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FY 2012 Oral Health (Rural-North) – Part A
DRAFT (as of 03-15-11)

HRSA Service Category Title: (RWGA only)	Oral Health
Local Service Category Title:	Oral Health – <u>Rural (North)</u>
Budget Type: (RWGA only)	Unit Cost
Budget Requirements or Restrictions: (RWGA only)	Not Applicable
HRSA Service Category Definition: (RWGA only)	Oral health care includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.
Local Service Category Definition:	Restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan. Prosthodontics services to HIV-infected individuals including, but not limited to examinations and diagnosis of need for dentures, diagnostic measurements, laboratory services, tooth extractions, relines and denture repairs.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected individuals residing in Houston Eligible Metropolitan Area (EMA) or Health Service Delivery Area (HSDA) counties other than Harris County. Comprehensive Oral Health services targeted to individuals residing in the northern counties of the EMA/HSDA, including Waller, Walker, Montgomery, Austin, Chambers and Liberty Counties.
Services to be Provided:	Services must include, but are not limited to: individual comprehensive treatment plan; diagnosis and treatment of HIV-related oral pathology, including oral Kaposi's Sarcoma, CMV ulceration, hairy leukoplakia, xerostomia, lichen planus, aphthous ulcers and herpetic lesions; diffuse infiltrative lymphocytosis; standard preventive procedures, including oral hygiene instruction, diet counseling and home care program; oral prophylaxis; restorative care; oral surgery including dental implants; root canal therapy; fixed and removable prosthodontics including crowns, bridges and implants; periodontal services, including subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Proposer must have mechanism in place to provide oral pain medication as prescribed for clients by the dentist.
Service Unit Definition(s): (RWGA/TRG only)	General Dentistry: A unit of service is defined as one (1) dental visit which includes restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous

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DRAFT (as of 03-15-11)

	<p>surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan.</p> <p>Prosthodontics: A unit of services is defined as one (1) Prosthodontics visit.</p>
Financial Eligibility:	Refer to the RWPC's approved <i>Financial Eligibility for Houston EMA/HSDA Services</i> .
Client Eligibility:	HIV-infected adults residing in the rural area of Houston EMA/HSDA meeting financial eligibility criteria.
Agency Requirements:	<p>Agency must document that the primary patient care dentist has 2 years prior experience treating HIV disease and/or on-going HIV educational programs that are documented in personnel files and updated regularly.</p> <p>Service delivery site must be located in one of the northern counties of the EMA/HSDA area: Waller, Walker, Montgomery, Austin, Chambers or Liberty Counties</p>
Staff Requirements:	State of Texas dental license; licensed dental hygienist and state radiology certification for dental assistants.
Special Requirements: (RWGA only)	Must comply with the joint Part A/B standards of care where applicable.

FY 2012 Service Category Definition - Ryan White Part A
 March 15, 2011

FY 2012 RWPC “How to Best Meet the Need” Decision Process

Step in Process: Council		Date: 06-09-11
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: Steering Committee		Date: 06-02-11
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: Quality Assurance Committee		Date: 05-19-11
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: HTBMTN Workgroup #2		Date: 04-26-11
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

**Service Category Definition - Ryan White Part B Grant
April 1, 2011 - March 31, 2012**

Local Service Category	Oral Health Care
Amount Available	To be determined
Unit Cost:	
Budget Requirements or Restrictions:	Maximum of 10% of budget for Administrative Costs
Local Service Category Definition:	<u>Restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan.</u> Prosthodontics services to HIV infected individuals including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected individuals residing within the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	<u>Services must include, but are not limited to: individual comprehensive treatment plan; diagnosis and treatment of HIV-related oral pathology, including oral Kaposi's Sarcoma, CMV ulceration, hairy leukoplakia, xerostomia, lichen planus, aphthous ulcers and herpetic lesions; diffuse infiltrative lymphocytosis; standard preventive procedures, including oral hygiene instruction, diet counseling and home care program; oral prophylaxis; restorative care; oral surgery including dental implants; root canal therapy; fixed and removable prosthodontics including crowns and bridges; periodontal services, including subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Proposer must have mechanism in place to provide oral pain medication as prescribed for clients by the dentist.</u>
Service Unit Definition(s):	<u>A unit of service is defined as one (1) dental visit which includes restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan.</u>
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Client Eligibility:	HIV positive; Adult resident of Houston HSDA
Agency Requirements:	Agency must document that the primary patient care dentist has 2 years prior experience treating HIV disease and/or on-going HIV educational programs that are documented in personnel files and updated regularly. Dental facility and appropriate dental staff must maintain Texas licensure/certification and follow all applicable OSHA requirements for patient management and laboratory protocol. Providers and system must be Medicaid/Medicare certified to ensure that Ryan White funds are the payer of last resort.

