Bureau of Primary Health Care (BPHC)
Oral Health and HIV/AIDS Webinar

December 19, 2018
2:30pm-4:00pm ET

Coordinator: Thank you for standing by, your conference will begin momentarily. Welcome and thank you for standing by, today's call is being recorded if you have any objections you can disconnect at this time. I would now like to turn the call over to [Indiscernible] you may begin.

Vy Nguyen: Good afternoon and good morning to those on the West Coast, I am the dental officer in the Bureau of primary healthcare officer of quality and improvement, I am joined by [Indiscernible] in the office of quality and improvement, Captain Mahyar Mofidi with the community HIV program, and [Indiscernible] public health analyst in the community of HIV program in the Bureau. I would like to thank everyone for joining us today, to bring awareness with today's webinar advancing oral and primary healthcare integration to sub or people living with HIV. We have wonderful speakers with us today, before we begin I would like to run through logistical items. The PowerPoint for today's presentation is available on the lower left-hand side of the Adobe connect room for download, we are also hoping to have time dedicated at the end of the session to answer questions for many of the speakers. Please feel free to type in your questions in the chat box at any time during the presentation, we will get to as many as we can toward the end. This session will be recorded and we will let you know when that is available. So let's go ahead and get started with the learning objectives. For today's session.

The first objective is to understand HRSA and BPHC and HAB mission strategic goals and initiatives and how they advance oral healthcare for people living with HIV. Second to understand the connection between HIV and AIDS and oral

healthcare. Third to explore different oral health and primary care integration models and resources for people living with HIV, and to learn about two examples of collaborative oral health and primary care integration models for people living with HIV in help can are sending -- center settings.

So, I'd like to kick off with the mission serves as the foundation for all of our activities. We were to improve the health of the nation's underserved communication that my communities, and underserved communities, with Healthcare Services through that mission we have three strategic goals to help advance the work towards integration and advancement of oral health as well as overall health, access to care, advance quality and impact and optimize operations.

In alignment with our strategic goals, health centers provide preventive dental services and various levels of additional services beyond prevention, serving as the access point for oral health care for the communities. With dental services provided to 6.1 million patients, in 2017. That is an 8.1 increase in patients in one year from 2016 to 2017, as part of the steady increase in the number of dental visits since 2010. In addition the dental workforce has increased by 10% from last year, with over 4800 full-time equivalent dentist, working at health centers to increase the programs capacity to provide oral healthcare.

In addition, health centers of required to refer to HIV testing. According to the survey, we know that HRSA funded patients are more likely to receive HIV testing in the public. With 1.8 million patients being tested, 84.5% of HIV patients were linked to care, and over 165,000 HIV patients were served as -- at health centers.

Given this population, and part of the HIV integration initiative, the partnership for care consisted of 22 health centers along with four funded collaborations through a three-year demonstration project from 2014 through 2017. The 22 health care centers built and expanded their service delivery, to optimize HIV testing, linkage to care, preplanning policies and procedures and continued partnership with state departments. Through the project these health centers demonstrated improved

outcomes throughout the continuum, including linkage to care, and bile suppression.

We will be hearing from one of the health centers later on in this webinar and how they were able to engage the dental departments in these efforts. And informed the development and implementation of the Southeast transformation projects, the project included 16 healthcare centers, to implement HIV practice transformation with the Southeast aid education program. Included a workshop, communities of practice, strengthen knowledge, culture change leadership, on-site trainings, prevention, one-on-one coaching as well as regional connections with HIV, clinic champions, specialist and providers. Additionally other technical assistant resources to prevent HIV integration are included on the Bureau websites, and also features an integration toolkit relating to these efforts.

Health centers are an essential primary care provider emphasizing coordinated and comprehensive care and the ability to manage patients and multiple healthcare needs. They serve our nation's most vulnerable populations including those living with HIV. Especially with a gamut of world health implications influenced by this population, health centers are uniquely positioned to integrate care, with testing, prevention, care and treatment, into other other primary care and enabling services. To increase access, and improve health outcomes for people living with HIV. We are really looking forward to hearing about some of these integration models from our speakers today.

Have my contact information, please feel free to reach out to me, and with that I will turn this over to Captain Mahyar Mofidi.

Mahyar Mofidi:

Thank you, good afternoon, everyone, I’m the director of the division of community programs, and the Bureau chief dental officer. On behalf of the Bureau, and the division of community programs I welcome you to this national webinar, on oral and primary healthcare integration to support people living with HIV, in community health centers. I hope that you are excited about this national webinar, I

know that I am, as was mentioned this is a collaborative effort between HRSA Bureau of primary healthcare and the HIV AIDS Bureau to provide the health outcomes of people living with HIV through oral health and primary care integration. As you all know, oral health is an integral part of overall health, particularly as it concerns persons living with HIV. The integration of oral health and primary care is a key strategy to improving both the overall health, and oral health outcomes for people living with HIV in community health centers as well as Ryan White funded clinics are an ideal laboratory for integration of oral health and primary care and uniquely positioned to fully realize the model of integrative primary care and oral health for individuals with chronic conditions.

