ANGEL JOHNSON: Good afternoon, everyone. My name is Angel Johnson, and I'll be moderating today's webinar on Improving Health Outcomes, Moving Patients Along the HIV Care Continuum and Beyond. This is the final webinar in this series, brought to you by the HRSA Special Project of National Significance or SPNS.

And as you can see from our agenda today, the agenda includes a brief overview about the Special Project of National Significance and IHIP, presented by me, and then we'll hear from Dr. Howell Strauss with AIDS Care Group who will discuss his SPNS demonstration model of oral health care intervention.

Dr. Strauss was a recipient of the Russel Brady Award for Innovative Health Care Delivery at the Ryan White all titled meeting in Washington D.C in August of 2010. He received his DMD at the University of Pennsylvania Dental School, and did his residency at Einstein hospital in Philadelphia.

Dr. Strauss trained in oral medicine with Dr. Michael Glick at Temple University School of Medicine, and was one of the first dentists to treat patients living with HIV/AIDS in the Philadelphia area. He's responsible for oversight of all clinical, physical, and administrative aspects of the AIDS Care Group. Following Dr. Strauss's presentation, we will have a brief Q&A session, and then I'll provide you with the link to give us your feedback about today's presentation.

So what does SPNS reflect? The SPNS program reflects changes in the overall HIV epidemic as well as the HIV landscape at large. It aligns with a number of national HIV policy strategies, changes in the health care environment, and its core focus is on funding, researching, and supporting replicable and sustainable care models.

The SPNS program advances the HIV care continuum to include all stages of the care continuum from diagnosing and linking individuals to care, to viral suppression and beyond. As such, initiatives funded through the SPNS program have helped to advance people living with HIV along the care continuum.
However, one of the challenges that HRSA encountered with the SPNS program was finding a way to effectively disseminate information about the successful models of care and the lessons learned to help other providers replicate these innovations.

The solution to this challenge was to develop the Integrating HIV Innovative Practices, or the IHIP Project, which was designed to promote, market, and disseminate effective strategies and lessons learned to support optimal implementation of these models. And as a result, the expectation is that providers are more informed, they have a stronger workforce, and ultimately, healthier patients. And as stated earlier, it also helps to advance and support federal priorities and strategies.

The IHIP project uses a few strategies to disseminate their information about the SPNS program. The first strategy is developing implementation tools and resources. For instance, manuals, curricula, and pocket guides. And these are specific to the evidence based interventions that have been implemented by the SPNS grantees.

We disseminate information to stakeholders through various means, which I will discuss shortly, and we provide capacity building assistance to support the replication of SPNS interventions. Capacity building assistance includes an e-newsletter that notifies recipients of new resources, training, and other upcoming events, a listserv, supporting knowledge exchange among HIV service providers, and peer to peer sharing of best practices.

For instance, I have webinar series, as well as presentations at various conferences and spend grantee meetings to introduce these interventions. Additionally, we rely on other listservs, e-newsletters, and blogs with our partner organizations to promote this information.

So a little bit about the TARGET Center. The TARGET Center is the Ryan White Technical Assistance Clearinghouse, where you can find IHIP resources, existing resources, and upcoming resources, and that's at care@target.org/ihip.

There you'll find both a broader overview of IHIP, as well as previously highlighted IHIP interventions, and technical assistance material. From jail linkage and oral health to opioid treatment, engaging hard to reach populations, and more.

Here we have a list of IHIP resources that are available on the TARGET Center. Please keep in mind that as tools and technical assistance resources become available, they will be posted to the TARGET Center. So we encourage you to visit the TARGET Center, if you haven't, and become familiar with what it offers.

So as we prepare to turn things over to Dr. Strauss, I wanted to provide you with some information on staying connected. If you have questions about any of the information shared during today's webinar or anything related to the replication of SPNS interventions, please send your inquiries to SPNS@hrsa.gov. That's S-P-N-S at H-R-S-A dot gov.
For additional information on tools the resources resources, and to sign up for the IHIP e-newsletter to see the latest news and announcements about IHIP resources and webinar trainings, please visit the TARGET Center at care@target.org/hip. So now, without further delay, we're going to turn things over to today's presenter, Dr. Howell Strauss from AIDS Care Group to discuss their oral health care SPNS intervention. Dr. Strauss?

