

HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)

# Oral Health Services Standards

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# Oral Health Services Standards

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC Eligible Metropolitan Area (EMA) such that customers of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and in quality management.

## I. SERVICE CATEGORY DEFINITION

Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants. Oral health care services are provided by fully registered dental health care professionals authorized to perform dental services under the laws and regulations of the jurisdictions of the District of Columbia Eligible Metropolitan Area.

Subrecipients of oral health care demonstrate how services help to address the burden placed on the immune system caused by oral infection and support positive health outcomes. Oral Health services includes evidence-based clinical decisions that are informed by the American Dental Association Dental Practice Parameters, is based on an oral health treatment plan, and adheres to specified service caps as appropriate and defined by HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA).

Services shall include (but not be limited to):

- ◆ Identifying appropriate patients for HIV oral health care services through eligibility screening
- ◆ Obtaining a comprehensive medical history and consulting primary medical providers as necessary
- ◆ Providing educational, prophylactic, diagnostic and therapeutic dental services to patients with a written confirmation of HIV disease
- ◆ Providing medication appropriate to oral health care services, including all currently approved drugs for HIV related oral manifestations
- ◆ Providing or referring patients, as needed, to health specialists including, but not limited to, periodontists, endodontists, oral surgeons, oral pathologists, oral medicine practitioners and registered dietitians
- ◆ Maintaining individual patient dental records in accordance with current standards
- ◆ Complying with infection control guidelines and procedures established by the

different jurisdictions in the DC EMA Occupation Safety and Health Administration (OSHA)

The following are priorities for HIV oral health treatment:

1. Prevention of oral and/or systemic disease where the oral cavity serves as an entry point
2. Elimination of presenting symptoms
3. Elimination of infection
4. Preservation of dentition and restoration of functioning (Dentures)

### **Synthesis of Published Standards and Research**

This document represents a synthesis of published standards and research, including:

- Oral Health Care Exhibit, Office of AIDS Programs and Policy, 2018 ([Oral Health Care Exhibit](#))
- Practice Guidelines for the Treatment of HIV Patients in General Dentistry, LA County Commission on HIV Services, 2002 ([LA Oral Health](#))
- Oral Health Care for HIV-Infected Patients 2013 ([Oral Health for HIV Positive Patient](#))
- Primary Care Recommendations for Oral Health Care in HIV+ Patients ([Oral Health Care Recommendations](#))
- Oral Health Standards, Virginia Department of Health, 2015. ([Oral Healthcare Standards, Virginia DOH](#))
- Oral Health Care Standards of Care, Connecticut Ryan White Part B Program ([Oral Health Care Connecticut Ryan White Part B Program](#))
- Clinical Guidelines Programs, Oral Health Complications, 2016, New York State Department of Health AIDS Institute ([Oral Health Complications](#))
- The LA County Commission on HIV ([Los Angeles County Commission on HIV](#))
- Dental Management of the HIV-infected Patient, Supplement to JADA, American Dental Association, Chicago, 1995 ([Infection Control Recommendation for the Dental Office and Dental Laboratory](#))
- Practice Guidelines for the Treatment of the HIV positive patients in general dentistry ([Practice Guidelines](#))
- American Dental Association 211 East Chicago Avenue Chicago, IL 60611-2678 312.440.2500. <https://www.ada.org/en/about-the-ada/contact>
- American Dental Association <https://www.ada.org/en/publications>
- Stephen, N.E, David Croser, Stuart L. F., Michael G. & Joan A. P (2000). Principles of Oral Health Management for the HIV/AIDS Patient; Dental Alliance for AIDS/HIV Care (DAAC)
- Lemay CA, Cashman SB, McDonald A, Graves JR. A New Approach to Ensuring Oral Health Care for People Living With HIV/AIDS: The Dental Case Manager. Prev Chronic Dis 2012;9:110297. DOI: <http://dx.doi.org/10.5888/pcd9.110297>
- American Dental Association (ADA). Oral Health Topics. <https://www.ada.org/en/member-center/oral-health-topics/hiv>
- Ryan White HIV/AIDS Program Services: Eligible Individual & Allowable Uses of Funds, Policy Clarification Notice (PCN) # 16-02 (Revised 10/22/18) ([PCN # 16-02](#))

## II. INTAKE, ELIGIBILITY & ANNUAL RECERTIFICATION REQUIREMENTS

The Ryan White HIV/AIDS Program has the following eligibility criteria: residency, financial, and medical. HRSA requires Ryan White patients to maintain proof of eligibility annually. Supporting documentation is required to demonstrate patient eligibility for Ryan White Services.

