Standards of Care: Oral Health Services

Introduction

HRSA Definition:

Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Local Exceptions: None

Goals: The goal of oral services is to reduce unmet oral care needs among people living with HIV, provide opportunities to prevent disease and address lifestyle behavior practices, offer nutritional counseling, help engage or reintroduce patients into the health care system and coordinate their care with other primary care providers.

Key activities include:

- Conduct semi-annual cleaning and check-ups
- Conduct annual comprehensive oral evaluation and periodontal examination
- Coordination with the medical provider to obtain completed information about the patient's health and medication status. Collect past and present history of tobacco, alcohol, and other substance use that affect oral health
- Develop comprehensive, multidisciplinary and timely treatment plans that include preventive care, pain management, infection control and/or emergency conditions. Include in patient chart proof of documentation that treatment plan was discussed with the patient.
- Provide oral health education that includes preventive oral health practices including oral hygiene, caries prevention and smoking cessation. Oral health education must be provided and documented by a licensed dentist, dental hygienist, dental assistant and/or dental case manager.
- Provide nutritional counseling or referral to the patients physician or a registered dietitian for patients having difficulty in consuming a balanced diet because of oral health issues
- Refer patients to additional providers including periodontists, endodontists, oral surgeon, oral pathologists and oral medicine practitioners.
- Retain patients in oral services and ensure continuity of services for patients.

Oral Health providers are expected to comply with the Universal Standards of Care, as well as these additional standards

1. Standard of Care: Intake

The Intake/Assessment determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation. Medical history, laboratory test results and medication history must be obtained at intake and updated on a regular basis. Whenever possible, the dentist must remind patients of the need for regular follow up and monitoring of CD4 and Viral load and must encourage patients to adhere to their medication.

It is recommended that the dental provider consult with the patient's primary care provider when additional information is needed to safely provide dental care.

SOC: Intake/Assessment: Intake/assessment should be completed for all clients receiving oral services

Time requirement: Intake process should begin during *first* contact with patient.

Criteria
1.1. Completion of agency required intake forms 1.1.1. Intake tools must include at a minimum 1.1.1.1. Proof of eligibility for RW services (can include current RW Card) 1.1.1.2. Current Photo ID 1.1.1.3. Documentation of HIV Status 1.1.1.4. Date of intake 1.1.1.5. Client demographics including mailing/home address and telephone number 1.1.1.6. Emergency contact information 1.2. Confidentiality policy and release of information will be discussed and completed 1.2.1. Release of information signed and dated by client, updated annually and saved in client file 1.3. Complete consent for services 1.3.1. Signed and dated by client and saved in client file 1.4. Client will be informed of Rights and Responsibility 1.4.1. Signed and dated by client and saved in client file 1.5. Client will be informed of Grievance Procedures 1.5.1. Signed and dated by client and saved in client file

2. SOC: Evaluation

All patients presenting for dental services must be given a comprehensive oral evaluation. Evaluation must include specific or chief complaints, problems with previous treatment (if any) or problems with or adverse reaction to anesthesia. All patients must have a full medical history with updates as appropriate. Medical history should include most recent lab results which may assist the dentist in identifying conditions that may affect the diagnosis and management of the patient's oral health. To develop an appropriate treatment plan, patient's medical history and medication list must be considered, including history of tobacco, alcohol, and other substance use that affect oral health. It is highly recommended that the dental provider consult with the patient's physician when additional information is needed to safely provide dental care.

SOC: After the oral health intake/assessment of the patient is completed, a comprehensive oral evaluation must be completed. If patients have follow-up or continued services, evaluation must be updated

Time requirement: Due within 15 days of initial assessment and within 5 days of a follow up or continued services

