

Primary Care Recommendations for Oral Health Care in HIV+ Patients

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About COH:

The Center for Oral Health (COH), founded in 1985, is a non-profit organization dedicated to promoting public oral health, with a focus on children and vulnerable populations. COH collaborates with national, state, and local partners to develop innovative community-based strategies for improving oral health outcomes. COH has offices in Northern and Southern California.

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Executive Summary

The unmet need for oral health care in People Living With Human Immunodeficiency Virus or Acquired Immunodeficiency Syndrome (PLWHA) is well documented, and the need to devise strategies to meet those needs has been recognized in the United States. A large proportion of PLWHA have very poor oral hygiene, and most do not receive the dental care they need. According to Regina Benjamin, the 18th Surgeon General of the United States, "While good oral health is important to the well-being of all population groups, it is especially critical for PLWHA. Inadequate oral health care can undermine HIV treatment and diminish quality of life, yet many individuals living with HIV are not receiving the necessary oral health care that would optimize their treatment."

Primary care, as a field, has yet to assume a strong leadership role in meeting the unmet oral health care needs of HIV+ individuals. HIV is now in its fourth decade, yet PLWHA still deal with a great deal of stigma, which hinders their access to oral health care. Primary care providers, however, are in a unique position to partner with dentists to triage, diagnose, educate and address the oral health needs of PLWHA. The purpose of this brief is to define the role that primary care physicians can play in advocating for more effective oral health care strategies for PLWHA.

Background and Introduction

It is estimated that approximately 39.5 million people worldwide are living with HIV (Peltzer & Mafuya, 2008). Additionally, it has been estimated that more than 90% of PLWHA will suffer at least one HIV-related oral lesion during the course of their disease (Weniert, Grimes, & Lynch, 1996). The U.S. Centers for Disease Control and Prevention (CDC) estimates that approximately 1.1 million people are living with HIV in the United States (Cohen et al., 2013). Because oral infections are common in PLWHA, this disenfranchised population is at a greater risk of developing HIV-related fungal, bacterial, and/or viral infections of the oral cavity (Patton & van der Horst, 1999). Overlooking these infections, by patients or care providers, may lead to the deterioration of teeth, gums, and the overall degradation of the oral cavity. Infections can then create oral pain, which can ultimately make eating, and possibly, breathing difficult (Birkhead et al., 2001).

Body weight may decline as food intake lessens, which can lead to mental and physiologic stress. The implications of this can be severe, as a lack of adequate nutrition can lessen the ability to fight off infections, as well as interfere with certain HIV medication regimens (Birkhead et al., 2001). This vicious cycle is perpetuated when anti-retroviral medications are not able to suppress HIV. In turn, the body's ability to fight off oral and other systemic infections is impaired.

Compounding the problems faced by PLWHA in accessing dental care is the shortage of providers that are willing to provide care for HIV positive patients, including primary care physicians and dentists (Levett et al., 2009). Health workers may be concerned with the risk of becoming infected with HIV and thus, may fear close contact with PLWHA. In a 2005 study by Giuliani et al., there were 1,247 dental hygienists who were asked if they had ever denied services to an HIV positive individual. Only 287 responded to the survey, and 5.9% admitted denying services to PLWHA. A later 2011 study by Giuliani et al. demonstrated that of 883 HIV+ patients that completed the survey (n=1,500), 630 people received dental care. Of this number, 209 individuals (or 33.2%) did not disclose their HIV status to their dentist. Of those patients that did disclose their status, 56 were refused care by their dentists.

This stigmatization, marginalization, and fear of HIV create barriers to care and contribute to the lack of providers that are willing to treat PLWHA. Therefore, the willingness to treat PLWHA by providers becomes inversely proportional to the increasing stigmatization, which stems from preconceived notions related to homophobia, IV drug users, and what some may perceive as a promiscuous lifestyle. In 2012, the Loyola Marymount University School of Law reported that 5% of dentists in Los Angeles, CA have a blanket policy of refusing services to PLWHA (Sears, Cooper, Younai, & Donohoe, 2012). While these rates are lower than that for many other types of health

care providers, each of these studies highlighted that PLWHA of lower economic status, LGBTQ, female gender, and people of color face a higher discrimination rate. Additionally, too few health care providers are adequately trained and experienced in providing for the oral health care needs of these patients (HealthHIV, 2014; Birkhead et al., 2001). As a result, the U.S. health care system is ill prepared to cope with PLWHA.

