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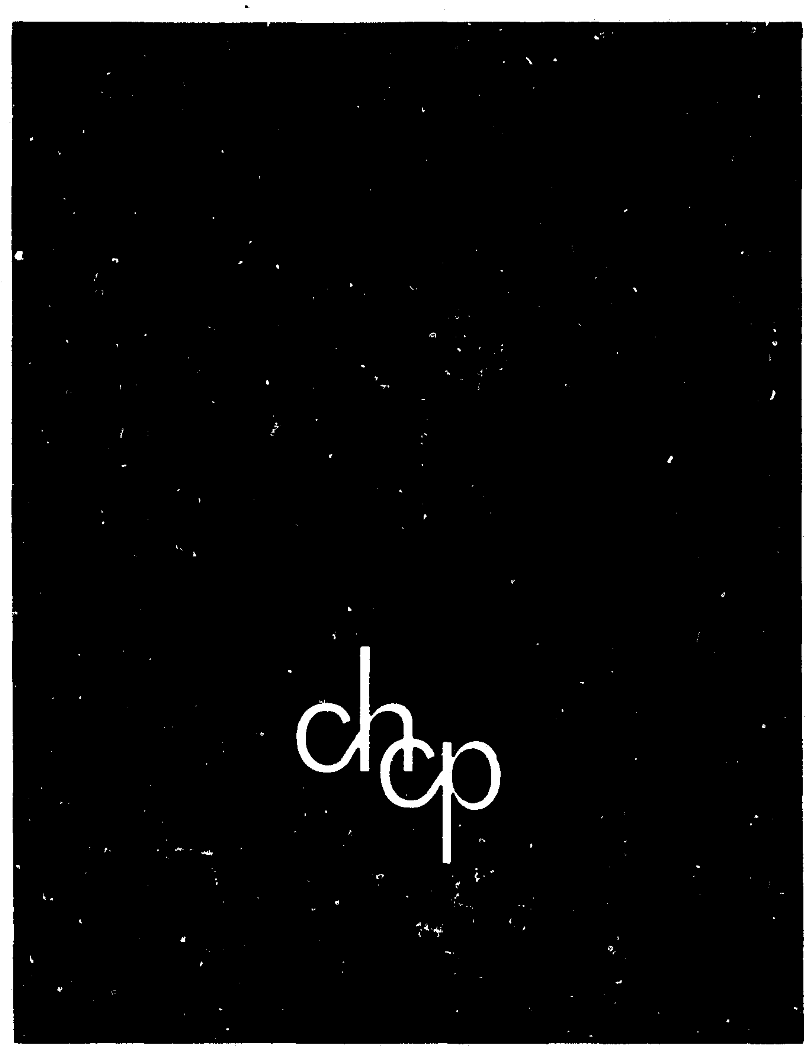

CORRECTIONAL HEALTH CARE PROGRAM

# Correctional Health Care Program

RESOURCE MANUAL

DENTAL HEALTH PROGRAMS

FOR

CORRECTIONAL INSTITUTIONS

FIRST EDITION

NCJRS

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ACQUISITIONS

MICHIGAN DEPARTMENT OF CORRECTIONS
OFFICE OF HEALTH CARE

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Correctional Health Care Program
Michigan Department of Corrections
Office of Health Care
Law Enforcement Assistance Administration

# DENTAL HEALTH PROGRAMS
# FOR
# CORRECTIONAL INSTITUTIONS

First Edition

Prepared By:

MICHAEL W. EASLEY, D.D.S.
Program in Dental Public Health, School of Public Health
The University of Michigan, Ann Arbor, Michigan
Formerly: Chief Dental Officer
Milan Federal Correctional Institute
Milan, Michigan, and
Assistant Dental Officer
Medical Center for Federal Prisoners
Springfield, Missouri

and

RICHARD L. LICHTENSTEIN, M.P.H., Lecturer
Department of Medical Care Organization
School of Public Health
The University of Michigan, Ann Arbor, Michigan
Co-Director, Correctional Health Care Program

The Correctional Health Care Program is funded by Grant Number 77-ED-99-0026 awarded to the Michigan Department of Corrections by the Law Enforcement Assistance Administration, United States Department of Justice. The primary purpose of this grant is to assist a group of ten states in improving health care services in their correctional systems. Collaborating with the Michigan Department of Corrections on this project are the American Medical Association, the Department of Medical Care Organization of the University of Michigan and the Department of Community Health Science of Michigan State University. Major activities condicted as part of this project include the development of standards for health services in prisons; training programs for administrators, trainers and providers of health services in participating states; and on-site technical assistance in the ten states. This report was prepared as part of the technical assistance phase of the project. Points of view or opinions stated in this report are those of the authors and do not necessarily represent the official opinion of the United States Department of Justice.

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Office of Health Care
3222 South Logan - Logan Center
Lansing, Michigan 48913

# F O R E W O R D

The issues of adequacy, accessibility, and quality of health care service delivery in correctional institutions are increasingly receiving well-merited attention. Long plagued by neglect and paucity of resources, most correctional agencies throughout the country have recognized the need for clear direction in addressing these issues. The unique characteristics of prison populations and facilities pose a problem in applying directly the standards and policies which prevail in community health care settings. Once the basic ingredients common to good health care practice have been identified, the challenge remains of their adaptation without essential compromise to the correctional environment. Implementation of a system which meets statutory and professional standards is the responsibility of correctional health care administrators in the 1980's.

Through a grant from the Law Enforcement Assistance Administration, the Michigan Department of Corrections has provided technical assistance to ten states with a view to improving their health care system for residents of correctional institutions. This manual is one of a series published under auspices of the grant. Together, the manuals will support and extend the training sessions and technical assistance efforts of the past two years. Their purpose is to define concisely the major elements which must constitute a comprehensive health care program for a correctional agency.

There is no substitute for proper planning, adequate resources and good management. These manuals can assist in the planning effort to identify the kind of resources which will comprise an adequate program. In addition, they address the alternatives which must be considered, the integration of various components, and establish a foundation for the decisions which must be made by each agency.

The manuals have been compiled by persons who are experts in their professional field and by persons active in the delivery of health services to correctional residents. There are too many divergencies among correctional agencies to permit a single approach to be universally applicable. For this reason, the manuals are intentionally broad in scope and will require careful analysis and specification by each user.

A health care system does not stand alone and isolated from its environment. It can succeed only through a cooperative and carefully planned effort which involves health care personnel, staff of the correctional system, community health resources, and residents as interested consumers of the services. Where multiple institutions exist within a state correctional agency, appropriate central direction and coordination are essential for coherent and consistent form and quality of the services provided. It is at this level, in particular, that the overall planning, resource development and management of policy should occur.

These manuals are written in a simple "how-to" format and are intended to be self-explanatory. Local regulatory agencies and other community and professional health resources can be helpful in their interpretation and application.

The goal which has prompted development and issuance of this manual and of others in the series has been attainment of professional quality health care for residents of correctional institutions comparable to that available in the community. The sponsors will consider their efforts well rewarded if, as a result, changes are implemented which improve access and cost-effective delivery of needed health services.

Jay K. Harness, M.D.
Director
Correctional Health Care Program

## MANUALS AVAILABLE IN THIS SERIES

Correctional Health Care: An Annotated Bibliography

Correctional Health Care Facilities: Planning, Design, and Construction

Dental Health Programs For Correctional Institutions

The Development of Policy and Procedure Manuals for Correctional Health Programs

Diet Manual For Correctional Health Care

Establishing Continuing Medical Education Programs

Establishing Protocol-Directed Health Care

Establishing Staff Development Programs

First Aid and Emergency Procedures Handbook

Information Systems For Correctional Health Care Programs

Informed Consent In Correctional Health Care Programs

Make-Buy Decision Analysis For Correctional Health Care

Mid-Level Practitioners in Correctional Institutions: An Analysis of Legislation

Pharmacy Services in Correctional Institutions

Problem Oriented Medical Records In Correctional Health Care

Quality Assurance: A Brief Overview for the Correctional Health Care Administrator

Resident Guide To Self-Care

Sample Policy Manual For Correctional Health Care

CONTRIBUTORS

William J. Byland, D.D.S
Assistant Director
Office of Health Care
Michigan Department of Corrections
Lansing, Michigan

Joan M. McGowan, R.D.H., M.A.
Assistant Professor,
School of Dentistry, The University
of Michigan; Ann Arbor, Michigan

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We are indebted to the Dental Services Branch of the Indian Health Service (Public Health Service, Department of Health, Education and Welfare) for their efforts in developing organized dental health programs. Some of the results of their research and many of their policies and procedures (because they are so adaptable to the correctional setting) have been included in this document.

Finally, we would like to thank Kay Pierson, Bev Ottney, and Laura Arriola for their assistance in typing and reproducing the manuscript.

## CHCP PROJECT STAFF

Michigan Department of Corrections
Office of Health Care

University of Michigan
School of Public Health
Department of Medical Care Organization

Michigan State University
Colleges of Human and Osteopathic Medicine
Department of Community Health Science

American Medical Association
Division of Medical Practice
Program to Improve Health Care in Correctional Institutions

University Research Corporation

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PREFACE

Unlike most other members of society, prison inmates characteristically do not have free access to comprehensive dental care. Many prison dental clinics simply lack the equipment, staff, materials, or finances necessary to fully meet the demands or the needs of inmates and thus must restrict, to some extent, full access to dental services.

Although some constraints on the total availability of dental services are warranted in the correctional setting, many prison dental programs are so underdeveloped that they fail to meet minimal professional standards and may even place the institution in legal jeopardy.

Recently the Comptroller General of the United States reported to the Congress," . . . federal and state prisons and local jails do not meet minimum standards for providing adequate levels of care, physical examinations, medical records, staffing, facilities, and equipment."[1] This General Accounting Office study concluded that there was a need to establish a federal strategy for improving medical and dental care in prisons and jails.

At this time a complete set of professional standards for correctional dental programs does not exist. While several professional and governmental groups, most significantly the American Public Health Association,[2] the American Medical Association,[3] The American Correctional Association,[4] amd the National Institute of Law Enforcement and Criminal Justice,[5] have provided sets of standards for health services in correctional institutions, these deal mostly with medical services. Although all briefly refer to dental care, none address the establishment of standards for dental services in much detail and none provide suggestions that might help prison administrators meet their obligations concerning dental programs. Likewise, Brecher and Della Penna, in a monograph written for the National Institute of Law Enforcement and Criminal Justice,[5] proclaim the need for careful consideration of comprehensive dental services

and recommend that studies be undertaken immediately, but unfortunately they provide little guidance for the correctional health administrator.

This document seeks to fill the gap left by these other efforts in the area of correctional dental services. It is hoped that it will provide some of the guidance needed for the establishment, maintenance, or improvement of the dental component of correctional health services programs. The document is not intended to promote special treatment for constituents of a padlocked society, but rather to describe how dental programs which are capable of meeting both legal requirements and minimally acceptable professional standards can be established within the financial and security constraints of the prison setting. At a time when many national and state agencies are focusing attention on improving correctional health services, and when the courts are increasingly ruling that inmates have a right to medical and dental care, it is assumed that correctional health administrators are interested in organizing their dental programs to meet such standards.

## REFERENCES FOR PREFACE

1. Comptroller General's report to the Congress: a federal strategy is needed to help improve medical and dental care in prisons and jails. Washington, D.C., U.S. General Accounting Office, 1978, viii+74p.

2. American Public Health Association, Jails and Prisons Task Force. Standards for health services in correctional institutions. Washington, D.C., The Association, c.1976. ix+121p.

3. American Medical Association. A.M.A. standards for medical and health services in prisons. 5th draft, revised. Chicago, The Association, 1978. 16p.

4. American Correctional Association, Commission on Accreditation for Corrections. Manual of standards for adult correctional institutions. Rockville, MD., The Association, 1977. xxi+95p.

5. Brecher, E.M., and Della Penna, R.D., National Institute of Law Enforcement and Criminal Justice. Health care in correctional institutions: prescriptive package. Washington, D.C., U.S. Government Printing Office, 1975. x+98p.

# INTRODUCTION

For residents of correctional institutions, proper health care (including adequate dental care), has become a focal point for numerous complaints to lawyers, legislators, judges, the media, and prison officials. Hundreds of lawsuits have been filed and the availability of proper medical and dental services has become a major prisoners' rights issue. Court decisions resulting from inmate litigation have declared that unreasonable deprivation of medical and dental care is unconstitutional. These rulings assert that a state's failure to provide adequate medical and dental treatment violates the rights of prisoners under the eighth and fourteenth amendments to the Constitution which prohibit "cruel and unusual" punishment. Other courts have ruled that failure of a state to provide adequate medical care constitutes a grave and substantial risk to the inmates' health and well-being.

The specification of what constitutes an adequate level of dental care has not yet been legally determined. However, by integrating the results of court decisions, existing standards for institutional dental services, and the ethics of dental practice as promulgated by the American Dental Association,[1] this document will serve to provide a summary of the essential elements of an adequate dental care program for prison inmates. The theme for this manual reflects two critically important principles inherent in the American Public Health Association's standards for health services in correctional institutions, (1) that adequate health care for incarcerated individuals is a public responsibility to be borne jointly by the criminal justice and health care systems and (2) that the level of health care service for those incarcerated should be of a standard comparable to that available to the community at large.[2]

While dental caries and periodontal disease afflict most people to

some degree, it has been generally accepted that both diseases tend to be more prevalent and more destructive in members of lower socioeconomic classes. This is not to say that evidence exists to indicate that members of lower socioeconomic classes suffer from increased incidence of dental diseases, but that due to their economic priorities the poor are less likely to be able to seek treatment for dental disease and thus are likely to have accumulated more lesions and more tissue destruction in their lifetime. Not only do most inmates originate in these lower socioeconomic classes and thus, predictably suffer a high rate of dental disease, but their incarceration also places them in a particularly vulnerable position since they often find needed dental services unavailable or inaccessible. When one is reminded that federal, state, and local governments currently house approximately 500,000 inmates in 4500 correctional institutions,[3] it can be concluded that the oral health status of prison inmates is a major dental public health problem in the United States.

The problems associated with providing a reasonable level of dental services to inmates are many. Corrections budgets are growing tighter while inmate populations are soaring. Adequate manpower is difficult to recruit: salaries are low and working conditions are generally poor; equipment is costly and the purchasing process is laboriously slow. Unfortunately, dental services typically are of lower priority than medical services, which themselves are often underfunded and inadequate.

The purpose of this document is to detail how correctional dental health programs should be designed and administered. Although it is recognized that the establishment of an acceptable level of dental services in the correctional setting may entail the expenditure of preciously scarce funds in the short-run, it is believed that a well-managed program can prove to be more cost-effective in the long-run than many of the

inadequately managed programs which exist today. Thus, corrections officials and health administrators can use the information presented in this manual to design dental health programs which will be effective in providing a predetermined level of quality dental care to inmates in a cost-effective manner. This seems to be a fundamental goal of all correctional health programs.

REFERENCES FOR INTRODUCTION

1. American Dental Association. Principles of ethics. Chicago, The Association, Oct. 1978. 4p.

2. American Public Health Association, Jails and Prisons Task Force. Standards for health services in correctional institutions. Washington, D.C., The Association, c.1976. ix+121p.

3. Comptroller General's report to the Congress: a federal strategy is needed to help improve medical and dental care in prisons and jails. Washington, D.C., U.S. General Accounting Office, 1978. viii+74p.

# PART I: DENTAL HEALTH CARE IN THE CORRECTIONS SETTING

# CHAPTER 1: GOALS & CONSTRAINTS OF DENTAL HEALTH PROGRAMS IN CORRECTIONAL INSTITUTIONS

## Goals of the Dental Health Program

Every correctional institution has the obligation to provide its inmates with reasonable access to dental care. Depending on the size and complexity of the institution, the dental care program may take varied forms. Where security is a problem, such as in a large maximum security penitentiary, prison administrators usually would prefer to provide clinical facilities for dental care within the institution. At the other extreme, in a small minimum security or community custody facility, prison officials might want to contract with local private dental practitioners or local dental public health clinics for a dental care program. The dental treatment may be provided by transporting the inmates to an outside clinical facility or it may be accomplished by having the contract clinician travel to the institution at specified intervals. These various forms of providing access to treatment will be discussed in greater detail in Chapter 7.

Regardless of the form utilized for providing dental treatment, the institution must ensure that the program provides dental services that are consistent with community standards of dental practice, while at the same time ensuring that other institutional goals are being met. Ultimate clinical objectives of the dental care program should be that inmates:

1. are free from active dental disease;
2. have a knowledge of basic oral hygiene and nutrition in order to be able to practice self-care and home prevention;
3. have adequate masticatory function so that conditions of the dental arches are such that they do not interfere with eating, talking, or sleeping; and

4. have a sufficient esthetic condition so that their appearance will not interfere with their self-esteem and subsequent adjustment to society or acquisition of employment.

Obviously, as long as inmates are continuously entering and leaving the correctional facility, it will be impossible to completely satisfy these ultimate clinical objectives for every inmate. However, it is necessary that the program be established with these objectives in mind and it is critically important that the program be supplied with the level of manpower, equipment, and financial resources needed to be able to work toward fulfilling these ultimate clinical objectives. How these levels can be determined and how they can be achieved most efficiently will be discussed in later chapters of the manual.

Ultimate clinical objectives are a function of a series of short-term clinical objectives. A comprehensive dental care program should be able to demonstrate attainment of many of these short-term objectives for a high percentage of the inmate population. These short-term objectives require that all patients are free from:

1. chronically infected and nonrestorable or nonfunctional teeth;
2. dental caries, especially severely involved carious lesions that threaten tooth retention;
3. edentulous spaces that affect masticatory function or esthetics;
4. periodontitis and gingivitis, and
5. other oral pathological conditions.

The attainment of these short-term clinical objectives will require the establishment of a number of program activities. These will include:

1. oral and radiographic examination, medical history review, diagnosis, treatment planning, and charting of all patients;
2. treatment for dental emergencies;

3. extraction of all teeth that cannot be restored because of advanced caries or periodontal disease;
4. treatment of all restorable teeth by employing the appropriate dental procedures, such as root canal therapy, restorations, or crowns;
5. dental prophylaxis;
6. brushing and flossing instructions;
7. nutritional counseling;
8. topical application of fluoride;
9. replacement of missing teeth through the fabrication and insertion of complete dentures or partial dentures and/or the construction and cementation of fixed bridgework;
10. restoration of esthetically compromised dentition;
11. occlusal equilibration;
12. periodontal surgery;
13. oral surgical services for traumatic or pathological conditions;
14. microbiological and pathological laboratory services; and
15. appointment control, dental records maintenance, equipment and facilities maintenance, inventory control, secretarial and reception services.

The resources needed to carry out these program activities are categorized into four broad components: personnel, facilities, supplies, and funding for the purchase of outside services. Personnel resources include the following personnel: dentists, registered dental hygienists, certified dental assistants, expanded functions dental auxiliaries, certified dental laboratory technicians, and secretary-receptionists. Facilities resources would include: fully equipped dental operatories with adequate armamentarium, dental radiographic facilities, dental

laboratory, business office, storage area for supplies, sterilization facilities, and reception area. Supply resources would include the necessary supplies and pharmocopeia to carry out the designated program activities. In addition, there should be a budget providing financial resources for the purchase of needed services from outside agencies. These outside services would include such things as consultation with dental specialists, laboratory services, and equipment maintenance by qualified dental repair technicians.

While resources and activities will be discussed in much greater detail in later chapters, Figure 1-1 briefly summarizes the objectives, activities, and resources required in a comprehensive dental health program. While it has been stated previously that the means to satisfy program requirements may vary, it must be emphasized that all of these activities are necessary in a comprehensive dental health program and all activities must be comparable to the level offered patients in local communities.

Orthodontic treatment has not been included in the objectives or activities list for an institutional dental health program. While orthodontic treatment would be a desirable inclusion ideally, it still remains an optional dental service within the community. There may be infrequent instances, however, where severe esthetic or masticatory considerations might dictate that an inmate be provided orthodontic treatment.

An administrative objective of the dental health program would be that the comprehensive dental health program be professionally directed and controlled by a dentist designated by the institution as the dental director. Many institutions currently employ dentists without providing the professionals with any administrative authority. Other facilities

place non-clinical administrators in the role of making professional decisions. Both of these situations are unacceptable. Professional activities of the dental department should remain the sole responsibility and prerogative of dental professionals; however, the overall operation of the dental program should be subject to general management control. The dental director, as a clinician with administrative authority, is an appropriate solution to this management problem. The dentist has been trained and licensed to provide a health service and has accepted professional, ethical, and legal responsibility for his activities and those professional activities of the dental auxiliaries he supervises. By making the dentist (or dental director) a part of the management team, the institution allows the dental program to have access to needed resources and administrative decisions while also subjecting it to the same level of management control and accountability as other departments in the organization.

The American Public Health Association's standards for health care in correctional institutions endorses this administrative objective[1] and carries the theme one step further when it states:

> . . . all health care services units in correctional institutions should ultimately be accountable to a governmental agency whose primary responsibility is health care delivery rather than the administration of such institutions.[2]

A discussion of alternative modes of organizing dental health programs is presented in Chapter 6: The Organization of the Dental Division Within the Correctional System.

For the dental health program to be successful in meeting its defined objectives, there must be a commitment by the correctional administrators to provide the dental program with the resources required to ensure the designated level of care. The commitment to improving dental services must also include a change in the extent to which corrections officials

Figure 1-1: A MODEL FOR THE COMPREHENSIVE DENTAL HEALTH PROGRAM

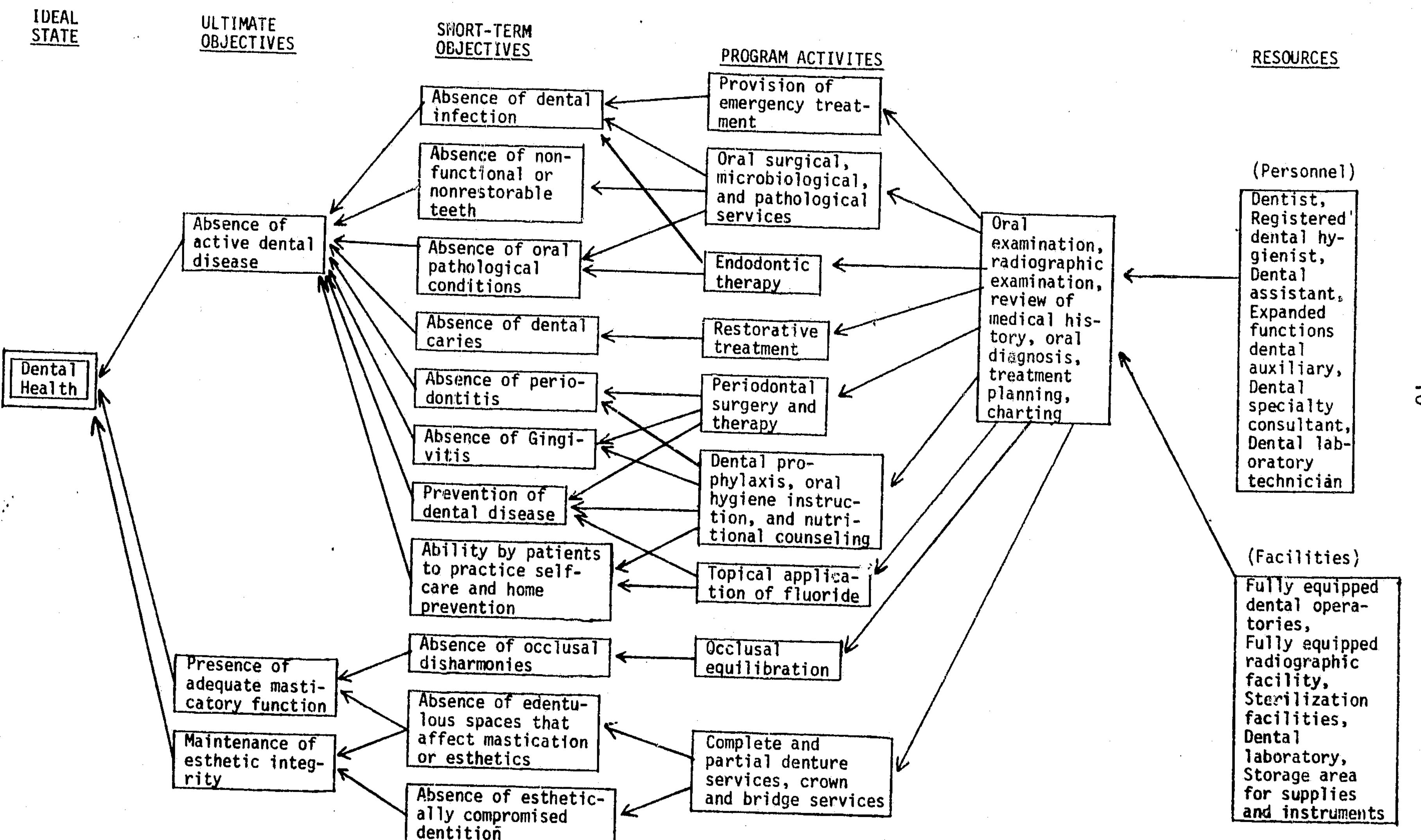
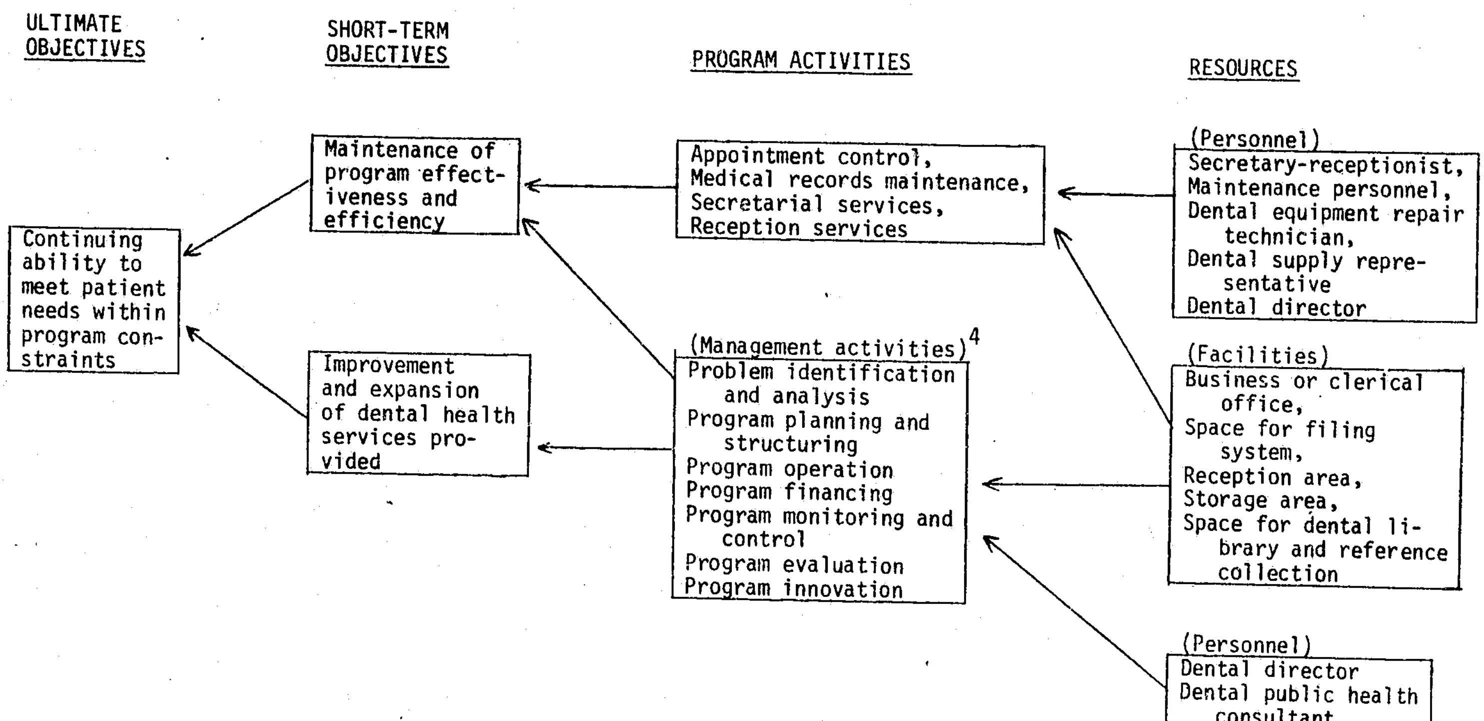


FIGURE 1-1 (continued)



become involved in professional activities. An APHA recommendation emphasizes the desired relationship between corrections personnel and health care personnel:

> Health services should not be a direct function of institutional security, nor should security requirements unnecessarily interfere with the provision of health care and a healthy environment. The independence of an institution's health program, the professional integrity of its staff and particularly the confidentiality relationship between patient and health professional must be respected and protected by the correctional administration. Care must be offered in an atmosphere which fosters dignity and reinforces the worth of the individual as well as the health professional.[3]

With this philosophy in mind, and with a knowledge of the need by dental health personnel to attain the designated dental program objectives, the conscientious prison health administrator would attempt to integrate the objectives of the dental department with the overall objectives of the correctional institution. Understanding and cooperation are paramount if both corrections and health care personnel are to successfully meet the challenge of providing an effective dental health program for the dentally underserved corrections population.

Constraints Affecting the Dental Health Program

The health or dental administrator trying to establish or to manage an effective dental health program within the correctional setting faces an awesome list of constraints. Not only does he encounter the constraints typically experienced by health administrators in the private sector, but he also encounters a series of constraints related to the operation of public health programs in general, and to correctional health programs in specific.

The list of constraints encountered in correctional health and dental programs is familiar to all administrators who have worked in the field:

*Inadequate Resources

- insufficient budget
- low salaries

- inadequate numbers of staff
- poor clinical facilities
- lack of needed equipment
- lack of needed supplies and pharmacopoeia

*Difficult Bureaucratic Procedures

- problems with hiring or obtaining new positions
- problems with budget modifications
- competition between departments concerning budget priorities
- difficulty with procurement of supplies and equipment
- ambiguous hierarchy of responsibility

*Difficult Patient Population

- high need and high demand
- orientation toward overuse of services
- tendency toward overuse of litigation
- high incidence of noncompliance

*Unattractive Setting for Professional Recruitment and Retention (The following conditions detract from the program's ability to recruit or retain professional staff.)

- low salaries
- poor working conditions
- inadequate support staff
- lack of equipment, supplies, or adequate facilities
- poor relations with patients
- stigmatized reputation of correctional work (low prestige and status of correctional work relative to other professional settings)
- fear of loss of autonomy to corrections or security staff

-professional isolation

-absence of a career ladder

-poor, often isolated, geographic location

-potential risks to personal safety

The list is extensive.

The theme implicit in this manual is that through effective management virtually all correctional organizations can establish a viable and effective dental health program without the need for large levels of expenditures over an extended period of time. Although constraints can sometimes seem overwhelming and may lead to program paralysis in some instances, most constraints can be relaxed, to some extent, by good management. While in most cases program improvement will require the expenditure of added amounts of capital in the short-run (e.g. - to add additional equipment or staff or to upgrade clinical facilities), in the long-run efficiently run programs can provide more services at equal or, in some cases, lower costs than inadequately managed or poorly designed programs. This will enable the dental program to meet its legal and professional goals without altering the institution's overall allocation of resources between program areas.

## REFERENCES FOR CHAPTER 1

1. American Public Health Association, Jails and Prisons Task Force. Standards for health services in correctional institutions. Washington, D.C., The Association, c.1976. ix+121p.

2. Ibid., p.viii.

3. Ibid., p.viii.

4. Young, W.O., and Striffler, D.F. The dentist, his practice, and his community. 2nd ed. Philadelphia, Saunders, 1969. xvi+346. (p.15).

## CHAPTER 2: GENERAL ISSUES CONCERNING DENTAL TREATMENT OF INMATES OF CORRECTIONAL INSTITUTIONS

The practice of dentistry in a correctional institution involves the understanding and resolution of a number of issues not normally confronted by dentists working either in private practice or in other types of organizations. These issues focus on the matter of why patients present themselves for care to the dental program on one hand, and how much care the program should provide to inmates on the other. In private practice such issues are not very often discussed because the nature of the private dentist-patient relationship seemingly deals with these matters. Aside from its therapeutic and professional dimensions, the dentist-patient relationship in our society is essentially an economic one. Patients present themselves to the dentist when they feel they require services and the dentist, utilizing his professional judgment, makes a determination of the type of care the patient needs. Depending on the urgency of the required care, the patient's ability to pay, and a variety of other factors, the question of what type and extent of treatment a patient will receive is basically determined by the intersection of the professional's judgment and the willingness of the patient to pay the dentist's fees. If the patient does not have the financial resources to pay for such care he or she would either visit a local public health program for subsidized care, or go without treatment. Thus, in the narrowest view, the key variables in determining the quantity of dental care to be delivered to a patient are, first, the amount of dental need the patient has, and secondly, the price of that care. It can be argued that the financial aspect of this decision is the basis for rationing dental care in the United States; the cost of care plays a large role in determining who will ask for care and, within the limits of ethical professional behavior, how much care will be

given.

One reason that dental practice in the correctional system is distinctly different from private practice in the United States is that the price of care to inmates is zero -- that is, the monetary cost of care plays no part in the inmate's decision to obtain care. With this financial barrier gone, correctional dentists must make a series of decisions which are not made by dentists in private practice, notably who to treat, when to treat them, and how much care to give them. These decisions are crucial ones, because they define how the program will allocate or ration services in the absence of an economic rationing device. In many respects, such decisions on the part of correctional dentists represent an improvement over the process in the private sector. Since the department of corrections is responsible for the dental care of all inmates, this need to determine the allocation of dental services will allow the program to respond to the inmate population in a rational fashion -- by giving care to inmates on the basis of their level of need, not on the basis of their economic status. A program for setting up such a system of priorities for care will be presented in Chapter 8.

A critical task facing the correctional dentist is to understand how the process of utilizing dental health services operates, and to analyze just which inmates are using services. It is important for the correctional dentist to recognize that the absence of an economic barrier to care in the correctional setting does _not_ mean either that he can look forward to seeing _only_ inmates with true dental needs or that he will treat _all_ inmates in the institution with serious dental needs. The reality is that the dental program will attract many inmates requesting services whose needs are not very great and that the program may never attract inmates with severe problems. This will mean that the successful dental program will have to

distinguish effectively between the need for dental care and the demand for such care.

Technically, the need for dental care in the inmate population would be based upon the judgment of dentists and would be ascertained largely by examining the mouths of all inmates and determining the presence of conditions or situations requiring care. Burt[1] has divided dental need into three major components: (1) diagnostic needs; (2) prevention needs; and (3) disease, disability and dysfunction needs; and thus indicates that "need" not only refers to conditions requiring diagnostic and therapeutic care, but also to situations requiring maintenance or preventive services.

This definition of need is obviously a professionally determined one and is based upon professional norms. Patients also may define themselves as having dental needs, however such patient definitions are not always congruent with provider definitions. Patients tend to define their needs not on the basis of professional criteria, but rather on their own perceptions of dental health vs. dental illness. Thus, pain, sensitivity, discomfort, inconvenience, unattractiveness and disability are the types of conditions used by most patients to define their dental needs. In the absence of such indications patients may not believe they need care, even though dental professionals might find them to have serious dental health problems.

There is a high correlation between the educational status, income, and previous use of dental services of patients and their recognition of dental needs.[2,3] Thus, wealthier, better educated patients would identify needs for dental care closely related to the needs dentists might identify. However, poorer, less well-educated patients, such as those typically found in correctional institutions, would not recognize dental needs in the same way as dental professionals, and this disparity can cause serious problems

in the correctional dental program -- ranging from the failure to seek such care for bona fide problems; to requests for services that seem unreasonable to the dentist; to the failure to comply with the dentist's therapeutic regimen. Dentists must take such perceptual and cognitive differences into account when providing dental services and may have to devote considerable program resources to the education of patients about their dental needs.

A concept separate from need, but certainly highly related to it is that of <u>demand</u> for dental services. A demand for service can be defined as the active request for care made to the program by a patient. Demands can be made because a need actually exists, but they can also be made when the patient only perceives he has a need (i.e., a perceived need that would not be considered a need by a dentist), or in the complete absence of need. As we have discussed, due to the generally poor economic background of inmates, they are likely to have high levels of dental needs when arriving at the institution, and thus most patients presented to the dental program will probably have actual needs which need to be met. However, the correctional dentist must also recognize that inmates often utilize, or make demands for care, not out of a primary interest in improving their dental health, but rather for reasons only secondary to improving their dental health. Such utilization is often termed "malingering" or use of care for "secondary gains."

Some inmates utilize care because they feel that it is a way to "get back at the system." For example, the inmate feels that "the system" has incarcerated him against his will and concludes that he will get all he can from the institution in order to compensate himself for his perceived involuntary servitude. Using this line of reasoning, some inmates repeatedly request inappropriate or nonessential treatment from the dental staff. Such

requests (or demands) can come in several forms: verbal requests, written requests, official complaints, tort claims, or lawsuits. These requests are likely to be for such things as: frequent dental prophylaxis (more frequent than is routinely necessary), cosmetic surgery, orthodontics, cosmetic crown and bridge (including "gold" anterior jacket crowns), and multiple prosthetic appliances (so that the inmate might have "spares" available). The request might be made because the inmate really feels that the service is owed him, or it might be made because the inmate wants the dental staff to deny him the treatment so that he can proceed to file a tort claim, a writ, or a lawsuit.

Inmates may use dental demands as a means to escape a boring or laborious job. Frequent appointments or sick call appearances require frequent absences from the inmate's assigned work detail. Both the travel time and the route between the work detail and the dental clinic might allow the inmate the opportunity to see friends or acquaintances he normally is unable to see because of institutional restrictions (probably one of the major causes of tardiness or failure to appear for dental appointments).

Inmates might overuse the dental facilities because they are seeking narcotics and are under the impression that the dentist is an "easy mark" for obtaining pain medications. Other inmates might be overusing the dental program because they suffer atypical dental symptoms that might in reality be caused by emotionally based disorders resulting from institutional stress.[4] Still other inmates misinterpret mild dental discomfort or normal thermal sensitivity as serious dental disorders, possibly because institutionalized individuals have more time for introspection and might convince themselves that a serious problem exists where a parallel situation in the civilian world might be accepted as a normal occurrence.

Thus, dental professionals working in the correctional setting are

likely to face a disparity between utilization based on actual need and utilization based on perceived need. While the health providers are aware of the high level of actual dental needs, inmates place excess demands on a limited delivery system, often for inappropriate reasons. Correctional health administrators need to recognize the interpretive problems that face the dental staff. The dentist, when attempting to separate legitimate from nonlegitimate complaints encounters a serious dilemma. If he is too selective concerning the patients he chooses to treat, he may overlook patients with legitimate needs. On the other hand, if he is not selective enough, he will overload the system with nonlegitimate complaints. This dental detective work, unfortunately, costs the dental health program precious time that would better be spent on actually providing needed services. Correctional health administrators, therefore, need to be supportive of the dentists' efforts to distinguish between these types of utilization. They must be prepared to accept both a lowered productivity and an increased incidence of patient complaints (from inmates whose nonlegitimate needs are not met) compared to the levels that would be expected in private practice.

The issue of how much care to provide to a given inmate is a critical one in correctional dentistry. The level of care that a system provides will be a function not only of the economic status of the correctional system, but also of the legal and ethical standards imposed on the system. A serious conflict arises when dental professionals attempt to balance the services they have the resources to provide with what the courts have ruled regarding inmates' rights to medical and dental care or what external standards call for. Dentists have often been placed in an unfortunate situation as a result of this conflict. Their extensive professional training has given them the knowledge, the skills, and the desire to

provide a much needed health service for patients. Their professional ethics and medico-legal responsibilities dictate that they provide quality care for patients according to need.[14,15,16] The resources and/or policies of the correctional institution on the other hand, severely restrict the amount and the scope of services that the dentist can provide his patients. Financial, personnel, and facilities constraints, and some institutional policies, all act to prevent the dentist from practicing his profession to the fullest extent. He therefore is forced to ration dental care, sometimes placing himself in conflict with the intent, if not the letter, of judicial dictates and organizational standards.

It has already been determined by courts that inmates have the right of access to adequate medical care and that denial of such medical care constitutes cruel and unusual punishment.[5,6,7,8] The court recognizes that prisoners are totally dependent upon prison officials for their medical needs and affirms the right of inmates to access for medical care:

> This does not mean that every prisoner complaint requires immediate diagnosis and care, but that, under the totality of the circumstances, adequate medical treatment be administered when and where there is reason to believe it is needed.
>
> Delays in necessary medical treatment are always undesirable, and this court, alert to the precarious position of a prisoner totally dependent upon prison officials for even the most rudimentary medical care, will look closely at cases where abuse of that fundamental duty is alleged.[6]

While courts fail to define what constitutes adequate medical care, they have tended to delineate what constitutes inadequate care. The court asserts that deprivation or inadequacy of "essential" medical care is unreasonable and amplifies this by stating:

> In determining whether medical care was "essential" in a given case, the question is whether a physician exercising ordinary skill and care would have concluded that the symptoms evidenced a serious injury; whether the potential for harm by reason of delay or denial of medical care was substantial; and whether such harm did result. Hence, a deprivation of medical treatment that seriously endangers the prisoner's well-being would be actionable (under the Civil Rights Act).[9]

Thus, while the dentist working in a correctional setting realizes that inmates have the right of access to "reasonable and adequate" medical (and dental) care, he is faced with only a negative legal definition of what constitutes "reasonable and adequate." Even though he is armed with this legal awareness, the dentist working in a correctional institution still is restricted by program constraints, most of which are financial in nature. Unfortunately for the dentist (and the correctional institution), economic considerations are not deemed an appropriate defense (or excuse) for not providing adequate health care for prisoners. In one recent case against the State of Alabama, the Court stated:

> It is not without some trepidation that we uphold the finding of a constitutional violation. Officials in the A(labama) P(enal) S(ystem) are shackled by anachronistic equipment, inadequate staffing, and parsimonious funding, factors which render Sisyphean their task of insuring that adequate medical care is available to inmates.
>
> By the same token, however, we cannot be impervious to the precarious position of inmates who, though dependent solely on a prison for medical attention, find their pleas for attention unheeded. Deep-seated inmate frustrations can be exacerbated by a perceived callous indifference to their medical plight. The incidence of frustration thwarts the purported goal of rehabilitation . . .[10]

The same principle, that limited budget does not justify insufficient care, was acknowledged by Judge Blackman: "Humane considerations and constitutional requirements are not, in this day, to be measured or limited by dollar considerations . . ."[11]

And finally, the whole concept of inmates' rights to adequate medical care is placed in perspective by the court ruling that:

> Actionable circumstances result where, as here, the level of medical care available to a confined and dependent population is inadequate to meet predictable health care needs because of obvious and sustained deficiencies in professional staff, facilities and equipment. When continued and systematic deficiencies of this nature exist and have resulted in the actual impairment of inmate health, and when such deficiencies continue to post a current and potential threat to the physical health and well-being of an entire prison population, then inmates are deprived of the basic elements of adequate medical treatment in violation of the eighth amendment . . .[12]

The only conclusion that can be reached at this time, given the current legal environment, is that correctional dental health programs must provide their practitioners with sufficient resources to fulfill their legal and ethical obligations. This does not mean that correctional dental programs must give practitioners a totally free hand in determining the level of care to be offered, nor does it mean that inmates must be given extravagant care. What it means is that the system must develop policies and resources which permit a deliberate rational program, aimed at providing inmates with an appropriate level of care, as determined by system managers and clinicians, in view of the external requirements.

Thus, it is important for correctional health administrators and dentists working in correctional programs to be aware of some of the situations that make correctional health care different from civilian health care programs. Correctional dental care must be approached, not only with a good understanding of the inmate population, but also with an appreciation of the need to manage the program within its societal environment. It is no longer possible to simply purchase a dental unit and hire a dentist, expecting that such a program will fulfill its legal and ethical obligations.

Note: Those wishing to more fully research the legal and constitutional issues discussed in this chapter are referred to the comprehensive work of Isele.[13]

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# PART II: PLANNING A DENTAL HEALTH PROGRAM

# CHAPTER 3: PERSONNEL

The largest component of the prison dental health program budget is that portion devoted to personnel. This component not only includes line items related to wages, salaries, and fringe benefits, but also to costs associated with recruitment, training, and retention of dental staff.

## Staffing The Dental Unit

There are several types of professional dental personnel necessary for the provision of adequate dental services in a correctional institution. This includes both dentists and a variety of dental auxiliary personnel. In addition, the dental health program will require clerical, secretarial, reception, and maintenance support in order to efficiently utilize the services of the trained professionals.

The following are brief descriptions of the various types of staff members which are usually included in a comprehensive correctional dental health program.

General Dentist - The typical dentist in correctional dental health programs is trained as a general dentist. He must have graduated from an accredited dental school and must be licensed by the appropriate state licensing board. His duties involve examination, diagnosis, treatment planning, provision of treatment, nutritional counseling, oral hygiene education, and referral to the necessary dental specialty consultant(s) when required. The general dentist is responsible for supervision of all dental auxiliaries in the performance of their designated duties and is legally required to ensure that the auxiliaries' activities remain in compliance with state dental practice acts. The dentist, therefore, must plan, maintain, evaluate, and monitor all facets of the dental health program.

If more than one general dentist is required to staff the dental facility, one should be designated dental director and should ultimately be responsible for all program activities and personnel, both on a professional and on an administrative basis.

Dental Specialty Consultant - The dental specialist, having received extensive training beyond that of the general dentist, will normally be consulted when considered appropriate by the general dentist. Consultation with a specialist may occur when a patient requires diagnosis or treatment for oral or medical problems that lie outside the realm of experience and/or expertise of the general dentist, or when the needed treatment necessitates the use of clinical facilities not available to the general dentist. The consultant's service will usually be obtained on a contractual basis. Rarely, except in the largest of correctional institutions or in the special case of a central or regional prison health facility, will it be necessary to have a full-time consultant on an institution's dental staff.

Although the decision to refer patients to specialists is a professional judgment of the dentist and should therefore not be questioned by nonclinical administrators, excessive referrals by individual dentists can be controlled by the institution. This would require that a dentist or a group of dentists, establish a set of standards and indications for referral. Once established, such a set of standards can be used by the dental director to monitor and evaluate the appropriateness of all referrals, without compromising an individual dentist's professional integrity.

Dental specialty consultants may have been trained in any of the following recognized areas: dental public health, endodontics, oral pathology, oral surgery, orthodontics, pedondontics, periodontology, prosthetics, and forensic odontology. Those specialty consultants most likely to be utilized by a prison dental health program are endodontics, oral pathology, oral surgery, orthodontics, periodontology, prosthetics, and forensic odontology. In addition,

the state or federal prison system would benefit from utilization of a consultant in dental public health, who is trained in the organization and administration of dental health programs. The dental public health specialist can be of considerable value to the system which is establishing a new dental health program, revising or redesigning an existing program, or evaluating program efficiency and effectiveness.

Registered Dental Hygienist - The dental hygienist is a specially trained dental auxiliary who has graduated from an accredited program of dental hygiene and is licensed by the appropriate state licensing board. The dental hygienist's duties involve the provision of such dental services as dental prophylaxis (cleaning and polishing of teeth), dental radiology, oral hygiene instruction, nutritional counseling, topical application of fluorides, and the establishment of a dental recall system to ensure routine re-examination and prophylaxis of all institutional patients.

In some jurisdictions, the dental hygienist may have been granted additional responsibilities and functions by the appropriate legislative or regulatory bodies. However, these additional duties are regulated by the various states' dental practice acts and will not necessarily be consistent from state to state. (Please see Appendix H for addresses of the appropriate state licensing board where information can be obtained about the professional and legal responsibilities of the registered dental hygienist).

The dental hygienist is required to work under the general supervision of the dentist according to most practice acts, and therefore cannot, under most circumstances, treat patients without a dentist present in the dental clinic. (More detail about the role of a registered dental hygienist is presented in Chapter 4 of this manual.)

Dental Assistant - The dental assistant may be trained either on the job (through a dental office apprenticeship program) or via an approved dental

assisting program. Dental assistants are not licensed by the state, however by successfully completing an examination the dental assistant may be certified and thus recognized by the state for attaining an excellent level of knowledge and experience. Some state dental practice acts specifically recognize certified dental assistants and allow them to perform duties that may not be performed by non-certified dental assistants.

The use of dental assistants, more than the use of any other dental auxiliary, has been shown to increase the efficiency and productivity of dental health programs and thus is an essential component to any correctional dental health program. The dental assistant works directly with the dentist in the same manner that a surgical nurse works with the surgeon. The assistant is responsible for: sterilizing the dental instruments; disinfecting the operatories and associated equipment; exposing and developing dental radiographs; setting up and dispensing the dental instruments during treatment procedures; mixing of cements, dressings, impression materials, and restorative materials; and overall coordination of patient flow through the dental operatories. Some states will permit the assistant to provide limited direct patient services under direct supervision by the dentist, however there remains wide variance among the practice acts as to what dental services the assistant may provide. (See Appendix H for the addresses of the appropriate state licensing board where information can be obtained about professional and legal responsibilities of the dental assistant and the certified dental assistant).

Expanded Functions Dental Auxiliary (EFDA) - Sometimes called an expanded duty dental auxiliary (EDDA) or a dental therapist, this specially trained dental auxiliary may either be a registered dental hygienist or a certified dental assistant who has been specifically trained in expanded functions by an accredited program. Most state practice acts have not yet allowed this

type of auxiliary to perform all of the functions that the individual has been trained to perform and there is wide latitude among the states as to what services the expanded functions auxiliary can legitimately provide. Where recognized, the auxiliary's duties might involve such things as: placing and carving restorations; making impressions for diagnostic and working models; injecting patients for infiltration anesthesia; removing sutures and periodontal dressings; scaling and polishing of teeth; and root planing, deep scaling, and curretage. This auxiliary is required to work under the direct supervision of the dentist and greatly increases the efficiency of the entire dental health program by performing the more routine and less technical procedures previously performed only by the dentist, thus freeing the dentist to perform more difficult and complex procedures.

Dental Laboratory Technician - The dental laboratory technician may receive training under a variety of circumstances: through trade, vocational, or military schools; from programs in junior or community colleges; through training programs at dental schools; or by apprenticeship with a commercial dental laboratory or a private dental office. (There are even training programs in dental laboratory technology in some of the state and federal correctional institutions.) Like the dental assistant, the laboratory technician may become certified by successfully completing a state examination, thus achieving recognition for attainment of an excellent level of knowledge and experience.

At the direction of the dentist, the dental laboratory technician fabricates complete and partial dentures; constructs precious and nonprecious cast metal restorations such as inlays, crowns, and bridges; makes surgical and periodontal splints; and constructs mouthguards and custom impression trays. The dental laboratory technician is an integral part of the dental

team; however he can work fairly independently of the dentist. State dental practice acts uniformly prohibit the dental laboratory technician from directly treating a patient, though, requiring him instead to work from a prescription or laboratory work request written by the dentist.

Only the very large correctional institutions or those with a sizable population of middle aged and older individuals will require a full-time dental laboratory technician. Often, a large institution can maintain a laboratory that provides technical services for several institutions. Some correctional institutions may find it economically advantageous to contract with a commercial dental laboratory for prosthetic laboratory services, an option which will be discussed in greater detail in a later section of this manual.

Secretary-Receptionist - The secretary-receptionist can be most important to the efficient running of the dental clinic. In addition to secretarial training, it would be advantageous for the secretary-receptionist to have some training in medical records technology. This individual should function as an office manager: coordinating patient scheduling, maintaining the dental record system, and handling the routine clerical and administrative matters necessary to the operation of a dental health facility.

A list of personnel involved with operation of the dental health facility would not be complete without mentioning two types of maintenance people who would be required: general maintenance and dental equipment service technicians. General maintenance personnel, probably already employed by the correctional institution, would be responsible for the plumbing and heating, electrical, water, sewer, compressed air, central suction, and natural gas systems for the clinic. The dental equipment service technician would be available through any local dental equipment supply contractor who provides a repair service.

## The Dental Team

Dental personnel can be utilized in various combinations in order to provide the dental services needed for any given institution's population. It must be emphasized that one of the more serious mistakes being made in the operation of many existing dental health programs for correctional institutions today is the use of a dentist without sufficient dental operatories or dental auxiliaries to make efficient use of his time or energy. To efficiently and economically utilize the professional services of the dentist(s), he/she, (they) must be provided with adequate levels of auxiliary and administrative personnel and with a sufficient number of dental operatories. It has been shown quite convincingly by the American Dental Association's Bureau of Economic Research and Statistics[1] and through a study by the Dental Services Branch of the Indian Health Service[2] that by increasing both the number of dental operatories and the number of dental assistants, a dentist can increase the number of dental services he can provide quite markedly. The Indian Health Service study also illustrates the advantages of adding a secretary-receptionist to the staff in order to eliminate the need for the dental professionals to interrupt professional services in order to attend to nonprofessional duties. Table 3-1 presents a summary of the findings of this important survey. Row one of this table illustrates, for example, that a dentist working with one operatory and no dental assistants can increase his productivity to 130.30 percent of his previous output just by adding one dental assistant. By adding another operatory and a second dental assistant, he can increase his productivity to 209.52 percent of his original output. Employment of a receptionist boosts the productivity of this last combination to 247.72 percent of the original output.

Although certain characteristics of the correctional setting (e.g., the inefficiency inherent in scheduling inmate appointments) may mean that the

Table 3-1: Dentist Productivity - The Percent Difference in Dental Services Provided as Related to Various Combinations of Dental Staff and Facilities[2]

| CORRESPONDING DENTAL STAFF AND FACILITIES | PERCENT CHANGE IN NUMBER OF DENTAL SERVICES PROVIDED* | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 CH 0 DA | 1 CH 1 DA | 2 CH 0 DA | 2 CH 1 DA | 2 CH 2 DA | 2 CH 1 DA 1 REC | 2 CH 2 DA 1 REC | 3 CH 0 DA | 3 CH 1 DA | 3 CH 2 DA | 3 CH 1 DA 1 REC | 3 CH 2 DA 1 REC | 4 CH 1 DA 1 REC | 4 CH 2 DA 1 REC | 4 CH 4 DA |
| 1 CH, 0 DA | Ø | 130.30 | 143.96 | 162.62 | 209.52 | 212.71 | 247.72 | 220.37 | 194.17 | 256.77 | 261.23 | 312.58 | 338.04 | 350.79 | 383.45 |
| 1 CH, 1 DA | | Ø | 110.48 | 124.80 | 160.80 | 163.25 | 190.11 | 169.12 | 149.01 | 197.06 | 200.48 | 239.88 | 259.43 | 269.21 | 294.28 |
| 2 CH, 0 DA | | | Ø | 112.96 | 145.53 | 147.75 | 172.07 | 153.07 | 134.87 | 178.35 | 181.45 | 217.11 | 234.80 | 243.66 | 266.35 |
| 2 CH, 1 DA | | | | Ø | 128.83 | 130.80 | 152.32 | 135.51 | 119.39 | 157.89 | 160.63 | 192.20 | 207.86 | 215.70 | 235.78 |
| 2 CH, 2 DA | 47.72 | 62.18 | 68.70 | 77.61 | Ø | 101.52 | 118.23 | 105.17 | 92.67 | 122.55 | 124.67 | 149.18 | 161.33 | 167.42 | 183.00 |
| 2 CH, 1 DA 1 REC | | | | | | Ø | 116.45 | 103.60 | 91.28 | 120.71 | 122.80 | 146.94 | 158.91 | 164.91 | 180.26 |
| 2 CH, 2 DA 1 REC | | | | | | | Ø | 88.95 | 78.38 | 103.65 | 105.45 | 126.18 | 136.45 | 141.60 | 154.78 |
| 3 CH, 0 DA | | | | | | | | Ø | 88.10 | 116.51 | 118.53 | 141.84 | 153.39 | 159.18 | 174.00 |
| 3 CH, 1 DA | | | | | | | | | Ø | 132.24 | 134.53 | 160.98 | 174.09 | 180.66 | 197.48 |
| 3 CH, 2 DA | | | | | | | | | | Ø | 101.73 | 121.73 | 131.64 | 136.61 | 149.33 |
| 3 CH, 1 DA 1 REC | | | | | | | | | | | Ø | 119.65 | 129.40 | 134.28 | 146.78 |
| 3 CH, 2 DA 1 REC | | | | | | | | | | | | Ø | 108.14 | 112.22 | 122.67 |
| 4 CH, 1 DA 1 REC | | | | | | | | | | | | | Ø | 103.77 | 113.43 |
| 4 CH, 2 DA 1 REC | | | | | | | | | | | | | | Ø | 109.31 |
| 4 CH, 4 DA | | | | | | | | | | | | | | | Ø |

* Productivity figures are for one dentist and listed combinations of dental staff and facilities.

CH = Fully equiped dental operatory

DA = Dental assistant

REC = Secretary/Receptionist

Indian Health Service findings are not fully generalizable to the correctional setting, there is no reason to believe that results of the same general nature would not be realized in a correctional dental health program.

It is readily apparent that the productivity of the dentist can be greatly affected by what is available in terms of facilities and auxiliary personnel, and that the use of dentists without such support is a costly mistake. While the aforementioned study compared the various combinations of personnel and operatories utilized by a single dentist, it would be quite simple to carry out the necessary calculations to reach similar conclusions in clinics employing more than one dentist. The study did not take into account the use of a registered dental hygienist or expanded functions dental auxiliary, but these auxiliaries can make a dental program even more productive and more efficient.[3,4]

The correctional health administrator who seeks to provide increased levels of dental services in a cost-effective manner cannot afford to neglect the implications of this study. Serious attention should be devoted to determining the appropriate mix of dentists, auxiliaries, and operatories needed to maximize the efficiency of the correctional dental health program.

Just how important this proper mix of personnel is to the cost-effectiveness of a dental health program can be further illustrated by "costing out" the example previously presented. A prison health administrator, needing to double the number of dental services provided in a dental program composed of a single dentist with one operatory and no dental assistant, might conclude that this could only be achieved by adding another dental operatory and hiring an additional dentist. Although this expansion might result in the desired increase in output, it is an expensive solution since the added expenditures just for the salary and fringe benefits of the additional dentist would probably be at least $25,000 per year and could likely be

much greater (unfortunately no figures for average salary and fringe benefits for dentists employed in correctional settings are available). Assuming the data presented in Table 3-1, (row one, column five) is applicable to the prison setting, we see that the prison health administrator could achieve the same increase in output by adding a second dental operatory and hiring two dental assistants rather than the second dentist.

The two dental assistants could probably be hired for approximately $6696 per year per assistant or $13,392 total per year (the mean yearly salary paid dental assistants in private practices according to the most recent American Dental Association survey figures available[5]) or virtually half as much as the cost of the second dentist.

By adding an additional input, a secretary-receptionist, to the combination of one dentist, two operatories, and two dental assistants, the program can be made even more cost-effective. Table 3-1 indicates that the resulting combination of inputs would produce 247.72 percent of the services provided by one dentist with one operatory and no dental assistants.[2] The mean yearly salary figures for secretary-receptionists reported by the American Dental Association survey is $7284 per year, although this would vary according to state or federal wage scales.[5] This cost/output ratio still represents an efficient decision for the correctional health administrator since it would increase output by another 42.20% while only involving about 34% of the cost of another dentist.

It is obvious that the efficiency and cost-effectiveness of a correctional dental health program are a function of the proper mix of dentists, dental assistants and operatories. Brecher and Della Penna,[6] the Comptroller General of the United States,[7] the American Dental Association,[8] and the American Public Health Association[9] all point out the necessity for providing the dentists with adequate staff, equipment, and

supplies. The Indian Health Service, which has done extensive research in the areas of staffing and efficiency of dental programs, concludes, "It must be recognized that staffing and operatory ratios are the major determinants of clinical productivity."[10] Program directors for prison health care programs must realize that it is inefficient to use general dentists, the most expensive single component of the cost of the dental health program, for routine or nonprofessional duties that could be provided much more economically by dental auxiliaries or other administrative staff. Achieving the mix of dental program inputs which is capable of meeting the dental needs of the population in the most cost-effective manner possible, is one of the most important goals of any correctional dental program.

Use Of Inmate Help

One crucial issue which must be addressed in a discussion of staffing in the dental unit is the use of inmates as dental health personnel. Correctional dental programs have frequently utilized inmates as dental laboratory technicians, dental assistants, or secretary-receptionists in the past, and many programs still do so, especially when staff and budget are in short supply. Unfortunately, the traditional use of inmates as dental health workers, expecially where used for the provision of clinical services, often violates state dental (and medical) practice acts and various correctional health standards, and thus raises problems of illegality. In addition, the use of inmates as workers in a prison health program also promotes other serious problems which involve the manipulation of the health care process for individual benefit.

Because of the various institutional constraints identified previously, there is a need to ration the supplies of dental services available to inmates. Because of the scarcity created by this rationing, any inmate

working in the dental program (and in many other prison jobs) is in a position to promote or to hinder access to precious goods or services. This usually means that the inmate dental worker will either be pressured by others to manipulate the flow of dental care goods or services, or will use his powerful position for his own economic gain. Although such practices seem to be commonplace in most aspects of prison life, we feel they are totally inappropriate in the health care sphere.

