Tuesday, May 13, 2025, 4:00 PM – 5:30 PM
Seville Plaza – Live Well Support Center
5469 Kearny Villa Rd, San Diego, CA 92123
1st Floor, Training Room D

The Charge of the Medical Standards & Evaluation Committee: Ensure that HIV Primary Care services provided through local Ryan White-funded clinics meet or exceed established HIV clinical practice standards and Public Health Services (PHS) guidelines, assuring availability and access to state-of-the-art medical care for all eligible persons living with HIV (PLWH).

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Meeting Packet

Meeting Location & Directions:

Medical Standards & Evaluation Committee (MSEC)

Tuesday, May 13, 2025,
4:00 PM – 5:30 PM

Seville Plaza - Live Well Support Center
5469 Kearny Villa Rd.
San Diego, CA 92123
(1st Floor, Training Room D)

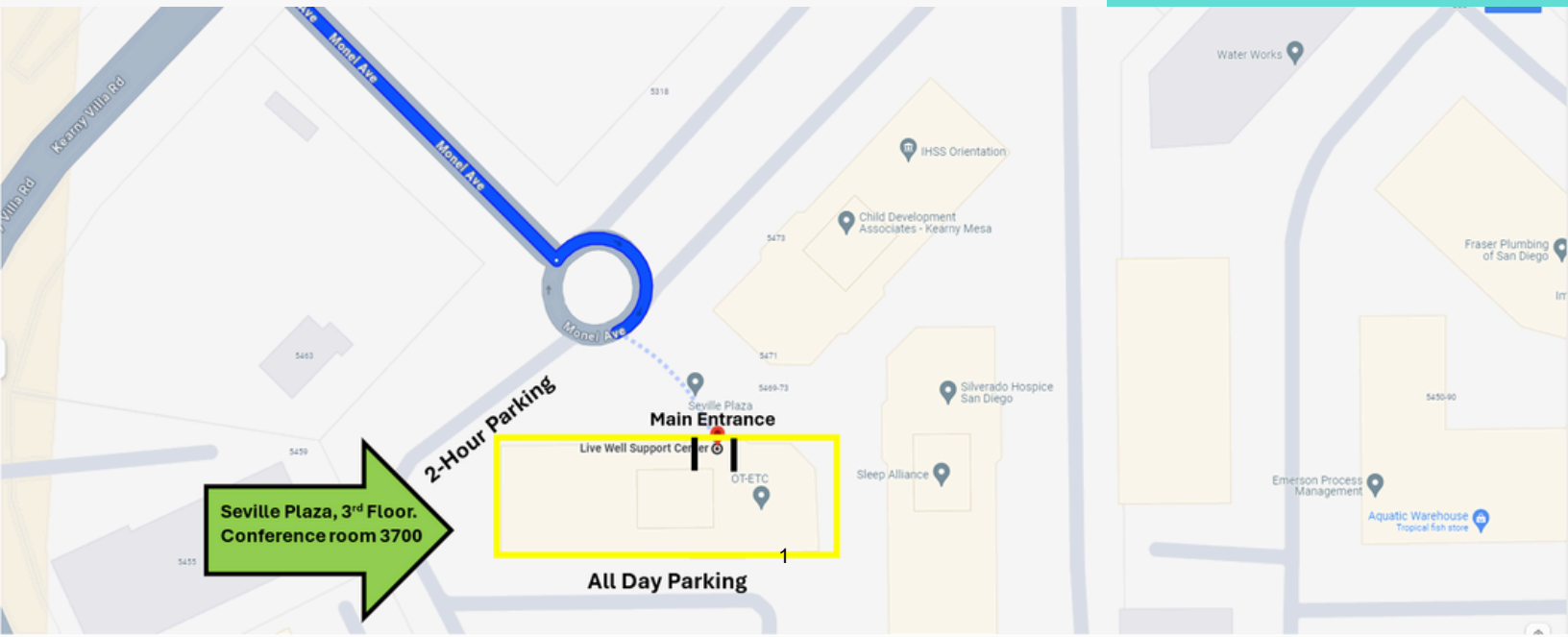
Parking is **free**. 2-hour parking and whole day parking is available in the parking lot. All visitors must check in with security at the main entrance of the building to be escorted to the elevator. Visitors include County employees who do not work in the building.

FROM I-63 S:

1. Use the right 2 lanes to turn left onto CA-163 N toward Escondido.
2. Merge onto CA-163 N
3. Take Exit 8 for Clairemont Mesa Blvd
4. Keep left, follow signs for Kearny Villa Rd
5. Sharp right onto Kearny Villa Rd
6. Turn Left onto Monel Ave

PUBLIC TRANSPORTATION

MTS Bus Routes:
27, 20, 120, 235



FROM TROLLEY & BUS:

1. Take the Blue Trolley Line to the Balboa Avenue Transit Center
2. Walk to Balboa Ave & Moraga Ave bus stop (about 7-minute walk, 0.3 miles)
3. Take Route 27 bus from Balboa Ave & Moraga Ave to Complex Dr & Clairemont Mesa Blvd
4. Head north on Complex Dr
5. Cross the street and turn left on Clairemont Mesa Blvd
6. Turn right onto Kearny Villa Rd
7. Turn right onto Monel Ave
8. Building 5469/Seville Plaza - Live Well Support Center will be on the **right** side at the end of the cul-de-sac

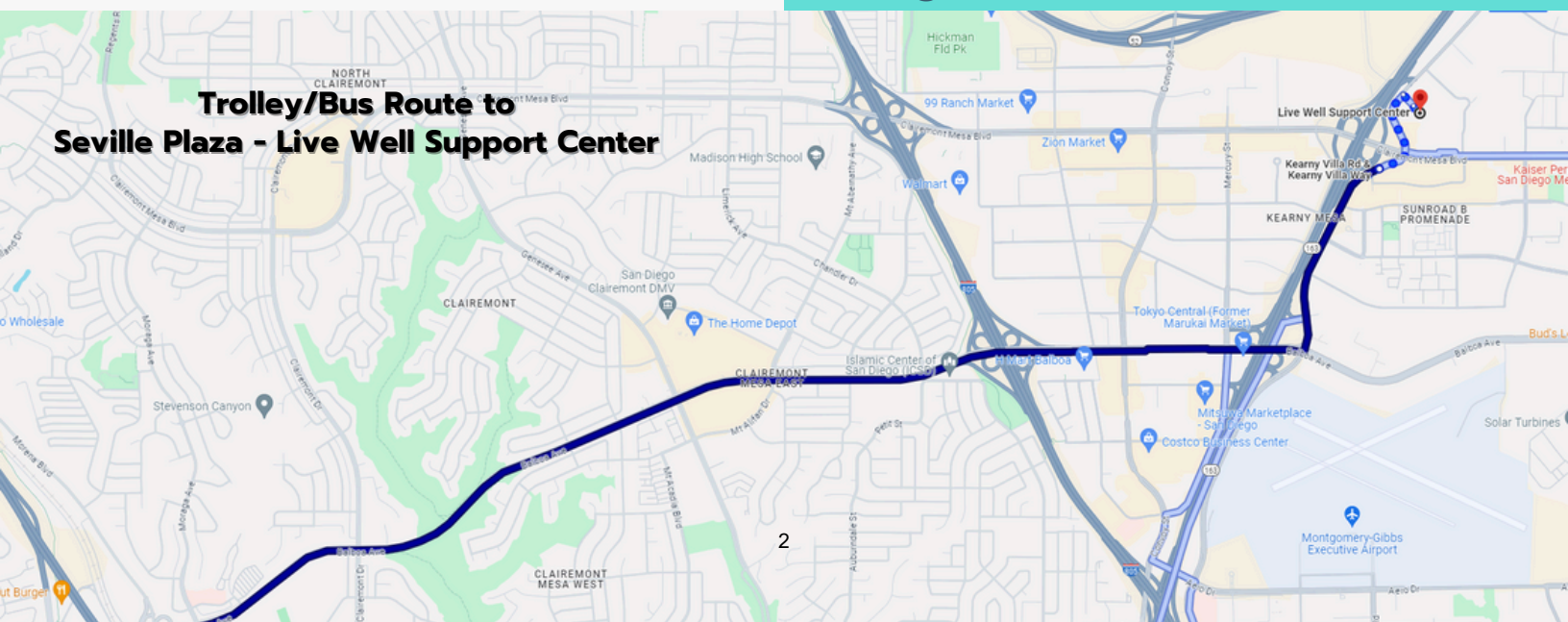
FROM BUS:

From Kearny Villa Rd & Kearny Villa Way:

1. Walk northeast on Kearny Villa Rd
2. Turn right onto Monel Ave
3. Enter the traffic circle
4. Building 5469/Seville Plaza - Live Well Support Center will be on the **right** side

From Clairemont Mesa Blvd:

1. Walk north on Complex Dr toward Clairemont Mesa Blvd
2. Turn left onto Clairemont Mesa Blvd
3. Turn right onto Kearny Villa Rd
4. Turn right onto Monel Ave
5. Enter the traffic circle
6. Building 5469/Seville Plaza - Live Well Support Center will be on the **right** side



Tuesday, May 13, 2025, 4:00 PM – 5:30 PM
Seville Plaza – Live Well Support Center
5469 Kearny Villa Rd, San Diego, CA 92123,
1st Floor, Training Room D

To participate remotely via Zoom:
https://sdcounty-ca-gov.zoom.us/j/87211982598?pwd=aB4GoyqB1wuPNNGWDbbPluqEjjsItt.1
Call in: 1-669-444-9171
Meeting ID: 872 1198 2598 **Passcode:** 444062

Language translation services are available upon request at least 96 hours prior to the meeting. Please contact HPG Support Staff via e-mail at hpg.hhsa@sdcounty.ca.gov.

A quorum for this meeting is seven (7).
Committee Members: Dr. Jeannette Aldous (Co-Chair) | Dr. Laura Bamford | Dr. Rosemary Garcia | Dr. David Grelotti (Chair) | Yessica Hernández | Bob Lewis | Shannon Paugh | Karla Quezada-Torres | Dr. Martha Rodriguez | Dr. Stephen Spector | Dr. Winston Tilghman | Dr. Fadra Whyte | Mikie Lochner

MEETING AGENDA
ORDER OF BUSINESS

1. Call to order, introductions, comments from the chair, and a moment of silence
2. Public comment (for members of the public)
3. Sharing our concerns (for committee members)
4. **Action:** Approve the MSEC agenda for May 13, 2025
5. **Action:** Approve the MSEC minutes from April 08, 2025
6. New Business:
    a. Ryan White Chart Review Summary – Jeanette Johnson
7. Old Business:
    a. **Action**: Update and approve Dental Practice Guidelines
    b. **Action**: Update and approve Oral Health Service Standards
        i. Language around implants
8. Other Updates:
    a. STI and MPox Update
    b. Committee member updates
9. Future agenda items for consideration
10. Announcements
11. **Next meeting date:** September 09, 2025, from 4:00 PM – 5:30 PM **Location:**
    To be determined AND virtually via Zoom
12. Adjournment

WORK PLAN
February 11, 2025 • Update Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services • Finalize 2025 work plan and priorities
April 8, 2025 • Finalize and Approve Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services • Finalize 2025 work plan and priorities • Review Mental Health Services and Psychiatric Medication Management
May 13, 2025 • Finalize and Approve Dental Practice Guidelines and Oral Health Service Standards • Ryan White Chart Review Summary – Jeanette Johnson
September 9, 2025 • Review 2024 Needs Assessment findings and identify priorities •
November 4, 2025 • • Review Ryan White Quality Assurance Chart Review tool • Identify priorities and develop work plan for 2026

Tuesday, April 08, 2025, 4:00 PM – 5:30 PM
Seville Plaza – Live Well Support Center
5469 Kearny Villa Rd, San Diego, CA 92123,
1st Floor, Training Room B

To participate remotely via Zoom:
https://sdcounty-ca-gov.zoom.us/j/84391377931?pwd=0aQAdexL884STJrEFblqanmnCYD4bQ.1
Call in: 1-669-444-9171
Meeting ID: 843 9137 7931 **Passcode:** 426890

Language translation services are available upon request at least 96 hours prior to the meeting. Please contact HPG Support Staff via e-mail at hpg.hhsa@sdcounty.ca.gov.

A quorum for this meeting is seven (7).

Committee Members Present: Dr. Jeannette Aldous (Co-Chair) | Dr. Laura Bamford | Dr. Rosemary Garcia | Dr. David Grelotti (Chair) | Yessica Hernández | Karla Quezada-Torres | Dr. Martha Rodriguez | Dr. Stephen Spector | Dr. Winston Tilghman | Dr. Fadra Whyte

Committee Members Absent: Bob Lewis | Shannon Paugh

Agenda Item	Action	Follow-up
1. Welcome and moment of silence, comments from the Chair	Dr. Grelotti called the meeting to order at 4:05PM and introductions were done. A moment of silence was observed. The chair comments from the chair: Thank you for accommodating this extra meeting due to unusual circumstances. The chair also asked for a County update on the Federal Impact. Dr. Tilghman mentioned that there have been cuts but nothing impacting Ryan White at this point. However, there may be some changes with MediCal.	
2. Public Comment	None.	
3. Sharing our Concerns	None.	
4. **Action:** Review and approve the April 08, 2025 meeting agenda	**Motion:** Approve the April 08, 2025, meeting agenda as presented. **Motion/Second/Count (MSC):** Spector/Tilghman/9-0 **Discussion:** **Abstentions: Dr. Grelotti**	

Agenda Item	Action	Follow-up
	Motion Carries	
5. Action: Review and approval of the February 11, 2025 meeting minutes	**Motion:** Approve the February 11, 2025 meeting minutes as presented. **M/S/C:** Bamford/Hernández/8-0 **Discussion:** **Abstentions: Dr. Grelotti and Quezada-Torres** **Motion Carries**	
6. Old Business:		
a. Action: Update and approve Dental Practice Guidelines	**Motion Tabled** The following discussion took place: -To support night guards as a covered preventive service, standardized eligibility guidelines should be created to make it easier for the Ryan White providers to decide. -Diagnosis of Bruxism/TMJ is subjective and based on clinical symptoms (e.g., jaw pain, tooth wear, clicking). -Dr. Whyte to create clear documentation criteria for when a night guard is clinically necessary. - Include formal language and coverage limits (e.g., one every 3 years for adults), with consistent footnotes across documents to clarify usage and restrictions. Outline separate, flexible guidelines for pediatric patients. -Emphasize clearly that CD4 count and viral load are not reasons to withhold or modify dental treatment. Mentioning CD4 in relation to care can unintentionally create barriers to care. -Keep the headers and simplify language by removing outdated content to mirror other guidelines.	Dr. Whyte will incorporate items discussed during the meeting for both dental documents. Committee members can email any recommended changes to HPG Support Staff (SS). Dr. Aldous will work with the HPG Support Staff (HPG SS) and the Chair to review and simplify the document before the next meeting.
b. Action: Update and approve Oral Health Service Standards	**Motion Tabled**	

Agenda Item	Action	Follow-up
c. Discussion: Reviewed the meeting schedule and identify priorities for 2025 work plan	• May- review/approve dental & review needs assessment and identify priorities. • September- address priorities from needs assessment. • November 4th selected meeting date.	
7. New Business:		
a. Discussion: Review the Mental Health Services and Psychiatric Medication Management	Tabled.	
8. Other Updates:		
a. STD and Mpox Update (Dr. Tilghman)	The committee reviewed the County of San Diego Monthly STD Report in packet.	
b. Committee member updates	None.	
9. Future agenda items for consideration	None.	
10. Announcements	-Gilead has a new PrEP brochure.	
11. Next meeting date:	**Date:** May 13, 2025, **Time:** 4:00 PM – 5:30 PM **Location:** TBD	
12. Adjournment	The meeting was adjourned at 5:33PM	

County of San Diego
Health and Human Services Agency
Public Health Services
HIV, STD, AND HEPATITIS BRANCH

RYAN WHITE OUTPATIENT AMBULATORY HEALTH SERVICES

REPORT ON

COMPLIANCE WITH PRACTICE GUIDELINES

2024

STUDY DESIGN AND METHOLDOGY

United Healthcare conducted a medical chart review for the County of San Diego's Ryan White HIV/AIDS Treatment Extension Act of 2009-funded primary medical care clinics between February 3, 2025, and April 18, 2025, at the request of the County of San Diego Health and Human Services Agency; Division of Public Health Services; HIV, STD, and Hepatitis Branch. The goal was to determine the quality of care provided to persons living with HIV/AIDS and contractor compliance with established Practice Guidelines, as well as to collect baseline data for future use. The review tool was slightly revised to clarify specific data points and capture additional relevant data. The County of San Diego HIV Health Services Planning Group's Medical Standards and Evaluation Committee reviewed and approved the data elements to be collected during the review.

The entire client registration database was examined, and the eligible population was selected. Eligibility for inclusion in the review required continuous enrollment in the program from October 2023 through September 2024 with a minimum of one medical visit during the 12-month period.

The resulting list was sorted by primary care sites to determine each clinic's patient population. Twenty-five percent of the eligible enrollees, but no fewer than ten patients, were selected as the sample for each clinic. The percentage of the clinic's sample population ranged from 25% to 50%. There was a eight percent increase in the number of patients eligible for inclusion in the review this year.

To present an equitable representation of cis-female, trans-female, and cis-male clients, gender selection was biased; charts for 100% of eligible cis-females, 34% of eligible cis-males, and 100% of eligible trans-female clients were reviewed. The resulting sample represents 33% of the eligible Ryan White clients.

The chart below illustrates the percentage of eligible clients reviewed for each site. In this report, clinic sites are lettered A through E; however, to preserve a blinded status, the letters representing each clinic do not coincide with those of the list below.

