HEALTH RESOURCES AND SERVICES ADMINISTRATION
HIV/AIDS BUREAU

INTEGRATION OF ORAL HEALTH AND PRIMARY CARE TECHNICAL ASSISTANCE TOOLKIT

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BACKGROUND

People with HIV struggle to access oral health care, and this lack of access to care can significantly impact overall health and quality of life including their ability to work and engage in community activities.[1] Adequate oral health care is especially important for people with HIV because they are predisposed to certain oral health problems such as dental caries, oral lesions, and periodontal disease, which may be further exacerbated by HIV treatments that worsen conditions like dry mouth.[2] Despite the importance of oral health care, there are notable gaps in utilization and access. The HRSA HAB Special Projects of National Significance (SPNS) Oral Health Initiative found that a majority of people with HIV had not seen a dentist in more than two years, and almost half reported an unmet oral health care need at some time since HIV diagnosis.[3]

The integration of oral health and primary care can alleviate some of these problems by ensuring early detection of oral diseases, reducing risk through education, and connecting clients to oral health care.[2] Providers funded through the RWHAP are uniquely positioned to support integration efforts, given they already seamlessly integrate HIV care with primary care while providing support services that help clients stay engaged in care.

To address the importance of oral health and reduce oral health disparities for people with HIV, HRSA HAB identified challenges, best practices, and strategies implemented by RWHAP recipients to integrate oral health and primary care services. The team completed an environmental scan of resources related to oral health and primary care integration, followed by nine site visits to recipients who had demonstrated excellence in delivering or connecting clients to oral health care. Site visits involved interviews with clinical, administrative, and support staff to understand how these recipients developed and maintained their oral health models. This technical assistance toolkit (toolkit) reflects the lessons learned from these activities.

KEY ABBREVIATIONS AND DEFINITIONS

Electronic dental record (EDR)

Electronic health record (EHR)

Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB): Federal agency that administers the RWHAP.

Primary care provider (PCP): Clinician, such as a doctor, nurse practitioner, or physician's assistant, who renders primary and preventive care services, including HIV care.

Primary care setting: A clinic that offers primary and preventive primary care services, including HIV care.

Primary care staff: Staff in a primary care setting, including PCPs, case managers, and intake staff.

Ryan White HIV/AIDS Program (RWHAP): A federal program that provides a comprehensive system of HIV primary medical care, essential support services, and medications for low-income people with HIV who are uninsured and underserved.

RWHAP recipient: An organization funded directly by HRSA HAB through the RWHAP.

RWHAP provider: An organization that receives RWHAP funding, either directly from HRSA HAB or from a RWHAP recipient, to provide direct care to people with HIV. Many RWHAP providers are also primary care settings.

Special Projects of National Significance (SPNS): Supports the development of innovative models of HIV care and treatment in order to quickly respond to emerging needs of clients served by RWHAP.

U.S. Department of Health and Human Services (DHHS)

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[1] USDHHS. (2010). Oral Health in America: A Report of the Surgeon General. Rockville: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health.

[2] HRSA/HAB. (2012). Oral Health and HIV. Retrieved from https://www.hrsa.gov/sites/default/files/publichealth/clinical/oralhealth/hivfactsheet.pdf

[3] Fox, J. E., Tobias, C., Bachman, S. S., Reznik, D. A., Rajabiun, S., & Verdecias, N. (2012). Increasing Access to Oral Health Care for People Living with HIV/AIDS in the U.S.: Baseline Evaluation Results of the Innovations in Oral Health Care Initiative. Public Health Reports, 127, 5-16. Retrieved 1 4, 2018, from https://ncbi.nlm.nih.gov/pubmed/22547872

GOALS OF THE TOOLKIT

Through the environmental scan and site visits, the team identified seven components of oral health and primary care integration, each of which is discussed in this toolkit:

- **Ask:** Assessment of risk of oral health disease
- **Examine:** Oral health examination to identify active disease
- **Educate:** Tailored education to improve oral health care literacy
- **Intervene:** Primary care interventions to reduce risk and treat disease
- **Refer:** Referral to oral health care provider for more extensive care
- **Support:** Patient navigation to improve treatment adherence
- **Share:** Data sharing between primary and oral health care settings

Each of these components includes tips and recommendations for best practices, which are designed to help providers identify areas to improve care integration at their own sites. Some best practices are more relevant to some providers than others. For example, providers who do not deliver case management could not rely on a case manager to ask about risk. However, each of these sections offers alternatives and findings that are applicable regardless of where oral health care is delivered. We encourage you to review all the sections and best practices in this toolkit to identify the pieces that can help inform integration efforts that match your organizational capacity and client needs.

This toolkit begins with a brief overview of the components of integration and the models of oral health care delivery observed in the literature and in the site visits. Next, each of these components is discussed in detail, including best practices and links to resources to help you understand what effective integration looks like. The last section discusses how to build and sustain oral health delivery over time.

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SECTION 1
WHAT IS INTEGRATION?

RWHAP providers help clients access oral health care through many models. Some providers offer HIV primary care and oral health care at the same location, while other models are entirely based on external referrals. Regardless of the model, all RWHAP providers can strive for the integration of oral health and primary care.

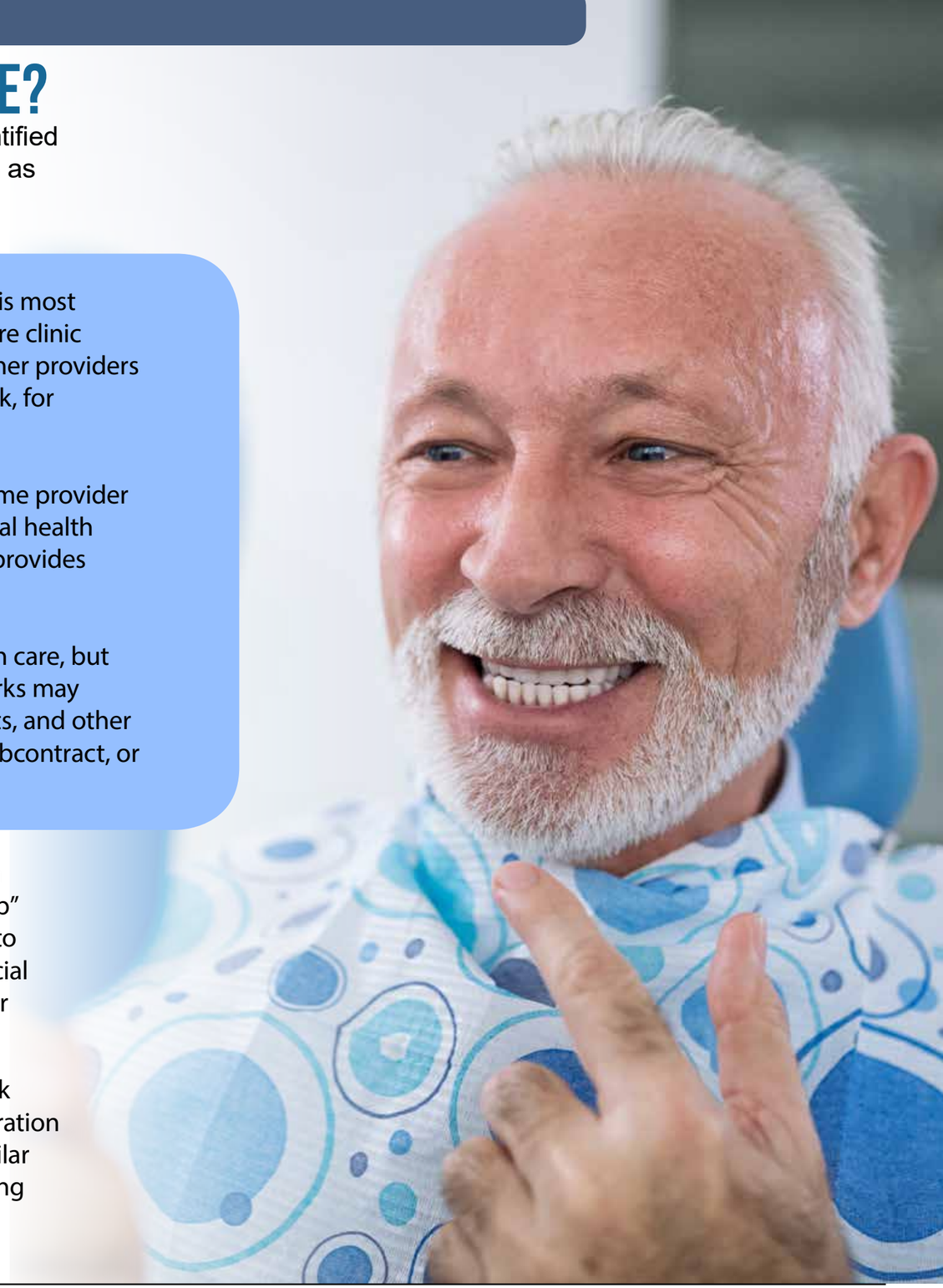
HOW ARE PROVIDERS DELIVERING ORAL HEALTH CARE?