A few of the abuses which have been experienced in programs which use inmate help include the following: (1) Inmates working in a dental department are often pressured (by other inmates wanting services) to use their influence or position to adjust waiting lists so that certain inmates might be seen without waiting the normal amount of time. (2) Inmates having access to dental or medical records may use confidential information for any number of activities, including extortion. (3) Inmates controlling access to health providers and inmates actually providing services (such as an inmate assigned to dental prophylaxis services or an inmate laboratory technician assigned to construct partial or complete dentures) are frequently in a position to sell their influence or services to other members of the captive population. (4) Inmate dental laboratory technicians have even been known to solicit contributions from patients for "extra special care" or "higher quality work" when making prosthetic appliances for these patients.

Inmate dental health workers also pose a security threat to the institution because they may become a conduit for contraband medications or potentially dangerous dental instruments. Dental laboratory facilities require the use of lathes with grinding wheels which could be used by inmate workers for fashioning such things as weapons, digging implements, or lock-picking instruments. Even without modifications, many of the dental instruments

necessary for routine dental services could be utilized for such unintended purposes.

The argument is sometimes made that an institution can develop a vocational training program in the dental occupations to provide inmates working in correctional dental programs with job skills to be used once they are released. Although such arguments are appealing, they are not realistic. Analysis of the employment market for dental auxiliaries indicates that former inmates are not likely to obtain employment in private or public dental facilities. Most state dental practice acts prohibit licensure of individuals who have been convicted of felonies, and many registration and certification boards follow this same philosophy. It is therefore quite unlikely that a former inmate could pass the legal requirements to become a dentist, a dental hygienist, or an expanded functions dental auxiliary, even if he had obtained the necessary training. Furthermore, there are currently a large number of well-trained dental auxiliaries available for employment as dental assistants or secretary-receptionists. It is quite unlikely that individuals with criminal records could effectively compete with them for jobs especially since dental auxiliaries have traditionally been females and most ex-inmates are males, and since most dentists would not permit ex-inmates to take jobs that provide access to or require the use of the various medications necessary in a dental practice.

A vocational training program for dental laboratory technicians might be a notable exception to the previous argument. Dental laboratory technicians are usually employed by commercial dental laboratories and technicians are prohibited by almost all state dental practice acts from directly treating patients and from having access to drugs. Training as a laboratory technician would thus provide former inmates with a much better chance for

employment since licensure requirements and narcotics regulations are less of a factor. A well-designed, secure, and efficiently run vocational training program in dental laboratory technology could indeed serve as as means to rehabilitate prison inmates and could function to supply a given correctional system with dental laboratory services. The program, however, should be specifically designed for training purposes and should remain independent of institutional clinical dental programs in its operation. A correctional health administrator intent on providing an efficient, cost-effective dental health program for inmates cannot afford to burden his clinical dentist(s) with the time-consuming responsibility of training inmates to become dental laboratory technicians. Unfortunately, this separation of programs is not characteristic of most correctional dental programs, and a good deal of the dentist's time is spent supervising inmate technicians rather than treating patients.

While there admittedly exists some disagreement concerning the use of inmates as workers in correctional health programs, many authorities believe that the problems involved in such employment of inmates far outweigh the potential benefits. Whenever possible, correctional health administrators are encouraged to replace all inmates working in health facilities with civilian employees at the earliest opportunity. At a minimum, correctional health administrators should follow the two principles considered unchallengeable by Brecher and Della Penna:

"(1) No inmate personnel should under any circumstances be used to handle medical records or drugs, and none should have access to medical records or drugs; nor should inmate clerks control the scheduling of health care appointments or access of other inmates to health care services.

(2) The use of unqualified inmate personnel to perform health care services of any kind should be forthwith discontinued, and civilian personnel should be secured to take their places."[11]

Recruitment & Retention Of Dental Personnel

One of the most perplexing problems that correctional health administrators face, probably second in importance only to budgetary inadequacies, is the inability to attract and retain qualified health professionals. Even when budgeted positions for dentists and dental auxiliaries exist, they often remain unfilled because no licensed professionals are willing to accept positions. And even in those cases where massive recruitment efforts have lead to the employment of qualified personnel, administrators are often frustrated by the fact that new personnel last only a few months before they resign and thus force the program to begin recruiting again. The scenario is quite frustrating, and all too familiar. The question is "what can be done?"

To answer this question, it may be useful to begin with a review of a few of the realities of professional employment. Professionals, such as dentists and physicians, have a great many employment choices in our society. Aside from the dominant forms of practice -- private solo practices and small groups -- there are a wide variety of organized practice settings ranging from health maintenance organizations to community health centers in existence in the United States. The professional's decision as to which type of employment to choose really depends upon a combination of three factors: the professional's own predilection for a style of practice; the relative merits or attractions of a particular situation within a given type of practice; and the professional's qualifications (and thus the range of choices open to him).

Thus, a dentist may decide that he would rather not go into (or stay

in) private practice but would rather work in a larger organization. He would then begin to investigate the attributes of the various sources of employment available to him. Assuming that his qualifications make him an attractive candidate, the organizations seeking to hire him would have to compete for his services. In order to compete successfully for this type of dentist, it is therefore necessary for the correctional health administrator first to understand the attributes of a job and an organization that will form the basis for the dentist's decision and, second, to structure the dentist's job and the entire dental program in a way that makes it attractive to the potential candidate. Among the attributes of the job and of an organized setting that most dentists will consider in selecting a place of employment are the following:

Salary And Other Benefits

This is likely to be the most critical dimension in recruiting dentists and is also extremely important for retention. Although the salary for a dentist does not have to be fully competitive with the income potential of private practices,(since dentists interested in organizational settings are often willing to accept lower salaries in return for some of the conveniences available in this type of setting) salaries offered in corrections must be comparable to those available in other organizations. Achieving parity with practice potentials in the organizational sector in terms of dentists' salaries should thus become a major objective of the correctional program experiencing difficulties with recruitment.

One additional financial aspect of the dentist's job which may play a critical role in the recruitment and retention of dentists is the matter of malpractice insurance. The cost of professional liability coverage has increased considerably, even in private practice. Given the propensity of inmates to bring suits against health care providers, the cost of malpractice

insurance for the correctional dentist are typically quite high. It would seem that any correctional system which wishes to attract and retain dentists should at the very least bear the cost of malpractice insurance. Although in most states the attorney general's office will represent a practitioner in any lawsuit at no cost to the practitioner, the fact that many of these states do not provide insurance against financial losses in addition is a serious mistake. The provision of adequate malpractice coverage, either through self-insurance on the part of the state, or through the purchase of private insurance, is a necessary part of any correctional dental program.

Salary and fringe benefits are also critically important in the recruitment and retention of other dental personnel. Since most dental auxiliaries are employed on a salary basis, either in private dental offices or in larger organizations, the competitive program must provide salaries that are comparable to those paid in other settings within the community, including those available in private practice.

Adequacy Of Personnel And Equipment

Another key component of the dental program which will be thoroughly investigated by potential employees is the adequacy of various resources in the dental program. The prospective dentist will want assurance that: (1) he will be able to practice in a style and with the necessary support that he requires; and (2) that the total complement of dental resources is capable of meeting the needs of the population to be served. Dentists who have become used to working with modern equipment, multiple operatories and several assistants and hygienists will be unlikely to join a program which forces the dentist to work alone and with older equipment. This is not because most dentists are arrogant or status conscious, but rather because their training and experience makes an adequate array of personnel and

equipment a necessity for practice. This is particularly true for dentists who have been trained in the last 15 years, but is applicable to older dentists also.

Even where a dentist finds a good array of resources available to him, he may find a setting unattractive because the supply of dentists and other personnel are insufficient to meet the needs of the population. A situation involving a severe undersupply of dental providers will undoubtedly mean that the available dentist(s) will be overworked and overwhelmed.*

Assuring an adequate number and mix of dental resources is thus a high priority objective of the health administrator interested in successful recruitment and retention.

The Condition Of Physical Facilities In The Dental Unit

Aside from the type of chairs, dental units, and other equipment available in the dental operatory, the prospective dentist will be concerned about the nature of the facility housing the dental unit: the amount of space available to work in; the level of heat, noise and dirt experienced in the unit; and the state of repair and maintenance of the facility. Most conscientious dentists will not work in unacceptable quarters, regardless of their level of pay or other factors.

The Degree Of Autonomy And Freedom From External Controls

Although this dimension of the dentist's job may not be considered by any but the most experienced dentists as a criterion for accepting employment, and therefore may not play a role in recruitment, the issue of autonomy may be the most critical factor in the retention of professionals.

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*Correctional health administrators should note that the Dental Services Branch of the Indian Health Service, following years of research, has devised an intricate formula for determining the ratio of dentists to population served.[12] It is felt, however, that such computations and methods are beyond the scope of this manual. Those interested in further research are referred to the I.H.S. manual.

Autonomy, the ability to make clinical and professional decisions and to carry them out without restrictions or interference, is a key attribute of the professional role. Although no member of an organization can operate without any rules or restrictions on his behavior, professionals are particularly sensitive to restrictions which impede or prohibit what they consider to be necessary actions in caring for patients. This is especially true when the restrictions are imposed by non-clinicians, or when they involve threats to the patient's health or to the doctor-patient relationship.

There seem to be two sources of infringement on the autonomy of dentists working in the correctional setting. The first, bureaucratic authority, is typical of other large organizations employing dentists; the second, the encroachment of security matters into the dentist's work, is specific to corrections. In any bureaucratic organization, management sets up rules and procedures, requires certain forms to be filled out, and dictates patterns of communication. Many professionals in organizations resent such bureaucratic encroachments into their practices, particularly when this is perceived as causing unnecessary delays in purchasing supplies or equipment, hiring new personnel, or making necessary referrals. Although many of these conditions are necessary to the management control of the dental unit, such restrictions are particularly onerous when they are made by non-clinical administrators who are perceived as knowing little about the requirements of dental practice. Some success in overcoming the conflict between bureaucratic control and professional autonomy have been achieved by creating a separate professional hierarchy in the organization to facilitate the management of professionals. Thus, dentists report only to other professionals (dentists or physicians) who report ultimately to the executive director of the department. In no case should professionals receive

directions about the clinical management of individual patients from non-clinicians.

This last point raises a serious problem experienced by many health providers in the corrections setting, i.e., the intrusion of security matters into the clinical content of the work. Undoubtedly, dentists resent the deprofessionalization of their job which results from security officials dictating the type and amount of treatment a dentist should provide a given patient. As stated previously, dentists are health professionals and should simply not be asked to engage in security or social control functions. It would seem that a key feature of any program whose goal is the retention of its staff should be that absolute respect would be given to the professional decisions of its clinicians, and that these decisions would be subject to review only by the professional's peers.

The Nature And Level Of Pathology In The Population

A major reason dentists have for entering the dental profession is an interest in serving their patients -- relieving pain and suffering, curing dental diseases, and preventing dental illness. One aspect of the correctional setting which may therefore prove challenging to a dentist is the high level of dental pathology predictably found in the prison population. General dentists interested in working in specific areas of dentistry are likely to find a wealth of "clinical material" within a correctional institution. This situation not only lends itself to the hiring of motivated dentists, but also may enable the correctional facility to encourage local dental schools to initiate clinical training programs in the facility.

The high level of need in the prison population can also be a deterrent to recruitment or retention, however. As discussed previously, without the necessary equipment and support personnel and without an adequate supply of providers overall, this high level of need can overwhelm even the most

dedicated dentist and influence him to seek employment elsewhere. Likewise, no dental school will permit its students to train in any facility that does not provide a high quality level of equipment, staff and supervision.

Relationships With Patients

As service occupations, dentistry and its auxilliary professions tend to attract people who place a high value on interpersonal relationships with patients. Not only will the typical dentist want to have pleasant interactions with patients for social reasons, but he will also want and expect to obtain the respect and cooperation of his patients for professional reasons. The dentist can neither perform satisfactorily nor enjoy his work if he cannot share mutual respect with his patients and perceive that the patient is trustworthy, cooperative, and interested in improving or maintaining dental health.

Unfortunately many dentists feel that a correctional practice cannot provide satisfactory relationships with patients. Whether because of the fear of dealing with "convicted criminals," or the discomfort associated with dealing with patients from a different culture and social class, many dental professionals simply will not enter a correctional setting because of the negative perception regarding patients.

There are not too many things that the correctional health administrator can do about such perceptions and attitudes. Certainly recruitment efforts should be focused at those individuals who are particularly interested in disadvantaged populations and who are able to cope with the realities of dealing with an incarcerated population. Some systems' recruitment activities involve exposing the potencial employee to the inmate population on several occasions before he is hired so that the individual's reactions can be closely observed and evaluated. Although it may be considered a

luxury to refuse to hire an interested prospect because of his negative reaction to the patient population, the price of hiring such a person is high; the expense incurred in orienting a new dentist (or auxiliary) only to see him/her resign within a short time so that recruitment must begin anew.

Another factor which seems to be associated with successful retention of professionals is the provision of ample security in the dental or medical area. The prevention of any untoward incidents in relation to patients and practitioners would seem to be the best way of avoiding resignations due to fears of patient reprisals.

An additional aspect of the dentist-patient relationship issue in corrections is one which pervades this entire monograph: the matter of the professional deportment of the dental staff. The assumption throughout this manual is that the dental program will be operated in a manner which is equivalent in professionalism to any private practice. Likewise, many correctional dentists and physicians have found that if they approach their patients in an uncompromised professional manner, then patients will respond to them just as patients do in the free world. Although there will certainly be instances where inmate-dentist relationships are less than satisfactory, we believe that the key to enjoyable relationships with patients rests mainly in the hands of the dental professionals themselves.

### The Ability Of The Unit To Address Other Professional Career Needs

The last attribute of a potential employment setting that will impact on recruitment and retention of dentists and dental auxiliaries is the degree to which the dental program addresses the professional career needs of the dental staff. An attractive setting does not simply involve extracting work from the professional all of the time, but rather involves providing the professional with sufficient time and resources to enable him to

continue his professional growth while serving the institutional population.

A variety of professional enrichment programs and resources can be provided by the correctional system. The provision of such services should not be regarded as a frill or luxury, but rather as a necessary part of employing professionals. For instance, the formal scheduling of time for dental staff to engage in regular and periodic continuing education not only enhances the performance (and satisfaction) of the staff, but also enables the staff to meet the licensure requirements of many state dental boards which require participation in continuing education activities.

Other programs which contribute to the professional milieu are such activities as affiliations with dental school training programs, encouragement of various types of research activities on the part of institutional dentists, and permitting dentists to work part-time at a dental school. All of these efforts will not only increase the level of professionalism of the program, but will also serve to decrease the sense of professional isolation felt by correctional health professionals (often culminating in the "burn-out syndrome" and eventual resignation of staff).

One other policy designed to decrease isolation and burn-out, (recently enacted by the U.S. Public Health Service and which will be presented as a resolution to the American Public Health Association) is that of requiring dentists in corrections to be employed less than full-time, allowing them to work part-time in another setting. It would seem that by employing dentists on a "majority time" basis (more than half, but less than full-time) the correctional setting can maximize the dentist's commitment to the setting while also permitting him to diversify his professional activities.

Other elements of professionalism which can be provided by the corrections system include: library facilities with current dental journals and dental reference texts; a career ladder so that dead-end jobs do not

become a reason for resignations; a peer review and quality monitoring system to maintain professional standards; and the other elements of a quality system identified previously.

Of course, the identification of the factors which contribute to the successful recruitment and retention of dental professionals is far easier to achieve than the implementation of a system imbued with these practice characteristics. Many of these attributes, e.g., salaries and equipment, are obvious to administrators, yet attempts to rectify low salaries or antiquated facilities typically are unsuccessful due to the greater importance of competing requests. Since the strategy for achieving some of the advances implied in the previous list will depend upon the specific economic and political realities found in the correctional system's environment, no attempt will be made here to suggest such a strategy.

However, one thing is clear: several systems have made great strides in their dental programs despite fiscal constraints and competing priorities. Salaries for dental (and medical) staffs have been increased through the provision of "hazardous duty pay" to correctional employees (thus enabling the state to maintain other publicly employed professionals at present levels), or through the payment of professionals on a contractual basis rather than through a civil service salary. The federal government has recently authorized the payment of $7000 - $10,000 above regular salaries to physicians taking positions for which recruitment difficulties have been experienced. Other systems have totally refurbished their health facilities, purchased new equipment, and modified program designs to attract new professionals to their health programs.

The key to such advances seems to be the tenacity, perseverance, and creativity of the administrative and clinical staffs working in the system. Although the process is generally a laborious and frustrating one, it seems

apparent that correctional health administrators must take their cases to their departmental leaders and to the legislative and executive bodies responsible for their budgets and legislative guidelines. Proper, legally mandated services cannot be provided without adequate professional staffs; and most professionals will not work in a non-professional setting.

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## CHAPTER 4: THE ROLE OF THE DENTAL HYGIENIST IN THE CORRECTIONAL SETTING

By Joan M. McGowan, R.D.H., B.S.D.H., M.A.

### Definition

The registered dental hygienist is a licensed, professional, oral health educator and clinical operator who, as an auxiliary to the dentist, uses preventive, therapeutic, and educational methods for the control of oral diseases to aid individuals and groups in attaining and maintaining optimum oral health.[1]

### Education

Three levels of education are available to the dental hygienist: the certificate and/or associate degree; baccalaureate degree; and masters degree programs.

1. The certificate and/or associate degree program is two years in length and is designed to prepare dental hygienists for dental office practice.

2. Baccalaureate degree programs may vary in the sequencing of professional and liberal arts courses, but are usually four years in length. They are designed to prepare hygienists for dental office practice and for the following specific areas of dental hygiene: public health, dental hygiene education, hospital practice, or practice in dental specialty offices.

3. Masters degree programs vary from one to two years in length and specifically prepare dental hygienists for administrative positions in dental hygiene education programs.[2]

It should be noted that the certificate and/or associate degree dental hygienist is more than adequately prepared to function as a clinician in a correctional dental health program.

Licensure

Licensure may be defined as: "the process by which an agency of government grants permission to persons to engage in a given profession or occupation by certifying that those licensed have attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected."[3] The dental hygienist is required to successfully complete a licensure examination given by the state board of dentistry where she desires to practice. The practice of dental hygiene is governed by the laws and regulations of the appropriate state board of dentistry, and it should be noted that duties legal in one state may not be legal in another state. The only exemptions to state licensure laws are dental personnel employed in federal agencies such as Veteran's Hospitals, federal penitentiaries or the Armed Services.

Traditional Utilization

The dental hygienist is recognized as a dental health educator and a skilled clinical technician. This combination of educator and technician makes the hygienist a valuable auxiliary in any dental clinic.

The American Dental Association, Commission on Accreditation which accredits all dental hygiene programs in the United States, has established requirements and guidelines for educational programs. These programs must provide background and clinical experience to ensure competency in the following areas:[4]

1. Medical/dental history
2. Emergency procedures
3. Oral examination and charting procedures
4. Appointment planning
5. Dental health education
6. Sterile techniques

7. Scaling and root planing: removal of hard and soft deposits from above and below the gum tissue
8. Use of ultrasonic devices for removal of hard deposits
9. Cleaning intra/oral appliances
10. Radiographs including panoramic surveys
11. Desensitization
12. Application of caries preventive agents
13. Polishing amalgam fillings
14. Taking impressions and preparing study models
15. Nutritional counseling
16. Dietary counseling for caries control

Given this list of responsibilities, correctional health administrators must consider the additional amount of time that will be available to the dentist to provide other services for the inmates, should the institution employ a registered dental hygienist.

Use of the dental hygienist has been found to be quite cost-effective in the private practice of dentistry. "By performing the professional duties for which she has been educated and licensed, the hygienist usually can be expected directly to increase the gross income of the (private) practice sufficiently to cover the cost of her employment. She can relieve the dentist of part of the time-consuming but essential duties to allow him to concentrate on more complicated aspects of his practice - all for the mutual benefit of the patient and the practice."[5] Although the correctional dental program cannot realize increases in income through the use of dental hygienists, it can reap benefits of lower overall costs and higher productivity.

According to a 1967-1970 questionnaire survey of all licensed dentists in the United States, there is a strong direct relationship between auxiliary utilization and the average number of patient visits per dentist per week.

"The statistical breakdown shows a steady increase in patient visits with each increase in the number of auxiliaries, from 45 visits with no auxiliaries, to 60 visits for dentists with one auxiliary, to 72 visits with two auxiliaries; the number rises to 95 patient visits for dentist with four or more auxiliaries."[6]

Another explanation for the increased efficiency of a dentist or dental program utilizing the services of a full-time dental hygienist can be seen by examining the hygienists' output of number of patients served per week.

The 1977 Survey of Dental Practice conducted by the American Dental Association reported that dental hygienists see an average of 37.4 to 52.7 patients per week depending on the region of the country in which they are employed.[7] The average adult visit with the dental hygienist is 45 minutes; thus representing a range of 1,683 - 2,371.5 minutes (or 28.05 - 39.53 hours) in time saved for the dentist. Therefore, the correctional institution employing a dental hygienist as an adjunct to the dentist(s) is likely to obtain maximum utilization of the dentist's valuable time, while expanding the service capacity of the dental program.

During the past ten years a number of changes have occurred in the dental hygiene profession.

1. While the number has not been great, a few men have entered the dental hygiene profession. The availability of male dental hygienists is a factor to be considered by those correctional systems still concerned about employment of females in male correctional institutions.

2. Many states have joined together to form regional boards for the purpose of examining candidates for licensure, thus simplifying licensure procedures.

3. Several states have revised their laws governing the practice of dentistry creating more flexible statutes.

4. Experimental studies have been conducted to determine the feasibility of utilizing dental hygienists in restorative dentistry. Restorative dentistry deals with the preparation of teeth and the placement of filling materials. Three of these studies will be examined in greater depth.

In 1972, Lobene conducted a study to determine if the graduate hygienist could be trained to do simple restorative dentistry, specifically the drilling and filling of teeth.[8] Results indicated that specially trained dental hygienists could: (1) perform restorative dentistry equal in quality to that performed by practicing dentists; (2) successfully administer infiltration anesthesia; (3) be favorably received by the patients who used the hygienist's services; and (4) be a useful addition to a general practice or clinic providing dental care for a large number of caries-susceptible people (such as residents of correctional institutions).

Mullins reported on the effects of expanded function dental auxiliaries in private fee-for-service dental practice.[9] An expanded function dental auxiliary is a dental assistant or hygienist who performs, under the direct supervision of a dentist, certain functions that traditionally have been performed only by dentists. Results indicated that there was an increase in: (1) productivity per hour; (2) services per hour; and (3) patient visits per hour.

Finally, Soricelli reported on a study concerning the control of quality in the delivery of dental care and the role of the technotherapist.[10] The study demonstrated that the expanded duties technotherapist (also termed EFDA, EDDA, or dental therapist) could contain costs of providing care and be favorably accepted by patients receiving the care.

As a result of these experimental studies, and many more, several states have changed their practice acts to allow dental hygienists to perform expanded functions. By utilizing expanded functions dental

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hygienists in a correctional dental health program, correctional health administrators are likely to increase both productivity and efficiency in a cost-effective manner.

<u>Summary</u>

The purpose of this chapter was to define the role of a dental hygienist and her/his subsequent effect on the efficiency of the dentist in a prison dental clinic. The dental hygienist is a dental health educator and a skilled clinician. This combination makes her a valuable asset to the prison dental program.

The literature suggests that the dental hygienist:

1. can cover the cost of her employment;
2. will increase the number of patient visits per dentist per week;
3. will save the dentist an average of 28.05 - 39.53 hours per week;
4. could perform restorative dentistry equal in quality to that performed by practicing dentists (in those states where expanded restorative functions are legal); and
5. is favorably received by patients who receive hygienist services.

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## CHAPTER 5: PHYSICAL FACILITIES AND EQUIPMENT

If a correctional dental program is to be efficient and cost-effective, the correctional health administrator must ensure that adequate, well-designed, and well-equipped clinical, laboratory, and administrative facilities are available for the program personnel. All too often, institutional dental facilities appear to be provided as an afterthought, tucked away into some leftover corner of the medical facility. The dental program is often left with space that is insufficient to accommodate all of the necessary equipment, and which is incapable of supporting an efficiently designed layout.

Correctional health administrators are encouraged to seek the services of professional dental practice consultants when considering construction of new dental facilities or remodeling existing clinics. Such assistance can be solicited from: dental divisions of state departments of public health; the regional dental consultants of the U.S. Public Health Service; departments of community dentistry, dental public health, or practice administration of dental schools; programs of dental public health in schools of public health; or from practice consultants provided through local dental equipment and supply retailers. (Please refer to Appendix H for addresses of the appropriate agencies or dental schools.) These consultants will be able to integrate the latest technological advances in dental science and dental equipment with time-and-motion studies and ergonomics* to assist the correctional health administrator and dental director in designing the most practical, cost-effective, and efficient dental facility that can be constructed within given institutional constraints.

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*Harris and Crabb define the ergonomics of dentistry as: "the study of all factors that relate to quality and quantity of dental care delivered in comparison to the amount of work input and the amount of physical and mental fatigue generated in the process."[1]

Correctional health administrators also need to consider environmental and safety factors when designing and constructing the dental facility. Besides adequate lighting and well-designed acoustics, the dental clinic must have: adequate ventilation in order to eliminate noxious gases generated through manipulation of certain dental materials or through the use of anesthetic gases; a well-controlled heating and air conditioning system (most important for patient safety, but also necessary for comfort, increased productivity, and safety of the dental personnel); adequate protection from radiation (generated from dental X-ray equipment and some types of dental operatory lighting); a well-designed scavenging system for use with gaseous anesthetic installations; and a central suction system that includes an adequate emergency auxiliary system. Clinical facilities should be designed to promote mercury hygiene (mercury, a poisonous heavy metal, is used extensively in the mixing of certain restorative materials) and to allow for adequate cleaning, disinfection, and sterilization. Correctional health administrators are encouraged to refer to Christen and Harris[2] for additional information on environmental hazards in the dental facilities, and to consult Stafne and Gibilisco[3] and O'Brien[4] for information concerning hazards surrounding exposure of patients and dental personnel to radiation.

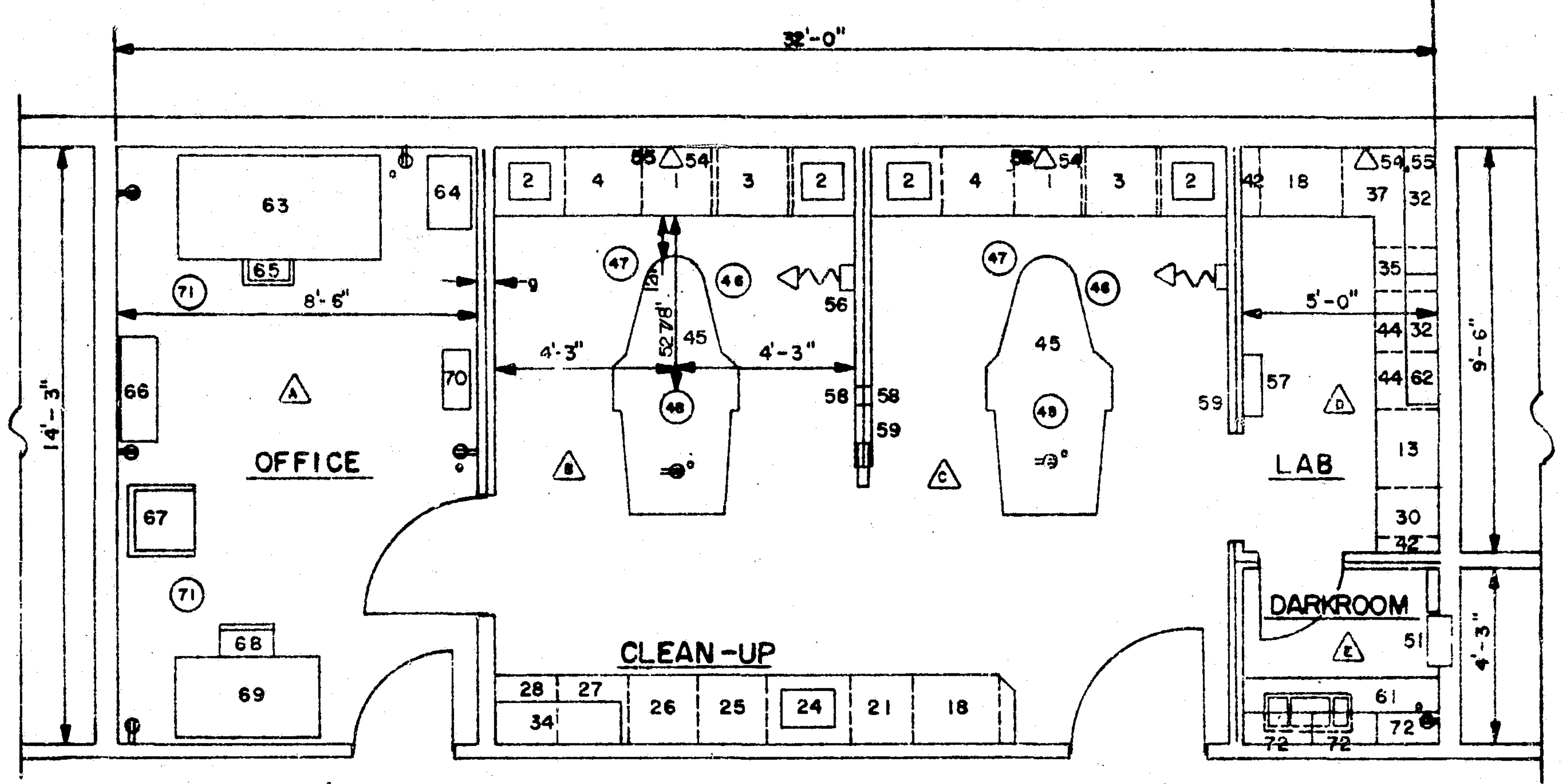
To assist correctional health administrators in planning and constructing dental facilities, the remaining portion of this chapter is devoted to a presentation of prototype clinical floor plans and a master equipment list for dental programs of varying sizes. These standard clinic plans and equipment lists were originally presented in a Department of Health, Education, and Welfare manual,[5] and were developed by synthesizing the accumulated research and experience of the Dental Services Branch of the Indian Health Service. This information is presented only as a guide for correctional health administrators, and should not be followed explicitly in the design

of any new program. Advances in dental technology continue to occur at a rapid rate and many of the designs and models presented in these prototypes may already be outdated (in terms of equipment dimensions). Prison administrators are again urged to seek the help of professional dental practice consultants before proceeding with construction or alteration of clinical facilities. The time and money spent on proper consultive services before construction begins will help ensure that an efficient and cost-effective dental health program can be achieved, hopefully preventing needless remodeling or costly inefficiency due to improperly designed and poorly built clinical facilities.

Standard Clinic Plans[6]

These plans do not include space for a reception area -- this must be added to fit the space available at each individual institution.

These standard clinic plans are presented so that correctional health administrators will be aware of space requirements for any given dental clinic floor plan, and will have some idea of the equipment necessary to adequately furnish a clinical facility.




TWO OPERATORY CLINIC[6]

Figure 4-1

Source: U.S. Department of Health, Education, and Welfare, Public Health Service. Dental program efficiency criteria and standards for the Indian Health Service. Washington, D.C., The Department, 1974. ix + 187 p.

## TWO OPERATORY DENTAL CLINIC (FIGURE 4-1)
## EQUIPMENT LIST[6]

### OFFICE EQUIPMENT

63. Desk
64. Cabinet, File, 5 drawer
65. Chair, Rotary
66. Bookcase
67. Chair, Straight w/Arm Rest
68. Chair, Typist
69. Desk, Typist
70. Rack, Wearing Apparel
71. Receptacle, Waste

### OPERATORY EQUIPMENT

1. IHS Console
2. Sink Cabinet
3. Mobile Cabinet
4. Mobile Cavitron Cabinet
45. Dental Lounge
46. DA Stool
47. DO Stool
48. Ceiling Mounted Track Light
54. Gas Jet
55. Air Jet
56. X-ray, tubehead & arm
58. X-ray, remote timing station
59. Lead glass window

### CLEAN-UP AREA

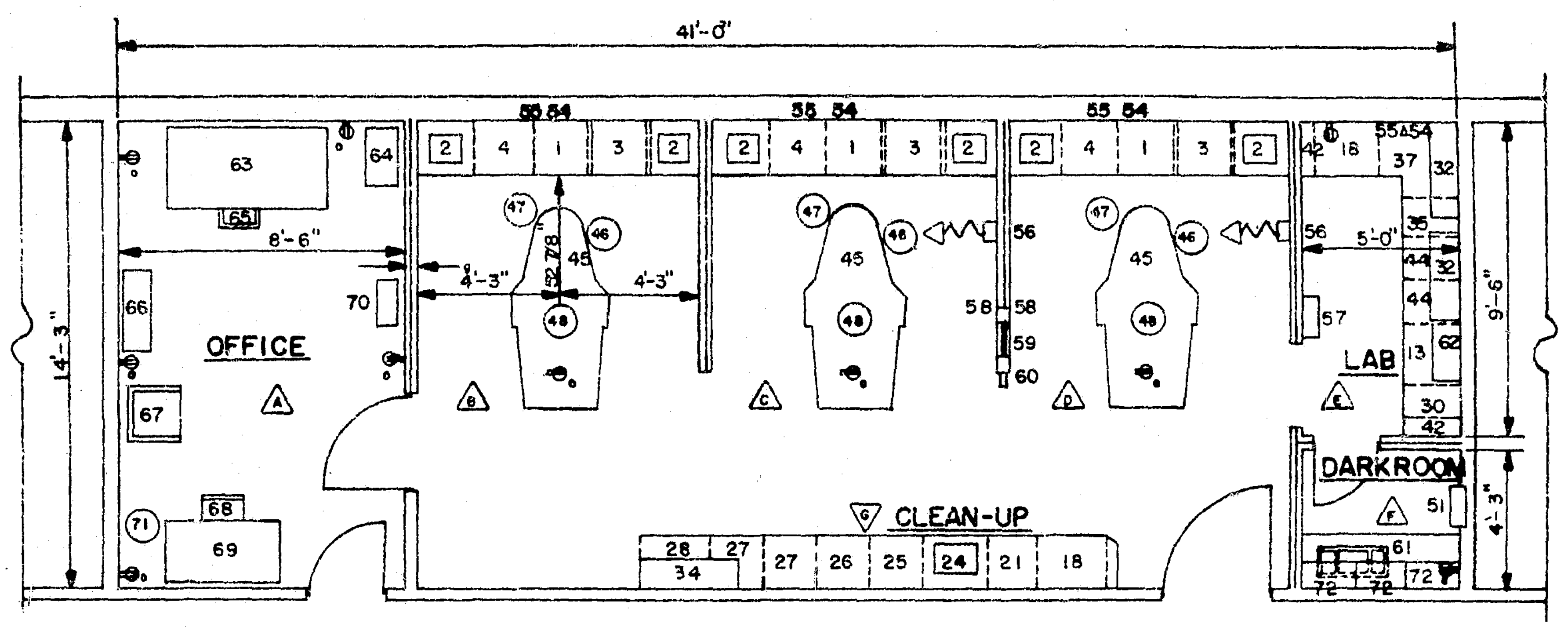
18. Instrument Cabinet
21. Instrument Cabinet
24. Sink Cabinet
25. Instrument/Storage Cabinet
26. Instrument/Storage Cabinet
27. Instrument/Storage Cabinet
28. Instrument/Storage Cabinet
34. Storage Cabinet

### LABORATORY EQUIPMENT

13. Sink Cabinet
18. Storage Cabinet
30. Storage Cabinet
32. Model Cabinet
35. Storage Cabinet
37. Casting Machine Cabinet
42. Filler Panel Component
44. Storage Cabinet
54. Gas Jet
55. Air Jet
57. X-ray Unit, master control
62. Plaster Bin

### DARKROOM EQUIPMENT

51. Viewbox, X-ray 13" x 18"
61. Developing tank
72. Storage Cabinet




THREE OPERATORY CLINIC[6]

Figure 4-2

Source: U.S. Department of Health, Education, and Welfare, Public Health Service. Dental program efficiency criteria and standards for the Indian Health Service. Washington, D.C., The Department, 1974. ix + 187 p.

## THREE OPERATORY DENTAL CLINIC (FIGURE 4-2)

## EQUIPMENT LIST[6]

### OFFICE EQUIPMENT

63. Desk
64. Cabinet, File, 5 drawer
65. Chair, Rotary
66. Bookcase
67. Chair, Straight w/Arm Rest
68. Chair, Typist
69. Desk, Typist
70. Rack, Wearing Apparel
71. Receptacle, Waste

### OPERATORY EQUIPMENT

1. IHS Console
2. Sink Cabinet
3. Mobile Cabinet
4. Mobile Cavitron Cabinet
45. Dental Lounge
46. DA Stool
47. DO Stool
48. Ceiling Mounted Track Light
54. Gas Jet
55. Air Jet
56. X-ray, tubehead & arm
58. X-ray, remote timing station
59. Lead glass window
60. X-ray film dispenser

### CLEAN-UP AREA

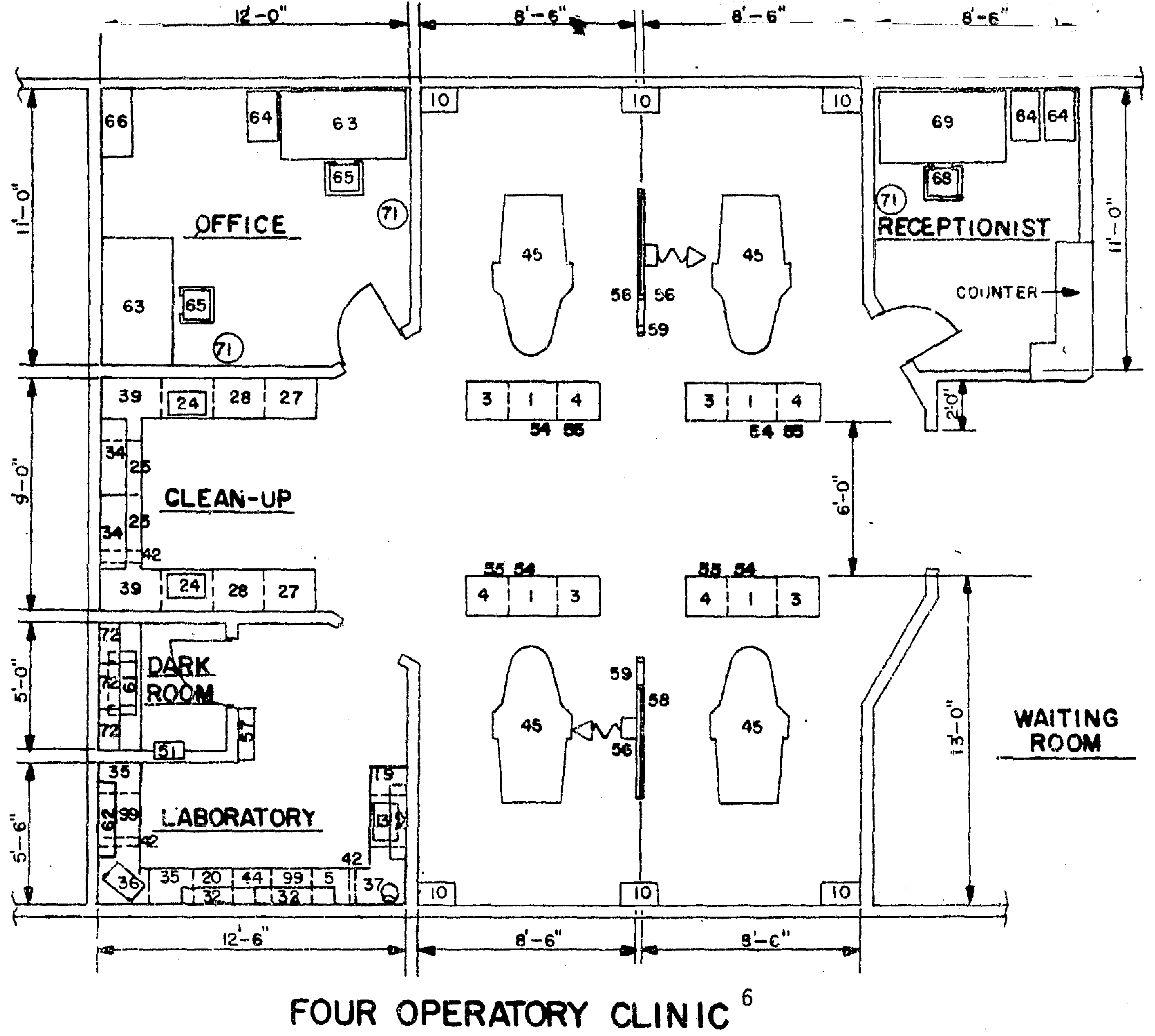
18. Instrument Cabinet
21. Instrument Cabinet
24. Sink Cabinet
25. Instrument/Storage Cabinet
26. Instrument/Storage Cabinet
27. Instrument/Storage Cabinet
28. Instrument/Storage Cabinet
34. Storage Cabinet

### LABORATORY EQUIPMENT

13. Sink Cabinet
18. Storage Cabinet
30. Storage Cabinet
32. Model Cabinet
35. Storage Cabinet
37. Casting Machine Cabinet
42. Filler Panel Component
44. Storage Cabinet
54. Gas Jet
55. Air Jet
57. X-ray Unit, master control
62. Plaster Bin

### DARKROOM EQUIPMENT

51. Viewbox, X-ray 13" x 8"
61. Developing tank
72. Storage cabinet




# FOUR OPERATORY CLINIC [6]

Figure 4-3

Source: U.S. Department of Health, Education, and Welfare, Public Health Service. Dental program efficiency criteria and standards for the Indian Health Service. Washington, D.C., The Department, 1974. ix + 187 .

CONTINUED

1 OF 5

## FOUR OPERATORY DENTAL CLINIC (FIGURE 4-3)
## EQUIPMENT LIST[6]

### OFFICE AND RECEPTIONIST EQUIPMENT

63. Desk
64. Cabinet, File, 5 drawer
65. Chair, Rotary
66. Bookcase
68. Chair, Typist
69. Desk, Typist
71. Receptacle, Waste

### OPERATORY EQUIPMENT

1. IHS Console
3. Mobile Cabinet
4. Mobile Cavitron Cabinet
10. Sink Cabinet
45. Dental Lounge
54. Gas Jet
55. Air Jet
56. X-ray, tubehead & arm
58. X-ray, remote timing station
59. Lead glass window

### CLEAN-UP AREA

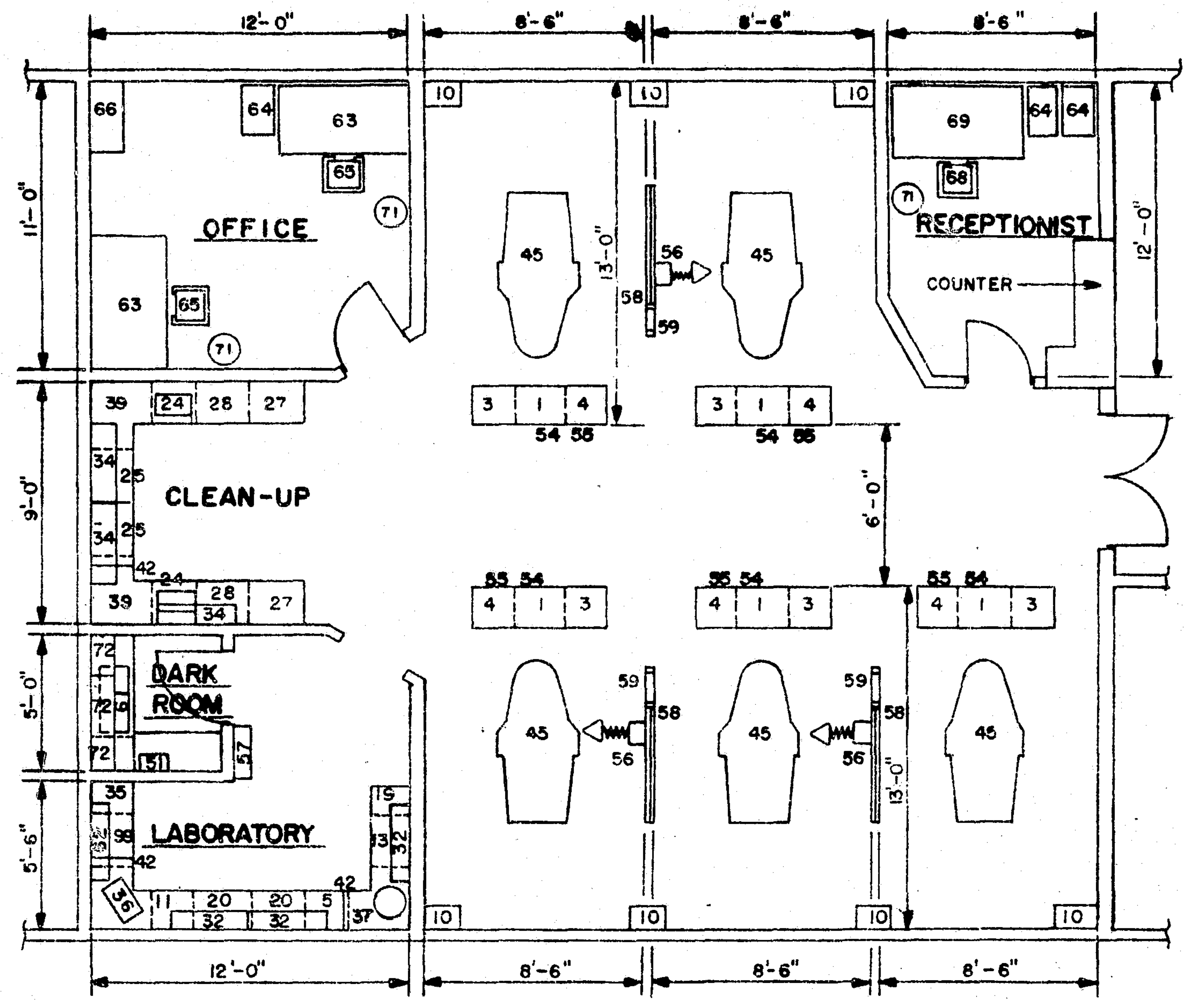
24. Sink Cabinet
25. Instrument/Storage Cabinet
27. Instrument/Storage Cabinet
28. Instrument/Storage Cabinet
34. Storage Cabinet
39. Corner Storage, Lazy Susan
42. Filler Panel Component

### LABORATORY EQUIPMENT

5. Instrument/Storage Cabinet
13. Sink Cabinet
19. Instrument/Storage Cabinet
20. Instrument/Storage Cabinet
32. Model Cabinet
35. Instrument/Storage Cabinet
36. Sink Cabinet
37. Casting Machine Cabinet
42. Filler Panel Component
44. Instrument/Storage Cabinet
57. X-ray Unit master control
62. Plaster Bin
99. Instrument/Storage Cabinet

### DARKROOM EQUIPMENT

51. Viewbox, X-ray 13" x 8"
61. Developing tank
72. Storage Cabinet




FIVE OPERATORY CLINIC [6]

Figure 4-4

Source: U.S. Department of Health, Education, and Welfare, Public Health Service. ent... efficiency criteria and standards for the Indian Health

## FIVE OPERATORY DENTAL CLINIC (FIGURE 4-4)
## EQUIPMENT LIST[6]

### OFFICE AND RECEPTIONIST EQUIPMENT

63. Desk
64. Cabinet, File, 5 drawer
66. Bookcase
68. Chair, Typist
69. Desk, Typist
71. Receptacle, Waste

### OPERATORY EQUIPMENT

1. IHS Console
3. Mobile Cabinet
4. Mobile Cavitron Cabinet
10. Sink Cabinet
45. Dental Lounge
54. Gas Jet
55. Air Jet
56. X-ray, tubehead & arm
58. X-ray remote timing station
59. Lead glass window

### CLEAN-UP AREA

24. Sink Cabinet
25. Instrument/Storage Cabinet
27. Instrument/Storage Cabinet
28. Instrument/Storage Cabinet
34. Storage Cabinet
39. Corner Storage, Lazy Susan
42. Filler Panel Component

### LABORATORY EQUIPMENT

5. Instrument/Storage Cabinet
11. Instrument/Storage Cabinet
13. Sink Cabinet
19. Instrument/Storage Cabinet
20. Instrument/Storage Cabinet
32. Model Cabinet
35. Instrument/Storage Cabinet
36. Sink Cabinet
37. Casting Machine Cabinet
42. Filler Panel Component
57. X-ray Unit, master control
62. Plaster Bin
99. Instrument/Storage Cabinet

### DARKROOM EQUIPMENT

51. Viewbox, X-ray 13" x 8"
61. Developing tank
72. Storage Cabinet

SIX OPERATORY CLINIC[6]

Figure 4-5

Source: U.S. Department of Health, Education, and Welfare, Public Health Service. Dental program efficiency criteria and standards for the Indian Health Jashin ton, D.C., The Department,

# SIX OPERATORY DENTAL CLINIC (FIGURE 4-5)

## EQUIPMENT LIST[6]

### OFFICE AND RECEPTIONIST EQUIPMENT

63. Desk
64. Cabinet, File, 5 drawer
66. Bookcase
67. Chair, Straight w/Arm Rest
68. Chair, Typist
69. Desk, Typist
71. Receptacle, Waste

### OPERATORY EQUIPMENT

1. IHS Console
3. Mobile Cabinet
4. Mobile Cavitron Cabinet
10. Sink Cabinet
45. Dental Lounge
54. Gas Jet
55. Air Jet
56. X-ray, tubehead & arm
57. X-ray apparatus
58. X-ray remote timing station
59. Lead glass window

### CLEAN-UP AREA

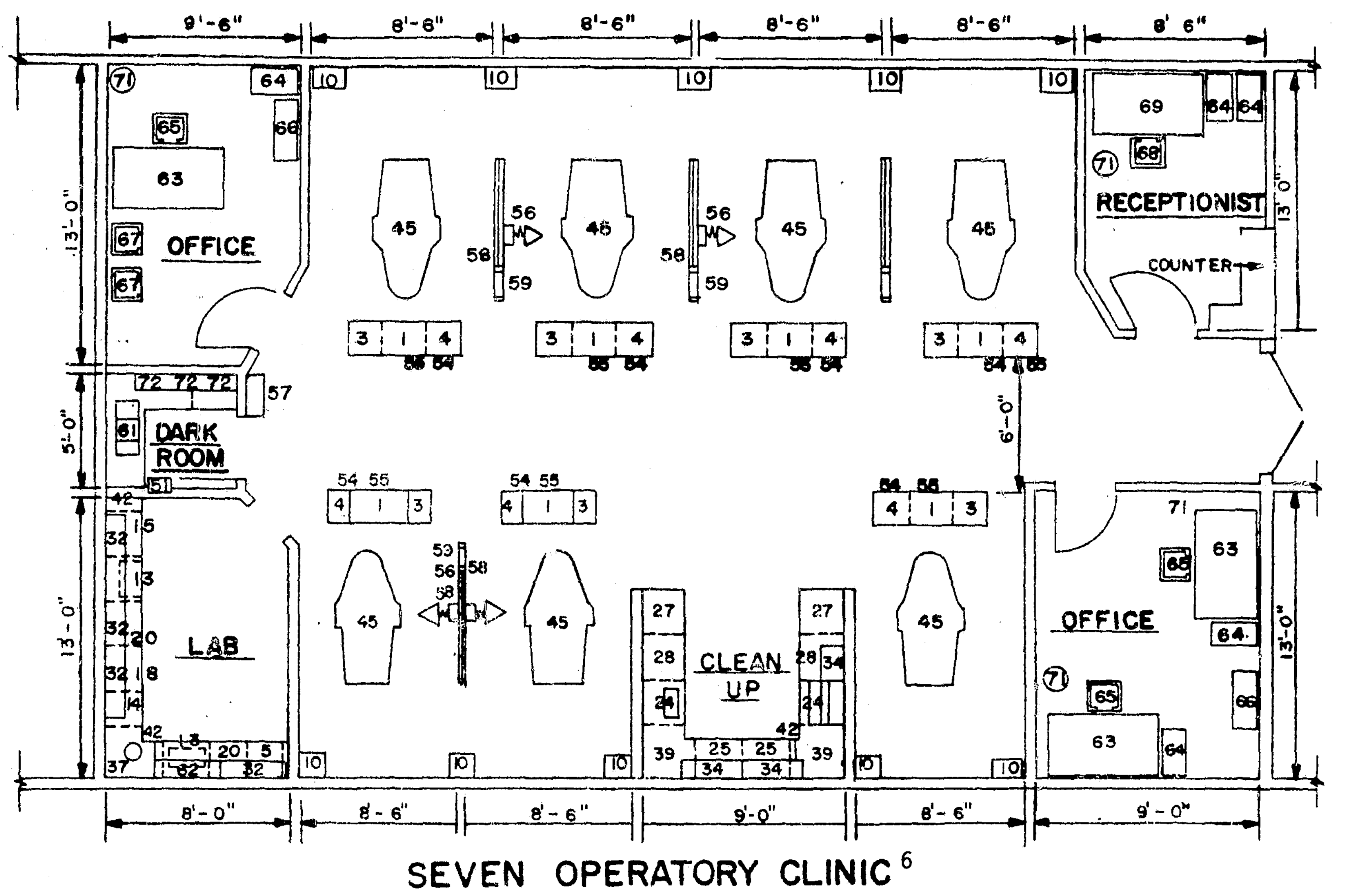
24. Sink Cabinet
25. Instrument/Storage Cabinet
27. Instrument/Storage Cabinet
28. Instrument/Storage Cabinet
34. Storage Cabinet
39. Corner Storage, Lazy Susan
42. Filler Panel Component

### LABORATORY EQUIPMENT

5. Instrument/Storage Cabinet
13. Sink Cabinet
14. Instrument/Storage Cabinet
15. Instrument/Storage Cabinet
18. Storage Cabinet
20. Instrument/Storage Cabinet
32. Model Cabinet
37. Casting Machine Cabinet
42. Filler Panel Component
62. Plaster Bin

### DARKROOM EQUIPMENT

51. Viewbox, X-ray 13" x 8"
61. Developing tank
72. Storage Cabinet




SEVEN OPERATORY CLINIC [6]

Figure 4-6

Source: U.S. Department of Health, Education, and Welfare, Public Health Service. Dental program efficiency criteria and standards for the Indian Health Service. Washington, D.C., The Department, 1974. ix + 187 p.

## SEVEN OPERATORY DENTAL CLINIC (FIGURE 4-6)

## EQUIPMENT LIST[6]

### OFFICE AND RECEPTIONIST EQUIPMENT

63. Desk
64. Cabinet, File, 5 Drawer
65. Chair, Rotary
66. Bookcase
67. Chair, Straight w/Arm Rest
68. Chair, Typist
69. Desk, Typist
71. Receptacle, Waste

### OPERATORY EQUIPMENT

1. IHS Console
3. Mobile Cabinet
4. Mobile Cavitron Cabinet
10. Sink Cabinet
45. Dental Lounge
54. Gas Jet
55. Air Jet
56. X-ray tubehead & arm
57. X-ray Unit, master control
58. X-ray remote timing station
59. Lead glass window

### CLEAN-UP AREA

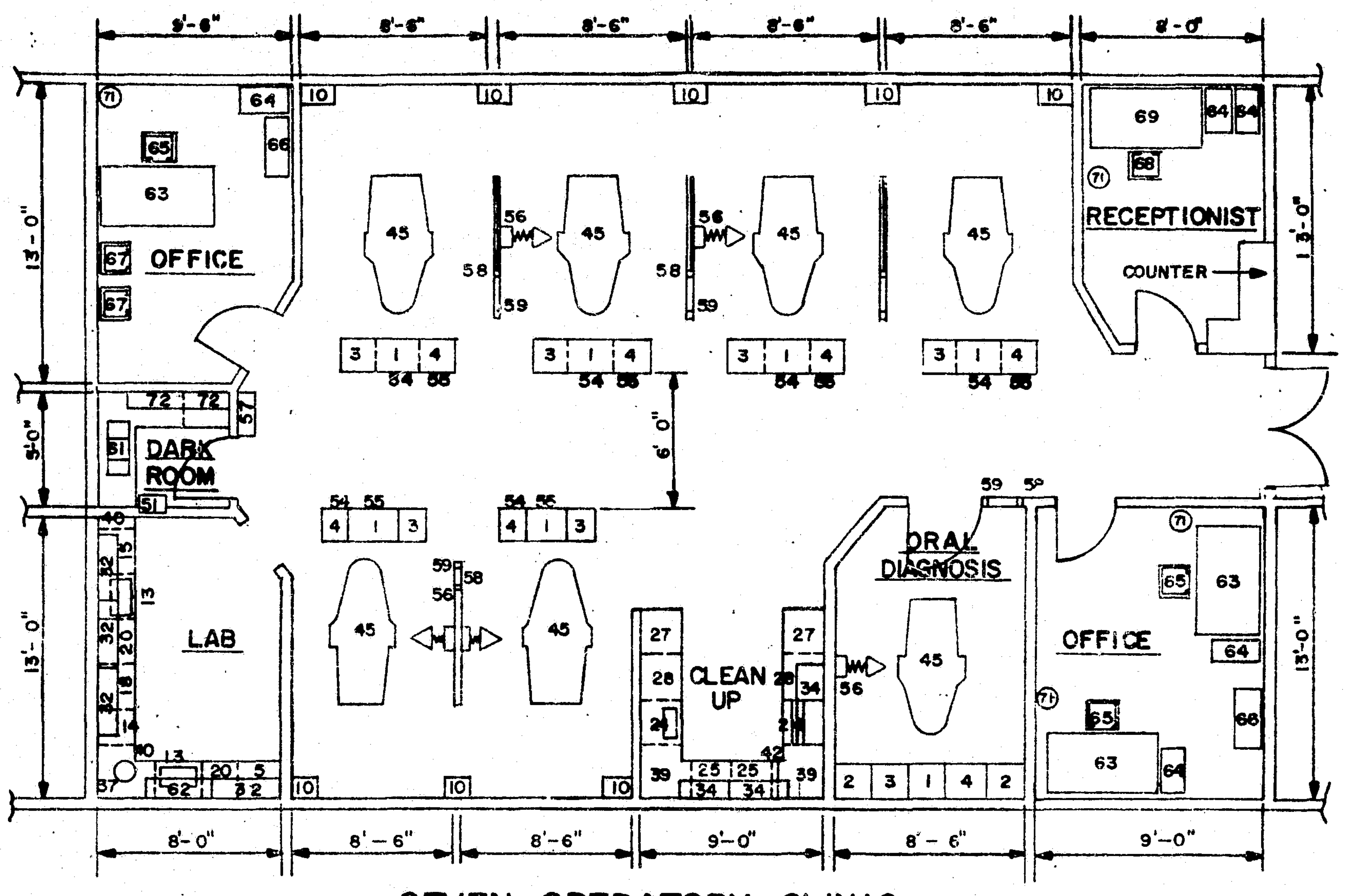
24. Sink Cabinet
25. Instrument/Storage Cabinet
27. Instrument/Storage Cabinet
28. Instrument/Storage Cabinet
34. Storage Cabinet
39. Corner storage, Lazy Susan
42. Filler Panel Component

### LABORATORY EQUIPMENT

5. Instrument/Storage Cabinet
13. Sink Cabinet
14. Instrument/Storage Cabinet
15. Instrument/Storage Cabinet
18. Storage Cabinet
20. Instrument/Storage Cabinet
32. Model Cabinet
37. Casting Machine Cabinet
42. Filler Panel Component
62. Plaster Bin

### DARKROOM EQUIPMENT

51. Viewbox, X-Ray 13" x 8"
61. Developing tank
72. Storage Cabinet




SEVEN OPERATORY CLINIC

INCLUDING ORAL DIAGNOSIS [6]

Figure 4-7

Source: U.S. Department of Health, Education, and Welfare, Public Health Service. Dental program efficiency criteria and standards for the Indian Health Service. Washington, D.C., The Department, 1974. ix + 187 p.