We start with our Bureau's vision and mission, this has been the guiding vision and mission of HRSA HIV AIDS Bureau for a while, we strongly believe in the division of -- the vision of care and treatment for all in support of the national HIV AIDS strategy. We provide leadership and resources to Ryan White funded programs many of whom are delete funded by the community health center funds. To ensure access to and retention of high quality, integrative care and treatment services are vulnerable people living with HIV and AIDS, and their families. If -- a few words about the program, since 1991 this program has been providing a comprehensive system of care that includes primary medical care and essential support services, for people living with HIV, it is the only disease the civic discretionary grants program for care and treatment of people living with HIV. The program works with cities, states and community-based organizations to provide HIV services to approximately 54% of all people diagnosed with HIV in the United States. That is around 540,000 people, the majority of Ryan White find support primary care and critical support services, smaller but equally critical is used to fund technical assistance, training and the development of innovative models of care, this program serves as an important source of ongoing supports. Working in the parameters of the legislation, recipients determine the service delivery and funding priorities which are based on the local needs and planning processes. Ryan White program is the payer of last resort, legislative provision to ensure that there are no duplications of efforts for those available states, and federal dollars, through all of

our collective and combined and persistent efforts, almost 86% of Ryan White patients with at least one medical visit achieved viral suppression in 2017 exceeding the national average of 59.8%.

In other words, 86 percent of our clients have an undetectable level of HIV virus, as you know the end goal of the continuum is achieving and maintaining viral suppression so that people can be healthy and less likely to transmit the virus, and Ryan White programs are making a great impact toward achieving that goal.

A bit more about the Ryan White program, it is divided into five parts, part A provides grant funding to population centers, that are mostly severely affected by this epidemic, part B provides grant funding to the states, and territories, part C provides grant funding for community-based organizations, part D provides grant funding also to community-based organizations with a focus on women, infants, children and youth living with HIV, and finally part F, provides grant funding that supports several research technical assistance and access to care programs including two specific dental programs. Are -- we administer these parts of the program.

The Ryan White program supports the provision of oral health programs, through a variety of mechanisms, these include Ryan White parts letter a -- a through D, the funds to the programs provide the provision of oral health provisions to programs focused on funding or healthcare, they are part F, dental reimbursement programs, and part F, community-based programs. Through the education and training centers, trainings are provided on oral health that targets healthcare professionals. As displayed on the table, these mechanisms support both the direct provision of oral health services to increase access to health care for people living with HIV, as well as support the training of oral health providers in how to care effectively for people living with HIV.

A little bit more about our two parts F dental programs, the dental reimbursement program and the community-based dental partnership program, key program elements are funding of oral health services for low-income people with HIV, and

the funding of education and training for oral health care dividers, -- providers.

At this point I would like to turn the presentation over to my colleague.

Sayo Adunola:

Thank you, I will now talk about [Indiscernible].
Oral health is essential to the overall health and quality of life and all families need access to high-quality dental care. The first ever Surgeon General report on oral health was released in 2000. Its purpose was to inform the American people about the importance of oral health and how crucial oral health is to overall health. I am pleased to mention on July 27, the Department of human health services, office of the Surgeon General the national Institute of dental research, and the U.S. Public health service oral health coordinating committee, announced the commission of a Surgeon General port on oral health. The report was document progress and oral health in the 20 years since the first Surgeon General's reports, on oral health in 2000. It will identify existing knowledge gaps, and articulate the vision for the future. Also, the national Institute of dental and craniofacial research will host a webinar on Thursday, January 10 from 12 to 1230 Eastern standard Time, to update the public on the status of the new Surgeon General report.

Oral health is critical for people living with HIV, past Surgeon General stated that while good oral health is important to the well-being of all population groups, it is especially critical for people living with HIV. Inadequate or healthcare can undermine HIV treatment, and diminished quality of life, yet many individuals living with HIV are not receiving the necessary oral healthcare that would optimize their treatment.

We know that oral infections and neoplasms occur with immunosuppression, there is a high prevalence of tooth decay and gum disease. Some HIV medications have side effects such as dry mouth, so for those with unknown HIV status, oral manifestation may suggest HIV infection although they are not diagnostic, for people living with disease not yet on therapy, the presence of certain oral

manifestations may signal progression of disease. And for persons living with HIV disease on antiretroviral therapy, the manifestations may signal if urine therapy, a failure in therapy.

It may have an impact on [Indiscernible]. Weight loss, nutrition, oral health diseases are linked to systematic diseases, such as diabetes and heart disease, impact the quality of life, if an individual is experiencing pain, infection and tooth loss they might find it difficult to chew, swallow or speak, they could also impact an individual's ability to sleep, socialize and work, which ultimately affects productivity.

So oral health is one of the top unmet needs for people living with HIV, who obtain services through the Ryan White Graham. People living with HIV have more unmet oral healthcare needs than the general population, they have more unmet oral healthcare needs and medical needs. People living with HIV most likely to report unmet need for dental care are African-American, uninsured, Medicaid recipients and those within the 100% of the federal poverty limits. At this point I would like to discuss the impact of Ryan White oral health programs.

Looking at parts letter a through D for 2016, approximately 16% of all Ryan White clients received oral health services and that is about 88,000 clients. 491 Ryan White providers delivered oral health services, and Ryan White clients received oral health services in 47 states, the District of Columbia and Puerto Rico.

