

**HIV HEALTH & HUMAN SERVICES PLANNING COUNCIL OF NEW YORK**

**Oral Health Care Service Directive**

Approved by the HIV Planning Council on July 30, 2020

Service Category	2017-2021 Integrated HIV Prevention & Care Plan Goals & Objectives	Program Directive & Service Model	Client and Agency Eligibility
<p><b>Goals:</b></p> <p>To promote optimal health and quality of life resulting from the prevention, early detection and treatment of dental decay and periodontal disease, opportunistic infections, and other health-related complications; and the restoration and maintenance of proper oral structure.</p> <p>To increase the number of people living with HIV(PWH) who have access to, and receive ongoing, appropriate oral health care services.</p> <p>To avoid interruptions in the receipt of HIV primary care or in the adherence to</p>	<p><b>GOAL #2 INCREASING ACCESS TO CARE AND IMPROVING HEALTH OUTCOMES FOR PEOPLE WITH HIV</b></p> <p>Strategy 2A-1. Assure systems of comprehensive core medical and necessary support services are available and accessible to PWH throughout the state.</p> <p>Strategy 2A-2. Enhance coordinated -centered care for PLWH including addressing co-occurring conditions.</p> <p>Strategy 2B-1. Enhance adherence to care and treatment services for PWH.</p> <p>Strategy 2B-2. Enhance activities to re-engage in care those PWH who are lost-to-care.</p>	<p><b>Service Delivery and Client Engagement Framework:</b></p> <p>Services should be client-centered, non-judgmental, guided by harm reduction and trauma-informed care principles, and delivered through a racial, health equity and social justice lens; be anti-racist, destigmatizing and culturally humble; be sensitive to physical, behavioral, psychosocial, and sensory impairments, and be tailored to the populations served. A variety of engagement strategies should be employed to ensure that client- specific needs are met.</p> <p>Client informed care: Clients should be included in decision making whenever possible. The utilization of peers in applicable service areas is strongly encouraged.</p> <p><b>Program and Service Design:</b></p> <p>Agencies are allowed to provide services without a full assessment for a grace period of up to 45 days wherein they can charge for services retroactively once a full intake is completed. Oral health care services should be integrated into, and coordinated with, medical case management and primary care services, with the oral health care provider considered part of the client’s care team and promptly communicating to the client’s medical provider/care team any clinical findings or planned procedures that may indicate a change in, or impact to, the client’s systemic health. Services under this directive should complement Medicaid, Medicare, Ryan White Part F, and ADAP oral health services to ensure a robust system of care.</p> <p>Oral health services should be provided in a user-friendly manner including flexible hours of operation (i.e. early morning, evening, weekend hours, and emergency tele-health services) which maximizes</p>	<p><b>Client Eligibility Criteria:</b></p> <p>PWH who meet Ryan White eligibility requirements are eligible for Ryan White Part A-funded oral health services, subject to payer of last resort requirements. Active substance use and/or criminal conviction history does not preclude client eligibility for and maintenance in services.</p> <p><b>Agency Eligibility Criteria:</b></p> <ul style="list-style-type: none"> <li>→ Non-profit organizations with experience working with PWH. Preference for agencies run and staffed by persons actively working to establish an environment that is steeped in a trauma-informed, anti-racist culture and practice that seeks to dismantle stigma and implicit bias.<sup>4</sup></li> <li>→ Physical location must be within the five boroughs of NYC, and services must be available to all clients in the EMA.</li> <li>→ Agencies must either be co-located or have established linkages with programs providing early intervention services, medical care, mental health, alcohol and substance use services,</li> </ul>

<sup>1</sup> Conceptualizing Stigma. Annual Review of Sociology Vol. 27:363-385 (Volume publication date August 2001) <https://doi.org/10.1146/annurev.soc.27.1.363>