DR. HOWELL STRAUSS: Angel, thank you very much for the introduction, and my thanks to all of the SPNS staff, Melinda and Pamela, and especially Adan Cajina who gave the AIDS Care Group ample opportunity, and the funding to develop a demonstration model of oral health care.

This project is supported by the Health Resources and Services Administration of the US department of Health and Human Services. We were awarded $400,000 per year for five years from the years 2006 to 2011, and no non-governmental funds were used.

What I'm presenting today are the conclusions of AIDS Care Group, and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the US government. We will follow an outline, which includes overview, goals of the target population, program description, implementation, and successes, lessons learned, sustainability, and key takeaway.

Going back prior to 2006, HRSA was identifying dental care as a top priority. You heard about it at one of the Ryan White conferences in Washington D.C, and soon after, a notice came out to apply for a five-year program under the Special Project of National Significance, SPNS, to identify inequalities regarding access to dental care for patients living with HIV/AIDS.

The primary purpose for the winners of this competition was to provide the resources to create demonstration models that could design, implement, and deliver a system of care unique for their patients living as targeted and underserved populations.

We're doing this today for Ryan White agencies, and any others. We want to provide dental services to under-served populations, and I invite everybody not only to take care of the learning curve experience by the AIDS Care Group, but also to take advantage of what we have learned from our other co-colleagues who were involved in this program.

We were one of 15 projects in the United States. We're here in Pennsylvania, and I do want to add that there were 12 states represented across the country, and every one of them had a usually unique program. Ours was unique to South Central Pennsylvania.

And in developing the analysis of the target population, out of our 67 counties, 14 became targeted, and within those 14 counties, we knew that there were 3,200 patients living with HIV disease, and most had poor access to dental care.
And we knew that because in those same 14 counties, there was a dental manpower shortage for even the most economically well-off of the population. Consequently, the ability to access care by those who lived below the poverty level was going to be very desperate.

We set up a program, as all SPNS projects are, under institutional review board of conditions. The project goal was to serve 175 patients in the first year, growing to a cumulative unduplicated total of 750 patients by end of the fifth year.

I put this slide up because I wanted to show the extent of the disparities in accessing care by this population, and contrast it to where people went to faith-based organizations, or went to major hospital organizations for their HIV care within the 14 county region.

And here I am not prepared to do corrective dental work, but in the blue bag were examining tools, gloves, red bags, and in my left hand was an obstetrics light that we carried around to create a working situation to do dental exams. But prior to this ever taking place, going out and marketing, we have to establish what our goals were and the target population, which will be very important, and probably very, very different for every listener on this call.

You could not expand your existing dental practice under the guidelines of the SPNS guidance. You have to establish a new satellite dental office, and we decided to do one which is more than 30 miles from our agency's principal office. We knew that we would collaborate with other area HIV medical and service providers to link their patients into our project.

We would serve patients receiving HIV medical care and case management services from other providers who were themselves, Ryan White Program grantees, but grantees that had little or no access to comprehensive oral health care.

Now, among the 3,200 patients, we chose 954 living with HIV in the 14 targeted counties. The patients were primarily adults, and all living at or below the local and federal poverty levels. Everything you'll hear pretty much from now on has to do more with the administrative and the outreach efforts rather than lessons in dentistry, or oral health care, or medicine.

It was very evident that while people were in great need of a dental program, they also needed to be made aware of the dental program. So we chose to convene the major providers of clinical, medical, social services, medical case management services from the 14 areas, and we were helped along by South Central HIV Planning Commission.

I think it's very important. to feel that you are part of a group, even if you don't live and work in that group's geographic area. And our message was to say that we had received funding. We had the money to provide dental care and services. We wanted to prove that a demonstration model, which made dental care more accessible to persons, could be successful, and they would take advantage of it, but we would need a lot of cooperation from their staff to sell that service to their patients.
So in the implementation of year one, we secured a location in coastal Pennsylvania, which was about 30 miles from our principal office. That hospital had a facility which was predominantly a pediatric facility, and it was miraculously equipped with a one-chair dental operatory, a waiting area, laboratory and storage, and with equipment that was old, and quite frankly, needing considerable upgrades.