### A. INITIAL ELIGIBILITY DETERMINATION

1. **HIV-positive status:** written documentation from a medical provider or laboratory reports denoting viral load.
2. **Residency:** The following are acceptable methods of meeting the burden for residency:
  - Current lease or mortgage statement
  - Deed settlement agreement
  - Current driver's license
  - Current voter registration card
  - Current notice of decision from Medicaid
  - Fuel/utility bill (past 90 days)
  - Property tax bill or statement (past 60 days)
  - Rent receipt (past 90 days)
  - Pay stubs or bank statement with the name and address of the applicant (past 30 days)
  - Letter from another government agency addressed to applicant
  - Active (unexpired) homeowner's or renter's insurance policy
  - DC Healthcare Alliance Proof of DC Residency form
  - If homeless, a written statement from case manager or facility

3. **Income:** Patient income may not exceed 500% of the Federal Poverty Level (FPL). Income sources should be reported by the applicant and any household members for whom applicants have legal responsibility. For each income source the applicant must indicate the gross amount, how often the income is received, and whether it is your income or a household member's from each source.

The following are acceptable forms of proof of income:

- Pay stubs for the past 30 days. The pay stub must show the year to date earnings, hours worked, all deductions, and the dates covered by the paystub
- A letter from the employer showing gross pay for the past 30 days, along with a copy of the most recent income tax return
- Business records for 3 months prior to application, indicating type of business, gross income, net income, and most recent year's individual income tax return. A statement from the applicant projecting current annual income must be included
- Copy of the tenant's lease showing patient as the landlord and a copy of their most recent income tax return
- SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days
- Zero income attestation form and/or a letter from a supporting friend or family member stating how they support the applicant

#### 4. **INTAKE**

To establish a care relationship, the customer intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of person completing intake
3. Customer name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (customer self-report)
7. Emergency contact information
8. Communication method to be used for follow-up
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)

10. Veteran status
11. Any other data required for the CareWare system
12. Any other service-specific data
13. Documented explanation about the services available within the provider agency and within the Ryan White Program

**C. MAINTENANCE OF ELIGIBILITY**

To maintain eligibility for Ryan White services, providers must conduct annual eligibility confirmations to assess if the customer's income and/or residency status has changed. RWHAP providers are permitted to accept a customer's self-attestation of 'no change' when confirming eligibility, however, self-attestation could be used every other annual confirmation and not be used in two consecutive years.

**III. KEY SERVICE COMPONENTS & ACTIVITIES**

The agency screening is the first point of contact between the applicants or affected family member/significant other or referring source that allows the agency to gather basic information about the applicant and share general information about their services. Screenings can be done in-person or by phone. The agency screening will determine what services the applicant may need and may be eligible to receive and what services the agency has available to meet those needs.

If a patient’s first contact at an oral health agency is with an oral health provider or other appropriately trained staff, the intake process will begin immediately, and this will include the information normally gathered at an agency screening.

If contact is made by phone, the oral health agency will gather as much information as possible and schedule a face-to-face meeting with the applicant to complete the entire intake process.

**1. Agency Screening & Acceptance of Referrals**

Standards	Measures
Oral Health agencies will accept referrals from other Part A funded providers as well as from hospitals, HIV counseling and testing centers, physicians, community organizations, HIV/AIDS service providers, county and state correctional systems, case management facilities, substance abuse treatment facilities, individuals and self-referrals, managed care groups and others.	Documentation of referral in customer’s record, signed and dated

An assessment will occur prior to the initiation of any formal treatment to determine which oral health services the patient will need.

Specifically, the assessment will collect information on the patient's medical history in addition to any factors that could act as barriers to the patient's accessing oral health care. Clinically, the assessment is comprised of an in-depth examination of the patient's oral cavity. The assessments shall be conducted by a licensed oral health provider, depending on jurisdictional regulations.