SEVEN OPERATORY DENTAL CLINIC INCLUDING ORAL DIAGNOSIS (FIGURE 4-7)

EQUIPMENT LIST[6]

## OFFICE AND RECEPTIONIST EQUIPMENT

63. Desk
64. Cabinet, File, 5 drawer
65. Chair, Rotary
66. Bookcase
67. Chair, Straight w/Arm Rest
68. Chair, Typist
69. Desk, Typist
71. Receptacle, Waste

## OPERATORY EQUIPMENT

1. IHS Console
2. Sink Cabinet
3. Mobile Cabinet
4. Mobile Cavitron Cabinet
10. Sink Cabinet
45. Dental Lounge
54. Gas Jet
55. Air Jet
56. X-ray, tubehead & arm
57 X-ray Unit, master control
58. X-ray remote timing station
59. Lead glass window

## CLEAN-UP AREA

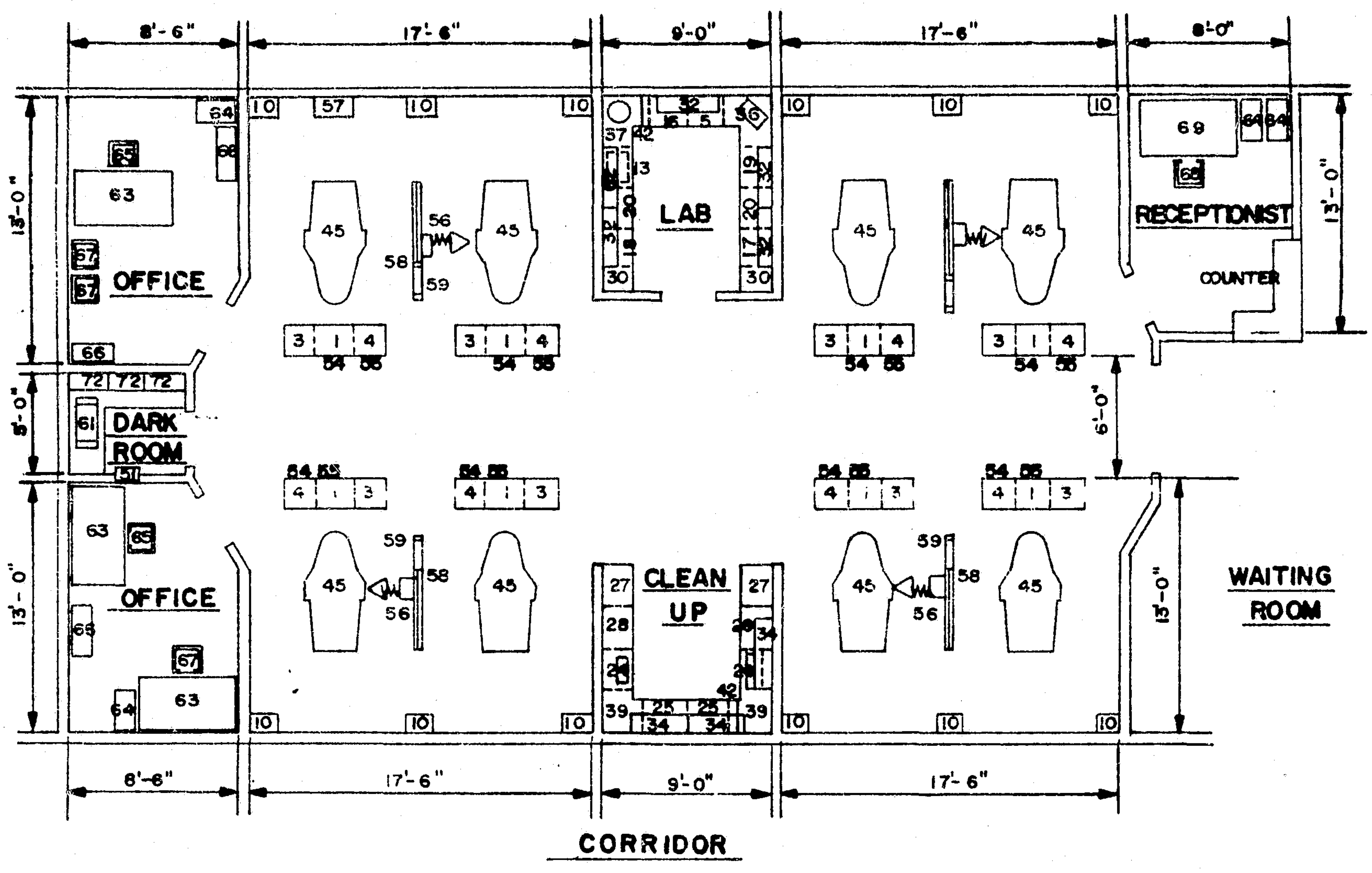
24. Sink Cabinet
25. Instrument/Storage Cabinet
27. Instrument/Storage Cabinet
28. Instrument/Storage Cabinet
34. Storage Cabinet
39. Corner Storage, Lazy Susan
42. Filler Panel Component

## LABORATORY EQUIPMENT

5. Instrument/Storage Cabinet
13. Sink Cabinet
14. Instrument/Storage Cabinet
15. Instrument/Storage Cabinet
18. Storage Cabinet
20. Instrument/Storage Cabinet
32. Model Cabinet
37. Casting Machine Cabinet
40. Formica Countertop
62. Plaster Bin

## DARKROOM EQUIPMENT

51. Viewbox, X-ray 13" x 8"
61. Developing tank
72. Storage cabinet




EIGHT OPERATORY CLINIC[6]

Figure 4-8

Source: U.S. Department of Health, Education, and Welfare, Public Health Service. Dental program efficiency criteria and standards for the Indian Health Service. Washington, D.C., The Department, 1974. ix + 187 p.

# EIGHT OPERATORY DENTAL CLINIC (FIGURE 4-8)
## EQUIPMENT LIST[6]

### OFFICE AND RECEPTIONIST EQUIPMENT

63. Desk
64. Cabinet, File, 5 drawer
65. Chair, Rotary
66. Bookcase
67. Chair, Straight w/Arm Rest
68. Chair, Typist
69. Desk, Typist

### OPERATORY EQUIPMENT

1. IHS Console
3. Mobile Cabinet
4. Mobile Cavitron Cabinet
10. Sink Cabinet
45. Dental Lounge
54. Gas Jet
55. Air Jet
56. X-ray, tubehead & arm
57. X-ray, Unit, master control
58. X-ray remote timing station
59. Lead glass window

### CLEAN-UP AREA

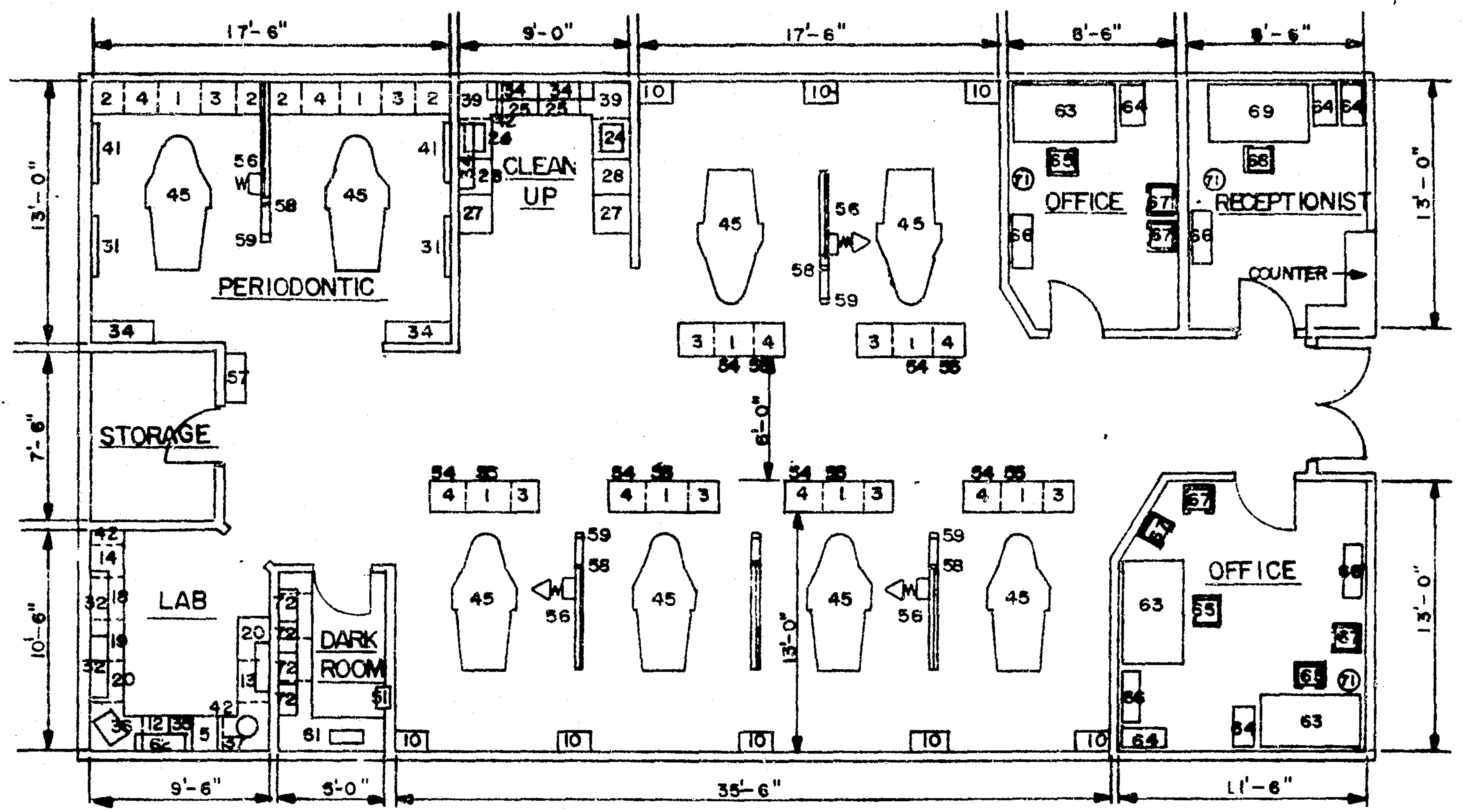
24. Sink Cabinet
25. Instrument/Storage Cabinet
27. Instrument/Storage Cabinet
28. Instrument/Storage Cabinet
34. Storage Cabinet
39. Corner Storage, Lazy Susan
42. Filler Panel Component

### LABORATORY EQUIPMENT

5. Instrument/Storage Cabinet
13. Sink Cabinet
16. Instrument/Storage Cabinet
17. Instrument/Storage Cabinet
18. Storage Cabinet
19. Instrument/Storage Cabinet
20. Instrument/Storage Cabinet
30. Instrument/Storage Cabinet
32. Model Cabinet
36. Sink Cabinet
37. Casting Machine Cabinet
42. Filler Panel Component
62. Plaster Bin

### DARKROOM EQUIPMENT

51. Viewbox, X-ray 13" x 8"
61. Developing tank
72. Storage Cabinet




# EIGHT OPERATORY CLINIC INCLUDING PERIODONTIC[6]

Figure 4-9

Source: U.S. Department of Health, Education, and Welfare, Public Health Service. Dental program efficiency criteria and standards for the Indian Health Service. Washington, D.C., The Department, 1974. ix + 187 p.

EIGHT OPERATORY DENTAL CLINIC INCLUDING PERIODONTIC (FIGURE 4-9)

EQUIPMENT LIST[6]

## OFFICE AND RECEPTIONIST EQUIPMENT

63. Desk
64. Cabinet, File, 5 drawer
65. Chair, Rotary
66. Bookcase
67. Chair, Straight w/Arm Rest
68. Chair, Typist
69. Desk, Typist
71. Receptacle, Waste

## OPERATORY EQUIPMENT

1. IHS Console
2. Sink Cabinet
3. Mobile Cabinet
4. Mobile Cavitron Cabinet
45. Dental Lounge
54. Gas Jet
55. Air Jet
56. X-ray, tubehead & arm
57. X-ray Unit, master control
58. X-ray remote timing station
59. Lead glass window

## CLEAN-UP AREA

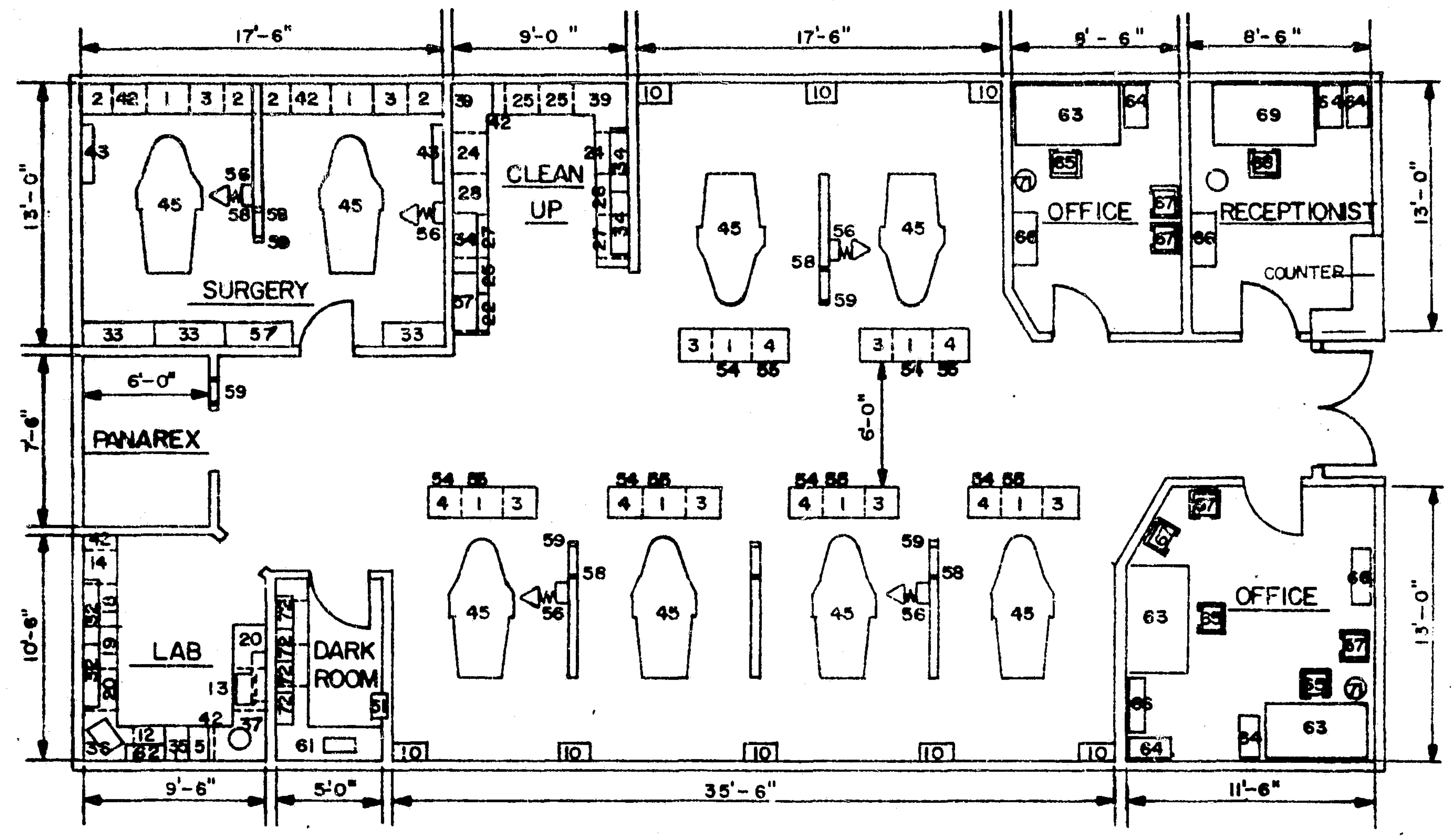
24. Sink Cabinet
25. Instrument/Storage Cabinet
27. Instrument/Storage Cabinet
28. Instrument/Storage Cabinet
34. Storage Cabinet
39. Corner Storage, Lazy Susan
42. Filler Panel Component

## LABORATORY EQUIPMENT

5. Instrument/Storage Cabinet
12. Instrument/Storage Cabinet
13. Sink Cabinet
14. Instrument/Storage Cabinet
18. Storage Cabinet
19. Instrument/Storage Cabinet
20. Instrument/Storage Cabinet
32. Model Cabinet
35. Instrument/Storage Cabinet
36. Sink Cabinet
37. Casting Machine Cabinet
42. Filler Panel Component
62. Plaster Bin

## DARKROOM EQUIPMENT

51. Viewbox, X-ray 13" x 8"
61. Developing tank
72. Storage Cabinet




EIGHT OPERATORY CLINIC
INCLUDING ORAL SURGERY [6]

Figure 4-10

Source: U.S. Department of Health, Education, and Welfare, Public Health Service. Dental program efficiency criteria and standards for the Indian Health Service. Washington, D.C., The Department, 1974. ix + 187 p.

# EIGHT OPERATORY DENTAL CLINIC INCLUDING ORAL SURGERY (FIGURE 4-10)

## EQUIPMENT LIST[6]

### OFFICE AND RECEPTIONIST EQUIPMENT

63. Desk
64. Cabinet, File, 5 drawer
65. Chair, Rotary
66. Bookcase
67. Chair, Straight w/Arm Rest
68. Chair, Typist
69. Desk, Typist
71. Receptacle, Waste

### OPERATORY EQUIPMENT

1. IHS Console
2. Sink Cabinet
3. Mobile Instrument Cabinet
4. Mobile Cavitron Cabinet
10. Sink Cabinet
33. Surgical Instrument Cabinet
42. Filler Panel Component
43. X-ray View Box
45. Dental Lounge
54. Gas Jet
55. Air Jet
56. X-ray, tubehead & arm
57. X-ray Unit, master control
58. X-ray remote timing station
59. Lead glass window

### CLEAN-UP AREA

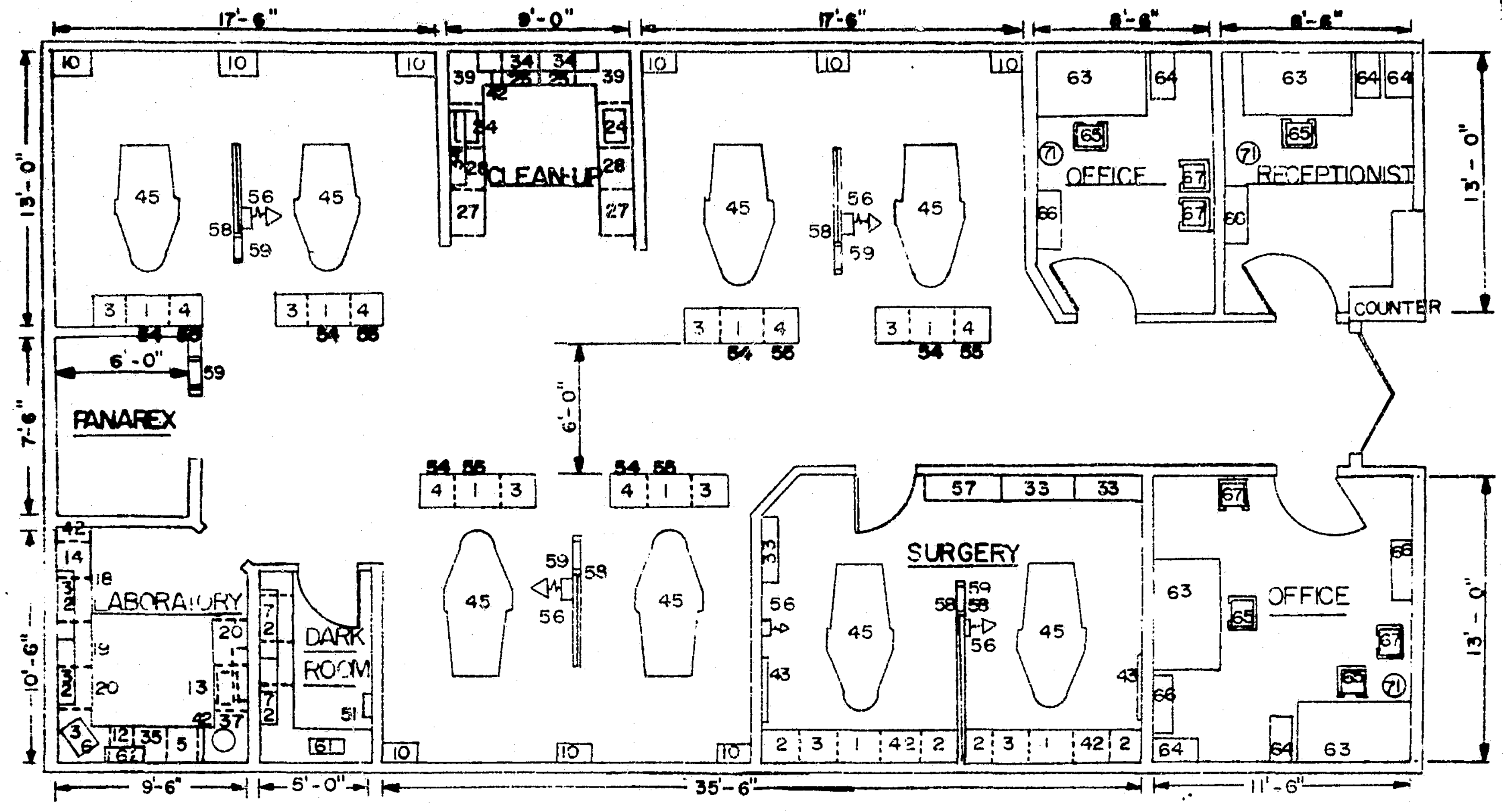
22. Instrument/Storage Cabinet
24. Sink Cabinet
25. Instrument/Storage Cabinet
27. Instrument/Storage Cabinet
28. Instrument/Storage Cabinet
34. Storage Cabinet
39. Corner Storage, Lazy Susan
42. Filler Panel Component
57. X-ray Unit, master control

### LABORATORY EQUIPMENT

5. Instrument/Storage Cabinet
12. Instrument/Storage Cabinet
13. Sink Cabinet
14. Instrument/Storage Cabinet
18. Storage Cabinet
19. Instrument/Storage Cabinet
20. Instrument/Storage Cabinet
32. Model Cabinet
35. Instrument/Storage Cabinet
36. Sink Cabinet
37. Casting Machine Cabinet
42. Filler Panel Component
62. Plaster Bin

### DARKROOM EQUIPMENT

51. Viewbox, X-ray 13" x 8"
61. Developing tank
72. Storage Cabinet




EIGHT OPERATORY CLINIC INCLUDING ORAL SURGERY & ORAL DIAGNOSIS[6]

Figure 4-11

Source: U.S. Department of Health, Educaiton, and Welfare, Public Health Service. Dental program efficiency criteria and standards for the Indian Health Service. Washington, D.C., The Department, 1974. ix+ 187 p.

## EIGHT OPERATORY DENTAL CLINIC INCLUDING ORAL SURGERY AND ORAL DIAGNOSIS (FIGURE 4-11)

## EQUIPMENT LIST[6]

### OFFICE AND RECEPTIONIST EQUIPMENT

63. Desk
64. Cabinet, File, 5 drawer
65. Chair, Rotary
66. Bookcase
67. Chair, Straight w/Arm Rest
71. Receptacle, Waste

### OPERATORY EQUIPMENT

1. IHS Console
2. Sink Cabinet
3. Mobile Cabinet
4. Mobile Cavitron Cabinet
10. Sink Cabinet
33. Surgical Instrument Cabinet
42. Filler Panel Component
43. X-ray View Box
45. Dental Lounge
54. Gas Jet
55. Air Jet
56. X-ray, tubehead & arm
57. X-ray Unit, master control
58. X-ray remote timing station
59. Lead glass window

### CLEAN-UP AREA

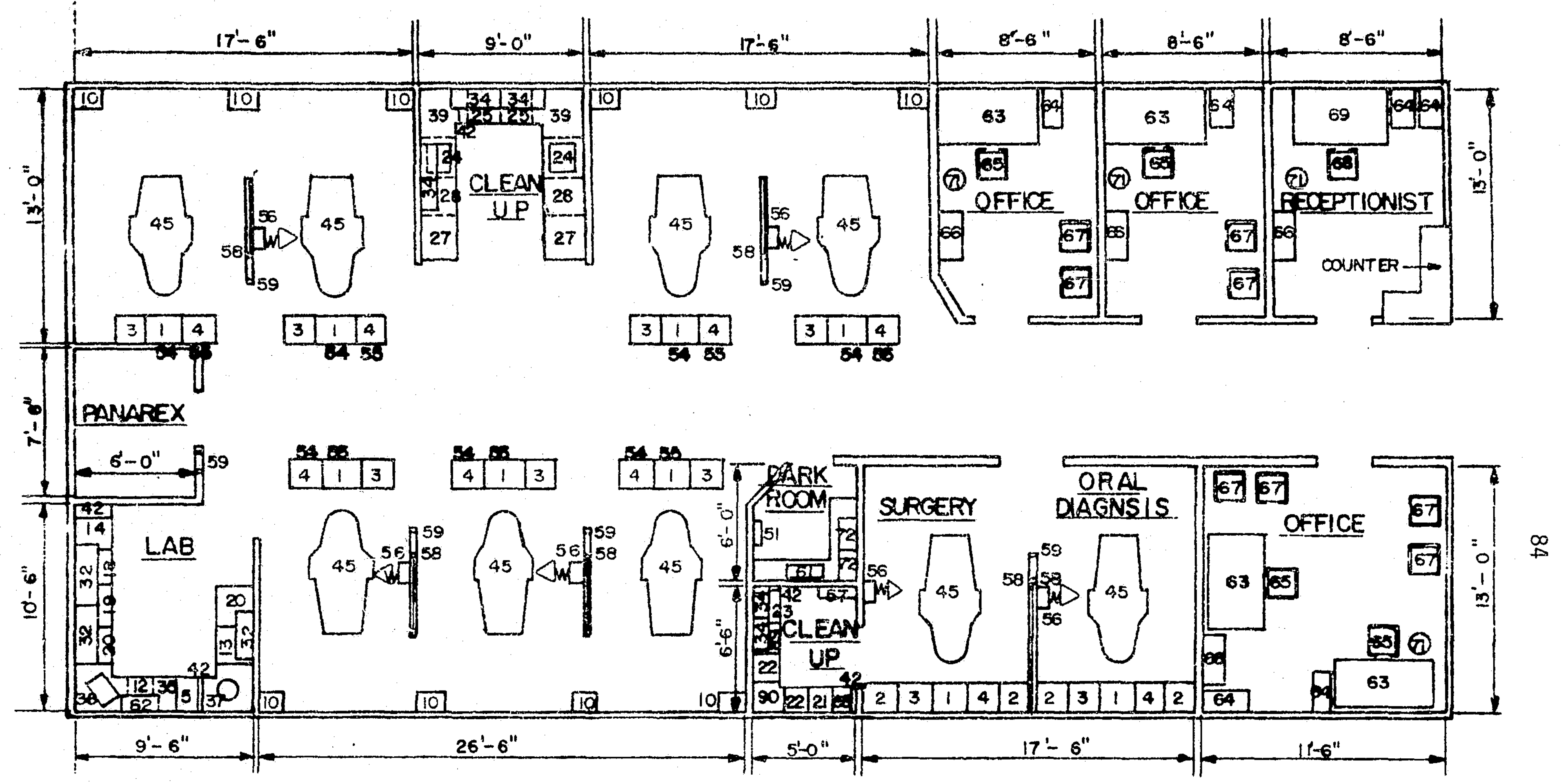
24. Sink Cabinet
25. Instrument/Storage Cabinet
27. Instrument/Storage Cabinet
28. Instrument/Storage Cabinet
34. Storage Cabinet
39. Corner Storage, Lazy Susan
42. Filler Panel Component

### LABORATORY EQUIPMENT

5. Instrument/Storage Cabinet
12. Instrument/Storage Cabinet
13. Sink Cabinet
14. Instrument/Storage Cabinet
18. Storage Cabinet
19. Instrument/Storage Cabinet
20. Instrument/Storage Cabinet
32. Model Cabinet
35. Instrument/Storage Cabinet
36. Sink Cabinet
37. Casting Machine Cabinet
42. Filler Panel Component
62. Plaster Bin

### DARKROOM EQUIPMENT

51. Viewbox, X-ray 13" x 8"
61. Developing tank
72. Storage Cabinet




# NINE OPERATORY CLINIC INCLUDING ORAL SURGERY & ORAL DIAGNOSIS SUITE[6]

Figure 4-12

Source: U.S. Department of Health, Education, and Welfare, Public Health Service. Dental program efficiency criteria and standards for the Indian Health Service. Washington, D.C., The Department, 1974. ix + 187 p.

## NINE OPERATORY DENTAL CLINIC WITH ORAL SURGERY AND ORAL DIAGNOSIS SUITE (FIGURE 4-12)

## EQUIPMENT LIST[6]

### OFFICE AND RECEPTIONIST EQUIPMENT

63. Desk
64. Cabinet, File, 5 drawer
65. Chair, Rotary
66. Bookcase
67. Chair, Straight w/Arm Rest
68. Chair, Typist
69. Desk, Typist
71. Receptacle, Waste

### OPERATORY EQUIPMENT

1. IHS Console
2. Sink Cabinet
3. Mobile Cabinet
4. Mobile Cavitron Cabinet
10. Sink Cabinet
45. Dental Lounge
54. Gas Jet
55. Air Jet
56. X-ray, tubehead & arm
58. X-ray remote timing station
59. Lead glass window

### CLEAN-UP AREAS

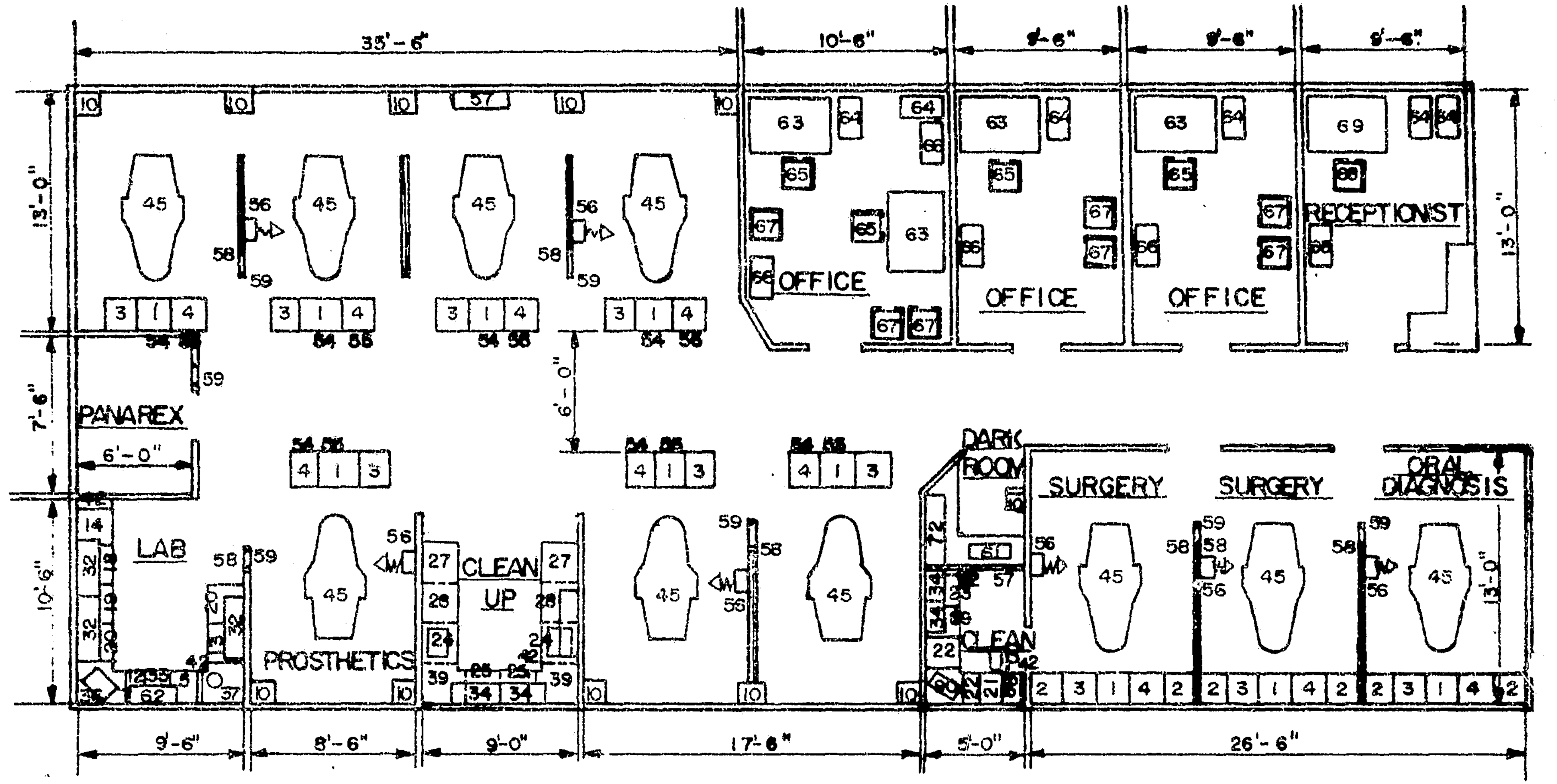
21. Instrument Cabinet
22. Instrument/Storage Cabinet
23. Instrument/Storage Cabinet
24. Sink Cabinet
25. Instrument/Storage Cabinet
27. Instrument/Storage Cabinet
28. Instrument/Storage Cabinet
34. Storage Cabinet
39. Corner Storage, Lazy Susan
42. Filler Panel Component
57. X-ray Unit, master control
88. Instrument/Storage Cabinet
89. Instrument/Storage Cabinet
90. Sink Cabinet

### LABORATORY EQUIPMENT

5. Instrument/Storage Cabinet
12. Instrument/Storage Cabinet
13. Sink Cabinet
14. Instrument/Storage Cabinet
18. Storage Cabinet
19. Instrument/Storage Cabinet
20. Instrument/Storage Cabinet
32. Model Cabinet
35. Instrument/Storage Cabinet
36. Sink Cabinet
37. Casting Machine Cabinet
42. Filler Panel Component
62. Plaster Bin

### DARKROOM EQUIPMENT

51. Viewbox, X-ray 13" x 8"
61. Developing tank
72. Storage cabinet




TEN OPERATORY CLINIC INCLUDING
ORAL SURGERY & ORAL DIAGNOSIS SUITE [6]

Figure 4-13

Source: U.S. Department of Health, Education, and Welfare, Public Health Service. Dental program efficiency criteria and standards for the Indian Health Service. Washington, D.C., The Department, 1974. ix + 187p.

## TEN OPERATORY DENTAL CLINIC WITH ORAL SURGERY AND ORAL DIAGNOSIS SUITE (FIGURE 4-13)

## EQUIPMENT LIST[6]

### OFFICE AND RECEPTIONIST EQUIPMENT

63. Desk
64. Cabinet, File, 5 drawer
65. Chair, Rotary
66. Bookcase
67. Chair, Straight w/Arm Rest
68. Chair, Typist
69. Desk, Typist

### OPERATORY EQUIPMENT

1. IHS Console
2. Sink Cabinet
3. Mobile Cabinet
4. Mobile Cavitron Cabinet
10. Sink Cabinet
45. Dental Lounge
54. Gas Jet
55. Air Jet
56. X-ray, tubehead & arm
57. X-ray Unit, master control
58. X-ray remote timing station
59. Lead glass window

### CLEAN-UP AREAS

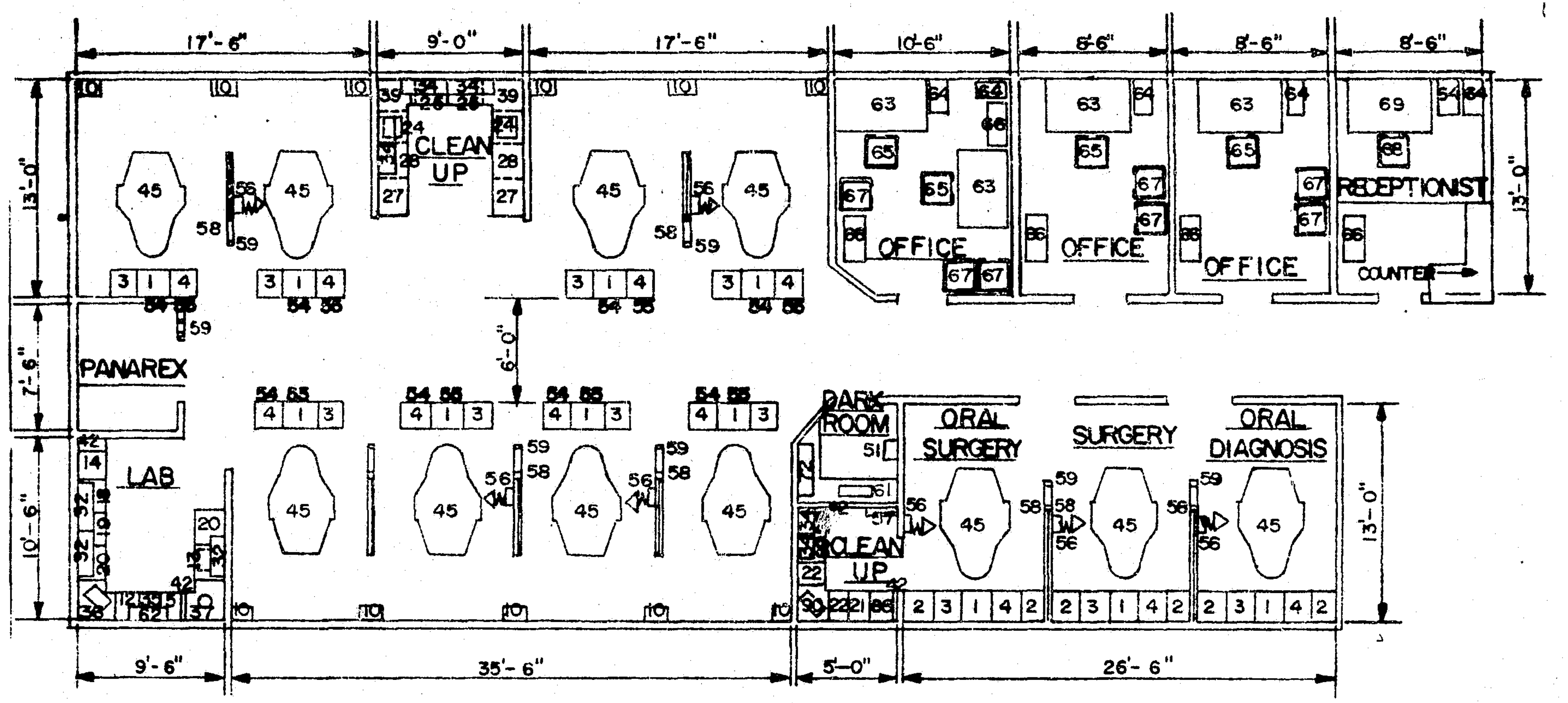
21. Instrument/Storage Cabinet
22. Instrument/Storage Cabinet
23. Instrument/Storage Cabinet
24. Sink Cabinet
25. Instrument/Storage Cabinet
27. Instrument/Storage Cabinet
28. Instrument/Storage Cabinet
34. Storage Cabinet
39. Corner Storage, Lazy Susan
42. Filler Panel Component
57. X-ray Unit, master control
88. Instrument/Storage Cabinet
89. Instrument/Storage Cabinet
90. Sink Cabinet

### LABORATORY EQUIPMENT

5. Instrument/Storage Cabinet
12. Instrument/Storage Cabinet
13. Sink Cabinet
14. Instrument/Storage Cabinet
18. Storage Cabinet
19. Instrument/Storage Cabinet
20. Instrument/Storage Cabinet
32. Model Cabinet
35. Instrument/Storage Cabinet
36. Sink Cabinet
37. Casting Machine Cabinet
42. Filler Panel Component
62. Plaster Bin

### DARKROOM EQUIPMENT

51. Viewbox, X-ray 13" x 8"
61. Developing tank
72. Storage Cabinet




## ELEVEN OPERATORY CLINIC INCLUDING ORAL SURGERY & ORAL DIAGNOSIS SUITE[6]

Figure 4-14

Source: U.S. Department of Health, Education, and Welfare, Public Health Service. Dental program efficiency criteria and standards for the Indian Health Service. Washington, D.C., The Department, 1974. ix + 187 p.

## ELEVEN OPERATORY DENTAL CLINIC WITH ORAL SURGERY AND ORAL DIAGNOSIS SUITE (FIGURE 4-14)

## EQUIPMENT LIST[6]

### OFFICE AND RECEPTIONIST EQUIPMENT

63. Desk
64. Cabinet, File, 5 drawer
65. Chair, Rotary
66. Bookcase
67. Chair, Straight w/Arm Rest
68. Chair, Typist
69. Desk, Typist

### OPERATORY EQUIPMENT

1. IHS Console
2. Sink Cabinet
3. Mobile Cabinet
4. Mobile Cavitron Cabinet
10. Sink Cabinet
45. Dental Lounge
54. Gas Jet
55. Air Jet
56. X-ray, tubehead & arm
58. X-ray remote timing station
59. Lead glass window

### CLEAN-UP AREAS

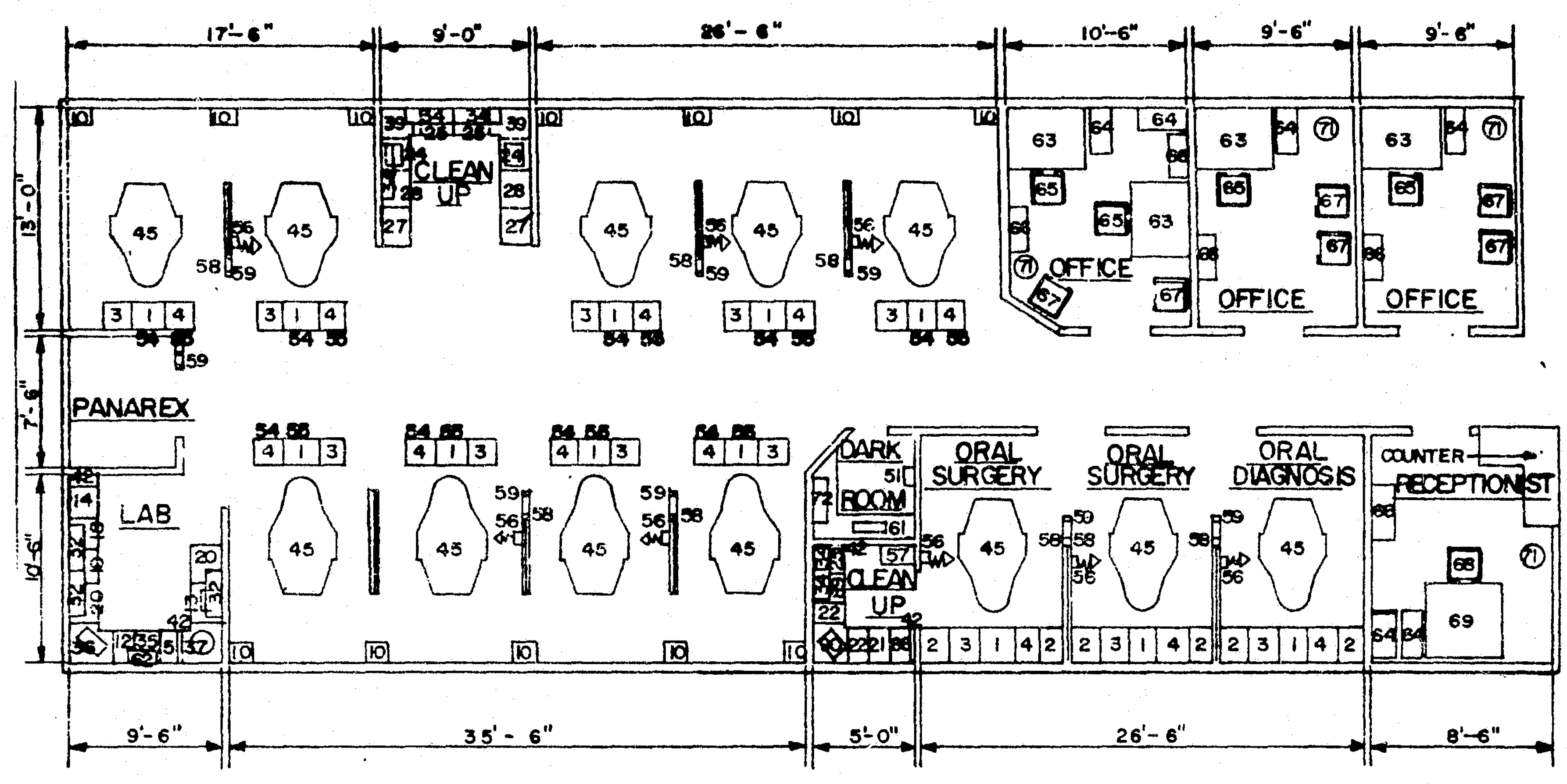
21. Instrument/Storage Cabinet
22. Instrument/Storage Cabinet
23. Instrument/Storage Cabinet
24. Sink Cabinet
25. Instrument/Storage Cabinet
27. Instrument/Storage Cabinet
28. Instrument/Storage Cabinet
34. Storage Cabinet
39. Corner Storage, Lazy Susan
42. Filler Panel Component
57. X-ray Unit, master control
88. Instrument/Storage Cabinet
89. Instrument/Storage Cabinet
90. Sink Cabinet

### LABORATORY EQUIPMENT

5. Instrument/Storage Cabinet
12. Instrument/Storage Cabinet
13. Sink Cabinet
14. Instrument/Storage Cabinet
18. Storage Cabinet
19. Instrument/Storage Cabinet
20. Instrument/Storage Cabinet
32. Model Cabinet
35. Instrument/Storage Cabinet
36. Sink Cabinet
37. Casting Machine Cabinet
42. Filler Panel Component
62. Plaster Bin

### DARKROOM EQUIPMENT

51. Viewbox, X-ray 13" x 8"
61. Developing tank
72. Storage Cabinet




TWELVE OPERATORY CLINIC INCLUDING
ORAL SURGERY & ORAL DIAGNOSIS SUITE [6]

Figure 4-15

Source: U.S. Department of Health, Education, and Welfare, Public Health Service. Dental program efficiency criteria and standards for the Indian Health Service. Washington, D.C., The Department, 1974. ix + 187 p.

## TWELVE OPERATORY DENTAL CLINIC WITH ORAL SURGERY AND ORAL DIAGNOSIS (FIGURE 4-15)

## EQUIPMENT LIST[6]

### OFFICE AND RECEPTIONIST EQUIPMENT

63. Desk
64. Cabinet, File, 5 drawer
65. Chair, Rotary
66. Bookcase
67. Chair, Straight w/Arm Rest
68. Chair, Typist
69. Desk, Typist
71. Receptacle, Waste

### OPERATORY EQUIPMENT

1. IHS Console
2. Sink Cabinet
3. Mobile Cabinet
4. Mobile Cavitron
10. Sink Cabinet
45. Dental Lounge
54. Gas Jet
55. Air Jet
56. X-ray, tubehead & arm
58. X-ray remote timing station
59. Lead glass window

### CLEAN-UP AREAS

21. Instrument/Storage Cabinet
22. Instrument/Storage Cabinet
23. Instrument/Storage Cabinet
24. Sink Cabinet
25. Instrument/Storage Cabinet
27. Instrument/Storage Cabinet
28. Instrument/Storage Cabinet
34. Storage Cabinet
39. Corner Storage, Lazy Susan
42. Filler Panel Component
57. X-ray Unit, master control
88. Instrument/Storage Cabinet
89. Instrument/Storage Cabinet
90. Sink Cabinet

### LABORATORY EQUIPMENT

5. Instrument/Storage Cabinet
12. Instrument/Storage Cabinet
13. Sink Cabinet
14. Instrument/Storage Cabinet
18. Storage Cabinet
19. Instrument/Storage Cabinet
20. Instrument/Storage Cabinet
32. Model Cabinet
35. Instrument/Storage Cabinet
36. Sink Cabinet
37. Casting Machine Cabinet
42. Filler Panel Component
62. Plaster Bin

### DARKROOM EQUIPMENT

51. Viewbox, X-ray 13" x 8"
61. Developing tank
72. Storage Cabinet

The Two Operatory Clinic Design and the Three Chair Dental Clinic Specifications have been provided to assist correctional health administrators during clinic construction. Measurements and installation recommendations can only be assumed appropriate for equipment and clinic design currently in use (and dated 7/1/74).

The Three Operatory Dental Clinic Specification only covers areas which have been of major concern to both the contractor and the correctional dental health program. As you read the specifications, you will note that reference is made to plans, manufacturers' shop drawings, and installation instructions.

You will need to refine the specifications to cover your own individual construction site and to include any equipment changes.[6]

# THREE CHAIR DENTAL CLINIC SPECIFICATIONS[6]

The following are room by room specifications for the Indian Health Service Standard Three Chair Dental Clinic.

## DENTAL AREA

A. The dental area is a 3-operatory area. Each operatory contains one (1) dental chair, 2 SFL-406 sink cabinets, 1 MFSL-421 mobile inst. cab., 1 IHS console cab., 1 continuous countertop 8'6". Each operatory is 8'6" (inside finished dimension) x 14' and partitioned by a 6'H x 7½' long partition. In order for the operatories to function properly and to be able to install pre-cut counter tops and cabinets, the location of the rough-ins must conform to the exact location requested.

1. Lavatories in (6) government provided Valtronic sink cabinets SFL-406, or equal. 34"h x 18-3/4"w x 18"d, are required to be connected to 1½" waste (drain) lines on a 2" waste (drain) line, by the contractor.

2. Hot and cold water lines shall have a shut off valve installed, contractor provided, in each SFL-406 cabinet-all connections-pipes, etc., shall be contained within the SFL-406 cabinets and made in such position as not to interfere with swinging waste door and allow the use of a large trash can in the cabinet.

3. To each IHS console the following service is required:

   a. ½" cold water line, see drawing*

   b. ½" copper air line, see drawing*

   c. 1½" waste (drain line) on a 2" waste line, by the contractor, see drawing*

   d. 110 volt line, see drawing*

   e. 2" suction line to turbo-vac

4. Gas and air lines to be installed behind splash board of continuous counter in each operatory. Gas and air cocks are government provided. Service cocks will be installed 12" left of center of IHS cabinet and projecting out of the splash board on the counter top.

5. Continuous electric outlet strip to be installed centered and on top of and flush with the splash board in each operatory, minimum of four outlets. Electric outlet is to face out towards operator and <u>not</u> up towards ceiling.

6. a. Contractor shall install dental x-ray head and arm (tubearm) on the wall or partition as indicated on drawing.*

* Drawings referred to, are those supplied by your architect, area construction branch, etc.

b. Center of x-ray mounting plate shall be installed to be in line with the center of the dental chair base.

c. Wall or partition behind the dental x-ray arm and head mounting plate must be reinforced to support 200 lbs. dead weight. Manufacturer recommends solid wood 2" in thickness behind plaster, between studs. Backing to go from floor to ceiling or top of partition.

d. Recommended height of top edge of mounting plate is 71" above floor.

e. To connect each tube arm, run five (5) #14 wires in conduit from tube arm junction box to control junction box. If run over 25', run two #12 wires and three #14 wires. Allow two feet slack at each box. Identify wires at each end for connection of wires from x-ray arm and x-ray control box. If installation involves more than one tube arm, be sure to connect five wires to proper row of terminals in control.

f. Top edge of mounting plate must be absolutely level - see paper template packed with x-ray tube arm.

g. Contractor shall be required to provide one 110/120 volt dual outlet centered and 6" below x-ray mounting plate.

Units to be installed ________________

7. Contractor to install remote timer control switch in wall adjacent to lead window and in location shown on drawing. Note relationship of tube arm, timer switch and wall between.
__________units to be installed, see manufacturer specs.

8. Contractor to hang government provided ceiling mounted track dental operating lights (3) one in each operatory, see manufacturers template for support backing required and electrical hook-up. Track light to be centered over long axis of dental chair (head-foot relationship).

9. Government will provide three each, power operated dental chairs for which 110/120 outlets are required. Outlets will be contractor provided National Electric 856 Protector Nozzle and moisture proof, floor bases, or equal. Outlets will be located 18" from center of chairs (6" in front of leading edge of chair base).

10. 3/32" laminated lead plywood panels are required on walls and doors of dental clinic as marked on drawing.

11. Lead glass window will be contractor provided and installed as shown on drawing. Center of window will be 60" from floor. Contractor shall provide:

a. G.E. lead control frame 25-3/4"h x 20-3/8"w x 5½"deep, model number E-3035A or equal.

b. G.E. lead glass, Model E-3035B.

12. Contractor shall install government provided paper towel and soap dispensers over each sink in clinic.

13. Contractor shall install government provided paper cup dispenser next to sink in SFL-406 cabinet in operatories on right side of room, (1) each operatory.

14. Contractor shall install government provided x-ray film receptacle adjacent to x-ray tube arm as shown on drawing.

B. CLEAN-UP AREA

1. Contractor to install wall mounted government provided cabinets with continuous counter top. Floor to work surface height in clean up area is 37". Single drawer wall mounted cabinet QDL-72 is to be wall mounted so its working surface is 41" from floor. All cabinets are mounted in a line with QDL-72 raised 4" above the rest. QDL-72 is also installed on the end of the clean-up work surface closest to the door entering the dental clinic from the patient waiting area. Wall hung cabinets and work surface will be mounted with sufficient reinforcement within the partition or wall to allow support of storage of bulk items and dental stainless steel instruments and 250 lbs. of sterilizing equipment.

2. Contractor will install government provided paper towel and soap dispenser over TDL-306 sink cabinet.

3. Contractor will provide hot and cold water lines and waste line (drain) to TDL-306 sink. All connections will be made through the back.

4. Contractor shall be required to provide and install shut-off valves on hot and cold water lines - said valves will be contained in valtronic sink cabinet, TDL-306.

5. Continuous electric outlet strip to be installed on top of counter top splash board - flush with top of splash board outlets face out not up.

6. Contractor shall wall hang government provided soap and towel dispensers over all sinks.

7. Contractor shall hang wall mounted Valtronic A-3T treatment cabinets 14" above the finished counter top. Cabinets to be mounted side by side and on the opposite end of clean-up counter from the QDL-72 cabinet.

8. Telephone wall mounted and paging system wall mounted shall be placed over and left of center QDL-72 Valtronic cabinet.

9. Contractor will install government provided automatic film processor (when furnished). Film processor will be located immediately to the right of the clean-up work counter next to TDL-327 Valtronic Instrument cabinet. Contractor will provide drain and hot and cold water lines to the film processor. See manufacturer installation manual, electric services required 100/130 volt, 60 cycle, 20 amps.

10. Contractor will install government provided water thermostatic mixing valve on the wall directly over the film processor. See manufacturer's manual.

11. Contractor will install government provided water filter between mixing valve and film processor (see manufacturer's installation manual).

C. LABORATORY AREA

1. Install government provided cabinets as depicted on drawing.

A. Floor cabinets:

| Code No. | Vendor No. | Vendor |
|---|---|---|
| 18 | QDL-72 (wall mounted) | Valtronic |
| 37 | SL10-C | " |
| 35 | SAL-402 | " |
| 44 | SAL-407 (two) | " |
| 13 | SDL-506 (sink cab.) | " |
| 30 | SAL-417 | " |

B. Wall hung cabinets:

| Code No. | Vendor No. | Vendor |
|---|---|---|
| 32 | B-2 Wall hung | " |
| 62 | Plaster Bin 666 | Coe Lab. |

2. Plaster Bin 666 will be installed on the wall and 14" above the finished counter top, directly over SDL-506 sink cabinet.

3. Install government provided soap and paper towel dispenser on wall to right of plaster bin.

4. B-2 cabinets will be mounted side by side on the wall to the left of the plaster bin 666.

5. Provide and connect ½" waste line on a 2" (drain) waste line. Hot and cold water lines are required to SDL-506 sink cabinet. Shut off valves to the hot and cold water lines will be provided by contractor and installed under SDL-506 sink cabinet.

6. Contractor will attach model trimmer to finished counter top to right of sink and on top of SAL-417. Model trimmer will be installed 3" from sink and 3" from front rolled edge of finished counter top. Contractor shall provide drain pipe from model trimmer which will dump plaster washings directly into sink. Contractor shall provide cold water to model trimmer and a shut off valve shall be provided and installed by contractor above the finished counter top, within easy reach of the operator.

7. Contractor will install a government provided plaster trap in drain line under sink in the SDL-506 sink cabinet.

8. Air and gas service cocks shall be government provided and contractor installed. Air and gas cocks will be located in the finished counter top splash board at the junction of QDL-72 and SL10-C cabinets.

9. QDL-72 wall mounted cabinet is installed at the same level as the floor mounted cabinets. The continuous finished counter top covers this cabinet. (QDL-72 is mounted higher in the clean-up area than the rest of the cabinets.)

10. Contractor will install the x-ray master control as shown in drawing in the laboratory.

11. Continuous electric tape strip will be contractor provided and installed on top of and flush with splash board.

D. DARK ROOM

1. Contractor shall provide and install a continuous L shaped white formica counter, finished top will be 37" from floor. Formica color is whitetide wood #601. Counter top will have a 12" splash board.

2. Contractor shall provide an enclosed storage shelf under L shaped counter top.

3. Contractor shall install government provided x-ray developing tank in counter top as shown in drawing.

4. Contractor shall provide 2" waste (drain) to developing tank.

5. Contractor shall provide hot and cold water to developing tanks with shut off valves above counter top.

6. Contractor shall provide and install wall mounted storage cabinets over developing tanks 14" above finished counter top, see drawing.

7. A light-proof louvre, Bar-Ray model B-115B, or equal, shall be furnished and installed in darkroom door by contractor.

8. Inside of heating and air conditioning ducts will be treated with a non-reflecting material to prevent light reflection.

9. Contractor shall provide and install a double safelight 8" x 10" complete with safelight filter, toggle switches, and plug-in terminal and mounted on darkroom wall. Safe light shall be Bar-Ray Combo-Lite, or equal. A second warning light shall be installed outside the darkroom door and wired to the safelight so that when the safelight is turned on in the darkroom the warning light will be lighted also, thus advising that the darkroom is occupied.

10. When provided, contractor shall install temperature control valve above developing tanks.

E. OFFICE

No less than four duplex electrical receptacles shall be provided in convenient locations within the room - one each wall. Each duplex receptacle shall be a Hubbell #5242 or equal, polarized unit with decor cover.

F. GENERAL

1. Dental clinic and office and clean-up area floors are to be furnished with wall to wall carpet __________ or equal.

2. Dental laboratory and darkroom floors shall be tiled with __________, or equal.

3. Electrical:

   a. Operatories, clean-up area and laboratory shall be provided with flourescent lighting of no less than 100 foot candles.

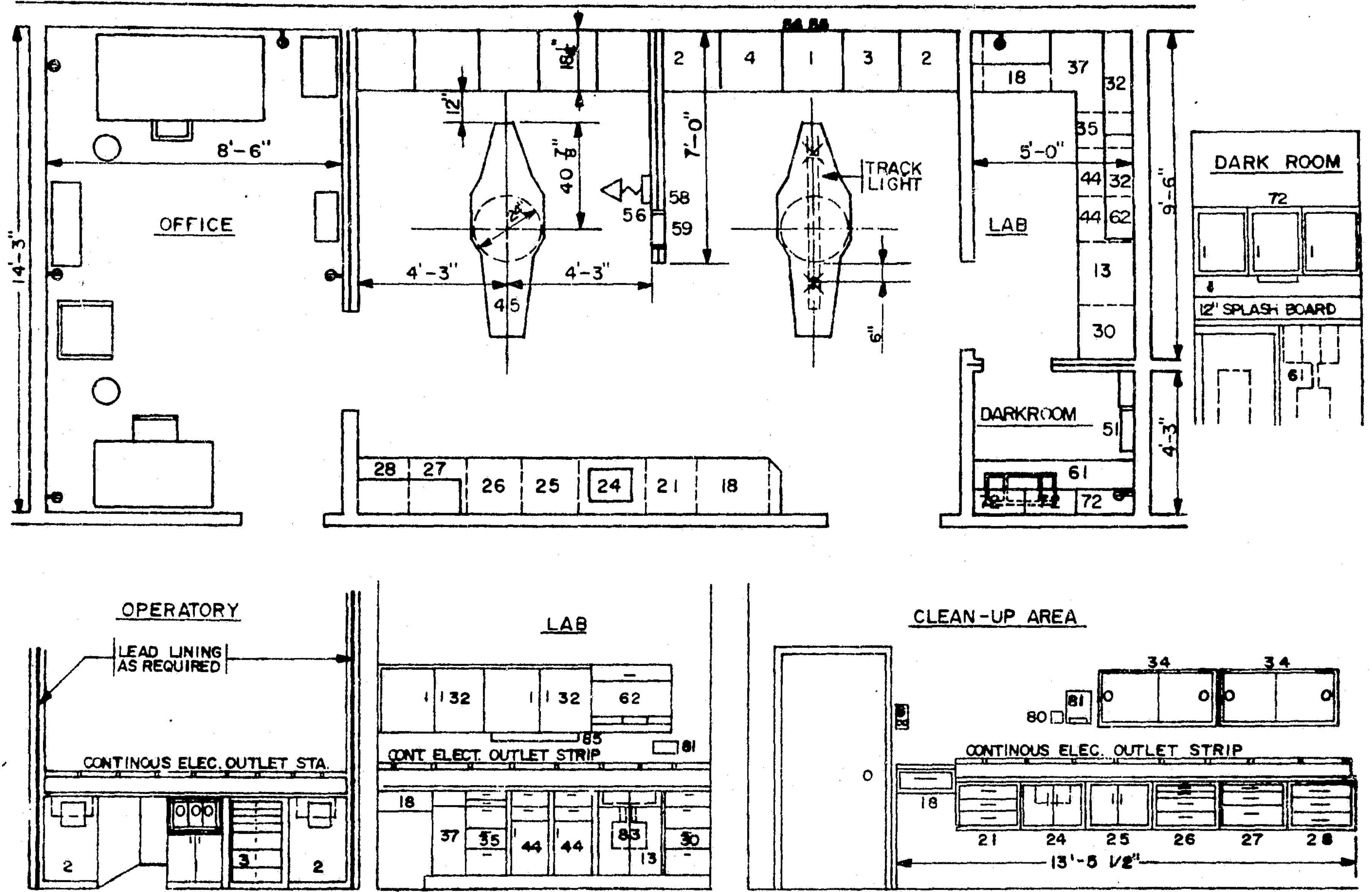
   b. Dental office shall have a minimum of 75 foot candles.

   c. Darkroom shall have a minimum of ________ foot candles.

   d. Contractor shall provide and install one (1) 20 watt single tube fluorescent fixture to the underside of the cabinets over the laboratory work top area.

