February 28, 2014

Dr. Laura Cheever
Associate Administrator
HIV/AIDS Bureau
Health Resources and Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857

Re: Ryan White HIV/AIDS Program Part F Dental Services Report
(OMB No. 0915-0151)

Dear Dr. Cheever:

The American Dental Education Association (ADEA) appreciates the opportunity to provide comments in response to the Health Resources and Services Administration’s (HRSA) solicitation for input regarding the burden estimate of Ryan White Program (“RW”) Part F grantees in reporting data for the Dental Services Report.

ADEA is the voice of dental education. Its members include all 66 U.S. dental schools and many allied and advanced dental education programs, faculty and students. The mission of ADEA is to lead individuals and institutions of the dental education community to address contemporary issues influencing education, research, and the delivery of oral health care for the health of the public. ADEA’s activities encompass a wide range of research, advocacy, faculty development, meetings and communications like the esteemed Journal of Dental Education.

To inform development of these comments, ADEA surveyed the reporting burden of our Part F grantee institutions, namely U.S. dental schools that serve as safety-net providers in administering either the Dental Reimbursement Program (DRP) or the Community Based Dental Partnership Program (CBDPP). ADEA received a robust response from dental institutions representing every region of the country: New England, Mid-Atlantic, Southeast, Midwest, and the West. The firsthand knowledge, experience, and acumen of these institutions providing Ryan White-funded oral health services offer invaluable perspective on managing the Part F program. Based on their direct insight with navigating completion of the Dental Service Report (DSR), our dental schools receiving Part F grants respectfully request significant revision to HRSA’s current data collection process.
I. Necessity of Information Collection for HRSA’s Proper Performance and Function

All responding institutions uniformly confirmed the necessity and utility of information requested by HRSA for the proper performance and function of the Ryan White Part F program. Most institutions termed the data sought by HRSA as “appropriate” and “reasonable.” Others specifically remarked:

“We believe that all of the information gathered in the DSR is valuable, but also believe there is a better way to do it.”

“Almost all the data requested is valuable, however we believe the data that can be combined are the responses to questions 12a and 12b in the Dental Services Report (DSR) about ethnicity and race. It would also be good to know how HRSA utilizes the information collected, and how institutions can benefit with enhanced future funding with the appropriate collection of this information.”

Merit is found with respect to the information asked for by HRSA, however a more streamlined collection method for that process is requested.

II. Accuracy of the Estimated Burden

All responding institutions consistently identified HRSA’s projection of estimated burden in completing the DSR to be highly underestimated or inaccurate:

“We have been participating in the Part F program for approximately 10 years. Over the 10 years we have developed a system to track the information requested for the report, but there is a massive amount of information to track, process, and review. We have one staff member who devotes about 80% of her time to processing and tracking the information for the Ryan White programs we participate in (Part A, B, D and F). She estimates that about 10 hours per week are spent keeping track of treatment that would fall under Part F, and any partial payments that insurance or the patient contribute toward their treatment. When it is time to compile the information and complete the DSR, she spends about 60-80 hours. This involves gathering the demographic data from our referral agencies, breaking down the total number of visits by patients for each type of service, and calculating the total unreimbursed costs. (We routinely have $600,000 - $1,000,000 in unreimbursed costs per year). As the director of the program, I spend about 10 hours reviewing and confirming the data, calculating the clinical and didactic training hours spent by residents, assistants, hygienists and rotating students, and writing/updating the remaining narratives. If we did have to train a new staff member to track and collect the information for the DSR, we estimate that it would take approximately 2 weeks to train her replacement.”

Another dental school overviewed its burden:

“There are a minimum of 8-9 people who work on the grant from beginning to end. It takes approximately 16 hours for us to process the DSR—this includes
reviewing instructions, downloading software, downloading data from our database, entering information into the DSR system, reviewing data entered, initiating proposal in grants.gov, routing internally for approval, reviewing data before final submission, submitting the grant via grants.gov and to the HRSA.”

Significantly more time was committed by a different institution:

“Information requested in the DSR cannot always be created by a data report in the electronic health record program used by our dental school. Personnel must manually review charts in order to provide an accurate and Oral Health Services,’ the patient’s HIV/AIDS status may be written in the chart notes and therefore not easily accessible unless the chart and/or patient’s health history is reviewed. This is also true of pregnancy status for female patients. Personnel collecting this information also have other job related duties and responsibilities, and, can devote three hours per day for two weeks reviewing charts to get this information. This alone can bring the burden to greater than 30 hours with three staff members working on the DSR.”