**Service Category Definition - Ryan White Part B Grant
April 1, 2011 - March 31, 2012**

Staff Requirements:	State of Texas dental license; licensed dental hygienist and state radiology certification for dental assistants.
Special Requirements:	Must comply with the Joint Part A/B Standards of care.

Service Category Definition - Ryan White Part B Grant
 April 1, 2010 - March 31, 2011

FY 2012 RWPC “How to Best Meet the Need” Decision Process

Step in Process: Council		Date: 06-09-11
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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3.		
Step in Process: HTBMTN Workgroup #2		Date: 04-26-11
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

RYAN WHITE PART B
HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
ORAL HEALTH CARE SERVICES

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	<p><u>Scope of Work</u> Oral Health Care as “diagnostic, preventive, and therapeutic services provided by the general dental practitioners, dental specialist, dental hygienist and auxiliaries and other trained primary care providers”. The Ryan White Part A/B oral health care services include standard preventive procedures, diagnosis and treatment of HIV-related oral pathology, restorative dental services, oral surgery, root canal therapy and oral medication (including pain control) for HIV patients 15 years old or older based on a comprehensive individual treatment plan.</p> <p>Additionally, the category includes prosthodontics services to HIV infected individuals including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs.</p>	<ul style="list-style-type: none"> • Program’s Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.
9.2	<p><u>Continuing Education</u></p> <ul style="list-style-type: none"> • Eight (8) hours of training in HIV/AIDS and clinically-related issues is required annually for licensed staff. (does not include any training requirements outlined in General Standards) • One (1) hour of training in HIV/AIDS is required annually for all other staff. (does not include any training requirements outlined in General Standards) 	<ul style="list-style-type: none"> • Materials for staff training and continuing education are on file • Documentation of continuing education in personnel file
9.3	<p><u>Experience – HIV/AIDS</u> A minimum of one (1) year documented HIV/AIDS work experience is preferred for licensed staff.</p>	<ul style="list-style-type: none"> • Documentation of work experience in personnel file

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.4	<u>Staff Supervision</u> Supervision of clinical staff shall be provided by a practitioner with at least two years experience in dental health assessment and treatment of persons with HIV. All licensed personnel shall received supervision consistent with the State of Texas license requirements.	<ul style="list-style-type: none"> • Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates compliance
9.5	<u>HIV Primary Care Provider Contact Information</u> Agency obtains and documents HIV primary care provider contact information for each client.	<ul style="list-style-type: none"> • Documentation of HIV primary care provider contact information in the client record. At minimum, agency should collect the clinic and/or physician's name and telephone number
9.6	<u>Consultation for Treatment</u> Agency consults with client's medical care providers when indicated.	<ul style="list-style-type: none"> • Documentation of communication in the client record
9.7	<u>Health History Information</u> Agency collects and documents health history information for each client prior to providing care. This information should include, but not be limited to, the following: <ul style="list-style-type: none"> • A baseline current (within the last 6 months) CBC laboratory test results for all new clients, and an annual update thereafter • Current (within the last 6 months) Viral Load and CD4 laboratory test results, when clinically indicated • Client's chief complaint, where applicable • Medication names • Sexually transmitted diseases • HIV-associated illnesses • Allergies and drug sensitivities • Alcohol use • Recreational drug use • Tobacco use • Neurological diseases • Hepatitis • Usual oral hygiene • Date of last dental examination • Involuntary weight loss or weight gain • Review of systems 	<ul style="list-style-type: none"> • Documentation of health history information in the client record. Reasons for missing health history information are documented

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.8	<u>Client Health History Update</u> An update to the health history should be made, at minimum, every six (6) months or at client's next general dentistry visit whichever is greater.	<ul style="list-style-type: none"> Documentation of health history update in the client record
9.9	<u>Comprehensive Periodontal Examination</u> Agency has a written policy and procedure regarding when a comprehensive periodontal examination should occur. Comprehensive periodontal examination should be done in accordance with professional standards and current US Public Health Service guidelines	<ul style="list-style-type: none"> Review of agency's Policies & Procedures Manual indicates compliance Review of client records indicate compliance
9.10	<u>Treatment Plan</u> <ul style="list-style-type: none"> A comprehensive, multi disciplinary Oral Health treatment plan will be developed in conjunction with the patient. Patient's primary reason for dental visit should be addressed in treatment plan Patient strengths and limitations will be considered in development of treatment plan Treatment priority should be given to pain management, infection, traumatic injury or other emergency conditions Treatment plan will be updated as deemed necessary 	<ul style="list-style-type: none"> Treatment plan dated and signed by both the provider and patient in patient file Updated treatment plan dated and signed by both the provider and patient in patient file
9.11	<u>Annual Hard/Soft Tissue Examination</u> The following elements are part of each client's annual hard/soft tissue examination and are documented in the client record: <ul style="list-style-type: none"> Charting of caries; X-rays; Periodontal screening; Written diagnoses, where applicable; Treatment plan. Determination of clients needing annual examination should be based on the dentist's judgment and criteria outlined in the agency's policy and procedure, however the time interval for all clients may not exceed two (2) years.	<ul style="list-style-type: none"> Documentation in the client record Review of agency's Policies & Procedures Manual indicates compliance
9.12	<u>Oral Hygiene Instructions</u> Oral hygiene instructions (OHI) should be provided annually to each client. The content of the instructions is documented.	<ul style="list-style-type: none"> Documentation in the client record