Clinic Organization	Total Eligible Clients	# of Charts Reviewed	Percent of total Eligible Clients Reviewed
UCSD-OWEN	30	10	33%
Hillcrest Family Health Centers	21	10	48%
San Ysidro Health	121	30	25%
King Chavez	20	10	50%
AIDS Healthcare Foundation	21	10	48%
Total	213	70	33%

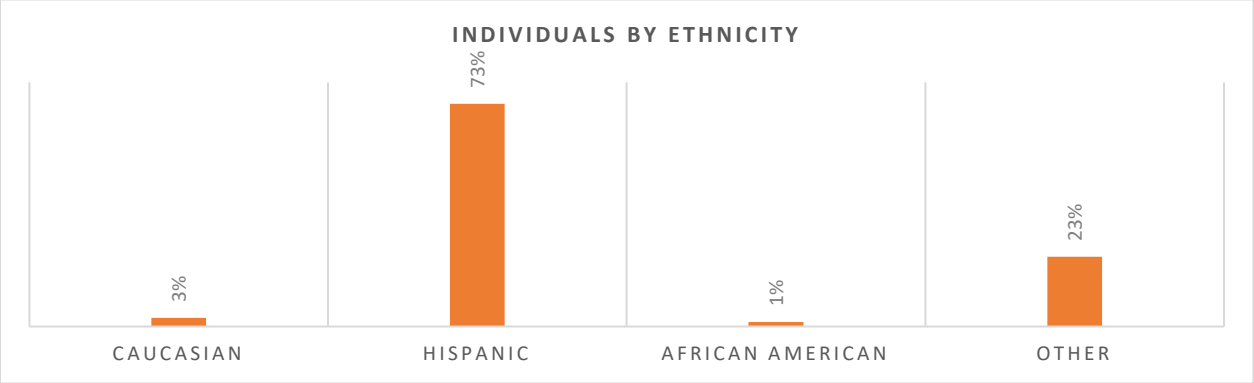
Each medical record was reviewed by a UHC licensed Registered Nurse Case Manager for all services provided from October 1, 2023, through September 30, 2024. The review included medical encounters, laboratory test results, medications, documentation of patient adherence, screening tests for sexually transmitted infections (STI) and tuberculosis (TB), Papanicolaou (PAP) smear tests for people assigned female at birth, documentation of dental referrals, hepatitis A, B, and C screening, lipid screening,

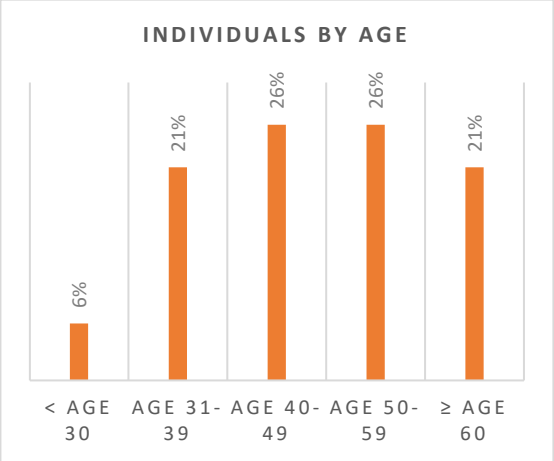
vaccinations, and mental health and substance use disorder screening. Data was entered into Microsoft Excel to ensure accurate and consistent collection.

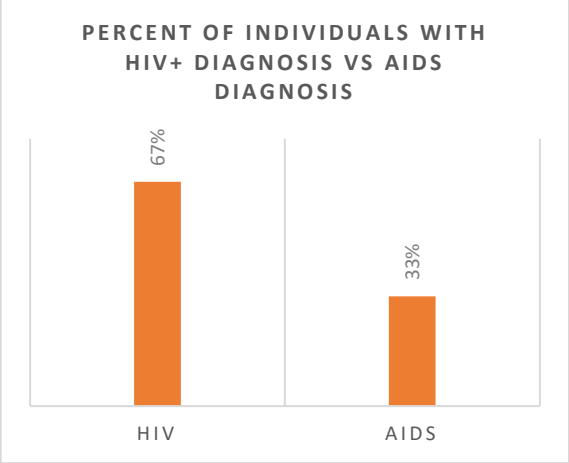
This document reports the overall results of the medical record review. In addition, statistical tests comparing 2023 and 2024 were completed on appropriate measures. Select sections from the review tool are presented anonymously by clinic to provide the County with comparative results of compliance. Subsequent reports detailing individual clinic performance will be provided to the County, which then will review clinic-specific results with each clinic. In addition, certain sections will show benchmarks for comparisons. For further information regarding these benchmarks please visit https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio.

DEMOGRAPHICS

Of the 70 clients included in the sample, 58 were cis-male, 10 were cis-female, and 2 were trans-female, representing 29%, 100%, and 100% of eligible clients in each respective population. The following charts show additional demographics and data for the sample population:

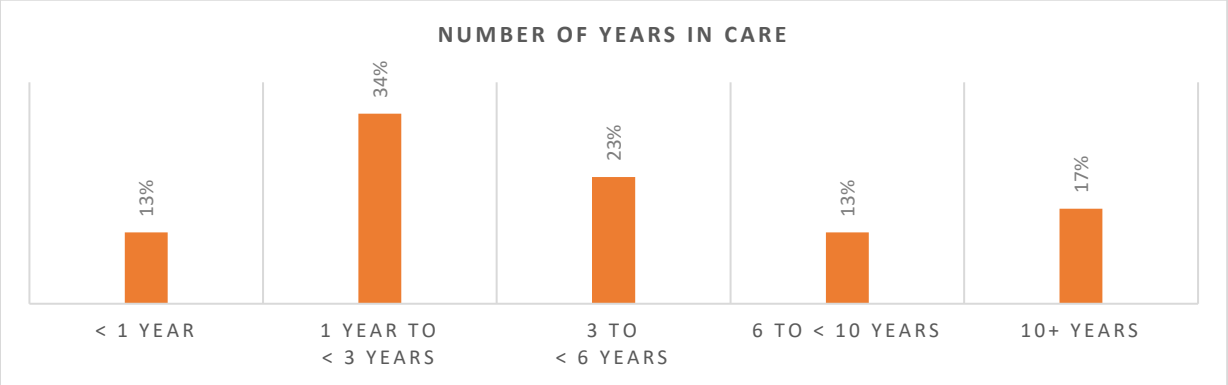






Because the amount of time receiving care for HIV can greatly influence outcomes, the number of years in care (i.e., enrolled in the Ryan White Outpatient Ambulatory Health Services) for the sample population is

present. The chart below shows that 9 (13%) of the sampled clients have been receiving care for less than one year, 24 (34%) one to three years, 16 (23%) three to less than six years, 9 (13%) six to less than 10 years, and 12 (17%) for over 10 years or more.



The average number of in-person visits per client documented for the 12-month period program-wide was 3, and the average number of telehealth encounters was 1. The total average number of encounters was 4 compared to 5 in 2023.

Summary of Medical Record Review Results – Comparison with the 2023 Review

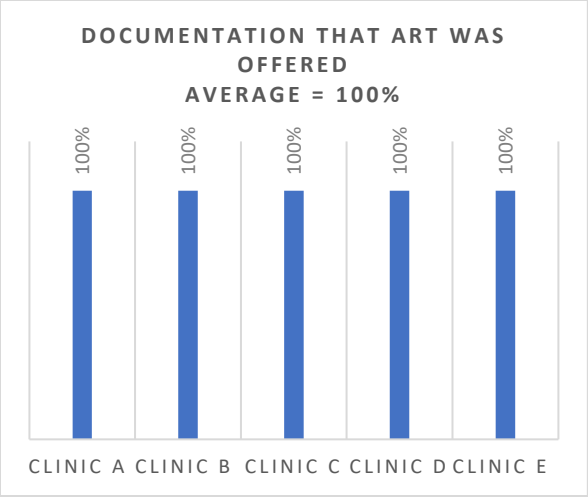
Treatment Plan Adherence

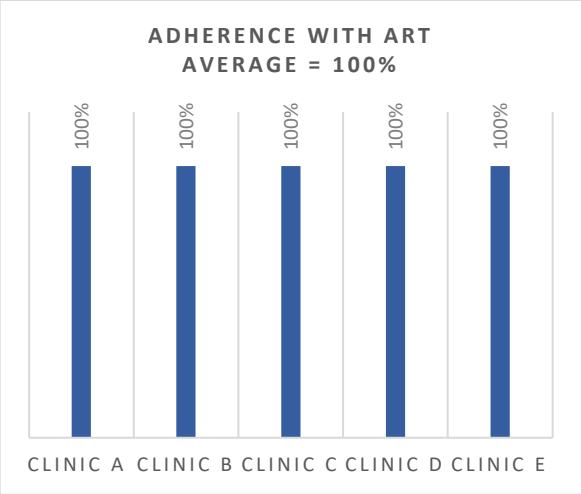
Questions were presented to determine patient adherence to the recommended treatment plan: documentation of follow-up visits scheduled, patient adherence to the schedule, and number of visits missed in excess of 30 days.

The reviewer found that 100% of the reviewed charts documented the follow-up schedule, consistent with same results from 2023. The current review also revealed that 96% of these patients were adherent to the schedule while 4% were non-adherent (i.e., missing more than one appointment by more than 30 days), an increase of seventeen percentage points compared to 2023.

Antiretroviral Therapy

The reviewer looked for documentation that antiretroviral therapy (ART) was prescribed for the clients and found confirmation in 100% of the records reviewed, which is identical to the previous year. Adherence to the medication regimen (i.e., documentation that the individual missed no more than three doses over a 30-day period) was confirmed in 100% of the records compared to 84% in 2023. The results are shown for each clinic in the graphs below.

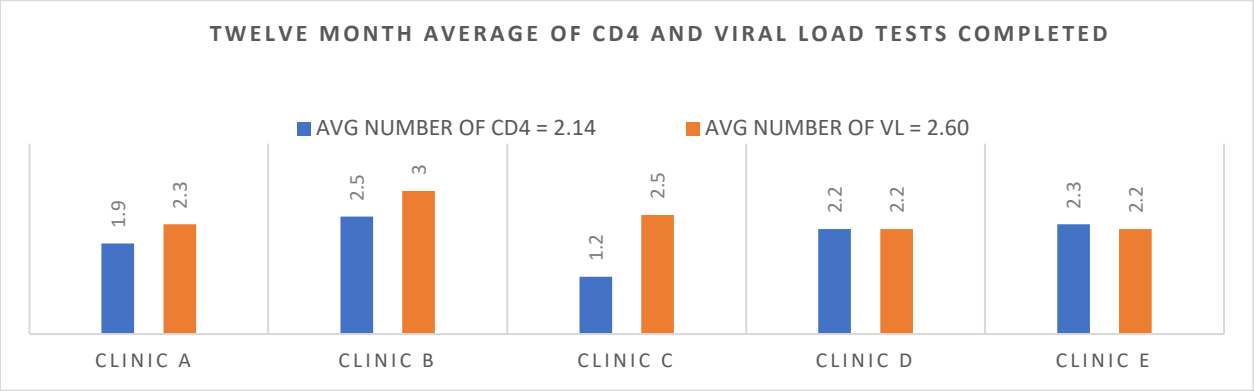




Frequency and Outcome of CD4 T-Cell Counts and Viral Loads

In December 2015, the San Diego County HIV Services Planning Group's Medical Standards and Evaluation Committee implemented a recommendation to decrease the required CD4 count frequency in certain cases for clients who have sustained undetectable viral load (VL) results. For clients who have consistently undetectable VL results on ART and CD4 counts between 300 and 500 for at least two years, the CD4 count only needs to be checked once per year. For clients who have consistently undetectable VL results on ART and CD4 counts over 500 for at least 2 years, CD4 counts are considered optional. These exceptions are listed in the current practice guidelines.

Clients are eligible for up to eight VL tests per year. On average, each client received 2.14 CD4 counts and 2.60 VL tests during the twelve-month review. The CD4 count average is higher in this review period compared to the average in 2023 of 2.08. This increase is *not* statistically significant. The average number of viral loads also increased from 2.52 to 2.60. This increase is also *not* statistically significant.

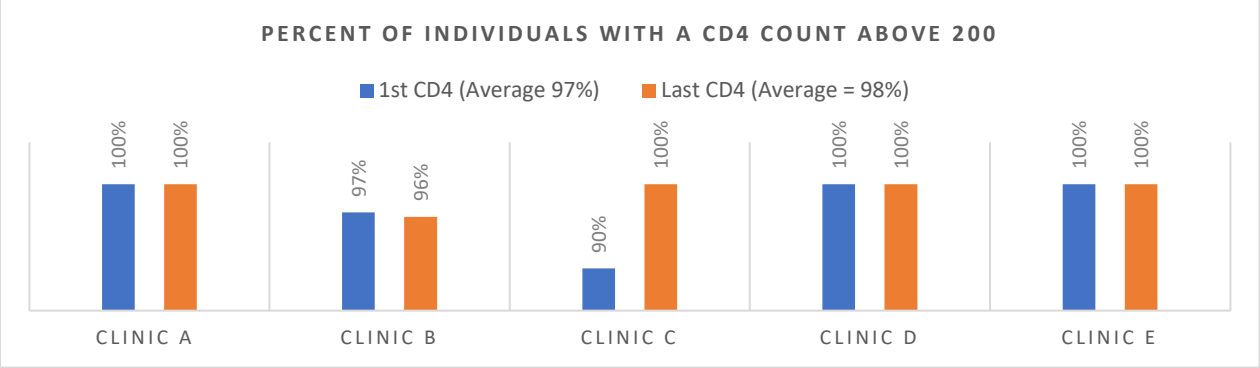


Previous reports used measures that looked at the percentage of clients with HIV infection who had two or more CD4 counts performed during the measurement year. There is currently no comparable measure to use as a benchmark, as the minimum recommended number of CD4 counts varies based on the clinical situation. The National HIVQUAL measure looks at CD4 counts every four months while the local measure, until recently, has been every three months.

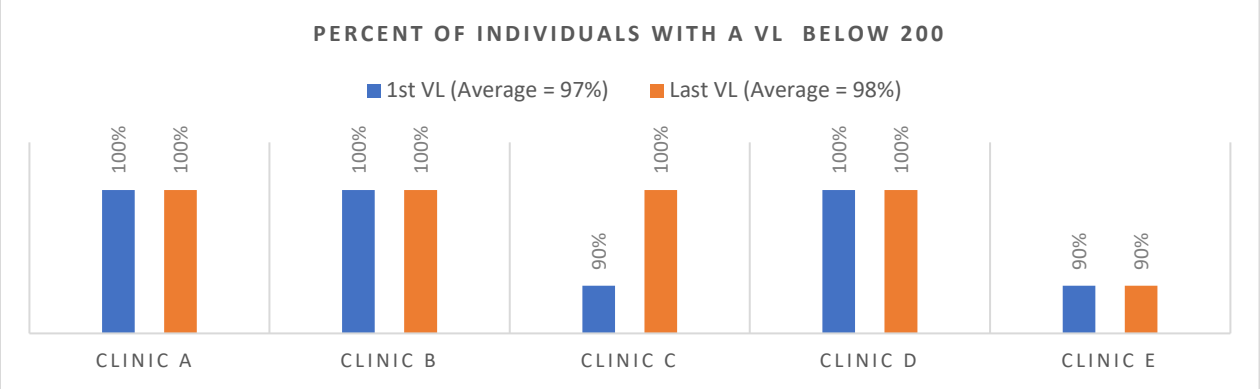
National HIVQUAL: Every 4 months: Percentage of patients for whom at least one VL test was performed in each four-month trimester of the review period at least 60 days apart. Every 6 months: Percentage of patients for whom at least one viral load test was performed in each six-month semester of the review period at least 60 days apart.

Outcomes of treatment were evaluated by collecting the values of the first and last CD4 and VL results during the twelve-month period. Parameters were set for CD4 counts greater than 200 cells/mm^3 and for VLs less than 200 copies/mL.

Analysis of CD4 counts shows an increase in the percentage of clients who received at least two CD4 tests with a count above 200 from first to last (97% to 98%) compared to 2023 (90% to 93%).



VL outcomes showed a decrease in the percentage of clients with results of <200 copies/mL from the first and last testing (97% to 98%) compared to 2023 (70% to 96%).



Resistance Testing

The Practice Guidelines state that those eligible for genotype testing are patients who are: a) treatment-naive, or b) patients with a detectable viral load greater than 1,000 copies/mL who have been on stable ART for at least one month at the time of VL testing. In addition, the US Department of Health and Human Services recommends genotypic testing as the preferred resistance testing to guide therapy in ART-naïve patients.

The chart extraction consisted of documenting those records that reported a genotype test during the 12-month period. The chart review included a screening for patients with no previous experience with ART.

There were 2 newly enrolled and treatment-naïve individuals reported in this sample, and both clients did not receive a treatment-naïve genotype. Last year's review consisted of 6 newly enrolled and all received a treatment-naïve clients who had a documented baseline/treatment-naïve genotype test.

In this year's review, there were no individuals who had a VL greater than 1000, marking a 33-percentage point decrease from 2023. This result *is* statistically significant (z=5.4549). During the 2023 review, 33% of individuals had a VL higher than 1,000 and two clients were on a stable ART regimen for at least one month prior to the VL test, with neither having a documented treatment-experienced genotype test.

Communicable Disease Screening

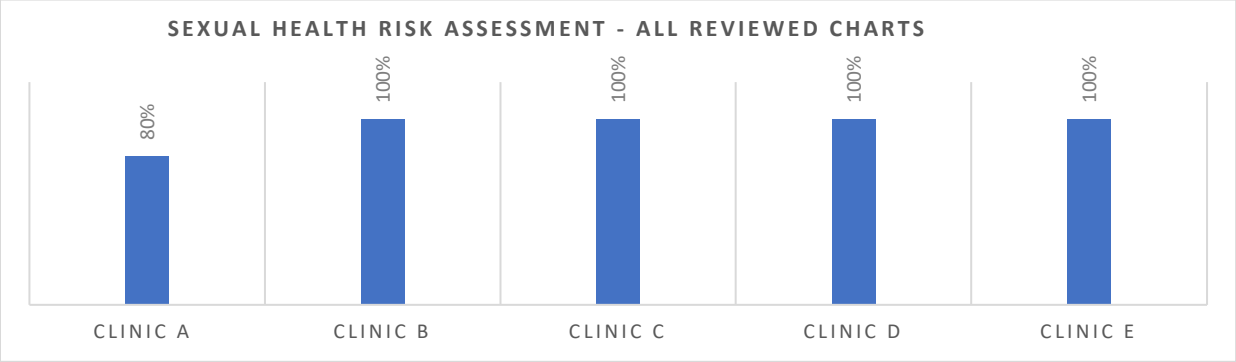
The Practice Guidelines specify the frequency for screening for STIs and TB:

- Sexual risk and drug use assessment should be repeated every three months (once per quarter); screening for syphilis, gonorrhea, and chlamydia should be done annually at a minimum; and
- Screening for TB (PPD or QuantiFERON) shall be completed annually unless already known to be infected/treated.

