their treatment plans.
2. ARCW – how transportation was handled for clients. Gave clients gas cards to help pay for transportation. Also contracted with dentists in more remote areas to deliver care closer to the patients – can't use the same solution for different circumstances. Also pay for care at a CHC in a more remote location.
3. CHC – program expansion. Wanted to open up a dental clinic in a public health clinic in Norwalk (a satellite office) based on input for client focus groups – PWAs said they did not want to come

in to a regular dental clinic, wanted a specialized clinic. So they built out a new operatory, beautiful new office in the public health clinic. Didn't have the right water flow, the right instruments, couldn't take the right kind of xrays. Saw 12 patients and then needed to bring them over to the Norwalk Clinic where more services were available. They misjudged the needs of their SPNS patient – they were too complex for the public health clinic. Also people had a greater level of need than they expected, as with ACG.

4. HH – focus has always been on DCM. Have conducted focus groups among patients about the role of DCM – very happy to have 1 person to call with any problems – insurance, questions about care or referrals, no need to explain diagnosis or situation – who could also provide comfort, holding peoples hand in the chair, or help alleviate fears about stigma, money, coverage. Medical case managers were relieved to have someone to turf the dental issues to.

5. HIV Alliance - they cover 63,000 square miles. Some people drive 5 hours to get care. Got transportation funding from the state to expand their service area. Now are totally at capacity. And just lost their full time dentist. Do they keep serving new people or finish up the care with the folks already enrolled.

6. LSU – Providing dental services in the mobile unit. Many issues with the equipment, couldn't run the AC and dry vac at the same time. Had a lot of problems with the van but then realized the problem was the driver, don't know if he was trying to sabotage the program. Was not taking care of the van as he should have. Space is limited and they are still using paper charts, now they are running out of space to keep the charts. In process of going paperless, but that will take awhile. Privacy is a problem since there are no walls. Have to turn on the dry vac to create white noise during the interviews. The bus is not wheelchair accessible. It takes too much time to set up and pack up every day. Would not use a mobile van if they had the choice again. (The other 3 places said yes they would use it again).

Question: has anyone looked at the cost of delivering care in the mobile van vs. in a standing clinic (or 3-4 mobile units).

1. Lutheran – without a fixed facility they had to work with governmental agencies, practices and public health officials to deliver services. See her write-up.

2. Sandhills – how many other folks have had to deal with state regulatory issues? Particularly with regard to dental vans, where proprietary providers are coming in to deliver care to Medicaid patients – not referring patients to other services, park outside the clinics and give them $ incentives to swipe their Medicaid cards. So states are clamping down on this, rightfully so, but the proprietary providers say they will fix it and then pack up and leave the state. But this makes it a little hard for other providers of services on mobile van. In NYC they had to meet the requirements for any other dental clinic in order to get a Medicaid provider number.

3. Montefiore – challenge of how to get referrals from clinics to the mobile van on the days the van is not parked outside the clinic. Also coordinate with front desk staff and patient navigators who may be at other sites. Providers are not always on top of which days the vans are parked outside their site so are not necessarily making referrals. Van staff go over to the clinics in the morning to walk patients over to the van. It's bad for data when the subway goes over the van, but it's nice for people sitting in the chair. Vandalism is also a problem, especially the terminals for the medical records.

4. NAHC – Have 4 different information systems – a practice management system, dentrix, paper charts, the ECHO data system. Need to continue to train and retrain people on the ground about how to use the systems. Have had great success in retaining patients and staff, due to the personal support that we give our staff who give their support for patients. Front line staff have been trained in confrontation management and de-escalation. Have worked to lobby internally about how successful this program has been, knowing that some of this funding will be going away but wanting to make sure the dental case management staff are retained. Working on sustainability now that DentiCAL has been eliminated – getting good at billing for emergencies.

5. SHRT – DCM. Serve 23 counties through 4 sites and have 1 DCM. Had established professional working relationships with HIV clientele previously so that was importance starting place for this. Serves as the bridge between medical, dental and case management services within the agency. Has had challenges contacting patients who have relocated for follow-up. Communication with many different people helps with this.