Ryan White Part A Quality Management Program–Houston EMA

Oral Health Care Chart Review FY 2010

Prepared by Harris County Public Health &
Environmental Services – Ryan White Grant Administration

August 2010

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Introduction

Part A funds of the Ryan White Care Act are administered in the Houston Eligible Metropolitan Area (EMA) by the Ryan White Grant Administration Section of Harris County Public Health & Environmental Services. During FY 10, a comprehensive review of client dental records was conducted for services provided between 3/1/09 to 2/28/10. This review included one provider of Adult Oral Health Care that received Part A funding in the Houston EMA.

The primary purpose of this annual review process is to assess Part A oral health care provided to persons living with HIV in the Houston EMA. Ryan White Grant Administration manages the review process and analyzes the subsequent data, while the reviews are conducted by TMF Health Quality Institute (TMF), under contract with Ryan White Grant Administration. Unlike primary care, there are no federal guidelines published by the U.S Public Health Service for oral health care targeting individuals with HIV/AIDS. Therefore, Ryan White Grant Administration has adopted general guidelines from peer-reviewed literature that address oral health care for the HIV/AIDS population, as well as literature published by national dental organizations such as the American Dental Association and the Academy of General Dentistry, to measure the quality of Part A funded oral health care.

Scope of This Report

This report provides background on the project, supplemental information on the design of the data collection tool, and presents the pertinent findings of the FY 10 oral health care chart review. In addition to this report, the reviewed provider will also receive an electronic copy of the raw database in order to facilitate further analysis. Also, any additional data analysis of items or information not included in this report can likely be provided after a request is submitted to Ryan White Grant Administration.

The Data Collection Tool

The data collection tool employed in the review was developed through a period of in-depth research and a series of working meetings between Ryan White Grant Administration and the review contractor, TMF. By studying the processes of previous dental record reviews and researching the most recent HIV-related and general oral health practice guidelines, a listing of potential data collection items was developed. Further research provided for the editing of this list to yield what is believed to represent the most pertinent data elements for oral health care in the Houston EMA. Topics covered by the data collection tool include, but are not limited to the following: basic client information, completeness of the health history, hard & soft tissue examinations, oral hygiene prevention, and periodontal examinations. Contact Ryan White Grant Administration for a copy of the tool.

The Chart Review Process

All charts were reviewed by licensed dentist experienced in identifying documentation issues and assessing adherence to published guidelines. The reviewer has extensive experience conducting dental chart reviews. The collected data was recorded directly onto the tool and this information was entered into a preformatted database. Once all data collection and data entry was completed, the database was forwarded to Ryan White Grant Administration for analysis. The data collected during this process is intended to be used for service improvement.

The Chart Review Process (cont'd)

The specific parameters established for the data collection process were developed from HIV-related and general oral health care guidelines available in peer-reviewed literature, and the professional experience of the reviewer on standard record documentation practices. Table 1 summarizes the various documentation criteria employed during the review.

Table 1. Data Collection Parameters

Review Area	Documentation Criteria
Health History	Completeness of Initial Health History: includes but not limited to past medical history, medications, allergies, substance use, HIV MD/primary care status, physician contact info, etc.; Completed updates to the initial health history
Hard/Soft Tissue Exam	Findings—abnormal or normal, diagnoses, treatment plan, treatment plan updates
Oral Hygiene Prevention	Prophylaxis, OHI
Periodontal screening	Completeness
Appointments	Kept, Not kept, Practitioner

The Sample Selection Process

The sample population was selected from a pool of 2,451 unduplicated clients who accessed Part A oral health care between 3/1/09 and 2/28/10. The medical charts of 200 of these clients were used in the review, representing 8% of the pool of unduplicated clients.