We established linkages to two of the largest targeted case management agencies, and we coordinated group meetings and leadership from all of the counties that-- or at least nine of the 14 counties that we were going to provide service. More importantly, we did outreach to consumer groups to introduce the project and the project staff.

Now, it was very wise of HRSA to say among the applicants, you needed to have a preexisting dental program. It serves many, many functions, but you would have to have considerable brand ideas to say, we don't have a dental program, and we're now going to establish a satellite office when it's hard enough to establish a dental office to begin with.

By having an ongoing dental program, we knew that there was administrative support, we knew there was facilities support, we knew there was financial support, we knew there was key stakeholder buy in, but more importantly is that we had clinical support. We already had four dentists, and hygienists, and dental assistants that could assist whoever and whomever we would hire in the demonstration model.

We knew that the satellite facility would need at least two part time dentists, two part time dental assistants, and in our model, a full time dental case manager and transportation expert. That was further supported by a project coordinator.

And so the staff evolved. In this picture there are three dentists. One in the middle that is Tim Martinez, who is from the Boston University Evaluation and Technical Assistance Center, and all the rest of the staff are in the facility within this pediatric center in Coatesville Pennsylvania.

Now, it was an effort. It was an arduous effort. The dentist that we chose was not sure that he was going to be successful in treating HIV patients, and so this is where your facility and technical support come in within your own agency.

We were able to position him in both the offices of AIDS Care Group, and in the offices of the dentists who were in their own private practices just so he could shadow them and see how you can transition from private practice, where there may or may not be HIV patients, to a major clinic serving exclusively HIV/AIDS patients.

But we felt that by design we could reduce the proximity to care from almost accessible to right around the block for many of our patients. Where they were having problems with transportation, we provided the transportation. Through the grants funds, we were able to secure a vehicle, and pay for the driver.
Unlike many of the other deaths in that area, unfortunately, where discrimination was identifiable, in our program, there was no discrimination. And as you know, I don't think there is discrimination in Ryan White programs, just sometimes inaccessibility to the proper provider group to provide comprehensive services.

What we found was the essential role that the dental case manager played, acting as an intermediary to find, to link, and to retain patients in care. And strangely, that dental case manager did an even better job also being the transportation coordinator and driver. There was minimal waiting time for appointments, and more importantly, dental care was tailored to patients perceptions, wants needs, and desires, along with diagnostic criteria of comprehensive oral health care.

This map, which Tim Martinez is pointing to, is a map of Pennsylvania. And the red dotted lines are based on a zip code analysis of where our patients were coming from at the end of the first year. To give you an idea of how transportation is important, in that first year we put 30,000 miles on the van, and had to require a new van just to keep the safety record intact.

The little brown dot, all the way to the right of the map, is the AIDS Care Group principle office. The next dot about an inch to the left is the Coatesville office, and this footprint, which we developed, is far in excess of a 14 county area which we originally targeted.

The far left of the footprint is Altoona, Pennsylvania, which was more than 100 miles away from the Coatesville office. And persons from that area would come in by train, going as far east as Philadelphia, and we would pick them up at Philadelphia Amtrak station, and drive them back to the Coatesville location.

I think everybody who was running a Ryan White office could take credit for having offices that are warm and friendly. What we did is we convinced HRSA to pay for food. Pay for food because people after some drives as long as an hour and a half would come into the facility hungry, and that is not an ideal dental patient to have.

So we were able to purchase food and serve it in the reception area, or we purchased coupons for the hospital's cafeteria. There were incentives for good free oral health care and hygiene reminders. We gave out everything we could get at a discount including toothbrushes, toothpastes, dental boxes, soaps, shampoo samples, anything and everything to feel that people had a gift for coming in.

Pre and post operative medications were available and dispensed to the patients who had poor access to pharmacy. And a dentist was on call daily, and there's where your infrastructure comes in so importantly.

Now, on the clinical side, we equipped the office with the new panorex in addition to the long cone radiology because we felt that utilization of tomographic x-rays and short cone x-rays
were essential to the beginning of a comprehensive dental plan, and we didn't want to miss anything by the restriction of radiology.