4. Contractor shall provide space within the building and outside of the dental clinic to contain the dental air compressor, Turbo-Vac suction system and the 8 gal. separating tank.

5. Contractor shall provide and install on the cold water line servicing the dental clinic an in-line water filter with changeable filter. Filter shall allow a 20 gallon flow per minute. A shut off valve will be installed at the inlet side of the water filter. On the outlet side of the filter, contractor shall provide and install a water pressure gauge and a shut off valve. Filter shall be placed in a conveniently accessible site to allow cartridge changes. Commercial Filters Corp., #SS4.5C-20-3/4, or equal.




NOTES:
1. FLOOR TO WORK SURFACE IN CLEAN-UP AREA IS 3'-1"
2. WALL HUNG CABINETS ARE MOUNTED 1'-2" OVER CLEAN-UP & LAB CABINETS FINISHED COUNTERTOP

Figure 4-16 [6]

Source: U.S. Department of Health, Education, and Welfare, Public Health Service. Dental program efficiency criteria and standards for the Indian Health Service. Washington, D.C., The Department. 1974. ix + 187 p.

MASTER LIST

GROUP I EQUIPMENT[7]

| ITEM # | ITEM | VENDOR |
|---|---|---|
| 1 | IHS Console-Current Model . . . . . . . . . . . . . . . . . . | Deeley Dental |
| 2 | SFL-406, Sink Floor Cabinet, special Height | |
| | 34" (32 1/2 cabinet + 1 1/2" top . . . . . . . . . . . | Valtronic |
| | Sink Z-250 . . . . . . . . . . . . . . . . . . . . . . . | Valtronic |
| | Faucet, Single Lever, Z-225 . . . . . . . . . . . . . | Valtronic |
| 3 | MSFL-421A, Instrument Cabinet, mobile, | |
| | special height 32 1/4" to flat top . . . . . . . . . | Valtronic |
| 4 | MSFL-431, Cavitron Cabinet, mobile, special | |
| | height 32 1/4" to flat top . . . . . . . . . . . . . | Valtronic |
| 5 | SFL-417, Instrument/Storage Floor Cabinet . . . . . . . | Valtronic |
| 6 | SFL-412, Instrument/Storage Floor Cabinet . . . . . . . | Valtronic |
| 7 | SFL-415, Floor Cabinet w/refrigerator . . . . . . . . . | Valtronic |
| 8 | SFL-405, Instrument/Storage Floor Cabinet . . . . . . . | Valtronic |
| 9 | SFL-421, Instrument/Storage Floor Cabinet . . . . . . . | Valtronic |
| 10 | SFL-406, Sink, Floor Cabinet | |
| | standard height . . . . . . . . . . . . . . . . . . . . | Valtronic |
| | Sink Z-250 . . . . . . . . . . . . . . . . . . . . . . | Valtronic |
| | Faucet, Single Lever Z-225 . . . . . . . . . . . . . | Valtronic |
| 11 | SFL-402, Instrument/Storage Floor Cabinet . . . . . . . | Valtronic |
| 12 | SDL-507, Instrument/Storage Floor Cabinet . . . . . . . | Valtronic |
| 13 | SDL-506, Sink, Floor Cabinet . . . . . . . . . . . . | Valtronic |
| | Sink Z-200A . . . . . . . . . . . . . . . . . . . . . | Valtronic |
| | Faucet, Single Lever Z-225 . . . . . . . . . . . . . | Valtronic |
| 14 | SDL-517 Instrument/Storage Floor Cabinet . . . . . . . | Valtronic |
| 15 | SDL-505 Instrument/Storage Floor Cabinet . . . . . . . | Valtronic |
| 16 | SDL-512 Instrument/Storage Floor Cabinet . . . . . . . | Valtronic |
| 17 | SDL-502 Instrument/Storage Floor Cabinet . . . . . . . | Valtronic |
| 18 | QDL-72 Instrument/Storage Wall Hung Cabinet, | |
| | 1 drawer . . . . . . . . . . . . . . . . . . . . . . . | Valtronic |
| 19 | SDL-503 Instrument/Storage Floor Cabinet . . . . . . . | Valtronic |
| 20 | QDL-72 Instrument/Storage Wall Hung Cabinet, | |
| | 2 drawer . . . . . . . . . . . . . . . . . . . . . . . | Valtronic |
| 21 | TFL-227 Instrument/Storage Wall Hung Cabinet . . . . . | Valtronic |
| 22 | TFL-205 Instrument/Storage Wall Hung Cabinet . . . . . | Valtronic |
| 23 | TAL-205 Instrument/Storage Wall Hung Cabinet . . . . . | Valtronic |
| 24 | TDL-306 Sink, Wall Hung Cabinet . . . . . . . . . . . | Valtronic |
| | Sink Z-200A . . . . . . . . . . . . . . . . . . . . . | Valtronic |
| | Faucet, Single Lever Z-225 . . . . . . . . . . . . . | Valtronic |
| 25 | TDL-305 Instrument/Storage Wall Hung Cabinet . . . . . | Valtronic |
| 26 | TDL-328 Instrument/Storage Wall Hung Cabinet . . . . . | Valtronic |
| 27 | TDL-324 Instrument/Storage Wall Hung Cabinet . . . . . | Valtronic |
| 28 | TDL-327 Instrument/Storage Wall Hung Cabinet . . . . . | Valtronic |
| 30 | SAL-417 Instrument/Storage Floor Cabinet . . . . . . . | Valtronic |
| 31 | B-1 Impression Tray Cabinet w/Insert-Wall Hung . . . . | Valtronic |
| 32 | B-2 Record Model Cabinet . . . . . . . . . . . . . . . | Valtronic |
| 33 | B-3 Surgical Instrument Cabinet . . . . . . . . . . . | Valtronic |
| 34 | A-3T Treatment Tray Cabinet-Wall Hung . . . . . . . . | Valtronic |
| 35 | SAL-402 Instrument/Storage Floor Cabinet . . . . . . . | Valtronic |
| 36 | SL-10B Corner Sink Floor Cabinet w/Z-160 | |
| | T.D. & Hamper . . . . . . . . . . . . . . . . . . . . | Valtronic |

| ITEM # | ITEM | VENDOR |
|---|---|---|
| 37 | SL-10C Corner Floor Cabinet (for casting Well) . . . . . . | Valtronic |
| | Z-190 . . . . . . . . . . . . . . . . . . . . . . . . . | Valtronic |
| | Z-196 . . . . . . . . . . . . . . . . . . . . . . . . . | Valtronic |
| 38 | TL-10B Corner Sink, Wall Hung Cabinet . . . . . . . . . | Valtronic |
| | Sink Z-200A . . . . . . . . . . . . . . . . . . . . . . | Valtronic |
| | Faucet, Single Lever Z-225 . . . . . . . . . . . . . . | Valtronic |
| 39 | TL-10B, Corner Storage, Lazy Susan, Wall Hung Cabinet. . | Valtronic |
| 40 | Formica Countertop, Operatory extended top, order 102 inch top w/64" of the 102 inches being the extended portion cost = 64" x 1.50 . . . . . . . . . . . . . . . | Valtronic |
| 41 | A-1XA X-ray view box . . . . . . . . . . . . . . . . . . | Valtronic |
| | Illuminator Cat. No. DE 300 Recess . . . . . . . . . . | Star X-ray Prod. Bronx, N. Y. |
| 42 | Filler Panel Components . . . . . . . . . . . . . . . . . (a) Hinged (b) Stationary | Valtronic |
| 43 | A-2XA, X-ray View Box . . . . . . . . . . . . . . . . . . | Valtronic |
| | Illuminator Cat. No. DE 300 Recessed . . . . . . . . | Star X-ray Prod. |
| 44 | SAL-407 Storage/Instrument Cabinet Floor Cabinet . . . . | Valtronic |
| 45 | Dental Lounge, C-3 Convertible Revelation II Chair LB . | S.S. White Co. Div. Penwalt Phila., Pa. |
| 48 | Light, Dental Operating, Ceiling Mounted Track, Light Fantastic Model LFT+Single Head . . . . . . . . | Pelton & Crane Charlotte, N.C. |
| 49 | V-1 Turbo Vac, Single Phase, 230 Volt . . . . . . . . . . (larger clinics will require V-2 or V-3 model) | Vacudent |
| | (a) Separating tank Model CDT 8 Gal. Capacity . . . . | Vacudent |
| | (b) Magnetic Starter . . . . . . . . . . . . . . . . . . | Vacudent |
| 52 | X-ray Viewbox, Model 15, Cat. No. 2452-4, recessed, illum. area 13 1/4 x 10 1/4 . . . . . . . . . . . . . . | S.S. White Co. |
| 54 | Ground Key Service Cock-Gas Wall Installation Z-240 . . | Valtronic |
| 55 | Ground Key Service Cock-Air Wall Installation Z-240 . . | Valtronic |
| 56 | Head, X-ray, #2420-4 Additional Long Beam with remote time control . . . . . . . . . . . . . . . . | S.S. White Co. |
| 57 | X-ray apparatus 90 with Long Beam<br>(a) #2455-33 (for 3 heads) Indicate<br>(b) #2455-35 (for 5 heads) one<br><br>(a) Timer Switch on Master Control ) Indicate<br>(b) w/o Timer on Control ) one | |
| | 2455-33 . . . . . . . . . . . . . . . . . . . . . . . | S.S. White Co. |
| | 2455-35 . . . . . . . . . . . . . . . . . . . . . . . | S.S. White Co. |
| 58 | X-ray Unit, Remote Timing Station (comes with #57) . . . | S.S. White Co. |
| 59 | Lead Glass Window | |
| | (a) Lead Control Frame 25 3/4" h x 20 3/8" w x 5 1/2 " deep Model #E-3035A . . . . . . . . . . . . . . . | General Electric |
| | (b) Lead Glass, Model #E-3035B . . . . . . . . . . . . | General Electric |
| 60 | X-ray Film Dispenser, Kodak Model 2 . . . . . . . . . . . | Silverman's |
| 61 | Developing Tank SS, 3 Compartment w/cover 11" x 14" x 17" w/water temperature control "mixer" valve, installed w/vacuum breaker & refrigeration unit . . . | Miller X-Ray Co. Okla. City. Okla. |

| ITEM # | ITEM | VENDOR |
|---|---|---|
| 62 | Plaster Bin, Coe 666 | Coe Laboratories |
| 72 | Metal Wall Gabinet, hinged doors, adjustable shelves | Local Purchase |
| 74 | Mirror | Local Purchase |
| 76 | Automatic Film Processor | |
| | Auveloper #2459-1 | S.S. White Co. |
| | (a) Base Cabinet 2459-14 | |
| | (b) Light Tight Shroud 2459-15 | |
| | (c) Enclosed Temperature Control System 2456-13 | |
| | (d) Superlife Water Filter 2459-7 | |
| 77 | Automatic Film Processor | |
| | Auveloper-B #2460-1 | S.S. White Co. |
| | (a) Base Cabinet 2460-3 | |
| | (b) Daylight Loader 2460-2 | |
| | (c) Enclosed Temp. Control 2456-13 | |
| | (d) Superlife Water Filter 2459-7 | |
| 78 | Panorex, complete #2411, Biscayne Blue | S.S. White Co. |
| | (a) Pancentric Head Positioner-#2411-11 | |
| | (b) Cassette 5 x 12 w/Pan-O-Screens (Specify Mach. Ser. No.) #2411-2 | |
| | (c) Cassette 5 x 12 w/Super-Pan-O-Screens (Specify Mach. Ser. No.) #2411-15 | |
| 79 | Air Compressor, 3 hp, 2 cylinders, delivers 7.4 CFM at 40 psi or 6.2 CFM at 100 psi, 20 gal. tank, Order number: 30GT 17384N | Sears & Roebuck |
| 80 | Soap Dispenser, Leaf | American Hospital |
| 81 | Paper Towel Dispenser, Multi-fold Brushed or Polished Chrome | Melton Co. |
| 82 | Casting Machine Jr. Centrifugal | Silverman's |
| 83 | Plaster Trap | Coe Laboratories |
| 84 | Model Trimmer, Torit Model 320A w/coarse wheel | Silverman's |
| 85 | Fluorescent Light with Reflector under ENS-45 | Local Purchase |
| 86 | Louvre, Lightproof for X-ray Door | Bar-Ray Co. |
| 87 | Ventilator, Exhaust, Lightproof | Bar-Ray Co. |
| 88 | TFL-221 Instrument/Storage Wall Hung Cabinet | Valtronic |
| 89 | TFL-228 Instrument/Storage Wall Hung Cabinet | Valtronic |
| 90 | TL-10A Sink, Wall Hung Cabinet | Valtronic |
| | (a) Z250 Sink, SS | |
| | (b) Z225 Faucet, Single Lever | |
| 91 | Fiber Optic Illumination System | |
| | (a) Basic Unit-Oral Luminator #650003 | Midwest- |
| | (b) Optic Bundle #650009 | American-Chicago |
| | (c) Diagnostic Instruments | |
| | Right Angle Probe #650011 | |
| | Straight Probe #650010 | |
| 92 | Nitrous Oxide Analgesic Unit - Wall Mounted (not to be used above 5,000 ft. altitude) | |
| | (a) Quantiflex MDM 30 Part #500006 | Fraser Sweatman |
| | (b) Wall arm, 12" wall mount 505005 | Fraser Sweatman |
| | (c) O2 Pressure Regulator (lg cylinder) 305104 | Fraser Sweatman |
| | (d) NO2 Pressure Regulator (lg cylinder) 305105 | Fraser Sweatman |
| | (e) Quick connect outlet station for NO2 & O2, concealed puritan Part #305135 | Fraser Sweatman |

| ITEM # | ITEM | VENDOR |
|---|---|---|
| | (f) O2 hose assembly Diss puritan female, part #305114, 3 ft . . . . . . . . . . . . . . . . . | Fraser Sweatman |
| | (g) NO2 hose assembly Diss puritan female, part #305115, 3 ft . . . . . . . . . . . . . . . . . | Fraser Sweatman |
| | (h) Nasal inhaler - small, part #515001 . . . . . . . . | Fraser Sweatman |
| | (i) Nasal inhaler - medium, part #515002 . . . . . . . | Fraser Sweatman |
| 93 | Kodak Dental Film Receptacle . . . . . . . . . . . . . . | Silverman's |
| 94 | Paper cup wall dispenser . . . . . . . . . . . . . . . . | Silverman's |
| 95 | Dento Drain . . . . . . . . . . . . . . . . . . . . . . . | Air Techniques |
| 96 | Dento-Dri . . . . . . . . . . . . . . . . . . . . . . . . | Air Techniques |
| 97 | Filter Separator . . . . . . . . . . . . . . . . . . . . | Air Techniques |
| 98 | Formica Backing for 3 cabinet, free standing Operative Units; Approximately 57" x 41" . . . . . . . . | Local Purchase |
| 99 | XFL-51 Instrument/Storage Cabinet Wall Hung . . . . . . | Valtronic |

# MASTER LIST

## GROUP II EQUIPMENT [7]

### STAFF OFFICE

| ITEM # | ITEM | VENDOR |
|---|---|---|
| 63 | Desk, 60" x 34", gray 7110-143-0832. . . . . . . . . . . . . . . | GSA |
| 64 | Filing Cabinet, Conserv-a-file, 3600 series, letter size, solid front, 4 tier, Color: Ince Blue, Model: SF 344 - Order Code: 114N5 . . . . . . | Supreme Equipment & Systems |
| 65 | Chair, Rotary 7110-262-6690. . . . . . . . . . . . . . . . . . . | GSA |
| 66 | Bookcase, 3 tier, 33" x 13" x 14-3/4", | |
| | Sections 7110-262-6681 Top. . . . . . . . . . . . . . . . . . . | GSA |
| | 7110-262-6673 Base . . . . . . . . . . . . . . . . . . | GSA |
| | 7110-262-6648 Midsection . . . . . . . . . . . . . . | GSA |
| 67 | Chair, Straight/arm rests 7110-264-5339. . . . . . . . . . . . | GSA |
| 70 | Rack, wearing apparel, gray 7195-275-5824. . . . . . . . . . | GSA |
| 71 | Basket, waste, gray 7520-281-5913. . . . . . . . . . . . . . . | GSA |
| N/A | Adding Machine, gray Model 61012-10. . . . . . . . . . . . . . | Remington |
| | Light, desk, gray, 6230-682-3423 . . . . . . . . . . . . . . . | GSA |
| N/A | Clock, Electric 6645-530-3342-12" dial . . . . . . . . . . . . | GSA |

### RECEPTIONIST OFFICE

| ITEM # | ITEM | VENDOR |
|---|---|---|
| 64 | Filing Cabinet, Conserv-a-file, 3600 series, letter size, solid front, 4 tier, Color: Ice Blue, Model: SF 344- Order Code: 1114N5. . . . . . . . . . . . . . . . . . . . | Supreme Equipment & Systems |
| 66 | Bookcase, 3-tier, 33" x 13" x 14-3/4" | |
| | Top 7110-262-6681. . . . . . . . . . . . . . . . . . . . . . . | GSA |
| | Base 7110-262-6673 . . . . . . . . . . . . . . . . . . . . . . | GSA |
| | Mid-section 7110-262-6648. . . . . . . . . . . . . . . . . . . | GSA |
| 68 | Chair, typist, gray 7110-273-8798. . . . . . . . . . . . . . . | GSA |
| 69 | Desk, typist, gray 7110-274-4914 . . . . . . . . . . . . . . . | GSA |
| 70 | Rack, wearing apparel, gray 7195-275-5824. . . . . . . . . . | GSA |
| | Light, desk, gray 6230-682-3423. . . . . . . . . . . . . . . . | GSA |
| | Typewriter, manual, 16" carriage Model 47-11 Royal . . . . . | Royal |
| 71 | Basket, waste, gray 7520-281-5913. . . . . . . . . . . . . . . | GSA |
| N/A | Clock, Electric 6645-530-3342-12" dial . . . . . . . . . . . . | GSA |

### OPERATORY

| ITEM # | ITEM | VENDOR |
|---|---|---|
| 46 | Dental Operating Stool, Model 15 D1 w/o ring base. . . . . . | Vacudent |
| 47 | Dental Operating Stool, Model 15 D1 w/ ring base . . . . . . | Vacudent |
| 50 | X-ray dental illuminator, Model DE 98 for table or wall hanging - viewing surface 14" x 4-3/4" . . . . . . . . . . | Star X-ray Products |
| N/A | Cavitron Model - 1010 Dental Unit, complete w/3 inserts P1, P3, P10. . . . . . . . . . . . . . . . . . . . . | Dentsply |
| N/A | Amalgamator, electric, dental 6520-500-5010. . . . . . . . . | Perry Point |
| | Pulp tester Dentotest. . . . . . . . . . . . . . . . . . . . . | Silverman's |

### CLEAN-UP AREA

| ITEM # | ITEM | VENDOR |
|---|---|---|
| | Ultrasonic Cleaner L & R Model 320 LU. . . . . . . . . . . . . | Silverman's |
| | a. Poisitioning Cover #600 ML . . . . . . . . . . . . . . . . | Silverman's |

## CLEAN-UP AREA (cont'd)

| Item | Source |
|---|---|
| b. Stainless steel bur tray | Silverman's |
| c. Stainless steel basket | Silverman's |
| Ritter Clave Sterilizer, Biscayne Blue | Ritter Co. |
| Harvey Sterilizer Model E | Harvey Dental |
| Clock, Electric, 6645-530-3342 12" dial | GSA |

## LAB EQUIPMENT

| Item | Source |
|---|---|
| Lab stool, adjusts from 20" - 28" Ball Bearing Casters - Model 2028 | Silverman's |
| Bath, water, impression Armed Services 6520-535-7100. compound heater | Armed Services |
| Spot Welder, Model 660 Multi-purpose w/J428 cables & J433 Auxillary Vise | Rocky Mountain |
| Lathe, Dental, Baldor 2-speed, Model 221 | Silverman's |
| Chuck Assortment | Silverman's |
| Waste paper basket, gray 7520-281-5913 | GSA |
| Motor, dental laboratory Emesco #92N w/ball bearing handpiece | Silverman's |
| Furnace, Dental Burnout, Model 434, Elec. | Silverman's |
| Lathe Pan w/light | Silverman's |
| Lathe Pan w/shield | Silverman's |
| Instrument Sharpener, oscillating | Silverman's |
| Tooth Selection Kit (7 items) #3143 1 ea. | Dentsply |
| Surveyor-Ney, Dental w/assorted points 1 each | Local Purchase |
| Articulator, Dental, Model D-4 each | Silverman's |
| Acri-Dense Pressure Unit (includes air gauge, tube, threaded cap) 1 each | Silverman's |
| Articulator, Dental Hanau 6520-501-0050 | Perry Point |
| Bunsen Burner, dental wax 6640-510-6075 | Perry Point |
| Vibrator (Foster 3-speed) | Silverman's |
| Torch, Soldering & melting gas and air #3A | Silverman's |
| Blow Torch, Alcohol, Hanau 6520-561-7150 | Perry Point |

## ORAL SURGERY SUITE

| Item | Source |
|---|---|
| Electro-Surgical Unit Model 26-230 w/electrode | Cameron-Miller Chicago, Ill. |
| Kerr Electro Torque Model A/TM | Kerr Mfg. Co. |
| a. Electro-torque 0-20,000 RPM Model A/QD | Kerr Mfg. Co. |
| b. Cord Set Quick disconnect | Kerr Mfg. Co. |
| c. Handpieces & heads | Kerr Mfg. Co. |
| Oral Headlight-Direct, Senior Headlight, Model #402 w/o single lens loupe | Silverman's |
| Harvey Sterilizer Model E | Harvey Dental Specialty Co. |
| Ultrasonic Cleaner L & R Model 320 LU w/timer | Silverman's |
| a. Positioning cover #600 ML | Silverman's |
| b. Stainless Steel Basket | Silverman's |
| X-ray Dental Illuminator Model DE 200, Viewing area 13" x 10" | Star X-Ray |
| Human skull | Denoyer-Geppert Co |
| Clock, Electric, 6645-530-3342, 12" dial | GSA |

## DARK ROOM EQUIPMENT

| | | |
|---|---|---|
| N/A | Drying racks . . . . . . . . . . . . . . . . . . . . . . . . . . . . | Local Purchase |
| 51 | Dental X-Ray Illuminator Model #DE 97 viewing area 13" x 8" . . . . . . . . . . . . . . . . . . . . . . . . . . . | Star X-Ray |
| 71 | Basket, waste, gray 7520-281-5913. . . . . . . . . . . . . . . | GSA |
| | X-ray Apron, No. 45-P. . . . . . . . . . . . . . . . . . . . . . . | Silverman's |
| | Timer, lever, No. 5000 GE. . . . . . . . . . . . . . . . . . . . | Silverman's |
| | Thermometer No. 580A . . . . . . . . . . . . . . . . . . . . . . . | Silverman's |

## CLINIC SUPPORT

| | | |
|---|---|---|
| N/A | Mobile Emergency Unit Inhalator. . . . . . . . . . . . . . . . . | Oxygen Equip. & Service Co. Chicago, Ill. |
| N/A | Film Processor, Dentl-D-Veloper, Model E-1004F, requires no water hook-up, only 110V. outlet . . . . . . . | General Electric |

## MASTER LIST - GROUP III EQUIPMENT[7]

### OPERATIVE

| ITEM | VENDOR |
|---|---|
| Burs, Friction Grip, Tungsten Carbide | |
| Regular | |
| Bur, 1/2, 6's, 6520-889-5782 | Perry Point |
| Bur, 2, 6's, 6520-754-2748 | " |
| Bur, 4, 6's, 6520-754-2747 | " |
| Bur, 6, 6's, 6520-754-2746 | " |
| Bur, 8, FG, dozen | Silverman's |
| Bur, 33 1/2, 6's, 6520-889-5784 | Perry Point |
| Bur, 35, 6's, 6520-754-2745 | " |
| Bur, 37, 6's, 6520-225-8288 | " |
| Bur, 57, 6's, 6520-754-2751 | " |
| Bur, 557, 6's, 6520-754-2750 | " |
| Bur, 558, 6's, 6520-889-5783 | " |
| Bur, 170L, 6's, 6520-754-2752 | " |
| Bur, 669, 6's, 6520-960-2639 | " |
| Bur, 700, 6's, 6520-960-2640 | " |
| Bur, 701, 6's, 6520-754-2749 | " |
| Bur, 330, #382837, Single | Midwest American |
| Bur, 331, #382838 " | " |
| Short Shank | |
| Bur, 1/2, 6's, 6520-225-8279 | Perry Point |
| Bur, 2, 6's, 6520-225-8281 | " |
| Bur, 4, #382405, Single | Midwest American |
| Bur, 6, #382406, Single | " |
| Bur, 33 1/2, 6's, 6520-225-8276 | Perry Point |
| Bur, 35, 6's, 6520-225-8278 | " |
| Bur, 37, #382413, Single | Midwest American |
| Bur, 57, 6's, 6520-225-8307 | Perry Point |
| Bur, 557, 6's, 6520-225-9697 | " |
| Bur, 558, #382428, Single | Midwest American |
| Bur, 699, 6's, 6520-225-8292 | Perry Point |
| Bur, 170L, #4870, Single | Star Dental |
| Bur, 700, #382432, Single | Midwest American |
| Bur, 701, #382433, Single | " |
| Bur, 330, #382461, Single | " |
| Bur, 331, #382462, Single | " |
| Miniature | |
| Bur, 1/2, #382702, Single | Midwest American |
| Bur, 2, #382704, Single | " |
| Bur, 4, #382705, Single | " |
| Bur, 33 1/2, #382709, Single | " |
| Bur, 35, #382711, Single | " |
| Bur, 37, #382713, Single | " |

| ITEM | VENDOR |
|---|---|
| Bur, 57, #382717, Single | Midwest American |
| Bur, 557, #382827, Single | " |
| Bur, 558, #382828, Single | " |
| Bur, 699, #382831, Single | " |
| Bur, 170L, #382746, Single | " |
| Bur, 700, #382832, Single | " |
| Bur, 701, #382833, Single | " |
| Bur, 330, #382837, Single | " |
| Bur, 331, #382838, Single | " |
| <u>Burs - Specialty</u> | |
| Denture Trimming, Straight Handpiece, Steel, 6's | |
| Flame shape, No. 1, 6520-076-8682 | Perry Point |
| Round shape, No. 2, 6520-076-8683 | " |
| Pear Shape, No. 3, 6520-076-8684 | " |
| Dental Surgery | |
| Straight Handpiece, Tungsten Carbide, No. 703, 6520-854-3091 | " |
| Friction Grip - 703, 25.4mm, carbide | Silverman's |
| " " - 559, 25.4mm, carbide | " |
| " " - 559R, 25.4mm, carbide | " |
| Dental Finishing Burs, Steel, 6's | |
| Round angle handpiece, latch, no. 200, 6520-510-0650 | Perry Point |
| Oval angle handpiece, latch, No. 218, 6520-510-1050 | " |
| Bud angle handpiece, latch, No. 224, 6520-510-1550 | " |
| Dental Diamonds FG | |
| Flat end taper, 371-702-12P | Star Dental |
| Round end taper, 400-769-T9F | " |
| Round end taper, 407-769-11P | " |
| Round end taper, 415-769-13P | " |
| Flame 188-210-10F | " |
| " 211-260-4F | " |
| " 227-265-8F | " |
| Tapered #3832-50mm miniature | Midwest American |
| Plugger, Amalgam, Marquette, Dbl.ended | Perry Point |
| Plugger, Amalgam, Black's, #1-2, Dbl ended | " |
| Plugger, Plastic Filling, Woodson, Dbl ended, #2 | " |
| Plugger, Plastic Filling, Dbl ended, #102 | " |
| Handpiece, Right angle w/prophy cups | " |
| Handpiece, Contra angle | " |
| Excavator, Darby Perry, Dbl ended, #5-6 | " |
| Excavator, Darby Perry, Dbl ended, #21-22 | " |
| Excavator, Black's, Dbl ended, #51-52 | " |
| Excavator, Dental, #17 | " |
| Excavator, Dental, Black's, 8992 (Discoid cleoid) | " |
| Carver, Dental Hollenback, #3 | " |
| Carver, Dental, Wall, #3 | " |

| ITEM | VENDOR |
|---|---|
| Carver, Amalgam, Hartzel Shooshan "A" | Western Dental |
| Holder, Cotton roll, Garmer, Pedo | Silverman's |
| Holder, Cotton roll, Garmer, Adult | Perry Point |
| Holder, Amalgam Capsule w/12 capsules & Pestles | " |
| Holder, Rubber dam U-shaped | " |
| Holder, Napkin, Ass't colors | Wm.Dixon, Inc. |
| Mandrel, Screw head, AHP, #303 | Perry Point |
| Mandrel, Screw head, str, HP, #303 | " |
| Mandrel, Moores, angle handpiece, latch | Silverman's |
| Disks, separating, flat, safe side - Joe Dandy, 7/8", 500's | " |
| Dedeco chairside FG kit, assorted finishing & polishing stones & disks | " |
| Spatula, Cement CRS, #324 | Perry Point |
| Spatula, Cement, #2 | " |
| Spatula, Beale, #7 | " |
| Spatula, Gritman, #31 | " |
| Chisel, Black's, #81-82 | " |
| Chisel, Wedelstaedt, Dbl ended, #41-42 | " |
| Matrix set | " |
| Matrix, Crown dental plastic, Size A-1 | " |
| " " " " " A-2 | " |
| " " " " " A-5 | " |
| " " " " " A-6 | " |
| " " " " " B-2 | " |
| " " " " " B-3 | " |
| " " " " " C-3 | " |
| " " " " " C-4 | " |
| " " " " " D-3 | " |
| " " " " " D-4 | " |
| " " " " " E-3 | |
| " " " " " E-4 | " |
| " " " " " F-1 | " |
| " " " " " F-2 | " |
| " " " " " F-3 | " |
| " " " " " F-4 | " |
| " " " " " F-5 | " |
| Dispenser, Cotton ball, tiptop #3 | Silverman's |
| Dispenser, Cotton roll, Excel | " |
| Dispenser, Dental, Strip | Perry Point |
| Dispenser, Mercury Screwcap | " |
| Retainer, Matrix Tofflemire, Contra Angle, Adult | " |
| " " " " " Jr. | " |
| Burnisher, Dental, #27-29 | " |
| Burnisher, Starlite S.E., No. 27 | Star Dental |
| Burnisher, Starlite D.E., No. 0-1 | " |
| Cotton, roll, 3/8 x 1 1/2", Richmond, 10,000 | Silverman's |
| Absorbent cotton, roll, 1/2" x 6", 500's, 6510-518-2000 | Perry Point |

| ITEM | VENDOR |
|---|---|
| Cotton pellet, 1/4", 2500's, 6510-518-1550 | Perry Point |
| Evacuation tips, disp., 100's, plastic | Vacudent |
| Evacuation tips, metal, Type A | " |
| Brush, Scratch, Dental | Perry Point |
| Brush, Scrub, Nylon, surgeons | " |
| Brush, Sable, straight, 00 | Silverman's |
| Brush, Sable, Curved, 00 | " |
| Brush, Sable, Straight, 000 | " |
| Brush, Sable, Curved, 000 | " |
| Floss, Round | Perry Point |
| Floss, Tape | " |
| Ammonia Inhalent Solution, Aromatic Ampules | " |
| Mercury NF, 1 lb | " |
| Thimerosal Tincture, MF | " |
| Lidocaine Hydrochloride Injection w/Epinephrine | " |
| Pacs - Preproportioned disposable capsules, #2 non zinc, 50 caps per box | Weber Consumable |
| Silver Alloy Pellet, Optaloy or Fine Cut, NZ | Local Purchase |
| Xylocaine Topical Ointment, flavored | Silverman's |
| Hemodent Liquid | " |
| Eugenol USP, 2 oz. | Star Dental |
| Isoprophyl Rubbing Alcohol, 70% | Perry Point |
| Karidium Phosphate, Fluoride Solution low ph | Lorvic Corp. |
| Buckleys Formocresol | Local Purchase |
| Cement, Zinc Phosphate, Dental, Light Yellow | Perry Point |
| Lubricant, Silicate Cement | " |
| Dycal | " |
| Z.O.E. Cement, pkg, #4 | S.S. White |
| Z.O.E. Cement, No. 2 w/fiber, Pkg #6 | " |
| Kerr's Cavitec | Silverman's |
| Cavity Lining & Thinner Set, Copal Resin, Copalite | Perry Point |
| Pulp protector, w/mixing pad & applying Instr. | " |
| Wedge, Dental, Matrix, Wood | " |
| Band, Matrix, Tofflemire #13, Child's Universal | " |
| Plastic Strip, Matrix, 45 ft. | " |
| Band, Matrix, Tofflemire 12's, #1, Adult Univ. | " |
| Band, Matrix, Tofflemire #3 Adult MOD 6520-721-9351 | " |
| Band, Matrix, Tofflemire, #14 Child's MOD 6520-655-4612 | " |
| Needles, Monoject, 27 gauge, short | Sherwood Medical, Inc. |
| Needles, Monoject, 27 gauge, long | " |
| Adaptic Universal Kit | Johnson & Johnson |
| Adaptic Tint, white, 4 gms | " |
| Adaptic Tint, yellow, 2 gms | " |
| Ivory Clamp Kit | Silverman's |
| SSW Clamp, #4A | M. F. Patterson |
| SSW Clamp, #27 | M. F. Patterson |

| ITEM | VENDOR |
|---|---|
| Mixing Slab, Dental, 3" x 6" Glass | Perry Point |
| Cloth Squeeze | " |
| Cover Bracket Table | " |
| Disc Set Abrasive Paper | " |
| Dish Dappen | " |
| Paper Articulating | " |
| Towel, Paper, Professional | " |
| Quiet Air Lubricant, Spray-a-day Aerosol | Midwest American |
| RM Emergency Anterior Asst. Crown Kit | Rocky Mountain |
| Nuva Seal Package, 86006 | L. D. Caulk Co. |
| Nuva Seal Starter Package, 847001 | " |
| <u>Miscellaneous Dental Instruments</u> | |
| Mirrors, front surface cone socket, size 4 | Henry Schein,Inc. |
| Handle, mouth ex., mirror cone socket | Perry Point |
| Explorer, Double Ended, #5 | " |
| Forceps, Dressing, Curved, Perry, 5" | " |
| Carrier, Amalgam, Lever type, Dbl ended | " |
| Syringe, Aspirating | " |
| Darby Plastic Trimmer, #6 | S. S. White |
| Plastic Filling Instrument, SSW PF10-3 | " |
| Dr. How Crown Plier, #110 | Wm. Dixon,Inc. |
| Contouring Plier #114, Dr. Johnson | " |
| Rubber Dam Scissors | " |
| Simplex Crown Remover | " |
| Abell Plier, #112 | Henry Schein, Inc. |
| Stripholder (Stainless) | " |

<u>SURGICAL</u>

| ITEM | VENDOR |
|---|---|
| Sponge, Absorbable Gelatin, USP Sterile | Perry Point |
| Sponge, Surgical Sterile, 2" x 2" | " |
| Sponge, Surgical Gauge, 4 x 4 | " |
| Scissors, Iris curved, 4 1/4" | " |
| Scissors, General Surgical, 6 1/2" | " |
| Scissors, Dean | Silverman's |
| Syringe, Luer, 20cc | Perry Point |
| Syringe, Irrigating, Dental, Moffat | " |
| Needle, Hypodermic, 12's, Luer-Lok, 20 ga., 1 1/2" CRS | " |
| Needle Holder, Mayo Hegar, carbide jaw | Silverman's |
| Elevator & Retractor, Seldin #23 | Perry Point |
| Elevator, Root, 34-S | " |
| Elevator, Root 301 | " |
| Elevator, Apical Howard #1 | " |
| Elevator, Apical Howard #2 | " |
| Elevator, Apical Howard #3 | " |
| Elevator, Periosteal Moose, #3 | " |
| SSW Rt. Elevator, #27, Hollow metal handle | S. S. White |
| SSW Rt. Elevator, #28, Hollow metal handle | " |
| SSW Rt. Elevator, #275, Hollow metal handle | " |
| SSW Rt. Elevator, #285, Hollow metal handle | " |

| ITEM | VENDOR |
|---|---|
| Elevator, Miller displacement, 3M | Silverman's |
| Elevator, Miller displacement, 4M | " |
| Elevator, Root, #190 w/#505 handles | Hu-Friedy Mfg Co. |
| Elevator, Root, #191 w/#505 handles | " |
| Forcept, Tooth Extracting #53L | Perry Point |
| Forcept, Tooth Extracting #53R | " |
| " " " #150 | " |
| " " " #151 | " |
| " " " #210 | " |
| " " " #23 | " |
| " " " #17 | " |
| " " " #150S | " |
| " " " #151S | " |
| " " " #222 | " |
| " " " #65, Root tip | " |
| " " " Winter, #1 | " |
| " " " 99c, straight handle | Henry Schein, Inc. |
| " " " #88L | Silverman's |
| " " " #88R | " |
| Chisel Moose Osseous #1 | Perry Point |
| Chisel Moose Osseous #2 | " |
| Chisel Moose Osseous #3 | " |
| Chisel Moose Osseous #4 | " |
| Chisel Moose Osseous #5 | " |
| File Bone Moose #3 | " |
| File Bone Moose #4 | " |
| Blade, Surgical Knife Detachable #10 | " |
| Blade, Surgical Knife Detachable #11 | " |
| Blade, Surgical Knife Detachable #12 | " |
| Blade, Surgical Knife Detachable #15 | " |
| Halstead Mosquito Haemostat, Curved 5" | Henry Schein, Inc. |
| Halstead Mosquito Haemostat, Straight 5" | " |
| Impression Material, Zoe Paste, Coe Flo | Perry Point |
| Mallet, Oral, Surgical | " |
| Rongeur Blumenthal, No. 3 | " |
| Surgeon's handle #3 for detachable blade | Henry Schein, Inc. |
| Arch Bar, Erich style, 1 yd coil | E. A. Beck & Co. |
| .020 Stainless steel ligature wire, 1 oz. | " |
| Tufts Ligature twister, 6" | " |
| X-316, 18" suture, catgut w/needle, sterile | Silverman's |
| 1/8 Surgical Tip (4530) | Teledyne Densco |
| 8/8 Cleaning wire for surgical tip (4525) | " |
| Union Broach, Long shank, FG Carbide Surgical Burs, 555 Cross Cut fissures | Union Broach Co. |

PERIODONTAL

| ITEM | VENDOR |
|---|---|
| Scaler, Dental D.E. #12 | Perry Point |
| Scaler, Dental Jacquette #1-B | " |

| ITEM | VENDOR |
|---|---|
| Scaler, Dental Jacquette 2 + 3 | Perry Point |
| Scaler, DE McCall #3-5 | " |
| Scaler, DE McCall #4-8 | " |
| Scaler, Dental 2-3, Regular | " |
| Scaler, Dental McCall 11A-12A | " |
| Goldman Fox Perio Scaler #12 Double Ended | Star Dental |
| Radcliffe Curettes | D.B. Lipton Co. |
| Tips, Radcliff Curettes, #1R,2R,3R,4R,5R,6R | " |
| Cone Socket Wrench (for placing & removing tips) #102 | " |
| Curette, Alveolar, Dental #10 | Perry Point |
| Curette, Alveolar, Dental #11 | " |
| Curette, Alveolar, Dental #12 | " |
| Goldman Fox Perio Curette #3, Dbl ended | Star Dental |
| Diamond Burs, Gingivoplasty #F2-S | D.B.Lipton Co. |
| Diamond Burs, Gingivoplasty #F3-S | " |
| #27, Tuft Junior Toothbrush | Anchor Brush Co. |
| #41, Tuft Adult Toothbrush | " |
| Interproximal Knife, Buch #5-6 DE | D. B. Lipton Co. |
| Kirkland Knives, DE 15-16 | Star Dental |
| Probe, Periodontal, Williams-Fox | " |
| Gum Scissors, Curved | " |
| Periodontal Pack, PPC Powder & Liquid | Professional Prod. |
| Coe-Pack Periodontal Dressing (Powder & Liquid) | Silverman's |
| Moyco Na F Paste | J. Bird Meyer Co. |
| Coe-Pack, Periodontal Paste | Silverman's |
| Tablet Test Wafer (1000) | Proctor & Gamble |
| POH Unwaxed Dental Floss (36 units) | POH Co. |
| POH Unwaxed Dental Floss (72 units) | POH CO. |

PROSTHODONTICS

| ITEM | VENDOR |
|---|---|
| Impression Tray, Crown & Bridge, #87 | Perry Point |
| " " Edentulous Lower #53 | " |
| " " " " #56 | " |
| " " " Upper #41 | " |
| " " " " #43 | " |
| " " " " #45 | " |
| " " Hydrocolloid Upper. Md lg, Perf,#603 | " |
| " " " " Med, Perf,#605 | " |
| " " " " Sm, Perf,#607 | " |
| " " " Lower, Md Lg, Perf,#618 | " |
| " " " " Med, Perf, #622 | " |
| " " " " Sm, Perf, #624 | " |
| " " " Upper, Lg, Perf, #601 | " |

| ITEM | VENDOR |
|---|---|
| Occlusal Indicator Wax, Kerr, Green | Silverman's |
| Wax, Baseplate, 1/2 lb sheets | Perry Point |
| Wax, 1 lb box strip, Red 12" x 1 1/4" | " |
| Wax, Sticky, 2 oz sticks | " |
| Wax, Dental Utility, 2 oz. | " |
| Wax, Inlay, 1 oz. sticks | " |
| Wax, Impression yellow, sheet 1/2 lb | " |
| Aluwax, Scored, Thick, 1 lb | " |
| Iowa Wax, Kerr, Sticks | Darby Dental |
| Adaptol Impression Wax, bx/6 tubes | Jelenko |
| Adaptol Impression Wax, bx/14 sticks | " |
| Impression Material, Sticks, green 1/4#, low heat | Perry Point |
| Hydrocolloid, Alginate Type, Regular, Set, 1 lb | " |
| Impression Material Paste, Rubber Base, Reg. Type | " |
| Coe Flex | " |
| Hold, Spray Can, 4 oz. Alginate Adhesive | Silverman's |
| Denture Elasticon Impression Paste | Darby Dental |
| Denture Elasticon Adhesive, bottle | " |
| Durelon (carboxylate) Cement (pdr & lq) | Silverman's |
| Duralay Inlay Pattern Resin, kit | " |
| Kerr's Red Compound Cakes | Perry Point |
| Trim, Bosworth, Comb Pkg | Silverman's |
| Superbite, Bosworth, ZNDE | " |
| Coe Comfort, Tissue Treatment Material | " |
| Truliner, Bosworth, Self Cure, Veined | Darby Dental |
| Tru Soft Bosworth, Self Cure | " |
| Trubase Baseplate Composition, Bx 50 lower, pk | Perry Point |
| Trubase Baseplate Composition, Bx 50 uppers | " |
| Denture milling paste, Black | Local |
| Lang's Liquid Foil, Qt. | VA |
| Plaster of Paris, 35 lb | VA |
| Bur, denture trimming, round shape #2, std hdpc | Perry Point |
| Bur, denture trimming, pear shaped, std hdpc Stl | " |
| Knife, compound dental w/6 blades | " |
| Scissors, Crown and collar, straight | " |
| Three prong clasp plier #200 | " |
| #11 Collar & Crown curved scissors SS | " |
| Millimeter Gauge, Baby type, #1074A | Silverman's |
| Blowtorch, Alcohol, Hanau | Perry Point |
| Sticks, orange wood | " |
| Band set Copper, Asst., 100's | " |
| Mixing Pad Parchment Paper | " |
| Impression Rubber Injection | " |
| Articulator, Dental Stephan, Model M type | " |
| Abrasive, Powder, Zirconium Silicate | " |
| Lang's Jet Acrylic Tooth Shades 6/1 Self Curing | " |
| Coe Flex Syringe | " |
| Coe Flex Syringe Tips, Box 25 | " |
| Racord #9, retraction cord | " |
| Preformed aluminum shells, 100 in partitioned box | Union Broach Co. |
| Seamless Copper Bands, 100 in Bakelite Chest | " |
| Fox plate, Occlusal Plane Guide | Local |
| Hot Plate, wax woodhandle | Local |

| ITEM | VENDOR |
|---|---|
| Dr. Thompson's Sanitary Transfer Color Appli. | Great Plains Dental |
| Set, Coe Bunce - Kanouse Solid Edentulous trays | Silverman's |
| Set, Coe McGowan-Winkler Perforated-full Dent. | " |

ORTHODONTICS (OPTIONAL)

| ITEM | VENDOR |
|---|---|
| Wire, .021 x .025, 10's | Unitek |
| Ligature wire, .010 | " |
| Ligature wire, .014 | " |
| Brass separating wire, .020 | " |
| Round wire, .016 standard | " |
| Round wire, .018 standard | " |
| Round wire, .020 standard | " |
| Round wire, .025 standard | " |
| Round wire, .028 standard | " |
| Round wire, .040 standard | " |
| Open Coil Spring, .010 x .040 | " |
| Open Coil Spring, .008 x .030 | " |
| Band material, .005 x .150 | " |
| Band material, .003 x .125 | " |
| Band material, .006 x .170 | " |
| Neck Pads, Beige, 7", 10's | " |
| Neck Pads, Beige, 5 1/2", 10's | " |
| Elastic, 1/8", 1000's Anterior | " |
| Elastic, 3/16", 1000's Regular | " |
| Elastic, 1/4", 1000's Regular | " |
| Elastic, 1/8", 1000's | " |
| Elastic 3/16", 1000's | " |
| Elastic, 1/4, 1000's | " |
| Elastic Ligature thread, medium | " |
| Space maintainer kit w/rest | " |
| Space Regainer Reorder Pkg | " |
| Hawley Labial Retainer Kit | " |
| Modified Arrowhead Clasp Introductory Kit | " |
| Vanadium Side Cutter, 5 1/2" | Wm. Dixon, Inc. |
| Wire Bending Pliers #139 | " |
| Heavy Duty Cutter, #102, 5 1/2" Bernard | " |
| Band Forming Plier, Anterior | Unitek |
| Band Forming Plier, Posterior | " |
| Face Bow | " |
| Preformed Hawley Gauge | " |
| Lingual Hook, Anterior, Pkg 50 | " |
| Lingual Hook, Posterior, Pkg 50 | " |
| Buccal Tubes, Konel, .040 | " |
| Double Buccal Tubes, w/flanges | " |
| Single Buccal Tubes, w/flanges | " |
| Edgewise Bracket Tubes L | " |
| Edgewise Bracket Tubes R | " |
| Hawley Arch Ruler | Rocky Mountain |
| Lingual Arch Ruler | " |
| Ruler for Maxillary Anterior Torquing Assembly | " |
| Orthodontic Blowpipe | Wm. Dixon, Inc. |
| RM Lingual Button | Rocky Mountain |

| ITEM | VENDOR |
|---|---|
| Incisal Angulator | Rocky Mountain |
| Carey Dental Calculator | " |
| Turret for .022 Edgewise Wire | Unitek |
| Orthocrylic, Kerr Introductory pkg candy | Kerr Mfg Co. |

LABORATORY

| ITEM | VENDOR |
|---|---|
| Wheel, Impregnated Rubber 3/8" | Perry Point |
| Wheel, Impregnated Rubber 5/8" | " |
| Wheel, Abrasive glass for dentures | " |
| Wheel Set, Abrasive, Asst. | " |
| Wheel Buffing Chamois, 3" | " |
| Wheel Buffing Chamois, 4" | " |
| Brush Fiber Rotary Wheel | " |
| Smock, man's standing collar, snap fast | " |
| " " " " " " | " |
| " " tan cotton sheeting | " |
| Dental Gowns 65% 35% dacron/cotton, Assorted sizes & colors | Silverman's |
| 1339A, Tripoli Buffing Compound, 1/4 lb. | " |
| Rouge, 2 oz. stick | Perry Point |
| Pumice NF Flour | " |
| Pumice, Coarse, 3 lbs. | " |
| Alcohol, USP, Ethanol,1 qt | " |
| Resin, Acrylic Dental, Denture Base Repair | " |
| Stone, Artificial Dental, 35 lbs, plaster | VA |
| Die Stone, Vel Mix, 15 lbs, pink | Kerr Mfg Co. |
| Hygon Tray Material, 3 lb., Blue | Henry Schein, Inc. |
| Orange Solvent, 1 qt. | " |
| Dura-Base, pink, w/fibers, regular | " |
| Anti-Rust tablets (Winthrop 50) | " |
| Cleaner and germicide, Quart | Vacudent |
| Type "B" Opaque Plastic | " |
| Zephrine Chloride, 4 oz | Silverman's |
| Solder Paste (700-302) | Unitek |
| Unitek Flux, oz (700-202) | " |
| Tin Oxide, 4 oz. | Star Dental |
| Kodak Dental X-ray Developer & Fixer, 2 btls | Eastman-Kodak |
| Cleaner | Perry Point |
| Tape, pressure sensitive, 1/2" x 60 yds | " |
| Tape holder, Adhesive, Desk Dispenser | GSA |
| Pencil, Assorted Colors, Red/Blue | " |
| Pocket, card, visible index file, Acme for cab, | " |
| #240 | " |
| Queen size appointment book cover item 965 | Professional Budget |
| " " " sheets undated form #7, 9 1/2" x 12" size, 100's | " |
| Hanger, X-ray film, dental | Perry Point |
| Mount, X-ray film, dental | " |
| Nylon film, 2", 12/rolls/ctn | American Hospital |
| Nylon film, 6", 12/rolls/ctn | " |

| ITEM | VENDOR |
| --- | --- |
| Snap X-Ray Film Holder | Silverman's |
| X-ray Envelopes, 500's | " |
| Periapical Ultra-Speed Dental X-Ray, DF-58 | Eastman-Kodak |
| Kodak Bite-Wing Radiatized Film, Posterior Type 0, DF-49 | " |
| Periapical Ultra-Speed Film, #0, DF-51 | " |
| Kodak Occlusal Ultra-Speed, DF-45 | " |
| Knife, Plaster, Dental | Perry Point |
| Pliers, Dental No. 118, Peeso | " |
| Frame, Dental Laboratory Saw | " |
| Blade, Dental Laboratory Saw, Spiral #2, 12's | " |
| Spatula, Laboratory, 4" blade | " |
| Knife Craftsman, Dental | GSA |
| Scies Saw Brand Saw Blades (#2/0 Fine) | Wm. Dixon, Inc. |
| Flat Saw Blades, Size 2 | " |
| " " " " 6 | " |
| 1084A, Soft Wheel Chuck, Left, #4 | Silverman's |
| 1083A, Hard Wheel Chuck, Left, #3 | " |
| Chuck, 1085A Bur, #6 | " |
| Arbor Chuck, #9R | Torit Corp. |
| Oil, Dental Engine | Perry Point |
| Casting Unit #5 (Scale, cristobalite, control powder, debubblizer, etc.) | Kerr Mfg Co. |
| Rollette Unit | " |
| Abrasive Bands, 3/8", 100/bx, medium | Wm. Dixon, Inc. |
| Cratex Special Asst. | " |
| Plastic Material Boxes, P#200 | " |
| " " " P#201 | " |
| Filter Bags, 25's | Vacudent |
| Mouthpiece Brush, Pkg/6 | " |
| Flexiboles, 4" | Silverman's |
| Flexiboles, 3" | " |
| Brass Dowel Pins, 100/pkg, size #1 | " |
| Williams Plastic Pins for castings | M.F. Patterson |
| Silver Solder Spool, 2 dwt (700-102) | Unitek |
| Casting Ring #20 | Torit Corp. |
| Green Band Stones, F-2 | " |
| Sprue Former | Star Dental |

## ENDODONTICS

| ITEM | VENDOR |
| --- | --- |
| Syringe, Luer, 5cc graduated to 1/5cc, 6515-584-2826 | Perry Point |
| Scissors, General Surgery, straight, 4-1/2" one point sharp, CRS, 6515-3[illegible]-1810 | " |
| Forceps, dressing, dental curved, Perry 5", CRS, 6520-584-3481 | " |
| Handle, Mouth examining, CRS, Cone Socket, 6520-584-9350 | " |
| Mirror, Rhodium Plated, front surface, Cone Socket #4, 624B | Star Dental |
| Glick, Double End, Endo Plastic Plugger #1 228G | " |
| Micro-grain excavators, double end, long shank #31, 120 MG | " |
| Guage, Root Canal, 427H | " |

| ITEM | VENDOR |
|---|---|
| DE-DG 16, Double End Root Canal Explorer, 129 MG | Star Dental |
| 25 Gauge, 5/8" disposable needle for Luer Syringe, box/100, 515-655-5751 | VA |
| 125cc through-the-top wash bottle, polyethylene bottle, tubing and tip, polypropylene closure, Pkg/6 | V.W.R. Scientific |
| Surgical Length Bur, Extra long latch type, 28 mm, size #2, 1 doz., 468 | Star Dental |
| Surgical Length Bur, Extra long latch type, 28 mm, size #4, 1 doz., 468 | " |
| Irrigating Solution, Sodium Hypochlorite, 2.5% soln., Hypogen 4 oz. | Premier Dental |
| Parachlorophenol,camphorated, mild 1 oz., M376 | Star Dental |
| Foamacreasal, 2 oz. | Union Broach or Local supplier |
| Superoxol, 30%, 4 oz. btl | " |
| Forceps, Hemostatic, curved Kelly, 5-1/2" CRS, Box lock, 6515-334-3800 | Perry Point |
| Micro-grain spreaders, Single End, D-11, 235 MG | Star Dental |
| Cement, root canal non-staining powder and liquid kit, M237 | " |
| Gutta Percha Points, fine-fine, box of 6 vials of 20 | Premier Dental |
| Gutta Percha Points, 120 - 6 vials of 20, size assort. 45 to 80 | " |
| Gutta Percha Points, 60 - 6 vials of 10, size assort. 90 to 140 | " |
| Cavit Temporary Seal, Bx/4 tubes | " |
| Point, pulp canal, Dental Std. Silver. size 25, 6520-850-5135 | Perry Point |
| Point, pulp canal, Dental Std. Silver size 30, 6520-850-5136 | " |
| Point, pulp canal, Dental Std. Silver, size 35, 6520-850-5137 | " |
| Point, pulp canal, Dental Std. Silver, size 40, 6520-850-5138 | " |
| Point, pulp canal, Dental Std. Silver, size 45, 6520-850-5139 | " |
| Point Assortment Pulp Canal, paper, 200's box, 6520-545-4650 | " |
| Files, standardized, style B, Short Handle, Color Coded Stops attached, stainless steel, blade length 25 mm, Size 10 | Ransom & Randolph |
| Files, standardized, style B, Short Handle, Color Coded Stops attached, Stainless steel, blade length 25 mm, Size 15 | " |
| Files, standardized, style B, Short Handle, Color Coded Stops attached, Stainless steel, blade length 25 mm, Size 20 | " |
| Files, standardized, style B, Short Handle, Color Coded Stops attached, Stainless steel, blade length 25 mm, Size 25 | " |
| Files, standardized, style B, Short Handle, Color Coded Stops attached, Stainless steel, blade length 25 mm, Size 30 | " |

| ITEM | VENDOR |
| --- | --- |
| Files, standardized, style B, short handle, Color Coded Stops attached, stainless steel, blade length 25 mm, Size 35 | Ransom & Randolph |
| Files, standardized, style B, short handle, Color coded stops attached, stainless steel, blade length 25 mm, Size 40 | " |
| Files, standardized, style B, short handle, Color coded stops attached, Stainless steel, blade length 25 mm, Size 45 | " |
| Files, standardized, style B, short handle, Color coded stops attached, stainless steel, blade length 25 mm, Size 50 | " |
| Files, standardized, style B, short handle, Color coded stops attached, stainless steel, blade length 25 mm, Size 55 | " |
| Files, standardized, style B, short handle, Color coded stops attached, stainless steel, blade length 25 mm, Size 60 | " |
| Files, standardized, style B, short handle, Color coded stops attached, stainless steel, blade length 25 mm, Size 70 | " |
| Files, standardized, style B, short handle Color Coded Stops attached, stainless steel, blade length 25 mm, Size 80 | " |
| Files, standardized, style B, short handle, Color coded stops attached, stainless steel, blade length 25 mm, Size 90 | " |
| Files, standardized, style B, short handle, Color coded stops attached, stainless steel, blade length 25 mm, Size 100 | " |
| Hedstrom file, standardized, style B, short handle, Color Coded, rubber stops attached, blade length 25 mm, stainless steel, Size 20 | " |
| Hedstrom file, standardized, style B, short handle, Color Coded, rubber stops attached, blade length 25 mm, stainless steel, Size 40 | " |
| Hedstrom file, standardized, style B, short handle, Color Coded, rubber stops attached, blade length 25 mm, stainless steel, Size 60 | " |
| Nerve Broaches, mounted, style B, Barbed, blade length 21 mm, Size 35 | " |
| Files, standardized, style B, short handle, Color coded rubber stops attached, blade length 32 mm, Size 15-40 assort. | " |
| Files, standardized, style B, short handle, Color coded rubber stops attached, blade length 32 mm, Size 45-80 assort. | " |
| Rubber Dam Clamp Forceps, Ivory Only, 6520-531-6000 | Armed Services |
| Rubber Dam Clamp, Carbon Steel, #00 | Ivory Co. |
| Rubber Dam Clamp, Carbon Steel, #0 | " |
| Rubber Dam Clamp, Carbon Steel, #2 | " |
| Rubber Dam Clamp, Carbon Steel, #4 | " |
| Rubber Dam Clamp | S. S. White Co. |

| ITEM | VENDOR |
| --- | --- |
| Rubber Dam Punch Disk and Screw (repl.) | S. S. White Co. |
| Pulp Tester, FSN 6520-656-1024 | Burton Cavitron Div. |
| Ready Cut Dam, Thin, Dark, 5" x 5" | Silverman's |
| N-O-Rubberdam Frame | Union Broach |
| Stainless Steel Root, Canal Box, 421W | Star Dental |

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3. Stafne, E.C., and Gibilisco, J.A. Oral roentgenographic diagnosis. 3rd ed. Philadelphia, Saunders, c.1969. xiii+427p.

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5. U.S. Department of Health, Education, and Welfare, Public Health Service. Dental program efficiency criteria and standards for the Indian Health Service. Washington, D.C., The Department, 1974. ix+187p.

6. Ibid., (p.F-2 - F-41).

7. Ibid., (p.G-2 - G-23).

# PART III: STRUCTURING A DENTAL HEALTH PROGRAM TO FIT CORRECTIONAL CONSTRAINTS

## CHAPTER 6: THE ORGANIZATION OF THE DENTAL DIVISION WITHIN THE CORRECTIONAL SYSTEM

One characteristic which may have a strong impact on the effectiveness and efficiency of the correctional dental program, but which until recently has not been considered an element to be determined by managerial decision, is the location of the dental division in the organizational hierarchy of the corrections system. In the past, most dentists were accountable to institutional wardens or assistant wardens. In this situation, either the activities of dentists were reviewed and managed by non-clinician administrators, or more likely, the operation of the dental program was left to the dentist, with little direct management from the institution's administration. Neither of these situations was satisfactory from a health management point of view because neither allowed for both professional supervision and management of the dental program and administrative accountability to higher levels of the hierarchy. Recently, however, several states have established separate divisions of medicine and dentistry within their departments of corrections. This has enabled the state to place all professionals in the system under the direction of a statewide medical and/or dental director, and thus to accomplish the dual goals of professional supervision and administrative accountability.

The purpose of this section is not to advocate specifically for the establishment of a separate dental division in all correctional systems. Rather, it is to assert that the organizational location of the dental program is a significant variable which should be a subject of management control. Thus the location of the dental program in the organizational chart should be a function of a rational management decision and not simply a matter of tradition.

As we discussed in the section on personnel, the management of professionals in an organization is a delicate, often conflictful process. Professionals tend to resent organizational structures which make them accountable to non-clinicians; and they particularly resent bureaucratic rules and controls which impinge on their clinical decisions or on the doctor-patient relationship. One resolution of this conflict has been the separation of the professional from the bureaucratic hierarchy on the system level, as has been accomplished in several states and the U.S. Bureau of Prisons. However, the operation of the medical program in the correctional setting also entails a second area of conflict not found in other organizational settings -- the conflict between the security component of the individual institution and the health component. Although the separation of the professional from the bureaucratic hierarchy may serve to reduce conflict on one level, this type of structure may also serve to aggravate the security-medical conflict and actually reduce the effectiveness of the medical program on the institutional level.