In an effort to make the sample population as representative of the actual Part A oral health care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate a list of client codes to be reviewed. The demographic make-up (race/ethnicity, gender, age, stage of illness) of clients accessing oral health services between 3/1/09 and 2/28/10 was determined by CPCDMS, which in turn allowed Ryan White Grant Administration to generate a sample of specified size that closely mirrors that same demographic make-up. Randomly-generated client codes were categorized in terms of stage of illness, as delineated by CPCDMS, in order to allow for assessment of a range of care.

- Asymptomatic CD4 \geq 500
- Asymptomatic CD4 200-499
- Asymptomatic CD4 $<$ 200
- Symptomatic CD4 \geq 500
- AIDS CD4 $<$ 200
- Symptomatic CD4 200-499
- Symptomatic CD4 $<$ 200
- AIDS CD4 \geq 500
- AIDS CD4 200-499

The lists of client codes were usually forwarded to the reviewer and corresponding agencies 5-10 business days before reviews were scheduled to commence.

The review sample population was generally comparable to the Part A population receiving oral health care in terms of race/ethnicity, gender, age and stage of illness.¹ It is important to note that the chart review findings in this report apply only to those who receive oral health care from a Part A provider and cannot be generalized to all Ryan White clients or to the broader population of persons with HIV or AIDS. Table 2 compares the review sample population with the Ryan White Part A oral health care population as a whole.

Race/Ethnicity	Sample		Ryan White Part A EMA	
	Number	Percent	Number	Percent
African American	91	46%	1124	46%
White	103	52%	1281	52%
Asian	2	1%	20	1%
Native Hawaiian/Pacific Islander	2	1%	6	<1%
American Indian/Alaska Native	2	1%	12	1%
Multi-Race	0	0%	8	<1%
	200	100%	2451	100%
Hispanic Status				
Hispanic	58	29%	669	27%
Non-Hispanic	142	71%	1782	73%
	200	100%	2451	100%
Gender				
Male	148	74%	1832	75%
Female	51	26%	609	25%
Transgender	1	<1%	10	<1%
	200	100%	2451	100%
Age				
18 – 24	1	<1%	47	2%
25 – 34	32	16%	322	13%
35 – 44	52	26%	680	28%
45 – 54	76	38%	934	38%
55 – 64	32	16%	393	16%
65+	7	4%	75	3%
	200	100%	2451	100%
Stage of Illness				
Asymptomatic, CD4>=500	39	20%	369	15%
Asymptomatic, CD4 200-499	22	11%	357	15%
Asymptomatic, CD4 <200	2	1%	25	1%
Symptomatic, CD4 >=500	6	3%	57	2%
Symptomatic, CD4 200-499	5	3%	104	4%
Symptomatic, CD4 <200	2	1%	19	1%
AIDS, CD4>=500	29	15%	316	13%
AIDS, CD4 200-499	45	23%	535	22%
AIDS, CD4 <200	30	15%	468	19%
HIV Positive/Status Unknown	20	10%	201	8%
HIV Negative/Status Unknown	0	0%	0	0%
	200	100%	2451	100%

¹ Significant differences in the review sample compared to the Part A population can occur if charts from the sample cannot be found at the provider site, and are replaced by charts with the same stage of illness, but not necessarily the same demographics (e.g. race, age, gender, etc.)

Findings

Clinic Visits

Information gathered during the 2010 chart review included the number of visits during the study period and the provider type (dentist, hygienist, prosthodontics, other). Generally, utilization of dentists and hygienists was significant. Of the 1,131 oral health care appointments, 76% of the total number of appointments were conducted by either a dentist or hygienist (80% - FY 09). The average number of oral health visits per patient in the sample population was six. Ninety-seven percent of review patients had an appointment conducted by a dentist at least once during the review period (98% - FY 09).

Health History

A complete and thorough assessment of a patient's medical history is essential among individuals infected with HIV or anyone who is medically compromised. Such information, such as current medication or any history of alcoholism for example, offers oral health care providers key information that may determine the appropriateness of prescriptions, oral health treatments and procedures. The form that is used by the agency to assess patient's health history captures a wide range of information; however, for the purposes of this review, this report will focus on the assessment of information that is of particular importance among HIV/AIDS patients compared to patients in the general population.

Assessment of Medical History

- 87% (89%-FY 09) of records reviewed for new patients contained an initial assessment of past medical history. Ninety-nine percent of applicable records documented a health history update every 6 months (98% - FY 09). Key highlights are as follows:
 - **HIV Associated Opportunistic Infections:** 100% (98%-FY 09) of records reviewed documented opportunistic infection status.
 - **Allergies & Drug Sensitivities:** 100% (98%-FY 09) of records reviewed had documentation for assessing allergies and drug sensitivities located in a prominently in the chart.
 - **Alcohol Use:** 90% (0%-FY 09) of records reviewed documented an assessment of alcohol use during the study period.
 - **Tobacco Use:** 91% (0%-FY 09) of records reviewed documented an assessment of either smoking status or current use of chewing tobacco/snuff during the study period.
 - **Street/Illegal Drug Use:** 90% (0%-FY 09) of records reviewed documented an assessment of recreational drug use during the study period.