Based on information shared by RWHAP recipients with their HRSA HAB project officers, we identified three primary model types. Many providers have models that incorporate multiple strategies, such as co-location for basic services and referral for complex procedures.

1. **In co-located models,** oral health and primary care are delivered at the same location. This model is most common in community health centers, where oral health and primary care are provided at one or more clinic locations. Some providers have full-time dentists and/or allied dental health professionals on staff. Other providers have designated times for dental clinics and bring in a dentist or hygienist one or more times per week, for example, to provide routine care.

2. **In coordinated but not co-located models,** oral health and primary care are delivered by the same provider but not at the same place. For example, a provider may have multiple clinic locations but only offer oral health services at one location. In these models, the primary care team generally completes screenings and provides patient navigation support to connect clients to the oral health setting.

3. **In referral-based models,** providers are not directly responsible for the provision of any oral health care, but they do link clients to services through relationships with external oral health providers. These networks may consist of community health centers, safety net providers, university-affiliated settings, private dentists, and other RWHAP-funded providers with whom the provider has a memorandum of understanding (MOU), a subcontract, or a fee-for-service relationship.



These models have their advantages and disadvantages, and the model that best suits your organization will depend on your capacity, your funding sources, and the services available near you. A "one-stop shop" that allows your clients to see a dentist when they come in for HIV care can be a great way to get clients to the dentist. However, you may not have the capacity to see all clients who need dental care due to financial restrictions or lack of funding. Similarly, if you have a dental clinic in your network, you may prefer to refer clients to them rather than to external dentists for easier appointment tracking and data sharing.

Before you move through the topics in this toolkit, check to see what model you have and what you think would be the best fit for your organization. Though these models may seem different, many of the integration components in this document are applicable across models; an oral health screening, for example, is similar regardless of model. As you review these components, think about which pieces make sense for improving integration at your site.

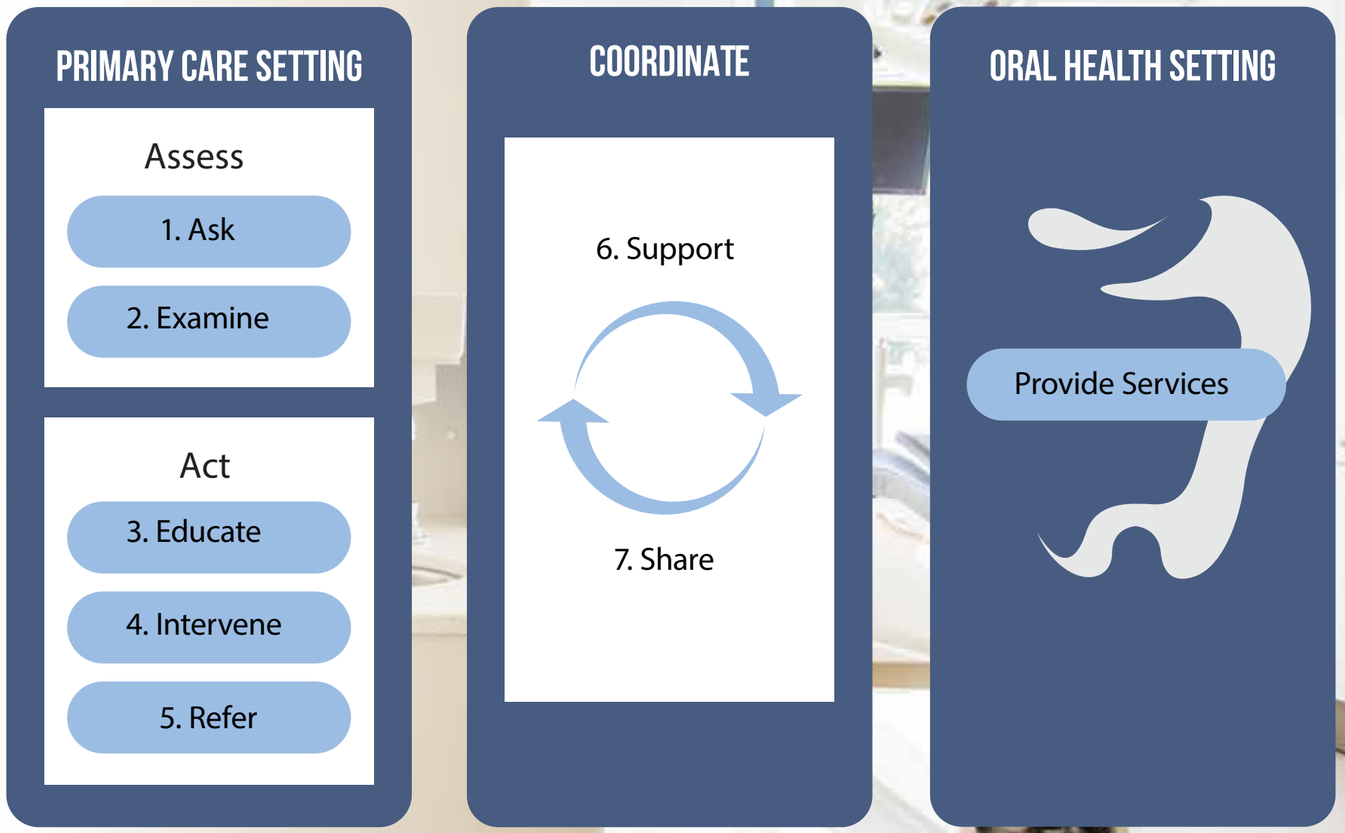
COMPONENTS OF INTEGRATION

From the environmental scan and the site visits, we identified seven areas for you to consider in integrating oral health and primary care services at your organization. These components include activities in the primary care setting as well as coordination between primary care and oral health settings.

In the primary care setting, linkage to appropriate services starts with determining clients' needs. This includes both assessment of oral health risk (ask) and conducting oral health examinations (examine) to check in on how clients are doing and identify active oral health disease. Staff should then act based on these assessments to improve oral health through education (educate), intervention (intervene), and referral to a dentist (refer).

These activities are necessary but not sufficient for a well-integrated model. Communication, collaboration, and coordination between the primary care and oral health care settings are essential for ensuring that clients are receiving needed services. Services that help connect clients to care and ensure adherence with referrals, hereafter referred to as dental patient navigation, are also important, particularly for individuals who lack transportation or are nervous about going to the dentist (support). Finally, data exchange and sharing between primary and oral health care settings can apprise the dental team of pertinent medical information and ensure that dental care is incorporated into clients' overall health planning (share).[1]

The remainder of this toolkit walks through each of these components and in the last chapter explores ways to build and sustain these integration components. If a component is an opportunity for your site, check out links to resources and best practices highlighted in that section.



[1] Cohen, L. A. (2013). Expanding the Physician's Role in Addressing the Oral Health of Adults. American Journal of Public Health, 103(3), 408-412. Retrieved from https://ncbi.nlm.nih.gov/pubmed/23327256

SECTION 2
ASSESS

Primary care settings play a role in reducing oral health disease through prevention efforts and ensuring that diseases are identified and treated.

ASK

An initial client assessment in the primary care setting is an essential first step in the provision of oral health care. Ask your clients about their oral health care service use, habits and possible conditions that put them at risk for oral disease to identify the appropriate next step in care.

BEST PRACTICE: KEEP IT SIMPLE

When selecting questions to include in your assessment, consider the time your organization has to administer the assessment as part of your regular care delivery and the typical oral health risk factors your client population faces. RWHAP providers reported that staff have "a lot on their plates," given people with HIV may have complex medical conditions and multiple comorbidities. Therefore, keeping the assessment to two to three essential questions may be the best approach to ensure successful implementation in the long run. At minimum, providers should ask clients about oral health care utilization.

WHAT TO ASK

Most of the RWHAP providers that participated in this project keep their assessments simple by asking one question on care utilization: whether the client has been to the dentist in the last year or the date of the last dentist appointment that occurred.

You can tailor your assessment to be more appropriate for the HIV clinical care setting. For example, HRSA HAB Special Projects of National Signification (SPNS) Oral Health Initiative asked individuals at enrollment "whether problems with their teeth and mouth have made it difficult for the client to take HIV medications."[1]

The Safety Net Medical Home Initiative recommends a comprehensive set of questions that range from diet to dry mouth:

- On average, how many days per week do you brush your teeth twice daily for at least two minutes, using fluoride toothpaste, and floss at least once daily?
- On average, how many times daily do you consume sugar (sugary snacks or sugary drinks) between meals?
- Has anyone in your immediate family had tooth decay or lost a tooth from decay in the past year?
- Do you commonly experience dry mouth (i.e., requiring swallowing water to eat crackers)?
- Do you experience stomach acid in your throat after eating or when lying down on a daily or almost daily basis?
- Do you experience tooth pain or bleeding gums when you eat or brush your teeth?