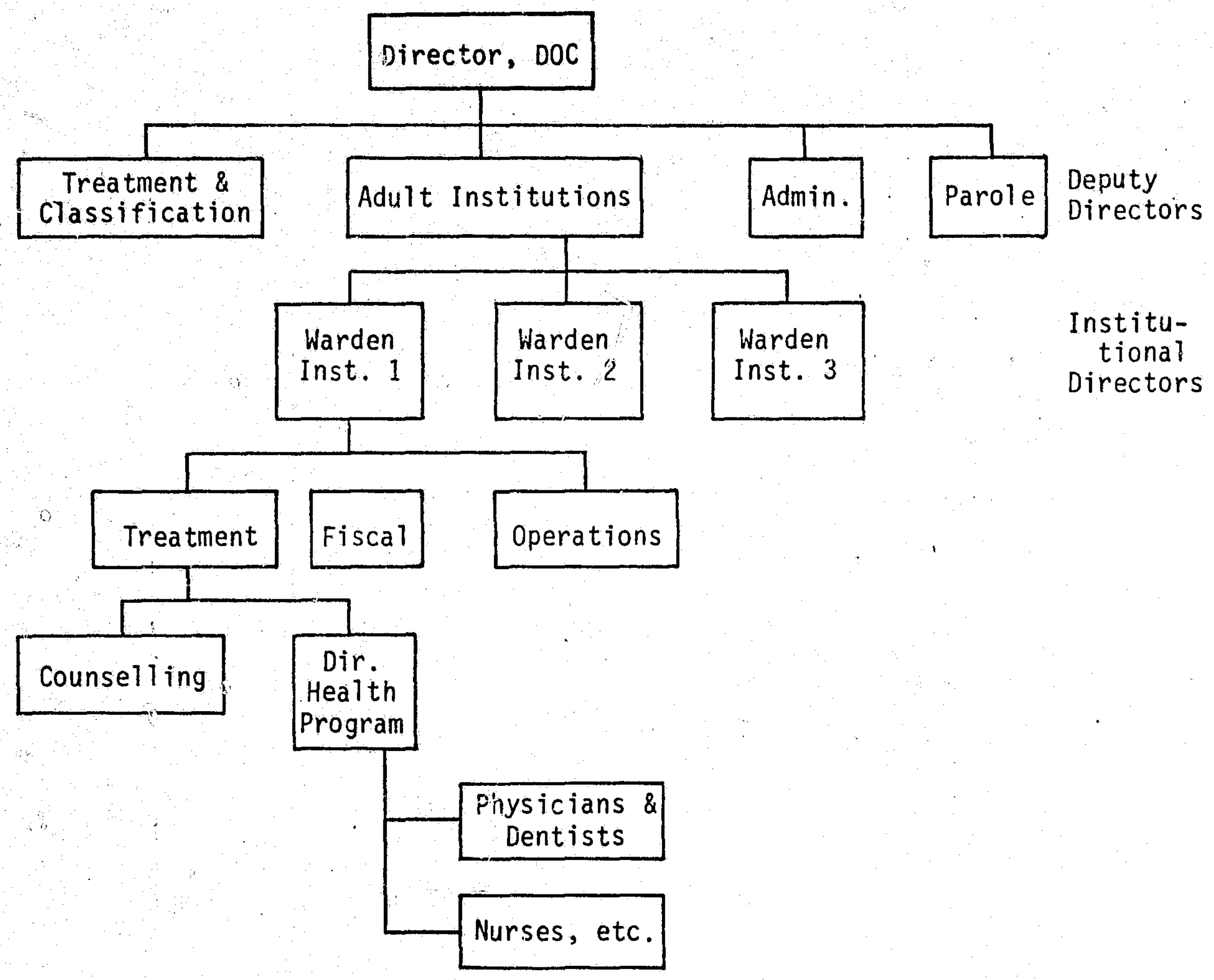
This problem may occur because, by creating a separate division of medicine and dentistry on the system level, the system is placing a boundary between the security section and the medical section at the institutional level. Since these two aspects of the institution have functions which are highly interdependent, it would be optimal to make both departments responsible to a single executive, such as the warden. By presiding over both departments, this executive could mediate problems between the two and make decisions which meet the goals of the entire organization. Of course, this is how the medical services in individual institutions have always been organized, and has been the cause of great problems. Perhaps the reason for these problems was that wardens tended

to side too heavily with the security aspects of the institution and insufficiently with the health section, and thus did not play the mediating role adequately. The point is, however, that even when the medical department is separated out from the individual institution, it will still be heavily reliant on the warden and the security staff, and it will need to work cooperatively with them. Although giving the medical department a certain autonomy may have very useful effects -- particularly in the professionalization of the department and the facilitation of certain administrative functions -- it cannot alleviate many of the security/medical problems which exist in the correctional institutions. Correctional health administrators should be aware of both the advantages and disadvantages of the various ways of organizing the medical and/or dental department before deciding to accept any given form of organization. What follows is a description of these different forms of organization along with an evaluation of the strengths and weaknesses of each.

1. Traditional Line Relationship Between Institutional Administration And The Health Section:

In this, the typical organizational arrangement, the medical department is simply another program area in each institution. Physicians and dentists in each institution in the system may report to a medical or dental director, but these directors report to, and are accountable to, an assistant warden or the warden himself.

A skeletal organization chart for a hypothetical 3- institution system utilizing this arrangement would be protrayed as follows:




Under such an arrangement the medical or dental director would be operating from a rather low position in the hierarchy of the correctional systems. Requests for such items as new equipment, supplies, new job classifications, and additional discretionary funds would be evaluated in comparison to the requests of other program areas such as food services, counseling or security. To say the least, this is not a position of power for the health unit and many of the complaints about this organizational arrangement center on its failure to fit the requirements of medical practice. For example, the need for new equipment in the health unit is viewed as more critical than a new table saw in the woodworking shop,

and yet this organizational structure does not account for this difference. In many situations, the dental program suffers even more than the medical program since it is viewed as a lower priority service.

Other criticisms of this arrangement have been mentioned previously. Not only does it place non-clinicians in the role of making decisions which bear heavily on the health unit's clinical capabilities, e.g., the purchase of a new dental operatory, but it also places a lay person as the supervisor of a clinician's work, and possibly in the role of evaluating the quality and productivity of his performance. This type of arrangement also can be criticized for fragmenting the system's health capacity and isolating its practitioners. Clinical facilities are probably uncoordinated and thus may be duplicated, or more likely, are unavailable to certain providers or patients on a systematic basis. Central purchasing of supplies and equipment, centralized personnel policies and personnel pooling are rendered inefficient, or even impossible. Providers are unlikely to be able to get together to discuss professional or job concerns and thus are unable to participate jointly in continuing medical education. The main advantage of this arrangement is that it places the medical or dental division in a position of direct accountability to the warden and thus responsive to his directions and goals. Although this can be quite a positive situation when the warden is well-acquainted in matters of health care administration, it does pose serious problems of either over-control or under-control in situations where the warden is not familiar with these issues.

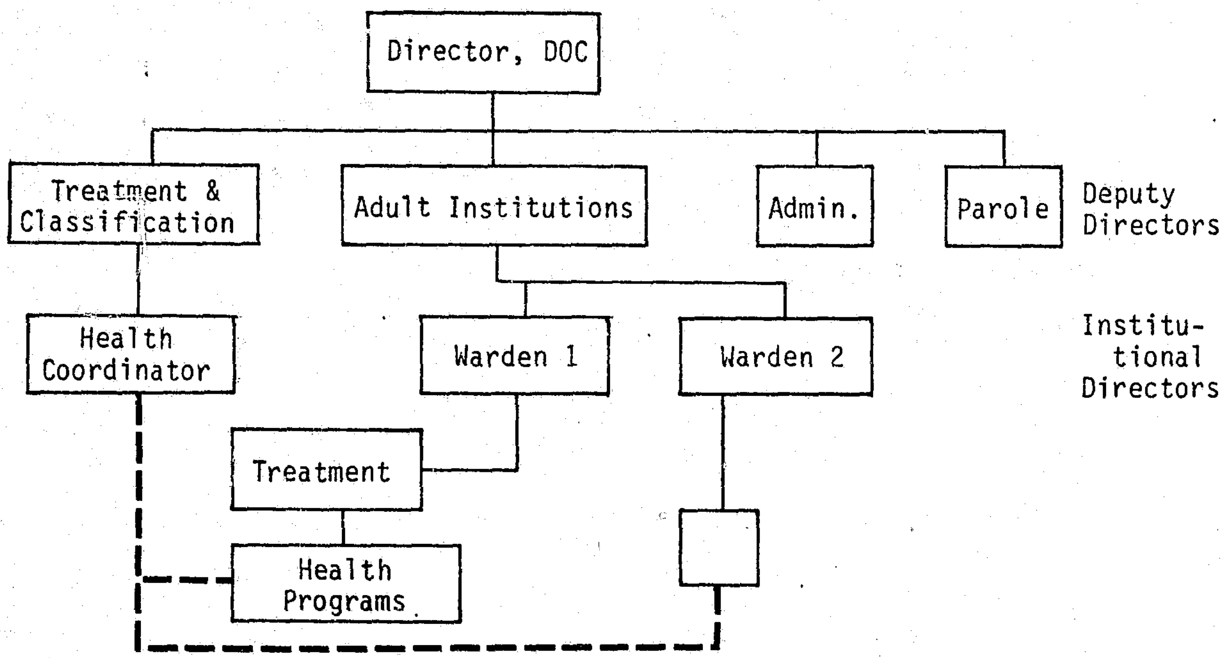
2. Traditional Line Relationship At The Institutional Level With A Health Care Coordinator In The Central Office:

One response to the increasing cost and complexity involved in the provision of medical and dental services in the corrections setting has

been the creation of a staff position in the central office of the department of corrections to facilitate health programming.

This organizational arrangement would keep the actual authority for managing health programs at the institutional level, but would permit the centralization of a variety of functions, e.g., negotiating contracts, paying bills, centralized purchasing, recruiting, program development, continuing education, and writing grants with the central office and the director of corrections staff.

This type of organizational arrangement would be portrayed as follows:




The advantages of such an arrangement derive from the economies and coordination that can be accomplished between institutions and for the system as a whole, and, to the extent that this attribute is valued, from the fact that it allows the wardens to continue the direct administration of activities occurring in their institutions.

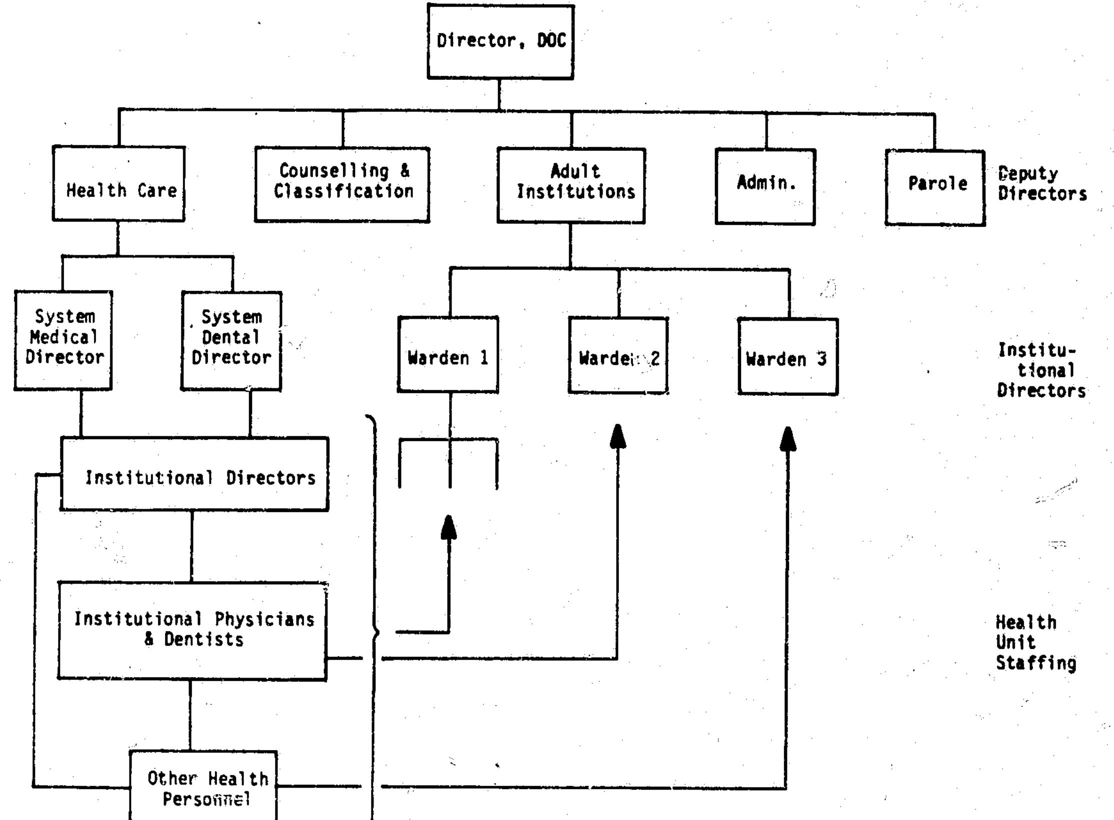
The disadvantage of this arrangement is that it does not provide the central coordinator with the fiscal or administrative authority to manage

the health program in the institutions. Thus, solutions to problems or plans for new programs may be developed in the central office, but then the coordinator has no power to implement these new programs; he still has to convince parties both at the system and institutional level to fund and authorize the changes. Of course, one may argue that new programs are unlikely to be implemented without the warden's approval regardless of the power of the central health coordinator. However, the fact that implementation of a program using one's own budget and personnel is far simpler than such implementation using someone else's budget and personnel cannot be denied.

3. <u>Establishment Of A Central Division Of Health Care, With A Budget Line Authority Over Institutional Health Providers</u>:

In this arrangement a new unit is created under the director of corrections. The unit is given a budget (which in part is removed from institutional budgets) and line authority over all personnel involved in the provision of health care services. The director of the new unit is directly accountable only to the director of the department of corrections.

The organization chart of such an arrangement would approximate:



This arrangement certainly increases the health orientation of the managers responsible for the health care sector. All people involved in the health care division can be specialists in that they do not have responsibilities for other program areas. Unified health planning and uniform health care delivery can be carried out, and all of the advantages of coordination and unified management can be realized. The system can undertake centralized purchasing and recruiting, uniform personnel and budgetary procedures, and can institute such programs as management and health information systems, quality evaluation audits, and continuing education classes. Most importantly, the program can identify itself foremost as a health care program whose major goal is the delivery of high quality care. By separating out the health unit, the system can reduce the conflicts which inevitably occur when the health care function is placed under the control of administrators whose major goal is not health.

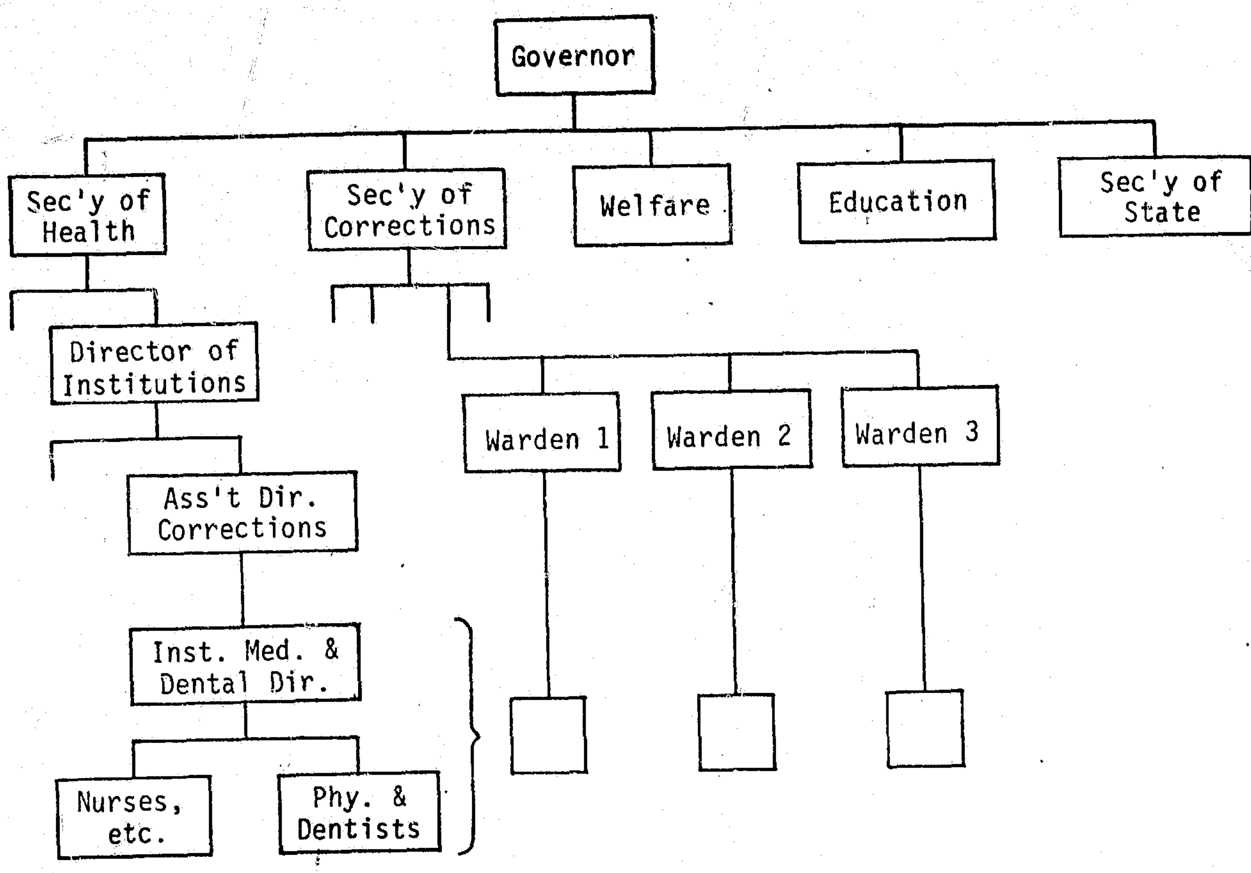
Of course, there is a major disadvantage inherent in this form of organization too. Besides increasing the health orientation of the staff, it also decreases their identification with correctional goals and their control by correctional administrators. Health providers frequently come to the corrections setting with health goals, not necessarily security goals, often presenting a problem to institutional managers and security officials. This organizational arrangement is likely to heighten the problem of goal orientation by further blurring lines of accountability and control between security and health personnel, and possibly causing certain activities to be even less coordinated than they are presently portrayed to be. Obviously, the decision as to which type of problem (insufficient health orientation or insufficient control of the health program) to accept represents, in large part, a value decision to be made by department of corrections officials. However, many fiscal, personnel,

and management criteria should play a role in the decision also. The objective in making such a decision should be consistent with the overall goals of the corrections system, which include not only the smooth, cost-effective operation of the prison (including emphasis on security considerations), but also the legal obligation to provide health services to inmates. Since many attributes of the separated health division are more likely to be consistent with the successful recruitment and retention of health professionals and are likely to produce a high quality, more efficient level of health care, this is an attractive arrangement from a health administration and legal point of view. However, circumstances in some systems may weigh against this approach and more in favor of some others.

4. Provision Of Health Services In Corrections By A Separate State Agency:

A more specialized version of the separate medical division (#3) would involve removing the responsibility for providing health services from the department of corrections entirely, and making it the responsibility of the state department of health. Here, an entire state agency already dealing with the problems of delivering and managing health services is assigned both the fiscal responsibility and line authority for running the health aspects of the corrections system. (This approach has recently been instituted by the State of Wisconsin.)

Under such an arrangement, the organization chart would look something like this:




The department of corrections is no longer responsible for staffing, financing, or monitoring the health care activities, except to the extent that corrections activities are interdependent with health activities. Corrections personnel theoretically no longer have to be familiar with or accountable for programs outside their regular domain, and such problems as malpractice suits, rising health care costs, and the purchasing of complex medical equipment supposedly would no longer fall to corrections officials. Furthermore, the health division would be housed in an agency whose primary mission is health-related and which is therefore more sensitive and responsive to the needs of health professionals. Already existing systems, such as purchasing, hiring, management, information and education systems can be expanded to service the correctional institutions;

and health administration expertise and research capabilities can be brought to bear on corrections.

Unfortunately, such an arrangement also means that two agencies of state government must agree to nearly total cooperation in the operation of the health units at the institutional level. Such cooperation is not characteristic of such state agencies, and one can foresee immense problems of accountability, power, financial responsibility, and "turf" occurring in this situation. For although this arrangement does remove the health function from the responsibility of the department of corrections, it does not remove the health program from the correctional institution and, of course, it does not remove the inmates from the responsibility of the department of corrections. Thus, as was the case for the separate medical division, an interorganizational boundary is set up between the two programs. However, in this instance, the over-arching administrator is not the director of corrections, but rather is the governor of the state, who is unlikely to become involved in issues of "turf" and accountability on this level. Regardless of the type of appeal or decision-making apparatus that would therefore have to be set up in this situation, problem solving could still be very difficult. This type of arrangement could lead to serious losses of program control and a great deal of frustration in the two separate agencies.

Thus, although the separate-agency-responsible-for-health-care approach has many virtues, it also represents a serious gamble unless tight agreements are made between the two involved agencies. It will be interesting to watch the events in Wisconsin to see how their experiment proceeds.

# CHAPTER 7: THE HIERARCHY OF PROGRAMS IN CORRECTIONAL DENTAL CARE

Within the correctional setting there are various types of programs which can be organized to serve the inmate population. These types or levels of programs reflect several varying program characteristics such as: types of services available, size of staff, adequacy of budget, and adequacy of facilities. For the purposes of this discussion, correctional dental health programs will be broadly divided into two groups, those that provide care at private or public facilities outside of the institution or correctional system. (Correctional health administrators, can, however, combine on-site and off-site treatment programs to better fit unique institutional requirements and constraints.)

The most elementary type of dental program provided to prison inmates would be the situation in which no dental personnel are employed by the institution and where no correctional or paramedical personnel have been trained to deal with dental emergencies. In such instances inmates would, by necessity, minister to their own dental needs (e.g., by brushing, flossing, rinsing, and taking aspirin for pain) and the "dental program" would consist only of "self-care". Programs which rely exclusively on self-care are inadequate and it is unlikely that this level of care would be tolerated by inmates, legislators, judges, or public-minded citizens, particularly at long-term correctional institutions. However, it is typical of many jails and workhouses to offer only this level of care to inmates -- often due to lack of financial resources, facilities, or personnel.[1]

The next level of program often found in correctional institutions relies mainly on the provision of first aid for dental problems. Although this level of care, when provided by qualified personnel in predefined

situations, might have a place as an adjunct to more comprehensive dental services, it is deemed unacceptable as the only service included in an institution's dental health program. The unacceptable situation exists where correctional personnel or paraprofessional medical auxiliaries handle extreme dental emergencies by fashioning temporary sedative dressings, by dispensing antibiotic and/or analgesic medications, and in extreme situations, by allowing untrained or poorly trained individuals (including inmates) to both anesthetize patients and extract teeth. This type of dental care is undoubtedly in violation of all state dental practice acts, but unfortunately, has been provided to inmates in some long-term and short-term correctional facilities.[2] It is an attempt by prison officials to make do with meager resources by trying to utilize available personnel to provide some semblance of dental care, even though these personnel have no formal or professional training.

Probably most characteristic of dental programs in correctional institutions is the provision of treatment by way of the "sick line". In this instance, inmates complaining of "dental emergencies" come to the dental or medical facility at a specific time set aside by prison staff. Often the timing of when the inmate becomes aware of his "emergency" is irrelevant -- he must wait until the next available sick call to be seen. Treatment on the sick line may be provided by other inmates, untrained correctional personnel, medical paraprofessionals, dental auxiliaries, or sometimes even a dentist. Regardless of the type of provider however, treatment is often of a temporary nature, dealing with symptoms rather than causes. The inmate is therefore left with the same basic dental problem that caused the initial symptoms and it is likely to result in another "dental emergency" in the near future. The use of the sick call approach to dental treatment has inherent weaknesses that usually aggravate rather than solve dental problems. Usually the sick

line is instituted as a mechanism for dealing with the overwhelming amount of dental need typically found in the inmate population. Since the level of need generally far surpasses the ability of the available resources to meet it, the sick line is used to regulate the flow of patients' demands on the system.

However, the use of the sick line approach is really dysfunctional and lends to a "vicious circle" in the pattern of need and use of services. Inmates can only see the dentist if they have an emergency, so both inmates with legitimate emergencies and ones with less urgent problems are forced to compete for the dental staff's limited time. As the number of inmates at sick call increases, staff have progressively less time available to provide routine and preventive services. The absence of routine care increases the likelihood that inmates with routine problems will progress to more serious levels of dental disease. This results in an increase in the numbers of "dental emergencies", and so on.

The use of sick call procedures to provide dental care runs counter to what dental professionals have been trained to provide for their patients. It emphasizes treatment after the damage from dental disease has become severe (and acute); when it should be geared toward preventing this destruction and resultant patient discomfort. It substitutes more expensive post-disease treatment for relatively inexpensive preventive services. Unfortunately, the ultimate price is paid by the inmate-patient who, because he is unable to acquire routine dental care, suffers more destruction from disease, loses more teeth, and suffers more pain and discomfort than is reasonably acceptable or ethically allowable.

In addition, total reliance on specified sick line treatment periods runs counter to recommendations of virtually all organizations currently

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involved in analysis of prison health programs, because it does not enable 24-hour coverage for dental emergencies (considered mandatory by the Comptroller General,[3] Brecher and Della Penna,[4] the American Public Health Association,[5] the American Medical Association,[6] the American Dental Association,[7] and the American Correctional Association[8]). We therefore recommend that sick line procedures, as the exclusive means of access to dental care, be phased out in favor of other access mechanisms, especially appointment systems.

The next, more elaborate, level of dental program involves the provision of a range of dental services within the institution's own dental facility. It might combine all of the levels of care previously discussed, but in addition will allow for the provision of some restorative and preventive services. The extent or comprehensiveness of the dental health program would depend on a number of variables, namely size of inmate population, age of the inmate population, adequacy of financing for dental care, adequacy of clinical facilities, number of dentists, the extent to which civilian dental auxiliaries are utilized, and the availability of specialty dental consultants.

The institutional dental facility might be augmented by utilization of the institution's infirmary or hospital facilities for more serious dental problems (e.g., major oral surgery, treatment for orofacial trauma, routine dental treatment for medically compromised patients, and provision of general anesthesia or intravenous sedation during dental treatment). Should the institution not have hospital or operating room facilities, inmates might still receive treatment for more serious problems within the correctional system by allowing temporary transfer to a central or regional correctional medical facility that does have the staff and facilities to provide the required care. Although this would require transportation of the inmate outside the institution to which he has been committed, he would still remain

under total control of the correctional system's personnel. If the state does not operate a hospital or surgical facility, inmates with serious problems would have to be treated in non-correctional facilities.

In contrast to care provided within the correctional system's facilities, certain types of treatment are often provided at off-site, non-correctional facilities. Health care administrators responsible for the health needs of very small, community custody or minimum security institutions and prison camps might find it more cost-effective to transport inmates to the offices of local private practitioners, to dental schools or other public dental health clinics, or to local hospitals with clinics equipped to provide comprehensive dental care for outpatients. In the future, correctional institutions might even be able to contract their entire dental programs to health maintenance organizations (HMOs), a method of delivering medical and dental services to groups of people who subscribe to the service, usually at a lower cost and of comparable quality to that available from private practitioners. Unfortunately, there currently are very few HMOs in existence that provide comprehensive dental care. However, pending legislation and the activities of many diverse citizen and governmental organizations will hopefully result in the widespread establishment of HMOs with dental components throughout the United States.

When considering the use of outside dental treatment facilities by a correctional institution, the correctional health administrator will have to arrange for the financing of these dental services and evaluate the costs of such services. Some systems pay for outside services through a set fee for all members of the inmate population (a capitation system); however, most pay for each individual service rendered (a fee-for-service system). One of the key functions of the correctional health administrator should be the assessment of the quality and level of services offered by various outside

programs in the light of the costs of these services and their ability to provide necessary security when caring for inmates. The relative costs and benefits of outside agencies can then be compared to the cost of providing comparable services on-site in determining whether the institution or system should purchase outside services or provide its own.

The last extramural program that might be utilized for more serious dental problems is one offered at a civilian hospital or major medical center. These facilities must be made available to inmates in the event that the correctional institution does not have a central or regional correctional medical facility that is equipped to handle major dental emergencies or major oral surgery. As in the utilization of all of the other facilities remote to the correctional institution, security and transportation become important and expensive factors. Correctional health administrators need to consider these transportation and security costs when comparing the cost-effectiveness of providing dental care on-site to the costs associated with utilization of off-site non-correctional facilities.

Regardless of the mode chosen to provide inmates with a dental health program, there are some principles which should be met and which must be considered unchallengeable if the program is to meet its legal and ethical obligations. All correctional dental health programs must ensure that:

1. Dental treatment will be provided only by qualified and licensed dental professionals in accordance with the appropriate state dental practice act;
2. 24-hour coverage for all dental emergencies must be provided;
3. Arrangements with dental departments of private hospitals and major medical centers (for care of inmates with serious dental problems requiring treatment too complicated to be performed within the

institution's dental facility) must be made in advance. Written contracts on these matters should be obtained;

4. Dental treatment of inmates must not be limited to emergency or sick call intervention; rather, every attempt must be made to establish routine and preventive dental services (within the constraints of the institution);

5. All treatment provided, regardless of where it is rendered, must be accurately recorded and documented in well-designed dental records which are maintained as part of the inmate's health record; and finally,

6. All policies and procedures of the dental department must be formally recorded in a policies and procedures manual so that there is no confusion among inmates, correctional staff, medical staff, and dental staff as to what services will be provided and what groups of patients will receive these services.

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# CHAPTER 8: PRIORITIES OF DENTAL CARE

It is quite unlikely that a correctional dental health program will be able to provide all of the dental services actually needed by the inmate population of a given institution. As we have discussed, correctional health administrators continually face severe constraints in such areas as budget, personnel, and facilities and therefore cannot hope to meet the total amount of need that faces them. Compounding the effects of these constraints is the problem of continuous inmate turnover experienced in most correctional facilities. Some inmates are frequently transfered from institution to institution for security reasons and therefore cannot be served adequately by any single dental program. Many inmates arrive at an institution with only short sentences to serve and may leave the correctional system long before they are seen for routine dental care. Others may be involved in vocational or educational programs that make them unavailable for appointments during the dental clinic's normal hours of operation. Some are confined to segregation units and cannot be served by the program except in emergencies.

Thus, even when the correctional health administrator is successful in developing a comprehensive set of dental services, he is fairly certain that all inmate problems will not be seen because he still must contend with problems concerning inadequacy and inaccessibility of services. Due to the presence of such problems, the administrator must be careful to avoid inequities in the services provided to different inmates. For example, the program should not be providing routine restorative care to a few inmates while many others' serious problems go untreated. It is therefore important that the dental health program be operated according to a defined classification system that allows for

treatment of dental health needs according to priorities based on rational criteria.

In order to implement such a classification system and to delineate priorities according to need, all inmates will require a comprehensive dental examination that includes: the charting of decayed, missing, and filled teeth; the taking of a health history; the complete physical examination of internal and external structures of the head and neck; examination for abnormal function or diseases of the mucous membranes and jaws; appropriate diagnostic radiographs; testing of the pulp; testing for caries susceptibility; taking of cancer smears and biopsies; microbiological culturing; and the making of diagnostic models when deemed necessary.

The task of performing such detailed examinations on an entire inmate population is an overwhelming, if not impossible one. In most institutions performing such examinations on all inmates already in the institution would mean that no resources would be available for therapeutic services for one or more years. This would certainly not be a wise use of the institution's dental personnel. And yet, since the classification of need in the population is a critical aspect of a dental program, some method for performing examinations must be developed. Programs with sufficient resources may want to bring in dentists from the outside to perform these examinations, thus leaving institutional dentists to care for the needs of inmates. Such outside dentists can also contribute to the dental program by making recommendations regarding the level and scope of a program sufficient to meet the actual needs of inmates. Although such an approach may be ideal, it would also be quite expensive and, therefore, unaffordable by most programs.

A more realistic approach might be to begin by initiating a program to screen and classify all new inmates as part of the systems' regular

reception and classification procedure. Recent American Medical Association standards[1] call for the provision of dental screening examinations for all new inmates within 14 days of admission, while the American Correctional Association requires that an initial dental screening examination be conducted on admission with a comprehensive dental examination to follow within 10 days.[2] Inmates already in the system can be screened as they present themselves for other services. Although this method means that many present inmates will never be screened and thus departs from the ideal, it is seen as an efficient way of initiating a classification system.

With information gathered during the comprehensive dental examination, the dentist cannot only design a treatment plan that will provide for a logical sequence of dental services for each inmate, but he can also use the information to classify inmates into priority categories so that those with the most urgent dental problems can be seen and treated first.

A simple patient classification system would group inmates as follows:[3]

Class I: These individuals, based on a comprehensive dental examination, apparently require no dental treatment except for ongoing preventive measures.

Class II: These individuals require treatment that is not of an urgent nature. Conditions included in this category would be: moderate calculus, those prosthetic cases not included in Class III, dental caries (not advanced or extensive), periodontal diseases (not advanced or extensive), and other oral conditions requiring routine corrective or preventive measures.

Class III: These individuals require treatment for such conditions as extensive or advanced caries, extensive or advanced periodontal disease, chronic pulpal or apical infection, chronic oral infection, heavy calculus, surgical procedures required for the removal of one or more teeth, other surgical procedures not included in Class IV,

and insufficient number of teeth for adequate mastication (indicating the need for dental prosthesis).

Class IV: Individuals in this category require emergency dental treatment for such things as traumatic injury, acute oral infections, suspected serious oral pathological conditions, and conditions involving pain and/or swelling.

With this classification system, the dental staff would then place priorities on treating Class IV patients first, followed by Class III patients, and so forth. This does not necessarily require that all Class III patients be treated completely before Class II patients can be seen, it only requires that the majority of time available for appointments should be reserved for treating (and reducing the number of) Class III patients. (The Class IV patients should be handled as they present themselves to the clinic.)

Recognizing that a correctional dental program is unlikely to be able to provide all of the services required to satisfy all of the needs (and demands) of the inmates, the following list of services, ordered in terms of urgency, is also provided. This list presents a slightly different "cut" at dental problems from the first classification list in that it presents the priority of services to be rendered at a given point in time. Even patients in the healthier groups (I and II above) may develop acute conditions which will have to be treated immediately, even while they are waiting for routine dental care. The correctional health administrator should thus ensure that available resources are used to provide dental treatment consistent with this treatment priority classification list.[4]

1. Relief of acute or chronic pain, treatment of acute infections, or treatment for traumatic injury,
2. Provision of prosthetic appliances for those patients whose health is compromised because of an insufficient number of teeth needed

for adequate mastication,

3. Elimination of all oral pathological conditions and extraction of all teeth decayed beyond restorability,
4. Removal of chronically irritating conditions which could lead to oral malignancies,
5. Treatment of bone and soft tissue diseases,
6. Restoration of injured or carious teeth, and
7. Replacement of lost teeth and restoration of function.

A more detailed classification system and a more extensive priorities list is presented in the standards developed by the American Public Health Association.[5] Interested administrators are referred to those standards.

Another factor involved in deciding which inmates are to be seen first centers on the relative length of incarceration. For example, priority for treatment of routine (non-emergency) dental problems should be given to those inmates who have been incarcerated the longest and to those who face the longest sentences within the correctional system. Given scarce resources, the correctional system would seemingly have a greater obligation to provide routine dental care to long-term residents than it would to recently sentenced inmates. Those inmates who have already served extended periods of time in the correctional system would be quite likely to have accumulated extensive dental defects due to problems of accessibility and availability characteristic of most correctional dental health programs of the past, while recently arrived inmates could have received routine dental care before their institutionalization. Those inmates sentenced to short terms are less of a priority since they will be able to seek routine care privately once released, and are also less likely to suffer or accumulate irrepairable damage to their dentitions during their relatively short-term institutionalization.

Before concluding the discusssion on priorities for treatment of dental

needs, it must be re-emphasized that routine <u>preventive</u> services are more cost-effective than the restorative services that become necessary due to the failure to provide such preventive dental care. Correctional health administrators should make every effort to ensure that an effective preventive program be established. Such a preventive dental health program would include such services as: regular oral prophylaxis and plaque control; topical application of fluoride; oral hygiene counseling; nutritional counseling; periodic recall of completed patients for examination, maintenance and prevention; and the provision of such patient care items as fluoride dentifrices, dental floss, interdental stimulators, bridge cleaners, toothbrushes, floss holders, denture cleansers, mouthrinses, and patient educational material. The responsibility for patient preventive dental services can be effectively assigned to a registered dental hygienist and correctional health administrators should consider the employment of such dental auxiliaries at the earlist possible time. (Please refer to Chapter 4, The Role of Dental Hygienist in the Correctional Setting.) Correctional health administrators also have the responsibility to negotiate with the security staff to see that these patient care items (fluoride dentifrices, dental floss, etc.) are made available to inmates on a regular basis.

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# CHAPTER 9: QUALITY ASSURANCE IN THE DENTAL HEALTH PROGRAM

One of the most critical functions involved in the management of the correctional dental program is the assurance of the quality of dental services provided by the program. If the dental program is to meet its program objectives and is to comply with legal requirements, it is imperative that the operations of the program be monitored and evaluated according to standards and criteria designed specifically for use in assessing the performance of the delivery system. Once such evaluations are made the system must provide for corrective actions to be taken in order to bring performance into compliance with program standards if deficiencies in performance are detected.

The assessment of the quality of dental care is the primary focus of this chapter. We have included a very detailed quality assessment program, developed by the Indian Health Service of the U.S. Public Health Service,[57] in this chapter as a guide for program administrators wishing to initiate a quality assessment program in their system. However, before discussing the specific aspects of a quality assessment methodology, it may be useful to place the role of this type of methodology in perspective relative to other quality assurance mechanisms within the comprehensive dental program.

First, a distinction must be drawn between "quality assessment" and "quality assurance". Quality assessment refers to the process of identifying what is occurring in a program and comparing these findings to various standards of performance according to specific criteria. The assessment process is thus one of evaluating the present performance of a system according to some objective or goal of the system. The assessment process consists of several components: program monitoring to identify or measure current operations; performance criteria to be used as the basis of evaluation; and program standards which define the expected level of

performance of the system. Quality assessment is therefore a process through which judgment about program performance are made.

Quality assurance programs combine the assessment process with an additional component. Not only do they contain an assessment phase, but they also provide for corrective action to be taken once the performance receives a negative assessment. Corrective actions may include constructive criticism of a professional or a change in program procedures. They can also involve termination of an employee or the complete renovation of a program. Quality assurance programs ensure that program performance meets legitimate standards.

It should be recognized that a program's quality can be assessed along several different dimensions. Donabedian[58] has discussed three major approaches to the evaluation of medical care: the assessment of structure; the assessment of process; and the assessment of outcomes or end results. In the assessment of structure, a quality assurance program would evaluate the facilities, equipment, and personnel involved in the provision of services (with the assumption being that the provision of high quality dental services cannot be effected without the necessary facilities, personnel, equipment, and financial resources).

When assessing the process of care, an evaluation system would review the activities of the dentists or other dental care providers, with respect to the treatment of patients. Here, the criterion of quality used is "the degree to which management of patients conforms with the standards and expectations of the respective professions."[59]

The assessment of outcomes is the evaluation of the results of care. Determinations are made regarding how well patients fared after treatment and these results are compared to what would be the expected results of such treatment. Outcomes would include not only aspects of patient's health, but also of their satisfaction with the treatment process.

Although the Indian Health Service Quality of Dental Services Evaluation System presented later in this chapter relies heavily on assessments of processes and outcomes in evaluating the quality of care, this does not mean that this constitutes an entire quality assurance system. First, and probably most importantly, this system does not involve many quality assurance activities in the area of structure (aside from some environmental and radiation hygiene criteria). Due to the neglect of the dental component of most correctional health programs in the past, one can argue that the most dramatic gains in quality of care offered in corrections are to be made by assuring the quality of the structure of care. This would involve bringing the dental program into compliance with the standards developed by the AMA, the APHA, or other agencies discussed previously. It also would involve structuring the program in as comprehensive and cost-effective a fashion as feasible. In a sense, the entire thrust of this manual, with its call for the professionalization and adequate staffing and equipping of correctional dental health programs, is an effort in quality assurance through a structural approach.

Once a high quality of structure is achieved in the dental health program, the correctional health administrator will want to ensure that the program is operating well and providing good quality services. Although certain structural features will still need to be monitored and corrected, e.g., proper functioning of equipment, continuing education of the staff, and updating of procedures, a greater reliance will be placed on the assessment of the quality of process and outcomes in the dental health program. This is where the Indian Health Service methodology can be of enormous value. It presents a comprehensive set of criteria for the assessment of dental activities as well as the rationale for the inclusion of each criterion, the method used for monitoring each activity, and the standard of performance against which the findings should be

compared. This version of the system is the result of many years of research and experience in Indian Health Service dental clinics and it has a documented history of success. It can be utilized either as it is or with modifications appropriate to the specific correctional setting.

It should be recognized that this system deals only with assessment and does not constitute a quality assurance program. What is missing is the system's responses to negative findings during the assessment phase. Such responses or corrective actions are obviously critically important to the assurance of quality and must be included if quality assessment is to be worthwhile. The range of possible actions varies from simply providing feedback to erring dentists, to establishing a continuing education program, to warning consistent violators that they had better modify their behavior, to terminating unresponsive employees. However, it is difficult to discuss the specifics of what should constitute the appropriate corrective action in each case of substandard performance. The appropriate action should be consistent with the type of problem uncovered, the reason for the problem, the options open to the program and the relative costs of the various options. Selecting the appropriate actions to be taken in a given situation constitutes one of the arts of administration; however a successful system may be predicated on the formalization of the specific actions that will be taken for each category of error disclosed in the assessment phase.

The Quality of Dental Care Evaluation System of the Indian Health Service

The fol[illegible]g quality assessment system is taken, in nearly complete form, from Quality of Dental Care Evaluation System written and published by the U.S. Department of Health, Education and Welfare, Public Health Service, Washington, D.C., 1978. It is reprinted here because it represents a highly effective and useable system which has a direct application to the

correctional setting.

This methodology deals heavily with the technical aspects of dental processes and outcomes. It is designed to assess the professional, rather than the managerial aspects of the dental program. As such, this instrument should be employed only by dental professionals trained in evaluation techniques. In the larger correctional systems, such professionals may be employed by the system, perhaps in a central office, and will probably visit each institutional site on a periodic basis. In the smaller correctional systems, however, such professionals are unlikely to be employed by the department of corrections, and so the system will probably want to bring in evaluators from outside the agency. (This is particularly necessary in systems employing only one, two, or three dentists.) To obtain such outside assistance the correctional health administrator would probably want to contact such agencies as local dental schools, state health departments, state dental societies, or regional offices of the U.S. Public Health Service. Many of these agencies' titles and addresses are listed in Appendix H of this manual.

The technique employed in the use of the following instrument is quite straightforward. Criteria for the evaluation of various activities are provided along with the methodology for performing the evaluation. The instrument also provides the standards of performance utilized by the Indian Health Services and which can be applied to the correctional setting. Also included are the forms used to evaluate the overall performance of a program and one that can be used to provide feedback to the program after it is evaluated. A complete list of references used in the instrument is also included.

The actual logistics of an evaluation visit can be arranged to fit any given correctional dental program. However, there are certain policies that should be followed no matter what the circumstances at the

individual institution. These standard policies are as follows:*

1. The quality of dental care assessment for correctional dental health programs must be carried out by dental professionals, trained in evaluation techniques, who have experience in both clinical and administrative matters.
2. Evaluations should be performed on every new dentist employed by the correctional system within the first six months of his employment. Each correctional dental clinic and dental staff should be reviewed at least every two years.
3. No evaluations can be conducted upon service provided or methods employed prior to the time the dentist being evaluated was provided the criteria and standards for the evaluation.
4. The evaluation of dental professionals must be by personal contact between the evaluator and the evaluatee. Evaluation of clinical facilities and dental staffs must be by site visit.
5. It is important that tact and discretion be preeminent throughout the evaluation process. The personal and professional dignity of the evaluatee must be preserved before all patients, peers, subordinates, and other persons in association with him/her.
6. Confidentiality of evaluation information must be ensured.
7. The evaluatee must be advised of all evaluation findings and should use the information provided him constructively in order to make improvements where deemed necessary.
8. When the quality of service provided is considered questionable by the evaluator, but is not definitely unsatisfactory, the decision must be in favor of the evaluatee.
9. The evaluation must include a confidential closeout meeting where all reports are signed by both the evaluator and the dentist being evaluated.

10. The evaluatee has the right of appeal for a re-evaluation by the same or a different evaluator.

*SOURCE: U.S. Department of Health, Education, and Welfare. Public Health Service. Quality of dental care evaluation system for the Indian Health Service. Washington, D.C., The Department, 1978. 54 p. (p. E1).

The following data collection methods are presented for the information of correctional health administrators and potential examiners:**

The examiner must:

1. Refer to the lettered section (in parentheses) reference for each category to be evaluated.
2. Review the respective criteria and methods to be used for assessing the criteria.
3. Select those criteria considered applicable and apply the respective methods to be used for assessing whether the criteria are met or unmet.
4. If all of the applied criteria are met, then conclude that the examined dental service is satisfactory and place a mark in the appropriate box of the satisfactory column of the quality evaluation form.
5. If any one of the applied criteria are unmet, then conclude that the examined dental service is unsatisfactory and place a mark in the appropriate box of the unsatisfactory column of the quality evaluation form.

The following data analysis method is presented for the information of correctional health administrators and potential examiners:**

For an examined dental service to be considered acceptable in quality, it must meet or exceed the respective D.O.C. quality standard. To determine this, the examiner must compute the actual percent of an

examined dental service found to be satisfactory and compare that percent with its D.O.C. standard. The actual percent is determined by applying the following computation:

$$\frac{\text{Total \# Satisfactory}}{\text{Total \# Satisfactory Plus Unsatisfactory}} \times 100 = \text{Actual Percent Found to be Satisfactory}$$

This analysis of the collected data will identify those examined dental services that meet quality standards and those that do not, revealing areas where improvements are deemed necessary. Analysis of the data also will provide correctional administrators with information needed to budget for improvements in facilities and expansion of professional staffs, in order to make necessary improvements in a given correctional dental health program. This information can also be utilized to determine how quickly new professional employees have adapted to working in a correctional setting and can be continuously referred to for comparison of employee performance.

**SOURCE: U.S. Department of Health, Education, and Welfare, Public Health Service, Quality of dental care evaluation system for the Indian Health Service. Washington, D.C., The Department, 1978. 54p. (p. E4).

SOURCE: U. S. Department of Health, Education, and Welfare, Public Health Service. Quality of dental care evaluation system for the Indian Health Service. Washington, D.C., The Department, 1978. 54p. (p.E51).

D. O. C. QUALITY EVALUATION FORM

DATE: ______________________

DENTIST EVALUATED ______________________ (SIGNATURE)

EXAMINER ______________________ (SIGNATURE)

PRE-EVALUATION CONFERENCE ________

POST-EVALUATION CONFERENCE ________

RE-EVALUATION REG'D OR REQUESTED ____

| SATISF. | UNSAT. | N/A | D.O.C. STD | |
|---|---|---|---|---|
| | | | 95% | PATIENT MANAGEMENT (A) |
| | | | 70% | ORAL HEALTH EDUCATION (B) |
| | | | 80% | PATHOLOGY (C) |
| | | | 80% | RADIOGRAPHS (D) |
| | | | 90% | RECORDS (E) |
| | | | 100% | DRUGS (F) |
| | | | 80% | PROPHYLAXIS (G) |
| | | | 80% | TOPICAL FLUORIDE (H) |
| | | | 90% | EXTRACTIONS (I) |
| | | | | |
| | | | 80% | SURGICAL PROCEDURES (J) |
| | | | 90% | RESTORATIONS (K) |
| | | | 80% | ENDODONTICS (L) |
| | | | 70% | CROWNS (M) |
| | | | 70% | FIXED PROSTHODONTICS (N) |
| | | | 80% | REMOVABLE PROSTHODONTICS (O) |
| | | | 80% | PERIODONTICS (P) |
| | | | | |
| | | | 80% | TREATMENT SERVICES (Q) |
| | | | 100% | ENVIRONMENT (R) |
| | | | 100% | RADIOLOGICAL PROTECTION (S) |
| | | | 100% | EMERGENCY CARE EQUIPMENT (and care) (T) |
| | | | | |

SOURCE: U. S. Department of Health, Education, and Welfare, Public Health Service. Quality of dental care evaluation system for the Indian Health Service. Washington, D.C., The Department, 1978. 54p. (p.E52).

## D. O. C. FEEDBACK FORM

(Provide to Evaluatee at close-out session)

**PART A** Date Completed: ______

Enter name of examined dental service concluded as unsatisfactory: ______

______

______

Enter specific number of each applied criterion considered to be unmet:

____, ____, ____, ____, ____, ____, ____, ____.

Describe deficiencies related to each unmet criterion noted above:

______

______

______

______

______

______

______

______

**PART B**

Evaluator and Evaluatee identify Service Unit and Area "Plan of Action" for correcting problem(s).

Service Unit actions: ______

______

______

______

______

Service Unit actions to be completed by: ______ (Date)

D.O.C. actions: ______

______

______

______

______

D.O.C. actions to be completed by: ______ (Date)

Signatures: ______ (Evaluator) ______ (Evaluatee) Date: ______

**PART C**

Date of "Re-evaluation" (when applicable): ______

Original: Director of Dental Services, ____ State D.O.C.
1st CC: Evaluatee

SOURCE: The following criteria, standards, methods, justifications, and resource references are taken totally from the following source (with a few minor revisions):
U.S. Department of Health, Education, and Welfare, Public Health Service. Quality of dental care evaluation system for the Indian Health Service. Washington, D.C., The Department, 1978. 54p. (p. E5-E50).

A. PATIENT MANAGEMENT

1. Criterion #1: Patient is treated with respect.

a. Method to assess criterion:

Observe the promptness shown by any staff member of the facility in recognizing the presence of people in the clinic or facility waiting area and whether the reason (s) for their presence was obtained. Also, observe the respect shown to the patient by the attending dentist and dental assistant (s).

Justification for criterion:

"The patient's presence should be acknowledged as soon as he enters the reception room.

The patient should be told when the dentist will see him. If there is to be a delay past the appointed time, the situation should be explained.

The dental assistant has an important role to play in the dental office, and she should give the same kind of fine impression that she likes to receive when she visits an office or store."[1]

2. Criterion #2. Treatment is explained to the patient before services begin, and services planned for the next appointment are explained.

a. Method to assess criterion:

Observe whether the attending dentist or dental assistant explains to the patient the planned treatment services for that visit before those treatment services begin, and explains services planned for the next appointment to the patient before they leave the clinic.

Justification for criterion:

"If the dentist or hygienist would take but a few minutes to query the patient, allowing him to ventilate and express his fears, and if the treatment procedure to be followed could be explained, time might be saved in the long run and many misunderstandings might be eliminated."[2]

STANDARD: A standard of 95 percent is suggested arbitrarily. This means that at least 95 percent of the patients present in the clinic during the evaluation visit received satisfactory patient management.

B. ORAL HEALTH EDUCATION

1. Criterion: Chairside oral health education is provided to each clinical patient at each visit.

a. Method to assess criterion:

Observe whether chairside oral health education is provided to each clinical patient at each visit.

Justification for criterion:

"... in addition to clinical services, dental staff must also provide educational services to the patient..."[3]

"If the patient exhibits extensive carious lesions or periodontal disturbances, the cause, measures necessary to correct the problem, and the possible sequelae if these measures are not taken should be discussed, in a general way, with the patient.

... a planned educational program should be tailored to the individual needs and interests of the patient and should not only stress toothbrushing, fluoride, restriction of carbohydrates, and regular visits to the dentist, but should also provide for the patient an exposure to the total realm of dentistry and dental procedures."[4]

STANDARD: A standard of 70 percent is suggested arbitrarily. This means that at least 70 percent of the patients present in the clinic during the evaluation visit received chairside oral health education.

C. PATHOLOGY

1. Criterion #1: All hard and soft tissue epidemiology data obtainable by clinical examination are recorded on patient's dental record.

a. Method to assess criterion:

Observe the clinical examination provided to the patient by the attending dentist, paying particular attention to the examination procedures of the soft and hard tissue. Immediately following the completion of the clinical examination provided by the attending dentist, the examiner refers to that patient's dental record and clinically examines the same patient. Light, mouth mirror and explorer used by attending dentist are used by examiner.

Justification for criterion:

Every patient should have an examination of all hard and soft oral tissues during his first dental visit each fiscal year. Results must be recorded on patient's dental record.[3]

"Swelling of the face, changes in contour, and lesions on the lips should be noted first. The quality of the breath should be observed and inspection made of the inside of the mouth; the labial and buccal mucosa, palate, fauces, tongue, and sublingual tissue. Deformities and abnormalities of the dental arch, the occlusion and masticating ability of the teeth are studied next, while the lips are raised and the cheeks retracted.

The gingvae must be examined carefully, in both the upper and lower jaws. The form, density and color should be noted, and small swellings, red spots, ulcers, and fistulous openings should be recognized.

The lymph nodes should be palpated, especially in the submental, submaxillary, and cervical regions."[5]

2. Criterion #2: All hard and soft tissue epidemiological data obtainable by B/W radiographic interpretation are recorded on the patient's dental record.

3. Criterion #3: All hard and soft tissue epidemiological data obtainable by F/M radiograph or Panographic interpretation are recorded on the patient's dental record.

a. Method to assess criteria #2-#3:

Observe the interpretation of the radiographs by the attending dentist and determine if all epidemiological data shown on the radiographs are identified and recorded on the patient's dental record. Radiograph illuminator must be used for the radiographic interpretation.

Note: Criteria #2 and #3 do not apply in instances when the x-ray unit is inoperable during the examiner's evaluation visit.

Justification for criteria #2-#3:

Bitewing radiographs should be taken annually.[6]

"Full mouth radiographs (or Panarex radiographs) should be taken for a complete examination." 7

4. Criterion #4: All factors of medico-dental significance that are obtainable from review of patient's medical record or the patient history questionnaire are recorded on patient's dental record.

   a. Method to assess criterion:

   Immediately following the attending dentist's review of the patient's medical record or patient history questionnaire, the examiner reviews the same records or questionnaire and then refers to the patient's dental record to determine if all significant medico-dental problems have been identified and recorded in the remarks section of the dental record. The examiner gives first preference to the patient's medical record and second preference to the patient history questionnaire.

   Note: Criterion #4 does not apply if either the patient's medical record or patient history questionnaire are unavailable for review. The examiner should take appropriate administrative action to determine the reasons why none of these records are available for the use of the attending dentist.

   Justification for criterion:

   No patient should be treated without prior review of the patient's medical record when the record is available to the dentist. "Any medical problem that might call for the postponement or extra precautions in dental care should be noted by the ...[dentist]...in a quick review of the outpatient and inpatient records." 8

STANDARD: A standard of 80 percent is suggested arbitrarily. This means that at least 80 percent of the patients examined during the evaluation visit received a satisfactory oral examination.

D. RADIOGRAPHS

1. Criterion #1: Density and contrast of radiographs are such that anatomical hard and soft tissue landmarks can be differentiated.

2. Criterion #2: No radiograph distorts image size in the region of the mouth under study.

3. Criterion #3: Radiographs disclose no overlapping of image in the region of the mouth under study.

4. Criterion #4: Radiographs disclose no cone-cutting.

5. Criterion #5: Bitewing radiographs include the distal surface of the erupted cuspids and mesial surface of the most posterior erupted teeth.

   a. Method to assess criteria #1-#5:

   Assess the radiographs taken on patients present in the clinic during the evaluation visit and/or review radiographs taken within the previous six months, selected randomly from the files. The radiographs should be viewed with a radiographic illuminator (View Box) and not by holding up to window light, ceiling or operating light. Then apply the criteria considered applicable to each of the radiographs being examined and determine their acceptability.

   Note: Criterion #3 is not applicable to radiographs selected from the files. To assess this criterion objectively, the patient needs to be present for determing whether crowded dentition may be the cause for overlap. Criterion #5 is not applicable when cuspids and/or molars are missing.

   Justification for criteria #1-#5:

   Radiographic films, when processed according to the manufacturer's instructions, are acceptable when the following characteristics are missing; blurred, fogged or partial images; too light or too dark to provide contrast sufficient to interpret; air bubbles; white blotches; stained film; overbent or crimped film (crescent shaped black mark); herringbone patterns on film, and clip lines on film.[9]

   The density and contrast of the images in the radiographs should enable the differentiation of tooth structure, periodontal membrane, and anatomical landmarks. Also, there should be a minimum of distortion of image size and lack of overlapping images.[10]

   "Dental radiographs when made with modern equipment and techniques are safe and absolutely essential to dental dianosis and treatment."[11]

STANDARD: A standard of 80 percent is suggested arbitrarily. This means that at least 80 percent of the radiographs met all applicable criteria.

E. <u>RECORDS</u>

1. Criterion #1: All entries recorded on the Patient Service Record and Services Provided Dental Progress Notes are done in ink.

   a. Method to assess criterion:

      Review the patient's dental record after the completion of entries to determine if they are in ink.

      Justification for criterion:

      "The significance of the health record as evidence in a court of law dictates that ...all handwriting should be in ink and legible."[12]

2. Criterion #2: Marking symbols as described in the applicable correctional system policy manual for dental programs are used on Patient Service Record.

3. Criterion #3: Abbreviations described in the applicable correctional system policy manual for dental programs are used on Patient Service Record.

4. Criterion #4: Treatment plan of the Patient Service Record completed for each patient prior to the next clinical visit.

5. Criterion #5: Services rendered are recorded correctly on the Services Provided Dental Progress Notes.

6. Criterion #6: Services provided are marked on tooth symbols with red pen.

   a. Method to assess criteria #1-#6:

      Review the patient's dental record after the completion of dental data entries by the attending dentist or dental auxiliary. Records may be selected at random from the file or may be records of patients present in the clinic during the evaluation visit.

      Justification for criteria #1-#6:

      Every patient shall have a comprehensive examination and a treatment plan designated during his first visit with the information recorded on the Patient Service Record.[3]

STANDARD: A standard of 90 percent is suggested arbitrarily. This means that at least 90 percent of the dental records and forms evaluated met all of the criteria applicable.

## F. DRUGS

1. Criterion #1: Drugs prescribed for and/or administered to dental outpatients or inpatients are recorded appropriately in patient's medical record.

   a. Method to assess criterion:

      Apply to dentists at locations where patient medical records are available to attending dentist. For outpatients: observe whether the attending dentist records the drug name and dosage on the Clinical Record sheet of the patient's medical record.
      For inpatients: observe whether the attending dentist records the drug name and dosage on the Doctor's Orders sheet of the patient's medical record.

      Justification for criterion:

      When the patient's medical record is available to the attending dentist, prescribed and/or administered drug information must be recorded on the Clinical Record Sheets for outpatients, and on the Doctor's Orders for inpatients.[8]

2. Criterion #2: Drugs prescribed for dental outpatients or inpatients are recorded on patient's dental record.

   a. Method to assess criterion:

      Apply to dentist at locations where patient medical records are not available to attending dentist, or when patient dental records are filed separately from patient medical records. For inpatients and outpatients: observe whether the dentist records the drug name, the daily dosage and the amount on the patient's dental record.

      Justification for criterion:

      It should be the appropriate correctional system's dental program policy that prescribed medications be recorded on the patient's dental record when conditions exist that prevent recording that information appropriately in the patient's medical record.[8]

3. Criterion #3: Prescribed drug and daily dosage are consistent with health problem described on patient's dental record and/or medical record.

   a. Method to assess criterion:

      Review the described health problem and determine the appropriateness of the prescribed drug and daily dosage by referring to an acceptable reference, such as American Hospital Formulary Service, Physicians Desk Reference,

or Accepted Dental Therapeutics.

Justification for criterion:

Drug utilization is an important program element in any health care delivery system. Any prescribed drug should be consistent with the health needs of the patient.

STANDARD: A standard of 100 percent is suggested arbitrarily. This means that each prescribed drug and daily dosage is recorded appropriately on patient records and is consistent with the described health problem.

G. PROPHYLAXIS

1. Criterion #1: Disclosing solution applied before prophylaxis begins.

   a. Method to assess criterion:

   Observe whether patient is provided disclosing agent to stain the protein material on the teeth. Also, observe whether patient is given a mirror to visualize where the protein material is located on the teeth. In addition, determine if the staff person explains to the patient why the material should be removed and how it may be removed by explaining acceptable oral health practices for maintaining a clean mouth.

   Justification for criterion:

   Success or failure in preventing and controlling periodontal disease is determined for the most part by good personal oral hygiene practices.[13]

   The American Academy of Periodontology recommended education of patients in home-care procedures as part of the professionally administered oral prophylaxis.[14]

2. Criterion #2: All debris removed (includes flossing of contacts).

3. Criterion #3: All gross calculus removed.

4. Criterion #4: All extrinsic stain removed.

5. Criterion #5: All crowns polished with fluoridated paste in a low heat producing manner.

   a. Method to assess criteria #2-#5:

   Observe whether prophylaxis procedures being provided are explained to the patient by the attending dental staff person. Following the completion of the procedures, assess the quality of the prophylaxis by means of

a disclosing agent. The absence of red colored areas on the teeth indicates that all gross debris and calculus have been removed. Extrinsic stains are assessed by instrumentation using mouth mirror, sharp explorer and adequate light.