We did complete dental treatment plans were devised for everybody, and there was an unbelievable high rate of 96.5% completion of initial treatment plants. Second lesson is marketing, marketing, marketing, marketing. Known collaborating agencies, the general and professional media, and targeted media such as Spanish radio talk shows for our target population.

Our staff went to dental society meaning and we provided informational gatherings. We went to every AIDS education training center lecture that we could get access to. We went to social service agencies and the religious groups, which is the first slide showed you of the gathering place, to disseminate information about the available services.

Among all the marketing techniques, a sign is simple. Posting on one of the doors in the Pinnacle hospital hallway that it was dental screening day ensured that by the time I came with my blue bag and portable examination light, that I would have a full day of patients to examine.

And what we do in those examinations is introduced ourselves, set up a private area where I could just do a cursory examination of the mouth, no x-rays at all, and an experienced dentist could say, for the most part, though I don't have x-rays, you have a fairly deteriorated mouth that could require care as you thought you did need, and today we will arrange to appoint you, and get the necessary transportation to you.

Some patients, you would say, things look pretty good in the absence of x-rays, probably could wait a couple of months before we could get you when there is less acuity to the population's dental care needs, and there was always acceptance of both those who needed immediate care, and those who could survive with delayed care.

So as of four years into the completing the program from the first years initial set up, and the experimentation with marketing, and getting the first group of patients in, we did see in excess of the 750 patients, and we were included in a very large paper written by Boston University, The Evaluation and Technical Center, that was entitled "Expanding Access to Oral Health Services for People Living with HIV/AIDS, Lessons Learned."

And at that time it was published, it was available on the Boston University School of Public Health, their health and disability working group site, which was then listed as http://echo.hdwg.board, the health and disability working group of Boston University.

I would like everybody listening to this to get a copy of a monograph if they can't access it directly. So in our sustainability project, we wanted also to prove to ourselves that when the $400,000 a year funding was gone that we had the wherewithal to continue with expanded services.
One of the unexpected outcomes was that the location we chose at the very beginning, Coatesville, which was very close to a high need area for HIV patients, also was in the epicenter of an area where there was not a dental manpower shortage, and we were beginning to get pushback from local dentists not to open up permanently in the hospital setting because it might detract from the growth of their individual practices.

And rather than use the power of federal dollars to put our colleagues at a disadvantage, we then chose another site, and essentially started a brand new SPNS project of our own in September of 2011. This is what we did. We went eight miles to the east of where our principal office was, and opened a new satellite dental office in Sharon Hill, Pennsylvania.

It is a three-chair dental operatory. That would give us improved efficiencies of care, and it was open five days a week. Our principal office in Chester, Pennsylvania was smaller, and not as efficient. We were able to put on four dentists, and two hygienists, and two assistants.

More importantly, all of the target patients from the original study, now more than 90 miles from the dental office, were contacted, and our attrition rate was less than 18%. We welcomed new patients from other underserved dental care areas, including within the city of Philadelphia, which is the behemoth just northeast of us, and is the epicenter of the part A authority for our eligible metropolitan area.

Original incentives, such as transportation and health case management were then not invented, by reutilized in our own new satellite office. And to our maybe surprise, but to our delight, we were identified as the third largest provider of dental care to HIV patients in Philadelphia, which came after the University of Pennsylvania's School of Dental Medicine and Temple University's School of Dental Medicine.

So we feel that you can do it once, you could do it again, and that program, which officially started August 2nd of 2011, is still very strong, and will be expanding by another two chairs in the next six months.

To aid in dissemination for our program and prior to this webinar, we went back and discussed with the people at Pinnacle Health, where I showed myself in front of the major hospital building, that they too should go from being a part C grantee without a dental program to one that included a dental program.

And over a period of 18 months, with just minimal technical advice from us, but 100% encouragement, they were able to use retained funds from their program income, and opened up a two-chair dental facility. We went to the opening, and I'm very proud to say that they are well on their way to having an ongoing dental program. And the only thing that I offered them is that you needed to have more dental chairs because they definitely will be growing.
Key takeaways, it's not just because you are the finest clinicians that people come to you. They need to find out about you all the time. Underserved populations, well-to-do populations all need marketing.