So, this chart shows the proportion of Ryan White clients received outpatient services that achieved viral suppression from 2010 through 2016. Among all clients who received outpatient amplitude Tory health services, viral suppression increased steadily over the seven-year period, you can see at 15.4% increase from 2010 through 2016.

Now this chart shows virus suppression among Ryan White clients who received both outpatient services and oral health services so the top line here, as compared to

all Ryan White clients who received outpatient amplitude Tory health patients the Blue Line. Among Ryan my client to receive both outpatient amplitude Tory health services -- amatory health services, the increased steadily over time, 289% in 2016. -- to 89% in 2016.

As was mentioned earlier, the program and partnership program specifically focus on finding oral healthcare for people living with HIV. From July 2016 through June, there were 56 entities funded through the dental reimbursement program. For calendar year 2016, there were 11 community-based dental partnership programs, recipients. So there were five times more DRP entities and community-based dental partnership programs recipients and you can see that in some of the clients served as well. If you combined clients served with the dental reimbursement program, and the community-based dental program, over 40,000 clients were served through the program. If you add this to the 88,000 clients that I mentioned earlier, I received services through parts letter a through part D of the Ryan White program a total of nearly 130,000 clients were served through the why and right program and that is parts letter a through D, and part littler. -- and part F.

All healthcare -- oral healthcare is an important component of healthcare for people living with HIV to ensure health outcomes, prevent further transmission of the virus, and to end the HIV epidemic.

Here is our contact information and HIV AIDS Bureau, please feel free to reach out if you have any questions.

At this time, I have the honor of introducing David Reznik. He is a graduate of Emory College, school of dentistry and is a director of the oral health center infectious disease program a program that he founded 27 years ago. He also serves as chief of the dental medicine service the Grady health system, he is president and founder of the HIV dental alliance. A nonprofit organization of concerned healthcare providers, committed to ensuring access to high-quality oral health care services for people living with HIV. He has lectured and published extensively on

HIV and oral health. He has also provided technical assistance to oral health programs throughout the United States for Ryan White HIV program recipients and he served as a clinical consultant for the Bureau. David Reznik.

David Reznik: Thank you for that introduction. It is a pleasure to be here. I am probably going to need some assistance in moving to the next slide. The main points on this word cloud that I have is the importance of integration and the key is bidirectional communication and how to gets referrals site to people that need it. Communication is very important for us to help our medical colleagues in our patients to get the end result which is viral suppression and keeping the patients engaged in care.

I'm going to go over a case that shows up in our program, we are a very comprehensive outpatient program for people living with the events -- the advanced HIV. We presently follow about 6200 patients of which about 64% are stage III or have an AIDS diagnosis. A patient came into the program to see me two days ago, the patient is actually -- had stated three months ago he was spitting teeth out. They are lower anterior teeth, to look at the patient you can actually see necrotic bone, you can see where the sockets were, and the amounts of remarkable soft tissue and bone destruction occurring. When I talked to the patient about whether he was on medication, because they had missed appointments, what I found was that he went to our pharmacy and was told that he could not get his prescriptions filled. Being that we are under one roof I was literally able to go upstairs, talk to pharmacy and the patient's provider, and get the prescriptions written and the patient's medication by the end of the day. At this -- had this patient not come to the oral healthcare Center form the appointment, they would've had a much worse outcome. The fact that we as a team had worked together with this results, to do the best that we can for those we serve is what we are here to talk about today.

On the next slide I will talk about a different type of example, we will have more wonderful examples as the presentation goes on, this has to do with CDC HIV counseling and testing recommendations, which were put in place initially in 2006. They want everyone to matter if you were gay, straight, transgender, bisexual, from

the ages of 13 to 64 to know your status, to be tested at least once. They recommend emphasize the importance of using outpatient healthcare centers to increase rates of detecting new HIV infections.

They also just updated the recommendations for streaming -- screening men that have sects with men. They need to test the patient population more frequently, the CDC actually concluded that it is not needed. However I would say in Atlanta, where we are seeing a lot of young people come in with advanced HIV disease, predominantly African-American men who have sects with men, the testing more frequently would not be appropriate or it would be appropriate so we can find people and get them linked into rapid care, get them on medication because as we all know if you're undetectable for a series of month you cannot transmit this disease through sexual intercourse. We need to test folks and make this available and it also helps reduce this matter associated with HIV if testing becomes routine for all.

So why screen or HIV in the dental setting? There is a significant number of patients who a visit a dentist in the course of the year who will not go to the medical side. We have opportunities to test folks who have not been tested before because they are only getting dental care. We can serve as an additional side to identify issues amongst diverse groups of patients.

One of the things that we do see, our referrals done on lesion based screening. A long time ago when I was in the private sector, a patient might come in with something like [Indiscernible] and I did not have, there was not rapid testing available, I would literally have to do a referral. As was mentioned earlier none of the oral manifestations are diagnostic. But you can have a way to raise the factor that this might be something that this person has so I had to do a referral. And then I would do follow up on the referral to make sure or's the if the patient would show in all the different things that we have in place.