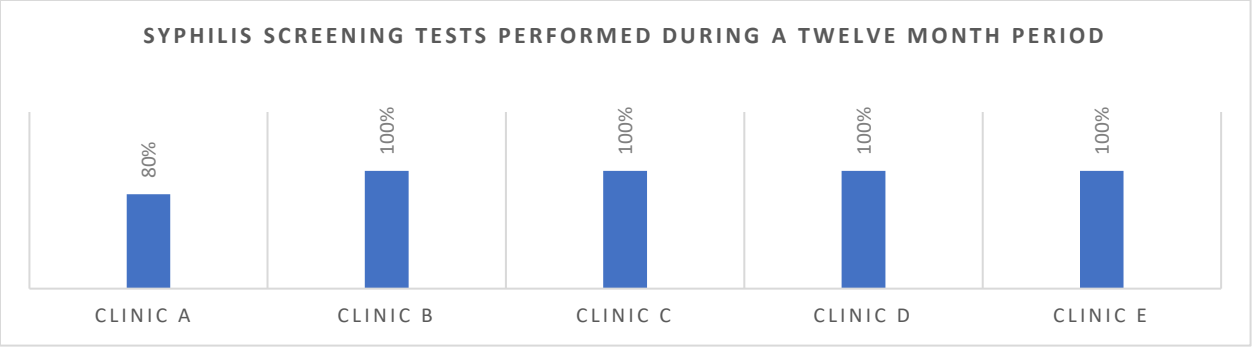
Sexually Transmitted Infections

Medical records were examined for evidence of either a notation by the practitioner or completion of the Sexual Health Risk Assessment form and laboratory results for STIs (syphilis, gonorrhea, and chlamydia).

Documentation confirming risk assessments were completed in a twelve-month period was found in 95% of charts, consistent with the findings from the 2023 review. This statistic could be misleading since some patients who have undetectable VLs may be seen only once or twice per year.



Laboratory testing for STIs averaged 97% for syphilis screens across all clinic sites, which is consistent with the 2023 review.



The charts were reviewed for evidence of screening for chlamydia and gonorrhea. Screening rates were assessed for each of the following groups (not mutually exclusive):

- Patients who were newly enrolled in care
- Patients who were sexually active and
- Patients who had STI documented in the last twelve months.

All individuals who were diagnosed with an STI in the last twelve months received urogenital screening for chlamydia and gonorrhea. This is an increase of 9% from last year's results which is *not* statistically significant.

Out of the 2 newly enrolled clients in 2024, 100% received urogenital screening for chlamydia and gonorrhea. In addition, the percentage of those documented as sexually active who received urogenital screening for chlamydia and gonorrhea increased from 94% to 97%, and this difference *not* statistically significant.

The overall averages using these three criteria are as follows:

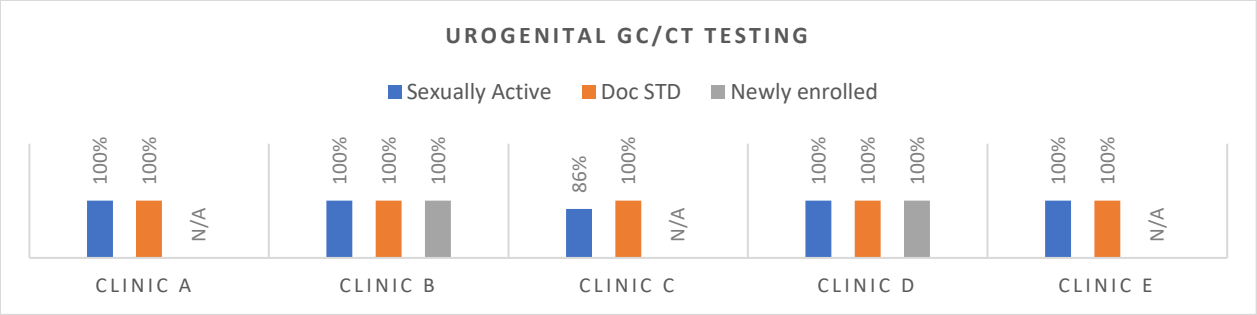
	Newly Enrolled	Sexually Active	Documented STI
Urogenital chlamydia and gonorrhea screening	100%	97%	100%

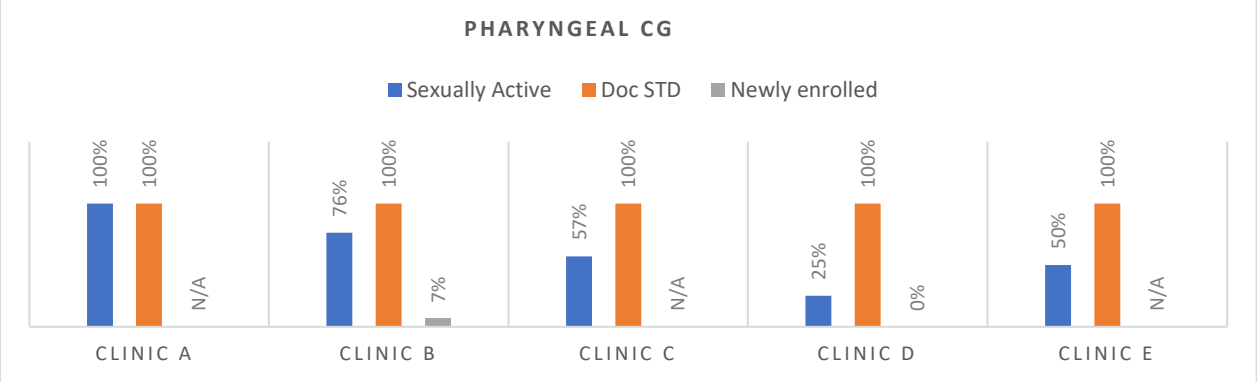
One hundred percent of clients with documented STI received pharyngeal screening for chlamydia and gonorrhea, consistent with the 2023 review. There was an increase of 61% in clients with a documented STI who received rectal screening for gonorrhea and chlamydia from 39% to 100% which was *not* statistically significant.

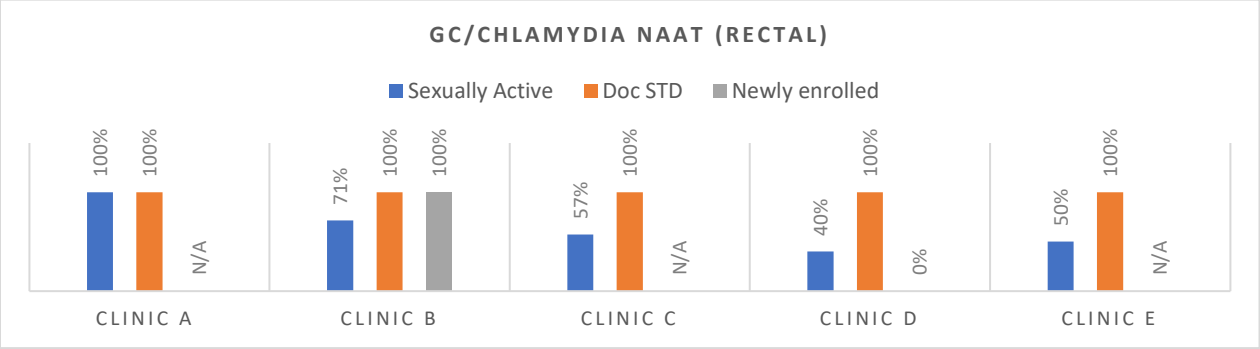
The percentage of clients who are sexually active received pharyngeal chlamydia and gonorrhea screening decreased from 78% in 2023 to 69% in 2024, a difference which was *not* statistically significant. The percentage of sexually active clients who received rectal gonorrhea and chlamydia screening decreased from 72% to 65%, and this difference is *not* statistically significant. The overall averages for extragenital screening for gonorrhea and chlamydia are presented in the chart below.

	Newly Enrolled	Sexually Active	Documented STI
Pharyngeal chlamydia and gonorrhea screening	50%	69%	100%
GC/Chlamydia Rectal	50%	69%	100%

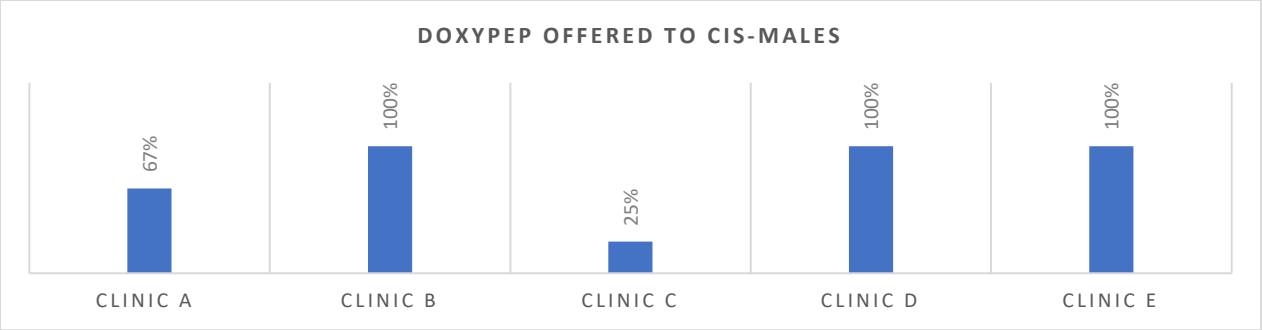
The following graphs represent the results by clinic:







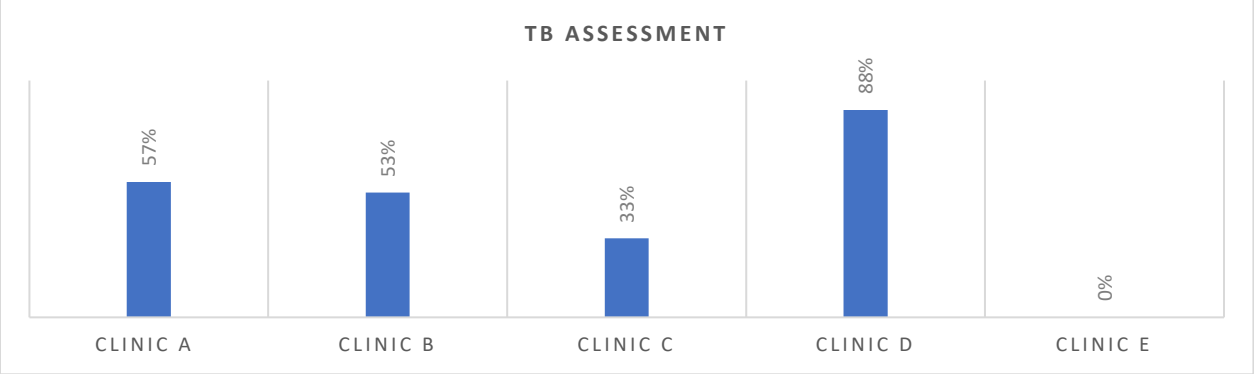
The reviewer also determined if Doxycycline STI Post-Exposure Prophylaxis (i.e., DoxyPEP) was offered to those clients who had a documented STI within the past 12 months. The results showed that 69% of cis males were offered DoxyPEP. There were no trans-female who had a documented STI



Tuberculosis Testing

To decrease the occurrence of opportunistic infections, persons living with HIV should have an annual TB skin test (PPD), chest X-ray (CXR), or QuantiFERON screening, unless there is documentation of a previous positive reaction. In addition, documentation of a baseline CXR and prophylactic therapy must be present in the medical record for all patients with a previous positive reaction. Medical records were examined for documentation of both items. The percentage of known positives and documentation of prophylactic treatment were collected.

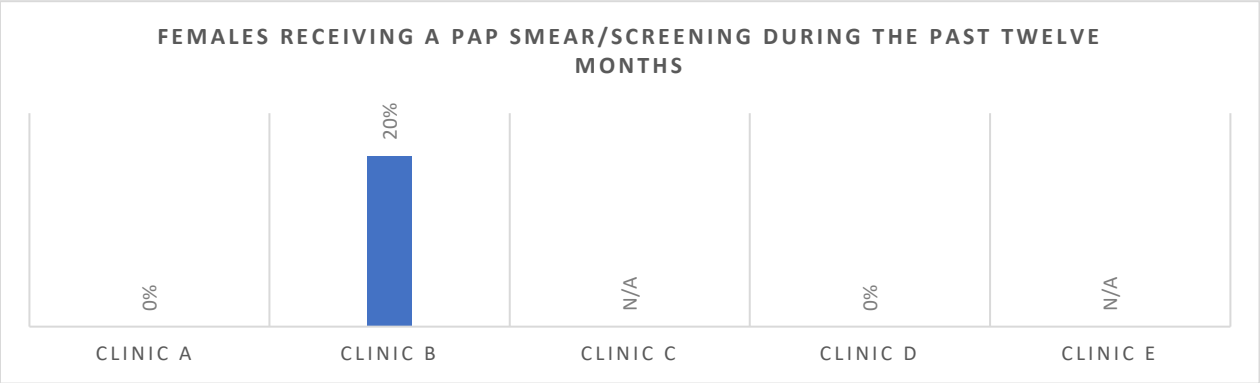
The following chart shows clinic results for the percentage of clients who received testing for TB. Twenty-six clients who had a previous positive test were excluded from these figures. Documentation in the medical records indicate that 50% of non-exempt individuals received a TB test during the twelve-month period, a decrease of twenty-eight percentage points. A decrease that *is* statistically significant (z=2.9473). QuantiFERON screening was used 100% of the time. The study found that 65% of charts for those clients with a prior positive test contained documentation of a CXR or a notation that a CXR had been performed in previous years. This is an increase of 51%. This result is *not* statistically significant. TB risk assessment for those with prior positive results were found in 15% of the medical records reviewed, which is a decrease of 28% over last year's results and is *not* statistically significant.



Papanicolaou (Pap) Test

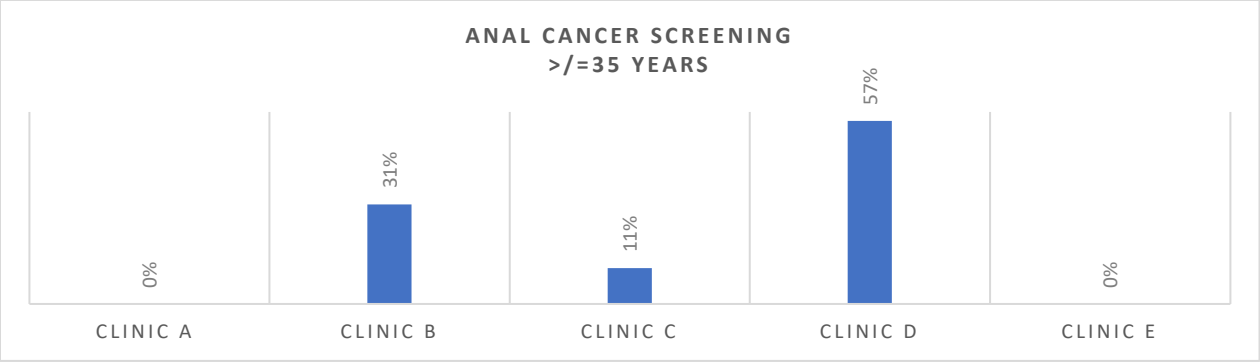
Practice Guidelines for persons assigned female at birth (PAFAB) include an initial and annual Pap smear to screen for cervical cancer unless a hysterectomy for non-dysplasia/non-malignant indications has been performed. A Pap test should be done annually for three years and if normal, can be done every three years thereafter.

The records were reviewed for an indication that the patient's cervical cancer screening had been addressed. Overall, 11% of PAFAB had received at least one Pap test during the twelve-month period or had an indication in their chart of when the next Pap smear is due. This represents a decrease of 70% from 2023 which *is* statistically significant (z=4.8993). The results by clinic are displayed in the following graph.



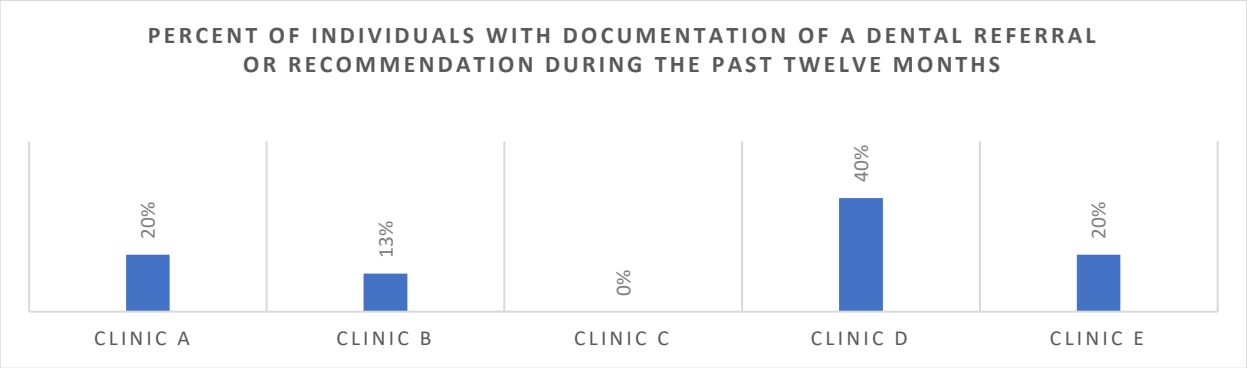
Anal Cancer Screening

The charts were also reviewed to determine if anal cancer screening was conducted for those clients aged 35 and older. The results show 24% of the clients were screened in comparison to 25% in 2023, which is *not* statistically significant.