It's very prevalent in the Philadelphia area, if you're a major cancer center, or an orthopedic center, or a vision center, or a dermatology center, your advertisements are on TV every single day. Targeted outreach works to help find, link, and retain patients.

Successful development of our programs required outreach and continual marketing throughout the entire course of the five years. And ongoing communication and supportive services, in fact, fuel additional successes for continuity of care, and continuity of care leads to more comprehensive care and services.

However, the one thing I didn't write is the one thing I want to stress the most, and that is that dentistry in the Ryan White setting can be conceived of as clinical care, or it can be seen as a supportive service to keep patients in adherent medical care.

Whatever you want to call it, clinical care or supportive service, it is more importantly, a humanitarian service due to it's often inaccessible nature, and the acute needs that can be provided to disenfranchised populations.

So that completes the formal presentation that was prepared for this webinar, and I do believe that we have enough time to respond to questions from the individuals who are on this webinar, and I want to thank everybody for their attention.

ANGEL JOHNSON: Thank you so much, Dr. Strauss, for that great presentation. I believe we do have a question that was entered in the chat box, and Chelsie, can you read the question, please?

CHELSIE WHITE: Yes, so the question is, is there an agency that provides services to the homeless people in the area that you targeted for the SPNS grant? Additionally, were any of the targeted population homeless?

DR. HOWELL STRAUSS: Yes. The gathering place was the outreach center for a homeless shelter, and we went to the homeless shelter, and we found a patient there that I had seen 10 years earlier. And I asked him if he would be interested in having more dental care, and he said yes, provided I could be the van driver's assistant.

And he stayed with us for 3 and 1/2 years of almost two or three days a week, helping to gather up additional patients who were living under conditions of homelessness, and to act as a facilitator to gather people and be with them.

We didn't make a big deal about in this presentation, but on second thought, it was one of the slides that we removed. I would put it back as one of the first slides to be reintroduced, and
how important it is to respond to all key stakeholders in anything we do in the Ryan White environment.

CHELSIE WHITE: There is another question that came in. Someone asked, would you mention the special issue of public health reports on the SPNS project?

DR. HOWELL STRAUSS: Are you referring to something that has been previously published? Anything and everything that's written on dentistry has been excellent. I can't help but emphasize that the project report that I mentioned, which Helene was co-author of, is almost absolute must reading for any agency looking to establish a primary office or a satellite office. And so I think what we should do is try and get the current address of that monograph published so that all of our listeners could get access to it.

CHELSIE WHITE: I have another question regarding sustainability. Has there been any decrease or loss in funds for dental care, and if funds to support dental health care were decreased or lost entirely, can you still provide services?

DR. HOWELL STRAUSS: Pennsylvania Special Pharmaceutical Benefit Program, or ADAP, AIDS Drugs Assistance Program, was able to retain revenues after it paid for legislative requirements in its program, and reinvested those dollars into dental care, of which the Philadelphia EMAs Part B, the state funds, were given to AIDS Care Group.

So we have had an increase, and we are now adding more dental hours, including Saturdays, to our program. AIDS Care Group is funded by parts A, B, C, D, and we have another SPNS project now. So we have F as well. Our dental program has grown fueling success upon success, and that has been recognized by the local funders, and our federal funders as well.

There is very little that we do receive from Medicaid program income. All over the government grants and support are not sufficient to fully equip and sustain a dental prep program. Every state's Medicaid reimbursement for dentistry is different. Pennsylvania's happens to be one of the most parsimonious in the country.

So we then devised ways to utilize program income coming in from medicine and our pharmacy services to support a very robust dental program. So we've tried to insulate ourselves from what could be fluctuations in government grants and support, but what we have at AIDS Care Group is a leadership from the board of directors, and my self serving as a dentist and the executive director.

That tends to skew the way program income is redeployed, and so we keep dentistry as a very high priority. I wish I could say that for more agencies. I would be happier to see more dentists in the leadership roles of their agencies, and we probably would have more dental programs. So AIDS Care Group might unique, but we’re able to take that capacity, and pass it on to more patients every single year.
ANGEL JOHNSON: Thank you. Do we have any other questions?