6. Sandhills – Tying dental system into electronic medical system – thought that would be easy, but found out no one else had done this. Calls this the Meisner barrier. All the medical information is available to the dental team because all the referrals come from the medical side. Some of the patients are in denial about their HIV or other medical conditions (Hepatitis) but they have the information. The medical providers have made referrals to the oral surgeon. They have been able to print out medical issues identified on the dental side and taken it over to the medical providers. When they've put dentures in patients they feel better, their nutrition is better, their social lives have improved. Comments provided by their ID doc about the importance of oral health care. HIV care without dental care is incomplete. What they have learned is a change in knowing – they knew some things conceptually and now they know it practically. The van travels 450 miles each week. Dental personnel tend to concentrate in cities. Rural patients have less of a tendency to seek care than urban patients – they have higher no-show rates. The integration of care is difficult but important.

7. St. Luke's – Went through a lot of changes. Started by renting space in private practices thinking people would be more comfortable getting care there than coming into the hospital clinics. After 3-4 when they were not able to bill for those eservices because they were not Article 28 clinics. They also underestimated the number of patients who would come to those clinics. They had too many patients to see and people had to wait too long for follow up appointments. So

the plan was to move the patients to an article 28 clinics and they would figure out how many more days they can serve patients. Then DOH said you have to rent the whole clinic or nothing. They need to know who the patient belongs to if something goes wrong. But they did not have enough funding to rent the whole clinic. So moved everything back to the hospital and the capacity issues were resolved. The question was – how many of their patients would leave them? Their retention rate is still 80%. Lessons learned – don't believe everything the senior administration says to you.

8. Tenderloin - Started with a small screening clinic at TLH, but it was too small and they could not do anything there. No-show rate was high, no one wanted to come in. Focused energy on building the clinic at TLH, co-located to dental clinic. Once the clinic opened up there was a dramatic improvement. Patients who missed an appointment will come back in – they are there for other reasons. What they wanted was a dental home. This is a big factor in their success. The challenge involved in building out the clinic – the 2 agencies, TLH and the Health Dept. were at loggerheads.

9. Umiami – No major van changes after Yves and Dr. Peleg did the initial wiring. Got dental residents donated, so no cost there. Working with the school was the best thing that happened unless you can find a dentist who is willing to do this full time at a lower salary. They only drive the van 5-6 miles/day. Without these perfect circumstances – affiliation with the school, residents donating time – not sure they would do a dental van program, but with these circumstances they would do it again. The van is an expensive machine – there are a lot of mobile parts, generators cost a lot to maintain, there is oil, tires are expensive, oil filters are expensive, if you only run the van 5-6 miles/day not a problem but more than that it would be. Suction becomes a problem. Comprehensiveness of care is related to the amount of fluid you can drain, the amount of water or supplies you can carry – there are limits to what you can do on a van. The smaller the van, the cheaper it is as well. Infection control is a major issue as well. Need to think about how many times the dentist can wash his or her hands. Statistically, 90% of the malpractice issues are filed by Medicaid patients (in Miami????). The van has to be equipped for medical emergencies. Oxygen, resuscitation equipment. People need to understand all the pros and cons of operating a program on the van. It's very difficult to modify a van once purchased.

10. UNC – Newly diagnosed folks have significantly less carries or gum disease. Their disease is more likely reversible. It is also cheaper. Providing education to the medical folks is critical to this. They are using existing infrastructure – where medical and dental care exist already. Ongoing contact with patients by the hygienist has made a difference in patient retention. Patients say it is important for them to know that someone else cares about this too. Doing a lot of training of dental students and residents at some of the community sites.

May 6th, 2010 4:30pm – Public Health Reports Journal Supplement – Sally Bachman

1. Jane found a partner for ECHO and journal supplements (Public Health Reports) – oldest public health report and the sergeant general's journal.

2. Adan will have to let ECHO know how to get this journal supplement in to the Sergeant General.

3. We are in hyper mode for the database because manuscripts are due by January 1st. So we need to have data cleaned and ready to give people enough time to have manuscripts ready by this deadline.

    a. Want a good mix of manuscripts from sites to include in this journal supplement. We will assemble a list of reviewers to review the journals.

    b. Our idea is to work with sites to make sure that sites interested in working on the journal supplement can and have access to the multisite database.

    c. We want to be able to showcase the great work that has been done by sites. We need at least 10 good-ish manuscripts to put in the journal supplement.

