Oral Health Care Services Standards

Description from Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02:
Oral Health Care Services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Program Guidance:
None at this time.

Virginia Ryan White Part B Service Unit Definition:
One visit for uninsured client (**or**) one oral health visit copayment or cost share for dental-insured client.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV (PWH), including the following:

1.0 Intake and Eligibility
As outlined in HRSA HAB Policy Clarification Notice (PCN) 21-02 Clarifications on Ryan White Program Client Eligibility Assessments and Recertification Requirements, people are eligible to receive RWHAP services when they meet each of the following factors:

1. **HIV Status:** A documented diagnosis of HIV. (Note: People who do not have an HIV diagnosis are eligible to receive certain services as outlined in HRSA HAB PCN 16-02)
2. **Low- Income:** The RWHAP recipient defines low-income. Low-income may be determined based on percent of Federal Poverty Level (FPL), which can be measured in several ways (e.g., Modified Adjusted Gross Income, Adjusted Gross Income, Individual Annual Gross Income, and Household Annual Gross Income).
3. **Residency:** The RWHAP recipient defines its residency criteria, within its service area. Note: Immigration status is irrelevant for the purposes of eligibility for RWHAP services. RWHAP recipients or subrecipients should not share immigration status with immigration enforcement agencies.

Standard	Measure
Referral	
1.1) Documentation of self-referral or referral by a Part B provider for Oral Health Care Services prior to initiation of the service.	1.1) Appointment documented to attend Oral Health Care Services is present in the client's record.
Eligibility	
1.2) The client's eligibility for Ryan White Part B services must be determined prior to providing the service. To be eligible for this service, clients must: a) Have an HIV diagnosis (one time only) b) Live in Virginia c) Have an individual or family income at or below 500% of the Federal Poverty Level (FPL) d) Be ineligible for other payer sources covered by Federal or State programs such as Medicare, Medicaid, all other forms of insurance or third-party payers such as private and commercial insurance plans, and other payers that provide the service they are seeking. • Client Access Reviews (CARs) - refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility. • Provide continuation of eligibility every 24 months with proof of income, changes in insurance coverage, or any changes in residency • Client eligibility ensures the use of Part B services as the payer of last resort while vigorously pursuing other funding sources**.** Client must agree to participate in the insurance option that the client is eligible for and that best meets the client's medical needs, regardless of preference.	1.2) Documentation of the client's eligibility is present in the client's record that verifies: a) Client is diagnosed with HIV b) Client lives in Virginia c) Client meets income guidelines d) Client's Medicaid status verified (gap of services) • Ongoing CARS and complete Continuation Eligibility Assessment every 24 months • Client agrees to participate in insurance option that best meets their medical needs and for which the client is eligible.

Submission of eligibility assessments should be through the Provide Enterprise® data system.	
Intake	
1.3) Complete eligibility screening and intake within 15 days of initial contact with client.	1.3) Documentation of intake and eligibility screening in record signed and dated.
Client Access Reviews/Continuation of Eligibility	
1.4) Client Access Reviews (CARs) refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility and continuation of eligibility conducted every 24 months to continue to receive Ryan White services. There is no grace period.	1.4) Documentation of CARS and continuation of eligibility is present in the client's record.

2.0 Key Services Components	
Standard	**Measure**
Documentation	
2.1) When a third-party payer provides service, the sub-recipient must maintain a client record. At a minimum, the payer's record and the dental agency's record must contain: • Referral • Initial assessment • Individualized treatment plan, including treatment modality, frequency and quantity of treatments • Documentation of all contacts & dates of service • Reassessment of treatment plan to include monitoring and assessment of client progress • Referrals and follow-ups • Discharge plan. Must sign and date all reports.	2.1) Documentation of provided services, signed, and dated records, including referral in record.
Assessment/Service Plan/Provision of Services	