MODERATOR: Yes, we do have a question coming from the phone lines from Helene [?] Bedinarsh [?] of Boston Public Health Commission. Ma'am, your line is open.

HELENE: Hi, Howell, that was terrific.

DR. HOWELL STRAUSS: Thank you, Helene.

HELENE: What I'd like to say is that it met the criteria for sustainability, and it's a program that can be replicated, and I think that aside being part of the mission of the SPNS project be innovative like it was, sustainable, and replicative. The model should be promoted as much as we can because it worked, and having visited there, and met with the staff and clients, it's an amazing program. So I'd like people to really be able to contact Howell, and find out more about it.

The report that you mentioned would be great if the TARGET Center could upload that onto their website as a resource, a PDF that people could download. I don't know the current status of the Health and Disabilities Working Group website, what is still available or not. Adan, or Mahi, or Melinda might have a better idea on that.

And the only other thing about reference I was referring to, there was a special issue of public reports when Regina Benjamin, Dr. Benjamin, was the Surgeon General, and that highlights all the models, and Howell, of course, was significant in that. So there are a lot of very good resources out there. Thank you.

DR. HOWELL STRAUSS: Helene, thank you very much for the compliment. I do want to say that there was no prepayment of your words of kindness to me just for full disclosure. The PDF that I'm referring to from Boston University, I do have as a PDF, and I would be very happy to pass it on to Angel.

And hopefully, she could work to see that it gets onto the TARGET Center because it is a seminal publication, and everything in it is applicable today. It was published in April of 2012. So five years later, it is still very much appropriate reading.

ANGEL JOHNSON: Thank you very much for that, and there is a message that has been posted, regarding findings from the SPNS oral health initiative can be found at the TARGET Center, careact.org/ihip, and this includes a curriculum training manual, and other TA webinars, and a case study specific to Howell’s program will be up on that site in the coming months.

And the monograph Howell mentioned can be found here, and that information is posted in the chat box. If you have access to the chat box, you can see that information in the chat box, for those that are interested. And are there any other questions? Any other questions over the phone or anyone wants to type anything else in?
CHELSIE WHITE: Hi, this is Chelsie. I had an additional question for you, Howell. I wanted to hear about whether or not there were any recommendations, suggestions, or strategies that you would say to other sites who were looking to get some more dental staff into leadership or more involved in more leadership positions, such as yourself, since you were saying that seems to be one of the key things that is supporting your effort.

DR. HOWELL STRAUSS: I wish I knew the answer to that, Chelsea. The number of dentists that are in administrative positions are very low. We have fewer than 50 dental schools, so we have fewer than 50 deans. Dental schools only have five or six departments.

So department heads that you would think would be very capable of providing administrative leadership in public health clinics, it’s not a very large pool. We’re selecting dentists from colleges where the criteria to get into dental school is based on not just eye-hand coordination, but an ability to succeed under high pressure circumstances, and those persons are more likely to go into private practice.

So we have a lot to do in our dental school to improve this because if you want dentists in public health, we have to teach them about public health in dental schools. And surprisingly, even in places like the University of Pennsylvania, we don't do that. We teach microbiology and biochemistry using isotope studies, but we don't get our students out into the field to see the haves and the have nots. They understand poverty by who happens to walk into the dental clinic.

So we have a lot to do there. I happen to be very lucky. I had the opportunity to leave private practice, and go into an academic training program, and it was from there that I was introduced into the real realm of public health through an FQHC appointment, and later realizing that I had the staff around me to establish a freestanding, not for profit, community-based HIV/AIDS dedicated service provider.

It's from that that my mission to see dentistry-- ready for this-- as a clinical service equal to that of medicine or psychiatry has been evolving for the last 19 years. So it is not easy, and we don't have a great pool of dentists upon which to draw from.

CHELSIE WHITE: Well, thank you very much for your answer.

ANGEL JOHNSON: Yes, thank you very much. Do we have any other questions? And we would really appreciate if you all would make note of the slide that's currently on the screen, and make note of that link to give us your feedback on today's presentation, and we will also send the link out to all the registered participants following this webinar as well. Are there any final comments? Anyone else on the line have any final comments?