4. Who really would be interested in writing manuscripts? If we can't get them from this multisite group, we will have to get it from someone else – which Sally doesn't really want to do.

    a. Paul – Integration with medical and some of the challenges there. Potentially using the multisite data.

    b. Jennifer – focus on importance of early intervention as best practice. Integrating medical with dental in order to get newly diagnosed into care. Although this is a local study concern, she believes she can query the multisite study comparing utilization data to what procedures the patients had.

    c. Peter – They have a periodontal database that has severity of disease. They can do analysis based on factors of non-clinical data to see if the level of severity with their sites is similar to that of other sites.

    d. Celeste – looking at differences of sites who had services delivered by dental case managers and see if there are difference in outcomes compared to sites that used other.

    e. Carolyn Brown – concerned about database being completely cleaned. Case manager.

    f. Howell – do the outreach and retention strategies used / treatment plan completion?

    g. Donna - Utilizing dental hygiene students as a source of labor in the dental market.

    h. Jessica – dental phobia/anxiety.

May 7th, 2010 8:30am – 10:00am Poster presentations

1. Site Discussion after poster presentation: Is there a unified definition of retention?
    a. Once sites have reached sustainability, retention rates should go up.
2. ACG – Patient centered care.
    a. RW model vs. ADA model
    b. Basic public health
    c. Ancillary data
        i. Miles
        ii. Food
        iii. Case Manager
        iv. Calls
    d. Increased work to get patients into/keep in care
    e. Meet patients where they are
    f. Came to care for problem
    g. No judgments
    h. Do what you can to get patients back
3. ARCW – Transportation
    a. Patients travel long distance for appointments
    b. 2 sites…Milwaukee, Green Bay
    c. Bus tickets and gas cards
    d. Responded based on patient feedback
    e. CQI model using feedback information from patients
    f. Contract dentists and CHC
4. CHC – Program expansion
    a. Norwalk, Stanford Department of HH

   b. New clinic – satellite (limited services)
      i. No water
      ii. Minimal instruments
      iii. No full x-rays
   c. Sent patients to Norwalk clinic for comprehensive care
   d. Patients' needs do not equal ability of new clinic
   e. Dental home and general dental practice

5. Harbor Health – Dental Case Manager (DCM)
   a. DCM role and how it impacts patients
      i. Gain access
      ii. Availability
      iii. Comfort
   b. Focus group results
      i. Happy to have someone who knows them
      ii. Insurance issues
      iii. Availability through one call
      iv. Comfort
         1. Hold hand
         2. Where to go?
         3. How would it be covered?
         4. Worry about HIV Case Manager has the same role as DCM

6. HIV Alliance – Stigma an issue in rural OR
   a. Comp OH
   b. DCM
   c. Contract w/ state to cover transportation

d. They are at capacity

e. Less clinical time

f. No implants, nor ortho, but everything else

g. Underestimated needs of patient

    i. Patient with ongoing dental needs

7. LSU – Mobile unit

    a. Issues with equipment running properly

    b. Repairs and rewiring

    c. Issues not necessarily the bus but the driver. Driver gone and new driver much better in taking care of bus

    d. Limited space

        i. Cannot keep chart on the bus

        ii. Privacy issues

            1. Use white noise

        iii. Accessibility issues

        iv. Whether and location w/ AIDS

8. Lutheran – Regulatory issues

    a. No initial fixed clinic in USVI

    b. Underestimated cultural/ family ties and inter island competition

    c. New governor

    d. 4 health commissioners/4 yrs

    e. Board examiners finally given verbal approval for licensure

    f. Hospital – DPH regulations

    g. Patients, persistence, advocates, family ties, politeness

9. Montefiore – Program expansion – mobile unit

a. Increased referral and outreach for van
b. Weekly reports to identify those patients coming in for medical care to then get them into dental care
c. Educating providers to refer to van
d. Medical/dental crossover report
e. Van staff go to clinic to escort patients to van
f. Sharing dental record in system
g. EMR on van

10. NAHC – Technology
    a. EDR
    b. Practical management system
    c. ECHO
    d. Paper records
    e. Trains and retrains on technical systems
    f. Staff retention and patient retention
        i. DCM staff weekly debrief
        ii. Confrontation on management
    g. Internal PR on program success
        i. Ways to keep DCM funded
        ii. Provide info to top NAHC folks about value of DCM
        iii. holistic approach to patients diversification and sustainability plan
11. SHRT – DCM
    a. RWCM → DCM
        i. Established relationship with HIV clientele
        ii. Personalized service

b. Training new HIV Case Mangers

c. DCM serves as a bridge between medical and dental

d. Compassion

e. Challenges contacting patients that have dropped out of care

    i. Use in house resources to locate patients

12. Sandhills – Integrating dental and medical

    a. Challenges integrating medical records and dental records (could not do it)

    b. Dental and medical speak different language but have the same goal.

