

NEWARK EMA HIV HEALTH SERVICES PLANNING COUNCIL ORAL HEALTH STANDARDS OF CARE

The Newark E.M.A. HIV Health Services Planning Council (Planning Council) represents the five counties of Essex, Union, Morris, Sussex and Warren. Newark E.M.A. is one of the 51 Planning Councils nation-wide, which were established by the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The CARE Act establishes and funds care and treatment for people living with and affected by HIV/AIDS (PLWHA) who would otherwise have little or no access to health care.

The Planning Council is comprised of approximately 34 non-paid representatives who have HIV/AIDS expertise from community-based AIDS service organizations, local public health agencies, affected communities, including PLWHA, and the NJ Department of Health & Senior Services. Currently a third of the Newark E.M.A.'s membership is people living with HIV/AIDS.

The Planning Council is responsible for establishing the Ryan White Title I funding priorities that determines local care and treatment needs of PLWHA in the Newark E.M.A. N.E.M.A. develops standards of care that are mandated by the Health Resources and Services Administration (HRSA) which funds all CARE Act services. These standards are part of HRSA's Strategic Plan to improve the quality of health care services for the nation's underserved and vulnerable populations.

In 2005 HRSA defined Core Services as Primary Medical Care, Medications, Mental Health, Substance Abuse, Dental and Case Management. NEMA's priority is completing standards of care for all core services. The following are Oral Health Standards of Care specific for HIV.

Methodology for developing these standards consisted of the following five phases:

Phase I: Draft standards were developed by reviewing what other major cities' standards, New Jersey Administrative Code and pertinent topical research.

Phase II: Care & Treatment Committee discussed the process and some members of the Committee, the grantee, Planning Council staff and members and service providers participated in an ad-hoc subcommittee to make recommendations on the standards.

Phase III: A Consumers Forum was held to obtain feedback for standards on Oral Health.

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Approved by the Planning Council on October 19, 2005

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Phase IV: Care & Treatment Committee reviewed the draft document after all feedback was incorporated and submitted its recommendations to the N.E.M.A. Planning Council to approve the final Oral Health Standards of Care.

Phase V: The N.E.M.A. Planning Council made final recommendations and approval.

Providers must continue to follow the standards set forth by the State of New Jersey for State Board of Dentistry Statutes, New Jersey Ambulatory Care Licensing Requirements, and New Jersey State Board of Dentistry Regulations. N.E.M.A.'s standards exist as an additional requirement for oral health treatment providers.

These standards are based on two major premises: 1) Good oral health maintenance and disorder prevention; and, 2) adherence to medical treatment to prevent opportunistic infections and malignancies. Standards ensure the possibility of reaching these outcomes. The standards we present are as follows:

Standard 1: Accessibility ensures that oral health services are available to PLWHA. This includes the following:

- A. Cultural Competence must be demonstrated throughout all standards. Cultural competence is the ability to communicate effectively with PLWHA, who are diverse in language (including literacy level), age, culture, socioeconomic status, sexual orientation, race, ethnicity, customs, beliefs, religion and communication. Agencies should strive to model the NJ Department of Health & Human Services, *New Jersey Culturally & Linguistically Appropriate Standards for HIV/AIDS Service Providers Implementation Guide, June 2003*.
- B. Oral health service providers must facilitate contact with primary medical care.
- C. Service providers must comply with the Americans with Disabilities Act (ADA).

Standard 2: Written policies and procedures exist to ensure protection of consumer rights, health, safety and quality care. Those policies contain:

- A. Physical Plant Safety:
 - 1. Ambulatory Care Facilities must comply with New Jersey Standards for Licensure of Ambulatory Care Facilities (NJAC Title 8:43A).
- B. Providers will ensure the development of Infectious Disease Prevention & Control Program which is reviewed annually.
- C. Policies and procedures for all Medical/Oral Health services will be provided by and under the responsibility of the Dental Director.