Health Assessments

- **Blood Pressure:** 87% (100%-FY 09) of reviewed records documented patient blood pressure at initial visit and an update of the patient's blood pressure every 6 months. Additionally, 100% of applicable records documented blood pressure results prior to an applicable dental procedure.
- **Pulse:** 100% of reviewed records documented patient pulse at initial visit and an update of the patient's pulse every 6 months.
- **Risk for infection and bleeding:** 100% of applicable records reviewed assessed the patients risk for infection and bleeding prior to an invasive procedure.
- **Need for Antibiotic Prophylaxis:** 100% (100%-FY 09) of records reviewed assessed the patients need for antibiotic prophylaxis.

Patient Medications

- 100% (100%-FY 09) of records reviewed documented a review of patient medications for either HIV or non-HIV medication.

Primary Care Provider Contact Information

- 100% (100%-FY 09) of records reviewed contained contact information for a primary care provider.

Prevention and Detection of Oral Disease

Maintaining good oral health is so vital to the overall quality of life for individuals living with HIV/AIDS because the condition of one's oral health often plays a major role in how well patients are able to manage their HIV disease. Poor oral health due to a lack of dental care may lead to the onset and progression of oral manifestations of HIV disease, which makes maintaining proper diet and nutrition or adherence to antiretroviral therapy very difficult to achieve. Furthermore, poor oral health places additional burden on an already compromised immune system.

An intraoral exam was performed in 98% of records reviewed (98%-FY 09). Ninety-eight percent of reviewed records documented an extraoral exam of the face, head and neck during the study period (98% in FY 09). One hundred percent of applicable records documented an x-ray (100% in FY 09 review). One hundred percent of reviewed records (99% in FY 09 review) documented the clinical chart of teeth was marked and up to date.

One hundred percent of the records reviewed (100% in FY 09 review) documented a statement by the dentist of an annual patient diagnosis. One hundred percent of reviewed records (99% in FY 09 review) contained a subsequent treatment plan and/or updates to the treatment plan. One hundred percent of those records documented the appropriate treatment was done for condition indicated.

Nine percent of reviewed records contained documentation of the patient's need to be seen by a specialist. Of these records, 87% of applicable records (78%-FY 09) contained documentation that a referral was provided.

The chart review examined assessed patients for the following oral manifestations associated with HIV: xerostomia, LGE periodontal disease, NUP periodontal disease, and candidiasis. One hundred percent of assessed records documented no pathology for any of these conditions. All of reviewed records, 100%, (3%-FY 09) contained no documentation of patient assessment of these oral manifestations.

Conclusions

Overall, oral healthcare services continues it's trend of consistent, high quality care. The Houston EMA oral healthcare program has established a strong foundation for preventative care. This is demonstrated in the rates of intraoral and extraoral exams, 98% for both. The provider has also shown excellent documentation of care with 100% of applicable records documenting an x-ray (100% in FY 06 through FY 09) and 100% of records containing a marked and up to date clinical tooth chart. Additionally, one hundred percent of the records reviewed (100% in FY 09 review) documented a statement by the dentist of an annual patient diagnosis. One hundred percent of reviewed records contained a subsequent treatment plan and/or updates to the treatment plan.

This review cycle also depicts great improvement in screening rate for alcohol, tobacco, and recreational drug use to 100% (0%-FY 09). Following last year's finding, the dental provider indicated that a recent conversion to an electronic records system may have impacted the chart abstractor's ability to locate these health history elements. Based on this year's performance it appears this issue has been resolved.

For several years our annual chart review has examined the impact of our oral healthcare providers scheduling policies on client access to care. However, during this review cycle the dental provider revised it's scheduling policy and no longer utilizes "block" appointments for patients with a history of no shows.

Overall, oral healthcare services continues to exhibit excellent performance. We look forward to continued high levels of care for Houston EMA patients in future.