    c. They can get printed MR for review

    d. Medical can review dental records for review

    e. Dental recruitment difficult in rural area

    f. No show rates higher in rural areas

    g. Capabilities for medical record

    h. Infectious disease …dentist contribution to HIV care

    i. HIV care without dental care is incomplete

13. St. Lukes – Sustainability

    a. Initial program

        i. Rented 2 private practice sites

        ii. Could not afford services in these sites

        iii. Only open 2 days/week and could not meet patient need for appointments

    b. Tried to move to a FQHC 2 ½ /wk

        i. DOH regulations – one set of patients per day

    c. Moved back to hospital

        i. Resolved capacity issue

        ii. Resolved billing issue

        iii. Maintained 80% patients

    d. Do not underestimate need

    e. Article 28 = NY Medicaid

14. TLH – program build out in Tenderloin

    a. Patients live on street (6-8 blocks) or SRO's

    b. Patients go to clinic 4 blocks

    c. Existing clinic 4 blocks away – patients refused to go there

    d. Started with small clinic and portable equipment. The no show rate limited services

    e. Build out at TLH – 2 chairs

        i. Patients come in

        ii. Dental state has access to patients

        iii. Patients like dental home

        iv. No show rate has dropped

    f. Lesson: location, integration into existing neighborhood and existing CBO.

15. UMiami – Connecting with schools

    a. Van issues → not so much

        i. Functioning at 2 sites only 6 miles apart

        ii. Dental residents donated to work on van

    b. Investigate partnering with schools

    c. Dental residents stay 1 month

    d. Van is expensive machine – many mobile parts

        i. Maintenance is expensive

        ii. Amount driven impacts amount of cost in maintenance

        iii. It is limited by how much you can do (level of care)

        iv. Infection control

    e. Liability issues

16. UNC – Integrating medical and dental
    a. Educating HIV providers about importance of oral health as part of HIV care.
        i. These providers then refer newly diagnosed patients into oral health care
    b. Using existing infrastructure of medical and dental together
    c. Patient center care
        i. Calls
        ii. Newsletters
        iii. Patient remark about "compassion/caring"
        iv. Sustainability
            1. Dental residents in North Carolina
                a. Educating next generation of dentists

May 7th, 2010 10:30am Getting the data to talk –Howard

1. Research Background with Hortensia Amaro, risk reduction interventions with tens, drug using mothers, evaluation of CDC system for assessing indicators of prevention at state and local departments of pub health.
2. Howard likes the fact that the data is longitudinal
3. What does the data mean to me?
    a. If you want to change something, you have to measure it
4. Why are we doing research?
    a. To inform the development of new practices and policy in the field. If we don't have good data, we have garbage.
    b. It is going to require a joint effort to make this goal possible (all sites!)

c. Due to synergy of team members, previous projects have been very successful. They took time to sit down and discuss what the ultimate goal was and this made it successful.

d. When people have life issues such as income, substance use, etc, it really differentiates the experience from patients to patients in retaining care.

5. **Challenge: Use the same strategy in ECHO:**

    a. Having structure is very important and time saving.

    b. Using each other as resources will end up putting together a strong project.

    c. Sites should start structuring time to make it a habit in entering data.

    d. Piloting your procedures is really key to having smoother operation.

    e. What can you do with this opportunity to change practicing policy.

May 7th, 2010 11:00am Using the multisite data – Howard, Amarachi, Serena, Carol, Jane, Sally, and David

1. Celeste feels there needs to be a uniformed job description that makes someone a Case Manager or not.

2. It all depends on what the personnel's role/description is to define what type of worker.

    a. The key is we need some form of discussion regarding uniformity in defining staff etc.

3. Determine what the unifying elements are across the board, continuity of services, and the amount of time involved.

    a. We have dose response variables from some sites that we would like to investigate (i.e. dental case management).

    b. DCM – is based on need (Celeste).