Criteria
2.1 Comprehensive oral evaluation 2.1.1 All patients requiring oral health services must have an evaluation completed. Evaluation must include 2.1.1.1 Documentation of patient's presenting complaint 2.1.1.2 Caries charting 2.1.1.3 Radiographs or panoramic and bitewings and selected peripheral films 2.1.1.4 Complete periodontal exam or periodontal screening record 2.1.1.5 Comprehensive head and neck exam 2.1.1.6 Complete intra-oral exam, including evaluation for HIV associated lesions 2.1.1.7 Pain assessments 2.1.2 Signed and dated evaluation by client and dentist. Must be saved in client file 2.2 Diagnostic test relevant to the evaluation including biopsies of suspicious oral lesions 2.2.1 Signed and dated evaluation by client and dentist. Must be saved in client file 2.3 Comprehensive medical history 2.3.1 Full medical status information must be obtained from the patient's medical provider during baseline evaluation and updated as needed 2.3.1.1 Medical history and current medication list will be updated to ensure all medical and treatment changes are noted 2.3.1.2 Most recent CD4 and viral load results must be documented 2.3.1.3 Medical conditions and allergies are noted and no known allergies (NKS) documented 2.3.1.4 Medical history must be updated at after all re-evaluation examinations 2.3.2 Signed and dated evaluation by client and dentist. Must be saved in client file

3. SOC: Treatment Planning

A comprehensive, multidisciplinary treatment plan that includes preventive care and maintenance should be developed and discussed with the patient. All treatment plans must be developed in conjunction with and signed by the patient. Primary reason for the visit should be considered by the dental profession when developing the treatment plan. Various treatment options should be discussed and developed in collaboration with the patient. An appropriate treatment plan should take into consideration patient's health status, financial status and individual treatment preference. Dental providers must also take into consideration patients behavioral, psychosocial, developmental and physiologic strengths and limitations when developing the treatment plan. The patient's ability to withstand treatment for an extended amount of time or return for subsequent visits should be determined when a preparing a treatment plan or initiating a dental procedure.

Appropriate treatment plan sequencing, which is the process of scheduling the needed procedures into a time frame, must be developed for each patient. Proper sequencing is a critical component of a successful treatment plan. Complex treatment plans often should be sequenced in phases, including an urgent phase, control phase, re-evaluation phase, definitive phase and maintenance phase. For most patients, the first three phases are accomplished as a single phase. Generally, the concept of the greatest need guides the order in which treatment is sequenced. This concept dictates that what the patient needs is performed first. Brief description of the different phases of sequencing is provided below:

Urgent phase

The urgent phase of care begins with a thorough review of the patient's medical condition and history. So, a patient presenting with swelling, pain, bleeding, or infection should have these problems managed as soon as possible and certainly before initiation of subsequent phases.

Control phase

It is meant to:

1. eliminate active disease such as caries and inflammation;
2. remove conditions preventing maintenance;
3. eliminate potential causes of disease, and
4. begin preventive dentistry activities.

This includes extractions, endodontics, periodontal debridement and scaling, occlusal adjustment as needed, caries removal, replacement/repair of defective restorations such as those with gingival overhangs, and use of caries control measures. The goals of this phase are to remove etiologic factors and stabilize the patient's dental health.

Re-Evaluation phase

The holding phase is the time between the control and definitive phases that allows for resolution of inflammation and time for healing. Home care habits are reinforced, motivation for further treatment is assessed, and initial treatment and pulpal responses are re-evaluated before definitive care is begun.

Definitive phase

After the dentist reassesses initial treatment and determines the need for further care, the patient enters the corrective or definitive phase of treatment. Sequencing operative care with endodontic, periodontal, orthodontic, oral surgical, and prosthodontics treatment is essential.

Maintenance phase

This includes regular recall examinations that:

1. may reveal the need for adjustments to prevent future breakdown, and
2. provide an opportunity to reinforce home care.

The frequency of re-evaluation examinations during the maintenance phase depends in large part on the patient's risk for dental disease:

1. A patient who has stable periodontal health and a recent history of no caries should have longer intervals (e.g. 9–12 months or longer) between recall visits.
2. Those at high risk for dental caries and/or periodontal breakdown should be examined much more frequently (e.g. 3–4 months).