The CDC really does not recommend lesion based screening but if you see a patient

that has something such as candidiasis you can see the effect that it could be an undiagnosed diabetic, they could have HIV, in this case very advanced, they could be using a steroid containing asthma inhaler, but you would want to refer this person in follow-up to make sure that they were tested. If the people know their status, they are up to 70% less likely to put anyone else to risk. The key point that I would like to make, is how key the communication between different disciplines is, the talking to each other, and sharing information bidirectionally both sides having an idea of what is going on. How has this works in our dead little -- dental facility? The screening was in the state of Wyoming, the dental hygiene's schools incorporated HIV screening as a part of the curriculum, so all of the dental hygienists would learn about HIV screening it would be able to perform that screening, this is a dental hygienist to literally screening a licensed dental hygienist. Then we have some of the classes the require all the students become certified in HIV counseling and testing. That is a remarkable progress from where we were in 2003 and I know we will hear wonderful examples of counseling and testing and the community health center, a little bit later in our conversation. I do think that the sooner that we train and we get dental students aware of this, dental hygiene students, aware of this and testing more routine and take away this mind becomes more of a chronic disease for all.

With the core measures, the retention measures, engagement in the medical care, these are many of the services that are offered in the Grady health system. You have outpatient, ambulatory health services, outpatient minority AIDS initiative, oral health center, nutrition, substance abuse, a referral for services, social support, transportation etc. The two areas the score the highest and retention of our patients are the oral health center, as well as our Hispanic translator. The Hispanic translator follows approximately 200 patients and she is an adopted member of my staff, and wins as far as retention and engagement she has a remarkable relationship and trust with the patient population. The second area or number two as far as engagement or retention and care is the oral health center. Years ago we set up a rule that you had to be seen by your primary care provider every six months to access and service is in the oral healthcare Center. We have never turned anyone away, we will handle an

emergency but we make sure that they get reenrolled or facilitated back into primary care. You do not need to be a one-stop shop to do that, but you do have to have people who are willing to look out for the best interest for the patient to make sure they stay engaged in care so they can get this disease under control. If you look at another which is viral suppression, actually our numbers in viral suppression were again the highest in the health system. We have a motivated patient population to a degree, but we always stress are you taking your medication, what can I do to help facilitate care, what barriers are you having? If we identify barriers we can get in touch with medical case management, we can get in touch with the primary care provider whatever our patients need we are here to do.

So what are the really good components of integration coming from the medical to the dental cider back and forth? In a primary care setting, I understand for my colleagues upstairs and around the country, that those visits are short. And some areas you might only have 15 minutes to do your comprehensive exam, but we do want you to at least ask or examine and then act. These are some of the key phases, if the person does have dental issues or has not seen a dentist, the question can be when was the last time you saw a dentist and then you can have someone refer to the oral health setting and that whatever services we need to share back. It is bidirectional communication.

So ask, keep it simple, I like that because things get complicated and you don't have a lot of time, you might overlook it. When was the last time you saw a dentist? Do you have conditions that might impact oral health? Which is dry mouth, acid reflux? Systemic diseases including HIV which you saw earlier, and diabetes definitely have an impact on oral health and disease. And incorporates it considered incorporating basic questions into the intake form, a visit with a PCP, or a case manager, I've had the opportunity to see wonderful programs and one best practice was an EMR alert electronic medical record alert to prompt some of these to take a look at these questions, when was the last time that the patient was seen by a dentist or have you seen a dentist? Oral health literacy is very low, amongst all people in the United States, but especially amongst low resource people. The majority of our

patients we see here are within 200% of poverty.

Examine, I know my colleagues do look in patients mouth because I get referrals from them all the time, and they notice broken teeth or abscesses, but as my best friend earlier life told me, physicians and nurse practitioners and PAs are great from the chin down and the nose up, and they leave oral health professionals to the mouth. We need to start working against the silo, and start working as a team. Train our medical colleagues to do a thorough quick exam, we realize there is very little time, and how important it is to document that oral exam and it did occur and a referral was made as necessary. I understand because I work with a lot of primary care folks, the lighting is not the best, so pan lights or whatever you can use to make sure you have access to the oral cavity and do a nice girl oral exam.'s in -- and do a nice thorough oral exam.

We educate on the importance of health practices, we can use income to purchase toothbrushes, floss and tooth A's, these are not expensive items. It would help promote oral health, it would remind people that oral health is important, and it does not actually need to come from the dental team, dental is not in height, -- on-site, even on-site our pediatric clinics stock pediatric toothbrushes, toothpaste and floss, and model up on the second floor even though we are in the building just to promote that concept of oral health coming from more than us. There are several things that you can do including getting educational materials, for waiting rooms that promote oral health, and you can ask basic questions, how many times a day should you brush your teeth? Two times, how many minutes to minutes, how many times did you loss, once, basic ideas whether you should drink sodas which is bad, in a separate study doing a minor intervention just getting that information literally helps raise literacy for the population.

Intervene, based on the assessment of examinations primary care providers can see some of the changes that we are talking about, the patient has really bad dry mouth, their medication changes that might occur or hypertension medications that can change, and then in certain environment such as our pediatric program we literally

have providers putting on fluoride virus -- varnish.