Appendix A – Resources

Abel, Stephen N. (and others) eds. Principles of Oral Health Management. Dental Alliance for AIDS/HIV Care, 2000. HAB00230

Periodontal Screening & Recording ®: An Early Detection System. (n.d.). Retrieved May 25, 2004, from <http://www.ada.org/prof/resources/topics/perioscreen/index.asp>

Heavy Drinking, Drug Abuse Present Health Complications for Dental Treatment. (December 1, 2003). Retrieved May 18, 2004 from <http://www.agd.org/media/2003/dec/abuse.html>

RYAN WHITE GRANT PROGRAM

SUMMARY REPORT 2009 RYAN WHITE FOCUS GROUPS

December 2009

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Executive Summary

The following findings highlight the most frequently discussed topics by focus group participants:

- Most participants are satisfied with transportation benefits provided through Ryan White funded bus passes. Many of the participants reported an awareness bus passes should be used exclusively for transportation to medical appointments.
- Many of the participants reported experiencing long waits for dental care services, particularly general cleaning appointments.
- Most participants reported receiving their annual Pap screenings as scheduled.
- Many of the participants emphasized the importance of peer support/mentoring groups in staying engaged in their own health maintenance.
- Most participants reported substance abuse, depression and/or incarceration as barriers to entering care after learning their diagnosis.

Ryan White Grant Program Summary Report on 2009 Ryan White Consumer Focus Groups

Background

The Houston EMA (Eligible Metropolitan Area) Ryan White Grant Administration office has conducted consumer satisfaction surveys on an annual basis since 2003. Since 2008, the Houston Ryan White Grant Administration office has conducted focus groups at each of the primary care agencies that receive Ryan White funding to augment the consumer satisfaction process. The focus groups are conducted to obtain client perspectives on a variety of core and support services.

In Fall 2009, Ryan White Grant Administration, and Harris County Public Health and Environmental Services staff conducted a series of focus groups with consumers who utilize Ryan White funded core and support services (as defined under the Ryan White HIV/AIDS Treatment Modernization Act of 2006). The data were collected to obtain additional insight into consumers' perceptions of their experiences with Ryan White funded services. The report presents common themes that arose from the four focus groups.

Methods and Analyses

Information was obtained on clients perceptions of access to and quality of care received through the Ryan White funded agencies in a variety of service areas including, primary care, dental care, transportation, and case management services, among others.

The Ryan White Project Coordinator collaborated with agency representatives to recruit clients to participate in the focus groups. The focus groups were moderated by the Ryan White Project Coordinator. An interpreter was present at two focus group sessions to ensure full engagement of Spanish-speaking consumer participants. However, no monolingual Spanish participants were present at any of the four focus groups. Agencies staff were prohibited from participating in the focus group sessions to encourage full disclosure of experiences among focus group participants.

Informed consent forms were obtained from each focus group participant prior to each focus group session. There were both English and Spanish versions of the informed consent form available to participants. Each focus group session was audio taped and transcribed verbatim (to the extent possible). Once the focus group sessions were transcribed the audiotapes were destroyed to protect the identity of the focus group participants. Focus group participants were encouraged to comment however they were informed that it was not necessary to respond to every question.

A thematic analysis was used to analyze the data. Thematic analysis identifies patterns in the data and organizes and describes the data in detail (Braun & Clarke, 2006)¹. It is important to note that focus group results are not generalizable to the larger population of consumers who receive Ryan White funded services.

Characteristics of Focus Group Participants

During the 2009 focus groups, several discussion questions focused on women's health issues, specifically Pap screenings. For this reason, most agency staff recruited exclusively from their female client base. However, one agency did have mostly male participants. The women in this group indicated they were comfortable discussing women's health issue questions in a mixed gender setting. Additionally, there was a mixture of other characteristics among focus group participants. There were individuals who had been

diagnosed as long as twenty years ago as well as newly diagnosed individuals. The education and socioeconomic level of participants also varied. For example, many participants heavily relied on the Ryan White Program for transportation services while a few reported owning their own vehicles. The majority of participants were African American. There were several White participants. Focus groups consisting of representatives from agency consumer councils/support groups tended to voice their concerns more readily than others.

¹ Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.

Findings

Dental Services

Consumers were asked if they were aware of any recent changes in Ryan White Dental services. Those who were aware were asked how the changes have affected dental services.

In an effort to increase access to dental services, at the beginning of FY 2009, the Houston EMA began funding a rural oral health care provider. Additionally, the Houston EMA's only untargeted oral health care provider relaxed their rescheduling policy regarding missed client appointments.

- Many of the focus group participants were currently engaged in dental care, and most of those individuals were aware of changes in the untargeted provider's rescheduling policy.
- Participants that were aware of changes in the rescheduling policy were universally pleased with its impact on access to dental services.
- One participant stated she had already benefited from the more flexible policy, and that she felt the dental provider were more understanding of the fact things arise in day-to-day scheduling that make keeping every appointment difficult for someone living with HIV/AIDS.
- A number of participants that had not been aware of the new policy commented that they would make an effort to engage in oral health care services again.
- Most participants were not aware of the new oral health care provider. The exception to this were patients who received primary medical care through the same agency that provides rural oral health care.
- Many focus group participants reported long waits for dental care appointments. One participant commented that she completed her prerequisite x-ray appointment with the untargeted dental provider and was told she would be contacted when an appointment was available for a cleaning. She followed-up for a year. After a year on the waiting list, she was seen for a cleaning, and told that her x-rays had expired and needed to be completed again. Participants reported the wait time at the rural dental provider to be approximately 30 days.