Treatment plans must include appropriate recall/follow-up schedules. Those at high risk for dental caries and/or periodontal breakdown or has CD4<100 should be recalled within three. Referral and referral follow-up must be incorporated into the treatment plan. Coordination of care with the primary care physician must be incorporated in the treatment plan

SOC: Treatment plan must be developed in conjunction with the patient, be interdisciplinary and be updated as necessary

Criteria
3.1 Comprehensive, multidisciplinary treatment plan will be developed in conjunction with the patient 3.1.1 Patients primary reason for dental visit should be addressed in treatment plan 3.1.2 Follow up with referring agency/medical provider to determine next steps 3.1.3 Patient strengths and limitations will be considered in development of treatment plan 3.1.4 Treatment priority should be given to pain management, infection, traumatic injury or other emergency conditions 3.1.5 Treatment plan must include 3.1.5.1 Treatment plan sequencing 3.1.5.2 Tooth and/tissue supported prosthetic options 3.1.5.3 Fixed prosthesis, removable prostheses or combination 3.1.5.4 Soft and hard tissue characteristics and morphology, ridge relationships, occlusion and occludal forces, aesthetics and parafunctional habits 3.1.5.5 Restorative implications, endodontic status, tooth position and periodontal prognosis 3.1.5.6 Craniofacial, musculoskeletal relationships 3.1.5.7 Treatment plan dated and signed by both the provider and patient and in patient file 3.2 Recall schedule will be used to monitor any changes 3.2.1 Treatment plan must be reevaluated at least every six months. Six months recall schedule will be used to monitor any changes in patient's status 3.2.2 If a patient's CD4 is below 100, a three-month recall schedule must be considered 3.2.3 Follow up with the referring agency/medical provider to determine next steps and changes to treatment plan 3.2.4 Recall schedule information and outcome must be detailed in the progress notes 3.2.5 Progress notes must be signed and dated and be in patients file. 3.3 Update treatment plan as necessary 3.3.1 Updated treatment plan dated and signed by both provider and patient. Maintained in patient file

4. SOC: Informed Consent

All dental service providers must have an informed consent process and must discuss all options for dental treatment and allow the patients to be part of the decision making process. All patients must sign an informed consent document for all dental procedures. The informed consent process will be ongoing as indicated by the dental treatment plan. Dental providers must describe all options for dental treatment (including cost considerations), and allow the patient to be part of the decision-making process.

SOC: Patients must sign an informed consent document for all dental procedures. This informed consent process will be ongoing as indicated by the dental treatment plan

Criteria
4.1. As part of the informed consent process, dental providers will provide the following before obtaining informed consent 4.1.1. Diagnostic information 4.1.2. Recommended treatment 4.1.3. Alternative treatment and sources of funding 4.1.4. Costs (if any) 4.1.5. Benefits and risks of treatment 4.1.6. Limitations of treatment 4.2. Dental providers will describe all options for dental treatment (including cost considerations), and allow the patient to be part of the decision-making process 4.3. Informed consent process must be ongoing as indicated by the dental treatment plan 4.4. After the informed consent discussion, both new and ongoing, patient must sign an informed consent document.

5. SOC: Medical Consultation

The dental provider should consult with the patient's primary care physician when additional information is needed to provide safe and appropriate care. Dentists can also play an important role in encouraging patients to seek primary medical care at least every three to six months. If a patient is not under the regular care of a primary care physician, he or she should be urged to seek care and a referral to primary care should be done. If after six months, a patient has not yet re-engaged in primary medical care, then dental providers may discontinue oral health services. Patients must be made aware of this policy at the time of intake into the program.

SOC: Dental providers must consult with patient's primary care physician on an ongoing routine basis and must referred and linked to primary care physician when the patient is not under regular care

Criteria
5.1. Primary care physicians must be consulted when providing dental treatment. Consultation with the medical providers will be to: 5.1.1. Obtain necessary laboratory results 5.1.2. When there is any doubt about the accuracy of the information provided by the patient 5.1.3. When there is a change in the patient's general health, to determine the severity of the condition and the need for treatment modifications 5.1.4. New modifications are indicated to ensure medication safety and prevent drug interactions 5.1.5. Oral opportunistic infections are present 5.1.6. Signed, dated progress note to detail consultations 5.2. Dentists must encourage consistent medical care in their patients and provide referrals as necessary. Under certain circumstances, dental professionals may require further medical information to determine safety and appropriateness of care 5.2.1. Signed, dated progress note to detail referrals and discussion