We just figure out what works for you, to get this oral health message apart. Then there is a necessity to refer, the primary care facilitators are concerned that the referrals really are not standard, that we need to come up to reduce the barrier to care to come up with a referral that will work for your community. I really do suggest communitywide or program wide that you standardize your referral and your document this process. And find out who your oral health care champions are, in the early stages of the epidemic it was the case managers who were constant advocates for the patients trying to get them into my private practice. Case management today is still that way, where I get most of my referrals are from the primary care folks in the office.

Uses EMR to track referrals, to know that a referral was made, that you did that and then it should be able to be documented on what happened during that roof Earl at the dental office. Those points are important as well. There are many different kinds of models, that you can have have a full integrated co-located model like the one I grew up in through the last 27 years, or to something that might be referral based. Are co-located but on different electronic medical and dental systems, and they are not communicating, it does not matter whether people are in the same building or people are off-site or people have to drive or get transportation to get where they need to go as long as the medical and dental teams, and case management are communicating we will have much better outcomes. I think that is what we all want.

Referrals are similar regardless of the model, I worked with a wonderful group of people from the [Indiscernible] grantee in Alameda County, and literally got dentists and medical folks in the same room and we came up with a model that would work for all. You need to get certain information to the dental team, the dental team would look at treatment plans and improve the treatment or get that approved, and they make sure the patient visits are cats, and barriers coming into play, talking together we can overcome the barriers to care and ensure treatment completion.

Sharing data is so important, dentist should have at least the lab values such as HIV viral loads, and other pertinent labs if the person is a diabetic, I'm sure the dental team wants a problem list and Alyssa medications. I do not know that the primary care provider needs to know that we did if willing and tooth number 28, but they do want to know the patients have kept their appointments, they are getting restorative care that the disease is eliminated and we are working toward health. Depending on their communications, between the health providers and oral care providers what kind of information do they need, what would be used for them.

For co-located models one of the best things that I have seen is where you have an electronic medical record that actually includes electronic general dental records. What I have in my program is an electronic dental record that speaks to the electronic medical records there is medication between the two. So any kind, having the communication and the data talk to each other is also important. It is really important that people share our information.

Patient navigators are so important to navigating treatment and care systems, and they are important when it comes to dental case management. They really can provide oral health education, help manage complex payment systems when they occur, they can remind patients that have overcome certain barriers such as transportation, or if they're in a rural community and you're going to send a number of patients over the same time they can help arrange that and arrange possibly lunch. And they can act as liaison between the dental providers, are dental teams, and our primary care teams. Again stressing the communication components. So best practices, identify one or two patient navigators, they can maybe have a desk -- dental assistance, or some away dental experience can help explain what the procedures are to get over the fear, created document with a hierarchy or dental coverage up and's, make sure the dental patients have a part of the team, make sure the providers are part of the case management team, offer HIV training opportunities through the centers, a wonderful component that allows for training of dentists, and dental healthcare workers and assistance and students. It is how those

programs train and we would like to do a program in Atlanta, where we have both medical and dental in the same room, to promote the same basic information and communication.

And the list for the patient navigators are generated so we have more folks coming into care. So dental patient navigation in addition to a case management card you overcome some of these barriers to care, but they also work as a team. I think that is what is important is that the team work components of what we do. People acting together, I saw this at the national conference, people acting together as a group can accomplish things that no individual alone could ever hope to bring about. It is that team-based care, working on communication that makes us have successful outcomes for those we treat. It is now my pleasure to turn this back to [Indiscernible].

Thank you. I would like to go ahead and introduce our next presenter, Doctor Joshua Bratt, graduated from Boston, and is a fellow and Academy of General dentistry. Has experience in serving rural and inner-city underserved populations, currently splits his time between private practice and being the associate dental director in Brooklyn New York.

Joshua Bratt:

[Pause] hello thank you. I just want to say thank you for the introduction, I hope to live up to Dr. Reznik excellence in presentation, I will go and show basically who we are. This is who we are, at the family Health Center, we have several sites which we will go over in a bit, mostly it is completely integrative care. We have medical, dental, pediatric, cardiology, etc., all in one building. The picture on the bottom is our CEO her name is Patricia Fernandez, she is one of the driving forces in getting all of this to be achieved. A basic brief history, we are a federally qualified health center, SQ HC, and New York State is known as an article 28 healthcare organization or clinic. We were incorporated in 1976, year and a half later we began providing clinical services and what I would describe a rather small 6000 square foot fifth for place approximately 3 1/2 blocks from where we are now which was

known as restoration Plaza, in 1989 we lived across the street about a block up to 1413 Fulton Street which was almost double at 10,000 square feet. Fulton Street in this area Brooklyn is very heavily trafficked, I will go over that a little bit as well but it allows for access for people who have transportation issues. That is a major plus. In 1991 we started to receive our first grants for HIV and AIDS, to fund the initial HIV services, in 2012, we moved out of the 10,000 square-foot space and into a 38,000 square-foot space, across the street yet again, about another two blocks up at 1456 Fulton Street. Two years later, we were qualified as a safety net provider, and we had 14,000 patients received annually they came to us for primary care, at seven sites including many that are school-based. With several partners in the area, in Brooklyn, between SQ HC, hospitals and other allied service providers, we continue to provide a lifeline to some of the most venerable people in Brooklyn. We have worked in a very rural setting, the changes in rural and inner-city can mirror each other tremendously, and it is somewhat shocking to see how that is. Our new Health Center is more than just the new building, it is our reinvestment in the community, our dedication to providing the care, in the Bedford neighborhood, it is a long struggle to continue to provide this and to enhance everyday life of those from liberal individuals that we have living in our neighborhood -- vulnerable individuals that we have living in our neighborhood.