The search for demographic information, such as income relative to the federal poverty line, exacerbates the time commitment for others:

“The DSR form notes that it should require about 20 hours to read the instructions, gather the information, and completed the form. I have not totaled my time on this exactly yet…but it will be considerably more than 20 hours.

The application requires an incredible amount of detailed information, such as how many visits were included for specific types of procedures, not to mention some of the financial information. In addition, it asks for demographic data that is impossible to determine – e.g., race of the patients and their income relative to the federal poverty line. We simply do not always know this information.”

Others stated candidly:

“The Part F reimbursement rate versus the time and burden to complete the report is a deterrent. For example, the dental hygiene students provide treatment that is not chargeable or the fee can be minimal when considering the effort and time put in by the dental hygiene student. As a result, while there may be unreimbursed cost/charges, the amount reimbursed may not warrant the amount of work required to get the information.”

“I know of a major dental institution that withdrew [from participating in Part F] due to the burden of reporting.”

III. Ways to Enhance the Quality, Utility, and Clarity of the Collected Information

A number of institutions suggested specific enhancements and revisions to improve the collected data’s utility and quality:
“Provide monthly newsletters to funded institutions on this topic; have year-round live contact at HRSA to answer any questions or concerns that may arise; provide the funded institutions with the ability to utilize the funds for longer than the current six months limit so school vacation time can be accommodated for completion of procedures.”

“Currently, we are required to submit the DSR and the narratives to different sites [for state and federal reporting]. It would help if we can submit just one report and to one site only.”

“Entering the clinical and support care data into the state and HRSA system occurs on a monthly basis, in addition to the annual performance report. The data entry is time-intensive and burdensome, requiring a full time data manager to enter all the clinical information including doctor visits and lab values. In addition, all the support staff, such as case managers and patient navigators, enter their own visit data, including support services provided and time spent with each patient. It would be beneficial to create an automated data bridge that can transfer information directly from the electronic health record to the reporting system.”

Another suggested means to improve and streamline the database platform:

“When starting the process, I found it difficult to even locate the appropriate forms and instructions online. Once I did, things became simpler, but negotiating the HRSA website is not easy. You can’t even copy and paste text into the Access-like database. It would save time if you could do this. Also, the application unnecessarily requires submission of both a fillable PDF form and an Access-like database.”

IV. Use of Automated Collection Techniques to Minimize Data Collection Burden

Most responding institutions responded favorably to HRSA’s suggested use of automated collection techniques to minimize information and data collection burdens:

“Perhaps there can be a central repository where patient data needed by HRSA is entered for patients encountered by all funded institutions. This feed can then be more real-time, plus it will definitely decrease the burden of data collection that now typically needs to happen within the few weeks from when the grant application is released and the due-date.”

“The benefit of an automated collection technique would decrease the burden. We utilize multiple Excel spreadsheets to track the information, which is cumbersome and inefficient.”

Others cautioned concern with preserving confidentiality and platform compatibility:

“Using our current software, we are concerned about potential interface challenges [with automated collection].”
“Please note that confidentiality has been one aspect that has encouraged patients to get tested [via OraQuick during our clinical services], i.e., the information is not recorded in their dental electronic health record. This may be something to consider when developing the data collection standards.”

The Ryan White Part F dental programs are a critical health benefit, and lifeline to adequate oral health services, for thousands of adult people living with HIV/AIDS (PLWHA). ADEA’s Part F grantee institutions augment the provision of dental services to PLWHA—as well as educate, train, and develop the safety net of oral health care providers for PLWHA. In turn, ADEA urges HRSA to consider effective implementation of the aforementioned enhancements and revisions, in an effort to both encourage new institutions to participate in the Part F program and not jeopardize the current involvement of contributing schools.

Thank you for considering ADEA’s comments on the reporting burden associated with the Part F Dental Services Report. Should HRSA have any questions, or like to discuss these comments further, please do not hesitate to contact Yvonne Knight, J.D., Senior Vice President for Advocacy and Governmental Relations, ADEA Policy Center at knighty@dea.org.

Sincerely,

Richard W. Valachovic, D.M.D., M.P.H
ADEA President and CEO

cc:
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