Bringing the Mountain to Mohammed: A Mobile Dental Team Serves a Community-Based Program for People With HIV/AIDS

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In spite of the direct referral system and family-centered model of primary oral health care linking medical and dental care providers, most HIV-positive patients at the Columbia Presbyterian Medical Center received only emergency and episodic dental care between 1993 and 1998. To improve access to dental care for HIV/AIDS patients, a mobile program, called WE CARE, was developed and colocated in community-based organizations serving HIV-infected people. WE CARE provided preventive, early intervention, and comprehensive oral health services to minorities, low-income women and children, homeless youths, gays and lesbians, transgender individuals, and victims of past abuse. More efforts to colocate dental services with HIV/AIDS care at community-based organizations are urgently needed, however.

THE SURGEON GENERAL'S 2000 report highlights existing oral health disparities, shortages of primary oral health care providers in underserved areas, and a decline in the proportion of underrepresented minorities in the dental professions.[1] The need to train clinically and culturally competent primary oral health practitioners who can work in an integrated, multidisciplinary primary care setting is even more urgent for underserved areas with high rates of HIV/AIDS.[2,3] Columbia University's School of Dental and Oral Surgery provides clinical training in predominantly minority and economically disadvantaged communities in northern Manhattan in New York City. The school developed a mobile program to bring dental health care services to community-based organizations serving people with HIV/AIDS.

THE WE CARE PROGRAM

On July 1, 1999, the WE CARE program was opened to HIV-positive clients attending 3 community-based organizations in Harlem, Washington Heights, and midtown Manhattan. The targeted subpopulations included African Americans, Hispanics, low-income women and children, homeless youths, gay and lesbian clients, transgendered individuals, and victims of past abuse. Between July 1999 and July 2000, WE CARE served 283 patients; 73% were African American, 25% were Hispanic, and 2% were White. Nearly half (46%) were women. More than half of WE CARE clients suffered from comorbid conditions, including substance use (53%), mental illness (24%), and tuberculosis (22%). The age distribution was as follows: 78% were between the ages of 20 and 49 years, 16% were aged 50 years or older, and 6% were younger than 19 years.[4]

WE CARE consists of a mobile dental team that emphasizes prevention, early intervention, and linkage to comprehensive care. Personnel include the program director, a primary care dentist, a clinical coordinator, a dental assistant, and primary care postdoctoral trainees in general dentistry. The team travels to the sites to provide care 4 days a week. Portable equipment is stationed at each site and instruments are sterilized at the School of Dental and Oral Surgery.

Cultural competency training is provided to all members of the dental team to improve communication between patients and providers. Team members are taught to identify barriers to communication based on cultural differences, to recognize the components of culturally competent provider behaviors, and to be aware of ways in which clinicians' assumptions and stereotyping can inhibit optimum delivery of services. The training consists of multiple sessions with interactive exercises that include case studies, role-playing sessions, and client and provider presentations of personal experiences.

their compromised immune systems; and, most important, the social stigma associated with HIV/AIDS. Not only did these men fear discrimination and lack of empathy by dental care providers, but they also expressed feelings of internalized stigma sufficient to keep them from seeking dental treatment.

All participants reported high satisfaction with the program; many felt that WE CARE was among the best services offered at the community-based organization. The dental staff's nonjudgmental attitudes and aggressive outreach alleviated clients' initial fears about seeking dental care. Many participants were overwhelmed by the fact that the WE CARE providers were not afraid to provide them with oral health care and that they addressed the clients' concerns regarding physical appearance and the relationship between oral health and systemic conditions. Because dental treatment plans were tailored to their specific needs, clients were motivated to engage in proactive oral health behaviors.

Partner organizations agree that WE CARE is making an important difference to the health and well-being of their clients. At Safe Home, a shelter for homeless teenagers infected with HIV, program manager Navah Steiner stated,

> The WE CARE program is one of the most valuable services that our clients receive. Homelessness, ignorance, and fear of rejection prevent them from seeking care until they are in severe pain. Now our clients receive these services in a less intimidating environment where they have the support of our staff. The dental team is an integral part of our family. The residents trust and like them. I think that what they do here goes beyond dental care.

The We Care Team at "Babette's Place," the Women and Children's Center, New York City, January 2001.

DISCUSSION AND EVALUATION

In June 2000, a focus group of 10 WE CARE patients was convened at one of the community-based organizations. The participants were male, 30 years or older, and either African American or Hispanic. Most (90%) of the group reported no regular use of primary dental care services before WE CARE; many indicated that it had been more than 2 years since their last dental visit. Most had sought only emergency care for painful and debilitating problems.

The participants cited several barriers to seeking care, including fear of pain; lack of available and accessible services; lack of provider education about the specific health needs and concerns of patients with HIV/AIDS and the risk of HIV transmission between client and provider; fear of contracting an illness, given

Highlights

- Many people with HIV/AIDS find the stigma of their status a barrier to seeking oral health care.
- Dental providers need to be educated about the specific concerns and oral health needs of people living with HIV/AIDS.
- Colocated services provide an effective way to improve access to primary oral health care for people with HIV/AIDS.

Colocated services provide an effective way to enhance the delivery of oral health services to individuals living with HIV/AIDS, who often face discrimination.

Currently, the program is funded by Ryan White Act Title I funds, and the scope of services provided is limited to those not reimbursed by Medicaid. The project is expected to continue as long as resources are available.

NEXT STEPS

WE CARE reaches some of the most disadvantaged, impoverished, vulnerable people in our nation, people who would otherwise not receive routine oral health services. Before the program's inception, very few patients with HIV/AIDS in northern Manhattan received preventive or comprehensive oral health care. It is crucial to expand the scope of this program and simultaneously to increase efforts to educate other dental providers

on the specific oral health needs of patients with HIV/AIDS. If the oral health status and quality of life of this special population is to improve, the concerns of both patients and providers will have to be addressed. ■

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G. Zabos is the principal investigator and program director of the WE CARE program and the principal author of this report. C. Trinh performed the data analysis, directed the focus group, and assisted in the writing of the report.

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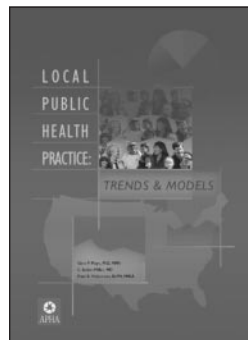

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