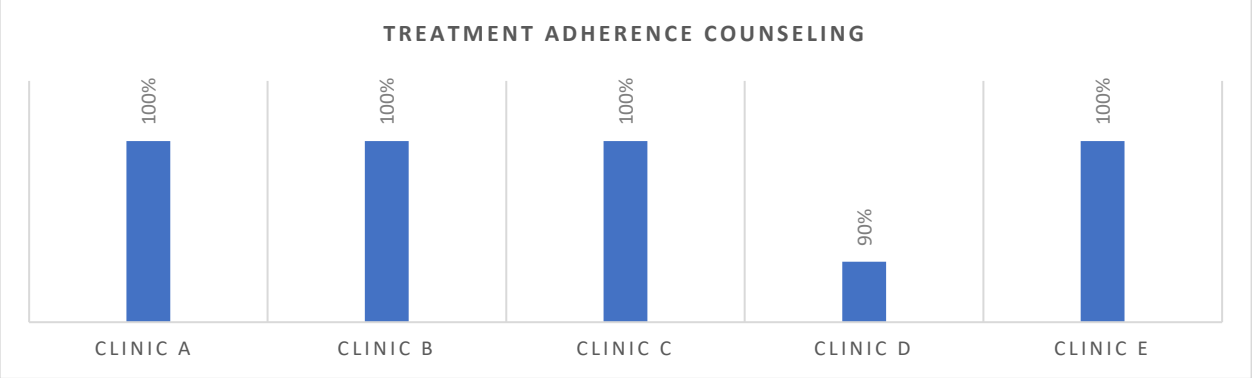
Dental Referral

The contract with the Ryan White service providers requires that the medical records contain documentation that the primary care practitioner referred to or advised the patient about annual dental care. Documentation was found in 17% of the records reviewed, a 22% decrease compared to 39% in 2023 which *is* statistically significant (z=2.8803)



Treatment Adherence Counseling

The overall average for documenting treatment adherence counseling was 99%, an increase of 1% compared to the previous review. The following graph represents the results of each clinic:

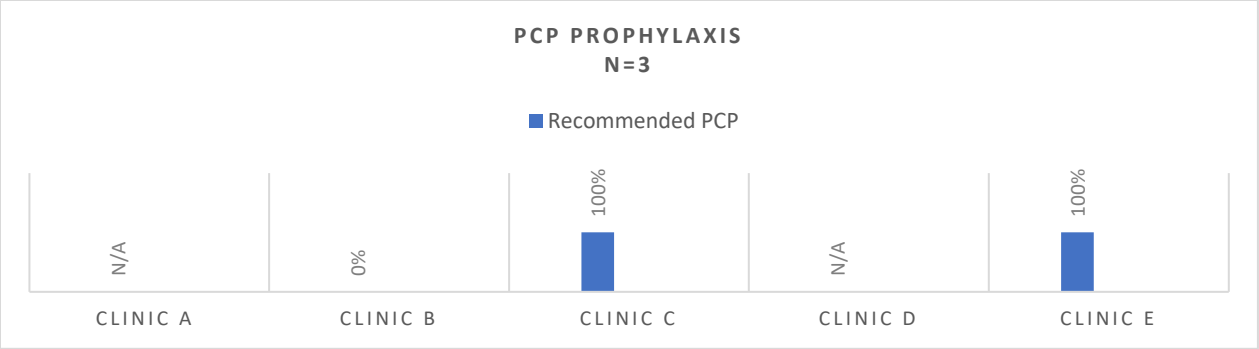


PCP (PJP) Prophylaxis

The HAB measures for the prescription of *Pneumocystis carinii* (now *jiroveci*) pneumonia (PCP/PJP) prophylaxis is based on the following criteria:

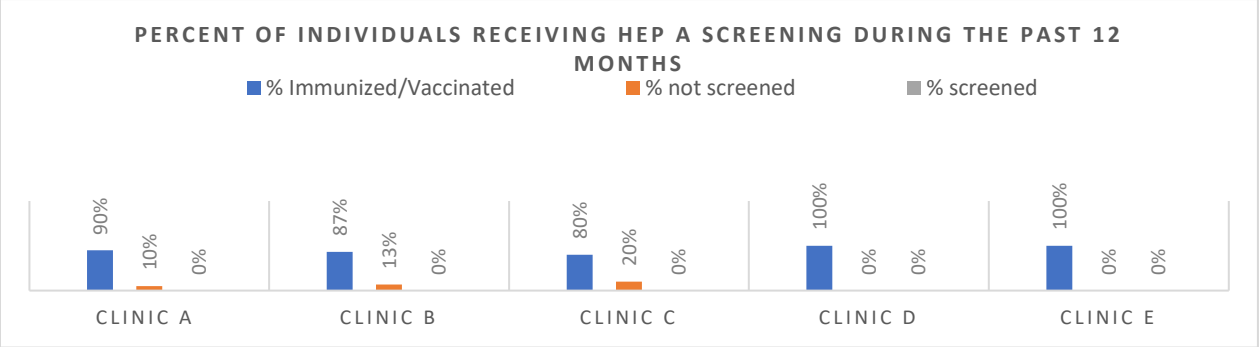
- The client is HIV +
- Is not newly enrolled, and
- Has a CD4 T-cell count <200 unless the post-test after three months rose above 200 cells/mm^3

Four clients met the above criteria, with 3 prescribed PCP/PJP prophylaxis, resulting in a rate of 66%. One client qualified for PCP but was not prescribed due to drug allergy. In the previous year, eight clients met the above criteria, and all were prescribed PCP/PJP prophylaxis. This difference is *not* statistically significant.



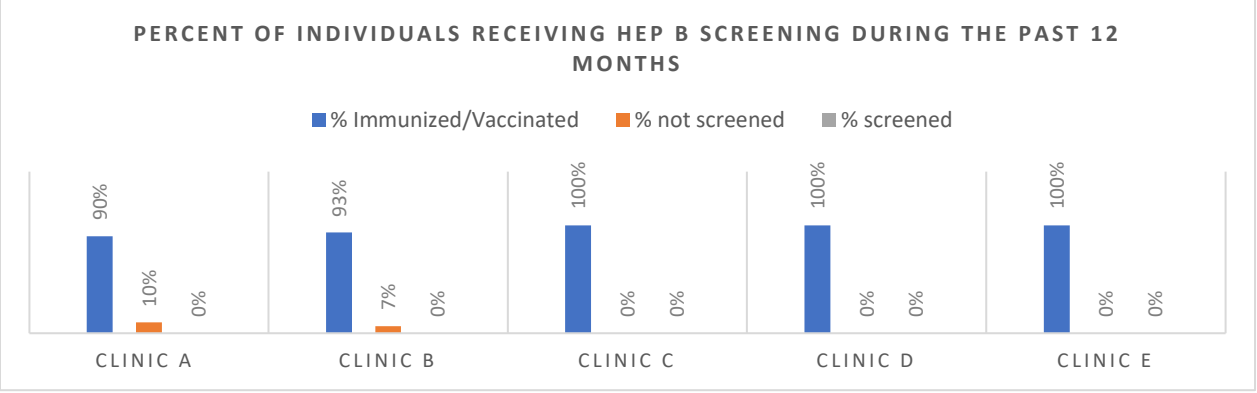
Hepatitis A Screening

Medical records were reviewed for Hepatitis A screening and vaccinations. Overall, 90% of clients were immunized/vaccinated during the review period. This is an increase of 6%, a result that is not statistically significant.



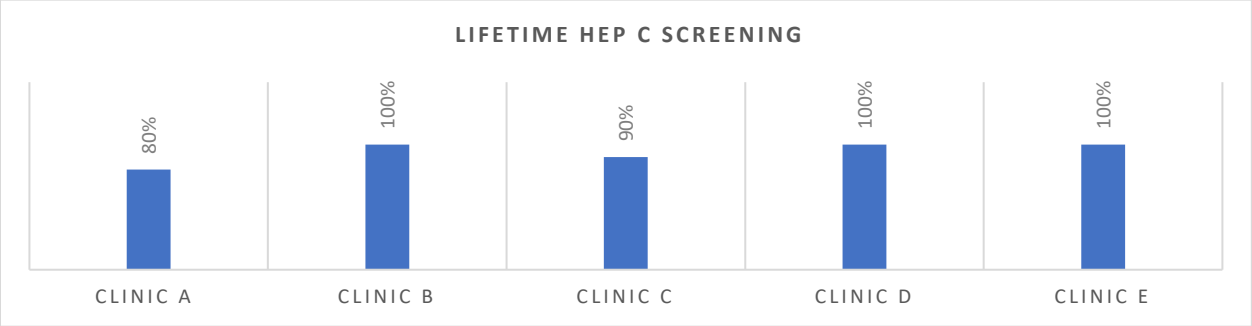
Hepatitis B Screening

Screening for Hepatitis B was also reviewed. Ninety-six percent of clients were immunized/vaccinated compared to 82% in 2023. This measure did consider previous infection and/or the vaccination status of each client. The graph below represents the results by clinic.

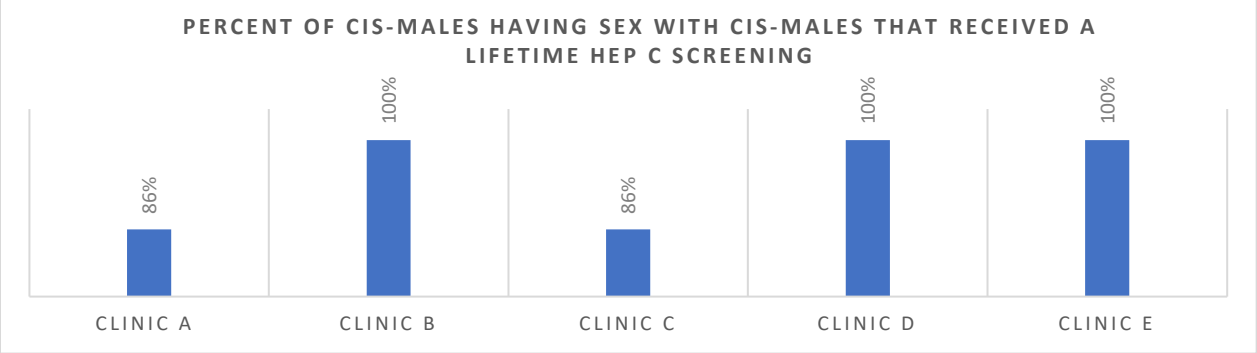


Hepatitis C Screening

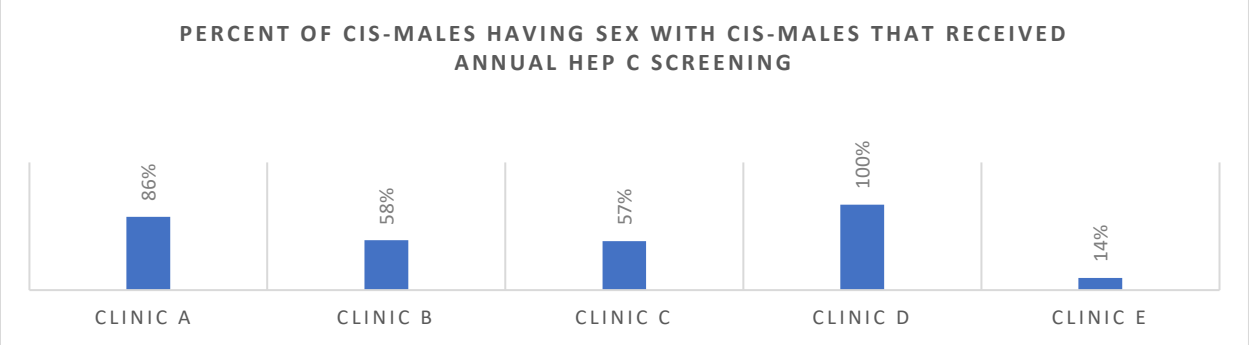
The review captured those clients who received a lifetime screening for Hepatitis C at any time. In 2024, the numbers of clients who had received a lifetime Hepatitis C Screening at any time or who were previously confirmed with Hepatitis C was 96%, which is a decrease of 2% from the previous year and is *not* statistically significant. The following graph represents the results by clinic:



Further review of the records revealed that 96% of cis-males who reported having sex with other cis-males, all received a lifetime Hepatitis C Screening. This is a 4% decrease from the previous year. A difference that is *not* statistically significant. The following graph represents the results by clinic:

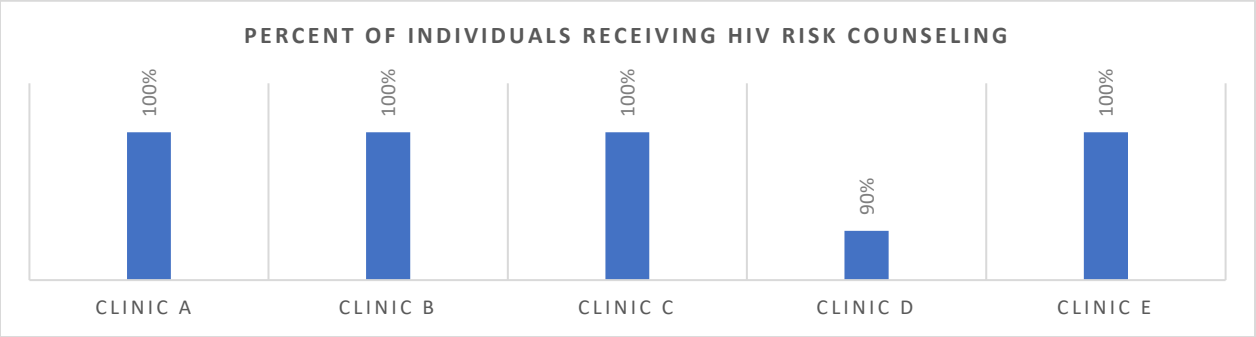


Medical records also were reviewed for documentation that annual Hepatitis C screening was done for cis-males who reported having sex with other cis-males or those with active or previous injection drug use not previously tested for Hepatitis C. It was found that 60% of those eligible for annual Hepatitis C screening based on the criteria above received the screening. This is a decrease of 15% from the previous year which *is* statistically significant (z=2.5875).

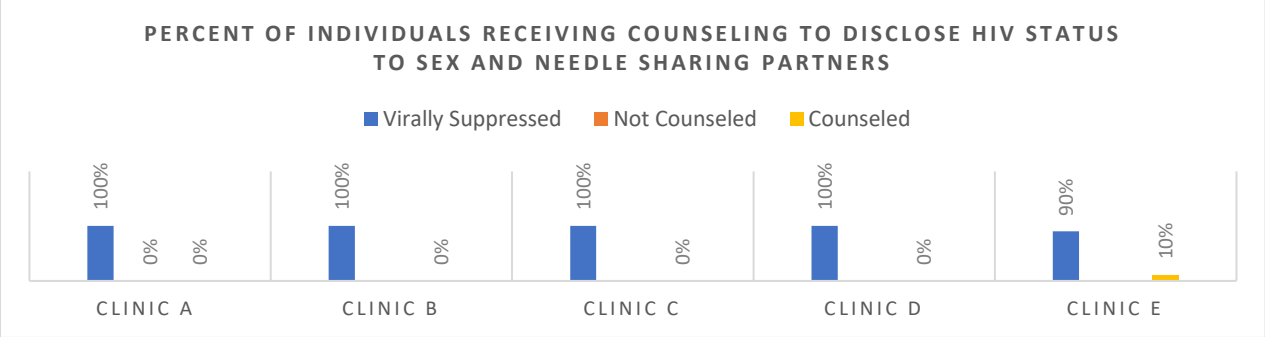


HIV Risk Counseling

Reviews of the medical records indicated that 99% of the clients received HIV risk counseling, an increase of 2% from the previous year. A result that is *not* statistically significant. The graph below represents the results by clinic:

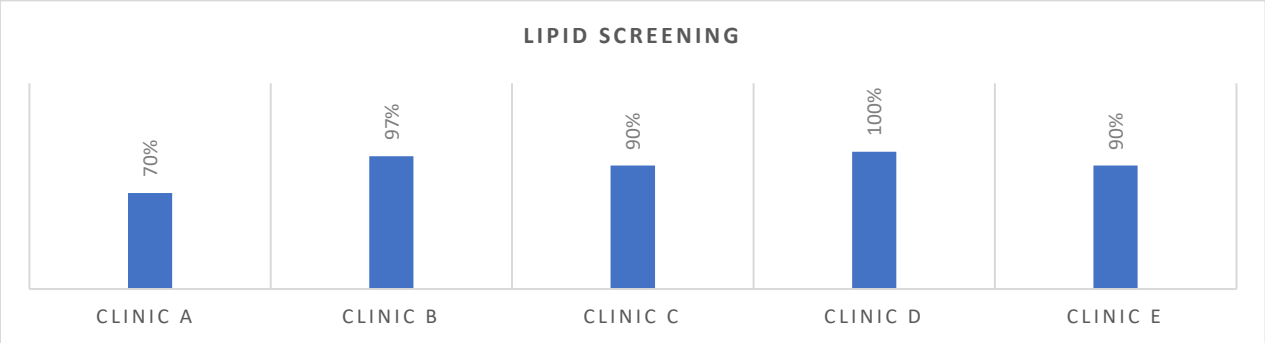


The reviewer also looked for evidence that individuals were counseled on the disclosure of HIV infection to sex and needle-sharing partners and/or were referred to HIV Partner Services if they were not virally suppressed. Ninety-nine percent of the clients were virally suppressed compared to 79% in 2023.



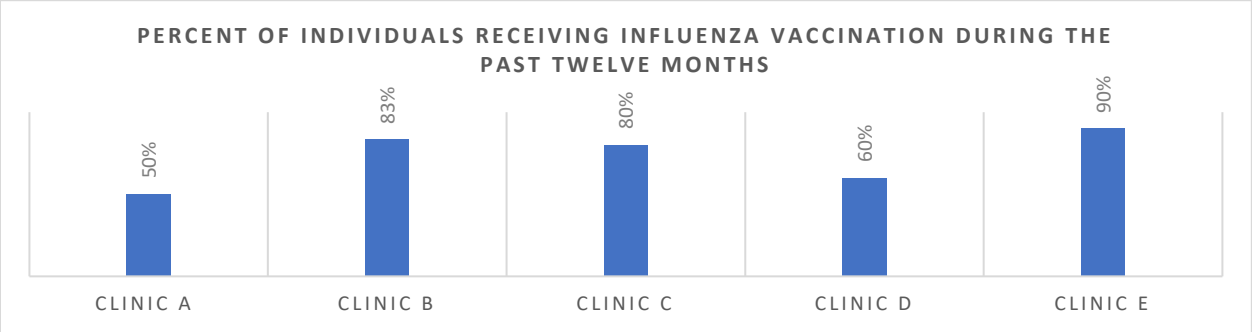
Lipid Screening

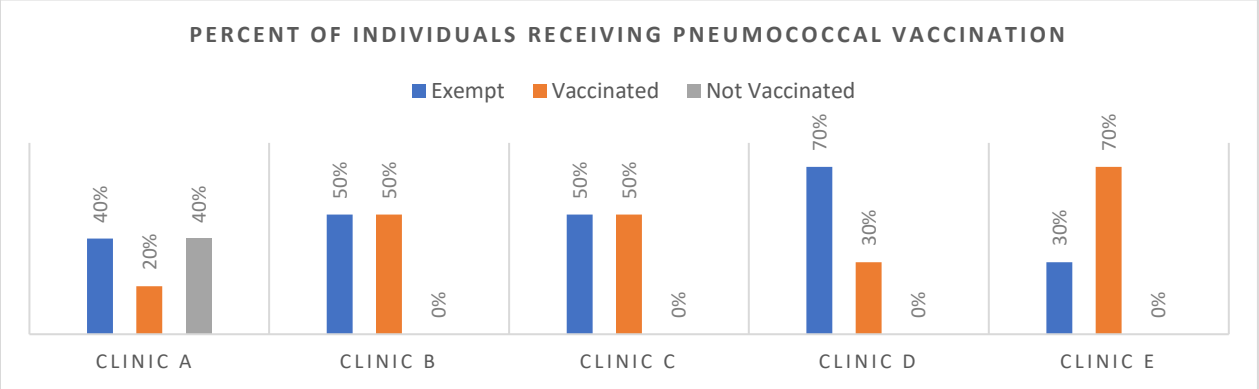
Ninety-one percent of individuals received lipid screening during the 2024 review period. This represents a 7% increase from the previous year and is *not* statistically significant.