Existing Resources

Several studies have shown that there is inadequate coverage by private insurance companies (HealthHIV, 2014). Secondly, there is a decline in state Medicaid program funding for dental care (McKinny, 2005; Johnson, Oliff, & Williams, 2011). Third, dental services are very expensive; this makes it difficult for individuals to pay for out-of-pocket expenses (Fox et al., 2012). Finally, there are few existing programs that are designed to specifically provide oral care to PLWHA (HealthHIV, 2014).

Programs funded under the Ryan White CARE Act promote innovative HIV/AIDS care models that utilize a variety of interprofessional collaborative methods. Many of these programs have been shown to be successful (Bachman, Abel, & Reznik, 2012). The results of the 1994 – 2000 Rand Corporation HIV Cost and Services Utilization Study (HCSUS) revealed that many unmet needs were improved by the use of innovative, collaborative approaches (Hays et al., 2000). However, continued, reliable funding and support from programs, such as the Ryan White CARE Act, Medicaid, and private sources will be essential if the oral health disparities that afflict PLWHA are to be overcome.

Recommendations

Data from the 1994 – 2000 Rand HIV Cost and Utilization Study found that only 26% of PLWHA reported daily flossing. Only 34% reported brushing and flossing, 23% reported seeing a dentist, and 11%

reported never doing an oral self-examination (Freed, et al., 2005). Additionally, the oral lesions that are often associated with HIV lead to decreased salivation (Peterson, 2003).

By comparison, the U.S. Centers for Disease Control and Prevention, (2012), reported that 61.6% of adults between the ages of 18 and 64 and 61.8% of adults over the age of 65 reported seeing a dentist in the previous year (U.S. Center’s for Disease Control and Prevention [CDC], 2012). Furthermore, 85% of all Americans report daily brushing and/or flossing (GFK Roper Public Affairs and Media, 2008). While these numbers do not separate those living with HIV or AIDS from those that are HIV negative, these sordid statistics show that more attention needs to be given to the oral healthcare needs of PLWHA.

Primary care physicians must be committed to taking a leadership role in reducing and eliminating the oral health disparities faced by PLWHA. In order to do this, primary care physicians must adopt effective and innovative strategies, as well as assume a greater role in providing oral health care to PLWHA. Additionally, primary care physicians should be open to new collaborative models of care that include working with dental care providers, participating in new training paradigms, and utilizing the resources of health educators and health coaches as a means to reduce the workload that many primary care physicians face in the clinic.

I. Primary care provision of oral health care to PLWHA

Innovations and the increasing effectiveness of HIV treatments over the past few decades have significantly improved survival rates for PLWHA (Deeks, Lewin, & Havir, 2013). As such, HIV for many individuals is considered as a chronic condition that can be managed by primary care physicians. Improving oral health care for PLWHA can be accomplished through health promotion and disease prevention, health maintenance, counseling, patient

education, diagnosis and the treatment of acute and chronic diseases. Primary care physicians and their clinic entity should also serve as care coordinators and patient advocates. These various roles are important for all patients, but particularly for PLWHA, when the patients do not have access to a regular source of dental care.

In primary care settings, there are opportunities to be the first providers to recognize key signs and symptoms, and to be the first to diagnose oral problems on the front line. Some of the recognizable and manageable oral health conditions manifested by PLWHA who neglect their oral health are the following:

- Dry mouth, which may cause ulcers to be more severe
- Salivary gland disease
- Gingivitis
- Periodontitis
- Fungal infection (such as Candidiasis, Cryptococcosis, Histoplasmosis)
- Viral infections (HBV, HSV, HZV, HPV)
- Aphthous ulcers
- Oral and throat cancer (Birkhead et al., 2001; Greenspan & Greenspan, 1997).