Criteria
5.3. Dental services may be discontinued if a patient has not engaged in primary medical care 5.3.1. Dental provider must develop a policy about discontinuation of services 5.3.2. Patients must be made aware of this policy at the time of intake into the program. Intake materials must state this policy 5.4. Signed, dated progress notes to detail referrals and discussion

6. Prevention/Early Intervention

Dental professionals must emphasize prevention and early detection of oral disease by educating patients about preventive oral health practices, including instruction in oral hygiene. Counseling on risk behaviors (e.g. tobacco use, unprotected oral sex, body piercing in oral structures) that compromise oral health must be provided. Impact of good nutrition on preserving good oral health must be discussed and when appropriate, a referral to an RD or other qualified person should be made.

SOC: All patients receiving dental services must receive basic education about preventive oral health practices including oral hygiene, good nutrition and risk of adverse behaviors that would compromise oral health

Criteria
6.1. Dental providers must educate patients about preventive oral health practices 6.1.1. Signed, dated progress note in patient file to detail education effort 6.2. Routine examinations and regular prophylaxis must be scheduled twice a year 6.2.1. Signed, dated progress note or treatment plan in patient file to detail schedule 6.3. Dental providers must offer basic nutritional counseling to assist in oral maintenance. Referrals to an RD and others must be made as needed 6.3.1. Signed, dated progress note to detail nutrition discussion and referral made

7. SOC: Triage/Referral/Coordination

When patients require a higher level of oral health treatment services than a given agency is able to provide, patients must be referred for these additional oral service providers including periodontists, endodontists, oral surgeons, oral pathologists and oral medicine practitioners. Oral care must be coordinated with primary care provider so that any changes to patient's health is quickly addressed and treatment plan modified accordingly. Similarly, ongoing constant coordination with the patient's case manager (medical and/non-medical) is critical to ensure integration of services and addressing any interruptions to wrap around services is easily resolved and will not hinder patient's oral care/treatment.

SOC: Patients receiving oral treatment must be triaged/referred to other dental services is necessary when full range of oral care cannot be provided by the agency

Criteria
7.1. Refer patients to full range of oral health care providers including periodontists, endodontists, oral surgeons, oral pathologists and other oral medicine practitioners when necessary 7.1.1. Document referrals and outcome in patients progress notes. Must be signed and dated by the dentist 7.1.2. Coordinate with patient's primary care provider at a minimum of once a year, or as clinically indicated to coordinate and integrate care 7.1.3. Documentation of contact with primary care provider to be placed in patients progress notes 7.1.4. Coordinate with patient's case manager at a minimum of once a year, or more frequently to coordinate and integrate care 7.1.5. Documentation of contact with primary care provider to be placed in patients progress notes

8. SOC: Patient Retention

Dental service providers must strive to retain patients in oral treatment services. Providers must establish a broken appointment policy. Follow-up can include telephone calls, written correspondence, and/or direct contact which helps to maintain a client's participation in care. Coordination with patients case manager and/outreach staff must be incorporated and such efforts must be documented in the progress notes in the client record.

SOC: Dental providers must establish a missed appointment policy

Criteria
8.1. Dental service provide shall provider regular follow-up procedures to encourage and help maintain a client in oral treatment services 8.2. Dental service provider will coordinate with patient's case manager or primary care physician, or with outreach service provider to reach out to patients lost to care 8.3. Documentation of attempts to direct contact with patient or coordination with other service provider must be in progress notes, dated and signed

9. SOC: Case Closure

Policies and procedures must be developed for proper case closure. Reasons a case is closed must be clearly documented and placed in client file. For those clients who have been referred to a different dental service, referral outcome must be clearly documented in patient file. There should be no instance where a case is closed because of 'unknown' reasons

SOC: Dental providers must develop procedures to close client files. All clients must be made aware of the case closure procedures

Criteria
9.1. Dental service provider shall develop proper procedures for closing out a case 9.2. Valid reason for case closure must be documented in client file 9.3. Documentation of attempt to coordinate with the patients case manager or primary care provider or outreach worker for those clients who refuse treatment, do not complete treatment or are lost to care must be in progress notes, dated and signed