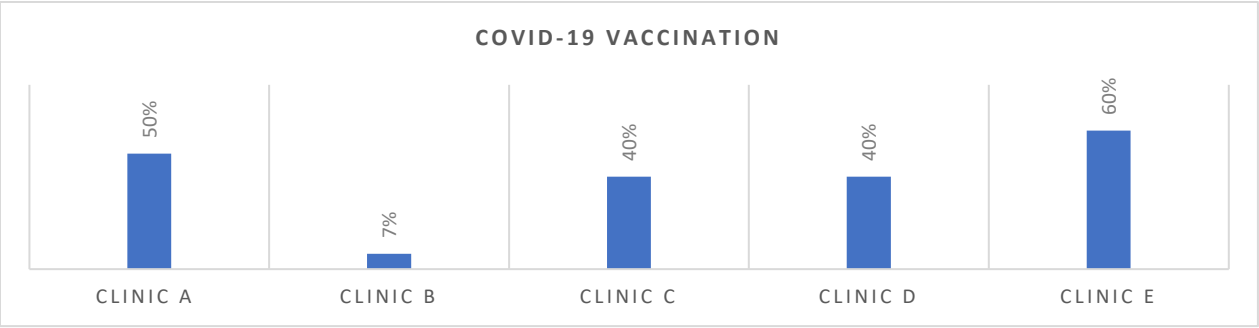
Vaccinations

A review of the medical records showed that 76% of clients received an influenza vaccination, an increase of 22% which is *not* statistically significant. Documentation showed 46% of patients received a pneumococcal vaccination and 49% were exempt. Of the thirty-two clients that were vaccinated, 84 percent received a combination of Prevnar 13 and Pneumovax 23, while 9% received Prevnar 13, and 6% received Pneumovax 23. The following graphs represent the results by clinic:



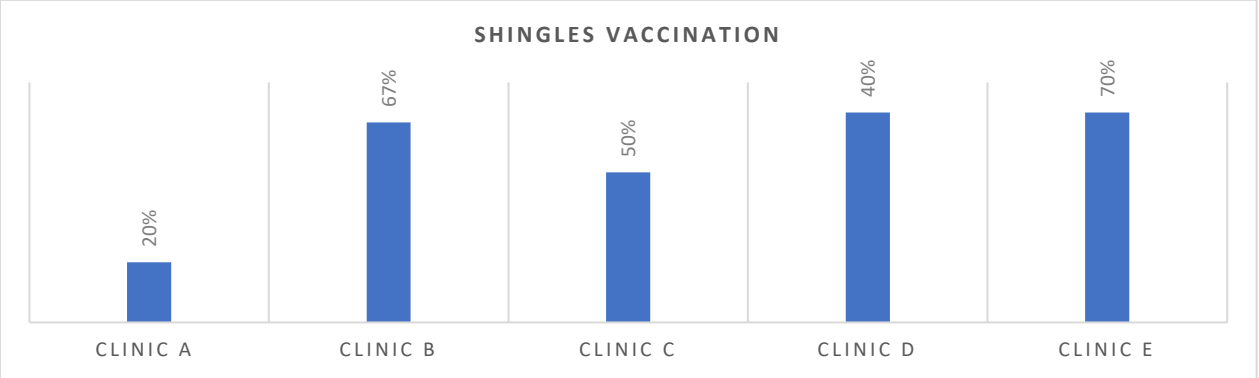


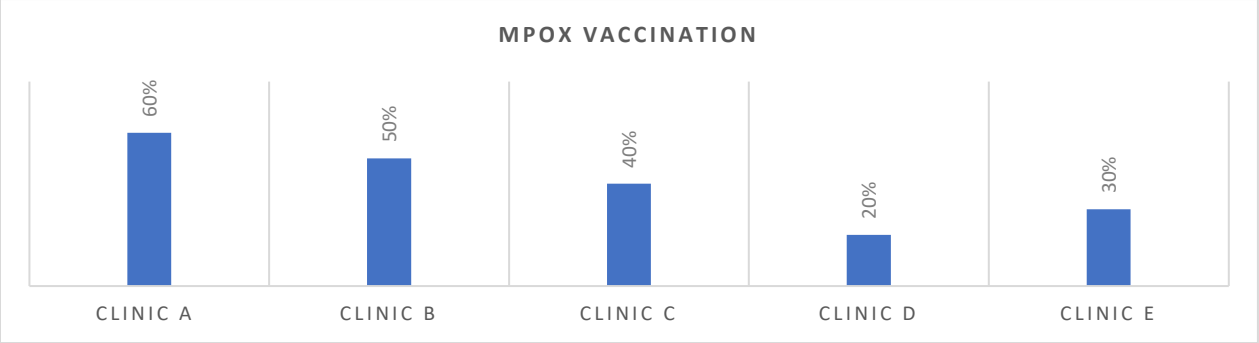
The charts were also reviewed for evidence of COVID-19 vaccination. Seventy percent of the clients had a documentation of COVID-19 vaccination compared to 82% from 2023. This is a decrease of 12% which *not* statistically significant.



During this year's review, the reviewer also looked for documentation of shingles vaccination for all clients and documentation of meningococcal and Mpox vaccination. The records indicated that 59% received the shingles vaccine an increase of 31% which is *not* statistically significant. Seventy percent of the clients received the meningococcal vaccine an increase of 4 percentage points in comparison to 2023. Forty-three

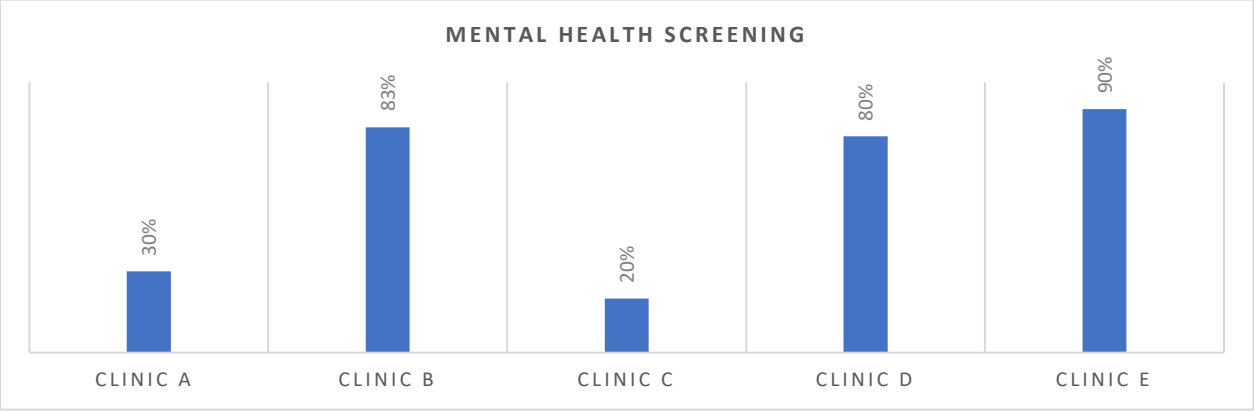
percent were vaccinated for Mpox, an increase of 9 percentage points from last year's results. The following graphs represent the results by clinic:

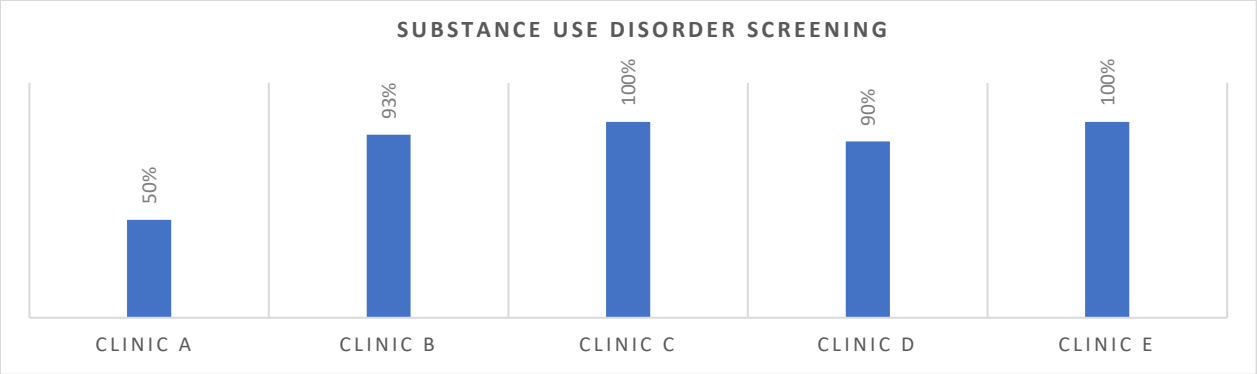




Mental Health and Substance Use Disorder Screening

In this year's review, the reviewer checked for documentation of mental health and substance use disorder screening were conducted. The records indicated that 67% of clients had documentation that mental health screenings, while 89% had documented substance use disorders screening. The following graphs represent each clinic's results:





Conclusions

In this review period clients continued to be adherent to their medication regimen and treatment plan. The primary overall conclusions and observations from this chart review include:

- An 8% increase in clients based on the 2023 chart review.
- No individuals had a viral load (VL) exceeding 1000
- A statistically significant decrease in tuberculosis testing, from 78% to 50%
- A 70% decrease in Papanicolaou test for PAFAB
- Decrease in dental referrals from 39% to 17%
- Annual Hepatitis C screening for MSM decreased by 15%

Based on the results of the review, there is an opportunity to discuss the frequency and level of documentation for certain measures as we move toward the next review period. United Healthcare will be providing individual clinic results as well as feedback from the Nurse Case Manager to use in future discussion with each clinic.

Oral Health Care

Service Category Definition

Oral Health Care services include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Purpose and Goals

The goal of oral health care is to improve oral systemic health outcomes for clients and prevent further deterioration resulting from oral disease.

Intake

To be eligible for oral health services, clients shall have a confirmed diagnosis of HIV or AIDS.

Dental Benefits

Exams and x-rays	Denture relines
Cleanings (prophylaxis)	Root canals (front and back teeth)
Fluoride treatments	Prefabricated crowns
Tooth removal (extraction)	Partial and full dentures
Fillings (restorations)	Periodontal maintenance
Emergency services	Deep cleanings (scaling and root planing)
Minimally invasive services	Laboratory crowns
Caries arrest services	
Sedation	
Other medically necessary dental services	

Custom nightguardss (aka occlusal splints) are a benefit only if with documented signs of bruxism (wear facets, cracked teeth/restorations, tooth pain, jaw pain, headache, facial pain) or Temporomandibular Joint Dysfunction (TMD) (jaw pain, neck pain, headache, earache, difficult jaw opening: catching, locking, or shifting, painful joint noises: clicking, popping, or grating). Replacements are
Replacement
allowed —every 3 years for adults. Pending a review, replacements may be allowed on an as needed basis for children
— as needed for under the age of 18 if the replacement is needed because of due to growth and and development.

Single tooth implants are not a benefit of the Ryan White Dental Program
Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed. Exceptional medical conditions include, but are not limited to:

i. cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prostheses.
ii. severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.
iii. skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anodontia and cleidocranial dysplasia).
iv. traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.

Key Service Components and Activities

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation of interviews and assessments of all potential clients utilizing a standard client eligibility screening tool

Standard	Measure
Staff maintains records of eligibility, intake and assessments	Documentation of eligibility, intake, comprehensive assessments, individual care plans, and progress of clients on a standard medical care management form
	Maintain a single record for each client
Staff ensures clients are connected to the appropriate services when needed	Documentation of all services provided/offered to clients
	Completion of the Client Transition Plan for clients who are deemed ineligible for oral health services or deemed ready to be transitioned out of these services

Personnel Qualifications

Prior to performing HIV/AIDS oral health services, all dental staff will be oriented and trained in policies and procedures of the general practice of dentistry and, specifically, the provision of dental services to people living with HIV.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate licensure and/or degrees
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff
These training programs shall include (at minimum): • Basic HIV information • Orientation to the office and policies related to the oral health of people living with HIV • Infection control and sterilization techniques • Methods of initial evaluation of the patient living with HIV disease • Education and counseling of patients regarding maintenance of their own health • Recognition and treatment of common oral manifestations and complications of HIV disease • Recognition of oral signs and symptoms of advanced HIV disease, including treatment and/or appropriate referral	Training documentation on file maintained in personnel record.

Assessment and Service Plan

Initial Assessment
At the start of Oral Health Services, a baseline dental evaluation must be conducted.

Medical history. The provider shall perform a complete medical history for every new patient. This should include:

- Client's chief complaint
- HIV medical care provider
- Current medication regimen(s) and adherence, including HIV medications
- Alcohol, drug, and tobacco use
- Allergies
- Other co-morbidities
- ~~Usual oral hygiene~~
- ~~Date of last dental examination, and name of last dentist if known~~
- Labs including viral load, CD4 count, CBC with differential

Dental History

- Usual oral hygiene
- Date of last dental examination, and name of last dentist if known
- Nutrition assessment

Oral examination. Each patient should be given a comprehensive oral examination and assessment. An oral examination should include:

- ~~Documentation of the client's presenting complaint~~
- ~~Medical and dental history~~
- Comprehensive head and neck exam
- Caries (cavities) charting
- Periodontal exam and charting
- Complete intra-oral exam, including evaluation for HIV-associated lesions or sexually transmitted infections (STIs), and oral cancer.
- Radiographs as indicted after clinical exam and may include: ~~X-rays~~: Full mouth radiographs or panoramic, ~~and~~ bitewings, periapicals, ~~x-rays~~

~~**Complete oral hygiene and periodontal exam**~~

- ~~Comprehensive head and neck exam~~
- ~~Complete intra-oral exam, including evaluation for HIV-associated lesions or sexually transmitted infections (STIs)~~
- ~~Soft tissue exam for cancer screening~~
- ~~Pain assessment~~
- ~~Risk factors~~

Preventative Care and Maintenance

Education shall include:

- Instruction on oral hygiene, including proper brushing, a strategy to remove plaque from between the teeth, and mouth rinses
- Counseling regarding behaviors that may influence oral health (e.g., tobacco use, unprotected oral sex, body piercing)
- General health conditions that may compromise oral health
- The effect of nutrition on oral health.

Clients should be scheduled for routine dental health maintenance visits, as follows:

- Routine examination. Prophylaxis and fluoride varnish or silver diamine fluoride (SDF) twice a year
- Comprehensive cleaning at least once a year
- Other procedures, such as root planing/scaling as needed

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Standard	Measure
Conduct a baseline dental evaluation that shall include at a minimum: • Medical history • Intra-oral and extra-oral ~~Oral~~ examination • Education	Performance of a timely initial assessment, including evidence of a medical history, oral examination, and education as specified above, as well as provision and documentation of applicable referrals/linkages, will be monitored via site visit chart review.
Oral Health providers should emphasize prevention with fluoride varnish application. Clients should always be provided with information regarding prevention, early detection of oral disease, and preventive oral health practices, including what to do if having a dental emergency.	All client contacts, findings, procedures, diagnoses, education, and other information pertinent to patient care must be recorded in the client chart.
Clients will receive an intra-oral and extra-oral ~~oral~~ examination ~~(this includes head and neck exam)~~ by an oral health provider at least annually. The oral examination should include fluoride varnish application. ~~and an oral cavity exam~~	Clients who received an oral examination by an oral health provider.

Commented [FW1]: Do you want this to include radiographs as part of the exam? Otherwise, this is just a visual exam. Also, these three standards seem to be duplicative and can probably condensed to two versus three measures

Treatment Plan

Oral Health providers should create an individualized dental treatment plan for each patient. The plan should:

• Identify and prioritize the patient's caries control status, periodontal status, and dental care needs
• Incorporate client input
• Describe the proposed interventions and treatment schedule
• Include any referrals and linkages to specialty care or other needed services
• Be signed and dated by the provider

The treatment plan should be reviewed at each appointment and revised as needed.

Standard	Measure
Clients requiring specialized care should be referred for and linked to such care via the client's case manager and/or Ryan White oral health provider with documentation of that referral in the client file and available upon request.	Development and revision of individualized treatment plans that meet the requirements laid out above will be monitored via review of client charts and/or electronic health records during site visits.

Practice Guidelines for the Treatment of People Living with HIV in General Dentistry

County of San Diego

Original Source:
Los Angeles County
Commission on HIV Health Services

Revised by:
San Diego County Standards of Care Dental Working Group, 9/4/08 and 4/7/11
San Diego County HIV Planning Group Dental Working Group 5/26/20 *and* 6/22/20

Recommended by:
Joint Planning Council/Grantee HIV Standards of Care Committee, 7/12/11
HIV Planning Group Strategies and Standards Committee, 7/7/20

Received and approved by:
San Diego County HIV Health Services Planning Council, 10/26/11
San Diego County HIV Planning Group, 7/22/20

Contents

Commented [FW1]: Will need to be updated once the document is approved

Initial and Periodic Exam

If there is any doubt about the accuracy of the information provided by a patient, the dentist should contact the patient's physician.

Medical Assessment

Annual Health History with updated review at each visit

Review of labs (see laboratory values)

When to Contact the Patient's Primary Care Physician

It is recommended that the dental provider consult with the patient's physician when additional information is needed to safely provide dental care. This is handled the same way as a consultation request for any other medical condition.

Dental History

History of last dental visit
Oral hygiene routine
Review of diet

Extra-Oral Examination

Patients who are living with HIV may develop associated skin manifestations and cervical lymphadenopathy along with bilateral salivary gland enlargement. Therefore, in addition to oral soft-tissue examinations, extra-oral head and neck examination should be performed routinely.

Intra-Oral Examination

Periodontal Examination

Gingival/periodontal disease, specifically linear gingival erythema (LGE) and necrotizing ulcerative periodontitis (NUP), have been associated with HIV infection. There is now evidence that these diseases also occur in HIV-negative immunocompromised individuals and are not specific to HIV infection. The prevalence of these two diseases remains unclear with current estimates of occurrence among HIV-infected individuals in the 5-10% range. There is some evidence that NUP and LGE is associated with a low CD4 count (<200 cells/mm3) and that LGE is caused by candida. Early recognition of periodontal problems allows treatment that can prevent progression of these conditions, including severe attachment/bone loss.

Soft Tissue Examination (including oral cancer screening)

30-80% of HIV-infected adults will present with abnormal HIV-related intra-oral findings.

Many different oral mucosal lesions have been associated with HIV infection including:.

- candidiasis
- cryptococcosis, cryptosporidiosis, and histoplasmosis.
- human papillomavirus may lead to condylomata, warts, or cancer.
- Epstein-Barr virus can lead to oral hairy leukoplakia
- human herpesvirus may develop into Kaposi's sarcoma
- cytomegalovirus may lead to cytomegalovirus oral ulcers.