MODERATOR: We do have a question coming from [unknown] of University of Maryland School of Dentistry. Ma'am, your line is open.
UNIDENTIFIED PARTICIPANT: Yes, I just want to thank you again for a very good presentation. You mentioned earlier that the area that you first targeted was not a resource poor dental area, and that dentists in the area did not want you to set up an office there. Do you have any information regarding if those offices were treating patients living with HIV disease?

DR. HOWELL STRAUSS: They were not. Valued This is discouraging to report. They were not seeing patients with HIV disease. Using a barrier known as, are you adequately insured or do you have the money to pay for our services, which in Pennsylvania and federally, is a perfectly legal way to set up barriers to not to serve certain populations because every one of those dental offices is a place of public accommodation.

What's worse though, is that we had first hand reports from the South Central HIV Planning Commission that patient's going to FQHCs were also denied adequate and accessible care. Waiting lists were in excess of three months, or if you came before 6:00 AM, and waited online, you might be chosen for care that day.

So we knew when we opened we would have many, many patients, and by opening up a facility like ours, we changed the playing field on accessibility. But to change a playing field properly, you have to let the target population know about it, and that was the learning experience to this.

Getting the word out to people that some of the discriminatory practices that you experienced before no longer would apply to you. Just sign up with your medical case manager or your medical provider. We've tried to notify everybody of our services, and it worked.

UNIDENTIFIED PARTICIPANT: So when you mentioned those discriminatory practices, those dental offices, would you say that they didn't want to be identified as being discriminatory by your clinic being there? Because clearly, if you're seeing patients that, for lack of a better phrase, they don't want, it shouldn't have been, in my opinion, any reason why you couldn't continue your services there as opposed to moving where now, people had to move, like you said, I think 90 miles away.

DR. HOWELL STRAUSS: The reason for that lies in the economic reality of maintaining a dental office. There is just no way on earth in Pennsylvania you could run a full service dental practice on Medicaid revenues alone or government grants and support alone.

We currently are the third largest practice, and we see 650 patients a year. Medicaid revenues for that would be under $12,000. Can't do it. Doesn't even cover the cost of medical malpractice or dental malpractice.

So the way you conceptualize opening up a new satellite office as a dentist is to build up a very large pool of patients, some of whom pay full fare, and others are supported either through government grants or support, or entirely through charitable giving by the dentist.
In the full fee for service arena where 99% of the revenues were going to come from, that we were not going to be successful. So rather than invest in a new facility that had to-- we couldn't stay in the hospital setting, which would require rents, commitment to rents, commitment to facility improvement, and commitment to equipment, which could run in excess of a half a million dollars.

Rather than go bankrupt, we chose to go further east, where we had communities that supported our type of programs, where we had shells of buildings where we could modify and build a new dental clinic, and where we would have greater access to not only our own population but a fee paying population.

Ironically, it was so successful serving the disenfranchised populations, that we were able to garner enough money from government grants, and support, and program income, that we in fact, did not encourage fee for service patients coming in. And that's pretty much where we are today because what it does is it puts more money in your bank account, but fewer slots for treatment for the disenfranchised population.

So in many ways, you can look at me as being a reverse discrimination dentist. You're more welcome if you have a communicable disease than you are if you have a lot of money in your pocket and you're healthy.

UNIDENTIFIED PARTICIPANT: I commend you for your efforts. It was very, very good. Congratulations.

DR. HOWELL STRAUSS: Thank you.

ANGEL JOHNSON: Thank you. Thank you for that great presentation. OK, well, we want to thank you all. Thank you, Howell, very much for that great presentation. Thank you to all our attendees for your participation. We really appreciate it.

And to let you know within the next few weeks, both the slide deck and the archive webinar recording of this presentation will be available on the TARGET Center. So thank you, again, for your participation. If you have any additional questions after today's webinar, please do not hesitate to contact SPNS at HRSA.gov. Thank you all for your time. Thank you very much, Dr. Strauss

DR. HOWELL STRAUSS: Thank you.