Standard	Measures
<p>The oral health provider must perform an <u>assessment</u> (initial exam) on every patient at the initiation of services.</p> <p>The patient's medical record will include an initial assessment completed within <b>20 business days of completing the intake</b>.</p> <p>All assessments must be maintained in the medical records.</p> <p>A comprehensive oral evaluation will be given to people with HIV presenting for dental services. The evaluation will include:</p> <ul style="list-style-type: none"> <li>• Documentation of patient's presenting complaint</li> <li>• Caries charting</li> <li>• Radiographs or panoramic and bitewings and selected periapical films</li> <li>• Complete periodontal exam or PSR (periodontal screening record) • Comprehensive head and neck exam</li> <li>• Complete intra-oral exam, including evaluation for HIV associated lesions</li> <li>• Pain assessment</li> </ul>	<p>Signed, dated oral evaluation on file in patient medical records within 20 business days of intake.</p>
<p>As indicated, diagnostic tests relevant to the evaluation will be used in diagnosis and</p>	<p>Signed, dated evaluation in medical records to detail additional tests.</p>

treatment planning. Biopsies of suspicious oral lesions will be taken	
The assessment must be completed by an oral health provider within 20 business days. In addition, full medical status information from the patient's medical provider, including most recent lab work, should be obtained	Documentation of completed assessment within 20 business days
Full medical status information will be obtained from the patient's medical provider and considered in the evaluation. The medical history and current medication list will be updated regularly to ensure all medical and treatment changes are noted.	Signed, dated evaluation in patient medical records to detail medical status information. Signed, dated progress note to detail updated medical information in patient medical records

<b>3 Treatment Plan</b>
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The Oral Health Provider must develop a Treatment Plan based on the initial examination of the patient. The provider should consider other supporting documentation as required by jurisdictional regulations. The plan should be specific measurable objectives with specified action steps including the specific set of services needed to meet those objectives and goals and designated individual(s) who will perform each activity. The plan must also include timeline for each step; start and target end date.

The treatment plan must be developed and documented in the patient record within timeframe required American Dental Association (ADA) and by local jurisdiction regulations. Complex treatment plans often should be sequenced in phases, including an urgent phase, control phase, re-evaluation phase, definitive phase, and maintenance phase. Once services are initiated, the oral health provider becomes part of the patient's health care interdisciplinary team and is encouraged to communicate with individuals who provide other health services to the patient.

The oral health provider is responsible for requesting recent medical and other clinical progress notes to initiate new oral health treatment plans, when necessary.

<b>Standard</b>	<b>Measures</b>
A comprehensive, multidisciplinary treatment plan will be developed in conjunction with the patient.	Treatment plan dated and signed by both the provider and patient in patient medical records.

	Approval of the treatment plan and affirmation that a copy of the treatment plan was provided to the patient or their legal representative, if applicable, by their signatures on the plan;
Patient's primary reason for dental visit should be addressed in treatment plan	Treatment plan dated and signed by both the provider and patient in patient file to detail.
Treatment priority will be given to pain management, infection, traumatic injury or other emergency conditions.	Treatment plan dated and signed by both the provider and patient in patient medical records to detail.
<p>Treatment plan will include consideration of following factors:</p> <ul style="list-style-type: none"> <li>• Tooth and/or tissue supported prosthetic options</li> <li>• Fixed prostheses, removable prostheses or combination</li> <li>• Soft and hard tissue characteristics and morphology, ridge relationships, occlusion and occlusal forces, aesthetics and parafunctional habits</li> <li>• Restorative implications, endodontic status, tooth position and periodontal prognosis</li> <li>• Craniofacial, musculoskeletal relationships</li> </ul> <p>Education on oral disease prevention.</p> <ul style="list-style-type: none"> <li>• Appropriate Evidence- based treatments that will be provided;</li> <li>• Identify resources for after hours crisis or other emergencies and</li> <li>• Treatment plan is reinitiated as necessary or as required by (ADA)/local jurisdictions' regulations.</li> </ul>	Treatment plan dated and signed by both the provider and patient in patient medical records to detail.
A copy of the treatment plan must be offered to the patient and their legal representative or members of the patient's health care interdisciplinary team, if applicable.	Approval of the treatment plan and affirmation that a copy of the treatment plan was provided to the patient or their legal representative, if applicable, by their signatures on the plan;
Treatment plans will be updated at least yearly	Updated treatment plan dated and signed by both the provider and patient in patient medical records.

<b>4. Management of Treatment Plan</b>
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The oral health provider should practice evidence-based oral health management with People with HIV (PWH) per American Dental Association guidelines. Guidelines are meant to be general and allow the dental healthcare worker flexibility to offer the best care available to Ryan White Program eligible patients in a timely manner.