[1] Fox, J. E., Tobias, C., Bachman, S. S., Reznik, D. A., Rajabiun, S., & Verdecias, N. (2012). Increasing Access to Oral Health Care for People Living with HIV/AIDS in the U.S.: Baseline Evaluation Results of the Innovations in Public Health Reports, 127, 5-16.

WHO SHOULD ASK

Assessments may be administered by any member of the primary care team. Typically, medical assistants or registered nurses ask basic questions at the beginning of primary care appointments.[2] However, primary care providers (PCPs) may choose to conduct the assessments during their exams, particularly if they ask more detailed questions. For example, at one RWHAP provider, PCPs ask during medical visits whether the client has seen a dentist, nutritionist, and optometrist in the last year.

Case managers who regularly interact with clients (during both medical and support service visits) also can ask clients about oral health. You may consider incorporating the assessment into interactions between the client and case manager, such as eligibility determination and care planning appointments.

BEST PRACTICE: MAKE IT ROUTINE

It doesn't matter who asks the questions and at what point in care delivery; just make the process routine. Discuss your client flow as a team to determine who has time to conduct the assessment, and make sure relevant staff are on board with their new responsibility.

HOW TO TRACK IT

A crucial aspect of "ask" is to prompt and document assessments in a way that facilitates follow-up actions to link clients to oral health care. Order sets, annual exam templates, and eligibility or care planning forms should include your assessment questions.

BEST PRACTICE: USE YOUR EHR

By incorporating questions and responses into your EHR, you can set reminders and track the completion of assessments and follow-up actions. Many EHRs will allow you to create custom prompts that remind you on an annual (or more regular) basis to ask about a client's oral health risk. Building in these automatic reminders ensures that clients don't slip through the cracks. In addition, all staff should know how and where data are collected to trigger follow-up activities, as described in the following sections.

An annual dental exam is expected; it's part of the order sets, so it's hard to forget that way. It's really part of what we order for the annual — lab, testing, and referrals. And then we also have it in our template. Under annual exam, it says, "when was their last biopsychosocial, their dental exam, and their eye exam." So again, lots of triggers to clinicians to remind them that it's part of it.

- RWHAP provider

[2] Maxey, H. (2015). Integration of Oral Health with Primary Care in Health Centers: Profiles of Five Innovative Models. Bethesda: National Association of Community Health Centers.

YOU MAY ALSO WANT TO REVIEW A CLIENT'S MEDICAL AND SOCIAL HISTORY IN YOUR EHR TO IDENTIFY OTHER ORAL HEALTH RISKS. SOME ITEMS TO CONSIDER:

- **Medication list:** Check for behavioral health medications, pain medications, muscle relaxants, antihistamines, and medications for overactive bladder, as well as proton pump inhibitors, which can cause dry mouth.[3] People with HIV are at particular risk because HIV medications can also cause dry mouth.

- **Smoking and substance use history:** Substance use can increase the risk of oral infection and affect clients' ability to engage in primary and oral health care.

- **Other medical issues that can place individuals at risk of oral disease:** These include acid reflux and poorly controlled diabetes.

[3] Hummel, J., Phillips, K. E., Holt, B., & Virden, M. (2016). Organized, Evidence-Based Care Supplement: Oral Health Integration. Seattle: Qualis Health and Safety Net Medical Home Initiative.

EXAMINE

To supplement the risk assessment of oral health disease, PCPs in RWHAP providers should identify active disease through hard and soft tissue examinations. These typically include the following activities:

- Examining teeth for signs of decay
- Seeing if clients are wearing their dentures and, if not, understanding why
- Inspecting soft tissues for thrush (candidiasis), warts (papillomas), and other lesions associated with uncontrolled HIV infection
- Percussing teeth
- Palpating the neck and lymph nodes
- Swabbing the mouth to diagnose pharyngeal gonorrhea

Many PCPs aim to conduct these oral exams at every or "most" visits.

BEST PRACTICES

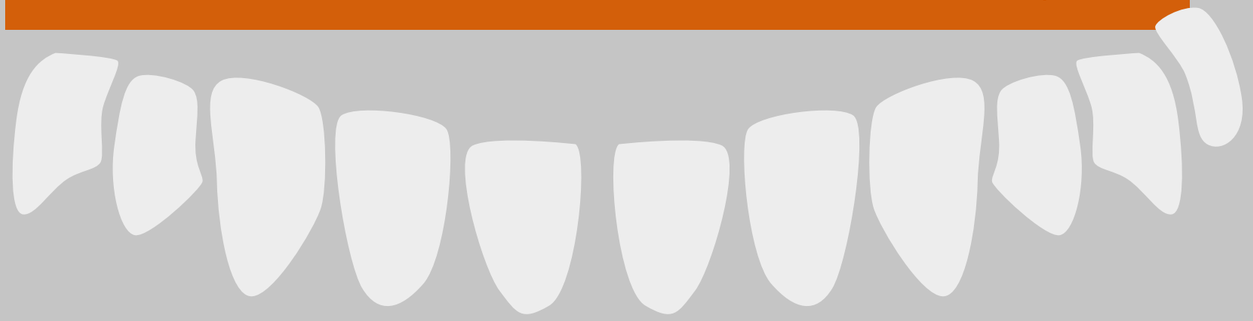
- **Streamline EHR documentation:** Standardized EHR documentation of exam results across PCPs facilitates tracking and follow-up. Ensure your EHR allows PCPs to document findings in a structured format (as opposed to free text in notes fields), indicating the quality of dentition, use of dentures, or other oral health issues. That said, data entry can be time consuming. Management at one RWHAP provider in this project reported, "You hear providers say, 'There's too many clicks, when do I get to be with the patient?' All the things are worth it, but when you have a 15-minute slot…" If your PCPs indicate that the process is too cumbersome, identify the most important aspects of the examination (e.g., no visible conditions of the oral cavity) and remove (or make optional) lower-priority fields.
- **Equip PCPs with lights and mirrors:** PCPs should have tools that allow them to see the client's mouth clearly and comprehensively, such as headlamps and mirrors. Headlamps allow PCPs to use two hands for assessments.

Assess adequacy of salivary flow; look for signs of poor oral hygiene, white spots, cavities, gum recession, or periodontal inflammation; and conduct examination of the oral mucosa and tongue for signs of disease.

Oral Health: An Essential Component of Primary Care, Qualis Health

An oral exam is part of any patient's primary care evaluation. We tend to look for: are there any oral lesions? Is there any thrush? Is dentition intact? Is the gum health poor? We do screen for STDs [sexually transmitted diseases], and we do multisite swabbing, and, of course, the oropharynx is one of the places that we swab.

- RWHAP provider



TRAINING TIPS

Oral health is not always covered in-depth in medical school or residency, and some specialties receive less training in the symptoms of active diseases. Therefore, PCPs may have varied confidence in conducting oral health examinations. One RWHAP provider that participated in this project said trainings focus on "mouth conditions that folks with HIV might have," not oral hygiene — or "cavities per se." Unfortunately, identifying a time when multiple PCPs can gather for an in-person training can be nearly impossible unless leadership explicitly blocks off schedules. Consider bolstering your training through the following:

- **Invite trainers to come onsite for a hands-on demonstration:** Invite a dentist to train PCPs to demonstrate proper techniques and describe what to look for. This training could also include hands-on demonstrations where you look into participants' mouths and tips on providing oral health education.
- **Have dental residents accompany PCPs during their appointments to point out oral health issues:** One PCP interviewed for this project reported that clinicians prefer to ask questions in smaller settings as opposed to large groups. For example, another PCP valued a program that paired PCPs with dental residents because he could "pick their brains" about oral health.
- **AIDS Education and Training Centers (AETC):** AETCs provide RWHAP providers with training and consultation to build clinical capacity and expertise along the HIV care continuum. If you can't find what you're looking for online, contact your regional office to request training, capacity building, or technical assistance. AETCs have oral health consultants that may be available to come on-site.
- **Look to online resources:** The TargetHIV website houses tools and resources for RWHAP providers, including a HRSA Guide to Oral Health Care in Primary Care Settings and HRSA HAB's training materials from the Oral Health Care Initiative. Smiles for Life is an important resource used to train PCPs on oral health care, and HIVdent is a repository for oral health and HIV information.
- **Give and take:** Cross-training is a great way to engage local dentists. One PCP interviewed for this project described the organization's innovative cross-training relationship, where he regularly discusses HIV and oral health care with oral surgeons in his health care system. These relationships may involve formal trainings or informal discussions.
- **Leverage Continuing Medical Education (CME) credits:** Make sure to offer CME credits as part of your training to encourage busy PCPs to attend.