Justification for criteria #2-#5:

The complete dental prophylaxis must be done carefully and diligently, making sure that all factors which in any way may cause gingival injury or irritation are eliminated.[15]

STANDARD: A standard of 80 percent is suggested arbitrarily. This means that at least 80 percent of the prophylaxis provided during the evaluation visit were satisfactory.

H. TOPICAL FLUORIDE

1. Criterion #1: Dry field is maintained during application of fluoride.

2. Criterion #2: Approved agent is applied to teeth for at least four minutes.

   a. Method to assess criteria #1-#2:

   Observe the technique and agent used by the dental assistant and assess the time element of the fluoride application.

   Justification for criteria #1-#2:

   An approved technique and agent(acidulated phosphate fluoride gel) is used.

STANDARD: A standard of 80 percent is suggested arbitrarily. This means that at least 80 percent of the topical fluoride applications during the evaluation visit were satisfactory.

I. EXTRACTION(S)

1. Criterion #1: Pre-extraction radiograph(s) taken.

   a. Method to assess criterion:

   Observe that pre-extraction radiograph(s) exist(s).

   Justification for criterion:

   The radiograph "is an indispensable aid in arriving at a correct diagnosis. It frequently reveals pathological processes that are not apparent on clinical examination. It reveals operative complications, localized impacted teeth or foreign bodies, and shows the relation of teeth to other vital structures."[16]

2. Criterion #2: Each tooth is removed completely, unless contraindicated.

   a. Method to assess criterion:

      Inspect the remnants of the extracted tooth to make certain that tooth removal is complete.

      Note: Contraindication applies when it is considered that removal of the tooth remnant may cause serious injury to other vital anatomical structures.

      Justification for criterion:

      "Occasionally a fractured root apex may be so located that any attempt to remove it will result in undesirable complications." 17

      An exception to the general rule of removing all roots is the very small root tip located near anatomical structures into which the fragment may inadvertently be forced when removal is attempted. 18

STANDARD: A standard of 90 percent is suggested arbitrarily. This means that at least 90 percent of all extractions provided during the evaluation visit were performed satisfactorily.

J. SURGICAL PROCEDURES

1. Criterion #1: Occlusal portion of flap design to extend at least one tooth adjacent to the interdental papilla both mesially and distally from the tooth to be extracted. (Exception to this would be the most distal tooth in the arch, if it is to be extracted.)

2. Criterion #2: Vertical incisions extend obliquely so that base of flap is wider than its margin.

   a. Method to assess criteria #1-#2:

      Inspect the surgical flap site to ascertain if prescribed principles of flap design have been adhered to.

      Justification for criteria #1-#2:

      The vertical incision "should...extend obliquely so as to make the base of the flap wider than its margin.

      The base of the flap should be wide and contain efferent blood vessels to insure its nutrition.

      If the incision has no bony support, it is likely to break down and cause a permanent defect." 19

      "The incision should always be made over bone that will not be removed, so that the sutured incisions are supported by bone." 20

3. Criterion #3: The tissue of the retracted flap is not mutilated or torn.

    a. Method to assess criterion:

    Observe the surgical flap procedure on patients present in the clinic receiving this service, or observe the flap design of revisit patients who received this service and are present in the clinic for post-op follow-up suture removal.

    Justification for criterion:

    "Make certain in planning and preparation of your flap that the operative site is adequately exposed. Not only is the oral surgeon handicapped by being confined to a small space, but the flap is usually severely traumatized by efforts to retract it, or the edges are traumatized by instrumentation. Such flaps do not heal by first intention and are a source of pain." 21

    "...flaps are apt to be torn when they are retracted further than the incision allows." 19

4. Criterion #4: All pathologic tissue found is removed.

5. Criterion #5: Alveolar margin is smoothed and displaced fragments of the alveolus and foreign particles are removed.

    a. Method to assess criteria #4-#5:

    On patients present in the clinic receiving this service, the examiner assesses these criteria by appropriate instrumentation and palpation, including a postoperative radiograph of the operative site when deemed necessary. On patients present in the clinic for postoperative follow-up or suture removal, the examiner assesses these criteria by palpation of the operative site and by postoperative radiograph, if the latter does not cause unwarranted discomfort to the patient.

    Justification for criteria #4-#5:

    "All pathologic tissue found should be removed at this time,...the pathologic tissue should be carefully detached from the adjacent bone; the latter should not be injured by the curette as this might cause the infection to spread.

    Sharp edges or projecting spicules of bone...should be made smooth. The checking of the part of the jaw... by a postoperative x-ray is advisable at this time. It will disclose...whether particles...or any foreign body such as filling material have been left in the socket." 22

6. Criterion #6: Soft tissue flap is repositioned into anatomical position and maintained there with sutures or gauze pressure pack.

   a. Method to assess criterion:

      Inspect the surgical flap site to make certain the soft tissue is repositioned appropriately over alveolar bone without excessive tension which might cause visible blanching of the soft tissue, indicating a compromise of the blood supply to the flap and a decrease of oxygenation of the soft tissue.

      Justification for criterion:

      Sutures approximating tissues too tightly may tear out with an increase in postoperative edema, and/or lead to necrosis of soft tissue.

STANDARD: A standard of 80 percent has been suggested arbitrarily. This means that at least 80 percent of the surgical procedures were performed satisfactorily.

K. RESTORATIONS

1. Criterion #1: Caries removal adequate.

2. Criterion #2: Contour simulates normal anatomy.

3. Criterion #3: Smooth marginal adaptation.

4. Criterion #4: Extension for prevention present.

5. Criterion #5: Contact is present.

6. Criterion #6: Gingival overhang is absent.

7. Criterion #7: Restoration not in supra occlusion.

8. Criterion #8: Shade matches restored tooth (esthetic restorations).

   a. Methods to assess criteria #1-#8:

      Assess each restoration placed by the dental staff for each criterion as follows:

      1) Caries removal adequate - Examine by sight the glossy appearance of the exposed dentin, and by explorer, determine that the dentin cannot be penetrated at the Dentino Enamel Junction of the cavity preparation.

      2) Contour - Determine whether the contour of the amalgam

restoration simulates the normal anatomy of that restored tooth, paying particular attention to the physiological function of that tooth - assessing in your own mind that the forces of mastication will deflect food away from the gingival tissues and interproximal areas, thus avoiding tissue injury and food impaction.

3) Smooth marginal adaptation - Utilize the explorer and determine by instrumentation whether smooth marginal adaptation of the filling material is secured at the junction of the cavity outline and the surface of the tooth.

4) Extension for prevention - Determine that extension for prevention is adequate if major developmental grooves and pits are included in the cavity outline and if the margin is accessible for polishing and that cleansing of the margins can be secured by tooth brushing.

5) Contact - Utilize dental floss and determine that adequate contact is present if the dental floss passes through the contact area with firm resistance.

Note: Contact is not applicable in all instances - e.g., proximal tooth or missing tooth, and occasionally there are wide interproximal embrasures between teeth so that contact cannot be established if normal tooth form is restored.

6) Gingival overhang - Utilize the explorer and determine by instrumentation whether smooth marginal adaptation of the filling material is secured at the junction of the gingival seat of the cavity preparation and the surface of the tooth. A radiograph taken at a 90° angle to the area in question may assist in assessing the criterion when the results of the instrumentation evaluation is questionable.

7) Restoration not in supra-occlusion - Utilize articulating paper to disclose high spots or surplus amalgam. Question the patient - "Does the filling feel comfortable and even when you bring all of your teeth together?" Also inspect the restoration for "shiny" areas that may detect high spots or surplus amalgam.

Note: This criterion does not apply in all instances, e.g., missing opposing tooth or teeth partially erupted not in occlusion, and teeth malaligned to teeth of the opposing arch.

8) Shade matches restored tooth - The trained eye of the examiner is more critical than that of the usual patient. Therefore, the shade is acceptable if it is in harmony with the natural tooth structure to the satisfaction of the examiner. Criterion #8 applies to esthetic restorations only.

Justification for criteria #1-#8:

The main objects to be attained in the restoration procedure (amalgam restoration, synthetic restoration, stainless steel crown, or other material) are: Arrest of the loss of tooth substance from caries and other causes, prevention of recurrence of caries, restoration or maintenance of normal interproximal spaces and contact points, establishment of proper occlusion, esthetic over-all effect, and resistance against the stresses of mastication. 23

STANDARD: A standard of 90 percent is suggested arbitrarily. This means that at least 90 percent of the restorations examined were found to be satisfactory.

L. ENDODONTICS

1. Criterion #1: Findings confirming the diagnosis are recorded on the patient's dental record and include a preoperative radiograph.

   a. Method to assess criterion:

   Observe the patient's dental record and determine whether documentation for the diagnosis is recorded, including the availability of a preoperative radiograph. (History, clinical symptoms and possible pulp test results are noted in remarks section of patient's dental record or progress notes of patient's medical record.)

   Justification of criterion:

   Recording diagnostic data is necessary to support the diagnosis and subsequent treatment rendered and provides information for future quality review and possible legal proceedings. 24

2. Criterion #2: Removal of tooth structure is minimal, but provides adequate access to pulp chamber and root canals.

   a. Method to assess criterion:

   Observe the routine postoperative radiograph and determine that the endodontic fillings materials conform to the original size and shape of the pulp chamber and root canal.

Justification for criterion:

Overextension of the access preparation unnecessarily weakens the crown of the tooth. Underextended access precludes complete debridement and obturation of the pulp chamber and root canal. 25

3. Criterion #3: Root canal(s) is(are) obturated with filling material laterally and apically within 2mm of the apical foramen and not beyond. The primary filling material in permanent teeth is to be non-resorbable and non-staining sealer is to be used.

   a. Method to assess criterion:

   Observe the routine preoperative and postoperative radiographs and determine the adequacy of the obturation with a solid core primary filling material.

   Note: Observe the clinic supply for non-staining sealer availability.

   Justification for criterion:

   Failure to obturate the canal laterally increases the failure rate. The highest degree of success is achieved by filling to, but not beyond the apical foramen and success is not reduced measurably when the filling material is as much as 2mm short of the apical foramen. Resorption of resorbable pastes from the canal breaks the seal and allows percolation. Silver containing root canal cements often permeate deeply into the dentin and indelibly stain the tooth. 26, 27, 28

4. Criterion #4: Esthetic restorative material is used on all lingual access preparations.

5. Criterion #5: Cusp protecting restoration is used on posterior permanent teeth when no marginal ridge is intact.

6. Criterion #6: All endodontically treated decidous molars are restored with stainless steel crowns.

   a. Method to assess criteria #4-#6:

   Observe restored teeth either clinically or radiographically.

   Justification for criterion #4:

   Esthetic restorative materials help to prevent discoloration and reduction to translucency.

Justification for criteria #5-#6:

The high incidence of vertical fracture following endodontic therapy requires that the cusps be protected on permanent molars and premolars, including all decidous molars. 29

7. Criterion #7: A rubber dam is placed or other precaution is taken to absolutely prevent the accidental aspiration or swallowing of root canal instruments.

   a. Method to assess criterion:

   Observe endodontic procedures and ascertain that no possibility exists for aspiration or swallowing of root canal instruments.

   Justification for criterion:

   A serious complication of clinical dentistry is the aspiration or swallowing of instruments used in the oral cavity. Root canal instruments are especially hazardous.

   "In the eyes of the court, when an endodontic instrument escapes from the dentist's fingers and is ingested or aspirated, expert opinion is unnecessary to justify claims of negligence." 30

STANDARD: A standard of 80 percent is suggested arbtrarily. This means that at least 80 percent of the endodontic services examined during the evaluation visit must be found to be satisfactory.

M. CROWNS (All Types)

1. Criterion #1: Smooth marginal adaptation.

2. Criterion #2: Crown not in supra occlusion.

3. Criterion #3: Contact is present.

   a. Method to assess criteria #1-#3:

      1) Smooth marginal adaptation - Inspect the margins of the crown to determine if the marginal adaptation is acceptable. The marginal adaptation of the crown should be considered unacceptable if gingival irritation or blanching of the tissues is being caused by the crown or if the smaller end of the #17 explorer can be inserted between the inner surface of the crown and the immediate tooth surface.

      2) Crown not in supra occlusion - Utilize articulating paper to identify high spots.

3) <u>Contact</u> - Utilize dental floss and determine that adequate contact is present if the dental floss passes through the contact area with firm resistance.

<u>Note</u>: Criterion #3 is not applicable in all instances, e.g., proximal tooth or teeth missing, wide interproximal embrasures are present between teeth whereby contact cannot be established when normal tooth form is restored.

<u>Justification for criteria #1-#3</u>:

Same as listed under "K. - RESTORATIONS."

4. <u>Criterion #4</u>: Crown contour is physiologic.

a. <u>Method to assess criterion</u>:

Inspect the external contours of its cross arch analog of a natural tooth. If the mate is not present or grossly restored, utilize the contours of the tooth most nearly representative of the test tooth. Compare with the aid of mouth mirror:

a) buccogingival contour
b) linguogingival contour
c) marginal ridge contour
d) embrasure spaces
e) total buccolingual width

The crown and its comparison mate should be viewed from one angle and the silhouette should conform. This is done from the right side, front, left side, lingual, and incisal/occlusal. If there exists any lack of conformity in contour, the crown is unacceptable.

<u>Justification for criterion</u>:

Three components of any restoration - form, surface characteristic, and color - are complementary to achieving an esthetic and functional result. Their importance to the success and acceptance of a crown lies approximately in the order stated. Although occassionally an increase or diminution in over-all size of the tooth is mandatory, the basic curves and angles present in the outline form should remain the same for physiologic acceptance in the oral cavity. 31

5. <u>Criterion #5:</u> Porcelain or resin shade blends favorably with remaining dentition.

a. <u>Method to assess criterion</u>:

Under natural light, inspect the crown with its cross arch analog using a Trubyte Bioform 24 button shade

guide. If the mate is not present or is not a natural tooth, compare shades to the adjacent natural or opposing blend within one button left or right of the matching button.

Justification for criterion:

"The aim is to select and reproduce a shade that blends with the natural teeth." 32

STANDARD: A standard of 70 percent is suggested arbitrarily. This means that at least 70 percent of the crowns examined were found to be satisfactory.

N. FIXED PROSTHODONTICS

1. Criterion #1: Crowns meet the criteria listed under "M-CROWNS (All Types)."

   a. Method to assess criterion:

   Refer to item "M-CROWNS (All Types)" of this document and apply the stated criteria and respective methods to be used for assessing whether the criteria are met.

2. Criterion #2: Pontic(s) meet (s) the principles of form and tissue adaption.

   a. Method to assess criterion:

   Observe the form of the pontic(s) approximate(s) two-thirds of the normal width of the replaced teeth.

   1) Facio-lingual width of the pontic(s) two-thirds of the normal width of the replaced teeth.

   2) Facial contour of the pontic(s) approximate(s) the normal contour of the replaced teeth.

   3) Gingival contour, approximating the alveolar process and mucosa is(are) convex enabling self-cleansing capability. Consider concave pontics as unacceptable. Thread dental floss thru the embrasure and pass the floss mesio-distally between the apex of the pontic and the mucosa of the alveolar process. To be considered acceptable, the floss should pass freely without impingement or bleeding of involved tissues.

   Justification for criterion:

   Mastication efficiency is restored to an acceptable level when the facio-lingual width of pontics approximates two-thirds of the normal width of the replaced teeth. In addition, the form of the pontics should facilitate the escape and/or mechanical removal of food, and should not

subject the alveolar process and mucosa to the disintegrating forces of mastication. 33

3. Criterion #3: Solder joints meet principles of adequate strength.

   a. Method to assess criterion:

      Use mouth mirror and/or direct observation and apply following principles for determining adequate strength:

      1) The facio-lingual size of the solder joint should be about one-half of the facio-lingual width of the existing pontics, and

      2) the occlusal gingival size of the solder joint should be about one-half of the distances from the occlusal (incisal) edge of the pontic to its gingival base.

      Justification for criterion:

      The solder joints must be of adequate size to prevent fracture of flexing of the prosthesis which ultimately results in failure.

4. Criterion #4: Esthetics are acceptable.

   a. Method to assess criterion:

      Question the patient: "Are you satisfied with the appearance of the bridge?" Determine in your own mind whether the existing porcelain or resin surfaces of the pontics and crowns are in harmony with the remaining natural teeth.

      Justification for criterion:

      An acceptable esthetic appearance is essential for encouraging patient acceptance and personal oral hygiene maintenance of the appliance.

5. Criterion #5: Occlusal functions are acceptable.

   a. Method to assess criterion:

      Use articulating paper to assess premature contacts in centric and eccentric relations. Also, observe whether there are heavy sear facets (or shiny areas) on any occluding surface of the bridge by using mouth mirror and/or direct observation. Question the patient: "Does the bridge give you any discomfort or pain when you eat?"

Justification for criterion:

Poor occlusion encourages unwarranted bone resorption, pain and discomfort of T.M.J. and will likely discourage patient acceptance. 34

STANDARD: A standard of 70 percent is suggested arbitrarily. This means that at least 70 percent of the examined fixed prostheses met all of the applied criteria.

O. REMOVABLE PROSTHODONTICS

1. Criterion #1: Esthetic appearance is acceptable to patient and examiner.

   a. Method to assess criterion:

   Ask patient if they are satisfied with the appearance of their teeth/smile. In your opinion, visually consider adequacy of shade, contour, shape (square, taper, ovoid, etc.), width and length of teeth.

   Justification for criterion:

   An acceptable esthetic appearance is essential for encouraging patient acceptance. 35

2. Criterion #2: Stability is acceptable.

   a. Method to assess criterion:

      1) Full denture test: Place your forefinger on incisal edge of either maxillary or mandibular denture with sufficient force to blanch your finger. If denture becomes dislodged, it is considered to be unstable.

      2) Partial denture test: Place your forefinger on any segment of partial denture framework and press firmly. If partial denture becomes dislodged or tips, it is considered to be unstable.

   Justification for criterion:

   Stability is essential to achieve retention. A lack of stability encourages tooth destruction, bone loss, mucosal injury and discourages patient acceptance of appliance(s). 36

3. Criterion #3: Flange of prosthetic appliance adapts with the soft tissue borders of oral cavity.

   a. Method to assess criterion:

   Gently retract lip to a minimum degree that will allow you to observe whether flange of prosthetic appliance approximates the soft tissue borders.

Justification for criterion:

Overextensions of flange encourages unwarranted tissue inflammation and discourages appliance retention. Underextension encourages food impaction in flange area and also discourages appliance retention. Either over or underextension will discourage patient acceptance. 37

4. Criterion #4: Occlusion is acceptable.

   a. Method to assess criterion:

      1) Check centric relation: Close patient's jaw into centric relation by placing your thumb on patient's point of chin and gently direct mandible to the most posterior position, with patient closing slowly at same time. Then, note whether simultaneous bilateral contact of the teeth occurs. If not, then occlusion is considered to be inadequate.

         Note: For all tooth borne removable partial dentures, the point of reference is centric occlusion (functional occlusion).

      2) Check eccentric relation: Place articulating paper between teeth bilaterally, ask patient to close and move jaw in all directions. Remove appliance(s) and observe whether premature contacts or lack of contact exists on any teeth from cuspid posteriorly. If so, eccentric relation is considered inadequate.

      3) Check occluding material: Determine if unglazed porcelain occlusal or incisal surfaces are contacting enamel, gold, alloy or composite resin. If so, rapid wear of softer occluding surface will occur and occlusion must be considered unacceptable.

Justification for criterion:

Poor occlusion encourages unwarranted bone resorption, tissue damage and lack of stability during the mastication process and may discourage patient acceptance of the prosthesis. 38

Unglazed porcelains are rapidly destroyed by abrasive action and may cause unfavorable anatomic damage in the opposing natural teeth,...disturbances in interproximal contact relationships, pulpitis, pulp or clinical crown exposure... unsightly reduction in the length of the tooth, etc. 39

5. Criterion #5: Vertical dimension and anterior tooth arrangement acceptable.

a. Method to assess criterion:

1) Check "S" sounds: Ask patient to say key words, such as Mississippi, sixty-six, whiskey, seventy-seven. When making "S" sounds, teeth should not contact. If so, appliance(s) is (are) considered inadequate.

2) Check "F" and "V" sounds: Ask patient to say key words, such as forty-four, fine food, vim and vigor, Vivian. When making "F" and "V" sounds, the incisal edges of #8 and #9 teeth should contact the wet-dry line of lower lip.

Justification for criterion:

The inability of a patient to enunciate words adequately will discourage patient acceptance of appliance(s) and suggests unacceptable vertical dimension and/or placement (arrangement of anterior teeth). 38

6. Criterion #6: All cardinal rules of partial denture construction are met.

a. Method to assess criterion:

Refer to "Justification" immediately following and review the stated "cardinal rules" and then apply the following methods for determining whether they are met.

1) Rest seats (depth): Request patient to remove partial denture. Place utility wax in patient's mouth and have patient close to centric occlusion. Remove wax and insert periodontal probe through wax in central area of identified rest seats until point of probe is exposed evenly with wax surface of opposite side. Refer to 3mm. mark on probe and determine visually whether wax in rest seat area is 1 to 1 1/2 mm. thick.

2) Rest seats (width): Observe whether rest seats approximate one-third width of tooth, and is positioned at a 90° angle to long axis of abutment tooth.

3) Partial denture base: Inspect removed partial and determine whether base material covers all framework in bone supporting areas. Request patient to replace partial in mouth and then use mouth mirror to observe whether retromolar pad(s) or tuberosity(ies) are completely covered without impingement of soft tissues in flange areas.

4) Arms of clasps in undercut zones: Attempt to dislodge partial from each abutment tooth by placing finger under retentive clasp and applying firm force occlusally. If there is no resistance to the force, then retention is considered inadequate.

5. Guiding planes: Place mouth mirror in lingual relationship to abutment teeth and visually determine whether all guiding planes of abutment teeth are parallel to one another.

Justification for criterion:

Prepared rest seats should be 1 to 1 1/2 mm. in depth and must approximate one-third width of tooth to achieve adequate strength of body of clasp. Base material should cover all framework of bone supporting areas to alleviate unwarranted tissue inflammation and must cover retromolar pad(s) or tuberosity(ies) to achieve acceptable stability and/or support of partial.

Retentive portion of arms of clasps should be undercut zones of abutment teeth to achieve adequate retention of partial. Guiding planes should be parallel to path of insertion of partial to achieve ease of its placement without undue force exerted mesially or distally on abutment teeth. 40

A clasp retained prosthesis can contribute much to oral health provided the mouth is correctly prepared for its retention and support and for positioning its parts. Otherwise, it can be an instrument of destruction. 41

STANDARD: A standard of 80 percent is suggested arbitrarily. This means that at least 80 percent of the examined removable prosthetic appliances met all applied criteria.

P. PERIODONTICS

1. Criterion #1: Detection of periodontal disease case pattern in each sextant has been recorded and treatment plans have been noted acceptably on the patient service record.

   a. Method to assess criterion:

   Observe patient service record and examine patient to determine if criterion meets standards set forth in instructions for record completion.

2. Criterion #2: Periodontal pocket debridement is acceptable.

   a. Method to assess criterion:

   Observe the patient immediately following the procedure to determine if the contents of the pocket have been debrided and that irregularities and roughness of the root surface adjacent to the pocket have been removed and smoothed.

3. Criterion #3: Periodontal evaluation is acceptable.

   a. Method to assess criterion:

      (1) After preventive care and before corrective care, complete periodontal evaluation should be accomplished to ascertain all contributing etiologic factors leading to treatment plan. (2) Observe Dental Progress Notes to determine if proper documentation has been performed leading to the treatment plan.

4. Criterion #4: Subgingival curettage is acceptable.

   a. Method to assess criterion:

      Observe the patient immediately following the procedure to determine if the soft tissue comprising the sulcus wall is surgically removed, including any residual calculus, granulation tissue or debris.

      Observe the patient postoperatively and determine decrease in pocket depth through gingival shrinkage by use of a calibrated periodontal probe.

5. Criterion #5: Periodontal surgery has been effective.

   a. Method to assess criterion:

      Observe the patient postoperatively to determine that: periodontal pockets have been eliminated by removing the soft tissue well and/or apically replacing the flap; the gingivae has been contoured to a morphologic and physiologic form; deformities in the alveolar bone have been corrected to a physiologic form. Probe all sulcular areas with a calibrated periodontal probe to determine whether sulcus depths have been reduced.

      In the assessment, compare the pre-treatment dental record findings with the post-treatment results.

6. Criterion #6: Mucogingival surgery has been effective.

   a. Method to assess criterion:

      Observe the patient postoperatively to determine that: an increased zone of attached gingivae has been attained; undesirable muscle pull on the marginal gingivae has been dissipated; and/or the vestibular fornix has been deepened to allow for maintenance of health of the periodontium.

      In the assessment, compare the pre-treatment dental record findings with the post-treatment results.

Justification for criteria #1-#5:

Recognition of overt periodontal conditions and elimination of periodontal pockets and gingival inflammation are of equal importance to the success of periodontal therapy and are a measure of the efficacy of treatment provided. 42

STANDARD: A standard of 80 percent is suggested arbitrarily. This means that at least 80 percent of the examined periodontal services met all applied criteria.

Q. TREATMENT SERVICES

1. Criterion #1: Complete oral examination rendered on first routine or emergency visit in fiscal year, except where the patient's physical condition does not allow.

   a. Method to assess criterion:

      Examine patient dental records to assess whether a complete oral examination was rendered on the first visit to the clinic.

      Justification for criterion:

      Every patient shall have an examination during his first visit each fiscal year. 3

2. Criterion #2: Patient treatment begun within 30 days following examination. (Depends on individual institution's constraints).

   a. Method to assess criterion:

      Refer to either revisit patient dental records selected from the file of patients treated during the current fiscal year, or records of patients present in the clinic during the evaluation visit.

      Justification for criterion:
      "Examinations should be provided as close as possible to the time when treatment is expected to be given." 43 This will depend, however, on individual institutional constraints.

3. Criterion #3: Instructions concerning restorative care are given to patient postoperatively.

   a. Method to assess criterion:

      Observe whether instructions concerning restorative care are given to the patient by the attending dentist or his dental auxiliary prior to dismissal of the patient.

Note: Criterion #3 does not apply in all instances, e.g., treatment that is provided to patients present in the clinic may not have included operative services, only an oral examination.

Justification for criterion:

To avoid mishap to provided services, to promote the best possible use of the correctional dental health service, and in respect for the patient's interest in himself, it is practical to provide postoperative instructions.

4. Criterion #4: Oral and written instructions concerning postoperative care of surgical or extraction services are given to patient postoperatively.

   a. Method to assess criterion:

   Observe whether oral and written instructions concerning postoperative care of surgical and extraction services are given to the patient before his dismissal.

   Justification for criterion:

   Written instructions in simple and brief terms should be given to and discussed with the patient. Information should include diet, control of pain and bleeding, and a contact if help is needed. 44

5. Criterion #5: Treatment provided in minimum number of visits.

   a. Method to assess criterion:

   Select current fiscal year dental records from the file for review and determine if quadrant restorative dentistry is being practiced. For patients present in clinic during the evaluation visit, observe whether quadrant dentistry is being provided.

   Justification for criterion:

   "Quadrant treatment or more should be attempted on as many persons as possible. Multiple short visits are commonly a hardship on patient's custody and schooling, as well as making the schedule vulnerable to and leads to higher patient failure rates, and are an inefficient use of clinic time." 43

6. Criterion #6: Patient's medical record or patient history questionnaire is reviewed prior to rendering service at each visit.

   a. Method to assess criterion:

      Observe that the attending dentist or auxiliary reviews the patient's medical record or the patient history questionnaire before treatment procedures are begun.

      Note: This criterion does not apply in instances when neither the patient's medical record nor patient history are available for review. The examiner is to take appropriate administrative action to determine if - in fact - neither the patient's medical record nor the patient history questionnaire are available at the evaluation site.

      Justification for criterion:

      "It is the responsibility of a dental officer starting treatment on a patient to know the general medical condition of the patient, and to be aware of any and all precautionary measures necessary for the management of the case. Information necessary to meet this responsibility may be found in the patient's medical record." 8

R. ENVIRONMENT

1. Criterion #1: Hand instruments are cleaned and sterilized effectively.

   a. Method to assess criterion:

      1) Observe whether hand instruments are free from visible debris prior to their use.

      2) Observe whether dental handpiece is cleansed with 70 percent isopropyl alcohol saturated gauze pad after each patient use.

      3) Observe whether autoclave is operated by staff in accordance with respective instructions.

      4) Determine whether autoclave is functioning effectively by placing a "Chieftain Indicator" in the middle of a prepared "test pack". Then, autoclave the 'test pack". Upon completion of the autoclaving cycle, remove the "test pack", open it and observe whether the purple spot of the "Chieftain Indicator" has turned green. If so, then consider that the autoclaved instruments are sterile.

Note: The "Chieftain Indicator" may be purchased from American Hospital Supply, Catalog #26295.

Justification for criterion:

Instruments should be cleansed thoroughly "...since the presence of dried blood, tissue or other material may present a barrier to the steam." 45

"Sterilization indicators may be used to check on the sterilizing efficiency of an autoclave." 45

2. Criterion #2: All housekeeping activities have been performed before clinical day begins.

   a. Method to assess criterion:

   Observe the cleanliness and neatness of all areas of the dental clinic. If observation in the morning is not possible, then question the dental staff in accordance with the acceptability of the housekeeping activities being provided. Suggested activities to be considered are cleanliness of floors, walls, furniture, cabinetry, dental chairs, dental units, wastebaskets, etc.

   Note: The neatness and cleanliness of all working counter top areas are considered to be a function of the dental auxiliary staff in order to avoid misplacement or disposal of dental supply items or materials relevant to patient treatment procedures. Otherwise, such supplies and/or materials may be disposed of accidentally by non-dental housekeeping personnel.

   Justification for criterion:

   The appearance of the suite of rooms that comprise the modern dental office is often held as the criterion of the type of professional treatment which the patient may expect. 46

3. Criterion #3: Dental staff are well groomed and clothes are clean and not unduly wrinkled.

   a. Method to assess criterion:

   Observe whether clothes of staff are clean and not unduly wrinkled, hair combed and neat.

   Justification for criterion:

   Obviously, the appearance of the staff is an essential factor in any health care delivery system.

4. Criterion #4: Cleanliness of hands before treating patients is acceptable.

   a. Method to assess criterion:

   Observe whether finger nails are trimmed and clean and that the dental staff wash their hands with soap and water before treating each patient. Also, observe whether areas of their hands exhibiting an open sore or wound are covered appropriately by a finger cot or other means of protection.

   Justification for criterion"

   Obviously, personal cleanliness is important, including the care of the hands, since the instruments and supplies handled by dental personnel will be used in the patient's mouth.

5. Criterion #5: The current copy of the IHS Guidelines for Mercury Hygiene or other appropriate mercury hygiene guide is on file, and has been reviewed and/or studied by all dental staff within the current fiscal year.

   a. Method to assess criterion:

   The dentist will show the examiner a copy of the Guidelines, as well as an attached page which contains signatures and dates of all dental staff indicating that they have reviewed the Guidelines.

   Justification for criterion:

   "Alert all personnel involved in handling mercury, especially during training or indoctrination periods, of the potential hazard of mercury vapor and the necessity for observing good mercury hygiene practices." 47

6. Criterion #6: The possibilities of mercury toxicity are minimized by the dental staff through the practice of good mercury hygiene.

   a. Method to assess criterion:

   Observe operations involving mercury transfer and determine whether the work surface is smooth, impervious, and suitably lipped to confine spilled mercury, and whether the floor covering is smooth and seamless.

   Spilled mercury is cleaned up immediately. Mercury falling into cracks and crevices on counter tops, equipment, etc., is coated with a suitable sulfur powder to inhibit vaporization, and thoroughly wiped from such crevices.

Observe that mercury is stored in a tightly sealed container, and is not stored near a heat surface.

Justification for criterion:

"Careless handling of mercury in the preparation of amalgam is usually the most important factor in contaminated dental offices." 48

"Occasional spills will occur, and mercury will accumulate in the deep recesses of the rugs and become continuous sources of mercury vapor." 48

"Mercury spills should be promptly cleaned up, either chemically, mechanically, or through a combination of both. Chemical dissolution is accomplished by use of either a chemical mercury solvent (liquid) or "flour of sulfur." The agent should be worked into the crevice as deeply as possible, then wiped out." 49

"Droplets that cannot be reached without causing an intolerable upheaval can be dusted with sulfur powder or covered with a water slurry of sulfur and calcium oxide. The sulfide layer will prevent vaporization as long as the droplets are not agitated." 50

"Store mercury in unbreakable, tightly sealed container. Avoid heating mercury or amalgam." 47

7. Criterion #7: Concentrations of mercury vapors in the environment should be below the threshold limit value (TLV) of 0.05 mg. $Hg/m^3$.

   a. Method to assess criterion:

   Ask to see a copy of the current year certification by environmental health services personnel and determine that the dental clinic vapor level was below 0.05 mg. $Hg/m^3$.

   Justification for criterion:

   "Air concentrations should be controlled so the employees are not exposed to mercury vapor levels greater than 0.05 mg. $Hg/m^3$, determined as a time-weighted average exposure for an eight-hour day." 49

STANDARD: A standard of 100 percent is suggested arbitrarily. This means that all stated criteria relevant to environment are met at the evaluation site.

S. RADIOLOGICAL PROTECTION

1. Criterion #1: Lead apron used on each patient during all exposures.

a. Method to assess criterion:

Observe directly whether the lead apron is used appropriately.

Justification for criterion:

"...the gonads shall be protected from the useful beam by the use of ..., special gonadal shields..." 51

2. Criterion #2: Lead aprons are stored correctly.

a. Method to assess criterion:

Observe directly whether lead aprons are hung properly without wrinkles.

Justification for criterion:

Aprons should not be folded because folding may result in cracking, thus diminishing the protective value." 52

3. Criterion #3: Tube head cone or cylinder positioned to just contact skin of patient and is stationary when exposure is made.

a. Method to assess criterion:

Observe directly whether tube head is touching patient before exposure is made. Also, observe processed radiographs for evidence of blurred image.

Justification for criterion:

"The operator should make sure the tube is not in motion while the exposure is being made." 53

4. Criterion #4: X-ray film not held in position during exposure by attending staff.

a. Method to assess criterion:

Observe directly whether attending dental staff is holding film in place during exposure.

Justification for criterion:

"In no case shall the film be held by the dentist or his assistant during exposure." 54

5. Criterion #5: Tube housing or cone not held during exposure by attending staff or patient.

a. Method to assess criterion:

Observe directly whether attending staff or patient is holding the tube or housing during exposure.

Justification for criterion:

"Neither the tube housing nor the pointer cone shall be handled during exposures." 54

6. Criterion #6: Operator is at least six feet from patient.

7. Criterion #7: Operator not in path of useful beam.

8. Criterion #8: Operator stands behind protective barrier during exposure.

a. Method to assess criteria #6-#8:

Observe directly the distance and location of the operator when the x-ray machine is activated.

Justification for criteria #6-#8:

"During each exposure, the operator shall stand at least six feet from the patient behind a protective barrier or at a designated location where survey measurements indicate radiation exposure is negligible." 54

9. Criterion #9: Only necessary persons allowed in radiographic area during exposure.

a. Method to assess criterion:

Observe directly whether unnecessary persons are in the x-ray area during exposure.

Justification for criterion:

"Only the person required for the x-ray procedure shall be permitted in the x-ray area during an exposure." 55

10. Criterion #10: Dosimeters worn by all dental personnel.

a. Method to assess criterion:

Observe directly whether dosimeter is worn by each dental staff member.

Justification for criterion:

"Personnel monitoring shall be performed for occupationally exposed person in controlled areas for each

individual for whom there is a reasonable possibility of receiving a dose exceeding one-fourth of the applicable MPD (Maximum Permissible Dosage)." 56

STANDARD: A standard of 100 percent is suggested arbitrarily. This means that all criteria of radiological protection were met.

## T. EMERGENCY CARE

1. Criterion #1: Basic emergency diagnostic and treatment equipment must be available in cases of life threatening episodes.

   a. Method to assess criterion:

   Observe that any member of the dental staff can promptly locate and bring to chairside the following equipment:

   1. Sphygmomanometer
   2. Stethescope
   3. Ambu-bag or oxygen tank with mask and bag
   4. Oral pharyngeal airways (adults & child size)
   5. Emergency Drug Kit

2. Criterion #2: The Emergency Drug Kit is adequately supplied.

   a. Method to assess criterion:

   Inspect the Emergency Drug Kit and assure that the following drugs and supplies are included as a minimum:

   DRUGS
   ammonia ampules (6)
   amyl nitrate ampules (6)
   nitro glycerine tablets 1/150 gr. (6)
   epinephrine (aqueous) 1:1000 in 1 ml.
   tubex ampules (6)
   benadryl (25-50mg) in tubex ampules (6)
   meperidine (demerol) 50 mg. in tubex ampules (2)
   vasoxyl, 5 mg. ampule (2)
   dexamethasone (decadron) 5 ml. vial (2)
   solu-cortef 100 mg. vial (2)
   pentobarbital (nembutal) 50 cc multiple dose vial
   diazepam (valium) 2 cc ampules (4)
   1000 cc $D_5W$ or $D_5W$ and Ringer's lactate

   SUPPLIES
   Molt mouth prop or taped stick of 9-10 wooden tongue depressors for use as a mouth prop.
   rubber tourniquet
   tubex syringes (2)
   alcohol sponges
   5 cc disposable syringe, sterile (2)
   22 gauge x 1" needles, sterile (2)
   25 gauge x 5/8" needles, sterile (2)
   13 gauge x 1" needles, sterile (2)
   intravenous infusion set
   1/2" adhesive tape

Justification for criteria #1-#2:

"A minimum amount of equipment and relatively few drugs are needed. The criterion of adequate treatment demands the doctor have a working knowledge of the drugs and equipment. This presupposes that the auxiliary office personnel have been trained and that all involved are able to instantly lay hands on the necessary drugs and equipment. The finest resuscitator or most potent drugs are worthless in unfamiliar hands. Precious minutes may be wasted because the equipment and drugs are not readily available or have been dispensed in such an inconvenient package as to render their immediate use impossible." 2

STANDARD: A standard of 100 percent is suggested arbitrarily. This means that all criteria of Emergency Care were satisfactory.

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# APPENDICES

APPENDIX A: SAMPLE DENTAL CLINIC POLICIES AND PROCEDURES MANUALS

1. Sample Manual
2. Sample Manual (William J. Byland, D.D.S.)

APPENDIX B: SAMPLE INSTITUTIONAL POLICY STATEMENT CONCERNING DENTAL HEALTH SERVICES FOR INMATES

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APPENDIX I: LIST OF SUGGESTED TEXTBOOKS FOR DENTAL REFERENCE LIBRARY

APPENDIX J: LIST OF RECOMMENDED PROFESSIONAL JOURNALS AND PERIODICALS

# APPENDIX A: SAMPLE DENTAL CLINIC POLICIES AND PROCEDURES MANUALS

1. The following policies and procedures manual is an adaptation of the one used by the dental department at a medium-sized, federal maximum-security facility which also maintained a large number of U.S. Marshall's prisoners awaiting trial.

This sample manual is provided to illustrate the types of activities for which written policies and procedures are needed, and to give examples of the content and wording of these policies and procedures. This manual is offered neither as an ideal model nor as an exhaustive list of all possible policies and procedures, and should not be adopted by other systems without modifications. This manual is designed to be used only at a single institution in a correctional system. Although certain policies may be promulgated by the central offices of state or federal systems, the details of such a manual should be specific to each institution in order to reflect the unique attributes of every facility.

PREFACE (to 1. Sample Dental Policies and Procedures Manual)

This booklet represents a compilation of the current policies and working procedures of the Dental Clinic at _____________. It is not meant to be a document which effects policies and procedures, but rather a reflection of the present situation and undoubtedly will need revision.

We have compiled this information primarily for two types of readers. The first group includes any outsider interested in our operation and general policies. The second group includes newly hired dental staff.

Hence, we have included some information of a fairly detailed nature which might be of assistance to a new employee, but would be of little interest to an outside observer.

## I. PERSONNEL

The breakdown of dental manpower currently being utilized in the clinic is as follows:

One staff dentist
One Certified Dental Assistant
Consultant(s)
Dental students
Dental assisting students
Dental hygiene students

The dental students rotate through our clinic as part of the Community Dentistry curriculum from the University of ____________. Each student is present for only a day or two per year.

Dental assisting students are supplied by the dental assisting program of _____________ Community College and each spend twenty hours per week for three weeks here at the institution.

Dental hygiene students are assigned to our clinic as part of their extramural experience for one day per year per student. Assignments are made by the Program Director for the School of Dental Hygiene at the University of _____________.

## II. PATIENT CARE

### A. Exams

An initial dental examination including medical history and oral soft tissue check is normally done on every newly committed resident at the time of his Arrival and Orientation (A&P) physical. These are currently performed on Wednesday mornings. The initial examination is required and should a resident fail to come for his A&O exam, his unit is notified immediately. If someone refuses to be examined, this is documented on his record and the Hospital Administrative Officer (HAO) is notified.

Preliminary examination of each patient may be done by the staff dentist or the Certified Dental Assistant (CDA).

The charting method used by the __________ of Prisons is outlined in the Health Services Manual of Policies and Procedures. See Appendix I. The medical history questionnaire is of our own design.

### B. Emergency Appointments

If a resident is having severe pain and/or swelling and wishes to see the dentist immediately for this emergency, he is expected to have his work supervisor or dormitory officer call the dental clinic on his behalf to notify us of the situation. Only under extremely unusual circumstances is a resident seen without this call. This man's name,

B. Emergency Appointments (cont'd.)

number, dormitory, and work detail are recorded on the daily calendar and he is called in as soon as possible. When the dental officer is absent, the CDA may screen the patient's problem and, if necessary, notify one of the Medical Technical Assistants (MTA) in the hospital for any necessary antibiotic, pain medication, or other treatment.

C. Referrals

Occasionally, the hospital refers a patient who has come to them with what may be a dental problem. Normally, these patients are seen as soon as possible. If the problem is not of an emergency nature, the patient may of course be scheduled at a later date.

D. Regular Appointments for Routine Dental Care

Routine dental care, e.g. prophylaxes, fillings, and prosthetic work are made only at the resident's request. The standard form "Inmate Request to Staff Member" (Cop-Out) is used for this purpose. When the form is received from a patient, his name, number, work detail, and dormitory, along with the nature of the request are recorded on the waiting list and the form is returned to the resident informing him of this action. As an inmate's name comes to the top of the waiting list, an appointment is made for him and the appointment is listed on the daily call-out sheet. It is the responsibility of the resident to check the call-out list each day and to be on time for his appointment. Failure to keep an appointment without prior notification or without an extremely good excuse means a patient must submit a new request form to again be placed on the waiting list. Forms are obtained from dormitory officers.

E. Idles

When extensive surgery has been done or severe infection exists, the dentist or Certified Dental Assistant may issue an idle slip so that the patient will be excused from work. Three copies are necessary; the resident takes one to his work supervisor, one to his dorm officer, and one to the Lieutenant's office.

F. Hospitalization

Occasionally, the dentist wishes to hospitalize a patient for one or more of the following reasons:

1. To insure rest following surgery;
2. To insure frequent medication is provided and taken as ordered;
3. To insure prompt attention by medical personnel should the situation call for it.

F. Hospitalization (cont'd.)

Any patient hospitalized overnight must be formally admitted to the hospital, while those simply placed in a bed during the day for rest and observation need not be admitted.

G. Consultant's Patients

Consultants are employed by the institution on a contract basis. Presently, the dental clinic utilizes only an oral surgery consultant, although the services of other specialists might be obtained, should a particular situation warrant it.

Patients to be seen and treated by the oral surgeon are selected by the staff dentist and placed on the consultant list (to be called-out when the consultant makes his next visit). Times for these visits are arranged by mutual agreement between the staff dentist and the specialist.

If an emergency arises, and a consultant is needed immediately, the Hospital Administrative Officer (HAO) is notified.

A list of consultants is maintained by the Medical Records Technician (MRT) in the hospital. The MRT also keeps the consultant's log which must be signed by the specialist each time he visits, to insure reimbursement for services rendered.

H. Vacation

When the staff dentist is on leave during the year, another dentist may or may not be obtained to cover the clinic on a temporary basis. These replacement destists are normally obtained through the University of ____________ Community Dentistry Department.

If coverage is not obtained, the clinic may remain open for screening of emergencies by the CDA.

I. Laboratory Cases

Fixed and removable prostheses requiring laboratory work may be divided into two simple categories: those which are handled in the clinic and those which must be sent out.

Most denture repairs, simple wire and plastic "flippers", custom impression trays, relines, and occlusion rims may be completed at the clinic's laboratory facilities.

Cast partial dentures and complete dentures are sent to the dental lab at the ____________ Correctional Institution in __________,_________. The standard form HSA-179 is used for denture prescriptions and a manual written at the lab describes the work they will do and how to utilize their services (see Appendix section of this Sample Clinic Manual). The service is free to all residents.

## III. OFFICE MANAGEMENT

### A. Scheduling

When a request is received, the patient's record should always be checked prior to the patient's name being placed on the waiting list.

In fairness to our own commitments, the present situation dictates that our policy toward Marshall's prisoners is to render emergency care only. Therefore, when a request for routine treatment is received from the detention area (Blocks D & E) the unit should be called to determine the man's status. If the individual is in fact a Marshall's prisoner, his Cop-Out is returned to him advising him of this policy and he is informed that if his problem is an emergency, he should have a staff member call the Certified Dental Assistant for an emergency appointment.

Inmates requesting prophys are presently scheduled with the Certified Dental Assistant, a dental student, a dental hygiene student, or the dentist, unless a quick check of his record indicates it has not been one year since his last prophy. In this instance, the request is sent back with a note indicating the approximate date the patient may request a check-up and prophy.

Restorative patients are scheduled with the dental officer, or dental students depending upon the situation. In general, the easier cases and more cooperative patients are assigned to the students.

Patients needing extractions are normally scheduled only with the staff dentist or the consultant oral surgeon.

Full and partial denture patients are appointed with the staff dentist only, while cases involving simple flippers may be assigned to see the CDA.

The daily call-out sheet for the following day's appointments must be submitted by 1:30 p.m. to the Education Clerk.

### B. Statistics

Daily records are maintained on all patient visits and procedures performed in the clinic. The name of every patient seen is recorded in the appointment book along with a notation of the procedures performed. These procedures are transferred at the end of each day to the monthly statistic sheet. Separate sheets are kept for each operator (D.D.S., Consultant, CDA, dental student or dental hygiene student).

C. Quarterly Reports

The monthly reports are used to compile the statistics section of the Quarterly Report. A narrative summary constitutes the remainder of the report. The report is due on the last day of the quarter and is routed to the warden through the HAO. Copies are maintained in the hospital and dental clinic.

D. Sanitation

Cleanliness and neatness of the entire clinic area is stressed continuously.

All trash cans are emptied each morning and taken to the incinerator. Floors are swept daily and sinks cleaned as often as possible. All shelves and cabinets are cleaned and dusted weekly. Vacuuming of the office is done frequently as well. The floors are damp mopped and buffed at least once a week and waxed every month. A part-time resident janitor is responsible for seeing that these tasks are performed and is supervised by the civilian dental assistant.

E. Sterilization

Sterilization of instruments used in patient care is of paramount importance and every effort is made to follow procedures which will insure this. (See Appendix section of this sample clinic manual.)

In addition, all handpieces, the triplex syringe, high volume evacuator, overhead lamp handles, and chair controls are wiped with an alcohol sponge prior to seating each patient. Bracket table covers and headrest covers are changed after each patient, as well.

F. X-Ray

The dental clinic patient care center is an open area with an X-ray tube located at the middle chair. Lead shields, placed only to the sides of this chair, provide protection from scatter radiation to operators and patients in the other chairs. These are the only shields, however, and an effort is made to not expose radiographs when people are standing or walking in the adjacent unshielded areas.

Each staff member wears a radiation badge replaced by the MTA X-ray technician each quarter, which is sent in for testing regularly. The X-ray unit itself is turned off when not in use.

At present, the dental director of the __________ Health Service for the ___________ of Prisons is responsible for periodic inspection of the unit.

G. Security and Controlled Items

It is extremely important that while operating the dental clinic in a professional and courteous manner, the staff realizes the setting in which they work.

G. Security and Controlled Items (cont'd.)

An endless number of items and supplies used daily in treating patients or performing lab procedures have a high potential for abuse in the wrong hands. Therefore, security is a priority for all working in the clinic. A watchful eye and regular inventories go a long way toward preventing a loss of instruments and supplies.

Controlled items such as needles, irrigating syringes, medications, alcohol, and scalpal blades are kept in either the locked cabinet in the laboratory or locked in the compressor/storeroom. A shadowboard holds "hot tools" and these are accounted for at all times.

A total of fifty (50) needles are kept in the clinic. Needles are taken out of the locked cabinet only as needed.

When cleaning up after a procedure, the syringe is dismantled and the used needle and carpules are dropped into the locked storage box.

When the stock of fifty (50) needles needs to be replenished, the used needles are counted to check the total and cut into unusable parts. These are then exchanged in the hospital for new sterile needles.

A total of used and unused needles should always number fifty (50). A count is done at least once a day. If a needle is found missing, an inspection of the dental clinic is done immediately. Should this inspection fail to turn up the missing needle, the Chief Correctional Supervisor (CCS) or any available Lieutenant is notified immediately and a memorandum is written to the CCS.

Prescription medications used in the dental clinic are obtained through the MTA's in the hospital.

H. Inventory

An inventory is kept of all equipment in the clinic. In addition, an inventory has been established for all depletable supplies. Three by five cards with the following information is kept on these items:

1. Description
2. Minimum and maximum amount to be kept on hand
3. Company usually ordered from
4. Date ordered
5. Date received
6. Quantity ordered

These cards are kept in a Rolodex file and an inventory made once a month to check depleting stocks.

When an item's numbers are reduced to a point near its recommended minimum, it is placed on an ordering list. A purchase is made when a reasonable number of items are in short supply. The cards are pulled on these items and the necessary information recorded.

I. Purchase Orders

Before any order may be placed, it is necessary to call the business office for a purchase order number. It is important when ordering supplies to use the correct purchase order form.

All Federal Supply Catalog (FSC) government orders should be made on the Standard Form #344 (nine (9) copies are necessary).

For all Government Services Administration (GSA) or open market orders, form #BP-Acctg-81 is used. Nine (9) copies are also necessary for this form.

When ordering from any company or catalog which states, "Prices are subject to change without notice", or the actual price is not known, Standard Form #BP-Acctg-2 (Request for Purchase) will be completed in three (3) copies.

All purchase order numbers are issued by the purchasing agent. A P.O. number must accompany <u>all</u> orders with the exception of the "Request for Purchase".

J. Requisitions

Items such as office supplies, cleaning supplies, paper towels, toothbrushes, etc., must be ordered through the institution warehouse.

Requisition forms for these supplies are obtained through the warehouse supervisor and are to be completed in four (4) copies. Requisitions must be submitted to the warehouse office at least one day before the issuing date. In the event the regular day falls on a holiday, supplies will be issued the following working day.

Each cost center requires separate requisitions, e.g., if one item is ordered from cost center 323, one from 315, and one from cost center 351, three (3) separate requisitions must be submitted.

The Warehouse Catalog, published annually, is referred to for the dates on which various supplies may be ordered (within the institution).

(Appendix to Sample Clinic Manual)

SUBJECT:

CLINICAL RECORD - DENTAL, STANDARD FORM 521

Standard Form 521 . . . . . . . . C2.5.1.1
Treatment Record, Form HSA-237 . . 2

.1 SF-521, "Clinical Record-Dental," is to be used as the basic dental record form in all dental departments. It is used for both inpatients and outpatients. In the case of inpatients, a copy is prepared for the patient whenever a complete dental examination is performed. For outpatients, a copy is prepared once a year, or more often at the discretion of the Dental Director. The SF-521 is prepared for every patient who visits the Dental Department, including those patients who require examination only. At correctional hospitals and outpatient clinics, examination findings will be recorded on the face of the form in accordance with instructions given herein.

It is imperative that SF-521 be executed clearly, legibly, and in accordance with the instructions given. Entries should be made with permanent black or blue-black ink. Generally, a fine-pointed accounting pen gives best results. A specimen copy of SF-521 is given in Attachment C2.5.1a.

SF-521 includes a chart at the upper left of the face of the form which outlines the surfaces of the thirty-two permanent teeth. The spaces in the upper arch (right to left) are numbered 1 to 16, while the spaces in the lower arch (left to right) are numbered 17 to 32. Carious processes are to be outlined and restorations shaded within the surface-outlines as they apply to natural teeth present in the mouth at the time of examination. Fixed bridges are to be designated in accordance with instructions given herein. When deciduous teeth are present in a space where a permanent tooth has not erupted, it is indicated with a block "D" inscribed around the number of the space. When the deciduous tooth and permanent tooth are both present, an arrow is drawn from the number with the "D" inscribed about it to indicate the position of the deciduous tooth.

In the area at the right space, number 2 through and including number 7, should be checked at the time of the examination. Space numbers 8 and 9 need not be used by the Public Health Service.

Section 10, "Additional Findings," is essentially self-explanatory. Appropriate entries not covered in other spaces should be made.

The section, "Recommendations," is reserved to provide for general supplemental information. The detailed instructions for marking the form designate the types of information to be entered in this section of the form. (See Attachment C2.5.1b, Detailed Instructions for Completing SF-521.)

CLINICAL RECORD - DENTAL, STANDARD FORM 521 (cont'd.)

Space number 12, "Approximate Time Required for Completion of Recommended Dental Treatment," need not be filled in unless it is of use to the particular station concerned.

Space number 13, "The Date," refers to the date on which the examination was made. Space number 14, "Signature of Dentist," refers to the signature of the dentist making the examination.

Spaces numbers 15 through 24, are self-explanatory.

The entire section "Information for Dental Service," should be filled in by the Chief of Service or Ward Surgeon in instances where entries may be useful to the station concerned. The section, "Authorization" is for use of stations, as needed.

Section 36, "Treatment Record," on the reverse of the SF-521, is designed for recording details of work performed during each dental visit. Upon termination of each dental visit, the date should be recorded. Diagnosis, treatment, and pertinent remarks necessary for an adequate description of work accomplished should be noted and the signature of the dentist performing the work affixed.

The "Dental Treatment Record," Form HSA-237, is to be used as a continuation of Section 36, "Treatment Record," SF-521.

Attachments C2.5.1a<br>
C2.5.1b

Standard Form 521
Rev. August 1954
Bureau of the Budget
Circular A-32 (Rev.)

CLINICAL RECORD | DENTAL

1. CHART

RIGHT

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

LEFT

2. ROENTGENOGRAMS
☐ PERIAPICAL ☐ BITE WINGS ☐ OTHER

3. PERIODONTOCLASIA
☐ INCIPIENT ☐ MODERATE ☐ SEVERE
☐ LOCAL ☐ GENERAL

4. CALCULUS
☐ SLIGHT ☐ MODERATE ☐ HEAVY

5. GINGIVAL PATHOLOGY
☐ GINGIVITIS ☐ VINCENT'S INFECTION
☐ STOMATITIS *(Specify)*

6. DENTURE INDICATED *(Include dentures needed after indicated extractions)*
☐ FULL UPPER ☐ FULL LOWER
☐ PARTIAL UPPER ☐ PARTIAL LOWER ☐ REPAIR

7. ABNORMALITIES OF OCCLUSION. ANGLES CLASSIFICATION
☐ I ☐ II ☐ III ☐ NORMAL

8. DENTAL CLASSIFICATION | 9. TYPE OF EXAMINATION

10. ADDITIONAL FINDINGS

11. RECOMMENDATIONS

| 12. APPROXIMATE TIME REQUIRED FOR DENTAL TREATMENT | 13. DATE | 14. SIGNATURE OF DENTIST |
|---|---|---|
| | | |

| 15. GRADE, RATING, OR POSITION | 16. TYPE OF BENEFICIARY | 17. SEX ☐ M ☐ F | 18. RACE | 19. AGE | 20. SERVICE ☐ INPATIENT ☐ OUTPATIENT ☐ OTHER |
|---|---|---|---|---|---|

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

| 22. IDENTIFICATION NO. | 23. REGISTER NO. | 24. WARD NO. |
|---|---|---|
| | | |

DENTAL
Standard Form 521 (Rev.)
521-104

ATTACHMENT C2.5.1a

**INFORMATION FOR DENTAL SERVICE** (*To be filled in by referring agency*)

| 26. PRINCIPAL MEDICAL DIAGNOSIS | | 27. CHECK HERE IF HOSPITALIZED FOR DENTAL TREATMENT ONLY ☐ |
|---|---|---|
| 28. PATIENT REFERRED FOR | | |
| 29. REMARKS | | |
| 30. APPROXIMATE PERIOD OF HOSPITALIZATION | 31. DATE | 32. SIGNATURE OF PHYSICIAN |

**AUTHORIZATION**

| 33. DENTAL TREATMENT AUTHORIZED | |
|---|---|
| 34. DATE | 35. SIGNATURE OF AUTHORIZING DENTIST |

**36. TREATMENT RECORD**

| DATE | DIAGNOSIS—TREATMENT—REMARKS | SIGNATURE |
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* U.S. GOVERNMENT PRINTING OFFICE 1961 O—602011

ATTACHMENT C 2.5.1a

| CLINICAL RECORD | DENTAL TREATMENT RECORD (Continuation) | |
|---|---|---|
| DATE | DIAGNOSIS – TREATMENT – REMARKS | SIGNATURE |
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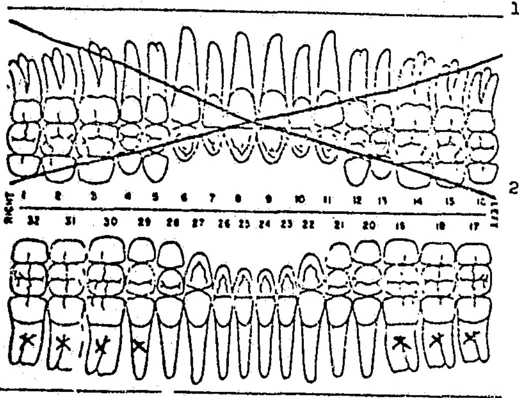
(Continued On Reverse Side)

| PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)* | REGISTER NO. | WARD NO. |
|---|---|---|
| | | |

DENTAL TREATMENT RECORD
HSA-237
4-73

The following are detailed instructions for completing Standard Form 521

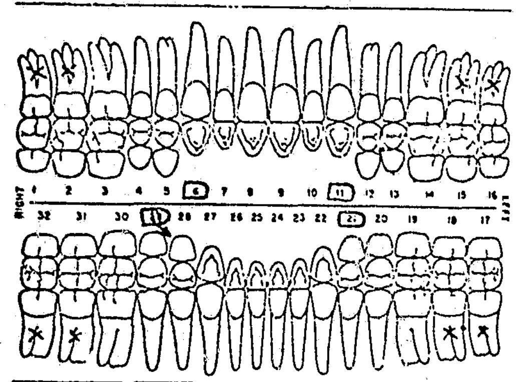
## A. MISSING TEETH




1. Edentulous arch:- Inscribe two crossing lines, each running from the upper-most aspect of one third molar to the lower-most aspect of the third molar on the opposite side.

2. Individual teeth:- Draw an "X" on the root or roots of each natural tooth that does not appear in the mouth at the mouth at the time of examination. This applies to unerupted, extracted or congenitally absent teeth, regardless of whether or not they have been replaced by partial dentures or fixed bridges.

## B. DECIDUOUS TEETH




1. If only the deciduous tooth is present, inscribe a block "D" around the number of the corresponding permanent tooth space. If both the deciduous and permanent teeth are present, show their relative positions by drawing an arrow from the block "D" pointing to the position of the deciduous tooth. Two parallel vertical lines drawn through the "D" shows that the tooth should be extracted; similar lines through the diagram of the tooth shows extraction of the permanent tooth is indicated, while two parallel lines through both the block "D" and the tooth diagram shows that extraction of both the deciduous and the permanent teeth is indicated.

## C. RESTORATIONS

(In the diagram of the tooth, draw, in permanent black or blue-black ink, an outline of the restoration, showing approximate size, location and shape. Identify restorative material, or materials, in accordance with the instructions listed below).

1. Amalgam:- Outline and black in solidly.

2. Gold (other than in bridge abutments and pontics. See D-2):- Outline and inscribe horizontal parallel lines within outline of restoration.

3. Non-Metallic (silicate, porcelain, acrylic, etc.):- Outline and stipple area within outline of restoration.

4. Combination:- Outline, showing approximate overall size, location, shape and partition at junction of materials used. Indicate each material.

5. Post crown:- Outline each aspect, indicating restorative materials. Outline approximate size and position of the post or posts and black in the post areas solidly.