Conclusions

The information obtained through these focus groups provided valuable insight on consumers' perceptions of their access to care and experiences with service providers. Issues such as patient mental health, substance abuse, stigma, the importance of social support networks and access to medical and dental appointments were common themes discussed across focus groups.

One of the most notable topics discussed was the profound negative effect depression and/or substance abuse has on patient retention in medical care. Depression and substance abuse were given as the chief reasons why patients were out of care for extended periods of time. This information further confirms the importance of mental health and substance abuse screenings for all patients that enter the care system. Mental health and substance abuse service availability and referral follow-up are equally important aspects of overcoming barriers to retention in care.

The importance of a support network was also a sentiment that was expressed across all focus groups. This appeared to be particularly true for patients that were new to HIV medical care. Participants indicated that in-clinic support groups were not only excellent resources for information on how to navigate the care system, but also a network for friends with similar life experiences. Many consumers comments that the "support groups" were like family, always available and helpful.

In addition to treatment adherence and retention in care issues, access to dental services continues to be a significant concern. Many participants were aware of increased flexibility with our untargeted dental providers rescheduling policy. Participants also believe that this change enhances their access to oral health care. However, appointment availability due to system capacity appears to be a growing problem.

Linkage to and retention in primary medical care is a central focus of quality improvement for HIV-positive individuals on both a local and national level. The information provided in the 2009 Houston EMA focus group offers excellent insight on what areas have the potential of making the greatest impact on this issue.



HIV-positive patients benefit from early dental intervention

By Rabia Mughal, Associate Editor

February 15, 2011 -- Early dental intervention can help newly diagnosed HIV-positive patients retain teeth and preserve dentition, according to research to be presented next month at the International Association for Dental Research (IADR) conference in San Diego.

The study, conducted at the University of North Carolina (UNC) at Chapel Hill, is part of a U.S. Health Resources and Services Administration project focused on access to oral healthcare in persons living with HIV/AIDS.

A team of researchers from the UNC School of Dentistry compared the value of early comprehensive dental intervention in individuals newly diagnosed with HIV with previously diagnosed HIV-positive patients receiving regular dental care and previously diagnosed HIV-positive patients not receiving regular dental care.

"It was our hypothesis that accessing oral healthcare early in the course of HIV disease would make a significant difference for the individual patient," study author Jennifer Webster-Cyriaque, DDS, PhD, an associate professor of dental ecology at the UNC dental school, told *DrBicuspid.com*.

The case-control study involved 196 HIV-positive individuals, 66 newly diagnosed cases (out of oral care and within 12 months of their HIV diagnoses), previously diagnosed controls (out of oral care and diagnosed with HIV between 1985-2007), and historical controls (receiving regular oral care and diagnosed with HIV between 1985-2007).

The researchers examined all patients -- clinically and radiographically -- for caries and bone loss, performed full-mouth periodontal probing, and recorded plaque and gingival indices.

Among their findings:

- Persons who were newly diagnosed had significantly more teeth at baseline compared to the previously diagnosed and historical groups.
- Newly diagnosed individuals had less attachment loss and less bleeding on probing.
- Previously diagnosed individuals had higher plaque scores, higher gingival index scores, and the most broken teeth and root tips.
- The control historical group had the least coronal caries.
- The previously diagnosed group had the most decay.
- With regard to root caries, the previously diagnosed group had the most dental decay.
- The higher levels of dental disease in the previously diagnosed group resulted in higher treatment costs.

"The highest level of dental disrepair was detected in the previously diagnosed group," the authors concluded. "Early dental intervention in the newly diagnosed HIV-positive individuals results in significant functional maintenance, more optimal oral health, and considerable financial savings."

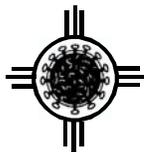
The researchers also found that service usage varied considerably among the study groups, suggesting more acute disease in the newly diagnosed HIV patients and more tooth replacements and extensive restorations in the previously diagnosed group, according to Dr. Webster-Cyriaque. More preventive and maintenance services were employed by the newly diagnosed group, while more costly prosthodontic services were utilized by the previously diagnosed group, she added.

"New HIV diagnosis provides a unique window of opportunity for treatment that may result in improved oral health and function, including retained dentition, less morbidity, and lower fiscal costs and avoidable economic burden," Dr. Webster-Cyriaque said.