One PCP interviewed for this project remembered that in a class on oral health in medical school, the professor told her to "pay attention" because it would be their only class on the topic.

SECTION 3
ACT

After assessing oral health risk and need, your organization can take action through oral hygiene education, PCP interventions, and referrals to a dentist.

EDUCATE

As a RWHAP provider, you can encourage positive health behaviors through education and the provision of oral hygiene supplies. According to HRSA HAB, education includes "how to maintain good oral health, which considers oral health literacy, nutrition, and client's perceived oral health barriers."[1] Providers recognized the lack of health care literacy and the "if it's not broke, then don't fix it" attitude among their client populations. They educate their clients on the importance of seeking oral health care for prevention purposes, not just when they are in pain. [2]

WHAT TO EDUCATE ABOUT

Providers who participated in this project had a variety of approaches to teaching clients about the importance of oral health. However, all providers stressed the importance of educating clients to seek oral health care as a preventive measure, not just when they are in pain. When clients understand the central role that oral health plays in their overall health, they are receptive to messages about how to achieve and maintain good oral health.

Components of Oral Health Education

- Importance of and tips for brushing and flossing
- Role of fluoride and dental sealants
- Dental appointment scheduling and coverage

BEST PRACTICES

- **Don't reinvent the wheel:** There are plenty of resources available to help inform your educational curriculum. Some places to start, with printable posters and handouts, include:
  - Summary of Primary Care Clinical Interventions by the Safety Net Medical Home Initiative
  - Integrating Oral Health Care in HIV Primary Care Settings: A Guide to Oral Health Care for people with HIV
  - California Dental Association Fact Sheet
  - Missouri Department of Health and Senior Services
  - North Carolina Department of Health and Human Services
  - Oral Health Nursing Education and Practice
  - Smiles for Life

- **Tailor education to your client population:** A case manager from a RWHAP provider that participated in the project said clients are receptive to the message that inadequate prevention can cost them "more time, more money, and more services." He reported that his clients often work multiple jobs and do not want to miss work for time-consuming procedures that could have been avoided with proper care. Another RWHAP provider developed educational resources around the relationship between methamphetamines (meth) and oral health due to high rates of meth use in the area. A PCP at a third RWHAP provider focused on denture care given his aging population.

- **Distribute hygiene supplies:** One RWHAP provider that participated in the project distributes hygiene supplies, including toothbrushes, floss, and toothpaste, to clients every three months. This strategy not only meets clients' direct needs but also emphasizes the importance of hygiene to clients. The provider used program income generated from 340B to purchase these supplies. The 340B Program provides eligible health care organizations and covered entities with rebates on outpatient drugs that can be invested back into program activities.

[1] Health Resources and Services Administration, HIV/AIDS Bureau. (2012). Oral Health and HIV.

[2] HIV/AIDS Bureau. (2017, October). Division of Community HIV/AIDS Programs Part CD Oral Health Data Collection Matrix. Rockville, MD, USA.

WHEN TO EDUCATE

You may think that oral health education and the distribution of hygiene supplies should be handled by dental staff, either co-located at your organization or at a referral dentist. However, not all clients are receiving dental care, and that makes the primary care setting the only chance for education. Even clients who are connected to the dentist might benefit from repeated messaging about establishing good oral health habits. PCPs and case managers can be the first line of oral health education.

BEST PRACTICES

Beyond these face-to-face interactions, other opportunities for education include:

- **Place posters, videos, or brochures in waiting and exam rooms, or create handouts for clients about HIV, oral health and what to expect in a dental appointment:** Clients can help inform the development of content to make educational materials more effective. One RWHAP provider that participated in the HRSA HAB SPNS initiative revised its printed materials after receiving feedback from clients. Another HRSA HAB SPNS grantee developed a video series for clients, case managers, and dentists after conducting a focus group with clients. HRSA HAB SPNS recipients also improved the impact of their educational efforts by printing materials in English and Spanish and repeating messages.
- **Use your EHR patient portal/newsletter:** One RWHAP provider that participated in this project recently launched a newsletter on oral health care. Clients can sign up to receive an email newsletter through the provider's online patient portal. This is a low-cost strategy that reinforces messages provided during appointments.

INTERVENE

You can also act by providing services that treat infection or reduce the risk of oral health disease. For example, while the client would be referred to a dentist in cases of gum inflammation and tooth decay, PCPs at your clinic can treat clients for dry mouth and acid reflux. Some possible interventions include:

- Pretreating for oral health services by prescribing antibiotics for abscesses (and immediately referring to the dentist, as described in the next section).
- Applying chlorhexidine rinse for individuals with recurrent denture-related problems.
- Prescribing 0.12% chlorhexidine rinses for gingival (gum) inflammation.
- Changing prescriptions, especially anti-depressants, applying oral lubricants to reduce dry mouth in addition to recommending frequent sips of water, and using sugar-free gum and hard candies to manage the symptoms of dry mouth.
- Applying fluoride varnish.

BEST PRACTICE

Don't rely solely on client complaints to intervene: Use assessments and examinations to better inform your interventions. More complete assessment and examination as described above and methods of tracking in EHRs will facilitate interventions in the primary care setting to respond to oral health needs. Ensure that staff are intervening proactively rather than relying solely on client complaints to identify when interventions are appropriate in the primary care setting.

FLUORIDE VARNISH

Fluoride varnish can prevent tooth decay and repair teeth in the early stages of disease. The American Dental Association recommends that fluoride be administered every three, six, or twelve months, depending on the client's risk. While fluoride administration typically occurs in a dentist office, RWHAP providers can apply fluoride by swabbing the fluoride gel or paste over a client's teeth during a primary care visit. A study on the oral health and primary care integration practices of five community health centers found that medical or dental assistants provided the fluoride treatment at the start of the client's appointment.[2]

[2] Maxey, H. L., Nordwood, C. W., & Weaver, D. L. (2017). Primary Care Physician Roles in Health Centers with Oral Health Care Units. Journal of the American Board of Family Medicine, 491-504.

REFER

While primary care settings play an important role in preventing and screening for oral health disease, they cannot replace dentists. Primary care settings must partner with oral health settings to improve the scope of care offered to clients. Even RWHAP providers with oral health services co-located with their primary and HIV care will likely need to build partnerships with external dentists for more complex services.

Building an ample network for oral health providers is no easy task. There is a shortage of dentists willing to serve low-income clients, especially Medicaid beneficiaries.[3] Additionally, discrimination in oral health practices against people with HIV, although unlawful, may affect potential partnerships.[4]

Clients with disclosure concerns may appreciate an oral health provider with a formal relationship with their RWHAP provider because the oral health provider is likely to already be aware of their status.

One RWHAP provider reported that through the system's complaint process, clients might mention dissatisfaction with the time it took to complete the treatment plan, but they never complain about "quality of care or feeling stigmatized."

WHAT TO LOOK FOR IN YOUR ORAL HEALTH NETWORK

Type of oral health care the dentist provides, ranging from basic dentistry to complex oral surgery: The types of oral health providers in your network depend on the services that you already deliver in-house. RWHAP providers with co-located models may only need to develop a network for specialists that conduct the most complex procedures, such as oral surgeons and endodontists. Providers with co-located oral health services may also need to establish partnerships to enhance their capacity to meet their clients' needs if they don't have a sufficient number of dentists on-site. A provider with a referral-based model, on the other hand, will need to create a much more comprehensive network with oral health providers that render a wider range of services.

Number of dentists in the network: The size of the network depends on your client population size and the capacity of your partners to take on clients. The number of referral settings ranged from two to several dozen across the RWHAP providers that participated in the project.

Insurance compatibility: When developing networks, insurance compatibility is probably the greatest consideration. You must determine whether oral health settings are willing to accept your clients' common insurance types, or lack thereof. If clients are uninsured or their coverage does not include all procedures (such as many state Medicaid programs and Medicare), you can seek dentists with low-cost services or those who will negotiate sliding fee scales or accept your RWHAP fee schedule (if available).

Welcoming, stigma-free environment: Several RWHAP providers that participated in the project reported that they partner with certain oral health providers because they treat their clients with a welcoming attitude. It's often helpful to find dentists who have a personal connection to HIV or are "community service minded."

BEST PRACTICES

- **Establish a Target Number of Referrals:** Some private oral health practices may be more likely to participate in a network if you can guarantee a certain number of referrals. Dentists that are close to capacity, on the other hand, may be concerned that a referral relationship might flood their system. Therefore, the RWHAP provider can work with the oral health provider to set the desired number of referrals.

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[3] Kaiser Family Foundation. (2018). Providers & Service Use Indicators. Retrieved from https://www.kff.org/state-category/providers-service-use/health-professional-shortage-areas/

[4] Sears, B., Cooper, C., Younai, F. S., & Donohoe, T. (2012). HIV Discrimination in Dental Care: Results of a Discrimination Testing Study in Los Angeles County. Loyola of Los Angeles Law Review, 909-962.