We have four dentists, some part-time some full-time, we have full-time hygienist, we have five dental assistants, olive full-time, we have one front office manager and we have two front desk coordinators.

It is a rather busy practice I would say we are just about at or near capacity, and there are weeks of a wait for an initial appointment although we do have same-day emergencies for patients that have pain. Because we want to take care of them as soon as possible. The first thought is who is this guy? That is me with the red circle around my face, that photograph was taken about one month and a half ago and the person to my left, is Doctor Charles Beard another dentist here, the woman in front of him and to his left is Rachel, she is our dental hygienist, the woman in the middle is Cindy, she is our rent office manager, and the lastly but not least is [Indiscernible]

our dental assistant and she is always smiling like that.

Basically what we come to calm as we are going over what patient care is, is how can we continually add and use quality improvements and quality assurance principles to make a more efficient and better patient care as you can see in front of your model it is a complete cycle you can pick any point in this and say let's start here, it is a cycle, and anyone who has taken biochemistry would realize she can start anywhere in the circle and get back to where you are. What we look at, to update our HIV clinical protocol and develop processes to assure a consistent comprehensive standard of care, that means across all of our clinics and platforms. We analyze our workflow and sure integration of testing, scheduling, referral, linkage to care, and maximum retention of care, as Doctor Resnick alluded to before. We conduct ongoing needs assessment to ensure identification and responsiveness to needs of HIV patients and those at greatest risk, and we continuously review, QI and QA, looking at the EHR data analysis to improve and make corrections as soon as we can. In the first thing we want to talk about with the rapid HIV testing is what was the workflow? How did it come about? How is it used? And what did we experienced during the process? So the first thing is, we train, I don't like the word train, we trained dogs, we educated people. We educated staff members, dental assistants, or office managers, they would offer the tests to the patients and educate them on the importance of knowing your status. A patient requested to take the test, or accepted the offer, the test ministered right away by a trained individual in the dental office. If the test was negative, the patient was informed right away. So they knew their status. If the test came back positive, then the patient would accompanied down the hall, to internal medicine, and given over to one of our internal medicine nurse practitioners or physicians, so that they could achieve and deliver the news and get the -- and get into treatment that day. Pace -- patients who tested positive, would become part of the treatments partnership, social workers as needed, whatever resources were out there to help them achieve that viral load of zero or undetectable as quickly as possible.

This is Kathleen Burnett whenever nurse practitioners she is on the front line in

treating HIV. You would notice on the bottom, there is a hyperlink and that is to a video about 8 1/2 minutes long that I will not play for you today but is available in the downloaded version, and she talks about how she does, but her challenges are, how she interacts with patients, and tries to get them not just treatment but services on dealing with an understanding with HIV disease processes. -- what the HIV disease process is.

As was alluded, there are challenges that we have in our dental clinic where the electronic dental records and medical records did not talk while to each other. Because of that some documentation and correlation are linking up of appointments became difficult. When we got to look at this, for this particular webinar, it became a challenge to understand exactly what took place and when. And I do not mean that if a patient was seen, but if it was done in dental because it was not documented a certain way. We had to use correlation factors and I will link that later.

Here's what we did, when we pulled other patients that had rapid HIV testing, entire organization center wide for 670. Of which, 64 of them had their last appointment within the dental office. And then of that 670, 25 were only dental patients. Meeting that I did not have a primary care provider which was within our organization, they were only there to see the test. The timeframe is a little over a year and a half, maybe a little bit more. And we can see that of all of these numbers, approximately 13 1/4% had a correlation of their last appointment being with the dentist.

Now, of those 64 patients, and again that is more of a correlation and coincidental as opposed to direct evidence that they were connected, all 64 of them were tested negative. So one tested positive. Which is what we do want. You can see a breakdown in male-female, and distribution and age of testing of those 60 or individuals.

64 individuals. Here's lessons learned when offering HIV testing in the dental setting, patient acceptance, we tried to emphasize the necessity and try to emphasize the health benefits, in the value of early detection so that they can continue

treatments before it advances to HIV or actually aids. The problem is that most patients do not want to be at the dentist. When we set with them and we talk to them, and get them a history, and say by the way we can offer rapid HIV testing, and you can know in 20 minutes, what your HIV status is, a lot of times the responses, go jump in a lake. On a few people that we asked that would allow us to give feedback, they thought that we were asking for our information and not theirs.

You can understand the challenges with that. Dr. Reznik alluded to a dental case manager, I will allude to that as well, that would've been helpful to help educate the patients and understand what we are trying to do, advocate for the testing, and coordinate perhaps with medical staff and medical personnel. The problem is, in a very cramped space, it can become a workflow issue. Especially when you are trying to see as many patients as possible. The patient comes in as a new patient, and comes in for their filling, they only want to get a filling they are not interested in you talking to them about HIV. Or their status that I should say. This is a repeated aspect that we faced. And then of course, we had our issues with the EDR and EMR not completely talking to each other, so then it we had inability to get completely accurate statistics and reports on this. However you can see from what we are able to get, from circumstantial evidence, that all of the patients tested were negative.