2.2) Perform a comprehensive oral history and assessment on all clients referred for oral health care. History and assessment includes: a) Dental and medical history b) Assessment of the oral cavity c) Assessment of extra-oral and intra-oral hard and soft tissue d) Medication history e) Assessment for HIV-specific oral manifestations f) Appropriate X-rays to assist with diagnosis and treatment g) Periodontal screening/examination h) Client complaints. Initial comprehensive history and assessment may require two visits.	2.2) Documentation of comprehensive oral history and assessment in client's record signed and dated.
2.3) An oral health treatment plan is developed and should: • Include only allowable diagnostic, preventive, and therapeutic services • Comply with dental practice laws • Include evidence-based clinical decisions that are informed by the American Dental Association practice parameters.	2.3) Documentation of oral health treatment plan in client's record, signed and dated.
2.4) For clients receiving preventive and therapeutic services, update Oral Health Treatment Plan at least every 6 months.	2.4) Documentation of updated Oral Health Treatment Plan in client's record at least every six months, signed and dated.
2.5) Clients referred for Oral Health Care Services should have an annual oral evaluation to include periodontal screening/examination.	2.5) Documentation of annual oral examination in client's record, signed and dated.
2.6) Client referrals to other services as appropriate, e.g., dental specialty care.	2.6) Documentation of referrals made and status of outcome in client's record, signed and dated.

2.7) Client education to encourage seeking routine dental care as recommended by the American Dental Association.	2.7) Documentation in the client's record encouraging the client to seek routine dental care, as recommended by the American Dental Association.
2.8) Offer appropriate dental education material to the client.	2.8) Note in the client's record the offered materials such as appropriate dental education material visible in the waiting room.
2.9) Have the client complete a consent for dental services.	2.9) Documentation that the Ryan White overseeing agency has given consent for the dental services.
2.10) Give treatment priority to pain, infection, traumatic injuries, or other emergency conditions	2.10) Documentation that treatment priority was given to pain, infection, traumatic injuries, or other emergency conditions.
Baseline evaluation	
2.10) Include in evaluation: a completed medical history, existing oral conditions, patient's chief complaint, medical alerts (if appropriate), radiographs (if appropriate for an accurate diagnosis and treatment), and drug history.	2.10) Documentation in the client's record signed and dated of a baseline evaluation.
Treatment Plan	
2.11) For cavities, missing teeth, and periodontal conditions, diagnoses must be made for each quadrant or sextant to address these conditions. Conduct a full mouth series of radiographs to substantiate periodontal disease. If periodontal disease exists, perform a full mouth probing every six months.	2.11) Documentation in the client's record showing concurrence with the standards.
2.12) Have the treatment plan reviewed and updated as needs are identified or at least every 6 months.	2.12) Documentation signed and dated that the treatment plan was reviewed and updated as needs are identified or at least every 6 months.

2.13) Have the treatment plan evaluated by appropriate staff.	2.13) Approval documentation on file.
2.14) Have all services provided recorded signed and dated.	2.14) Documentation signed and dated that all services provided recorded.
2.15) Have all the prescriptions and drugs dispensed signed and dated.	2.15) Documentation signed and dated in the client's record of prescriptions and drugs dispensed.
2.16) Give post-operative instructions to client for surgical procedures.	2.16) Documentation signed and dated in the client's record post-operative instructions given for surgical procedures.
2.17) Have record of all pre-medications and local anesthetic used signed and dated.	2.17) Documentation signed and dated in the client's record of all pre-medications and local anesthetic used.
2.18) Identify if the provider is a third party payer or not.	2.18) Documentation that provider is a third party payer.
Extractions	
2.19) Assess the client need for replacement teeth.	2.19) Documentation of the client need for replacement tooth/teeth due to no other viable options such as removable or fixed prosthesis, and/or cone beam analysis results.
Documentation	
2.20) Keep updated records including: Medical history, Physical examination, Laboratory reports, Medications, Treatment plan of care, Interim progress notes, Laboratory reports, Referrals, and follow-ups.	2.20) Documentation signed and dated in the client's record of Medical history, Physical examination, Laboratory reports, Medications, Treatment plan of care, Interim progress notes, Laboratory reports, Referrals and follow-ups.
Transition and Discharge	
2.21) Client discharged when oral health care services are no longer needed, goals have been met, upon death or due to safety issues. (*see 2.22*) <u>Prior to discharge</u>: Conduct discussion with client over reasons for discharge and options	2.21) Documentation of discharge plan and summary in client's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable. **Exception: If the client has noted during*