HOW TO FIND AND RECRUIT DENTISTS

To identify viable partners, conduct an environmental scan of local dentists. Include dental and dental hygiene schools as well as residency programs to expand your provider pool. Local and state dental societies/associations, social service programs that assist low-income individuals, and searchable databases, such as InsureKidsNow, which displays dentists that accept Medicaid, and ZocDoc can help you build your list.

Encourage participation by inviting the local dentists to an open house to connect with the primary care team. Personal connections and an emphasis on the goals of the partnership — supporting individuals to access needed care — can help build the relationship.

BEST PRACTICES

- **Cast a wide net:** When identifying oral health providers to participate in integration efforts, cast a wide net, including accredited dental and dental hygiene schools and residency programs.
- **Partner with dental service organizations (DSOs):** DSOs are growing as they buy up more individual private practices. By partnering with a DSO, you may have access to more dentists.
- **Leverage the dependability of RWHAP payment:** Several providers who participated in this project indicated that the dependability of payment by RWHAP is an incentive for partnerships. They reported that dentists often "don't get RWHAP," so be sure to educate them on the program. Consider developing a billing letter to send to dentists that describes the program and funding sources and establishes a payment schedule.
- **Formalize the agreement:** You may choose to sign formal agreements or contracts that include information regarding referral processes, management of protected health information, payment mechanisms, insurance considerations, and protocol for sharing clinical information, including a consultation report for the referring PCP to close the loop (see next sections).
- **Keep clients with their dentist and consider partnership:** Some clients who come to your clinic for HIV care may be already engaged with private dentists. Partnerships with these dentists promote continuity of care and may be an avenue to establish more referrals.
- **Promote RWHAP support:** Let the dentist know what you can/will do to remind clients of their appointments, support them in their attendance, and follow up on no-shows (see the next section). Some dentists may prefer to do all of this themselves, but others may appreciate the help. These wraparound services can be a powerful motivator for providers to join your network.

SECTION 4
COORDINATE

Referrals are not enough to improve clients' access to oral health care. Integration also includes supporting clients in appointment adherence and exchanging information between settings.

SUPPORT

Patient navigation is a cornerstone of successful oral health integration as people with HIV who are assigned a dental patient navigator may be more likely to access care.[1] Clients may need assistance with scheduling and attending appointments, especially with dentists that have more stringent no-show policies than RWHAP providers. Supporting clients to keep referral appointments includes the following activities:

TOPIC AREA	RESPONSIBILITIES
Referral coordination and management	▸ Matching clients to oral health providers ▸ Scheduling appointments ▸ Sending appointment reminders
Supporting appointment adherence	▸ Financial/insurance enrollment assistance ▸ Arranging transportation to oral health visits ▸ Linking to other support services (e.g., housing, nutritional services, substance use services) ▸ Helping clients overcome fear and anxiety
Appointment follow-up	▸ Following up on missed appointments ▸ Facilitating data sharing between oral health and primary care

[1] Pereyra, M., Metsch, L. R., Tomar, S., Valverde, E., Jeanty, Y., Messinger, S., & Boza, H. (2011). Utilization of dental care services among low-income HIV-positive persons receiving primary care in South Florida. AIDS Care, 98-106.

REFERRAL COORDINATION AND MANAGEMENT

First, develop a process for making referrals to dentists when your client assessments identify a need for oral health services. The RWHAP providers that participated in this project primarily rely on case managers and dental patient navigators to find dentists appropriate for the client (e.g., based on insurance and location) and to schedule appointments. At one RWHAP provider site, after conducting oral health assessments and examinations, PCPs discuss client needs with case managers (including oral health needs). Case managers then follow up with oral health providers to schedule appointments. A "warm handoff," where the primary care setting makes the appointment, may lead to better engagement in oral health care.

Co-located models allow for additional opportunities for scheduling coordination. Several providers indicated that a case manager will "walk a client over" to their co-located oral health setting to schedule an appointment. Integrated EHRs and EDRs may allow staff from the primary care setting to schedule appointments directly in the oral health system.

That said, it's not always feasible to have your staff make appointments on behalf of clients. Clients may be better suited to communicate directly with the dentist to discuss availability. In addition, some oral health providers prefer to work directly with the client rather than with RWHAP provider staff.

COMMON BARRIERS TO ORAL HEALTH ACCESS

- Lack of dental coverage
- Limited oral health literacy
- Separate appointments with unfamiliar providers
- Lack of transportation
- Dental fear and anxiety
- Lack of financial resources
- Lack of dental coverage
- HIV stigma and fear of disclosure
- Mistrust of dentists
- Mental health (e.g., depression)
- Prior avoidance of oral health care

BEST PRACTICES

- **Identify an oral health point of contact:** Regardless of whether your staff or clients are making appointments, having at least one staff person who has knowledge of where and how clients can receive services is crucial to connecting them to oral health services. Several providers who participated in this project posted fliers and distributed business cards for one staff person who clients could ask for assistance.

- **Build your referral process into your EHR:** Many EHRs allow you to create customized workflows. You may be able to program your EHR to route a referral through appropriate channels. One provider in this project built a ".dent" command in Epic that automatically sends a prepopulated referral from their PCPs to a case manager and to a billing specialist for approval.

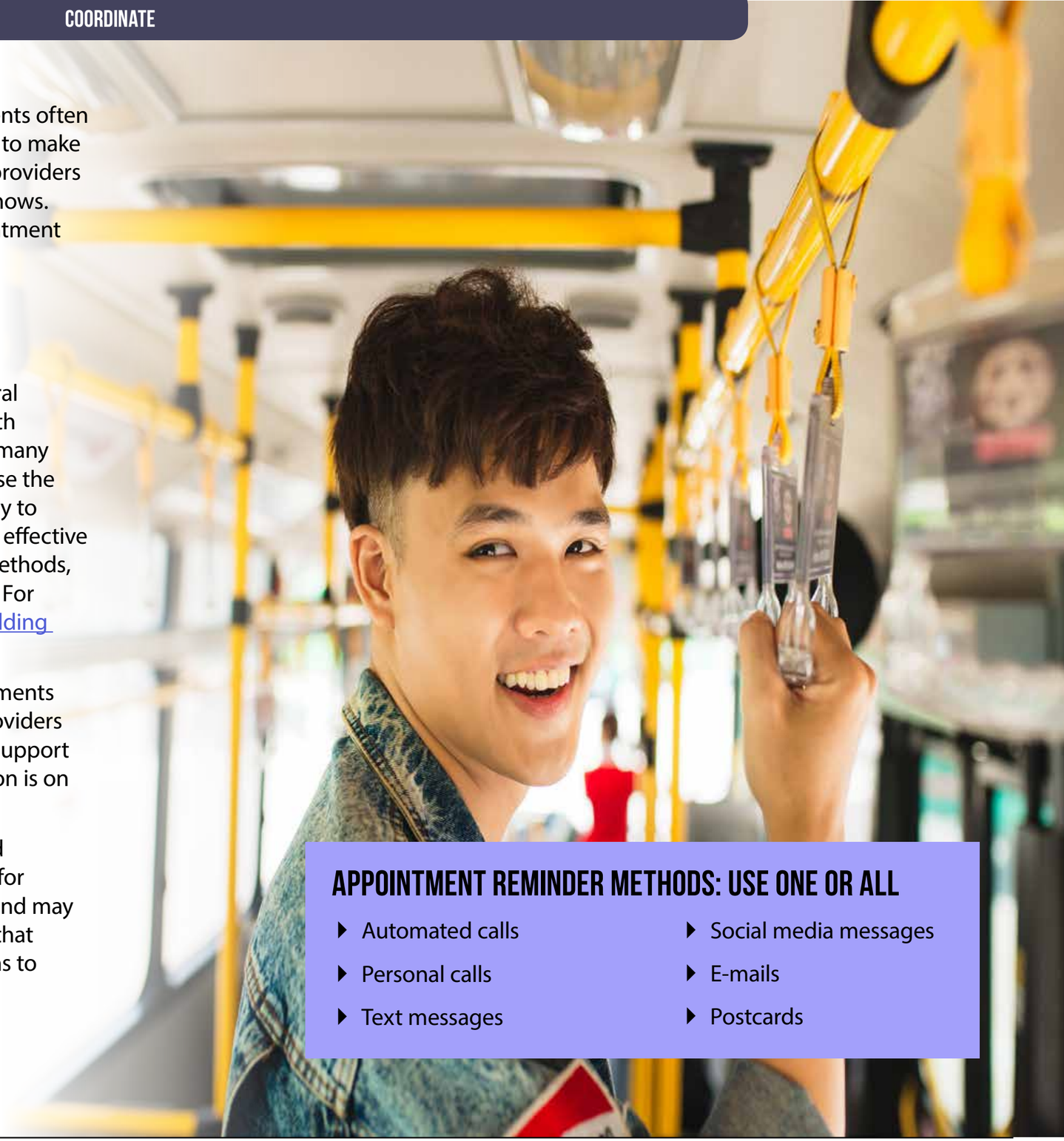
Oral health settings can play an important role in linking clients back to medical care. At one recipient site, with co-located oral health and primary care services, the EHR raises a red flag if an individual lost to care comes in for a dental appointment. The dental staff immediate call the individual's case manager who meets with the client to schedule a medical appointment.