4. Are the differences in DCM vs. Not DCM and service utilization – Sites say show-rate. How much care the patients receive comparing sites with DCM vs. No DCM.

5. Definition of Retention in Care? – Medical retention is had a visit in 6 months.

6. Did someone stay connected with a provider after receiving care? –

    a. Justifying the role of dental case managers for improving a vulnerable population's HRQL.

    b. Is there a difference in treatment plan completion and phase 1 and oral health?

7. Nicole – Suggest what are everyone's ideas of retention of care? And we need to agree.

    a. Nicole defined it – If they have had a dental visit in the last year.

May 7th, 2010 12:30pm – 1:30pm - Qualitative work group/Publication in progress and Dissemination plans – Carol

Habits Research Question Group

Present: Carolyn Gray, Horace Griffith, Carolyn Brown, Jennifer Webster Cyriaque, Monty Monteiro, Ernesto Guevera, Julie Kazimirof, Pam Belton, David Reznik.

1. Who wants to work on the paper: Carolyn, Horace, Carolyn, Carol, Julie, Pam. Ernesto and Monty will ask their PI's and Jennifer says someone from UNC.

2. Take people who have teeth and have completed Phase 1 treatment plans, do they need more restorative work and how is that related to brushing and flossing frequency.

3. Habits are reflected by responses to the questions.

4. Tie to utilization data. If they had perio work at the beginning and they move to maintenance phase, look to see if there is a change in their brushing and flossing.

5. Just look at brushing and flossing. People want to add smoking.

6. Look at rates per 30 days.

7. Not many studies look at these issues over time. This measures whether or not your hygiene education was successful. There are 3 oral hygiene education codes that could be used.

8. Some sites measured gingival index – that's a better measure of whether interventions were successful.

9. Look at HIV Alliance in the context of an oral hygiene school – are they doing it better at that site? That would be a huge asset if the answer is yes.

10. Look at other sites where they primary dental clinician is a hygienist. Sandhills, UNC, SHRT.

11. Look at oral health literacy at baseline and how it related to this.

12. Changes in grinding and clenching might be correlated with removal of pain, look at the utilization data for treatments that may have removed pain, fillings, extractions, root canals.

13. Need to do this paper at the end, to look at changes over a longer period of time. Compare short term and long term. A lot of the literature is on tiny samples over a short period of time. The interventions are usually more discreet. This is a cluster of activities over time, but maybe it doesn't matter what you do but that you do something and keep at it over time. We have geographic diversity, and the interventions reflect the different populations.

14. Also should look at dental case manager role.

15. Carolyn B. has never seen changes in nutrition – like drinking sugar soda and eating sugar candy.

16. Can we correlate the changes in habits with oral health quality of life. Do this on the 12 month sample.

17. Jessica may want to work on this. Don't have calls on Fridays or Mondays. Carolyn Gray wants to lead this.

1. <u>Next steps in how to look at the data</u>

    a. Carolyn agrees to lead a paper on health behaviors

2. <u>Retention</u>

    a. The population is transient. People come in for acute pain. They see retention as retaining that pain temporarily.

3. <u>Constraints</u>

    a. Self perceived health status is not accurately being captured.

    b. Engagement in care should be based on 2 visits in 12 months

4. <u>Unmet needs – Time needing care but couldn't get it?</u>

    a. Patient self perception barriers and facilitators of care- if you have an HIV case manager, you're more likely to have care.

        i. Earlier diagnosis if medical needs were already met…How much does this affect the need of care?

5. <u>Difference between needing care and actively getting it?</u>

a. Really should ask if one has ever sought care?

b. Develop literacy scale that measures perceived need.

c. Follow-up has a lot of patients reporting not being able to get care.

May 7th, 2010 12:30am – Plans for next Grantee Meeting – Carol and Sally

1. Have work groups/reviewers for the articles we are working on in order to provide comments and feedback
2. Have a meeting in late November
3. Have a HW agenda deadline for publications for sites
    a. Ideas/post supplement ideas
4. Dental people bring a small poster – types of oral manifestations, types of lesions by sites.
    a. Sites should audit charts and note any lesions they have seen.
5. Have a session about where do you see yourself 5yrs from now?
6. Crystallizing lessons learned and its policy implications
    a. Qualitative data shapes policy. What were the problems patients were facing?
    b. Policy briefs
    c. Using our data not just for peer reviews but as state policy