So after we had that pushback from patients we decided that we were not going to verbally offer it anymore, because a lot of them are getting disgusted with us for even offering, we're going to put up posters everywhere, so that they know that they can do it here. Here are a couple of examples that you can see of these posters. So they were in the waiting room of the dental clinic, they walk in, we do this here, here is our options, and they would come to us. Now, that is very different from patients who already know they are HIV status, when I have patience and say that there HIV, when were you last tested? What are your count ratios? Viral load counts, antiviral medications? They are very open about that. They understand that you are asking for their benefit. Is complete 180 of trying to offer someone the rapid testing in our experience. When I did a search, we found two articles recently, that talked about and there are links to the abstract here which I will not pull up but you

are able to link to, that talk about the difficulties in the challenges in doing HIV testing in a dental setting.

I felt a lot better when I saw that it is they realize I was not the outlier, it has been happening before. There may be ways to fix this, I think Dr. Reznik is the best person to talk to about that, beyond that, until patients are more appreciative or understanding, and perhaps it is on as to educate, we had a lot of pushback. I did have an immense amount of help putting this together with one of our informatics data analytics, Tracy, she was thankful for that, that is short of the aspect that we saw.

I want to thank everyone for their time, and I will give this to [Indiscernible]. Thank you. I will go ahead and introduce our next speaker, Doctor Gonzalez, graduated with a doctorate of general medicine, in the Philippines, and started her career in the rural health clinic providing dental care to underprivileged communities. She is been the dental director or [Indiscernible] system in San Bernardino California, a nonprofit organization and affiliate to [Indiscernible] University and Medical Center. Her leadership through the dental department led to a standalone clinic in 2012, her passion and community dentistry with a vision to improve access to care, provide comprehensive services and assist patients in underserved communities has helped define her goals through the dental career. So I will turn this over to Dr. Gonzalez.

Dr. Gonzalez: Thank you. I will be sharing with you the system model for our HIV oral health integration. To give you a brief background of our dental program, the social action community health system, was funded in 1960 by medical students to provide free health care to people in local areas, who could not afford a services in our area. We back in 1992, the Norton Air Force Base in San Bernardino closed, and its medical dental clinic was transferred to Loma Linda University, it is an affiliate with special considerations to use the facility for teaching and health [Indiscernible]. Since then it became a sub recipients of the Ryan White program, under title I eligible

metropolitan area, which provides dental services to people living with HIV AIDS, residing in San Bernardino and Riverside counties. In 2003, in 2002, this all started the integration of the Ryan White program to the SAC health system.

In 2002, HRSA HIV awards part F grant dentistry, authorize the community-based dental partnership program, and allowed nine-month period to develop academic grants for dental and dental hygiene student. In 2003 through 2004, there was an academic program that began at the University school dentistry, and made the completion of the community-based dental program made a graduation requirements. And also in 2003, a portion of the part F funding were used for patient care including HIV patients residing outside of San Bernardino and Riverside counties, we also have a poll question if everyone would like to participate. Is your health center participate in your local dental schools extramural community activities for oral health service delivery?

[Pause] it looks like [Pause] it looks like we have 43% that has relationships with the local dental schools and the community. So we are hearing some background noises? If you are not a presenter, please mute your phone thank you.

[Pause] so we wanted to let everyone know from 2002 through 2003, the part F program developed as a program in partnership between the SACHS program, with us being a federally qualified health center, we provide the HIV clientele and the San Bernardino Department of Public Health provides an is the recipient of the part a and B grants. Loma Linda University, [Indiscernible] into the different clinics in the area, which one of them is the SACHS health system.

The population that we serve in the SACHS system, since 1995, the number of our HIV patients grew tremendously from 150 unduplicated patients to over 500 per year due to expanded locations that we have. To date SACHS has continued to provide conference of dental services for HIV patients residing in San Bernardino and Riverside counties. The design of the student training program and integration, we usually have a small group of five through seven senior level students per week.

We have two successive days of of half-day sessions, per week, which includes a mix of didactics, patient interviewing, case evaluation, and presentation, and patient care. It takes three academic quarters each year to complete entire senior glass -- class of dental, international dental and dental hygienist.

The community-based partnership, role, with the SACHS the community-based clinic, provides the dentist and a large base of HIV clientele but also provides classroom settings for the today's sessions. Loma Linda University is the recipient of the Ryan White part F the provides teaching supervising faculty, students and program logistics. Loma Linda the University -- linda University, provides financial oversight and grant management, and the San Bernardino County Department of Public health provide just ask and technical support such a state of California AIDS regional information evaluation system database

Client participation is really important, to maximize patient contact with the intent to reduce Sigma and to build student confidence in treating HIV patients, the interview with patients on the first day, includes the patient representative, to coordinate with patients to sign the consent form for the interview, as well as on the second day the patient would be signing and the patient clear that Medicare by the students. -- patient care by the students. The students engage in clinical care during the second day, they can be completed with the time allowed by the SACHS. With patient dissipation, there is a formed advisory group. They give us updates and inputs for all the services we provide another participation by the students under oral healthcare.