SUPPORT APPOINTMENT ADHERENCE

Once referred, people with HIV may face barriers to attending appointments. Clients often struggle with competing priorities and comorbid conditions that make it difficult to make it to any appointment, particularly if they are not experiencing pain. Oral health providers are often less flexible than RWHAP providers with regard to scheduling and no-shows. In this environment, it is important to provide clients with comprehensive appointment support.

BEST PRACTICES

- **Use multiple reminder methods:** Whenever possible (e.g., when the referral process includes making appointments on behalf of the patient), follow up with clients in the days prior to remind them of an oral health appointment. While many oral health providers will also reach out to the patient, duplicate efforts increase the likelihood that the client will be reached. In addition, clients respond differently to different methods of outreach, so try multiple approaches to see what is most effective with your client population. You might also want to consider nontraditional methods, such as outreach through social media, that are more relatable to your clients. For ideas, check out "Improving Communication with Youth" in the HRSA HAB Building Futures Toolkit and the HRSA HAB SPNS Social Media initiative.
- **Provide transportation support:** Many clients struggle to attend appointments because they have no easy way to get to the appointment, and oral health providers may be inaccessible through public transportation. Arranging transportation support for clients to make their appointments (and reminding them that transportation is on the way) is a great way to use RWHAP funding for wraparound services.
- **Stress the importance of visit compliance:** To ensure that clients attend dental appointments, stress that oral health providers require advance notice for appointment cancellations. Oral health providers may not tolerate no-shows and may refuse to see clients who regularly miss appointments. The RWHAP providers that participated in the project reported that by communicating these expectations to clients, clients were less likely to miss the opportunity for care.



APPOINTMENT REMINDER METHODS: USE ONE OR ALL

- Automated calls
- Personal calls
- Text messages
- Social media messages
- E-mails
- Postcards

APPOINTMENT FOLLOW-UP

Whether you are referring clients to an on-site or external oral health provider, it is essential to follow up on your referrals to make sure that clients make it to their appointments. The next section has tips for using your EHR to share data, which you can also use to track visit compliance. In addition, encourage partners to alert you and/or follow up directly with clients about appointment attendance. Your team should contact clients who missed an appointment and address any barriers that prevented them from attending. Track client oral health visits and integrate this data with primary care visits to perform continual quality improvement and direct outreach activities.

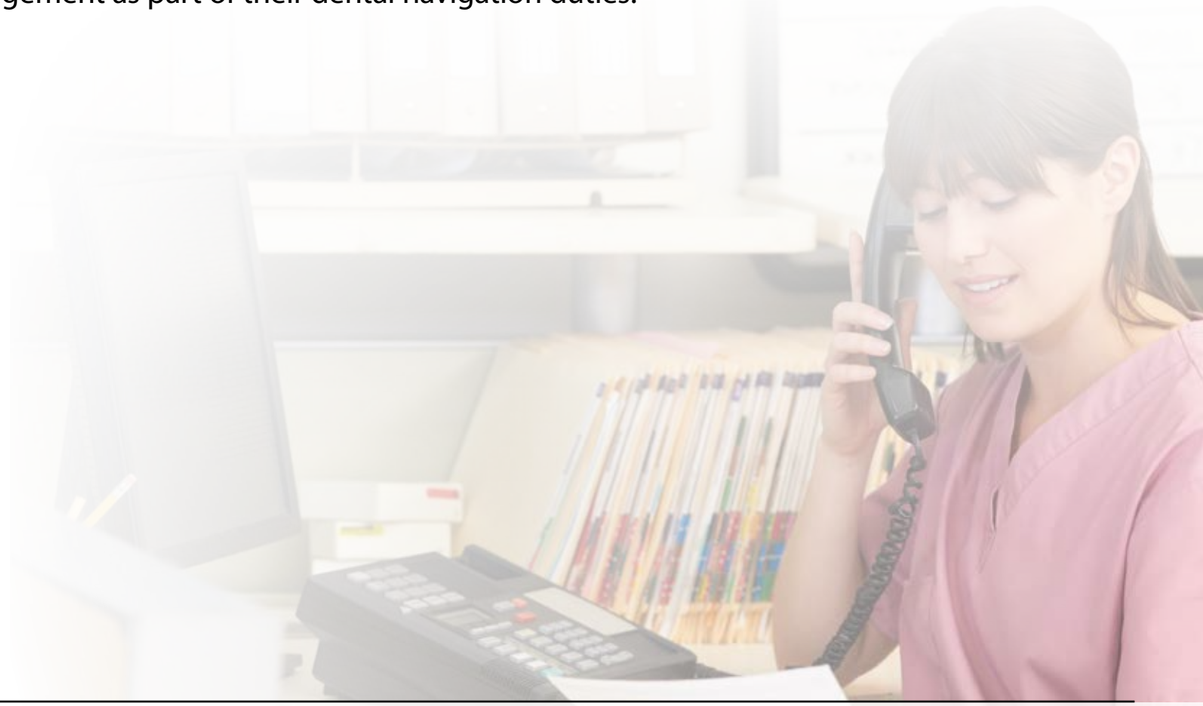
BEST PRACTICE: USE YOUR EHR

You can track appointment adherence by integrating oral health visits into your EHR, ranging from a yes/no indicator on attendance to detailed treatment plans from the oral health provider (see page 26 for addditional tips for using your EHR to share data).

DENTAL PATIENT NAVIGATION

One approach to offering comprehensive oral health support is to appoint or hire a dental patient navigator. Dental patient navigators function similarly to case managers, but their background in oral health is leveraged to facilitate referrals, explain oral health procedures to clients, and provide the support discussed in this section. While dental patient navigators are a part of the primary care setting, their oral health knowledge is a powerful bridge to oral health settings. As the "bridge" between clients and their dental care providers, patient navigators are well suited to educate and provide comfort to reduce anxiety.[2,3,4]

Dental patient navigation has been shown effective in many studies and projects, including those specific to HIV, such as the HRSA HAB SPNS Oral Health Initiative, many of which have different implementation approaches. Some providers prefer to hire dental assistants or hygienists as navigators given their expertise in the field. Other providers train HIV case management staff on oral health so they are able to specialize. Regardless of the approach you choose, the providers who participated in this project who had dental patient navigators emphasized the importance of continuing to provide HIV case management as part of their dental navigation duties.



[2] Jones, J., Mofidi, M., Bednarsh, H., Gambrell, A., & Tobias, C. (2012). Increasing Access to Oral Health Care for People Living with HIV/AIDS in Rural Oregon. Public Health Reports, 65-72.

[3] Lemay, C. A., Kretsedemas, M., & Graves, J. R. (2010). Satisfaction with dental case management among people living with HIV/AIDS. Journal of Community Health, 43-52

[4] Theile, C. W., Strauss, S. M., Northridge, M. E., & Birenz, S. (2016). The Oral Health Care Manager in a Patient-Centered Health Facility. Journal of Evidence Based Dental Practice, 34-42.

BEST PRACTICES

- **Choose a staffing model and formalize roles:** Depending on your case management and oral health capabilities, you may want to designate and train an existing employee or hire a new staff person (see the Sustain section for information on how providers are paying for staff). You will need to clearly distinguish how the role of dental patient navigator differs from HIV case management.
- **Bring oral health into the care team:** Many RWHAP recipients have adopted an interdisciplinary care team approach to treat clients' HIV needs as a whole. Your dental patient navigator should be integrated into the care team to represent oral health as a part of clients' overall health.
- **Offer regular training:** Offer regular training opportunities on HIV to dental patient navigators to ensure they understand HIV and oral health and can communicate effectively with clients. Your dental patient navigators are also valuable resources to cross-train your primary care team on oral health.

Having patient coordinators does a lot for patients because they feel that someone is there to hold their hand, basically, and to take care of them. So we need that push to get through their dental care. There's a lot of things that patients don't understand as far as terminology and the process and the time that it takes to get through their dental treatment plan. And if there's someone there explaining that the whole way, I think they have a better chance of sticking through and completing what they start.

- RWHAP provider

SHARE

Successfully integrating oral and primary health care requires a mechanism for exchanging information between the primary care and oral health care settings. Data help to inform both settings on clients' treatment plans as a whole and inform all of the topics discussed in this toolkit. Determining what – and how – data sharing is best for your site is crucial for model development, operation and evaluation.

WHAT DATA MATTER?