10. SOC: Staffing Requirements and Qualifications

Oral health services must be provided by qualified dental care professionals who possess the applicable professional degrees and current California state licenses. Dental staff may include dentists, dental assistants and dental hygienists. Clinical supervision must be performed by a licensed dentist responsible for all clinical operations. Prior to providing oral care, all dental staff must receive orientation in policies and procedures of the general practice of dentistry and specifically, the provision of dental services to persons living with HIV

SOC: Description of qualifications required for all dental staff

Criteria
10.1. Dentists 10.1.1. Dentists must complete a four-year dental program and possess a Doctor of Dental Surgery (DDS) degree 10.1.2. Dentist must pass a three-part examination as well as the California jurisprudence exam and a professional ethics exam. 10.1.3. Dentists are regulated by the California Dental Board 10.2. Registered Dental Assistants (RDA) 10.2.1. RDAs must possess a diploma or certificate in dental assisting from an educational program approved by the California Dental Board, or 18 months of satisfactory work experience as a dental assistant. RDAs are regulated by the California Dental Board 10.2.2. RDAs may perform all procedures authorized by the provisions of the California Dental Board and in addition perform all functions which may be performed by a dental assistant under the designated supervision of licensed dentist. 10.3. Registered Dental Hygienist (RDH) 10.3.1. RDHs must have a diploma or certificate in dental hygiene from an approved dental hygiene educational program. RDHs are regulated by the California Dental Board 10.3.2. RDHs may perform all procedures authorized by the California Dental Board and in addition my perform all functions which may be performed by a dental assistant and RDA under the designated supervision of a licensed dentist 10.4. Supervision : Direct or General 10.4.1. Direct supervision is based on instructions given to an RD or RDH staff by a licensed dentist who must be *physically* present in the treatment facility during the performance of those procedures 10.4.2. General supervision is based on instructions to an RD or RDH staff given by a licensed dentist, but *not* requiring the physical presence of the supervising dentist during the performance of those procedures 10.5. Patient's clinical notes must be signed by supervising dentist and must be documented in patient charts.

11. SOC: Licensure or Assurance

Oral health services must be provided by dental care professionals who possess the current California state licenses.

Criteria
11.1. All dental staff must have current license issued by the California State Dental Board 11.2. Dental service provider must comply with Health Resources Services Administration (HRSA) standards as well as other federal, state, and local authorities for certification and/or license as required 11.2.1. Copy of license must be in the staff personnel file

12. SOC: Staff Training

All dental staff must receive initial trainings on basic HIV information, Ryan White program eligibility and service requirements and policies and procedures related to general dentistry as well as those specific to treating people with HIV. Ongoing training as required by the California Dental Board as well as HIV disease and associated oral health treatment considerations must be offered to all staff. Dental staff must have ongoing cultural sensitivity training specifically related to working with persons affected by HIV disease

SOC: Description of how staff will be trained, including orientation, required training topics, and frequency of training. Describe the process for assessing staff training needs, monitoring and documenting all training, including where training records are located.

Criteria
12.1. All dental staff must meet with the training requirements required by the California State Dental Board 12.2. Dental service provider must also participate in at least 3 hours of education/training every year on HIV related oral health care issues including oral manifestations, dental treatment considerations for PLWH and other co-morbidities, cultural sensitivity, available resources in community, & infection control and post exposure prophylaxis, Non-licensed staff must participate in at least one hour of education/training annually on these topics 12.2.1. Documentation of all trainings in employee file

13. SOC: Access to Services

Standards identified in Universal Standards of Care (USOC 4)

14. SOC: Outreach and Provider Continuity

Additional standards identified in Universal Standards of Care (USOC 6)

15. SOC: Continuous Quality Improvement

Standards identified in Universal Standards of Care (USOC 7)

References and Published Clinical Guidelines:

1. **Ryan White Title I Standards of Care for Dental Care Services,** Approved by the Santa Clara County Health Services Planning Council March 12, 2013
2. http://hiv.lacounty.gov/LinkClick.aspx?fileticket=PXjkCQwMU_o%3d&portalid=22
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5. http://hivmemphis.org/wp-content/uploads/2015/02/Memphis-TGA-Standards-of-Care-Oral-Health-approved-05-25-16.pdf
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