6. Root canal filling:- Outline and black in solidly, each canal filled on the diagram involved. Example shows tooth with root canal filled and crown restored with an acrylic crown.

7. Defective restorations:- Under RECOMMENDATIONS, indicate, by designating numerals, if defective restorations or recurrent caries are present.

RECOMMENDATIONS

#15 amalgam, defective margins.

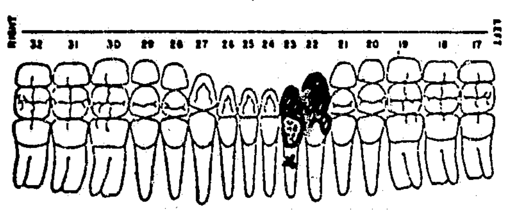
ATTACHMENT C2. 5. 1b

D. PROSTHESIS

1. Dentures (any removable replacement):- Indicate under RECOMMENDATIONS if full or partial replacements are present at time of examination. For partial replacements indicate, by designating numerals, the tooth or teeth replaced.

RECOMMENDATIONS

Partial denture present replacing 17, 18, 19, 29, 30, 31, 32.




2. Fixed bridges:- Outline each aspect, including abutments and pontics; show partition at junction of materials and indicate each material used as in Section C-Restorations above, except that Gold shall be shown by inscribing diagonal instead of horizontal parallel lines.

3. Defective prosthesis:- Any defective replacement (fixed or removable) shall be indicated under recommendations; give nature of defect as-- fractured denture, broken clasp, defective pontic, etc.

RECOMMENDATIONS

Partial denture present replacing 17, 18, 19, 29, 30, 31, 32, broken clasp needing repair.

## E. DISEASES AND ABNORMALITIES

1. Caries:- In the diagram of the tooth effected, draw an outline of the carious portion, showing approximate size, location, and shape. Indicate presence of carious activity adjacent to a restoration under RECOMMENDATIONS.

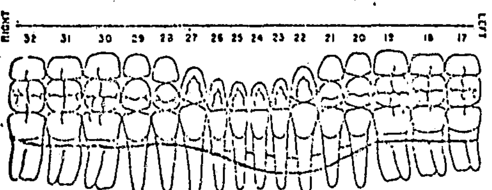
2. Extraction indicated:- Draw two parallel vertical lines through all aspects of the tooth and root or roots involved. This includes an unerupted tooth or retained root in an otherwise edentulous arch, only if extraction is indicated.

3. Abscess or cyst:- Outline approximate size, form and location.

4. Fistula:- Draw a straight line from the abscess area, ending in a small circle in a position on the chart corresponding to the location of the fistulous opening in the mouth.

5. Unerupted tooth or imbedded root:- Outline all aspects of the tooth or imbedded root with a single oval. This includes unerupted tooth and imbedded roots in an otherwise edentulous arch. When extraction is indicated draw two parallel lines through the oval. (This does not apply to unerupted permanent teeth in a child when a normal deciduous dentition is present).

6. Fractured tooth:- Trace the fracture line in the relative position on the crown and/or roots. When extraction is indicated draw two parallel vertical lines through all aspects of the tooth. If not indicated for extraction indicate work needed under recommendations.




7. Periodontoclasia:- Indicate extent of gingival recession with a continuous line drawn across the roots. If desired, alveolar crest resorption can be indicated by a second line drawn in the same manner.

8. Other abnormalities:- Any oral abnormality not classified above should be indicated under RECOMMENDATIONS.

RECOMMENDATIONS

Biopsy of neoplasm on posterior right dorsum of tongue.

ATTACHMENT C2.5.1b

EXAMPLES

Upper right first molar:- Occlusal and bucco-cervical restorations, non-metallic (acrylic, porcelain, silicate, etc.). Outlined to show approximate size, shape, and location of restorations, stippled to indicate that a non-metallic restorative material was used.

Upper right second bicuspid:- Three quarter crown restoration, gold. Outlined to show approximate size, shape, and location of restoration. Horizontal parallel lines inscribed within outline indicate that the restorative material is gold and that it is a restoration rather than a bridge abutment.

Upper right cuspid and lateral:- Three quarter crown on cuspid used as a bridge abutment, lateral replaced by a bridge. All aspects of bridge outlined showing partition at junction of materials. The three-quarter crown is outlined and diagonal parallel lines inscribed within outline indicate that gold is the restorative material. The "X" drawn on the root portion of #7 indicates that the tooth is missing. The crown portion of the lateral has been outlined and stippled within the outline to indicate that the pontic is constructed of a non-metallic material (acrylic, porcelain, etc.). This combined information indicates that the lateral is missing and has been replaced by a pontic attached to a three-quarter crown on the cuspid.

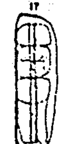
Upper right central:- The crown portion has been restored by a post crown on a root which has had the canal filled. Each aspect of the crown has been outlined showing partition at junction of materials. Horizontal parallel lines have been inscribed within the outline of the lingual surface to indicate that gold was used. The stippling within the outline of the labial surface indicates that a non-metallic material was used. The post has been outlined and blacked in solidly, showing its size and location. The root canal filling has been outlined and blacked in solidly.

Upper left lateral:- Fractured root and crown, indicated for extraction. The diagonal wavy lines on root and labial and lingual aspects of the crown show the relative positions of the two fractures. The two vertical parallel lines drawn through all aspects of the crown and root indicate that extraction is indicated.

Upper left second molar:- Mesio-occluso-distal amalgam restoration. Outlined showing approximate shape, size and location of restoration, and solidly blacked in to indicate that the restorative material is amalgam.

Upper left second bicuspid:- Mesio-proximal amalgam and disto-occlusal gold restorations. The mesio-proximal restoration is outlined, showing approximate size, shape and location and solidly blacked in to indicate that the restorative material is amalgam. The disto-occlusal restoration is outlined showing its approximate shape, size, and location. The parallel horizontal lines inscribed within the outline indicate that the restorative material is gold.

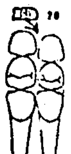
ATTACHMENT C2.5.1b



Lower left third molar:- Impacted and extraction indicated. All aspects of the tooth have been included within a single oval indicating that the tooth is unerupted or imbedded. The two parallel vertical lines drawn through all aspects of the crown and roots indicate that the tooth should be extracted.

Lower left first molar:- Caries involving the mesial, occlusal, lingual and buccal surfaces. The carious portions have been outlined showing the approximate shape, size and location of carious areas on the various surfaces involved.

Lower left central incisor:- Porcelain jacket crown restoration, root canal filling and periapical abscess with a fistula. All aspects of the crown have been outlined and the area within the outline stippled to indicate that the restorative material is non-metallic (acrylic, porcelain, etc.). The root canal filling has been outlined and solidly blacked in on the diagram of the tooth. The abscess area has been outlined to show approximate shape, size and location. A straight line ending in a small circle has been drawn from the area to indicate that there is a fistulous opening on the labial mucous membrane below the apex of the root of the left lateral incisor.



Lower right first and second bicuspids:- Deciduous molar present between the first and second bicuspids. The block "D" inscribed around 29 indicates deciduous tooth. Two parallel vertical lines within the "D" indicates extraction of deciduous tooth. The arrow drawn from the "D" indicates that the deciduous tooth is located between and buccal to the bicuspids.

Lower right first molar:- The "X" drawn on the roots indicates that the tooth is missing.

Lower right third molar:- Retained roots, and extraction indicated. The parallel vertical lines drawn through the roots indicate that only the roots are present and that extraction is indicated.

(Appendix to Sample Clinic Manual)

POLICY SUPPLIED BY THE __________ DENTAL LABORATORY

The laboratory is equipped to do complete dentures, removable partial dentures using ticonium frameworks, and crown and bridge. The laboratory staff consists of two full-time dental laboratory technicians. A training program is conducted for inmate trainees.

A prescription made in duplicate must accompany each case submitted (use Central Dental Laboratory, __________ Penitentiary's prescription form). A detailed description of the work requested must be made including the tooth shade, mold and type posterior. The color of denture base resin should be indicated also.

The dental laboratory will strive to provide efficient service; all cases referred to the laboratory should be of high quality. The ______________ dentists are available for consultations and will be glad to help in treatment planning, partial denture design, etc. Each case will be supervised by a staff technician. Minor changes of design may be required and will be made only with the approval of a dentist. (The dental laboratory will not construct a partial denture when the teeth have not been adequately restored or occlusal rests have not been properly prepared.)

To assist us with our workload, institutions should advise inmates involved that no prosthesis is made unless they practice good oral hygiene, the periodontal status is in an acceptable state and all carious teeth have been restored; inmates should realize that it is in their best interest. This should save time, money, and patient discomfort and greatly adds to the overall efficiency in patient treatment. We have found very few instances where a temporary partial denture was required. This allows more time for the laboratory to devote to the fabrication of longer term dental prosthesis.

Laboratory services supplied:

A. Complete dentures
B. Removable partial dentures
c. Crown and bridge

# A. COMPLETE DENTURES

## 1. Casts

Impressions must be border molded and properly extended to include all the area available for denture support. Maxillary casts must include the hamular notches and the entire tuberosity. Mandibular casts include all of the retro-molar pads.

The impression should be boxed before pouring. The master cast should be at least 1/2" thick at its thinnest area. The cast must record the peripheral roll of the impression. The periphery must be protected by a land area extending out 1/8 inch from the roll.

All casts must be accurate and properly trimmed with a hard surface free of voids and blebs. Hand carving of casts is not acceptable.

The posterior palatal seal must be done by the referring dentist. If the posterior seal is not included in the impression technique, the clinician must modify the cast by scraping.

## 2. Base Plates and Occlusion Rims

____________ Laboratory prefers base plates made of acrylic and will be glad to provide this service. Shellac base plates are discouraged because of poor adaptation, extension and rigidity.

The occlusal surface of the maxillary occlusion rim must be formed to establish the plane to which the dentist desires the teeth set. The occlusion rims should be contoured to indicate the desired positions of the denture teeth. The maxillary rim should show the mid line and cuspid positions.

## 3. Jaw Relationship Records

To prevent soft tissue displacement interocclusal records should be made in a material that is "dead soft" while recording the centric relationship. The material must become rigid after setting and not distort when separated or during packing and shipping. The records must be indexed to permit positive reassembly at the laboratory. Materials suitable for recording the centric relationship include aluwax, plaster, and zinc-oxide-eugenol impression paste.

## B. REMOVABLE PARTIAL DENTURES

Proper mouth preparation is essential for the success of the dental appliance. Study casts should be made and surveyed. Tooth modifications and rest preparation must be made before the final impressions are taken. The study casts should be evaluated for the following:

1) irregularities of occlusion which should be corrected by shortening of extruded teeth, extraction of the offending tooth, etc.

2) disharmonies in occlusion

3) lack of sufficient space
   - --for denture bases and artificial teeth
   - --for rest, indirect retainers, connectors and clasp arms

4) Recontouring of tooth surfaces
   - --to parallel surfaces which provide the guiding plane
   - --to reposition survey lines that do not permit proper clasping.
   - --to minimize undesirable undercut areas and unhygienic spaces.

### 1. MASTER CAST for PARTIAL DENTURE

The master cast should be poured in die stone (at least the teeth). All areas to be covered by the partial denture must be included. The cast must not be trimmed too close. The master cast must include tripod marks for surveying. Mark the limits of the major connector with a sharp, black pencil line.

### 2. PRESCRIPTIONS

The dentist must mark on the prescription form the teeth to be clasped and type clasp desired. The design may be drawn on the master cast using a soft #2 lead pencil making very thin lines.

### 3. MANDIBULAR DISTAL EXTENSION CASES

Corrected casts are highly encouraged for all mandibular free-end saddles. The dental laboratory will fabricate custom trays on the metal framework for the dentist to border mold and take a final impression. If the referring dentist has any questions concerning the technique, he is urged to contact one of the dentists employed at the laboratory.

4. JAW RELATIONSHIP RECORDS FOR PARTIAL DENTURES

If the casts can be related to each other in unmistakable centric occlusion by means of the remaining teeth, vertical, connecting lines may be drawn across the facial surfaces of occlusing teeth at widely separated points. Other cases require stable record bases with occlusion rims. Opposing teeth must not contact the opposite ridge or penetrate the recording media and contact the hard portion of the occlusion rim.

After the casts have been related to each other with the registration, this relationship should be checked clinically against the patient's natural occlusion. To do this the registration should be trimmed so that only the indentations of the tips of the opposing cusps remain. "Must Bites" or registrations made with a single sheet of wax are usually inaccurate and will distort in packaging and mailing.

5. TEETH AVAILABLE

We are using Trubyte Bioblend Plastic Anterior Teeth and Bioform Twenty Degrees Posteriors. Trubyte Biotone Rational Posteriors are also available.

a. ANTERIOR MOLDS

11G, 12E, 12G, 31F, 21D, 22E, 24F, 25G, 21G, 42F, 42H, 42D, 42G, 43D, 45F, 45H, 54F, 55D, 62D, 62G, 65G, 75E

SHADES

102, 104, 106, 108, 109, 110, 112, 113, 116 (Bioblend Shade Guide).

b. POSTERIOR MOLDS

29S, 29M, 29L, 31S, 31M, 31L, 33M, 33L

SHADES

65, 66, 67, 69, 77 and 81

c. RATIONAL

29M, 31M, 31L, 33M, 65, 67, 69, 77

6. DENTURE BASE RESIN

Regular - for reddish pink gingiva
Pigmented - mildly pigmented for patients with dark gingiva

## C. CROWN AND BRIDGE

The _________ Dental Laboratory can provide a limited amount of crown and bridge services. Prior to starting any crown and bridge work approval must be obtained from the dental director of the central laboratory, and when requesting approval the following data must be sent:

- a brief summary of the inmate's dental condition and the reason crown and bridge work is being considered
- maxillary and mandibular full arch study casts
- radiographs, preferably full mouth series

After obtaining approval, the requesting institution must provide:

- full arch master casts (regardless of the number of crowns to be fabricated)
- removable dies poured in die stone, trimmed and margins marked with a fine pencil line
- if there are sufficient teeth to band articulate casts, the casts should be indexed with pencil lines to indicate proper occlusion.
- a stable occlusal registration (wax bites are not acceptable)
- for porcelain-to-gold restorations, a minimal tooth reduction of 1 1/2mm on the labial and 2mm on the incisal should be made
- shade should be selected from the Trubyte Bioform shade guide

The casting will be returned for try-in and adjustment prior to the baking of the porcelain. For fixed bridges a soldering index is required after the casting and porcelain have been properly adjusted in the mouth.

DISACE
(REV. ...)

TRANS NO.
ALLOT. CODE

BATCH NO.

ACCT.
DATE MO/YR
R. P. NO

DOC

# PURCHASE ORDER

(NAME)

POINT OF ISSUE

THIS NUMBER MUST APPEAR ON ALL PACKAGES AND PAPERS RELATING TO THIS ORDER AND SHOULD BE ACCOMPANIED BY PACKING TICKETS.

| APPR | BA | COST CENTER | PMS | PROJ | SUB-OBJECT | IG | PURCHASE ORDER NO. | | DESG | DESG | STORES INDICATOR |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Fiscal Year 62 | 4 | 350 | 697 | 000 | 2657 | | 05 | | | | |

ALL INVOICES MUST BEAR THE ORDER NUMBER AND BE SUBMITTED IN DUPLICATE

TO SELLER

SHIP AND BILL TO:

Correctional Institution
Hospital P.O. #-fiscal year

| INVITATION NO. | CONTRACT NO. | TIME FOR DELIVERY | DISCOUNT TERMS |
|---|---|---|---|
| N/A | OH - open market or GS # | 10 days | included in price |

| FOB POINT | SHIP VIA | GOV'T B/L NO. |
|---|---|---|
| destination | See below | |

| ITEM NO. | ARTICLES OR SERVICES | QUANTITY | UNIT | UNIT PRICE | AMOUNT |
|---|---|---|---|---|---|
| 1. | Spher-A-Caps, Kerr, Zinc free, 70gm | 8 | box | 23.95 | 191.60 |
| 2. | Adaptic Kit - Double size, Complete | 1 | kit | 61.50 | 61.50 |

Sample

APPROVED: ____________________

HOSPITAL ADMINISTRATOR

FPI-MI—6-19-73-1800 PADS-745

TOTAL

SIGNATURE PROCUREMENT OFFICER

(DATE) 12/12/75

VENDORS COPY

DOC

# REQUEST FOR PURCHASE

INSTITUT...

FOR PURCHASING OFFICE USE ONLY

VENDOR Mauzy Rubber Stamp

ADDRESS P.O. Box 1142
Ann Arbor, MI. 48106

Leave Blank

indicates Fiscal year

DATE current

QUOTATION OR CONTRACT NO. ______

DELIVERY ______

TERMS ______

FOB ______

| | APPR | BA | COST CENTER | PMS | PROJ | SUB-OBJECT | IG | PURCHASE ORDER NO. | DESG | DESG | STORES INDICATOR |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 62 | 4 | 350 | 647 | 000 | 2657 | | | | | |

| ITEM | GSA OR OTHER STOCK NO. | DESCRIPTION | QUANTITY | UNIT | UNIT PRICE | TOTAL |
|---|---|---|---|---|---|---|
| | | Rubber Stamps as follows | | | | |
| 1 | 212c | Allergy To ______ | 1 | ea | | |
| | | Sample | | | | |

DELIVERY DATE REQUIRED ______

DELIVER TO: Hospital (DEPT. OR SHOP)

| PRICE QUOTATION ABSTRACT BIDDER | TERMS | ITEM 1 | 2 | 3 | 4 | 5 | DELIVERY |
|---|---|---|---|---|---|---|---|
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| | | | | | | | |

RECOMMENDED SOURCE:

FPI-MI—8-27-74-3900 PADS-2622

1 Vendor's Address

2 ______

3 ______

REQUESTED BY ______

APPROVED BY ______

REQ. OFFICE NO. ______

REQUEST NO. ______

COST CENTER MANAGER

P.O.# (1204) Date: June 9, 1976 DOCUMENT IDENTIFICATION Page 1 of 2 Julian: 7350 R/P HOSPITAL

| DOC IDEN | ROUTING IDEN | M & S | DOCUMENT NUMBER REQUISITIONER | DATE | DEMAND | SUPPLEMENTARY ADDRESS | SIG | FUND | DISTRIBUTION | PROJECT | PRIORITY | REQ'D DELIVERY DATE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1-3 | 4-6 | 7 | 30-35 | 36-39 | 44 | 45-50 | 51 | 52-53 | 54-56 | 57-59 | 60-61 | 62-64 |
| AOA | 59M | A | 1 55402 | (7)350 (Fiscal Year) | N | | | SE | | (1204) | 03 | |

SIGNATURE (If required)

_______, Pruchasing Agent
_______ Corr Inst - _______, _______

(6)2-1-350-696-000-2657-Y-05-1204-00-00-N (Fiscal year)

REQUISITION DATA

NOTE: Entries in shaded blocks may be in either the FIXED (F) or VARIABLE (V) sections—NEVER in both.

GRAND TOTAL$ 7.92

| FSC | FIIN | ADDITIONAL | UNIT OF ISSUE | QUANTITY | SERIAL | SUPPLEMENTARY ADDRESS | SIG | DISTRIBUTION | PROJECT | ADVICE | DESCRIPTION | UNIT | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 8-11 | 12-18 | 19-22 | 23-24 | 25-29 | 40-43 | 45-50 | 51 | 54-56 | 57-59 | 65-66 | 23. REMARKS | | |
| 520 | 00 225 8306 | | pkg | ØØØØ2 | 0001 | | | | | | BUR, FISSURE #57 | $ 2.96 | $ 5.92 |
| 6520 | 00 550 2000 | | ea | ØØØØ4 | 0002 | | | | | | DAPPEN DISH | .50 | 2.00 |

Sample

VENDOR: DEFENSE PERSONNEL SUPPORT CENTER
2800 South 20th Street
Philadelphia, PA 19101

APPROVED: ____________________
HOSPITAL ADMINISTRATOR

SINGLE LINE ITEM REQUISITION SYSTEM DOCUMENT

STANDARD FORM 344
JAN 1972 EDITION
GENERAL SERVICES ADMINISTRATION
FPMR (41 CFR) 101-26.2

(Appendix to the Sample Clinic Manual)

## STERILIZATION PROCEDURE

1. Scrub all instruments after use, prior to sterilization.

2. Put instruments indicated for cold chemical sterilization into the cold chemical.*

3. All instruments (except endodontic instruments) indicated for steam under pressure should first be dipped in emulsion, then placed into the autoclave. All syringes, suction tips and surgical instruments should be placed into autoclave bags prior to sterilization.

4. Always wash hands before putting any instruments away.

### COLD CHEMICAL

Saliva ejector tips
Dappen dishes
Plastic instruments
Rubber prophy cups
Bite blocks
X-ray film holders

All other instruments that would be damaged by excessive heat.

### EMULSION

Everything that DOES NOT go into cold chemical should be dipped into emulsion prior to being sterilized with the exception of endodontic instruments.

### ENDO FILES

These should be brushed free of debris and placed in either the bead sterilizer or in dry heat for 1 hour at 360°.

### AUTOCLAVE

All instruments placed in emulsion are to be placed into the autoclave to be sterilized at a temperature of 260°F at 15-20 lbs of pressure for twenty minutes.

* Instruments indicated to go into the autoclave do not need to go into cold chemical first.

CONTINUED

3 OF 5

APPENDIX A: Sample Dental Clinic Policies and Procedures Manuals (cont'd.)

2. The following sample clinic manual* was adapted from one used by a state correctional system's division of dental services and was designed to apply to all institutional dental health programs within the correctional system. This sample manual is provided only to illustrate some of the necessary areas to be covered and is not presented as an ideal manual for all situations facing health care administrators. This manual provides yet another approach to promulgating written rules and procedures for a dental health program.

*Source: Division of Dental Services
Office of Health Care
Michigan Department of Corrections
William J. Byland, D.D.S., Assistant Director

4

DENTAL SERVICES - MICHIGAN DEPARTMENT OF CORRECTIONS

Index for Section 500

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# DENTAL CARE

## SECTION 500

### 500.00 DENTAL CARE AND TREATMENT

Dental service will be provided, within the limits governed by facilities and resources, for the residents of the Michigan Department of Corrections.

### 500.01 PRIMARY MISSION OF DENTAL SERVICE

The function of the dental department shall be to provide the highest quality comprehensive dental care possible for the residents, with their consent and within the limits of available resources. The first priority will be correcting oral conditions detrimental to the health of the individual which constitute a hardship in the rehabilitation of the resident.

### 500.02 POLICY

The policy of the dental department is to provide the best care possible to the greatest number of residents. Basic essential services should be provided first and no service should be provided that could not be provided to all residents with similar needs. The availability of funds and personnel will define the parameters of services to be offered.

### 500.03 OBJECTIVES

The objectives of dental service are to relieve pain and infection, to provide adequate mastication and function, to restore and maintain the mouth in a healthy condition, and to provide reasonable prosthetic appliances when needed.

### 500.04 MEDICAL DIRECTOR, OFFICE OF HEALTH CARE

The Medical Director is responsible for the administration of the medical care delivery system at all state correctional institutions. The Dental Director will be responsible to the Medical Director for the delivery of dental care at all state correctional institutions and camps.

### 500.05 DENTAL DIRECTOR

The Dental Director is responsible for the operation of the dental section of the Office of Health Care:

1. Secure the services of qualified personnel to adequately staff the dental clinics.

2. Ensure that all such personnel meet the requirements of the Civil Service Division and the Michigan State Board of Dentistry.

3. Ensure compliance of the dental program with the policies and objectives of the Office of Health Care, through the chief dentists at each facility who will report to the Dental Director.

4. Direct the administration of the Dental Associate Degree Program in conjunction with Jackson Community College.

5. Direct the operation of the prosthetic laboratory at Camp Waterloo.

500.06 DENTAL CLINICS

There will be an adequately equipped and staff clinic at each institution.

500.07 CHIEF DENTIST

Each clinic will be under the supervision of a chief dentist. The chief dentist will be responsible to the Medical Director of the institution on matters pertaining to that particular institution and to the Dental Director on issues of dental policy and procedures.

500.08 INSTITUTIONAL DENTAL STAFF

An adequate number of dentists and auxiliary dental personnel will be assigned to each institution based on need and staff availability. The dental staff will be responsible to the chief dentist and Dental Director. At the smaller institutions, with only one dentist, that dentist will act as chief dentist.

500.09 AUXILIARY DENTAL PERSONNEL

This term refers to dental aides, hygienists, resident aides and laboratory technicians as well as clerks and porters who are assigned to the dental care area.

500.10 DENTAL HYGIENIST

The hygienist will perform the duties of oral prophylaxis including x-rays and examinations. Oral prophylaxis will include scaling and polishing of the teeth plus oral hygiene instruction. In addition, the hygienist will assist the dentist in the operation of the clinic.

500.11 DENTAL AIDE

The primary duty of the dental aide is to provide assistance to the dentist in the operation of the clinic. The aide's duties are:

1. Chairside assistance with all procedures
2. Develop and mount x-rays
3. Perform clerical duties when necessary
4. Maintain the inventory of dental supplies
5. Maintain the cleanliness of the operatory and instruments

Proper utilization of the dental aide by the dentist will contribute greatly to the efficiency of the operation of the clinic.

500.12 DENTAL CLERK

The duties of the dental clerk are:

1. Maintain the dental records, making sure that entries are properly recorded
2. Schedule appointments
3. Prepare call-out lists for the next day
4. Perform any clerical work required by the dentists

500.13 PORTER

The porter is responsible for the cleanliness of the floors, sinks and waste receptacles of the clinic, office and laboratory.

500.14 LABORATORY TECHNICIANS (C.D.T.)

The laboratory technician assists in the operation of the dental prosthetic laboratory and the technician training programs. All laboratory technicians are responsible to the supervisor of the dental laboratory.

500.15 LABORATORY SUPERVISOR

The laboratory supervisor is responsible for the operation of the dental laboratory and the quality of the prosthetic appliances produced. He/she also supervises the duties of

500.15 LABORATORY SUPERVISOR (cont'd.)

the C.D.T., and selects, evaluates and monitors the progress of the student technicians. The laboratory supervisor is responsible to the Dental Director.

500.16 PROSTHETIC DENTAL LABORATORIES

The prosthetic laboratory will produce dental prosthetic appliances. The Dental Director is responsible for the operation of the laboratory.

500.17 DENTAL TECHNICIAN ASSOCIATE DEGREE PROGRAM

The Dental Director is the administrator of the Associate Degree Dental Technician Program which operates in cooperation with the Jackson Community College. The Dental Director will:

1. Screen and select resident students
2. Monitor the progress of the students
3. Supervise instructors participating in the program.

500.18 ACADEMIC LABORATORY TECHNICIAN

The academic laboratory technician functions as principal instructor in the Associate Degree Program and is responsible to the Dental Director.

500.19 RECEPTION AND GUIDANCE CENTER EXAMINATION

The initial dental examination for all male residents will occur at the Reception and Guidance Center. A complete dental history will be taken, dental needs charted and priorities assigned or suggested. Approximately 30 minutes will be needed for each initial examination. There will also be a briefing session for the new residents to explain the dental services that are available and the procedures for making dental appointments.

The initial dental examination for all female residents will take place at the Women's Prison in Ypsilanti.

The non-emergent dental plan recommended by the initial examination will begin after the resident has been transferred. Only emergency dental treatment will be available at R&GC.

500.20 INSTITUTIONAL DENTAL SERVICE POLICY

Dental Services will be provided at the institution to which the resident is transferred from the Reception and Guidance Center. Treatment will be in the area of oral surgery,

500.20 INSTITUTIONAL DENTAL SERVICE POLICY (Cont'd.)

operative, preventive and prosthetic dentistry. Treatment will be in accordance with departmental policies and within the limits of the available staff. According to the classification system of dental treatment, Class 1 should be given number one priority with all other priorities assigned at the discretion of the dentist delivering the services.

500.21 RE-EXAMINATION

The institution will initiate treatment on the basis of the initial examination and arrange the treatment schedule according to assigned priorities. Appointments will be scheduled until the case is completed. A program will be implemented for yearly recall where conditions permit.

500.22 SCHEDULING APPOINTMENTS

Residents will be scheduled for dental treatment in the chronological order of their arrival at their home institution.

500.23 EMERGENCY TREATMENT

Emergency treatment will be provided at dental sick call by written request, i.e., "kites," or by the request of the housing unit supervisor or work supervisor. Urgent cases will be seen immediately.

500.24 CAMP TRANSFERS

Residents eligible for camp transfer should be given scheduling priority so that their dental work can be completed.

500.25 PAROLE OR DISCHARGE

Residents eligible for parole or discharge should also be given priority, so that their work can be completed. The resident does have the choice of signing a waiver which releases the Corrections Department from the responsibility of completing dental procedures that have been initiated. This policy is still pending approval.

500.26 THE DENTAL EXAMINATION

The dental examination will occur at the R&GC or Ypsilanti Women's Prison and will consist of a case history and x-rays (Bite-Wings and Periapical as needed). It will be documented by diagramming the case and indicating periodontal condition.

500.27 DENTAL CLASSIFICATION AND PRIORITY

At the initial examination, the patient will be classified in the category of greatest need according to Department of Corrections and Office of Health Care classification. This will be plainly marked on the patient's record. We will thereby minimize the need for reexamining the resident upon arrival at the "home" institution.

500.28 DOC DENTAL CLASSIFICATION SYSTEM

Class 1. This category indicates teeth requiring extraction.

1. Teeth decayed beyond possibility of filling and/or injurious to the individual's health.
2. Root fragments remaining indicate pathology and/or interfere with construction of prosthetic appliance.
3. Impactions creating pathology to the hard and soft tissues.
4. Severe periodontal condition with extreme involvement of bone loss and mobility of the teeth.
5. Suspected ulcerative lesions or growths.

Class 2. Teeth with carious lesions that can be restored.

Class 3. This category indicates cases requiring prosthetic procedures.

1. Edentulous mouth without dentures or ill fitting dentures.
2. Prosthetic appliance(s) needing repair or reline.
3. Partial removable appliance(s) to replace missing teeth.

Class 4. Category 4 indicates cases requiring oral prophylaxis and/or oral hygiene instruction.

1. Scaling and prophylaxis by the dentist or hygienist.
2. Education in proper care using dental floss, proper brushing and massaging techniques.
3. Attempt to reverse developing periodontal problems.

500.28 DOC DENTAL CLASSIFICATION SYSTEM (cont'd.)

Class 5. The examination reveals no need for dental work at this time.

500.29 RESTORATIVE PROCEDURES

Materials to be used

The material of choice will be Silver Amalgam for restorations of posterior teeth and Composite for anterior teeth. The use of Acid-Etch technique should be employed on fractured incisal angles of anterior teeth.

Temporary Fillings

Materials for emergency treatment should be Zinc Oxide-Eugenol cement and/or Cavit at the discretion of the operator.

Gold - Porcelain Jackets

Will not be used.

Root Canal

Root canal fillings will be placed when it is deemed advisable by the dentist. Anterior teeth and bicuspids will be treated, if practical, but no molar teeth will be treated.

500.30 PERIODONTAL TREATMENT

Prophylaxis

Urgent Oral Prophylaxis will be given to residents on the recommendation of the dental office. All other routine prophylaxis will depend on the absence of work or a higher priority and will depend on the availability of time, personnel, and facilities.

Other Treatment

Prep scaling, curettage, flap operation and/or gingivectomies will be done when the prognosis is favorable and there is time, facility and personnel to perform this service.

500.31 FIXED DENTAL PROSTHESIS

Crown and Bridge

Crown and bridge work will not be undertaken. In selected cases, stainless steel crowns will be used on posterior teeth.

500.31 FIXED DENTAL PROSTHESIS (cont'd.)

Precious Metals

Precious metals are not available nor are they to be used even if the resident wishes to pay for them personally.

500.32 REMOVABLE DENTAL PROSTHESIS

Prothestic Service

Prosthetic service is available upon recommendation of the dentist when deemed necessary for the proper mastication of food and for the replacement of missing anterior teeth.

The full denture is the appliance of choice when the prognosis of a partial denture is doubtful. If the patient refuses the dentist's recommendation, the case should be handled as a refusal of treatment.

Partial denture will be restricted to the replacement of missing anterior teeth, or cases where the remaining posterior teeth are insufficient to provide proper mastication of food.

Extractions and restorative procedure related to preparations for partial dentures, should be completed before impressions are taken.

500.33 PROSTHETIC PRIORITIES

A denture list will be maintained and patients seen in the sequence in which they are placed on the list. Edentulous cases should have first priority.

500.34 INMATE RESPONSIBILITY

The resident will have his/her prosthetic case completed only once. Loss, destruction or mutilation of the denture or dentures is solely the resident's responsibility. Any remaking will be solely at the discretion and judgment of the dentist. If it is necessary to construct a second appliance due to neglect, it will be done at the resident's expense. If the resident is unwilling to pay the expense, treatment will be refused. This care will not be furnished at state expense.

500.35 CENTRAL LABORATORY

The dental laboratory supervisor will be responsible for dealing fairly with cases, in reference to chronological order of arrival and delivery. Also, the supervisor will devise a system to check the progress of the case in the laboratory, and examine the completed case for quality and anatomical fit on the duplicated model.

500.36 ORAL SURGERY

Most surgery procedures will be performed by the staff dentist. This will include routine extractions, alveolectomies, bone reduction, cyst removal, and impactions. The Dental Director will approve each dentist for various procedures in accordance with the proficiency of the individual operator. The more difficult cases will be referred to board qualified oral surgeons on staff form _____.

500.37 REFUSAL OF TREATMENT

If the resident refuses the treatment recommended by the examining dentist, or the dentist providing treatment, a written notation of refusal of treatment will be made on form ____ and the resident will sign the refusal of treatment slip attached and file this form in the resident's central file.

Patients refusing treatment will have relinquished their right to any further dental treatment until they are willing to accept the recommended treatment. When there has been a history of refusal of treatment, no work should be done without first having the resident sign a consent form.

500.38 ORIENTATION OF NEW DENTAL PERSONNEL

Institutional

A five week course of general institutional orientation is provided for all dental personnel under the direction of the institutional training department of the Department of Corrections.

Infirmary and Dental Clinic

The senior dental officer and the institutional Medical Director or Chief Administrator will indoctrinate new employees in infirmary and clinic operation.

Staff Meetings

Monthly staff meetings will be held by the entire dental staff at each institution. The Dental Director will meet with the entire dental staff of each institution at least once a year at their clinic.

In-Service Training

When applicable, the dental staff will attend in-service training meetings. Administrative leave will be granted by the Office of Health Care.

500.38 ORIENTATION OF NEW DENTAL PERSONNEL (cont'd.)

Specialized Out-Training

The staff will be encouraged to pursue post-graduate or continuing education courses. Administrative leave will be granted for such purposes, whenever possible, by the Dental Director and the Office of Health Care. A brief written report will be made to the Dental Director following the course/meeting. Conventions will follow the same procedure.

Peer Review

There will be a peer review of dental procedures at least once a year by the Dental Director. Periodically the review will be conducted by an outside review committee approved by the Michigan Dental Association.

500.39 ANNUAL MEETING

An annual meeting will be held for the dentists and hygienists in Lansing (or other suitable location) to review any changes in policies and procedures, and increase communications and efficiency of operation.

500.40 PREPARATION OF BUDGET

The Dental Director will advise the Director of the Office of Health Care in the preparation of the clinical budget as it pertains to dental expenditures for equipment, personnel, supplies, and capital outlay projects.

500.41 NEW DENTAL CLINICS AND REMODELLING

The Dental Director will assist in the planning for new health facilities and/or the remodeling of existing facilities whenever dental areas are involved.

500.42 DENTAL SUPPLIES

Dental supplies will be ordered on form ____ through the institutional business manager's office. A central supply depot will be established for expendable items, which will then be ordered directly by the individual dental clinics on a weekly basis.

500.43 CONSTANT VIGILANCE

The dental officer shall see to it that all security measures recommended by the individual institutions and the Corrections Department are strictly adhered to.

500.43 CONSTANT VIGILANCE (cont'd.)

Dental supplies recommended by the Dental Director, will be utilized whenever possible in order to better control financial expenditures of the Office of Health Care.

The chief dental officer at each clinic will maintain a carefully controlled inventory and instrument record system.

500.44 CSO FORMS

CSO Forms are ordered from stock supplied to the institutions. Those forms not carrying a CSO number must be produced locally at each individual institution. Any frequently used form not on the CSO form list can be added to the list upon request.

Note: See appendix to this manual section for all forms listed and used in the dental clinics.

FORM ADMISSION DENTAL CARD

Completed in the R&GC clinic upon examination by the dentist or hygienist.

ENTRIES TO BE MADE

This form will record findings at the initial dental examination; caries, missing teeth, pathology, bridge (fixed or removable), and a dental history, taken at this time. Patients will be classed according to priority rating, and this record will be part of the resident's master record.

FORM OUTPATIENT DENTAL RECORD

This form will be initiated at the resident's "home" institution and will record all procedures performed, date of treatment and signature of the provider.

DEFINITIONS

A separate page will define terms used in the dental record and procedures to follow in completing the record.

NUMERICAL FILING

The dental record will be part of the medical record and filed numerically in the medical records office. The dental aide/clerk will request those records needed for each days list of patients by submitting a list to the medical records office by 2 p.m. on the preceding day.

TRANSFER WITH MEDICAL RECORD

When the resident is paroled or discharged, this record will be returned to central records.

FORM RECEIPT FOR DENTAL GOLD REMOVED FROM RESIDENT'S MOUTH

FORM ____________

A receipt and envelope containing the gold will be filed with the property officer. One copy will be filed with the resident's dental record.

FORM PROSTHETIC PRESCRIPTION

FORM ____________

This form must accompany laboratory case to the laboratory and a copy included in the dental jacket.

FORM CENTRAL SUPPLY REQUISITION FORM

FORM ____________

This order form will be used for supplies not available through central supply and forwarded to the business office at the institution.

Note: On items over $100, a request for quotation, form _______, must be used.

FORM CONSENT FOR SURGICAL OPERATION

FORM ____________

To be used on all cases requiring general anesthesia, or any extensive surgical procedure, as well as any circumstance requiring a consent form by virtue of DOC/OHC policy.

FORM DAILY DENTAL WORK RECORD

FORM ____________

A daily log of all work performed in the lab each day.

FORM MONTHLY REPORT OF DENTAL ACTIVITIES

FORM ____________

This form will be completed at the end of each month, and copies sent to: Institutional Medical Director/Administrator, Warden/ Superintendent, Office of Health Care, and one for the dental clinic file. Attached should be a report to the monthly staff meeting and any items of importance to the dental clinic.

FORM MEDICAL-PSYCHIATRIC-DENTAL CHRONOLOGY

This chronological report will be used for any notation to be inserted in the inmate's central file. This form will be used to record resident's refusal of treatment.

FORM CONSULTANT RECORD

This form will be used when consultant's services are required.

REFERENCES

1. "California Medical Services Manual" California Department of Corrections, Sacramento, California, April 7, 1975 TL 9/75

2. "Standard of Health Services in Correctional Institutions" Official report of American Public Health Associations. Washington, D.C.

3. "Federal Prison Dental Program" U.S. Federal Correctional Department. Washington, D.C., August 18, 1976.

4. "Key to Health for a Padlocked Society" Michigan Department of Corrections, Lansing, Michigan October 1974.

5. "Michigan Institution Survey" Michigan Dental Association, U.S. Public Health, Department of Mental Health, Department of Social Services. 1964.

# APPENDIX B: SAMPLE INSTITUTIONAL POLICY STATEMENT CONCERNING DENTAL HEALTH SERVICES FOR INMATES

The following policy statement for institutional dental services is presented as an illustration of the areas which might be addressed by such a statement. It was adapted from the policy statement used by a medium-sized, federal maximum-security correctional institution that employed one dentist and one civilian dental assistant. Dental directors of correctional dental health programs are urged to formulate policy statements that will address the particular situation present at their own institutions. This sample statement is not offered as an ideal policy statement, and it should not be considered as universally applicable.

<u>DENTAL CARE</u>: All dental treatment is provided by appointment only; no walk-in patients will be accepted. Appointments are made according to the type of treatment needed and are classified as follows: emergency dental care, interim dental care, and routine dental care.

(a) <u>Emergency dental care</u>: An inmate experiencing severe pain and/or swelling who wishes to see the dentist will have his quarters' officer or his work supervisor call the dental clinic on his behalf to notify the dental staff of his situation. The calling staff member will be instructed as to when the inmate can be seen. It is emphasized that this procedure is designed for legitimate emergencies only and staff members are urged to use discretion when calling -- no routine dental appointments will be made over the phone. An inmate treated via an emergency appointment will be treated for the emergency only.

(b) <u>Interim dental care</u>: Because of the rarity of true dental emergencies, the majority of dental problems that the inmate and/or officer feel require immediate attention will be handled on an appointment basis. Interim dental care includes the placement of temporary fillings in those teeth that would have to be extracted if not given prompt attention and the removal of those teeth decayed beyond restorability. It also might include treatment for chronic or acute gingival (gum) problems and for chronic or acute tooth hypersensitivity. Appointments for interim dental treatment must be made before 10:00 a.m. and again, must be made by the inmate's quarters' officer or work supervisor. Every effort will be made to give the inmate an appointment on the day the clinic is called -- however, occasionally dental emergency and interim calls are extremely numerous and inmates will be asked to wait until the next morning so that the day's regularly scheduled patients, as well as those with true emergencies, can be seen and treated.

(c) <u>Routine dental care</u>: Routine dental care is provided by appointment only. Patients who desire routine dental treatment are required to submit a "Cop-Out" (inmate request to

staff member) to the dental department requesting that routine dental care be provided. The patient's name is then placed on a waiting list by the dentist or the civilian dental assistant (listed in the same order as his request arrives at the dental department). Patients will be scheduled, in order, from this list for routine dental appointments and will be routinely reappointed until all necessary treatment is completed. This treatment can include, but is not necessarily limited to prophylaxis (cleanings), diagnostic procedures (radiographs, impressions, etc.), surgery (extractions, etc.), and restorative treatment (fillings). It may include prosthetic work (partial or complete dentures and crowns or bridges) if, in the opinion of the dental director, the patient's health or appearance is seriously affected because of missing teeth. Prosthetic appliances will not routinely be made for every inmate who has a tooth or teeth missing. All inmate requests to staff members will be answered, signed, dated, and returned by the dentist(s) or civilian dental assistants. Questions regarding an inmate's status on the waiting list will be handled by the inmate request forms only.

(d) Treatment for uncommitted residents and marshall's prisoners: Inmates who have not been committed to the institution will be treated only on an emergency basis. No routine dental treatment will be provided.

(e) Treatment for inmates confined to segregation: Inmates confined to segregation units will be treated only on an emergency basis. No routine dental treatment will be provided.

NOTE: Exclusion of (d) and (e) categories of inmates are for several reasons. Both categories of patients would require escort by members of the correctional staff and are likely to tie up security staff who are needed elsewhere. Both categories are likely to present security problems to both the correctional and professional staff. In addition, with the long waiting lists and high need/demand of the committed residents, priorities must be given to them, at the expense of noncommitted and marshall's prisoners (category d).

(f) Failure to report for appointment: Patients failing to report for an appointment made through a call from a staff person (emergency or interim appointment) or via the call-out sheet (interim or routine appointment) will not routinely be reappointed. If the appointment missed was for emergency or interim care, a staff member will have to call and request again that the [illegible]tient be seen. Patients missing a routine appointment will be [illegible]ved from the waiting list and will be required to submit another request to staff members in order to be returned to the bottom of the waiting list. Legitimate excuses will be considered on an individual basis, however, in all cases of missed appointments, an incident report may be filed, and notations will be made in the dental record.

(g) Patient accountability:

(i) An inmate reporting to the dental clinic for an appointment must have a pass, even if his name is on the call-out sheet. Inmates reporting to scheduled appointments without passes may be rescheduled at the discretion of the dentist or civilian dental assistant, and might therefore forfeit that particular time to another inmate. Notations will be made in the dental record in all cases of patient tardiness.

(ii) Since all patients are seen by appointment only as previously stated, inmates coming to the clinic without an appointment and a pass are to be considered out of bounds; this possibly resulting in the filing of an incident report (at the discretion of the dentist or civilian dental assistant). Again, a notation will be made in the patient's dental record.

(iii) Patients are expected to report on time for their appointments. Patients reporting more than five minutes late will have their appointment rescheduled. The second time that a patient reports for his appointment more than five minutes late, his appointment will be cancelled and his name will be placed at the bottom of the waiting list. Legitimate excuses will be considered on an individual basis by the dentist or civilian dental assistant. However, all incidents will be documented in the patient's dental record.

# APPENDIX C: DENTAL EMERGENCY REFERENCE*

NOTE: These references are presented only as guidelines for the dianosis of dental emergencies -- professional discretion of the attending dentist must take precedence over such generalized guidelines.

1. There is seldom a true dental emergency. In fact, many metropolitan hospitals have discontinued the service due to lack of patients and need.

2. Common dental problems that might be encountered:

   A. Tooth Ache

   A severe tooth ache will have a sudden onset and will disappear just as suddently.

   Remedies:
   1. A pledget of cotton soaked in Dentalone or Eugenol placed in the cavity.
   2. Aspirin or Tylenol taken orally and swallowed.
   3. Hot or cold towel, whichever provides relief.
   4. Schedule on next dental call.

   B. Variations of Tooth Ache

   Sensitive Tooth After Fillings

   1. Most teeth can be sensitive a few days after a filling and this usually subsides, disappears.
   2. Filling might have a high spot or interference in biting and usually is indicated by a shiny spot on the filling where it strikes. Solution - often adjusts itself by wear or in some cases the dentist must reduce the interference if pain persists. This should be done as soon as possible.
   3. Tooth is sensitive to biting because of being loose. Remedy is extraction because of gum infection caused by mobility. Schedule on next visit of dentist.

---

*Source: Division of Dental Services, Office of Health Care, Michigan Department of Corrections, William J. Byland, D.D.S., Assistant Director.

Tooth Sensitive To Cold

Causes can be:

1. New filling
2. Cavity present
3. Receding of gum line around neck of tooth
4. Usually can be corrected by dentist
5. Some teeth can be sensitive by their very nature

Tooth Sensitive To Heat

Indicates an abscessed tooth. Usually not sensitive to cold. Advise extraction. This can be a moderate to severe sensitivity and the severe condition will obtain instant relief by application of cold water or towel.

C. Abscess - Swelling - Cellulitis

1. Can be sensitive or not sensitive

2. May appear frightening in appearance

3. Often is present after extraction if the area has been severely infected or mouth condition generally dirty

Remedies:

1. If dentist unavailable, have physician call in prescription to nearest druggist.

2. See dentist at first opportunity.

3. If painful, use aspirin, Tylenol or hot or cold application, whichever feels better.

D. Gum Boil

A common name for a fistula draining an infected area, tooth or periodontal (tissue around tooth root) involvement. This is usually chronic and not painful, however, should receive dental attention and extraction or removal of cyst is indicated. Will never correct itself by medication.

E. Extraction Related Problems

Swelling Post-Operative - see Section C, Remedies (above).

Sharp Edge to Tongue and Area Sensitive and Painful

Cause: Bone fragment or root fragment

Remedy: Sometimes comes out by itself, other times, dentist will have to remove before healing can be completed.

Excessive Bleeding

Remedies:

1. Apply cotton gauze pad, very small, but thick enough to provide pressure when biting down. Avoid spitting. Do not lay down. Application of ice (wrapped in towel) will slow the bleeding.

2. May appear as a large purplish glob hanging in mouth from socket. This indicates weakness in clotting mechanism. Call prescription for Vitamin K, refer to Section C, Remedies.

3. If blood flow is heavy or extreme, take to neareast emergency room for attention, BUT ONLY IF HEAVY FLOW.

4. Bleeding usually ceases after 4-6 hours, in a few cases this can be as long as overnight and we are referring to slight amount of bleeding and not the condition referred to above in 2 and 3.

Dry Socket

Blood clot does not develop after extraction and symptoms are pain, bad taste, odor, headache. Solution - have dentist pack area. Usually takes 14 days for condition to begin healing as discomfort gradually subsides. Individuals that have had this condition will often experience this condition. Does not usually indicate serious pathology or problem.

F. Third Molar Eruption Problem

Patient will complain about swelling in back of last lower molar and tender to biting and in some cases difficult and even impossible to open mouth. Usually temperature present.

Remedy: Call sources for prescription of antibiotic (check if patient is allergic). This usually reduces swelling and then patient should be scheduled to see the dentist.

G. Tenderness or Difficulty in Opening Mouth After Injection of Local Anesthetic

Cause: Anesthetic needle penetrated muscle tissue

Remedy: Tenderness will gradually disappear - may take 7-14 days - can apply moist heat.

H. Serious Injury

Fractured Tooth

Pink area can be seen which is the pulp chamber of the tooth. Suggest emergency room if extreme discomfort and dentist is not available.

Any severe blow or injury to face should be X-rayed at the first opportunity.

Symptoms of pain can subside after 24-48 hours and then appear as severe condition at a later time.

## APPENDIX D: SAMPLE POSITION DESCRIPTIONS

The following sample position descriptions were adapted from those currently in use at several correctional facilities. They are presented as examples of some of the areas that should be covered by position descriptions. They are not considered ideal for all situations, however, and should therefore not be used in the institutions without site-specific modifications. For instance, several of the descriptions required certain functions of the dental auxiliaries that would be in violation of other states' dental practice acts. Correctional health administrators therefore should be aware of their state's dental practice acts and other institutional or system constraints, policies or guidelines before adapting any of these position descriptions to their own situation.

APPENDIX D:

1. Sample position description for Level I Dental Assistant

DENTAL ASSISTANT (Correctional)

LEVEL 1

## I. Introduction

Incumbent serves as Dental Assistant in the Health Services Department at the ___________ Correctional Institution, _____, _____. For a preponderant part of the time, incumbent provides technical chairside assistance, as well as clinical support duties, to the dentist(s) who is/are responsible for the dental care and treatment of institutional residents. Reference is made to the institution's organizational charts which show the lines of supervision and the number of subordinates.

## II. Major Duties and Responsibilities

The duties and responsibilities consist of, but are not necessarily limited to, the following:

1. Receptionist

   a. Maintains complete records in the prescribed manner.

   b. Schedules all clinical activities in such a manner that a consistent balance of dental services are rendered.

   c. Appoints patients.

   d. Takes routine dental history of patients, noting any remarkable findings which are called to the Dental Officer's attention.

   e. Receives the patient, which includes seating the patient and providing any reasonable comfort; administering any prescribed oral pre or postoperative oral medication; whenever necessary, reassures the patient in order to reduce apprehension and encourage cooperation with the Dental Officer.

   f. Prepares the monthly dental statistical report.

   g. Provides postoperative instructions for routine procedures.

2. Maintenance Duties

   Incumbent is responsible for the housekeeping procedures of the dental clinic, which includes maintaining a clean operatory; cleaning, sterilization, and storing of instruments and equipment; and the inventory and ordering of supplies.

1. (Cont'd.)

3. Chairside Assistant

a. Exposes and develops routine x-rays.

b. Determines from the treatment prescription what instruments and materials will be required for a given operation and prepares operatory with such prior to receiving patient.

c. Assists during treatment in an alert manner so as to instantly recognize the dentist(s)' need for instruments materials, retraction, etc., in order that services are rendered in a smooth and consistent manner.

d. Mixes and fabricates restorative materials as required in the immediate clinical area.

e. Assists in the clinical procedures of prosthetic dentistry.

f. Assists in clinical oral surgical procedures with the dentist and consulting oral surgeon.

g. Performs laboratory procedures such as pouring and trimming of casts, fabrication of custom-made trays, repair of dentures, etc.

h. Incumbent must be skilled in recognizing symptoms of fainting and shock in order to be able to call those conditions to the attention of the dentist(s), and provides necessary aid as directed during emergency procedures.

III. Job Controls

The dental assistant is immediately responsible to the dental directory, who delegates to the incumbent a wide latitude of authority in decision-making. Incumbent normally receives specific instructions from the dentist(s), however, in unusual and emergency cases.

IV. Other

Position requires that incumbent possess a knowledge of, and the ability to perform all duties of assistance in restorative dentistry, oral surgery, and prosthetic dentistry. The incumbent is also required to be able to function independently in dental radiography.

The dental assistant supervises dental students on clinical assignments to the dental clinic and is responsible for the security of dangerous supplies, e.g., needles, syringes, and surgical instruments.

Incumbent must be certified as a Dental Assistant by the American Dental Assistants Association.

1. (Cont'd.)

This position requires frequent direct contact with prisoners and the incumbent is a "law enforcement officer" as the term applies to retirement eligibility.

APPENDIX D (cont'd)

2. Sample position description for Level I Dental Assistant (alternate description)

DENTAL ASSISTANT (Correctional)

LEVEL 1

______ Correctional Institution

__________, ________

I. Introduction

The incumbent performs all types of dental assistance at the ______ Correctional Institution, ________, ________. Residents being treated have somewhat involved medical and social histories making treatment much more complicated and difficult. Males and females of various ages are treated.

II. Major Duties and Responsibilities

1. Reception

   Establishes and maintains dental record, receives and prepares patient for treatment, reappoints and dismisses patient.

2. Assistance to the Dentist

   a. Serves as the first assistant to the dentist during the delivery of dental care using the techniques of "Four Handed Dentistry" for all aspects of dentistry

   b. Prepares instruments for the procedure indicated

   c. Has knowledge of treatment procedures and assists in restorative dentistry, oral surgery, periodontics, prosthodontics and endodontics

3. Dental Radiology

   Operates dental radiographic equipment, exercises skill in methods of positioning patient and determining exposure, processes and mounts the film.

4. Clinic Operations

   a. Assists in the preparation of dental call-out

   b. Keeps dental operatories supplied

   c. Performs support functions including filing, preparing reports, correspondence, etc.

2. (Cont'd.)

5. Penological Responsibilities

Exercises supervisory custodial control over assigned resident workers and resident patients. Responsible for the safeguarding of drugs and general hospital security in a correctional setting. Maintains constant alertness to conditions which might endanger the security of the institution, personnel and residents.

6. Supervision, Training, Guidance of Residents

Supervises, lectures and provides on-the-job training for residents enrolled in the "Dental Assistant Training Program".

7. Expanded Duty Dental Assistant (EDDA) Functions

Has the knowledge and ability to perform services beyond those regularly assigned to a dental assistant. Included are: placement of matrix bands, fabrication and cementation of temporary crowns, suture removal and placement of dressings, taking impressions for study casts, teaching dental disease control to patients.

8. Performs other duties as assigned

9. Assumes the duties of the Senior Dental Assistant when necessary

III. Supervision & Guidance Received

Works under the direction of the senior dental assistant and dentist. Follows established clinical techniques, procedures and policies and uses own initiative and tact in assigned duties.

IV. Other

This position requires frequent direct contact with prisoners and the incumbent is a "law enforcement officer" as the term applies to retirement eligibility.

APPENDIX D (cont'd)

3. Sample position description for Level II Senior Dental Assistant

________ CORRECTIONAL INSTITUTION

________, ____________

Senior Dental Assistant (Correctional) - Level II

I. Introduction

The position is located in the Dental Clinic of the Medical-Educational Complex of the ________ Correctional Institution, ________,____________. The heart of the incumbent's work will involve chairside assisting with expanded duty functions and clinical support for the dentist, who is responsible for the dental care and treatment of the residents of the institution. In addition, however, the incumbent will be responsible for coordinating and supervising many of the phases of clinic operations including security.

II. Major Duties and Responsibilities

The duties and responsibilities consist of, but are not necessarily limited to, the following:

A. Chairside Assisting

1. Determines from the dentist or treatment plan which instruments and materials will be required for a given operation, and prepares the operatory for the patient.
2. Seats the patient and provides reasonable comfort; administers preoperative oral medication; whenever necessary reassures the patient in order to reduce apprehension and anxiety and encourages cooperation with the dentist.
3. Assists during treatment in an alert manner so as to instantly recognize the dentist's need for instruments, materials, etc., so that care is rendered in a smooth, efficient, consistent manner.
4. Mixes and fabricates restorative materials as required.
5. Assists in the clinical procedures of prosthetic dentistry.
6. Assists in surgical procedures with the staff dentist and consultant Oral Surgeon.
7. Assists in the procedures of endodontic treatment, endodontic surgery and periodontal surgery.
8. Provides the patient with postoperative instructions following routine procedures.
9. Exposes and develops routine x-ray films.

3. (Cont'd.)

10. Performs laboratory procedures such as pouring models, trimming casts, fabrication of custom trays and occlusion rims, repair of dentures, construction of wrought wire partials, etc.
11. Possesses ability and awareness to recognize symptoms of fainting and shock in order to be able to call these conditions to the attention of the dentist and provides necessary aid as directed during emergency procedures.

B. Hygienist

1. Gives patients instruction in areas relating to their proper oral hygiene including brushing, flossing and proper diet.
2. Performs dental prophylaxes under the dentist's direct supervision.
3. Applies topical fluoride to patient's teeth.
4. Takes alginate impressions for the construction of simple wrought wire partials under the Dental Officer's supervision.
5. Takes medical histories and performs initial examinations on new commitments which are subsequently checked by the dentist.
6. Removes sutures.

C. Supervisor

1. Is directly responsible for the smooth running of the operations of the dental clinic both when the dentist is present and in his absence.
2. Schedules all clinical activities in such a manner that a consistent balance of dental services is rendered.
3. Sees to it that the clinic is always clean.
4. Takes inventory and assures that supplies and instruments are stocked in sufficient quantity.
5. Manages the daily maintenance of the dental units.
6. Instructs and supervises resident worker(s) in their assigned duties.
7. Aids in the orientation and supervision of dental students assigned to the clinic from the University of __________.
8. Has the primary responsibility for the orientation and supervision of the dental assistant students on their assignments from __________ Community College.
9. Makes daily security checks of needles and assists in the constant security evaluation of the clinic.

D. Secretary and Bookkeeper

1. Answers written inmate requests and maintains a list of all residents desiring care.
2. Appoints patients.
3. Maintains complete records in the prescribed manner.

3. (Cont'd.)

4. Compiles the figures for the daily, monthly, and quarterly statistical reports.
5. Types all memorandums, letters and written documents sent from the dental clinic.
6. Compiles and types all purchase orders and requisitions.
7. Occasionally acts in the capacity of Medical Records Technician in his/her absence.

E. Other

1. May instruct other hospital employees in basic dental emergency procedures, dental x-ray work, dental terminology, oral hygiene instruction, etc.
2. Schedules for him/herself and the dentist time for continuing dental education to keep abreast of current developments.

The incumbent must be a Certified Dental Assistant by the American Dental Assistants Association.

This position requires frequent direct contact with prisoners and the incumbent is a "law enforcement officer" as the term applies to retirement eligibility.

APPENDIX D (cont'd)

4. Sample position description for Level II Dental Assistant (alternate description)

_______ CORRECTIONAL INSTITUTION

________, ___________

Senior Dental Assistant (Correctional) - Level II

I. Introduction

This position is located in the Dental Clinic of the Comprehensive Health Services Unit, _______ Correctional Institution, ________, _______. The incumbent, while primarily serving as a Dental Assistant with expanded duty functions, will have the additional duties of coordinating certain clinical activities, supervising and training of "resident" dental assistants and dental auxilliary interns and assisting in security control in the dental clinic area.

II. Major Duties and Responsibilities

The incumbent will regularly perform the necessary procedures for assisting the dental professional staff in the following dental disciplines: operative, prosthetics, periodontics, endodontics, radiology, and oral surgery. To achieve this, the individual must exhibit a thorough knowledge of dental terminology and its uses in charting, history taking and treatment documentation; of dental instruments and their uses and of the mixing and handling properties of the following dental materials: amalgam, composites, polysulfide base, and silicone base rubber impression material, gypsum products, acrylics, irreversible, hydrocolloid, zinc-oxide-eugenol preparation, and dental cements. The incumbent must exhibit expertise in the concept of four-handed dentistry, high volume evacuation, the taking, processing and mounting of periapical and occlusal radiographs, the placing of rubber dams, and the removal of sutures and periodontal dressing.

The incumbent will supervise the hiring and will coordinate the training of "resident" dental assistants to a functional performance level in clinical and laboratory procedures, supervise and assist in the training of dental hygiene and dental assistant interns on rotation from local academic institutions.

The incumbent will perform and be responsible for daily security checks of needles and syringes and assist in the constant security evaluation of the "residents" in the dental clinic.

The incumbent will perform ultrasonic prophylactic procedures and topical fluoride application under the direct supervision of the professional staff. The incumbent will be directly involved in the education aspect of the preventive dentistry program conducted for the "resident" population.

4. (cont'd.)

The incumbent will perform the following laboratory procedures as directed by the professional dental staff: model pouring and trimming; processing, repairing and polishing of prosthetic appliances; fabrication of custom trays and bite blocks.

The incumbent is responsible for the proper sterilization of instruments and the daily maintenance of high speed hand pieces and oral evacuation systems.

The incumbent is responsible for maintaining daily clinical appointments, the preparation of letters and memos as required and the supervision of the accumulation of statistical data for the preparation of quarterly and annual reports for approval by the dental officer(s).

## III. Job Controls

The incumbent will work independently in all areas of the position with review and supervision supplied by the professional dental staff.