The oral health provider guides the patient toward completion of the treatment plan. There is no evidence to support modifications in oral health care based solely on the presence of HIV infection. However, such modifications may be indicated on the basis of certain medical problems that occur as a result of HIV infection, e.g., screening for opportunistic infections and the impact of treating them. Various treatment options should be discussed and developed in collaboration with the patient.

Documentation of all face-to-face encounters between patient and the oral health provider must be documented in the patient record.

Standard	Measures
<p>Treatment is guided by the individual’s treatment plan and the jurisdiction’s requirements.</p> <p>Oral Health providers will document all screening and prevention efforts alongside treatment and other examination information in patient progress notes.</p> <p>Opportunistic Infection (OI) screening and prevention is provided alongside standard examinations and treatment.</p> <p>As part of all new patients’ treatment, education on oral diseases, infectious diseases and HIV/AIDS risk reduction must be provided in a timely manner.</p> <p>Patients should be seen in a timely manner.</p>	<p>Documentation that the treatment plan was initiated within the timeframe required by the local jurisdiction’s regulations.</p> <p>Documentation of progress notes and contacts (phone/in-person) in the patient’s medical records for each face-to-face encounter, based on the frequency required by the local jurisdiction’s regulations.</p>

All face-to-face encounters must be documented in the patient record.	
Oral health providers must take active steps to address instances of patient noncompliance.	Documentation in patient's medical records

**5. Referral to Higher level of Care**

The oral health provider is responsible for referring patients to a higher level of oral health treatment, if medically indicated, as identified through the assessment and as required through the treatment plan.

Referral involves the process of connecting the patient to a full range of oral health care providers, including periodontists, endodontists, oral surgeons, oral pathologists, oral medicine practitioner. Also vital is the coordination of oral health care with primary care medical providers. Referral for consultation or oral health specialty care when appropriate must be available. A referral is successful only when the patient makes the connection with the end-point organization/provider to which the patient is being referred.

<b>Standard</b>	<b>Measures</b>
<p>As needed, dental providers will refer patients to a full range of oral health care providers including:</p> <ul style="list-style-type: none"> <li>• periodontists</li> <li>• endodontists</li> <li>• oral surgeons</li> <li>• oral pathologists</li> <li>• oral medicine practitioners</li> </ul> <p>Providers will attempt to contact the patients' primary care clinic at a minimum of once a year, or as clinically indicated, to coordinate and integrate care.</p> <p>The agency must maintain a referral system to request services for a patient and have a tracking system to follow-up on the status of the referral.</p>	<p>Based on documentation of the patient's needs, copies of appropriate referrals and linkages to care are filed in the patient's records.</p> <p>Referral documentation must include the:</p> <ol style="list-style-type: none"> <li>1. Reason for referral</li> <li>2. Patient's contact information</li> <li>3. Oral health provider's contact information</li> <li>4. Name and contact information of agency or staff accepting referral, including address</li> <li>5. Status of the referral and</li> <li>6. Signed ROI form(s), if necessary</li> <li>7. Copies of reports from accepting agency, when necessary for treatment and only with patient/guardian's consent to release.</li> </ol>

A copy of the request and any Request for Information (ROI) must be filed in the patient's chart.	Documentation of contact with primary medical clinics and providers to be placed in progress notes.
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**6. Discharge/Transfer/Closure**

The oral health provider must discharge a patient from oral health services when they no longer actively receive oral health services and close their case if they no longer actively receive any other services from the agency in 12 months. Discharge and case closure are systematic processes implemented in response to the patient's choice, progress, situation and/or actions. A patient can be discharged from an agency's oral health program and still receive other services within the same agency. Every effort must be made not to disrupt the patient-provider relationship. Patients should only be transferred to another oral health agency if the first agency does not accept the patient's new insurance.