for other service provisions. Whenever possible, discussion should occur face-to-face. If not possible, provider should attempt to talk with client via phone. If verbal contact is not possible, a certified letter* must be sent to client's last known address. Must return to provider, if client is not present to sign for the letter. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.* <u>Documentation:</u> Client's record must include: a) Date services began b) Special client needs c) Services needed/actions taken, if applicable d) Date of discharge e) Reason(s) for discharge f) Referrals made at time of discharge, if applicable.	*the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*
<u>Transfer:</u> If client transfers to another location, agency or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If client moves to another area, transferring agency will make referral for needed services in the new location.	Discharge summary and other records send with the patient
<u>Unable to Locate:</u> If client cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. The three attempts should start no later than three months prior to the due date. A certified letter* must be mailed to the client's last known mailing address within five business days after the last attempt to notify the client. The letter will state case	Document attempts made

closure within 30 days from the date on the letter if no appointment is schedule with the provider. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.* <u>Withdrawal from Service:</u> If client reports no longer needing services or decides to no longer participate in the Service Plan, the client may withdraw from services. Because clients may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure understanding reasons for withdrawal, or if client still needs services identify factors interfering with the client's ability to fully participate. If other issues are identified that cannot be managed by the agency clients should be referred to appropriate agencies. <u>Administrative Discharge:</u> Discharge clients who engage in behavior that abuses the safety or violates the confidentiality of others. Prior to discharging a client for this reason, agency leadership according to that agency's policies must review the case. Provide clients discharged for administrative reasons written notification of and reason for the discharge, and notify of possible alternative resources. A certified letter* that notes the reason for discharge and includes alternative resources must be mailed to the client's last known mailing address within five business days after the date of discharge, and a copy must be filed in the client's chart. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the*	

case, case managers will document this in progress notes and discharge summary.	
Case Closure	
2.22) Case will be closed if client: a) Has met the service goals; b) Decides to transfer to another agency; c) Needs are more appropriately addressed in other programs; d) Moves out of state; e) Fails to provide updated documentation of eligibility status thus, no longer eligible for services; f) Fails to maintain contact with the oral health assistance staff for a period of three months despite three (3) documented attempts to contact client; g) Can no longer be located; h) Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan; i) Exhibits pattern of abuse as defined by agency's policy. j) Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program; or k) Is deceased.	2.22) Documentation of case closure in client's record with clear rationale for closure.
3.0 Client Rights and Responsibilities	
Standard	**Measure**
3.1) Services are available and accessible to any individual who meets program eligibility requirements. Each provider shall assist clients with conducting Ryan White Part B eligibility,	3.1) Written eligibility requirements and non-discrimination policy on file.

regardless of whether they receive other Part B services at your agency. All providers shall be in compliance with all applicable federal, state, and local anti-discrimination laws and regulations, including but not limited to the American's with Disabilities Act. All providers shall adopt a non-discrimination policy prohibiting the refusal of rendering services based on the fact or perception of race, color, creed, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, domestic partner status, marital status, height, weight, disability, or HIV/AIDS diagnosis. Each provider shall make available to clients a process for requesting interpretation services, including American Sign Language.	
3.2) Each agency should have a Client's Rights and Responsibilities policy, which requires each client to sign & date a form indicating they has been offered: a) explanation of the policy, and b) copy of *'Client's Rights and Responsibilities* and to communicate client's understanding of the policy	3.2) Written policy on file.
3.3) Provide explanation of *Client's Rights and Responsibilities* to each client. Client rights include: • Be treated with respect, dignity, consideration, and compassion; • Receive services free of discrimination; • Be informed about services and options available. • Participate in creating a plan of services; • Reach an agreement about the frequency of contact the client will have either in person or over the phone.	3.3) Current *Client's Rights and Responsibilities* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the rights and responsibilities.