The evolution of the program, multiple factors contribute to the success of the program over the years, SACHS patient scheduling and logistics work, the Loma Linda students faculty experiences and continuing education, made a very good experience for all of the faculty and most of the students, on having rapid changes that we need to keep up with, with new developments of providing care to a dance. And also increased emphasize consideration for any process, in context of the HIV-AIDS, the importance of blood values were introduced to each student. Each student

was also signed of the end of the first day I worked on the case that evening to resent an evaluation and management recommendation and the faculty would be acting as a patient and asked probing questions and the faculty using the live system, the results are posted, which is a formatted exercise, [Indiscernible].

The feedback from the patients is important so we provide them the pre-and post-survey, discussions with advisory group and partners, and growing support from other community partners, made this program a success.

The design of the curriculum for dentistry, was presented way back in 2002, and the major assistance, of the dental group and the dental school, and ongoing participation in continuing education at the UC San Francisco the program has continued to be able over the past Eckstein years, we had been established with the Ryan White program, which is the community dental program partnership, for the last 16 years. For our quality measure, SACHS system converts the EDR in 2002, which captures data collection for her sick, -- HRSA, HIV, oral health performance measures, requited for the dental service recording every year. The post patient survey after dental care, that is also one of the few measures that we work on, so with the pre-and post-surveys, community-based dental partnership programs also uses faculty discussions, community engagement, and in education, student feedback, advisory group consultation to keep program current and relevant. Lessons learned? Evaluation strongly support growth in knowledge, consolidated original didactic presentations to maximize patient contacts, student surveys addressing two articles in peer-reviewed journals, for innovative HIV training programs are dental students, and then hiking students. Surprising findings from the student surveys, consistently indicated the desire for more patient contact, there are no other programs like these at the dental school having such a diverse and specialized population located at the dental school.? We have a second poll question, is your health center provide HIV medical control integrated care?

[Pause] very good. There is about 70% to 80% health center providing HIV and medical and dental integrative care.

So what is next? SACHS is committed to continue the partnership with the school of dentistry and San Bernardino County Department of Public health. And we will keep the Health Center as one of the extramural community facilities for the Loma Linda University students and residency programs. And's SACHS mission we will continue to provide whole person patient centered healthcare to our San Bernardino and Riverside community including HIV patients, and we will continue to educate future healthcare professionals so that we can empower our patients to live vibrant healthy lives through culturally responsive and exceptional care.

Thank you. This is my information. You need to contact me. And from this on I will turn this back to [Indiscernible].

Thank you Doctor Gonzalez are sharing your work. If anyone has any questions please go ahead and type it in the chat box now. We can read them out loud to the appropriate speaker.

Vy Nguyen: We do have one question, currently, Doctor Gonzalez, the question is for you, what has stood out to you the most from the patient survey? The students, they had a greater feeling of care to treat HIV patients, they are more comfortable being with student dentist and the regular dentist. It has been a good experience for the patient to be seen by the students.

Great thank you. This is Dr. [Indiscernible]. Can you speak to those system-level key success factors to ensure effective integrative oral health and primary care? System-level key successful factors in the context of community health centers?

David Reznik: One of the system-level changes that would be best is to have electronic records communicate with each other. Either to be one units, an example that we saw were everything was under one EMR including dental, or where the to talk to each other, I also think from a systems level, is when you have the case management meetings, discussing certain patients, that the dental team is included. And I use the term

dental team, because many times especially when it comes to HIV screening, we find that our champions are dental hygienist. They are a key component of our oral healthcare team, especially because we would like to focus more on preventative care as opposed to eliminating disease. We would like to keep people in that area. As far as I'm concerned there is a structural where you have EMR, either as a single unit or communicating to each other, and then having the dental team as a component of your overall primary care team. Thank you.

I would like to thank mission analytics specifically AJ Jones, as well as Allie to use some of their slides on the presentation. There a great team to work with and I wanted to get that across, as far as other references for looking at HIV screening, as a part of dental visits, there is an excellent researcher from [Indiscernible] University Anthony, who has done a tremendous amount of work in this realm. That is another great resource for the people on this call.

Mahyar Mofidi:

I would like everyone to know that next year 2019, HRSA has the HIV-AIDS Bureau, we will provide several national webinars, to go a little bit deeper in terms of successful practices, promising strategies, and interventions, in Ryan White funded clinics, some of whom are also fully funded by community health care funding. In terms of best practices around integration. Primary care and oral health integration, so please stay tuned, and we are excited about this initiative, this is an initiative that Doctor -- Dr. Reznik has been a part of and a contributor to, we look forward to seeing many of you in those national webinars next year.

Thank you. If there are no other questions, on this last slide, we have some additional resources, and some website links. On behalf of the HRSA team we would like to think our position -- think our presenters for their time, their insightful presentations and willingness to share their work around oral health and primary care HIV integration.

Also, before you log off, there is an evaluation if you would like to share feedback

with us, we would love to hear about it. Thank you again for joining us. Have a great rest of your day.

Coordinator:

Thank you for your participation in today's conference, you may disconnect at this time.

END