- D. Policies and procedures must exist for the administration, control and storage of medications.
- E. Laboratory & Radiology services will be either provided by the facility or assured through written affiliation agreement.
- F. Policies for Consumer Records will include procedures for production, maintenance and retention of clinical records, and those policies will be reviewed annually by the Director. Confidentiality policies concerning records will meet HIPAA requirements.
- G. Each facility will have written policies and procedures for surgical and anesthesia services limited to the provisions outlined by the New Jersey Board of Dentistry.
- H. A Quality Assurance Plan shall be developed for patient care.
- I. Emergency Plan must include written procedures for fire, bomb threat, evacuation, other accidents and natural disasters.

Standard 3: Human Resources certify competent experienced staff in the provision of quality clinical care for Oral Health Services of PLWHA. This standard is evidenced by:

- A. Meeting the requirements for New Jersey Administrative Code 13:30 via the New Jersey Board of Dentistry.
- B. Degrees, licensing, certifications and resumes must be kept on file.
- C. Job descriptions must exist for all positions.
- D. Personnel policies and procedures must comply with NJAC 8:43A .
- E. Dental Directors must demonstrate experience and training with HIV/AIDS disease process, the effects of HIV/AIDS-related illnesses and co-morbidities on patients, adverse oral effects of HIV medications and current strategies for HIV management.
- F. Dental Directors must ensure HIV experience of their staff.

- G. Direct service providers must receive continuing education in HIV/AIDS Training, including prevention education.

Standard 4: Ryan White eligibility is determined prior to service provision by:

- A. Verifying HIV status
- B. Verifying Income status
- C. Verifying Insurance status

Standard 5: The intake process clarifies the service contract of responsibilities and rights of consumers and providers through:

- A. Orientation of services offered;
- B. Written “Client Rights and Responsibilities” as documented in NJAC 8:43A;
- C. Explanation of confidentiality and HIPAA requirements;
- D. Explanation of grievance process;

Standard 6: A medical assessment must be completed during initial visit and must identify the following:

1. Medical History including the following:
 - a. medications
 - b. co-morbidities
 - c. laboratory results within the last 6 months
 - d. current viral load and CD4 count results when necessary
 - e. sexually transmitted diseases
 - f. HIV-associated illnesses
 - g. allergies and drug sensitivities
 - h. alcohol and drug use
2. Confirm information with primary care physician and obtain more complete medical information when necessary;
3. Consult with primary care physician in addition to medical history and laboratory results to determine if treatment should occur in a hospital when necessary.
4. Laboratory tests prior to surgery including: CBC w/differential, Platelet Count, Hemoglobin Level, Hematocrit and Coagulation.

Standard 7: Patient Treatment Plans outline treatments that provide expected outcomes. They must be completed after the assessment and before first treatment and consist of:

- A. Preventative care and maintenance goals;
- B. Incorporation of medical history, substance use, assessment of oral tissues, evaluation of radiographs and periodontal evaluation;

- C. Treatment should be based on general medical status not HIV infection;
- D. Referrals to specialists and HIV primary medical treatment offered;
- E. Monitoring the adherence to dental and primary medical care;
- F. Treatment must address patient's ability to chew, swallow, esthetic needs and phonetics.
- G. Discussion and agreement of treatment options and service decisions;
- H. Ongoing HIV-Oral Health education with patients and other members of the primary care team;

Standard 8: Procedures for dental records must be written and records must include:
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- A. Patient identification information;
- B. Patient complaint and purpose of the visit;
- C. Dental diagnosis;
- D. Orders for laboratory, radiological, diagnostic and/or screening tests and results;
- E. Documentation for prescriptions;
- F. Documentation of medical history;
- G. Patient assessments;
- H. Treatment Plan progression documented by clinical notes;
- I. Documentation of consultations;

- J. Record of referrals;
- K. Documentation of informed consent when required;
- L. Instructions for follow-up care;
- M. Record of any treatment, drug or service offered and refused by the patient;
- N. Treatment Plan assessment and revision documented;

Standard 9: Ensure continuing dental care for consumers :

- A. Preventative care planning;
- B. Follow-up contacts;

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