In order to support the overall health of PLWHA and address their special oral health concerns, access to prevention, detection, early intervention and the provision of treatment are essential. Primary care physicians who see PLWHA are in a unique position to fill these critical service needs.

II. Tailoring Primary Care Visits to Meet the Oral Health Needs of PLWHA

There is no doubt that primary care physicians face challenges related to time and resource utilization, while providing patient care. However, making minimal adjustments to the focus of the history and physical will not add significant time to the patient’s

visit. At each visit, the physician should take into account the following items related to oral health:

History taking:

- Previous dental visits – to assess frequency of visits and any new diagnosis
- Oral health care behaviors – to assess good oral hygiene, self-monitoring of disease process
- Assess for other risk factors affecting oral health, as listed below:

Recreational drug use

- Corrosive to teeth- due to chemical contents
- Severe dry mouth
- Loss of the natural antimicrobial properties of saliva resulting in deterioration of teeth and gingivitis
- Periodontitis, if left untreated. Number one reason for adult tooth lost

Tobacco

- Smoking and chewing tobacco have long been associated oral cancers with smoking

Alcohol consumption

- Alcohol consumption is a major risk factor for certain head and neck cancers, particularly cancers of the oral cavity, pharynx (throat), and larynx (voice box).
- People who consume 50 or more grams of alcohol per day (3.5 or more drinks per day) have at least a two to three times greater risk of developing these cancers than nondrinkers.

Physical exam

- Examination of the oral cavity should be included in both the initial and subsequent physical examinations of all PLWHA.
- Patients with lesions that are suspected to be oral manifestations of HIV disease should be referred to

a dental health expert with experience in treating oral lesions associated with HIV/AIDS. Other oral lesions may be a sign of a systemic disease, a side effect of medications, or a result of poor oral hygiene.

When making treatment plans for the patient, primary care physicians should counsel patients on the following recommendations from the American Dental Association (ADA):

- Brush teeth twice a day with a soft-bristle brush
- Replace toothbrush every three to four months
- Clean between teeth daily with floss or interdental cleaner
- Eat a well-balanced diet and limit snacks, especially sugary foods and sodas
- Visit the dentist regularly for professional cleanings and oral exams
- Stop smoking, use of other tobacco products, and alcohol intake
- Use over-the-counter antimicrobial or fluoride rinses (American Dental Association [ADA], 2014; Wikholm, Galanti, Soder, & Gillijam, 2003; Petti & Scully, 2009).

The challenge faced by primary care physicians is to manage the office visit in a timely and efficient manner. These recommendations, however, allow for an efficient assessment of the patient; and, the physician has an opportunity to impress upon the patient the importance of dental care. To emphasize the collaborative, interdisciplinary care approach, primary care physicians should make dental referrals, where appropriate, for all PLWHA: 1) at the point of seroconversion diagnosis; and, 2) at any initial and/or subsequent primary care visit.

III. Oral Health Care Training for Primary Care Physicians and Increased Interprofessional Collaboration

Despite the high prevalence of oral disease in the United States, and its far-reaching health

consequences, primary care physicians and dental practitioners typically treat the oral cavity separately from the rest of the body (Sheiham & Steele, 2001; Sheiham & Watt, 2000; Mertz, Lindler, & Dower, 2011). Physicians receive little or no training in oral health care (Krol, 2004; Ferullo, Silk, & Savageau, 2011). Meanwhile, dentists receive little or no integration with other specialties within the medical community (Ifie, Anderson, & Valachovic, 2009). This is mainly because of the traditional separation of the dental and medical fields (Mertz et al., 2011). This has implications for how little primary care physicians and dentists, and their respective clinical care teams, know about how to communicate and jointly support their patients' oral health.

Despite the current state of affairs, promising research with Registered Nurses, Nurse Practitioners, and physician care extenders suggests that oral health care can be successfully integrated into primary care practice. For example, primary care physicians have been trained and enlisted to provide oral health services in school-based programs, such as the one managed by Hamilton Health Center in Harrisburg, PA, that uses nurses and other non-physician personnel to provide oral health assessments and fluoride varnish treatments (Pekruhn & Strozer, 2010).