• File a grievance about services received or denied; • Not be subjected to physical, sexual, verbal and/or emotional abuse or threats; • Voluntary withdraw from the program; • Have all records be treated confidentially; Have information released only when: • A written release of information is signed; • A medical emergency exists; • There is an immediate danger to the client or others; • There is possible child or elder abuse; or • Ordered by a court of law. Client responsibilities include: • Treat other clients and staff with respect and courtesy; • Protect the confidentiality of other clients; • Participate in creating a plan of service; • Let the agency know any concerns or changes in needs; • Make and keep appointments, or when possible, phone to cancel or change an appointment time; • Stay in contact with the agency by informing the agency of change in address and phone number, respond to phone calls and mail • Avoid subjecting the agency's staff to physical, sexual, verbal and/or emotional abuse or threats.	
4.0 Grievance Process	
Standard	**Measure**
4.1) Grievance policy requires each client to sign & date indicating they have been offered: a) explanation of the policy, b) copy of *Grievance Procedure* and	4.1) Written grievance procedure on file, available in languages and formats appropriate to populations served.

c) communication of client's understanding of the policy. Policy shall describe the process for resolving client grievances, including identification of whom to contact and applicable timelines. Policy shall be available in languages and formats (e.g. for persons with disabilities) appropriate to populations served.	
4.2) Provide explanation of *Grievance Procedure* to each client. Clients may file a grievance if denied their request for services, if they have any complaint, or concern about the services received.	4.2) Current *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the grievance procedure.
4.3) Grievance process shall be fair and expeditious for resolution of client grievances.	4.3) Documentation of client grievances, status, and resolution.
4.4) Review of grievance policy yearly with client signature.	4.4) Current *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the client's grievance procedure.
5.0 Personnel Qualifications (including licensure)	
Standard	**Measure**
5.1) All oral health professionals, including third-party payers, have appropriate and valid licensure and certification as required by the Commonwealth of Virginia. • Dental practitioners, dental specialists and dental hygienists must be licensed by The Commonwealth of Virginia Board of Dental Examiners. • Dental Assistants who make x-rays must register with the Virginia Board of Dental Examiners.	5.1) Copy of current licensure/certification for staff providing services in personnel file.
5.2) Must have malpractice insurance.	5.2) Documentation of malpractice insurance on file.

5.3) Supervision of all dental hygienists and dental assistants by a licensed dentist.	5.3) Documentation of supervision according to agency policy.
5.4) All oral health professionals must complete 2 hours of continuing education in HIV/AIDS annually.	5.4) Documentation of training completed in personnel file.
6.0 Cultural and Linguistic Competency	
Standard	**Measure**
6.1) Health services are culturally and linguistically competent, client-guided and community based. At a minimum, provider's documentation should include: a) Experience with providing services to the diverse ethnic, linguistic, sexual or cultural populations targeted; b) Capacity of staff, including volunteers and Board, to design, provide and evaluate culturally and linguistically appropriate services; c) List of cultural competency trainings completed by staff.	6.1) Documentation of cultural and linguistic competence as reported in annual Cultural and Linguistic Competency Report.
6.2) Easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area shall be available.	6.2) Culturally and linguistically appropriate materials and signage accessible.
7.0 Privacy and Confidentiality (including securing records)	
Standard	**Measure**
7.1) Client confidentiality policy exists which include: a) Release of information requirements, and b) Health Insurance Portability and Accountability Act.	7.1) Written client confidentiality policy on file at provider agency.
7.2) Client's consent for release of information is determined.	7.2) Current *Release of Information Form* signed and dated by client and provider representative and located in client's record.

	Each release form indicates who may receive the client's information and has an expiration of not more than 12 months.
7.3) Each client file is stored in a secure location with electronic client records protected from unauthorized use.	7.3) Files stored in locked file or cabinet with access limited to appropriate personnel. Electronic files are secure with password protection and access is limited to appropriate personnel.
7.4) Annual submission of *Verification of Receipt of Assurance of Key Requirements* document by all staff that handle client identifying information.	7.4) Documentation of signed *Verification of Receipt of Assurance of Key Requirement* forms.
8.0 Quality Management	
Standard	**Measure**
8.1) Measure and report client health outcomes using Oral Health Care Services measures approved by VDH.	8.1) Performance measurement data on the following indicators: • Percentage of persons with an HIV diagnosis who are receiving Oral Health education session in the 12-month measurement period

References

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