Hard Tissue Examination

Xerostomia occurs in up to 40% of HIV positive patients, due to the side effect of some ARV medications. The combination of periodontal disease, reduced salivary flow and antibodies increases the likelihood of caries.

Radiographs

As indicated after intra-oral and extra-oral exam is completed but may include full mouth series or panorex, bitewings, periapicals.

Laboratory Values

- At the initial exam a Complete Blood Count (CBC) with differential, CD4 Count, and Viral Load should be obtained
- Frequency of labs is based on individual patients and their treatment needs, but if CD4 >200 every six months or as order by physician and if CD4<200 every 3 months or as ordered by the physician.
- Thrombocytopenia, anemia, and hepatobiliary diseases may occur in the course of HIV disease progression and with opportunistic infections
- Evaluate each patient on a case-by-case basis. Use the above recommendations as general guidelines and not as an absolute, especially when urgent or emergency care is needed.

CD 4 Count

- The normal value for adults is 750 – 1000 cells/mm3.

CD4 count is not a reason to not do dental treatment but instead indicates the immune status of the patient and the risk for certain oral conditions that can affect oral and overall health.

- Patients with values less than 200 cells/mm3 are considered to have advanced immunosuppression.
- CD4‹ 50 – Evaluate patient for severe opportunistic disease. Usually there is no problem with routine dental care. If white count is expected to increase, then you may consider delaying elective dental procedures until white count improves. Emphasize good oral care and have them contact you immediately if oral problems start.

Viral Load

- While the viral load does not indicate the immune status of the patient, it reflects the viral burden in the body and the risk of clinical progression and immunosuppression

The dentist can play an important part in reminding patients of the need for regular follow up and monitoring of these markers.

It is essential for all practitioners to understand that most HIV patients, even if symptomatic, can be treated safely in a typical dental office or clinic.

- The viral load itself does not directly influence dental treatment, but a detectable viral load may indicate to the dentist that the patient is not on an optimized ARV regimen and may benefit from timely follow-up with the primary care provider

Platelet Count

- Normal Value (Normal values: 150,000-450,000 cells/mm3
- ‹60,000-80,000 consider intervention depending of risk of bleeding

White Blood Cells (total)

- Normal Value 4,000-10,000cells/mm^3
- ‹2,000 may want to consider delay of elective procedures and/or use of antibiotic prophylaxis in consultation with physician.

Absolute Neutrophil Counts

- Normal Value
- ‹500 may want to consider delay of elective procedures and/or use of antibiotic prophylaxis in consultation with physician.

Hematocrit (%) (HCT)

- Normal values: female 37-47%, male 42-52%
- <10% consult with physician -consider red cell transfusion for invasive procedures.

Hemoglobin (HGB)

- Normal values: female 12-16q/dL, male 14-18q/dL
- Less than 10 consult with physician -consider red cell transfusion for invasive procedures

Red Blood Cell (RBC)

- Normal values: female 4-5 million/mm3, male 4-6 million/mm3.
- Less than 1.0 million/mm3. Consult with physician - consider red cell transfusion for invasive procedures

Modifications to dental treatment

Antibiotic Prophylaxis

For patients who are living with HIV, there are no data supporting the need for routine antibiotic coverage to prevent bacteremia or septicemia arising from dental procedures. In fact, patients with AIDS have shown a higher incidence of allergic reactions to antibiotics and other medications, so it may endanger the patient's health by over-prescribing antibiotics.

Following invasive dental procedures (that involve manipulation of the gingival tissue, manipulation of the periapical region of teeth, or perforation of the oral mucosa) patients with a compromised immune system may be at risk for complications of bacteremia and distant site infection. The American Dental Association states when "white-blood-cell neutrophil counts <500 cells/mL, [ ]may require antibiotic prophylaxis.[28] However, antibiotic use may predispose patients to adverse drug reactions, superinfection and drug-resistant microorganisms, so antibiotics should be used judiciously, not routinely.[28, 34]" Consultation with the patient's physician is recommended for management of patients with a compromised immune system.

Medications in HIV

Medications may interfere with dental treatment and cause adverse effects, such as decreased salivary flow, altered liver function, and bone marrow suppression, resulting in anemia, thrombocytopenia, and neutropenia. HIV Medicine is a dynamic field and knowledge of ARV medications is constantly evolving. It should be emphasized that long-

term clinical data on drug interactions does not exist for many of the newer medications. It is recommended that the dental care provider consult a reference that thoroughly discusses drug side effects and interactions prior to prescribing any medications or consult with the patient's primary care provider.

For more information on specific ARV medications is available at:

https://medlineplus.gov/hivaidsmedicines.html

http://hivinsite.ucsf.edu/InSite?page=ar-drugs

To look at specific drug-drug interactions, excellent clinical tools include:

http://www.hiv-druginteractions.org

http://hivinsite.ucsf.edu/insite?page=ar-00-02

Medications may interfere with dental treatment and cause adverse effects, such as decreased salivary flow, altered liver function, and bone marrow suppression, resulting in anemia, thrombocytopenia, and neutropenia.

Other Considerations

A pre-treatment antibacterial mouth rinse will reduce intra[illegible] those patients with periodontal disease.

A six-month recall schedule should be instituted to monitor any oral changes. If the patient is severely immunosuppressed (i.e., CD4 count of <100 cells/mm3), a shorter recall period such as a three-month interval should be considered.

Commented [FW2]: I would suggest CD4 <200 to match the rest of the recommendations

Oral hygiene and the use of silver diamine fluoride (SDF) are important in a medically compromised patient. A proactive attitude and an emphasis on prevention should be encouraged. Dental treatment should also be prioritized based on the patient's health and circumstances (e.g. patients without the ability to tolerate long appointments, ability to perform oral hygiene, etc. should be treated with SDF to arrest existing caries and restored with a glass ionomer material when necessary until more definitive treatment can be comfortably and appropriately provided).

Infectious diseases, such as Hepatitis B, Hepatitis C, or Tuberculosis, should be ascertained and preventative protocols followed.

Oral Health Education: Caries Prevention and Smoking

A higher risk of dental caries in patients with HIV may be caused by decreased salivary flow, which may occur because of salivary gland disease or as a side effect of several medications. Also, some topical antifungal medications have high sugar content, possibly resulting in increased susceptibility to caries. In these cases, the frequent application of

fluoride applications of Silver Diamine Fluoride (SDF) several times a year as needed should be considered. The adverse effects of using tobacco should be discussed with the patient. If the patient is a tobacco user, cessation should also be discussed.

For in-office consumer and provider materials on tobacco cessation programs, dentists can access https://smokefree.gov/help-others-quit/health-professionals.

Nutritional Counseling

Because of certain oral conditions, people living with HIV may have difficulty consuming a balanced diet. The patient may suffer from changes in taste and decreased ability to chew and swallow because of drug-induced xerostomia. This can lead to gastrointestinal upset and nausea, further inhibiting the intake of a balanced diet. It is the role of the dentist to recognize oral manifestations, which are associated with nutritional deficiencies that can cause intraoral manifestations such as vitamin B 12, folic acid, etc. Nutritional supplements or referral to the patient's physician or a registered dietitian may be necessary. Some areas to be aware of include:

- Poor oral intake of food or fluid
- Difficulty chewing and swallowing due to continuous mouth sores resulting from candidiasis, herpes simplex, aphthous ulcers, etc.
- Severe dental caries
- Changes in perception of taste or smell
- Patient complaints of economic inability to meet caloric and nutrient needs

Annual Updated Treatment Plan

A comprehensive treatment plan that includes preventive care and maintenance should be developed and discussed with the patient. Various treatment options should be discussed and developed in collaboration with the patient. As with all patients, a treatment plan appropriate for the patient's health status, financial status, and individual preference should be chosen.

Covered Services

Phase 1 treatment includes procedures related to prevention, maintenance, and/or elimination of oral pathology that results from dental caries or periodontal disease. This may include minimally invasive dentistry to include caries control using SDF, restorative treatment, basic periodontal therapy (non-surgical), basic oral surgery that includes simple extractions and biopsy, non- surgical endodontic therapy, and space maintenance

Commented [FW3]: From this section to the end I did not edit because I was not sure if it was language the program required. There is one exception, I removed some of the language around PEP

and tooth eruption guidance for transitional dentition. Dental services that are part of Phase 1 Treatment as indicated as "Primary" in the County of San Diego, Health and Human Services Agency Ryan White Primary Care Medical Care Allowable Dental Services List.

Community and migrant health center oral health programs seek to increase access to oral health care for the underserved. Completing Phase 1 Treatment Plans within twelve months addresses two fundamental areas within these dental programs: 1) the need to perform a comprehensive oral health exam that culminates with an accompanying treatment plan and 2) assuring that quality care is incorporated in the process of completing needed treatment in a timely manner. Completion of the Phase 1 Treatment Plan facilitates the identification of contributing and restricting factors and practical low-cost improvement options relevant to significant areas listed above. With access to codes associated with comprehensive oral exams and Patient Treatment Completion (PTC), most information management systems will be able to provide an average length of time associated with completion of treatment. With this information, staffing patterns, financial costs (overhead expenses) and efficiency of the oral health program can be assessed. These additional benchmarks could also be measured across health center programs at the local, regional, and national levels. The ultimate goal is to measure and assure that health centers routinely and systematically deliver comprehensive, quality oral health services, and patient treatment is completed within a reasonable amount of time.

Completion of Phase 1 Treatment Plan within 12 months is comprehensive in that subsequent performance analysis can broach a number of significant areas, such as: appointment scheduling, ratio of oral health providers to dental operatories, ratio of oral health providers to support staff, collaboration with medical colleagues emphasizing oral health as an essential component of an interdisciplinary approach to patient care, prioritization of patients and/or procedures, general productivity and efficiency.

Additional clarification is available on pages 13-15 of the HAB HIV Oral Health Performance Measures document: https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/oralhealthmeasures.pdf.

Oral health education may be provided and documented by a licensed dentist, dental hygienist, dental assistant and/or dental case manager.

Post-Exposure Prophylaxis (PEP)

Most occupational HIV exposures do not result in the transmission of HIV. There have been no documented reports of transmission from a dentist to a patient. Documentation of the event and assessment of risk remain important. The person who is exposed should be referred immediately to a physician who can provide counseling, testing, and appropriate medications.

Warmline: 800-933-3413

PEPline: 888-448-4911

Perinatal HIV Hotline: 888-448-8765

Discrimination and Legal Issues

Referrals to a specialist or to a hospital setting must always be based on the clinical needs of the patient, not the ignorance or fear of the dentist, staff, or other patients. The legal obligation of the dental provider is to refer patients for testing and follow-up.

It is a violation of the Americans with Disabilities Act, California law, and the law of some local jurisdictions, and of the ethical standards of the California Dental Association and the American Dental Association to refuse to care for patients with HIV because of fear of the risk of infection.

Privacy

Many patients are reluctant to disclose HIV status to the dentist because they fear discrimination, even when they understand that full disclosure is essential for providing the best possible care.

- Dentists **must** establish an atmosphere in which patients feel comfortable in disclosing their status by indicating on the medical intake form that patients are not discriminated against on the basis of disability, and that all medical information disclosed is confidential.
- Dentists are responsible for training staff to ensure that all patient information is kept confidential and is in accordance with all state laws and the Health Insurance Portability and Accountability Act (HIPAA).

- A thorough discussion of HIV privacy law, including practice tips for protectingthe privacy of dental records, can be found in the Schulman article in the Journal of the California Dental Association: https://pubmed.ncbi.nlm.nih.gov/7508498/
- HIPAA guidelines are found at https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/index.html.
- Dentists should also refer to information available from the California Department of Health Services, Office of AIDS at https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAmain.aspx.
- In the state of California, written consent of the patient is not required for exchange of treatment-related information between health care providers, as long as that information is obtained for the patient's benefit. However, many medical and dental offices are reluctant to provide lab data over the phone because of the especially sensitive nature of the information. You can more easily obtain medical information related to patient treatment if you offer to fax or mail a consent form.

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Selected Websites for HIV/AIDS Information

Commented [FW4]: I removed non-working links

Sites of Particular Interest to Dentists

American Dental Association
https://www.ada.org/en

HIVdent
http://www.hivdent.org/

National Institute of Dental & Craniofacial Research
http://www.nidcr.nih.gov/

Pacific AIDS Education and Training Center
http://paetc.org/

American Nursing Association Safe Needles Save Lives
https://www.nursingworld.org/practice-policy/work-environment/health-safety/safe-needles/safe-needles-law/

Other Helpful Links

Morbidity and Mortality Weekly Report (CDC)
http://www.cdc.gov/mmwr/

The Body - A Multimedia AIDS & HIV Information Resource

http://www.thebody.com/index.shtml

National HIV/AIDS Clinicians' Consultation Center (Warmline and PEP line)
http://www.nccc.ucsf.edu/

L.A. Public Health Organization: AIDS Info
http://publichealth.lacounty.gov/dhsp/

American Medical Association
http://www.ama-assn.org/

County of San Diego HIV/AIDS Reporting
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/hiv_aids_epidemiology_unit/reporting.html

SERVICE STANDARDS FOR ORAL HEALTH CARE SERVICES

LOS ANGELES COUNTY
COMMISSION ON HIV

APPROVED BY THE COH ON 04/13/23

IMPORTANT: The service standards for Oral Health Care Services adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:

Human Resource Services Administration (HRSA) HIV/AIDS Bureau (HAB) Policy Clarification Notice (PCN) # 16-02 *(Revised 10/22/18)*: Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds

HRSA HAB, Division of Metropolitan HIV/AIDS Programs: National Monitoring Standards for Ryan White Part A Grantees: Program – Part A

Service Standards: Ryan White HIV/AIDS Programs

INTRODUCTION

Service standards for the Ryan White HIV/AIDS Part A Program (RWHAP) outline the elements and expectations a service provider should follow when implementing a specific service category. The standards are written for providers for guidance on what services may be offered when developing their Ryan White Part A programs. The standards set the minimum level of care Ryan White-funded agencies offer to clients, however, providers are encouraged to exceed these standards. The Los Angeles County Commission on HIV (COH) developed Oral Health Care Services standards to establish the minimum services necessary to provide oral health care services to people living with HIV. The development of the standards includes guidance from service providers, people living with HIV, the Los Angeles County Department of Public Health Division of HIV and STD Programs (DHSP), members of the Los Angeles County COH Standards and Best Practices Committee (SBP), caucuses, and the public-at-large.

SERVICE DESCRIPTION

Oral health care services are an integral part of primary medical care for all people living with HIV. Most HIV infected patients can receive routine, comprehensive oral health care in the same manner as any other person. All treatment will be administered according to published research and available standards of care. In addition, the COH developed a Dental Implants addendum to provide specific service delivery guidance to Ryan White Part A-funded agencies regarding the provision of dental implants. For more information, see the Oral Health Care Service Standard Addendum.

Service shall include (but not limited to):

- Routine dental care and oral health education and counseling
- Obtaining a comprehensive medical and oral hygiene history and consulting primary medical providers as necessary
- Providing educational, prophylactic, diagnostic and therapeutic dental services to patients with a written confirmation of HIV status

- Providing medication appropriate to oral health care services, including all currently approved drugs for HIV-related oral manifestations
- Providing or referring patients, as needed, to health specialists including, but not limited to, periodontists, prosthodontists, endodontists, oral surgeons, oral pathologists, oral medicine practitioners and registered dietitians
- Maintaining individual patient dental records in accordance with current standards
- Complying with infection control guidelines and procedures established by the California Occupation Safety and Health Administration (Cal-OSHA)

The following are priorities for HIV oral health treatment:

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

Recurring themes in this standard include:

- Good oral health is an important factor in the overall health management of people living with HIV.
- Treatment modifications should only be used when a patient's health status demands them.
- Comprehensive evaluation is a critical component of appropriate oral health care services.
- Treatment plans should be made in conjunction with the patient.
- Collaboration with primary medical providers is necessary to provide comprehensive dental treatment.
- Prevention and early detection should be emphasized.

GENERAL CONSIDERATIONS: **There is no justification to deny or modify dental treatment based on the fact that a patient has tested positive for HIV**. Further, the magnitude of the viral load is not an indicator to withhold dental treatment for the patient. If, however, a patient's medical condition is compromised, treatment adjustments, as with any medically compromised patient, may be necessary.

SERVICE/ORGANIZATIONAL LICENSURE CATEGORY

HIV/AIDS oral health care services shall be provided by dental care professionals who have applicable professional degrees and current California State licenses. Dental staff can include dentists, dental assistants, dental assistants in extended functions, dental hygienists, and dental hygienists in extended practice. Clinical supervision shall be performed by a licensed dentist responsible for all clinical operations.

Dentists: A dentist must complete a four-year dental program and possess a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) degree. Additionally, dentists must pass a

three-part examination as well as the California jurisprudence exam and a professional ethics exam. Dentists are regulated by the California Dental Board (please see Dental Board of California for further information).

Registered Dental Assistants (RDA): RDAs must possess a diploma or certificate in dental assisting from an educational program approved by the California Dental Board, or 18 months of satisfactory work experience as a dental assistant. RDAs are regulated by the California Dental Board (please see Dental Board of California for further information).

Unlicensed Dental Assistants (DA): Unlicensed dental assistants are not licensed by the Dental Board of California, but they are subject to certain laws governing their conduct. Section 150.1 is the statute governing the duties that unlicensed dental assistants are allowed to perform. Unless a specific duty is listed in that regulations, the dental assistant is NOT allowed to perform that duty. A dental assistant may only expose radiographs after successful completion of a board-approved radiation safety course. Dental assistants with certain experience or educational backgrounds may qualify to apply for Registered Dental Assistant (RDA) licensure.

Registered Dental Assistants in Extended Functions (RDAEF)[1]: RDAEF holds a current licensure as a Registered Dental Assistant or has completed the requirements for licensure as a RDA, completed a Board-approved course in the application of Pit & Fissure Sealants, completed a Board-approved RDAEF program, passed a written examination administered by the Board, and submitted fingerprint clearances from both the Department of Justice and the Federal Bureau of Investigation. RDAEFs are regulated by the California Dental Board (please see Dental Board of California for further information).

Registered Dental Hygienists (RDH): RDHs must have been granted a diploma or certificate in dental hygiene from an approved dental hygiene educational program. RDHs are regulated by the California Dental Board (please see Dental Board of California for further information).

Registered Dental Hygienists in Extended Functions (RDHEF)[2]: RDHEF holds a current license as a registered dental hygienist in California, completed clinical training approved by the dental hygiene board in a facility affiliated with a dental school under the direct supervision of the dental school faculty, performed satisfactorily on an examination required by the dental hygiene board, and completed an application form and paid all application fees required by the dental hygiene board. RDHEF are regulated by the California Dental Board (please see Dental Board of California for further information).