Providers who are working together to treat a patient should have access to client health information and medical and oral health history. This information, along with medications and appointment attendance history, can inform a comprehensive client care plan. Care plans serve as a "road map" to a client's individualized care. Without an effective method for sharing data, PCPs may not have the information they need to incorporate oral health treatment into their care plan. Finally, client evaluations, including verbal oral health screens and reviews of client data, can signal to PCPs how often clients should return for oral health care services based on risk factors such as tobacco and alcohol use, oral hygiene practices, and diet.

WHAT DO DENTISTS NEED FROM PCPS?

1. Client Health Information, medical and dental history and up-to-date labs
2. Medication regimen
3. Barriers to care that could affect dentistry (fear, etc.)

WHAT DO PCPS NEED FROM DENTISTS?

1. Client's care plan
2. Prescribed medications
3. Appointment adherence and follow-up information
4. Risk factors that may impact primary health (significant dry mouth, gingivitis, etc.)

BEST PRACTICE: IDENTIFY NEED-TO-KNOW DATA

Oral health providers who feel overburdened by data sharing responsibilities may not want to partner with you. Similarly, your primary care team may not want or need detailed data back. For example, one PCP we interviewed indicated that upcoming procedures (and treatment timeline) inform primary care delivery, but x-rays do not. Coordinate across teams to figure out what data elements and reporting format makes the most sense for everyone.

DON'T FORGET ABOUT CASE MANAGEMENT

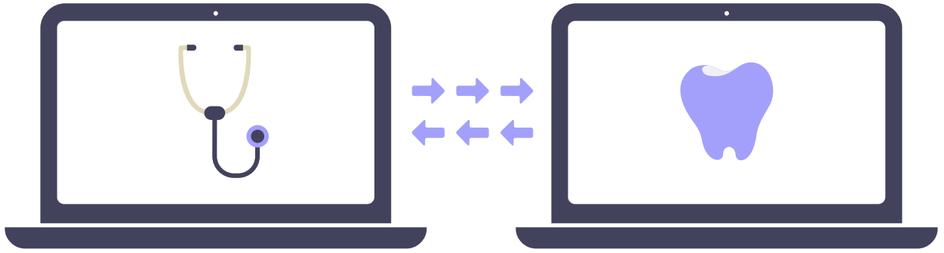
Case managers may have a better understanding of the effort required to facilitate a transfer of information. When deciding what information to share between settings, include case managers in the discussion.

HOW TO SHARE IT

Once you know what data to exchange between settings, you will need to come up with strategies for getting data to and from the oral health setting. This is heavily influenced by your model type: co-located models may want to build out interoperable EHRs and EDRs, whereas referral-based models do not have that ability. While being able to fully access all data in both the primary care and oral health setting is great, other strategies work better in different contexts. The providers who participated in this project fell into three categories of data system integration, each of which gave them access to needed data.

Single system: Some data systems contain both medical and dental information in one place. These systems allow both teams access to comprehensive information such as medications, labs, treatment plans, and notes from both teams. Some information may be held back for client privacy.

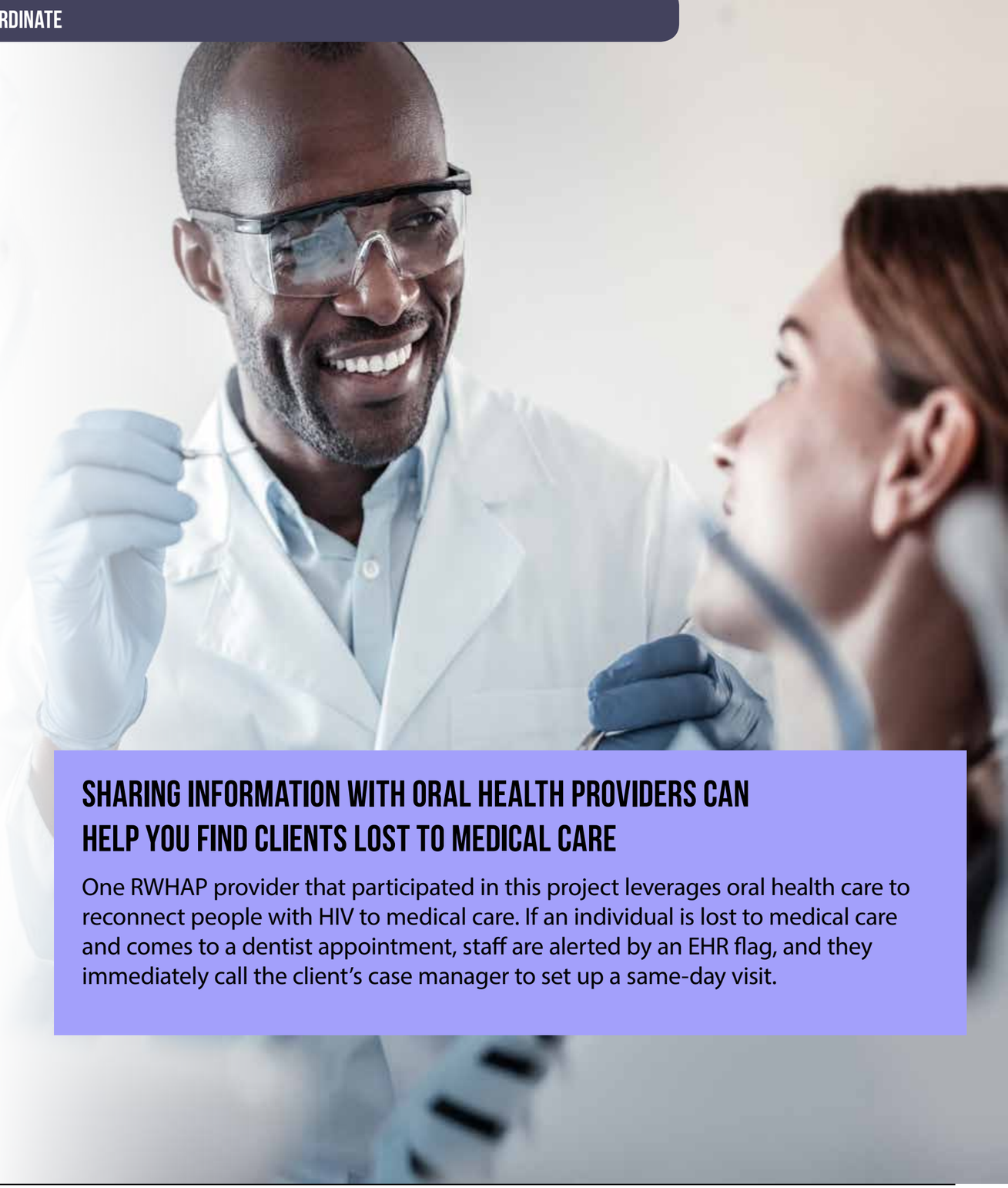
Linked: Other data systems allow more limited access by linking an EHR and EDR to one another. For example, the primary care team at one provider can "click the tooth" in their EHR to see all oral health records. Data are available but may require an extra step to access or have restrictions on who can see certain fields.



Manual: Even if data are not shared electronically, manual integration is possible. You may use your EHR to generate a referral sheet with relevant data to send with a referral and request a dental treatment plan in return to scan and upload into your EHR notes.

BEST PRACTICES

- **Evaluate your current capacity:** No one approach to data sharing is best for every provider. Evaluate your system and check in with relevant members of your team to see what data can be accessed. Integration may be as simple as giving privileges within your existing EHR or designating a staff person to scan treatment plans. Think outside the box — one provider realized that their billing staff received treatment plans along with the oral health providers' invoices, so they were able to easily integrate this information into their EHR.
- **Keep it standard:** Creating standard referral forms that include client information such as a medication list, viral load, CD4 count, and other recent lab work as applicable (for example, an A1C test for a diabetic client) can help ensure oral health and primary health teams are on the same page. A standardized template, such as the example below, can help oral health providers quickly identify the information they need.
- **Meet to discuss data:** If your oral health and primary care services are co-located, consider bringing everyone together for interdisciplinary care team meetings to go over data such as missed appointments and high-need clients. In addition, creating designated break rooms where clinicians and support staff can meet without being interrupted by clients is a great way to get additional face time and allow cross talk in a relaxed setting. If care teams are not co-located or can't make time in their schedules to meet in person, consider meeting digitally.
- **Require treatment plans for payment:** If you refer to external oral health providers, one way to ensure that you get data back is to require that they submit treatment plans with their invoices. Treatment plans can then be reviewed and approved, meaning you can monitor expenses and incorporate data into your internal system.
- **Cross-train your staff:** To make sure that staff are able to interpret and use the data they have access to, train your primary care staff on basic oral health information (e.g., what common conditions are named and how they are treated) and, if applicable, your oral health staff on basic HIV information (e.g., what a vial load means). Train all staff on how to access data in your EHR and/or EDR.