Standard	Measures
<p>Patients can be discharged from an oral health program for any one or more of the following reasons:</p> <ul style="list-style-type: none"> <li>• Patient has successfully met all identified goals and objectives and no longer wishes to receive oral health services at the agency</li> <li>• Patient is receiving oral health services at another agency</li> <li>• Patient is unwilling to participate in oral health treatment planning</li> <li>• Patient requests to end oral health services</li> <li>• Patient dies</li> </ul> <p>A patient must be discharged and their case closed if any one or more of the following apply:</p> <ul style="list-style-type: none"> <li>• Agency is unable to contact or reengage patient after six months</li> <li>• Patient is incarcerated for more than 6 months</li> <li>• Patient moves/relocates out of service area</li> <li>• Patient ages out of agency's programs</li> <li>• Patient falsifying claims about their HIV diagnosis or falsifies documentation</li> </ul>	<p>A discharge summary must be filed in all discharged patient's charts.</p> <p>The discharge summary must include at a minimum the following:</p> <ol style="list-style-type: none"> <li>1. Patient's name</li> <li>2. Reason for admission for services</li> <li>3. Reason for discharge</li> <li>4. Summary of the treatment provided, including frequency and duration</li> <li>5. Progress in meeting treatment goals</li> <li>6. Diagnosis and prognosis at time of discharge</li> <li>7. Current medications, if applicable</li> <li>8. Continued service recommendations</li> <li>9. Signature of oral health provider</li> <li>10. Signature of patient/guardian, if available</li> <li>11. Referrals as needed and</li> <li>12. Information on how to re-enter services, if appropriate</li> </ol>

<ul style="list-style-type: none"> <li>• Patient exhibits a pattern of abuse of agency staff, property and services (Requires completion of an Unusual Incident Report)</li> <li>• Disciplinary action</li> </ul>	<p>When conducted, follow-up information after discharge should also be attached to the discharge summary of the patient record.</p>
<p>The oral health provider must complete a discharge summary within 10 business days of discharging the patient from oral health services.</p> <p>The summary will become part of a discharge packet that will also include any discharge meeting minutes, if applicable, and the discharge letter.</p> <p>If the patient is receiving other services from the agency, the record will remain in an active status. The discharge letter should be based on information in this packet and should outline the timeframes for post-discharge follow-ups. The discharge letter should be mailed to all members of the patient’s health care interdisciplinary team and this must be entered into the patient record.</p>	<p>Documentation in patients’ medical record</p>

#### IV. PERSONNEL QUALIFICATIONS

HIV/AIDS oral health care services will be provided by dental care professionals possessing applicable professional degrees and current licenses in the jurisdiction of practice ([DC regulations](#)). Dental care staff can include dentists, dental assistants, and dental hygienists. A dentist will be responsible for all clinical operations, including the clinical supervision of other dental staff. Prior to performing HIV/AIDS oral health care services, all dental staff will be oriented and trained in policies and procedures of the general practice of dentistry, and specifically, the provision of dental services to persons living with HIV.

These training programs will include (at minimum):

- ◆ Basic HIV information
- ◆ Orientation to the office and policies related to the oral health of people living with HIV
- ◆ Infection control and sterilization techniques
- ◆ Methods of initial evaluation of the patient living with HIV disease
- ◆ Education and counseling of patients regarding maintenance of their own health
- ◆ Recognition and treatment of common oral manifestations and complications of HIV disease

- ◆ Recognition of oral signs and symptoms of advanced HIV disease, including treatment and/or appropriate referral. Providers are encouraged to continually educate themselves about HIV disease and associated oral health treatment considerations.

All oral health professionals, including third-party payers, have appropriate and valid licensure and certification as required by the jurisdiction they practice.

- Copy of current licensure and certification in personnel file.
- All oral health professionals must complete 2 hours of continuing education in HIV/AIDS annually.
- Documentation of continuing education credits in personnel file.

## **V. CLINICAL QUALITY MANAGEMENT**

Include at least two performance measures in the clinical quality management program for the service. Please refer to Policy Clarification Notice (PCN) #15-02 (updated 09/01/2020). Oral Health agency must report clinical quality management activities, improvement projects and performance measures per updated PCN-15-02 - 09/01/2020.

Performance Measures are:

- Percentage of patients with HIV infection who received an oral exam by a dentist at least once during the measurement year.
- Percentage of Ryan White (RW) oral health patients with a dental treatment plan developed or updated at least once within the measurement year.
- Percentage of RW oral health patients with a Phase 1 treatment plan completed within 12 months of development.
- Percentage of RW oral health patients receiving oral health education at least once within the measurement year.
- Percentage of patients, regardless of age, with a diagnosis of HIV who had at least two care markers in a 12 month period that are at least three months apart.

## **VI. APPROVAL & SIGNATURES**

This service standard has been reviewed and approved on August 1, 2025. The next annual review is July 31, 2026.



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