The oral cavity should not be the sole responsibility of the dentist or infectious disease physician – it should be every physician's and dentist's responsibility. The mouth can be a harbinger of other medical issues when it presents to the primary care physician clues that may signal other disease states. Furthermore, the health of the mouth may give hints as to whether or not HIV medications are working. To this end, every primary care physician should receive oral health care training. This training would allow primary care physicians to better assess and take care of the needs of their HIV positive patients. In fact, the New York State Department of Health AIDS Institute recommends HIV oral health care training for all

members of the primary healthcare team (Birkhead et al., 2001).

Beyond increased training, what else can primary care practitioners do to ensure that their HIV positive patients receive adequate oral health care services? Primary care providers can and should advocate for increased collaboration and cooperation with their dental counterparts. Increasing interprofessional collaboration between primary care physicians and dentists may improve the early detection of oral manifestations of HIV, access to care, and treatment outcomes for patients. Other reasons to advocate for increased collaboration among primary care physicians and dentists include:

- Reducing the large number of preventable dental conditions that are too often treated in the emergency room (McNamara, 2012).
- Improve HIV and other chronic disease management.
- Address oral health issues by expanding entry points into the oral health care system (Institutes of Medicine [IOM], 2011).
- Facilitate the use of interdisciplinary techniques to overcome patient-specific barriers to accessing services (Munger, 2012).
- Provide cost savings to the health system by controlling oral health risk factors that are common to dental disease and chronic disease (Ide, Hoshuyama, & Takahashi, 2007).

In addition, primary care physicians are in a position to help patients find dentists who are knowledgeable about HIV. The stigma faced by PLWHA makes the search for an HIV-friendly dentist harder. Having a dentist who is open to treating HIV positive patients, and has experience in HIV oral care, will help alleviate the patient's fear of being denied care. The dentist will also be an ally in recognizing HIV-related oral health problems and treating these manifestations. Thus, a referral to a dentist is an absolute must for good, holistic care.

Finally, primary care physicians must partner with dentists not only to seamlessly provide good oral health care, but also to educate patients about the importance of good oral health care practices. Studies have shown that good oral health care practices are linked to better HIV care and overall health outcomes (Tobias, Fox, Walter, Lemay, & Abel, 2012). Because primary care physicians and dentists are so busy with seeing patients and concerning themselves with issues such as care coordination, there is typically little time to provide health education. This is where the services of trained health educators or health coaches should be utilized.

IV. Involving Health Educators and Health Coaches in Oral Care for PLWHA

Being a primary care physician has always been a time consuming job. Primary care physicians must not only treat patients, but also be responsible for coordinating care for their patients. In order to achieve these goals, primary care physicians must have time, a fairly large knowledge base, the ability to navigate complex health systems, and have the ability to look at the big picture regarding a patient's health and life (Dugdale, Epstein, & Pantilat, 1999). Despite advances that have been touted to allow physicians to better utilize their time, one of the consistent complaints from primary care physicians, not just in the United States, but in Europe as well, is that many feel that they do not have adequate time to spend with their patients (Konrad et al., 2010; Tsigas, Panagopoulou, Sevdalis, Montgomery, & Benos, 2013).

So then, what tools exist that might help primary care physicians better utilize their time when seeing patients? Some have suggested the use of trained health coaches and health educators to assist with providing patient education, medication list reconciliation, and other administrative duties that take up so much of a physician's time. Broadly speaking, health coaching is a process that facilitates healthy, sustainable behavior change by using

Motivational Interviewing (MI) to challenge a client to listen to their inner wisdom, identify their values, and transform their goals into action (Starr, 2008; Riley & Mittelman, 2013). Educationally speaking, health coaches may range from having a high school diploma to a master's-level degree. While there is no national-level certification, various companies have started to offer training programs that lead to Certificates of Completion. This is a first step toward some sort of national certification (Riley & Mittelman, 2013; Lawson, 2013).