Interdisciplinary collaborations of dentists with HIV healthcare providers are critical to overcoming structural barriers and implementing successful oral interventions for persons living with HIV and AIDS, she concluded.

**“Early dental
intervention ... results in
considerable financial
savings.”**

— Jennifer Webster-Cyriaque, DDS, PhD



HIV AND THE MOUTH

HOW DOES HIV AFFECT THE MOUTH?

In the early years of the HIV epidemic, dentists were often the first health professionals to notice signs of a weak immune system. These signs were infections that are normally controlled by a healthy person. When people get tested for HIV infection and get treatment, most of these infections never show up. However, many people do not get tested for HIV. They may be infected and now know it. Regular dental care is an important way they may learn they have a weak immune system.

DON'T IGNORE MOUTH PROBLEMS!

Pain or bleeding in your mouth can be a sign of infection. It can keep you from eating normally. Severe pain makes some people skip taking their medications. Serious infections in your mouth can cause other health problems. Be sure to see a dentist or let your health care provider know if you have trouble swallowing, changes in how food tastes, or pain or other problems with your mouth or teeth.

Some dentists or their office staffers do not want to treat patients with HIV. ***This goes against community standards and violates the Americans with Disabilities Act.*** Dental health care workers know how to protect themselves from diseases carried in the blood of their patients, including HIV.

WHAT ARE THE SIGNS OF HIV IN THE MOUTH?

Several problems with the teeth, mouth and gums can show up in people with HIV. These are discussed below.

- Dry Mouth and Tooth Decay
- Candidiasis (thrush)
- Canker sores (aphthous ulcers)
- Cold sores (herpes simplex)
- Gum disease (periodontitis)

- Hairy leukoplakia
- Kaposi's Sarcoma
- Enlarged saliva glands
- Shingles (herpes zoster)
- Oral warts (human papillomavirus):

Dry Mouth and Tooth Decay

Many people with HIV have dry mouth. They don't make enough saliva to chew and swallow comfortably. Saliva protects teeth and gums from infection and decay.

HIV infection can cause dry mouth. So can some medications, as well as coffee, carbonated beverages, alcohol, and smoking. If you have dry mouth, take frequent drinks of water. You can talk to your health care provider about using sugar-free gum or candy, or a saliva substitute.

Candidiasis (thrush) See fact sheet 501 for more information. This infection is caused by a fungus (yeast) called *Candida*. It shows up as red patches on the tongue or roof of the mouth or white lumps that look like cottage cheese that can form anywhere in the mouth. Candidiasis infection can move into the throat. It can also cause painful cracks at the corners of the mouth called angular cheilitis. Many anti-fungal treatments can treat thrush. However, some cases of thrush are resistant to the usual medications.

Canker sores (aphthous ulcers) are small, round sores on the inside the cheek, under the tongue, or in the back of the throat. They usually have a red edge and a gray center. The sores can be quite painful. They can be caused by stress or by certain foods such as eating too many tomatoes. Hot and spicy or acidic foods or juices make them hurt more. Some ointments, creams or rinses can help.

Cold sores are caused by herpes simplex (see fact sheet 508,) a common infection. In people with HIV, cold sores can be more severe and can keep coming back. The most common treatment is the antiviral drug acyclovir.

Gum Disease (periodontitis or gingivitis) is swelling of the gums. Sometimes

painful and bloody, it can progress from gum loss to loosening and even loss of teeth. This can happen as quickly as 18 months. Dry mouth and smoking can make gum disease worse. Brush your teeth, floss, and see a dentist regularly.

Recently, gum disease has been linked to higher levels of inflammation (see fact sheet 484), throughout the body. This can increase the risk of heart disease and stroke.

Hairy Leukoplakia is an irritation that usually shows up as painless, fuzzy white patches on the side of the tongue. It can be an early sign of HIV infection.

Kaposi's Sarcoma (KS), see fact sheet 511, usually shows up as dark purple or red spots on the gums, the roof of the mouth, and the back of the tongue. It is rarely seen when people are tested early and start using antiretroviral therapy for HIV infection. It can be the first sign of HIV infection in people who have not been tested for HIV. The best treatment for oral KS in someone with HIV is effective antiretroviral therapy.

Oral Warts - Human Papillomavirus, HPV (see fact sheet 510) is a sexually transmitted disease. Some strains of HPV cause warts or cancer. HPV warts can show up in the mouth. The warts can be frozen or cut out.

THE BOTTOM LINE

Signs of HIV infection often show up in the mouth. You might know people who haven't been tested for HIV. Encourage them to pay attention to any mouth problems.

Keep your mouth healthy by brushing your teeth and flossing. Get your teeth cleaned regularly by a dental health professional. See a health or dental care provider about any serious issues.

Revised February 4, 2011