[1] Registered Dental Assistant in Extended Functions Applicants - Dental Board of California
[2] Codes Display Text (ca.gov)

SERVICE STANDARDS

All contractors must meet the Universal Standards of Care approved by the COH in addition to the following Oral Health Care Services standards. The Universal Standards of Care can be accessed at: https://hiv.lacounty.gov/service-standards

SERVICE COMPONENT	STANDARD	DOCUMENTATION
INTAKE	Intake process will begin during first contact with client.	Intake took in client file to include (at minimum): • Documentation of HIV status • Proof of LA County residency • Verification of financial eligibility • Date of intake • Client name, home address, mailing address and telephone number • Emergency and/or next of kin contact name, home address and telephone number
	Confidentiality Policy and Release of Information will be discussed and completed.	Release of Information signed and dated by client on file and updated annually.
	Consent for Services will be completed.	Signed and dated Consent in client file.
	Client will be informed of Rights and Responsibilities and the Division on HIV and STD Programs (DHSP) Customer Support Program[3].	Signed, dated forms in client file.
EVALUATION When presenting for dental services, people living with HIV should be given a comprehensive oral evaluation. When indicated,	A comprehensive oral evaluation will be given to patients living with HIV and will include: • Documentation of patient's presenting complaint • Caries charting	Signed, dated evaluation on file in patient chart.

[3] The program aims to assist consumers of HIV and STD services who have experienced difficult accessing services from DHSP-funded providers throughout Los Angeles County.

diagnostic tests relevant to the evaluation of the patient should be performed and used in diagnosis and treatment planning. In addition, full medical status information from the patient's medical provider, including most recent lab work results, should be obtained, and considered by the dentist	• Radiographs or panoramic and bitewings and selected periapical films • Complete periodontal exam or PSR (Periodontal Screening Record) • Comprehensive head and neck exam • Complete intra-oral exam, including evaluation for HIV-associated lesions • Pain assessment	
	As indicated, diagnostic tests relevant to the evaluation will be used in diagnosis and treatment planning. Biopsies of suspicious oral lesions will be taken.	Signed, dated evaluation in patient chart to detail additional tests.
	Full medical status information will be obtained from the patient's medical provider and considered in the evaluation. The medical history and current medication list will be updated regularly to ensure all medical and treatment changes are noted.	Signed, dated evaluation in patient chart to detail medical status information.
	Obtain a thorough medical, dental, and psychosocial history to assess the patient's oral hygiene habits and periodontal stability and determine the patient's capacity to achieve dental implant success and the possibility of dental implant failure.	Client Chart/Treatment Plan/Provider Progress Notes
	Clinician, after patient assessment, will make necessary referrals to specialty programs including, but not limited to smoking cessation programs; substance use	

	treatment; medical nutritional therapy, thereby increasing patients' success rate for receiving dental implants.	
	The clinicians referring patients to specialty Oral Healthcare services will complete a referral form, educate the patient, and discuss treatment plan alternatives with patient.	
TREATMENT PLANNING In conjunction with the patient, each dental provider shall develop a comprehensive, multidisciplinary treatment plan. The patient's primary reason for the visit should be considered by the dental professional when developing the dental treatment plan. Treatment priority should be given to the management of pain, infection, traumatic injury, or other emergency conditions. Dental provider will support and reinforce patient understanding, agreement, and education in the patient's treatment plan. Ensure patient understanding that dental implants are for medical necessity (as determined by the dental provider through assessments and evaluation) and would lead to improved HIV health outcomes. Reinforce that Ryan White	A comprehensive, multidisciplinary treatment plan will be developed in conjunction with the patient.	Treatment plan dated and signed by both the provider and patient in patient file.
	Patient's primary reason for dental visit should be addressed in treatment plan.	Treatment plan dated and signed by both the provider and patient in the patient file to detail.
	Patient strengths and limitations will be considered in development of treatment plan.	Treatment plan dated and signed by both the provider and patient in patient file to detail.
	Treatment priority will be given to pain management, infection, traumatic injury, or other emergency conditions.	Treatment plan dated and signed by both the provider and patient in patient file to detail.
	Treatment plan will include consideration of the following factors: • Tooth and/or tissue supported prosthetic options • Fixed protheses, removable prostheses or combination • Soft and hard tissue characteristics and morphology, ridge relationships, occlusion and occlusal forces, aesthetics, and parafunctional habits • Restorative implications, endodontic status, tooth	Treatment plan dated and signed by both the provider and patient in file to detail.

funds cannot be used to provide dental implants for cosmetic purposes.	position and periodontal prognosis • Craniofacial, musculoskeletal relationships	
	Six-month recall schedule will be used to monitor any changes. A three-month recall schedule may be considered to limit disease progression and maintain healthy periodontal tissues in advanced cases of periodontitis or caries.	Signed, dated progress note in patient file to detail.
	Treatment plans will be updated as deemed necessary.	Signed, dated progress note in patient file to detail.
	The receiving clinician will review the referral, consider the patient's medical, dental, and psychosocial history to determine treatment plan options that offer the patient the most successful outcome based on published literature. The clinician will discuss with patient dental implant options with the goal of achieving optimal health outcomes.	Referral in Client Chart/Treatment Plan/Provider Progress Notes
	The clinician will consider the patient's perspective in deciding which treatment plan to use.	Client Chart/Treatment Plan/Provider Progress Notes
	The clinician will discuss treatment plan alternatives with the patient and collaborate with the patient to determine their treatment plan.	
	The clinician and the patient will revisit the treatment plan periodically to determine if any adjustments are necessary to achieve the treatment goal.	

	The clinician will educate patients on how to maintain dental implants and the importance of routine care.	
INFORMED CONSENT Patients will sign an informed consent document for all dental procedures. This informed consent process will be ongoing as indicated by the dental treatment plan.	As part of the informed consent process, dental professionals will provide the following before obtaining consent: • Diagnostic information • Recommended treatment • Alternative treatment • Benefits and risks of treatment • Limitations of treatment	Signed, dated progress note or informed consent in patient field to detail.
	Dental providers will describe all options for dental treatment and allow the patient to be part of the decision-making process.	Signed, dated progress note or informed consent in client file to detail.
	After the informed consent discussion, patients will sign an informed consent for all dental procedures.	Signed, dated informed consent in client file.
	This informed consent process will be ongoing as indicated by the dental treatment plan.	Ongoing signed, dated informed consents in client file (as needed).
MEDICAL CONSULTATION AND PRIMARY CARE PARTICIPATION Dentists can play an important part in reminding patients of the need for regular primary medical care and CBC, CD4, viral load tests every three to six months depending on the past history of HIV infection and level of suppression achieved and encouraging patients to adhere to their medication	Primary care physicians will be consulted when providing dental treatment.	Signed, dated progress note to detail consultations.
	Primary care physicians will be consulted when providing dental treatment depending on the medical needs of the patient. Consultation with medical providers will be: • To obtain the necessary laboratory test results • When there is any doubt about the accuracy of the information provided by the patient	Signed, dated progress note to detail consultations.

regimens. However, even the highest number of viral copies has no impact on the provision of dental care. If a patient is not under the regular care of a primary care physician, the patient should be urged to seek care and a referral to primary care will be made.	• When there is a change in the patient's general health, determine the severity of the condition and the need for treatment modifications • If after evaluating the patient's medical history and the laboratory tests, the oral health provider decides that treatment should occur in a hospital setting • New medications are indicated to ensure medication safety and prevent drug/drug interactions • Oral opportunistic infections are presents	
	Dentists will encourage consistent medical care in their patients and provide referrals as necessary. Under certain circumstances, dental professionals may require further medical information to determine safety and appropriateness of care.	Signed, dated progress notes to detail referrals and discussion.
	Programs may decide to discontinue oral health services if a client has not engaged in primary medical care. Patients will be made aware of this policy at time of intake into the program.	Signed, dated progress notes to detail referrals and discussion. Policy on file at provider agency. Intake materials will also state this policy.
	Under certain circumstances, dental professionals may require further medical information to determine safety and appropriateness of care.	Signed, dated progress notes to detail discussion.

PREVENTION/EARLY INTERVENTION Dental professionals will emphasize prevention and early detection of oral disease by educating patients about preventive oral health practices, including instruction in oral hygiene. In addition, dental professionals may provide counseling regarding behaviors (e.g., tobacco use, unprotected oral sex, body piercing in oral structures) and general health conditions that can compromise oral health. The impact of good nutrition on preserving good oral health should be discussed.	Dental professionals will educate patients about preventive oral health practices.	Signed, dated progress note in patient file to detail education efforts.
	Routine examinations and regular prophylaxis will be scheduled twice a year.	Signed, dated progress note or treatment plan in patient file to detail schedule.
	Dental professionals will provide basic nutritional counseling to assist in oral health maintenance. Referrals to an RD and others will be made, as needed.	Signed, dated progress note to detail nutrition discussion and referrals made.
	Root planing/scaling will be offered as necessary, either directly or by referral.	Signed, dated progress note or treatment plan in patient file to detail.
SPECIAL TREATMENT CONSIDERATIONS	As indicated, the following modifications to standard dental treatment should be considered: • Bleeding tendencies may determine whether or not to recommend full mouth scaling and root planning or multiple extractions in one visit. • In severe cases, patients may be treated more sagely in a hospital environment where blood transfusions are available. • Deep block injections should be avoided in patients with bleeding tendencies. • A pre-treatment antibacterial mouth rinse should be used for those	Signed, dated process note or treatment plan in patient file to detail treatment modifications and referrals.

	patients with periodontal disease. • Patients with salivary hypofunction should be closely monitored for caries, periodontitis, soft tissue lesions and salivary gland disease. • Fluoride supplements should be prescribed for those with increase caries and salivary hypofunction. Referral to dental professional experiences in oral mucosal and salivary gland diseases should be made in severe cases of xerostomia.	
	Routine examinations and regularly prophylaxis will be scheduled twice a year.	Signed, dated progress note or treatment plan in patient file to detail scheduled.
	Root planning/scaling will be offered as necessary, either directly or by referral.	Signed, dated progress note or treatment plan in patient file to detail.
TRIAGE, REFERRAL, COORDINATION On occasion, patients will require a higher level of oral health treatment services than a given agency is able to provide. Coordinating oral health care with primary care medical providers is vital. Regular contact with a client's primary care clinic will ensure integration of services and better client care. Train referring dental providers on how to adequately complete referral	As needed, dental providers will refer patients to full range of oral health care providers, including: • Periodontists • Endodontists • Prosthodontists • Oral surgeons • Oral pathologists • Oral medicine practitioners	Signed, dated progress note to document referrals in patient chart.
	Providers will attempt to contact a client's primary care clinic if required or as clinically indicated to coordinate and integrate care.	Documentation of contact with primary medical clinics and providers to be placed in progress notes. In

forms to allow more flexibility in treatment planning for receiving specialty dental providers.		
OUTREACH Programs providing dental care for people living with HIV will actively promote their services through known linkages and direct outreach.	Programs will promote dental services for people living with HIV through linkages or outreach.	Service promotion/outreach plan on file at provider agency.
CLIENT RETENTION	Programs shall develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
	Programs shall provide regular follow-up procedures to encourage and help maintain a client in oral health treatment services.	Documentation of attempts to contact in signed, dated progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact • Text messaging
STAFFING REQUIREMENTS AND QUALIFICATIONS	Provider will ensure that all staff providing oral health care services will possess applicable professional degrees and current California state licenses.	Documentation of professional degrees and licenses on file.
	Providers shall be trained and oriented before providing oral health care services both in general dentistry and HIV specific oral health services. Training will include: • Basic HIV information • Office and policy orientation • Infection control and sterilization techniques	Training documentation on file maintained in personnel record.

	• Methods of initial evaluation of the patient living with HIV disease • Health maintenance education and counseling • Recognition and treatment of common oral manifestations and complications of HIV disease • Recognition of oral signs and symptoms of advanced HIV disease	
	Oral health care providers will practice according to California state law and the ethical codes of their respective professional organizations.	Chart review will ensure legally and ethically appropriate practice.
	Dentist in charge of dental operations shall provide clinical supervision to dental staff.	Documentation of supervision on file.
	Dental care staff will complete documentation required by program.	Periodic chart review to confirm.
	Providers will seek continuing education about HIV disease and associated oral health treatment considerations.	Documentation of trainings in employee file.

ACRONYMS

AIDS *Acquired Immune Deficiency Syndrome*
CAL-OSHA *California Occupation Safety and Health Administration*
CD4 *Cluster Designation 4*
DDS *Doctor of Dental Surgery*
DHSP *Division of HIV and STD Programs*
HBV *Hepatitis B Virus*
HIPAA *Health Insurance Portability and Accountability Act*
HIV *Human Immunodeficiency Virus*
RDA *Registered Dental Assistant*
RDAEF *Registered Dental Assistant in Extended Functions*
RDH *Registered Dental Hygienists*
RDHEF *Registered Dental Hygienist in Extended Functions*
STI *Sexually Transmitted Infection*

DEFINITIONS AND DESCRIPTIONS

Client registration and intake is the process that determines a person's eligibility for oral services.

Oral prophylaxis is a preventive dental procedure that includes the complete removal of calculus, soft deposits, plaque, and stains from the coronal portions of the tooth. This treatment enables a patient to maintain healthy hard and soft tissues.

Direct supervision is supervision of dental procedures based on instructions given by a licensed dentist who must be physically present in the treatment facility during performance of those procedures.

General supervision is the supervision of dental procedures based on instructions given by a licensed dentist, but not requiring the physical presence of the supervising dentist during the performance of those procedures.

Basic supportive dental procedures are the fundamental duties or functions which may be performed by an unlicensed dental assistant under the supervision of a licensed dentist because of their technically elementary characteristics, complete reversibility, and inability to precipitate potentially hazardous conditions for the patient being treated.

Standard precautions are an approach to infection control that integrates and expands the elements of universal precautions (human blood and certain human body fluids treated as if known to be infectious for HIV, Hepatitis B Virus (HBV) and other blood-borne pathogens). Standard precautions apply to contact with all body fluids, secretions, and excretions (except for sweat), regardless of whether they contain blood, and to contact with non-intact skin and mucous membranes.

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Pacific Protocols for the Dental Management of Patients with HIV Disease

This Protocol was redesigned and supplemented January 2007 by:

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I. Medical Assessment of HIV Infected Patients:

Medical assessment HIV infected patients, relative to their safe dental treatment, is primarily based upon current laboratory test values.

"Significant Laboratory Tests" are listed below, along with their relevance to the patient's health.

"Critical Laboratory Test Values", the values at which a change in dental management is appropriate, is listed in the next section.

The "Frequency of Laboratory Tests" is also outlined and is primarily dependent on the patient's CD4 T-helper cell count.

If you feel the patient needs a more through medical evaluation, then they should be referred to their physician. Such an evaluation/physician consult is seldom necessary relative to dental treatment planning. Appropriate and timely laboratory tests, along with a current health history, are almost always adequate to identify any problems and safely manage the patient.

Significant Laboratory Tests

The laboratory tests listed below provide important information relative to the HIV infected patient's overall health. All, except CD4 and viral load, can be gotten by ordering a "Complete Blood Count (CBC) with a differential").
The next section "Critical Laboratory Test Values," outlines their impact on dental management.

CD4, T-helper Cell Count

Measures the number of T-helper cells. These cells stimulate the immune system to fight infections. As their numbers go down, the risk of infection goes up.

CD4 – CD8 ratios

CD4 cells, as mentioned above, are T-helper cells. CD8 cells are T-suppressor cells. As this ratio goes down, essentially by a decrease in the number of CD 4 cells, the risk of infection goes up.

Viral load/Plasma HIV-1RNA

This measurement reveals the number of copies of the virus per milliliter of blood. Ideally, there would be zero detectable copies (virus). As the viral load goes up, indicating the virus is replicating at an increasing rate, the incidence of secondary problems increases. However, even the highest number of copies has no impact on the provision of dental care.

CBC with differential

Platelets: Platelets are necessary, along with other factors, for blood to clot. An important concern in HIV-infected patients is low platelets (thrombocytopenia) (see critical laboratory test values). If this occurs the risk of bleeding may be so severe as to delay any elective and, at times, even emergency therapy, until the platelets can be replaced.

White count: The white cells in the body are designed to do a variety of things including fight infections. As the white count decreases (leukopenia), the risk of infection increases.

Absolute neutrophils: The neutrophils are a special class of white cells which are also important in fighting infection. If their numbers decrease, the risk of infection increases.

Hematocrit: The hematocrit is the percentage of whole blood that is red cells. In most cases of anemia the hematocrit will decrease.

Hemoglobin: Hemoglobin is the oxygen carrying component of the red blood cells. In certain types of anemia it is possible to have an adequate number of red blood cells, but inadequate amount of hemoglobin and, therefore, a decreased capacity for the blood to carry oxygen.

Red Blood Cell Count: Red blood cell count measures the number of red blood cells per cubic mm of blood. A decrease in number means an inadequate number of red blood cells (anemia). This leads to an inadequate ability to carry oxygen. The patient becomes easily fatigued and is a poor healer. A low red blood cell count is usually reflected in a low hematocrit.

Critical Laboratory Test Values

These lab test values represent critical information relative to dental management. All, except CD4 and viral load, can be gotten by ordering a "Complete Blood Count (CBC) with a differential").

White Blood Count (total)

Less than 2,000 (Granulocytopenia) (Normal values: 4,000-10,000 cells/mm^3). Low counts are a cause for concern because the body becomes more susceptible to infection. Consider a therapeutic regimen of antibiotics concurrently with invasive procedures or delay elective dental procedures until white count improves.

Absolute Neutrophils

Less than 1,000 (Neutropenia) – Consider therapeutic regimen of antibiotics concurrently with invasive procedures. Delay elective dental procedures until white count improves.

Platelets

Less than 60,000 (Thrombocytopenia) (Normal values: 150,000-450,000 cells/mm^3) Consult with physician and recommend intervention to boost platelets prior to invasive procedures. Physician may elect to give platelet infusion or administer prednisone to increase platelet count. The dentist must receive laboratory confirmation of platelet count immediately (1-2 days) before invasive procedure. Delay elective dental procedures until platelet count improves. Platelet count should be above 60-80,000, depending on invasiveness (risk of bleeding) and extent of planned procedure.

Hematocrit (%) (HCT)

Less than 10% – Consult with physician (Normal values: female 37-47%, male 42-52%) – consider red cell transfusion, at the recommendation of the physician, for invasive procedures. Low values are an indicator of anemia.

Hemoglobin (HGB)

Less than 10 (Normal values: female 12-16q/dL, male 14-18q/dL) – consult with physician – consider red cell transfusion, at the recommendation of the physician, for invasive procedures.