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<p>antiretroviral treatment due to oral health issues.</p> <p>To improve and maintain proper nutritional intake.</p> <p>To assure that oral health care is an integral part of HIV primary care for all PWH.</p> <p>To support comprehensive, coordinated client-centered oral health care for PWH.</p> <p>To increase the proportion of clients who have an optimal level of antiretroviral (ART) adherence and an undetectable viral load through improved access to support services that help increase retention in HIV care and treatment.</p>	<p><b>GOAL #3 REDUCING HIV- RELATED DISPARITIES AND HEALTH INEQUITIES</b></p> <p>Strategy 3A-2. Expand availability of services to reduce HIV-related disparities among specific populations disproportionately infected with HIV.</p>	<p>access and promotes health; services should be accessible by public transportation.</p> <p><b>Services should include, but are not limited, to the following:</b></p> <ol style="list-style-type: none"> <li>1. Comprehensive oral care services --- which must include periodic screenings and preventive, diagnostic, therapeutic and restorative services<sup>1</sup>, regularly scheduled examinations, cleanings, and treatment procedures, in accordance with best practices and individual needs --- and may be provided by general dentists, dental specialists, dental hygienists and/or other professional oral health practitioners operating under the standards of the American Dental Association, the American Academy of Pediatric Dentistry and the NYS AIDS Institute.</li> <li>2. Clients should receive an initial intake assessment and periodic reassessments to develop a comprehensive service plan that includes a scheduled plan of treatment. Encourage client involvement and engagement through clear communication of client progress, issues, and updates.</li> <li>3. Coordination of care with client’s care team to address barriers to care and ensure timely completion of the comprehensive service plan.</li> <li>4. Services delivered in accordance with an approved scope of services, but with the understanding that the nature of a client’s illness may indicate treatment beyond those services listed in a fee schedule. Recommended services beyond the approved scope will be reviewed on a case-by-case basis and require approval prior to treatment.</li> </ol>	<p>housing programs, food and nutrition services, legal services, supportive counseling services, health education and risk reduction, employment related services, and other unmet social needs and make referrals as appropriate.</p> <ul style="list-style-type: none"> <li>→ To ensure maximum coordination of care, Part F funded agencies may be preferred, but not limited to for Part A Oral Health funding.</li> <li>→ Agencies must ensure that staff members are fully trained, appropriately licensed, in compliance with DOHMH requirements, grounded in anti-stigma and culturally and linguistically humble practices for the populations served, and have knowledge and skills related to the needs of the populations served, including the use of people-first language.</li> <li>→ Agencies must have the capacity to provide services in the languages spoken by the populations served.</li> <li>→ Agencies must implement a plan or policy that ensures that staff across the program, including clinical and</li> </ul>

<sup>1</sup> Must include screenings for HPV and other oral cancers

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<p>To reduce (and then maintain below significance) socio-demographic inequities in: oral health access and utilization, retention in primary medical care, and undetectable viral load and HIV related mortality.</p>		<p>5. Recommend and utilize dental materials that are rated as highest quality and known to be long lasting per dental experts.<sup>2</sup></p> <p>6. Provision of oral health education and preventive oral health care must be a routine part of care. Preventive oral health care practices include:</p> <ul style="list-style-type: none"> <li>a. Conduct a screening in line with best practices to identify oral health discomfort and issues among clients</li> <li>b. Detecting oral health care manifestations associated with HIV.</li> <li>c. Instituting appropriate oral health care treatment and referring to medical care, if necessary.</li> <li>d. The dental clinician must stress good oral hygiene and home care procedures (i.e. brushing, flossing, mouth rinses). On a case-by-case basis, the dentist should establish a plan for periodic dental visits for oral examinations and periodontal supportive therapy. These procedures constitute fundamental standards of care and facilitate the early diagnosis of oral disease.</li> <li>e. Instituting oral health care preventive protocols for all clients, throughout the care continuum. There are two phases: <ul style="list-style-type: none"> <li>i. A primary program consisting of early identification of dental caries-susceptible oral environments and restoration of dental carious lesions.</li> <li>ii. A secondary program including identification of risk factors for dental caries, dietary counseling, client education in oral hygiene procedures and home dental</li> </ul> </li> </ul>	<p>non- clinical partners, affirm and respect gender identity and expression. Programs must ensure that staff are/will be able to provide care according to current best practices in care of transgender and gender non-binary persons, and can engage trans/gender non-binary persons in evaluations of and satisfaction with program services.</p> <p>→ Programs should be located throughout NYC to ensure: the highest level of access to care is available for clients; and that areas and populations of highest need have appropriate access to care.</p> <p>→ Agencies should engage in outreach, recruitment and employment practices that attract staff with life experience and expertise that is shared by the agency’s target population in order to improve access to and ensure appropriate utilization of health care services. As allowable, per required licensure(s), value should not be placed solely on level of education. This includes but is not limited to: age, socio-economic status, sexual</p>