Health educators, on the other hand, are formally trained allied health professionals. Usually requiring a minimum of a bachelor's degree in health education, community health promotion, wellness, or public health, these individuals have the opportunity to take the Certified Health Education Specialist (CHES) exam. Upon successfully passing the exam, individuals are considered to have met a set of seven core competencies for health educators. These competencies are:

Area I: Assess Needs, Assets and Capacity for Health Education

Area II: Plan Health Education

Area III: Implement Health Education

Area IV: Conduct Evaluation and Research Related to Health Education

Area V: Administer and Manage Health Education

Area VI: Serve as a Health Education Resource Person

Area VII: Communicate and Advocate for Health and Health Education (National Commission for Health Education Credentialing, Inc. [NCHEC], 2008).

In order to maintain this certification, one must earn 75 CEU's every five years. These CEU's can cover topics ranging from nutrition, to chronic disease management, and to HIV/AIDS care.

While many primary care physicians and dentists are unaware of what role health coaches and health educators could play in providing health education services to PLWHA in the clinical setting, research has

clearly demonstrated the utility of these two fields when dealing with other disease conditions. For example, a 2010 study by Wolever et al. demonstrated the utility of using health coaches and health educators not only to educate patients about their diabetes, but to also coach them on behavior change. The study showed that after six months, individuals who were coached showed an improvement in medication adherence. Coaching also had a positive effect on the patient's knowledge, skills, self-efficacy and behavior change surrounding diabetes and nutrition. Individuals in the control group did not show any improvement. Additionally, the coached participants, with a hemoglobin A1C over 7%, showed significant improvement in their A1C levels. There is no reason to think that utilizing health coaches and/or health educators in the clinical setting would not assist physicians with better utilizing their time to provide care for PLWHA.

Conclusion

In 2009, the HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America (IDSA) published "Primary Care Guidelines for the Management of Persons Infected with Human Immunodeficiency Virus." This document included recommendations for routine health maintenance, behavioral interventions, laboratory testing, and prophylaxis care for PLWHA (Aberg et al., 2013). The report, however, did not include recommendations related to oral health care. With no clear guidelines for primary care physicians regarding the provision of oral care for PLWHA, there may be inadequate history taking and little ownership of comprehensive patient education.

One area in which primary care physicians can advocate for change begins in the medical school curricula. It is important that schools train future physicians who are competent in recognizing, diagnosing, and managing the new chronic aspects of HIV. Primary care physicians should advocate for curricula that stress holistic care and interprofessional

training with dentists and other health professionals. Ultimately, the goal of medical education is to train physicians that are dedicated to improving the health of all patients, including PLWHA.

On a day-to-day basis, physician preceptors model desired behaviors to medical students, medical residents, and other health professions students. There are opportunities to model cooperative behavior for the students, to show how one can reach out to dental and other health professional colleagues for advice and referrals. Physicians should also model how to eliminate HIV stigma and allow patients who are PLWHA to feel safe and welcomed in the medical environment. It is especially an important charge to model compassionate and competent care when it comes to eliminating the stigma surrounding HIV and AIDS.

Finally, primary care physicians should advocate for policy changes that mandate the inclusion of HIV/AIDS-related Continuing Education Units (CEU's) for physicians that are seeking to renew their licensure. The State of Florida requires all osteopathic and allopathic physicians that are renewing their license for the first time to have a minimum of one CEU related to HIV/AIDS care (Florida Board of Medicine, 2014; Florida Board of Osteopathic Medicine, 2014). While this is undoubtedly a step in the right direction, physicians in Florida must only participate in earning HIV/AIDS CEU's once. Because the state of HIV/AIDS care has rapidly changed in the four decades since the virus was first recognized, it is important for physicians to stay abreast of the current knowledge regarding HIV. Primary care physicians can and should advocate for physicians of all specialties to pursue more continuing education related to HIV and AIDS that goes beyond the minimum. They should also advocate for the pursuit of HIV/AIDS CEU's mandatory for re-licensure nationwide.

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