Red Blood Cell (RBC)

Less than 1.0 million/mm^3. (Normal values: female 4-5 million/mm^3, male 4-6 million/mm^3). Consult with physician - consider red cell transfusion at the recommendation of a physician, for invasive procedures. Low values are an indicator of anemia.

CD4 T-Lymphocytes (Helper cells) (absolute)

Less than 50 (normal values 590-1120 cells/mm) – Evaluate patient for severe opportunistic disease. Usually there is no problem with routine dental care. If white count is expected to increase, then you may consider delaying elective dental procedures until white count improves.
Emphasize good oral care and have them contact you immediately if oral problems start.

Viral Load

As noted, viral load does not have an impact on dental treatment planning. The number of viral copies is indicative of disease, but any modification of dental treatment would be based on the other above laboratory test results and not on the viral load.

Suggested Frequency of Obtaining Lab Reports

Laboratory tests are important to monitor the patient's health. The suggested frequency of tests is listed below and is based on the patient's prior CD4 test results. Current laboratory test results are very important for some dental procedures, for example those associated with significant bleeding or dental infection. At the same time, clinical judgment is appropriate; most dental procedures should not be delayed just because the laboratory results are older than ideal.

CD4 Above 200

Obtain a lab report minimally every 6 months, or as performed by primary care physician.

CD4 Less than 200

Obtain a lab report minimally every 3 months, or as performed by primary care physician.

Any CD4 count – all patients

Inform all patients that you would like to be sent a copy of their laboratory reports any time a test is done, in order to keep their dental records current. Doing so will insure that no unknown medical problems will impact their dental care and will help in keeping their dental care progressing smoothly.

Use good clinical judgment

Evaluate each patient on a case-by-case basis. Use the above recommendations as general guidelines. Proper and timely patient care, especially urgent care, may require flexibility with critical values. Keep current on your patient's medical care and antiretroviral therapy. Your knowledge of their medical status, just like your knowledge of all of your patients' medical status, will insure their safest and most efficient dental care.

II. Suggested Drug Management of Common Oral Conditions

Oral Candidiasis (erythematous, pseudomembraneous, hyperplastic)

Rx Mycelex troche, 10 mg (clotrimazole)
Disp: (70) seventy tabs
Sig: Dissolve one tab in mouth 5 times a day

For resistant cases, use systemic antifungal

Rx Nizoral, 200 mg (ketoconazole)
Disp: (28) twenty-eight
Sig: Take one tab per day
Refill x 2

or

Rx Diflucan, 200 mg (fluconazole)
Disp: (28) twenty-eight
Sig: Take one tab per day

Angular Cheilitis

Rx Mycolog cream
Disp: (15) fifteen grams
Sig: Apply to corners of mouth 4 times a day

Note: Consider antifungal therapy when the patient is recommended for antibiotic treatment.

Herpes Simplex Virus (HSV)

Rx Valacyclovir 500 (Valtrex®)
Disp: (28) twenty-eight
Sig: Take 1 tablet two times per day

Rx Acyclovir, 200 mg (Zovirax)
Disp: (70) seventy tabs
Sig: Two tabs three times per day

Herpes Zoster Virus (HZV)

Rx Acyclovir, 200 mg
Disp: (140) one hundred forty tabs
Sig: Two tabs every 3 hours for up to 10 tabs/day

Recurrent Aphthous Ulceration (RAU)

Mild - (few lesions present in accessible area of mouth)

Rx Lidex ointment in Orabase, 50:50
Disp: (30) thirty gms
Sig: Apply to oral lesions 4-6 times a day

Moderate to Severe – (or for lesions in inaccessible areas such as tonsillar pillars, soft palate, or oropharynx regions)

Rx Dexamethasone elixir, .5 mg/5ml
Disp: 200 ml
Sig: Rinse and gargle with ½ oz 4-6 times a day

In some cases of very severe or persistent RAU consider systemic prednisone. This should be done only in consultation with patient's physician. In fact you may recommend systemic prednisone therapy as the treatment and the physician will do the prescribing and managing.

Rx Prednisone 5 mg
Disp: 87
Sig: Take 4 tabs a.m., 4 at noon for 7 days, then reduce dose by 1 t ablet a day over next 7 days until O

Rx Solumedrol dose pack
Disp: 1
Sig: Take as directed on package

HIV- Related Periodontal Diseases:

HIV-Gingivitis (Marginal Gingival Erythema)

Rx Chlorhexidine Gluconate, .12% (Perio Gard) or (Peridex)
Disp: 16 oz
Rinse with ½ oz twice a day

HIV-Acute Necrotizing Ulcerative Gingivitis (ANUG), or Necrotizing Ulcerative Periodontitis (NUP) (formerly HIVPeriodontitis)

Rx Metronidazole, 500 mg
Disp: (21) twenty-one tabs
Sig: One tab three times a day

Rx Augmentin, 500 mg
Disp: (24) twenty four
Sig: One tab three times a day

or
For severe or resistant cases

Rx Clindamycin, 300 mg
Disp: (21) twenty one tabs\
Sig: One tab three times a day

Palliative Treatment for Oral Lesions

Rx Xylocaine 2% viscous
Disp: 45 ml
Sig: Rinse with two teaspoons as needed for pain

Rx Baking soda and hydrogen peroxide
1 teaspoon baking soda in cup of solution that is ½ water and ½ 3% hydrogen peroxide.

Useful Internet Resources:

www.hivdent.org/main The best overall site for HIV dental care information.
www.critpath.org/daac/standards.html Learning modules for all aspects of HIV dental care.

We would like to acknowledge the assistance of Mr. Luis Rodriques and Dr. Ruijuian Zhang, in the preparation of these guideline revisions.

We would also like to acknowledge the contributions of Dr. Gene Gowdey relative to the inception of the guidelines and the Pacific HIV CARE Program.

County of San Diego Monthly STD Report

Volume 17, Issue 4: Data through November 2024; Report released May 1, 2025.

Table 1. STDs Reported Among County of San Diego Residents, by Month and Previous 12 Months Combined.

	2023		2024	
	November	Previous 12-Month Period*	November	Previous 12-Month Period*
Chlamydia	1308	17625	1259	16192
Female age 18-25	377	5705	424	5377
Female age ≤ 17	68	622	44	565
Male rectal chlamydia	107	1714	75	1235
Gonorrhea	507	6524	482	6140
Female age 18-25	48	746	43	581
Female age ≤ 17	8	92	11	83
Male rectal gonorrhea	134	1513	117	1465
Early Syphilis (adult total)	75	1043	31	566
Primary	9	163	4	86
Secondary	26	307	13	152
Early latent	40	573	14	328
Congenital syphilis	2	38	3	28

* Cumulative case count of the previous 12 months.

Table 2. Selected STD Cases and Annualized Rates per 100,000 Population for San Diego County by Age and Race/Ethnicity, Year-to-Date.

	All Races*		Asian/PI		Black		Hispanic		White	
	cases	*rate*	*cases*	*rate*	*cases*	*rate*	*cases*	*rate*	*cases*	*rate*
All ages										
Chlamydia	14977	496.5	451	117.9	606	428.0	1616	154.1	1974	151.2
Gonorrhea	5633	186.8	217	56.7	363	256.4	1120	342.0	1211	92.8
Early Syphilis	514	17.0	28	7.3	52	36.7	231	22.0	146	11.2
Under 20 yrs										
Chlamydia	2240	298.0	36	45.3	91	262.3	222	67.8	321	123.2
Gonorrhea	373	49.6	5	6.3	29	83.6	65	19.8	47	18.0
Early Syphilis	18	2.4	1	1.3	2	5.8	9	2.7	2	0.8

Note: Rates are calculated using 2023 Population Estimates; County of San Diego, Health and Human Services Agency, Public Health Services Division, Community Health Statistics Unit. 01/2025.

* Includes cases designated as "other," "unknown," or missing race/ethnicity.

Note: All data are provisional. *Case counts are based on the earliest of date of diagnosis, date of specimen collection, and treatment date. Totals for past months might change because of delays in reporting from labs and providers.*

Figure 1. Chlamydia and Gonorrhea Reported Among County of San Diego Residents, by 3-Month Period.

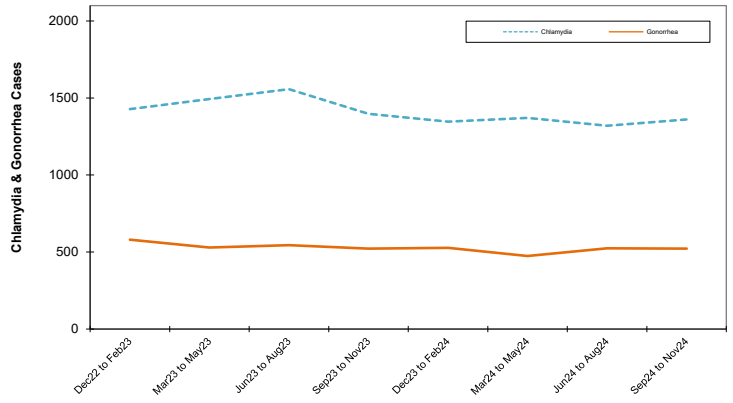
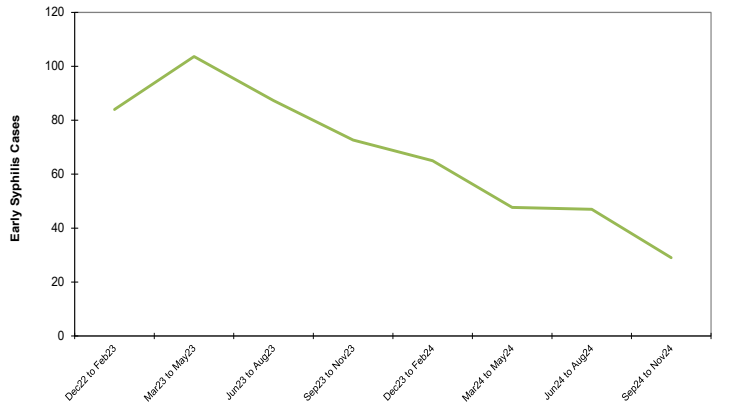


Figure 2. Early Syphilis Reported Among County of San Diego Residents, by 3-Month Period.



Editorial Note: 2023 Sexually Transmitted Infection Surveillance Data Now Available

From 2022 to 2023, reported cases and rates of early syphilis (i.e., primary, secondary, and early latent syphilis), gonorrhea, and chlamydia decreased in San Diego County, while reported cases and rates of congenital syphilis and total syphilis (including late latent syphilis and syphilis of unknown duration) increased (**Figure 3 and Figure 4**). Among congenital syphilis cases, two stillbirths and one infant death were reported. 2023 sexually transmitted infection (STI) surveillance data slides are now available at http://www.stdsandiego.org by clicking on the "Reports and Statistics" tab. Key observed trends include:

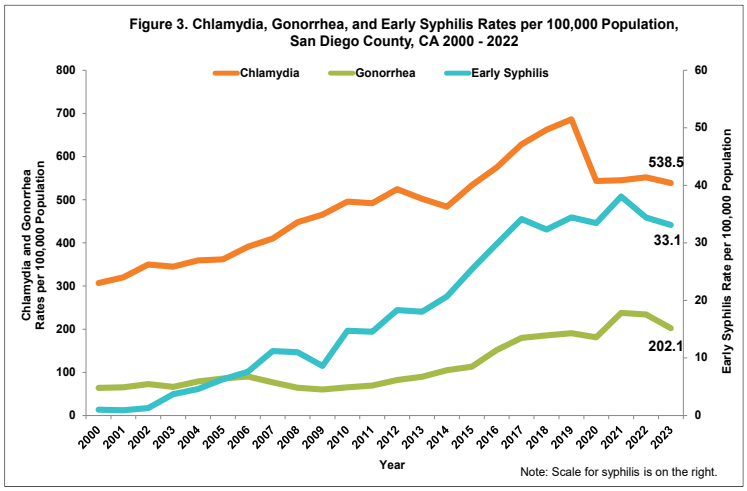
- 36 cases of congenital syphilis, with a rate of 95.0 cases per 100,000 live births (an 8.2% rate increase from 2022)
- 2,431 cases of syphilis of any stage, with a rate of 73.9 cases per 100,000 population (a 13.7% rate increase from 2022)
- 1,089 cases of early syphilis, with a rate of 33.1 cases per 100,000 population (a 3.8% rate decrease from 2022)
- 6,651 cases of gonorrhea, with a rate of 202.1 cases per 100,000 population (a 13.7% rate decrease from 2022)
- 17,720 cases of chlamydia, with a rate of 538.5 cases per 100,000 population (a 2.4% rate decrease from 2022)

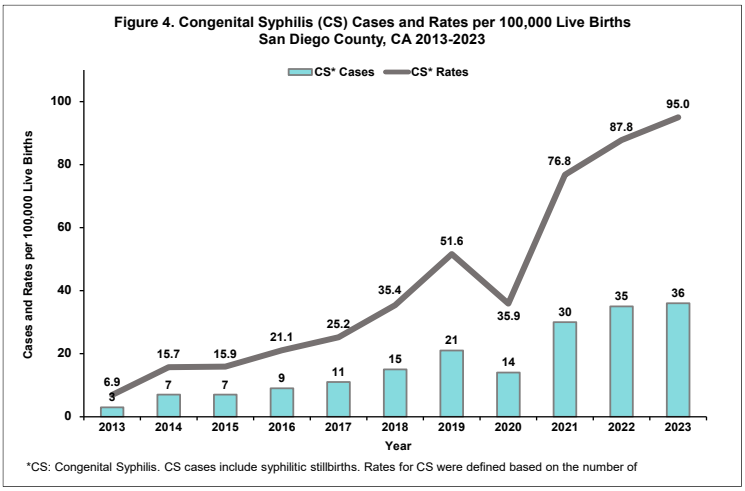
Significant health disparities persist, with disproportionate impacts of STIs on communities of color, men who have sex with men, and youth. The rates of early syphilis, for which race/ethnicity information is most complete, among black men and women were 3.0 and 3.2 times the rates among white men and women, respectively. MSM accounted for 64.3% of reported early syphilis cases in 2023. The highest rates of chlamydia were among women aged 20-24 years.

Editorial Note (Continued)

Providers can decrease the impact of STIs in the region by:

- Providing low-barrier access to sexual health services
- Conducting appropriate STI screening and testing and, if indicated, treatment according to the 2021 STI Treatment Guidelines (Centers for Disease Control and Prevention (CDC))
- Screening for syphilis according to the most recent guidance from the California Department of Public Health and ensuring that pregnant persons receive appropriate screening and timely treatment for syphilis
- Linking persons who are candidates for doxycycline STI post-exposure prophylaxis (Doxy-PEP) and HIV pre- and post-exposure prophylaxis (PrEP and PEP) to those interventions.
- Promptly reporting cases of syphilis, gonorrhea, and chancroid to the HIV, STD, and Hepatitis Branch within the required timeframes. This helps to ensure accuracy of local STI surveillance data and timely investigation of priority STI cases to interrupt disease transmission.





HIV PLANNING GROUP
4-MONTH COMMITTEE TRACKING
September 2024 - April 2025

Medical Standards & Evaluation Committee					
MSEC	**Sep**	**Nov**	**Feb**	**April**	**#**
Total Meetings	1	1	1	1	**4**
(12) Members					
Tilghman, Dr. Winston	*	**JC**	*	*	**0**
Aldous, Dr. Jeannette [CC]	*	*	**JC**	*	**0**
Bamford, Dr. Laura	*	**1**	*	*	**1**
Grelotti, David [C]	*	*	*	*	**0**
Hernandez, Yessica	*	*	*	*	**1**
Lewis, Bob	**1**	*	*	**1**	**2**
Spector, Dr. Stephen	**1**	**1**	*	*	**2**
Quezada-Torres, Karla	*	*	**1**	*	**1**
Rodriguez, Martha		*	*	*	**0**
Paugh, Shannon			*	**1**	**1**
Garcia, Rosemary				*	**0**
Whyte, Fadra				*	**0**

To remain in good standing and eligible to vote, the committee member may not miss 3 consecutive meetings or 6 meetings within 12 months.

* = Present

1 = Absent for the month

1 = Absence when there are multiple meetings that month. Member needs to attend at least one (1) meeting for attendance to count for that month.

JC = Just Cause

EC = Emergency Circumstance

NM = No Meeting

NQ = No Quorum

If the physical attendance quorum requirement is met, AB 2302 permits a member who is not physically present to request virtual attendance at the local legislative body's meeting under two circumstances: ***(1) for "just cause"*** *and* ***(2) due to "emergency circumstances"****.*

Qualifying Reason	Provisions to Attend Remotely	Requirements/Limitations
"Just Cause"	▪ There is a childcare or caregiving need (*for a child, parent, grandparent, grandchild, sibling, spouse, or domestic partner*) that requires the member to participate remotely. ▪ A contagious illness prevents the member from attending the meeting in person. ▪ There is a need related to a defined physical or mental disability that is not otherwise accommodated for. ▪ Traveling while on official business of the legislative body or another state or local agency.	A member is limited to **<u>two (2)</u>** virtual attendances due to "just cause" per calendar year.
"Emergency Circumstances"	**"*A physical or family medical emergency that prevents a member from attending the meeting in person*."** A member is ***<u>not</u>*** required to disclose any medical diagnosis or disability, or any personal medical information that is already exempt from existing law.	**A member of the legislative body must:** 1. Make a request to the body to allow the member to meet remotely due to an emergency circumstance; and 2. Provide a general description of no more than 20 words of the circumstance justifying such attendance. A request from a member to attend remotely requires that the legislative body take action and <u>approve</u> the remote attendance at the start of the meeting for the member to be allowed to participate remotely for that meeting[1].

[1]If the request does not allow sufficient time to be placed on the agenda as a proposed action item, then the legislative body may take action at the beginning of the meeting.

Additional Requirements for a Member Participating Remotely

In addition to making a request either for "just cause" or due to an "emergency circumstance" for remote appearance, AB 2302 imposes the following three (3) additional requirements on legislative body members seeking to appear remotely at public meetings:

1. The member:
    - Notifies the legislative body at the earliest opportunity possible, including at the start of a regular meeting, of their need to participate remotely for just cause, including a general description of the circumstances relating to their need to appear remotely at the given meeting. **OR**
    - Requests the legislative body to allow them to participate in the meeting remotely due to emergency circumstances and the legislative body takes action to approve the request. *(See "requirements/limitations" for the use of emergency circumstances.)*
2. The member shall publicly disclose at the meeting before any action is taken, whether any other individuals 18 years of age or older are present in the room at the remote location with the member, and the general nature of the member's relationship with any such individuals.
3. The member shall participate through both audio and visual technology.