<sup>2</sup> Experts in the field of dentistry for clients with HIV include persons and institutions such as Dr. David Resnik of HIV Dent, NYU College of Dentistry and Columbia University College of Dentistry

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		<p style="text-align: center;">care, application of topical fluoride, and periodic recall examinations for supportive therapy.</p> <p>7. Recommend comprehensive, preventative and recurring dental services and procedures</p> <p>8. Implement recommendations for common co-morbidities, i.e. Diabetes and Hepatitis C</p> <p>9. Smoking is a potential risk factor for periodontal disease and oral precancerous and cancerous lesions and providers should, whenever possible, refer clients to smoking cessation programs and resources.</p> <p>10. Offer four (4) dental cleanings per year, including scaling/deep cleaning. Offer tooth extractions, bridgework, crowns, root canals, dentures (with less than 8 points of contact), as needed.</p> <p>11. Up to 20% of allocated funding may be used to cover the following: on a case by case basis<sup>3</sup>: gum and bone grafts, and/or partials/implants when one or more teeth is missing.</p> <p>12. Provide services that promote engagement and maintenance in care, including referrals to transitional, supportive and permanent housing, adherence to primary medical care, inpatient treatment (as necessary) and modes of healthy living.</p> <p>13. Concerted outreach efforts should be made to schedule and re-confirm appointments for those such as the homeless, mentally ill, and substance users, whose conditions may present added barriers to maintaining oral health and medical care.</p>	<p>orientation, gender identity and expression, race/ethnicity, substance use history, history of incarceration, immigration status, and HIV status.</p>

<sup>3</sup> The grantee will consult a dental expert, such as the NYU Dental School, to make these determinations.

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		<p>14. As appropriate, and under best practice guidelines, telehealth/telemedicine may be used to conduct aspects of service delivery.</p> <p><i>Addendum to the Medical Case Management Directive:</i></p> <p>A centralized oral health care management service will provide support across all RWPA programs to increase access to and engagement in oral health care services. It must:</p> <ol style="list-style-type: none"> <li>1. Support clients' medical and non-medical case managers and/or providers in facilitating access and navigation for oral health treatment plans, including complex treatment.</li> <li>2. Provide technical assistance and conduct capacity building among RWPA providers to increase utilization of oral health care services. Work in partnership with client's case manager(s) and care team to facilitate coordination and support for clients' oral health care.</li> <li>3. Compile resources that facilitate access to complex treatment plans by mapping alternate funders, referrals, and sites with available and associated services.</li> <li>4. Establish relationships to facilitate access to emergency services and specialized, complex care.</li> <li>5. Support the full integration of oral health care into the RWPA system of care.</li> </ol> <p><i>Additional Recommendations</i></p> <ol style="list-style-type: none"> <li>1. Encourage RWPA FNS programs to incorporate oral health education into the health education modules provided under FNS.</li> <li>2. Expand use of Emergency Financial Assistance and Food &amp; Nutrition program personal hygiene allowances for oral health care supplies such as electronic toothbrushes.</li> </ol>	

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