SHARING INFORMATION WITH ORAL HEALTH PROVIDERS CAN HELP YOU FIND CLIENTS LOST TO MEDICAL CARE

One RWHAP provider that participated in this project leverages oral health care to reconnect people with HIV to medical care. If an individual is lost to medical care and comes to a dentist appointment, staff are alerted by an EHR flag, and they immediately call the client's case manager to set up a same-day visit.

SECTION 5
BUILD AND SUSTAIN

Integrating oral health and primary care services requires both short- and long-term planning, but there are various implementation facilitators that can help bridge the gap between these two settings. In addition, providers should consider funding sources and sustainability of these services.

IMPLEMENTATION FACILITATORS AND TIPS

The RWHAP providers that participated in this project cited various facilitators that helped them build out these integration components. In some cases, there were clear "oral health champions" who made oral health and primary care integration a priority and served as a resource that "bridged the gap" between these two settings. Similarly, close working relationships between dental directors and medical directors helped build successful co-located models. Another RWHAP provider indicated that a PCP's passion for including oral health in comprehensive care was essential in building out the model. In other cases, the availability of funding, such as program income generated from 340B, encouraged staff to brainstorm innovative approaches to oral health.

To support ongoing implementation, RWHAP providers highlighted the importance of having specific, passionate staff who make oral health and primary care integration a priority on a day-to-day basis. For example, dental patient navigators can support scheduling, billing, and visit compliance but also train primary care staff about oral health, advocate for frequent referrals from the primary care setting, and request additional information beyond that on the standard referral form to prioritize clients with the greatest need. These individuals can keep oral health "on the radar" with so many other competing priorities.

Finally, support implementation by measuring progress and sharing the good news. Consider adopting an "oral health care cascade," starting with the number of people with HIV who received a medical visit and then tracking the share with a dental referral, a dental visit, and a completed dental treatment plan. Also consider adopting measures that address aspects of integration, such as data sharing and dentist/PCP communication.

BE AN ORAL HEALTH CHAMPION!

Regardless of model, oral health champions — staff members who are passionate about oral health care access — help to make integration a priority on a day-to-day basis. Champions help to keep oral health in the conversation as decisions are made about resources, clinic priorities, and care planning. Reading and sharing this toolkit is a great step toward becoming a champion at your site!

SUSTAINABILITY

Oral health services can be expensive, and coverage of services is often inadequate. Integrating oral health and primary care services requires both short- and long-term planning

CONSIDER THE COSTS

While paying directly for services is an important piece of connecting clients to care, there are numerous other costs you must consider. Once you have reviewed the strategies outlined in this toolkit, consider those that are the best fit for your site and think through the costs associated with implementation, such as the following:

- **Service costs,** including the expense of the procedures and assisting clients with cost-sharing responsibilities.
- **Staffing costs** to hire a dentist, dental patient navigator, or other allied dental health care worker. Providers who designate a current employee to conduct screenings or manage referrals will need to determine if additional staff are necessary to maintain continuity of care for other priorities.
- **Unreimbursed staffing costs** such as time for client education and assessments, interdisciplinary care team meetings, referral coordination, communication, and training staff on oral health care needs.
- **Supply costs** for procedures and for oral health promotion, such as the distribution of products to clients.
- **IT costs** related to building EHR/EDR capacity, integration, and/or interoperability. While integrated systems are powerful tools to support coordination across settings, they can be expensive to develop.

CONSIDER THE COSTS

- Identify relevant components of integration
- Decide which approaches are feasible

IDENTIFY PAYMENT OPPORTUNITIES

- Look for funding options for oral health services
- Identify existing state, jurisdiction and local programs
- Develop supporting documentation for coverage

DEVELOP COST CONTAINMENT STRATEGIES

- Develop care utilization controls
- Sets caps and/or a fee schedule for services
- Engage lower-cost professionals

RWHAP AND ORAL HEALTH

Oral health services are paid for under all Parts of the RWHAP, including RWHAP Part F programs specifically designed to support oral health care. Some states and jurisdictions have developed networks of providers and dentists to help connect RWHAP clients to services; other providers have developed strategies using their own direct grant funding. Several uses of RWHAP funds for oral health services are shared below.

- All RWHAP Parts pay directly for RWHAP health services, often through reimbursement. One provider bills RWHAP Part B for reimbursement of services and also uses RWHAP Parts C and D funds for emergency services if payment is required up-front.
- One RWHAP Part A recipient funds a single organization for dental patient navigation and case management services, which manages referrals to oral health care for all the jurisdiction's providers.
- RWHAP Part B and ADAP programs in several states purchase dental insurance for clients.
- In collaboration with NYU Langone, one provider leverages RWHAP Part F funding to hire a dental patient navigator and pay directly for services. In turn, the provider helps prepare the new dental workforce by offering training to dental residents on treating people with HIV.
- Several providers have built up oral health capacity using program income for activities such as hiring staff, paying for services, and purchasing dental hygiene supplies.
- One provider uses 340B program income funding to purchase dental supplies and cover care coordination costs.

OTHER ORAL HEALTH PAYERS

Though RWHAP is a key player in paying for oral health services, funds may only be used to pay for services if no other sources are available. Many RWHAP clients are also eligible for Medicaid coverage, but Medicaid coverage of dental services is far from comprehensive. Extensive dental coverage for adults is available in only 19 states, with many states offering only emergency or limited coverage. RWHAP will cover procedures that are not covered by Medicaid if it is to assure the best health outcomes: for example, a root canal and crown as opposed to a tooth extraction. In addition, Federally Qualified Health Centers receive federal funding that can be channeled to oral health services.

You may use RWHAP to cover administrative costs or wraparound services. For example, you may bill Medicaid for a specific procedure and use RWHAP funds to pay for patient navigation and transportation services to help your clients make it to their dental appointment.

BEST PRACTICE: SEE WHAT OTHER RWHAP PARTNERS ARE DOING

If you are funded by any RWHAP recipient, particularly through RWHAP Parts A and B, a great place to start is reaching out to your recipient(s) to ask what they currently do — and are interested in doing — to expand access to oral health care. If there is currently no infrastructure, look to what other recipients have done; there's no need to reinvent the wheel! Models such as the Boston Public Health Commission's Ryan White Dental Program have been successful templates for other providers.

COST CONTAINMENT STRATEGIES

Even with these resources available, funds are not always sufficient to meet all needs. RWHAP funds may not be enough to cover complex (and expensive) procedures for all clients. Therefore, consider the below cost-containment strategies to ensure that your model is sustainable.

- **Develop a fee schedule:** Providers that reimburse dentists using RWHAP funds should consider establishing a fee schedule that will encourage participation while containing costs. While Medicaid reimbursement rates could be used as a baseline, providers may need to raise some rates to enhance the provider network. Several HRSA HAB SPNS Oral Health Initiative recipients also implemented a sliding-fee scale so clients could pick up some of the costs based on their ability to pay. You may also wish to negotiate set fees with private oral health providers in your referral network.
- **Set a cap on yearly per-client expenditures:** Providers commonly set a cap on the amount of money that can be spent on an individual client's oral health services during the year. Most commonly, the providers that we visited had an annual cap of $1,000 to $3,000 for services. However, all providers offered exceptions for clients when medically necessary procedures were over the cap.
- **Develop a prior authorization process:** Providers also commonly require that a PCP, case manager, dental staff person, and/or administrator review and approve all treatment plans before funds may be expended for services. Referral-based providers in particular may want to require external dentists to submit treatment plans to ensure optimal services are approved. When developing these prior authorization processes, providers may mitigate conflicts of interest by having an independent party review proposed treatment plans, as opposed to the dentists who will perform the services themselves. Exceptions to prior authorization for dental emergencies is a key component of successful programs.
- **Engage dental schools and residents:** Providers should also consider partnering with accredited dental education programs so that undergraduate dental students, dental residents, dental hygiene students, and dental assistant students can provide some oral health care. This strategy not only prepares a new generation of oral health staff to treat people with HIV but also controls costs because services delivered by students are not as costly as those by professionals. [1]
- **Engage diverse professionals:** Innovations in the dental workforce to expand the role of allied oral health professionals such as dental therapists and hygienists can help increase capacity and willingness to treat individuals with low income. For example, dental hygienists are often capable of performing many of the procedures commonly performed by dentists. Check the regulations in your state regarding dental hygienists' ability to provide services without the direct supervision of a dentist (for example, see the National Advisory Committee on Rural Health and Human Services' 2018 brief on oral health access). [2]

[1] Fox et al. (2012). Increasing Access to Oral Health Care for People Living with HIV/AIDS in the U.S.: Baseline Evaluation Results of the Innovations in Oral Health Care Initiative. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3314388/

[2] National Advisory Committee on Rural Health and Human Services. (2018). Improving Oral Health Services in Rural America.

HRSA Ryan White & Global HIV/AIDS Programs