This position requires direct contact with prisoners and the incumbent is a "law enforcement officer" as the term applies to retirement eligibility.

APPENDIX D (cont'd.)

5. Sample position description for Level III Dental Assistant

_______ CORRECTIONAL INSTITUTION

_______, _______

Dental Clinic Supervisor (Correctional) - Level III Dental Assistant

I. Introduction

Incumbent performs all types of dental assistance at the _______ Correctional Institution, _______, _____. Residents being treated frequently have involved medical and social histories related to abuse of drugs and alcohol which makes treatment more complicated and difficult. Incumbent serves as primary supervisor/instructor for the resident training program in dental assistance at the _____ Correctional Institution. Additional duties include serving as principal assistant in more involved clinical procedures. Supervises one staff dental assistant and 8-10 resident dental assistant trainees in all phases of dental assistant activities and education.

II. Major Duties and Responsibilities

Incumbent has primary responsibility for organizing and conducting the resident training program in dental assistance. Arranges weekly lectures and training schedules; presents lectures, demonstrations, and supervises the presentation of additional material to provide individual instruction for resident trainees in on-the-job clinical experience. Counsels resident trainees to stimulate their interest in obtaining good work habits and acquiring a marketable skill.

Incumbent is well informed in all clinical specialties and serves as principal assistant in the more involved clinical cases. Is able to properly prepare all instruments and supplies for use in the various treatment phases of endodontics, periodontics, restorative, crown and bridge, prosthodontics and oral surgery. She is skilled in all aspects of dental radiology and uses proper radiation hygiene in making intra-oral and extra-oral radiographs. Incumbent provides dental assistant instruction in all these areas of clinical dentistry.

Performs Expanded Duty Dental Assistant (EDDA) Functions: After the cavity preparation has been completed by the dentist, the incumbent places the cement base and cavity liner, contours and adapts the matrix band, inserts and contours the filling material. Incumbent fabricates and cements temporary crowns, places surgical dressings, removes sutures and makes study cast impressions. Provides post-treatment instructions and instructs patients in proper dental disease control techniques.

5. (cont'd.)

Incumbent supervises the scheduling of all appointments in the dental clinic for four dentists, four dental hygiene students and consultants. Is responsible for keeping the dental operatories supplied, procurement of pharmaceutical supplies and sterile solutions, arrangements for special diets and nutrition as they relate to health, and obtains necessary repairs and maintenance from Mechanical Services. Incumbent also performs and/or supervises a variety of support functions such as filing, preparation of reports, correspondence, etc. Keeps records of patients with medical conditions requiring special pretreatment medications and assures these services are provided prior to the time of treatment.

Exercises supervisory custodial control over assigned resident workers and resident patients. Responsible for safeguarding of drugs and general hospital security, maintaining constant alertness to conditions which might endanger the security of the institution, staff and residents. Serves as custodial escort for residents to medical appointments in downtown Lexington.

III. Job Controls

Works with minimum supervision of the dentists. Follows established clinical techniques, procedures and policies and uses own initiative and tact in assigned duties. Except in very unusual situations, performs without direct supervision.

This position requires frequent direct contact with prisoners and the incumbent is a "law enforcement officer" as the term applies to retirement eligibility.

APPENDIX D (cont'd)

6. Sample position description for Level III Dental Assistant (alternate description)

_______ CORRECTIONAL INSTITUTION

____________, __________

Dental Clinic Supervisor (Correctional) - Level III Assistant

I. Introduction

This position is located in the Dental Clinic of the Comprehensive Health Services Unit, _____ Correctional Institution, _______,_______. The incumbent serving as a Dental Clinic Supervisor supports the dentist(s) by coordinating certain clinical activities, supervising and training of "resident" dental assistants and dental auxilliary interns and assisting in security control in the dental clinic area. This incumbent supports the dental mission by being responsible for the following functions:

II. Major Duties and Responsibilities

The incumbent will regularly perform the necessary procedures for assisting the dental professional staff in the following dental disciplines: operative, prosthetics, periodontics, endodontics, radiology, and oral surgery. To achieve this, the individual must exhibit a thorough knowledge of dental terminology and its uses in charting, history taking and treatment documentation; of dental instruments and their uses and of the mixing and handling properties of the following dental materials: amalgam, composites, polysulfide base, and silicone base rubber impression material, gypsum products, acrylics, irreversible, gydrocolloid, zinc-oxide-eugenol preparation, and dental cements. The incumbent must exhibit expertise in the concept of four-handed dentistry, high volume evacuation, the taking, processing and mounting of periapical and occlusal radiographs, the placing of rubber dams, and the removal of sutures and periodontal dressing.

The imcumbent will supervise the selection and coordinate the training of "resident" dental assistants to a functional performance level in clinical and laboratory procedures; supervise and assist in the training of dental hygiene and dental assistant interns on rotation from local academic institutions.

The incumbent will perform and be responsible for daily security checks of needles and syringes and assist in the constant security evaluation of the "residents" in the dental clinic.

The incumbent will perform ultrasonic prophylactic procedures and topical fluoride application under the direct supervision of the professional staff. The incumbent will be directly involved in the education aspect of the preventive dentistry program conducted for the "resident" population.

The incumbent will perform the following laboratory procedures as directed by the professional dental staff: model pouring and trimming;

6. (cont'd.)

processing, repairing and polishing of prosthetic appliances; fabrication of custom trays and bite blocks.

Dental Clinic Supervisor (Correctional) - Level III Dental Assistant

The incumbent is responsible for the proper sterilization of instruments and the daily maintenance of high speed hand pieces and oral evacuation systems.

The incumbent is responsible for maintaining daily clinical appointments; the preparation of letters and memos as required and the supervision of the accumulation of statistical data for the preparation of quarterly and annual reports for approval by the dental officer(s).

The incumbent's primary responsibility will be to supervise the other dental assistants, to insure that the dental staff operates in an efficient and effective manner, and to be responsible for coordination of staff, patients, and operatories. The Dental Clinic Supervisor will be the administrative superior over the other dental assistants and will report directly to the dental director concerning administration of the other assistants' work schedules, efficiency evaluations, and in-office training.

III. Job Controls

The incumbent will work independently in all areas of the position with review and supervision supplied by the professional dental staff.

IV. Other

This position requires direct contact with prisoners and the incumbent is a "law enforcement officer" as the term applies to retirement eligibility.

APPENDIX D (cont'd)

7. Sample position description for Level IV Dental Assistant

_________ CORRECTIONAL INSTITUTION

______________, ______________

Senior Dental Clinic Supervisor (Correctional) - Level IV Dental Assistant

I. Introduction

The position is located in the Dental Clinic of the Medical-Educational Complex of the ______ Correctional Institution, ________, ________. The incumbent serves as dental clinic supervisor with primary responsibilities involving chairside assisting with expanded functions and clinical support for the dentist(s), who is/are responsible for the dental care and treatment of the residents of the institution. In addition, the incumbent will be responsible for coordination and supervision of the many phases of clinical, laboratory, and administrative operations including security.

II. Major Duties and Responsibilities

The duties and responsibilities consist of, but are not necessarily limited to the following:

A. Dental Clinic Supervisor:
1. Is directly responsible for the smooth running of the operations of the dental clinic both when the dentist(s) is/are present and in his/their absence.
2. Schedules all clinical activities in such a manner that a consistent balance of dental services is rendered, including making all appointments for patients.
3. Maintains custodial control over the resident worker(s) and patients.
4. Instructs and supervises resident worker(s) in the performance of his/her duties.
5. Is responsible for the maintenance of proper sanitation conditions of the dental clinic.
6. Practices sound inventory control and assures that supplies and instruments are stocked in sufficient quantity to provide for efficient operation of the dental clinic.
7. Is responsible for the security of dangerous supplies such as needles, syringes, drugs, dental instruments, laboratory equipment, etc. of the dental clinic.
8. Is responsible for the daily maintenance of the dental units.
9. Aids in the orientation and supervision of dental students (from the University of ________, Department of Community Dentistry) who rotate through the clinic.
10. Aids in the orientation and supervision of dental hygiene students (from the University of _______, School of Dental Hygiene) in their rotation through the clinic.

7. (cont'd.)

11. Has the primary responsibility for the orientation and supervision of the dental assisting students on their extramural assignments from _______ Community College.
12. Acts as liaison between the Dental Department and the consultant dental specialists concerning scheduling of patients to be seen in-house or at community medical facilities.
13. Acts as liaison between the Dental Department and the scheduling staffs of the various educational institutions assigning students to the department for their extramural programs (The University of _______ and _______ Community College), insuring efficiency and continuity of departmental programs.
14. Acts as liaison between the Dental Department and the _______ _________ Hospital Dental Department concerning scheduling or continuing dental education courses offered by their service.

B. Dental Records Technician:

1. Answers written inmate requests and maintains a log of all residents desiring routine dental care.
2. Maintains complete records in the prescribed manner.
3. Compiles the figures for the daily, monthly, and quarterly statistical reports.
4. Types all memoranda, reports, letters, and written documents originating from the Dental Department.
5. Compiles and types all purchase orders and requisitions.
6. Obtains departmental mail from the institution mailroom or hospital administrator's office.
7. Provides the Dental Director with copies of all directives and memoranda from the Department of Justice, Bureau of Prisons, or local institution that pertain to the operation of the department.

C. Chairside Assistant:

1. Determines from the dentist(s) or from the treatment plan which instruments and materials will be required for a given operation and prepares the operatory for the patient.
2. Seats the patient and provides reasonable comfort; administers any ordered preoperative oral medication; whenever necessary reassures the patient in order to reduce apprehension and anxiety and encourages cooperation with the dentist(s).
3. Assists during treatment in an alert manner so as to instantly recognize the dentist's need for instruments, materials, etc. so that care is rendered in a smooth, efficient, and consistent manner.
4. Mixes and fabricates restorative materials as required.
5. Assists in the clinical procedures for prosthetic dentistry.
6. Assists in surgical procedures with the staff dentist(s) and consultant oral or periodontal surgeon.
7. Assists in the procedures of endodontic treatment, endodontic surgery, and periodontal surgery.
8. Provides the patient with postoperative instructions following routine procedures.
9. Exposes and develops routine radiographs, both intraoral and extraoral.

7. (cont'd.)

10. Possesses ability and awareness to recognize symptoms of fainting and shock in order to be able to call these conditions to the attention of the dentist(s) and provides necessary aid as directed during emergency procedures.

D. Dental Laboratory Technician

1. Takes impressions and pours models for diagnostic, master, or working casts including any necessary trimming and mounting (on the appropriate articulator).
2. Fabricates custom trays, baseplates, and occlusion rims.
3. Repairs, relines, or rebases complete or partial dentures.
4. Fabricates wrought wire prostheses, splints, and mouth protectors.

E. Oral Hygienist and Expanded Function Dental Auxiliary

1. Gives patients instruction in areas relating to their proper oral hygiene including brushing, flossing, and proper nutrition.
2. Performs dental prophylaxis under the general supervision of the dentist(s). This includes scaling and polishing the teeth and the polishing of amalgam restorations.
3. Applies topical fluoride to patients' teeth.
4. Takes medical histories and performs initial examinations on new commitments and records the findings in the prescribed manner. These examination findings are subsequently reviewed by the dentist(s).
5. Removes sutures on postsurgical patients.
6. Places the appropriate sedative packing in postsurgical sockets for the treatment of acute localized osteitis (dry socket) at the direction of and in consultation with the dentist(s).
7. Places sedative pulpal dressings and temporary restorations to relieve acute sensitivity in patients having teeth with large carious lesions or fractured coronal structures (including fractured or lost restorations).
8. Condenses and carves amalgam restorations in cavities prepared by the dentist(s).
9. Places and finishes composite resin restorations in cavities prepared by the dentist(s).
10. Recements avulsed permanent or temporary crowns or bridges and adjusts occlusion subsequent to cementation.
11. Fabricates and cements necessary temporary crowns to replace lost, damaged, or fractured crowns or for the immediate relief of sensitivity due to caries or fractured tooth structure.
12. Dispenses the appropriate analgesic or antibiotic medication or prescription at the direction of the dentist(s), or at the direction of the physician or medical technical assistants in the event of the dentist(s)' absence.
13. Is responsible for the adequate sterilization and disinfection of instruments, equipment, and supplies.

F. Other duties

1. May instruct other hospital employees in basic dental emergency procedures, dental radiography, dental terminology, oral hygiene instruction, nutrition, sterilization procedures, etc.
2. Schedules for himself/herself and the dentist(s) time for

7. (cont'd.)

continuing dental education to keep informed of new developments in dental science and to constantly review medical, surgical, and dental techniques.

III. Job Controls

The incumbent will work independently in all areas of the position with review and supervision supplied by the professional dental staff.

IV. Administrative Controls

The incumbent is administratively responsible to the Hospital Administrative Officer who delegates to the incumbent a wide latitude of authority is decision-making, and is professionally responsible to the Dental Director.

V. Other

This position requires frequent direct contact with prisoners and the incumbent is a "law enforcement officer" as the term applies to retirement eligibility.

APPENDIX D (cont'd.)

8. Sample position description for Level IV Dental Assistant (Alternate Description)

SENIOR DENTAL CLINIC SUPERVISOR (CORRECTIONAL)

LEVEL IV DENTAL ASSISTANT

I. Introduction

Incumbent serves as Senior Dental Clinic Supervisor in the Health Services Department at the _________ Reformatory in _______,_________. For the majority of the time, the incumbent provides overall supervision of dental clinic, dental hygiene services, dental laboratory services, as well as clinical support duties such as the supervision and training of resident workers in the field of chairside assistance, x-ray, and laboratory work to support the dentist(s) who are responsible for the dental care and treatment of residents in this institution.

II. Major Duties and Responsibilities

The duties and responsibilities consist of, but are not necessarily limited to,the following:

A. Dental Clinic Supervisor: Maintains custodial control over the resident worker(s) and patients; trains and supervises resident workers in x-ray, chairside assistance, and laboratory procedures; maintains complete records in the prescribed manner; schedules all clinical activities in such a manner that a consistent balance of dental services is rendered, including making all appointments for patients; is responsible for the security of dangerous supplies such as needles, drugs, and syringes, etc.; is responsible for the maintenance of proper sanitation conditions of the dental clinic; assures that supplies and instruments are stocked in sufficient quantity.

B. Dental Hygienist: Maintains a dental prophylaxis program that requires the performance of prophylaxis, polishing teeth, amalgams, fluoride treatments, all dental x-rays, and temporary tooth restorations; is responsible for instructing the patient concerning proper oral hygiene (brushing, use of dental floss, diet, etc.); performs oral examinations of new patients, charts in the prescribed manner, recognize any abnormalities such as cavities, texture and surface, color, disease, etc.

C. Dental Technician: Supervise and perform the following duties in the dental laboratory: fabrication of removable full and partial dentures that include impressions, master casts, occlusion rims, articulators, and identification and selection of denture teeth, arrangement of denture teeth for typical and atypical conditions, waxing of trial dentures, flasking and elimination of wax, and packing and polymerizing (curing) acrylic resin, deflasking and remounting, correcting the occlusion, recovering, finishing, and polishing the completed dentures, repair, reline, and rebase an old denture; fabricate wrought wire prostheses, splints, orthodontic appliances, resilient denture base lining material, mouth protectors, and guards.

8. (cont'd.)

D. Chairside Assistant: Supervise and train resident workers as chairside assistants in the following areas: determining the correct instruments and materials that will be required for any given operation; receiving the patient (includes seating patient and providing any reasonable comfort), reassuring the patient in order to reduce apprehension and encourage cooperation with the dental officer; assisting the dental officer during the treatment in an alert manner so as to recognize the need for instruments, materials, etc., so that services are rendered in a smooth, efficient, consistent manner; assist the staff dental officers and consultant oral surgeons with surgical procedures; expose and develop routine x-ray films; mix and fabricate restorative materials as required; and provide necessary aid as directed during emergency procedures.

OTHER: Instructs physician assistants in basic dental emergency procedures, dental x-ray, dental terminology, oral hygiene, etc.; provides all new commitments, while in A&O status, with information of dental services and medical services available to them while incarcerated.

III. Controls Over Work

The Dental Clinic Supervisor is immediately responsible to the Dental Director who delegates to the incumbent a wide latitude of authority in decision-making. The incumbent receives specific instructions concerning treatments for a patient from the Attending Staff Dental Officer.

This position requires frequent direct contact with prisoners and the incumbent is a "law enforcement officer" as the term applies to retirement eligibility.

APPENDIX D (cont'd)

9. Sample position description for Dental Hygienist (Correctional)

Dental Hygienist (Correctional)

## I. Introduction

The position is located in the Dental Clinic of the Comprehensive Health Services Unit, _______Correctional Institution, _______,______. The incumbent, serving as a dental hygienist, supports the dentist(s) by coordinating certain clinical activities, supervising and training of assigned dental hygiene students, and assisting in security control in the dental clinic area. The incumbent supports the dental mission by being responsible for the following functions:

## II. Major Duties and Responsibilities

The incumbent will regularly perform the necessary procedures relevant to the practice of dental hygiene. The incumbent is resposible for providing all of the following functions: oral examination and diagnosis, topical application of fluoride, oral radiography, patient education, prophylaxis, polishing of restorations, deep scaling, root planing, curettage, and the necessary infiltration anesthesia required in the performance of his/her duties. The incumbent may also be required to supervise and train dental or dental hygiene students assigned to the dental clinic by local professional educational institutions.

The incumbent will assist the other professional staff in the performance of daily security checks and will be responsible for constant security evaluation of the hygiene section of the dental clinic.

The incumbent is responsible for proper sterilization and disinfection of instruments and equipment used in his/her daily activities and will be responsible for performing daily maintenance of equipment in the hygiene operatory.

The incumbent is responsible for maintaining his/her own appointment list and will be required to establish and maintain a proper recall schedule for all patients.

## III. Job Controls

The incumbent will work independently in all areas of the position with review and supervision supplied by the dental director.

## IV. Other

This position requires frequent direct contact with prisoners and the incumbent is a "law enforcement officer" as the term applies to retirement eligibility.

APPENDIX D (cont'd)

10. Sample position description for Staff Dentist (Correctional)

1. Organization (Bureau, Division, Branch, Section, etc.) and location of duty station:

_________________ Area _________________ Service Unit

Facility:_____________ City:_______________ State:__________

2. Functional Title - Staff Dentist

3. Pertinent program information (e.g. size of hospital; geographic limits of water pollution control project; type of hospital; primary function and size of Branch, Section, Unit; etc.):

The Dental Program includes preventive, educational and corrective dental services to inmates who fall within the scope of the Correctional Dental Program. This position is located in (City) _________________ (State)_____________ with a clinical staff of ________dentists and ________dental auxiliaries.

4. Brief statement of most important duties, including significant supervisory responsibilities and work relationships:

1. Provides dental health services to the designated population in accordance with policies of the dental department.

2. Provides information and assistance to the Dental Director for the purpose of program development, implementation and evaluation.

3. Participates in development and maintenance of public relations with other health disciplines and other official and non-official health, educational, and governing organizations.

4. Assists the Dental Director in the supervision, technical and professional guidance of other dental personnel as assigned.

5. Direction received (title of supervisor and type of direction received and assignment of work, during course of work, and at its completion):

Supervision is provided by the Dental Director through personal contact. Technical guidance is provided by the Dental Director by review of work, reports, and personal contact. Appraisal by Standards of Performance.

6. Minimum qualifications (education and experience) required to perform satisfactorily:

D.D.S., or D.M.D. Degree from an accredited school of dentistry

APPENDIX D (cont'd)

11. Sample position description for Senior Staff Dentist (Correctional)

1. Organization (Bureau, Division, Branch, Section, etc.) and location of duty station:

_______________ Area _______________ Service Unit

Facility:_______________ City:_______________ State:_______________

2. Functional Title - Senior Staff Dentist

3. Pertinent program information (e.g., size of hospital; geographic limits of water pollution control project; type of hospital; primary function and size of Branch, Section, Unit; etc.):

The Dental Program includes preventive, educational and corrective dental services for the inmates who fall within the scope of the Correctional Dental Program in the ___________ Service Unit. The dental staff is composed of _________ dentist(s) and _________ dental auxiliaries.

4. Brief statement of most important duties, including significant supervisory responsibilites and work relationships:

1. Provides dental health services to the designated inmate population in accordance with policies of the dental department.

2. Participates in development and maintenance of public relations with other health disciplines and other official and non-official health, educational, and governing organizations.

3. Assists the Dental Director in supervision and professional guidance of other personnel as assigned.

4. Provides special consultant, research, educational and administrative services as requested by the Dental Director.

5. Direction received (title of supervisor and type of direction received upon assignment of work, during course of work, and at its completion):

Supervision is provided by the Dental Director. Professional guidance is also provided by the Dental Director through review of work and personal contact. Appraisal by Standards of Performance.

6. Minimum qualifications (education and experience) required to perform satisfactorily:

D.D.S. or D.M.D. Degree

APPENDIX D (cont'd.)

12. Sample position description for Dental Director (Correctional)

1. Organization (Bureau, Division, Branch, Section, etc.) and location of duty station:

_______________Area _______________Service Unit

(Hospital/Hlth,Center) City:__________ State:__________

2. Functional Title - Dental Director

3. Pertinent program information (e.g., size of hospital, geographic limits of water pollution control project; type of hospital; primary function and size of Branch, Section, Unit; etc.)

The Dental Program includes preventive, educational, and corrective dental services to inmates who fall within the scope of the Correctional Dental Program. This position is located in (City) _______________(State)_______________ with a total staff of ________ dentists and _______ dental auxiliaries.

4. Brief statement of most important duties, including significant supervisory responsibilities and work relationships:

1. Provides dental health services to designated population in accordance with policies of the dental department.

2. Provides Dental Services Director of the state correctional system with information and assistance in development, coordination, implementation and evaluation of the Service Unit Dental Program.

3. Is responsible for supervision of facility dental staff.

4. Is responsible for implementation of facility dental activities in accordance with the Service Unit Dental Program Plan.

5. Advisor to the correctional Health Administrator on all matters pertaining to oral health.

6. Establishes and maintains relations with other health disciplines and other official and non-official health, educational and governing organizations.

7. Responsible for acknowledgement of communications and submission of required reports.

12. (cont'd.)

5. Direction received (title of supervisor and type of direction received upon assignment of work, during course of work, and at its completion):

Administrative supervision by correctional Health Administrator through personal contact. Professional guidance achieved through Dental Services Director by review of reports and work as well as personal contact. Appraised by Standards of Performance.

6. Minimum qualifications (educational and experience) required to perform satisfactorily:

D.D.S., or D.M.D. degree - preferably with previous clinical dental experience, or general practice residency.

APPENDIX D (cont'd.)

13. Sample position description for Dental Director (Correctional) - (Alternate Description)

1. Organization (Bureau, Division, Branch, Section, etc.) and location of duty station:

_______________ Area _______________Service Unit

City:_______________ State:___________

2. Functional Title - Dental Director

3. Pertinent program information (e.g., size of hospital; geographic limits of water pollution control project; type of hospital; primary function and size of Branch, Section, Unit; etc.)

The Dental Program includes preventive, educational, and corrective dental services to inmates who fall within the scope of the Correctional Dental Program in the _______ Service Unit. The dental staff is comprised of _____ dentists and _________ dental auxiliaries.

4. Brief statement of most important duties, including significant supervisory responsibilities and work relationships:

1. Provides dental health services to the designated population in accordance with policies of the dental department.

2. Develops, coordinates, implements, and evaluates quantity and quality of the Service Unit dental program and resources, direct and contract.

3. Is advisor to the correctional Health Administrator on all matters pertaining to oral health.

4. Is responsible for authorization, obligation, and justification of funds under the Service Unit contract dental care program.

5. Establishes and maintains relations with other health disciplines and with other official and non-official health, educational and governing organizations.

6. Responsible for the career development of the Service Unit dental staff.

7. Acknowledges all communications and submits required reports.

8. Promotes dignity, respect and mutual understanding between the Service Unit dental staff and the people they serve.

13. (cont'd.)

5. Direction received (title of supervisor and type of direction received upon assignment of work during course of work, and at its completion):

Administrative supervision is provided by the correctional Health Administrator by personal contact. Professional guidance is provided by the Dental Services Director of the ___________ State Corrections Department through review of reports and work as well as personal contact. Appraisal by Standards of Performance.

6. Minimum qualifications (education and experience) required to perform satisfactorily:

D.D.S., or D.M.D. degree - preferably with general practice residency and/or previous administrative experience.

APPENDIX D (cont'd)

14. Sample position description for contract Dental Specialty Consultant (Correctional)

1. Organization (Bureau, Division, Branch, Section, etc.) and location of duty station.

2. Functional Title: Periodontic Consultant

3. Pertinent program information:

Serves as the Staff Periodontist for the ___________ Correctional Institution, ____________, ____________.

4. Brief statement of most important duties, including significant supervisory responsibilities and work relationships:

A. THE CONSULTANT RESPONSIBILITIES
   1. Functions as a consultant in the development, implementation and evaluation of the periodontal care program based upon the objectives of the overall dental program.
   2. Contributes to the establishment of dental policies as related to the periodontic dental program.
   3. Conducts special surveys on prison inmates in order to secure baseline information related to the periodontal dental services they require.
   4. Carries out research and study programs related to the periodontal dental program.
   5. Conducts continuing dental education courses for dentists, dental assistants, and dental hygienists.
   6. Provides consultant services to all correctional system dentists about technical procedures related to the field of periodontics.

B. FACILITY STAFF DENTAL RESPONSIBILITIES
   1. Responsible for dental services rendered to beneficiaries by himself.
   2. Actively participates in the establishment of relationships with other health disciplines as well as other official and non-official health, educational and governing organizations.

5. Direction received (title of supervisor and type of direction received upon assignment of work, during course of work, and at its completion):

Responsible to the Dental Director for all professional and administrative materials.

6. Minimum qualifications (education and experience) required to perform satisfactorily:

D.D.S., or D.M.D. Specialty Degree of Certificate in Periodontics Dental Education Residency

# APPENDIX E: DENTAL RECORDS

Dental records are a very important part of a comprehensive dental health program. Not only do they document the treatment history of the patient, but they also serve to protect both the patient and the health provider. Records should be kept in a thorough and conscientious manner by all members of the health staff, and should be maintained permanently as a record of the patient's treatment history.

It is the practice of many correctional systems, when transferring an inmate from one institution to another, to transfer his medical and dental records with him. Unfortunately, only one set of records is usually maintained so that treatment records at any given correctional clinic do not necessarily reflect a complete record of all care provided at that facility. While it is necessary that the patient's original medical and dental charts accompany him when he is transferred to another institution, it is just as important that a complete copy of his record be kept at any clinical facility that has examined and/or treated him. Correctional health administrators need to ensure that appropriate equipment is available to copy dental records and radiographs. Such copies should be maintained in a permanent file system and are necessary for a number of reasons:

1. Some patient dental records get lost during inmate transfers and, because there is only one set of records, cannot be duplicated or reproduced.

2. Some inmates start litigation against health providers at a former institution after having left that institution. Medical and dental personnel then have no access to records that might be needed to answer legal challenges.

3. Treatment started at one institution may need to be continued at a different institution. Health providers attempting to ensure continuation of health services sometimes need to consult with their counterparts at the inmate's former institution. The health provider at the former institution needs the health chart in order to provide accurate information to the inmate's new medical or dental staff.

Many correctional institutions have inadequate or incomplete dental record systems. In order to provide correctional health care administrators with information needed for the design of an adequate dental chart, we have included sample dental record forms that are used by the U.S. Navy Dental Corps. These forms have been altered somewhat to better fit the requirements of a correctional dental health program, however, correctional health administrators are urged to use these only as an aid in designing a form that would better fit the requirements of the appropriate correctional system. It is recommended that all forms used within a correctional system be uniformly designed to facilitate inter-institutional record-keeping.

# PRIVACY ACT STATEMENT – HEALTH CARE RECORDS

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397

2 PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

The purpose for requesting personal information is to assist medical personnel in developing records to facilitate and document your health condition in order to provide you health care treatment and to provide a complete account of such care rendered, including diagnosis, treatment, and end result. The Social Security Number (SSN) is necessary to identify the person and records.

3 ROUTINE USES

This information may be used to plan and coordinate health care It may be used to provide medical treatment; conduct research; teach; compile statistical data; determine suitability of persons for service or assignments; implement preventive health and communicative disease control programs; adjudicate claims and determine benefits; evaluate care rendered; determine professional certification and hospital accreditation; conduct authorized investigations; provide physical qualifications of patients to other Federal, State and local agencies upon request in the pursuit of their official duties; and report medical conditions required by law to Federal, State and local agencies. It may be used for other lawful purposes including law enforcement and litigation.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of active duty military personnel, disclosure of requested information is mandatory. In the case of all other personnel/beneficiaries, disclosure of requested information is voluntary If the information is not furnished, optimum medical care may not be possible.

I understand that the foregoing one time Privacy Act Statement will apply to all requests for personal information made by medical treatment personnel or for medical treatment purposes. I further understand that a copy of this form which I have signed will be placed in my health care records as evidence of this notification. I have received a copy of this statement which I can retain, and I understand that I can receive additional copies of this statement from any medical treatment facility upon request.

| SIGNATURE OF PATIENT *(or authorized sponsor or guardian of patient)* | DATE |
|---|---|
| | |

## DENTAL HEALTH QUESTIONNAIRE

| CHIEF COMPLAINT | DATE | CHIEF COMPLAINT | DATE |
|---|---|---|---|
| | | | |
| | | | |

**CHECK AND SIGN**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| PRESENTLY UNDER CARE OF PHYSICIAN | | | LIVER OR KIDNEY TROUBLE | | |
| MEDICAL DIAGNOSIS: | | | MAJOR WEIGHT CHANGE | | |
| ANY ALLERGIES OR SENSITIVITIES | | | GROWTH OR TUMOR | | |
| CONVULSIONS OR DIZZY SPELLS | | | HIGH BLOOD PRESSURE | | |
| RECENT ILLNESS | | | TUBERCULOSIS | | |
| ILL EFFECTS FROM INJECTIONS OF NOVOCAIN OR XYLOCAINE | | | SINUS TROUBLE | | |
| TOOTH EXTRACTION—DIFFICULTY | | | HEART DISEASE/RHEUMATIC FEVER/MURMUR | | |
| PROLONGED BLEEDING FROM CUTS, ETC. | | | RECEIVING MEDICATION | | |
| DIABETES OR JAUNDICE | | | X-RAY TREATMENT | | |

OTHER

| SIGNATURE *(Patient's)* | DATE | SIGNATURE *(Dental Officer's)* | DATE |
|---|---|---|---|
| | | | |

| RADIOGRAPHS | WET | DRY | DATE | RADIOGRAPHS | WET | DRY | DATE |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

**ROUTING/TREATMENT PLAN**

**PATIENT IDENTIFICATION**

| SEX | GRADE, RATE OR POSITION | ORGANIZATION UNIT | COMPONENT OR BRANCH | SERVICE, DEPT., OR AGENCY | PHONE |
|---|---|---|---|---|---|
| | | | | | |

| PATIENT'S LAST NAME-FIRST NAME-MIDDLE NAME | DATE OF BIRTH (DAY-MONTH-YEAR) | SOCIAL SECURITY NO. |
|---|---|---|
| | | |

# HEALTH RECORD — DENTAL

## SECTION I. DENTAL EXAMINATION

| 1. PURPOSE OF EXAMINATION | | | 2. TYPE OF EXAM. | 3. DENTAL CLASSIFICATION |
|---|---|---|---|---|
| INITIAL | SEPARATION | OTHER (Specify) | 1 2 3 4 | 1 2 3 4 5 |

4. MISSING TEETH AND EXISTING RESTORATIONS

RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

REMARKS

PLACE OF EXAMINATION | DATE

SIGNATURE OF DENTIST COMPLETING THIS SECTION

5. DISEASES, ABNORMALITIES, AND X-RAYS

RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

A. CALCULUS

| SLIGHT | MODERATE | HEAVY |
|---|---|---|

B. PERIODONTOCLASIA

| LOCAL | GENERAL | |
|---|---|---|
| INCIPIENT | MODERATE | SEVERE |

C. STOMATITIS (Specify)

| GINGIVITIS | VINCENT'S |
|---|---|

D. DENTURES NEEDED
(Include dentures needed after indicated extractions)

| FULL | | PARTIAL | |
|---|---|---|---|
| U | L | U | L |

ABNORMALITIES OF OCCLUSION—REMARKS

E. INDICATE X-RAYS USED IN THIS EXAMINATION

| FULL MOUTH PERIAPICAL | POSTERIOR BITE-WINGS | OTHER (Specify) |
|---|---|---|

DATE | PLACE OF EXAMINATION

SIGNATURE OF DENTIST COMPLETING THIS SECTION

## SECTION II. PATIENT DATA

| 6. SEX | 7. RACE | 8. GRADE, RATING, OR POSITION | 9. ORGANIZATION UNIT | 10. COMPONENT OR BRANCH | 11. SERVICE, DEPT., OR AGENCY |
|---|---|---|---|---|---|

| 12. PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME | 13. DATE OF BIRTH (DAY-MONTH-YEAR) | 14. IDENTIFICATION NO. |
|---|---|---|

## SECTION III. ATTENDANCE RECORD

**15. RESTORATIONS AND TREATMENTS (Completed during service)**

RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

**REMARKS**

**16. SUBSEQUENT DISEASES AND ABNORMALITIES**

RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

**REMARKS**

**17. SERVICES RENDERED**

| DATE | DIAGNOSIS—TREATMENT | CLASS | OPERATOR AND DENTAL FACILITY | INITIALS |
|---|---|---|---|---|
| | | | | |

PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME

**HEALTH RECORD** | **DENTAL—Continuation**

SECTION III. ATTENDANCE RECORD

15. RESTORATIONS AND TREATMENTS (*Completed during service*)

RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

REMARKS

16. SUBSEQUENT DISEASES AND ABNORMALITIES

RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

REMARKS

17. SERVICES RENDERED

| DATE | DIAGNOSIS—TREATMENT | CLASS | OPERATOR AND DENTAL FACILITY | INITIALS |
|---|---|---|---|---|
| | | | | |

PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME

IDENTIFICATION NO.

## SECTION III. ATTENDANCE RECORD

**15. RESTORATIONS AND TREATMENTS** (*Completed during service*)

RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

REMARKS

**16. SUBSEQUENT DISEASES AND ABNORMALITIES**

RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

REMARKS

**17. SERVICES RENDERED**

| DATE | DIAGNOSIS—TREATMENT | CLASS | OPERATOR AND DENTAL FACILITY | INITIALS |
|---|---|---|---|---|
| | | | | |

PATIENT'S LAST NAME– FIRST NAME– MIDDLE NAME

IDENTIFICATION NO.

## PERIODONTAL SCREENING EXAMINATION

Prepare ORIGINAL ONLY
File in DENTAL FOLDER.

### PART I – NAVY PERIODONTAL DISEASE INDEX

**INSTRUCTION**

For each tooth examined, record score on the adjacent chart as follows:

*Obtain* GINGIVAL SCORE and enter figure in gingival score column.

*Obtain* POCKET SCORE and enter figure in pocket score column.

*Add* GINGIVAL SCORE to POCKET SCORE and enter sum in TOOTH SCORE column.

*To amend chart*: If the tooth designated on the chart is missing, strike through indicated number and insert substituted tooth number beside it. If *3, 12, 19*, or *28* is missing, substitute the next most posterior tooth. If *9* or *25* is missing, substitute the nearest incisor in the arch; or where all incisors are missing from the arch, substitute a cuspid.

*To determine GINGIVAL and/or POCKET score*:

*Gingival Score* (Dry tissues around tooth before scoring)

**0** Gingival tissue is normal in color and tightly adapted to the tooth–tissue is firm and no exudate is present.

**1** Inflammatory changes are present, but do not completely encircle the tooth. Changes may include one or a combination of the following:
- Any change from normal gingival color
- Loss of normal density and consistency
- Slight enlargement or blunting of the papilla or gingiva
- Tendency to bleed upon palpation or probing

**2** Inflammatory changes listed above completely encircle the tooth.

*Pocket Score* With calibrated periodontal probe take six measurements of each designated tooth–mesial, middle, and distal areas of the facial and lingual surfaces. The greatest single measurement determines the Pocket Score for the tooth.

**0** Probing reveals sulcular depth not over 3 mm.

**5** Probing reveals pocket depth greater than 3 mm. but not over 5 mm.

**8** Probing reveals pocket depth greater than 5 mm.

**DIAGNOSTIC AND TREATMENT RECOMMENDATIONS:**

*NPDI SCORE of 0 to 2*: Oral prophylaxis, cariostatic agents, plaque control instruction.

*NPDI SCORE of 5 to 7*: Complete oral examination, periodontal treatment, cariostatic agents, plaque control instruction by general practitioner.

*NPDI SCORE of 8 to 10*: Complete oral examination, periodontal treatment initiated by general practitioner, with possible referral to periodontist.

| TOOTH NO. | GINGIVAL SCORE + | POCKET SCORE = | TOOTH SCORE |
|---|---|---|---|
| 3 | | | |
| 9 | | | |
| 12 | | | |
| 19 | | | |
| 25 | | | |
| 28 | | | |

TOTAL SCORE FOR ALL TEETH ________

*NPDI SCORE*
Record in circle highest score for any one tooth.

*NPDI TOTAL*
Record in square total score for all teeth.

| PLACE OF EXAMINATION | EXAMINER | | | DATE |
|---|---|---|---|---|
| PATIENT'S LAST NAME, FIRST, MIDDLE | GRADE/RATE | SSN | SEX | AGE |

**PART II – NAVY PLAQUE INDEX**

**Diagram of surface areas:**
*M*—mesial; *G*—gingival; *D*—distal; and *R*—remaining

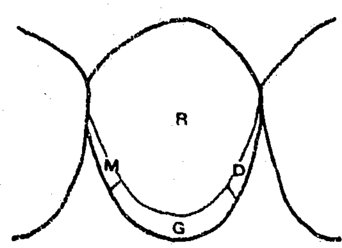



CHART FOR RECORDING PLAQUE FORMATION

| TOOTH NO. | FACIAL | | | | LINGUAL | | | | TOOTH SCORE |
|---|---|---|---|---|---|---|---|---|---|
| 3 | M 3 | G 2 | D 3 | R 1 | M 3 | G 2 | D 3 | R 1 | ______ |
| 9 | M 3 | G 2 | D 3 | R 1 | M 3 | G 2 | D 3 | R 1 | ______ |
| 12 | M 3 | G 2 | D 3 | R 1 | M 3 | G 2 | D 3 | R 1 | ______ |
| 19 | M 3 | G 2 | D 3 | R 1 | M 3 | G 2 | D 3 | R 1 | ______ |
| 25 | M 3 | G 2 | D 3 | R 1 | M 3 | G 2 | D 3 | R 1 | ______ |
| 28 | M 3 | G 2 | D 3 | R 1 | M 3 | G 2 | D 3 | R 1 | ______ |

TOTAL SCORE FOR ALL TEETH ______

INSTRUCTION

For each tooth examined, record score on adjacent chart as follows:

***Circle*** (M 3) If you find plaque in contact with gingival tissue on *mesial* proximal surface.

***Circle*** (G 2) If you find plaque in contact with gingival tissue on *facial* or *lingual* surface.

***Circle*** (D 3) If you find plaque in contact with gingival tissue on *distal* proximal surface.

***Circle*** (R 1) If you find plaque on *facial* or *lingual* surface that is not in contact with gingival tissue.

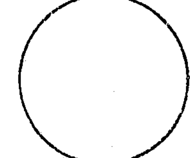
***Add*** Encircled numbers for each tooth, and record in *TOOTH SCORE* column.

***Enter*** Highest score for any *one* tooth in *NPI SCORE* circle.

To complete the chart, total score for all teeth, and enter sum in *NPI TOTAL* square.

*To amend chart*: If the tooth designated on the chart is missing, strike through indicated number and insert substitute tooth number beside it. If *3, 12, 19,* or *28* is missing, substitute the next most posterior tooth. If *9* or *25* is missing, substitute the nearest incisor in the arch, or where all incisors are missing from the arch, substitute a cuspid.

*NPI SCORE*
Record in circle highest score for any one tooth.



*NPI TOTAL*
Record in square total score for all teeth.

| PLACE OF EXAMINATION | EXAMINER | | | DATE |
|---|---|---|---|---|
| PATIENT'S LAST NAME, FIRST, MIDDLE | GRADE/RATE | SSN | SEX | AGE |

**MEDICAL RECORD** | **REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES**

**A. IDENTIFICATION**

1. OPERATION OR PROCEDURE

**B. STATEMENT OF REQUEST**

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be ____________________
*(Description of operation or procedure in layman's language)*

________________________________________

________________________________________

________________________________________

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: ____________________
*(If "none", so state)*

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:
   a. The name of the patient and his/her family is not used to identify said pictures.
   b. Said pictures be used only for purposes of medical study or research.

*(Cross out any parts above which are not appropriate)*

**C. SIGNATURES** *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

____________________
(Signature of Counseling Physician)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

____________________ (Signature of Witness, excluding members of operating team)

____________________ (Signature of Patient) (Date & Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, ____________________ sponsor/guardian of ____________________ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

____________________ (Signature of Witness, excluding members of operating team)

____________________ (Signature of Sponsor/Legal Guardian) (Date & Time)

| PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)* | REGISTER NO. | WARD NO. |
|---|---|---|
| | | |

| CLINICAL RECORD | CONSULTATION SHEET |
|---|---|

REQUEST

| TO: | FROM: *(Requesting ward, unit, or activity)* | DATE OF REQUEST |
|---|---|---|

REASON FOR REQUEST *(Complaints and findings)*

PROVISIONAL DIAGNOSIS

| DOCTOR'S SIGNATURE | APPROVED | PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL | ☐ EMERGENCY ☐ ROUTINE |
|---|---|---|---|

CONSULTATION REPORT

*(Continued on reverse side)*

| SIGNATURE AND TITLE | DATE | IDENTIFICATION NO. | ORGANIZATION |
|---|---|---|---|

| PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)* | REGISTER NO. | WARD NO. |
|---|---|---|

| CLINICAL RECORD | TISSUE EXAMINATION |
|---|---|
| SPECIMEN SUBMITTED BY | DATE OBTAINED |

SPECIMEN

BRIEF CLINICAL HISTORY *(Include duration of lesion and rapidity of growth, if a neoplasm)*

PREOPERATIVE DIAGNOSIS

OPERATIVE FINDINGS

| POSTOPERATIVE DIAGNOSIS | SIGNATURE AND TITLE |
|---|---|

**PATHOLOGICAL REPORT**

| NAME OF LABORATORY | ACCESSION NO(S). |
|---|---|

*(Gross description, histologic examination and diagnoses)*

*(Continue on reverse side)*

| SIGNATURE OF PATHOLOGIST | DATE |
|---|---|

| | AGE | SEX | RACE | IDENTIFICATION NO. |
|---|---|---|---|---|

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

| REGISTER NO. | WARD NO. |
|---|---|

**TISSUE EXAMINATION**

SICK CALL MEMO

| NAME | RATE | UNIT |
|---|---|---|
| | | |

It is recommended that action be taken on above person as indicated below.

ION

☐ EXCUSE FROM
☐ PLACE ON

☐ DUTY ☐ LIGHT DUTY ☐ PHYSICAL EXERCISE ☐ DRILLS ☐ FOR HRS.

REASONS

| ITEM | TIME | DATE | MEDICAL/DENTAL OFFICER | GOOD UNTIL | | UNIT DUTY |
|---|---|---|---|---|---|---|
| | | | | TIME | DATE | |
| ISSUED | | | | | | |
| REISSUED | | | | | | |
| REISSUED | | | | | | |
| REISSUED | | | | | | |
| REISSUED | | | | | | |
| RETURNED TO DUTY | | | | | | |

*Valid only if renewed as indicated.* *Not a Gate Pass.*

**PRESCRIPTION**

FOR (Full name, address & phone number.) (If under 12 years, give age.)

| MEDICAL FACILITY | DATE |
|---|---|
| | |

℞ | Gm. or ml.

| MFGR: | EXP DATE: |
|---|---|
| LOT NO: | FILLED BY: |

| ℞ NUMBER | SIGNATURE AND DEGREE |
|---|---|

EDITION OF 1 JAN 60 MAY BE USED

PREVENTIVE DENTISTRY RECALL FILE

| Last Name First Middle | | |
|---|---|---|
| Birth Month | Service Entry Date | SSN |
| | Dept. | Tel. (work) |

| Date | Treatment | Operator |
|---|---|---|
| | | |
| | | |
| | | |



NAME

| DENTAL OFFICER | ROOM NUMBER |
|---|---|

| DAY | DATE | HOUR | ARRIVED | DEPARTED |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Verify appts the wk. day before prior to 1500.

DENTAL APPOINTMENT, FRONT

Please report 10 mins. early. (Over)

FOR PATIENT ______________________

POSTOPERATIVE INSTRUCTIONS TO BE FOLLOWED AFTER ORAL SURGERY

BLEEDING: Keep firm pressure on your gauze for two hours. Then remove gauze and take first dose of medication supplied. If bleeding persists, renew gauze pack taking care to place it over the surgical area so as to create pressure when the jaws are closed. DO NOT SMOKE FOR 24 HOURS. Avoid spitting while gauze pack is in your mouth. Wet new gauze packs in COLD water. There may be slight bleeding with lots of saliva for up to 48 hours. This is not abnormal. However, if bleeding is excessive, return to the dental clinic for care.

PAIN: Some discomfort is to be expected following the removal of impacted teeth, difficult extractions or multiple extractions. Take medications exactly as directed, starting when first gauze pack is removed. If antibiotics are prescribed, take exactly as directed.

SWELLING: Swelling after surgical extractions is not abnormal. To minimize the swelling, use ice bag or ice wrapped in a towel to the affected area, 30 minutes of each hour for the first 12 hour period. Sleep with your head on two pillows the night after surgery.

RINSING: DO NOT RINSE the first 24 hours after surgery. Then use a salt solution (1/2 teaspoon salt in 8 oz. glass of warm water) to cleanse the affected area. Rinse gently every 2-3 hours while awake. This will also help reduce soreness and swelling.

DIET: Eat soft foods the day of surgery returning to normal diet AS SOON AS POSSIBLE. Definitely eat something to prevent nausea. Drink plenty of water and fruit juice.

ORAL HYGIENE: It is very important that you keep your mouth clean. On the day after your extractions, brush your teeth after each meal and use other dental aids recommended by your dentist. The rate of healing is greatly dependent on the degree of cleanliness of your mouth.

SUTURES: You may notice that some small stitches have been placed in the gum; these will have to be removed. Return on _______ for removal.

GENERAL: If in 48-72 hours following surgery, complications arise that have not been described, call this clinic to arrange for advice and further examinations if indicated. REMEMBER, most complications arise when patients fail to follow ALL directions. Avoid mouth washes except salt water. DO NOT SMOKE or drink from a straw, these acts may prolong bleeding or interfere with a delicate healing mechanism possibly setting the stage for an infection.

## PATIENTS INSTRUCTION SHEET FOLLOWING EXTRACTION

You have had minor surgery performed, and your cooperation and faithful fulfillment of these instructions are necessary to keep postoperative pain and infection to a minimum.

1. Keep the gauze in your mouth for 45 minutes. (If you have to spit, you can drool out the opposite corner of your mouth and still maintain slight pressure upon the gauze pack).
2. Keep fingers and tongue away from the tooth socket.
3. Wait 24 hours before rinsing mouth; hold warm salt water in the area of extraction every two hours for 3 to 5 minutes after the lapse of the first day, (1 teaspoon salt to 8 oz. glass warm water).
4. In case of extreme pain or bleeding, report to the dental office for treatment.
5. It is advisable to keep the mouth in a clean condition, brush your teeth except in the area of extraction (immediate area) for the first two days, then try to include the extraction area after the two day period.
6. Do not use mouthwash for one week, as mouthwash will dissolve the clot and can cause a dry socket.
7. Ensure maximum liquid intake to include water, fruit juices, milk, malts, etc.
8. Special instructions, tablets and/or capsules will be issued if deemed necessary.

## PROSTHODONTIC WORK REQUEST AND PRESCRIPTION

| DATE STARTED | DATE DELIVERED | SIGNATURE OF DENTAL OFFICER | CASE NUMBER |
|---|---|---|---|
| | | | |

| PATIENT'S NAME (LAST, FIRST AND MIDDLE INITIAL) | GRADE/RATE | SERVICE | |
|---|---|---|---|
| DUTY STATION | SOCIAL SECURITY NO. | SEX | AGE |

| PHONE | REQUESTING ACTIVITY | FABRICATING ACTIVITY (LABORATORY) |
|---|---|---|
| ADDRESS | | |

| TYPE OF PROSTHESIS | |
|---|---|
| MAXILLARY | |
| MANDIBULAR | |

INSTRUCTIONS

7 8 9 10 11 12 13 14 15 16
6 5 4 3 2 1
R MAXILLARY L

R MANDIBULAR L
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

### FIXED PROSTHESES

*(CHECK ONE)*
CROWN ☐ INLAY ☐

| TYPE | TOOTH NO. |
|---|---|
| GOLD | |
| Gold Veneer | |
| CHROME | |
| Chrome Veneer | |
| ACR | |

### FIXED PARTIAL DENTURES

| | SHADE ANT | SHADE POST | TEETH INVOLVED | MOLD |
|---|---|---|---|---|
| MAXILLARY | | | — THRU — | |
| MANDIBULAR | | | — THRU — | |

OTHER:

REMARKS/INSTRUCTIONS

6 7 8 9 10 11

27 26 25 24 23 22



| DENTURE TEETH | | |
|---|---|---|
| Teeth | Max | Mand |
| TYPE ANTERIOR | | |
| TYPE POSTERIOR | | |
| SHADE | | |
| MOLD ANTERIOR | | |
| MOLD POSTERIOR | | |

| INSTRUCTIONS TO LABORATORY | | |
|---|---|---|
| Procedure | Date-Time Due | Technician |
| TRAY | | |
| MASTER CAST | | |
| FRAMEWORK | | |
| RECORD BASE-RIM | | |
| TOOTH ARRANGEMENT | | |
| COMPLETED PROSTHESIS | | |
| SHADE GUIDE UTILIZED | | |

| METAL USED | | OUT | | IN | | USED | |
|---|---|---|---|---|---|---|---|
| ITEM | STOCK NO. | DWT. | GR. | DWT. | GR. | DWT. | GR. |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

COPY 1 INSTRUCTION: COMPLETE RED INK BLOCKS IN ALL INSTANCES

DISTRIBUTION: ORIGINATOR — Retain Copy 1, Copies 2 and 3 to Laboratory
LABORATORY — Retain Cop 3, Co 2 to Ori inator

| DENTAL SERVICE REPORT | REPORT CONTROL SYMBOL |
|---|---|

| ☐ ARMY ☐ NAVY ☐ AIR FORCE | REPORTING FACILITY AND LOCATION | PERIOD COVERED |
|---|---|---|
| | | |

## PART I - DENTAL PROCEDURES

| | ARMY<br>A | NAVY-MARINE<br>B | AIR FORCE<br>C | DEPEND-ENTS<br>D | ALL OTHER<br>E | TOTAL<br>F | <br>G |
|---|---|---|---|---|---|---|---|
| **A. OPERATIVE AND CROWN AND BRIDGE** | | | | | | | |
| 1. AMALGAM *(One surface)* | | | | | | | |
| 2. AMALGAM *(Two or more surfaces)* | | | | | | | |
| 3. BASE INTERMEDIATE | | | | | | | |
| 4. RESIN | | | | | | | |
| 5. ROOT CANAL FILLING *(Teeth)* | | | | | | | |
| 6. SILICATE | | | | | | | |
| 7. TEMPORARY OR SEDATIVE FILLING | | | | | | | |
| 8. | | | | | | | |
| 9. GOLD *(Inlay, foil)* | | | | | | | |
| 10. BRIDGE | | | | | | | |
| 11. GOLD CROWN *(All types)* | | | | | | | |
| 12. RESIN CROWN | | | | | | | |
| 13. RESIN CROWN WITH METAL | | | | | | | |
| 14. OTHER CROWNS | | | | | | | |
| 15. CROWN OR BRIDGE REPAIR | | | | | | | |
| 16. | | | | | | | |
| **B. PROSTHODONTICS** | | | | | | | |
| 17. DENTURE, RECONST., RELINE, REPAIR | | | | | | | |
| 18. FULL DENTURE | | | | | | | |
| 19. PARTIAL DENTURE | | | | | | | |
| 20. OTHER MAXILLOFACIAL APPLIANCES | | | | | | | |
| 21. | | | | | | | |
| **C. ORAL SURGERY** | | | | | | | |
| 22. ABSCESS, INCISION AND DRAINAGE | | | | | | | |
| 23. ALVEOLECTOMY | | | | | | | |
| 24. APICOECTOMY | | | | | | | |
| 25. BIOPSY | | | | | | | |
| 26. CYSTECTOMY | | | | | | | |
| 27. FRACTURE MANDIBLE REDUCTION | | | | | | | |
| 28. FRACTURE MAXILLA REDUCTION | | | | | | | |
| 29. FRACTURE *(Other)* REDUCTION | | | | | | | |
| 30. ROOT RESIDUAL - REMOVAL | | | | | | | |
| 31. TOOTH REMOVAL | | | | | | | |
| 32. TUMORS *(All types)* EXCISION | | | | | | | |
| 33. | | | | | | | |
| 34. | | | | | | | |
| 35. | | | | | | | |
| 36. | | | | | | | |
| **D. PERIODONTICS AND ORAL HYGIENE** | | | | | | | |
| 37. EQUILIBRATION | | | | | | | |
| 38. GINGIVECTOMY | | | | | | | |
| 39. GINGIVITIS OR STOMATITIS TREATMENT | | | | | | | |
| 40. PROPHYLAXIS | | | | | | | |
| 41. SCALING *(Periodontal)* | | | | | | | |
| 42. CARIES PREVENTION TREATMENT | | | | | | | |
| 43. | | | | | | | |

PREVIOUS EDITIONS ARE OBSOLETE.

| PART I - DENTAL PROCEDURES *(Continued)* | | | | | | | |
|---|---|---|---|---|---|---|---|
| | ARMY A | NAVY-MARINE B | AIR FORCE C | DEPENDENTS D | ALL OTHER E | TOTAL F | G |
| **E. RADIODONTICS** | | | | | | | |
| 44. INTRA-ORAL ROENTGENOGRAM | | | | | | | |
| 45. EXTRA-ORAL ROENTGENOGRAM | | | | | | | |
| **F. OTHER** | | | | | | | |
| 46. EXAMINATIONS *(Types 1, 2, and 3)* | | | | | | | |
| 47. ORTHODONTIC TREATMENT | | | | | | | |
| 48. POST OPERATIVE TREATMENT | | | | | | | |
| 49. | | | | | | | |
| 50. | | | | | | | |
| 51. *TOTAL PROCEDURES LINES 1 - 50* | | | | | | | |
| 52. *TOTAL PATIENTS TREATED* | | | | | | | |

| PART II - LABORATORY DATA | NUMBER |
|---|---|
| A. TEETH REPLACED IN ITEMS 10 AND 19, PART I | |
| B. PROSTHETIC APPLIANCES PROCESSED *(Items under Part I, Section B)* | |
| 1. ENTIRELY IN REPORTING FACILITY | |
| 2. PARTLY IN OTHER FACILITY *(Name)* | |
| 3. ENTIRELY IN OTHER FACILITY *(Name)* | |
| C. CHROME-COBALT OR OTHER NON-PRECIOUS METAL APPLIANCES | |
| 1. CAST LOCALLY DURING REPORTING PERIOD | |
| 2. MAXIMUM MONTHLY POTENTIAL OUTPUT | |

| PART III - CLASSIFICATION OF ACTIVE DUTY PERSONNEL *(At end of month)* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | MILITARY STRENGTH SERVED | | NUMBER CLASSIFIED | CL. 1 | CL. 2 | CL. 3 | CL. 4 | CL. 5 |
| | REPORTING FACILITY | OTHER | | | | | | |
| 1. ARMY | | | | | | | | |
| 2. NAVY-MARINE | | | | | | | | |
| 3. AIR FORCE | | | | | | | | |
| 4. TOTAL | | | | | | | | |
| 5. GRAND TOTAL | | | | | | | | |

PART IV - REMARKS

| DATE | TYPED OR PRINTED NAME AND GRADE | SIGNATURE |
|---|---|---|
| | | |

| DENTAL SERVICE REPORT | REPORT CONTROL SYMBOL |
|---|---|
| REPORTING FACILITY AND LOCATION | PERIOD COVERED |

## PART V - PROFESSIONAL ASSIGNMENT AND UTILIZATION

| DENTAL OFFICERS | | | OTHER COMMISSIONED | | | WARRANT OFFICERS | | | ENLISTED | | | | | | | CIVILIAN | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | GENERAL | | PROSTHETIC | | OTHER | | | | |
| GRADE | AUTH | PRES | GRADE | AUTH | PRES | GRADE | AUTH | PRES | GRADE | AUTH | PRES | AUTH | PRES | AUTH | PRES | | AUTH | PRES |
| O-8 | | | O-6 | | | W-4 | | | E-7 | | | | | | | DENTISTS | | |
| O-7 | | | O-5 | | | W-3 | | | E-6 | | | | | | | ASSISTANTS | | |
| O-6 | | | O-4 | | | W-2 | | | E-5 | | | | | | | CLERKS | | |
| O-5 | | | O-3 | | | W-1 | | | E-4 | | | | | | | HYGIENISTS | | |
| O-4 | | | O-2 | | | | | | E-3 | | | | | | | LAB. TECHS | | |
| O-3 | | | O-1 | | | | | | E-2 | | | | | | | | | |
| O-2 | | | | | | | | | E-1 | | | | | | | OTHERS | | |
| TOTAL | | | TOTAL | | | TOTAL | | | TOTAL | | | | | | | TOTAL | | |

FULL TIME PERSONNEL EQUIVALENT

### INDIVIDUAL ASSIGNMENTS AND CHANGES

| NAME<br>A | GRADE<br>B | MOS, NJC OR AFSC<br>C | DUTY ASSIGNMENT OR CODE<br>D | E | F | G |
|---|---|---|---|---|---|---|
| | | | | | | |

INDIVIDUAL ASSIGNMENTS AND CHANGES *(Continued)*

| NAME<br>A | GRADE<br>B | MOS, NJC OR AFSC<br>C | DUTY ASSIGNMENT OR CODE<br>D | E | F | G |
|---|---|---|---|---|---|---|
| | | | | | | |

REMARKS

| DATE | TYPED OR PRINTED NAME AND GRADE | SIGNATURE |
|---|---|---|
| | | |

# DENTAL SERVICE REPORT
## EQUIPMENT AND FACILITIES SUPPLEMENT

| REPORTING FACILITY AND LOCATION | DATE OF REPORT |
|---|---|
| | |

PART I - DENTAL DEPARTMENT OR FACILITY SPACE

| SPACE | NUMBER A | APPROXIMATE SIZE *(Width and length)* B | ADEQUATE C YES | NO | REMARKS D |
|---|---|---|---|---|---|
| 1. DENTAL OPERATING ROOM | | | | | |
| 2. EXAMINING ROOM | | | | | |
| 3. X-RAY EXPOSURE ROOM | | | | | |
| 4. DARKROOM | | | | | |
| 5. PROSTHETIC LABORATORY | | | | | |
| 6. STOREROOM/SUPPLY ROOM | | | | | |
| 7. WAITING ROOM | | | | | |
| 8. RECORD OFFICE | | | | | |
| 9. DENTAL OFFICER'S OFFICE | | | | | |
| 10. DENTAL REPAIR SHOP | | | | | |
| 11. CLEANING GEAR LOCKER | | | | | |
| 12. OFFICERS' LOCKER ROOM | | | | | |
| 13. ENLISTED LOCKER ROOM | | | | | |
| 14. TOILET FACILITIES | | | | | |
| 15. OTHER MAJOR FUNCTIONAL ROOMS | | | | | |
| 16. CLINIC UNIT *(If several clinics, give number and size of each)* | | | | | |

PART II - DENTAL EQUIPMENT

| ITEM | MAKE A | NUMBER ON HAND B | NUMBER IN USE C | CONDITION OF EQUIPMENT D |
|---|---|---|---|---|
| 1. STANDARD OPERATING UNIT | | | | |
| 2. JUNIOR OPERATING UNIT | | | | |
| 3. DENTAL CABINET | | | | |
| 4. DENTAL CABINET | | | | |
| 5. X-RAY UNIT | | | | |
| 6. AIR COMPRESSOR | | | | |
| 7. AUTOCLAVE | | | | |
| 8. STERILIZER | | | | |
| 9. OTHER MAJOR EQUIPMENT | | | | |

## PART III - PROSTHETIC DATA

*(If a prosthetic facility is attached fill in Section A, if not, fill in Section B)*

### A. PROSTHETIC FACILITY ATTACHED

| | |
|---|---|
| 1. POTENTIAL CASE CAPACITY PER MONTH *(Assume availability of all needed personnel)* | |
| 2. IS PROSTHETIC SERVICE PROVIDED TO OTHER ACTIVITIES | |
| 3. ARE PRESENT PROSTHETIC FACILITIES ADEQUATE | |
| 4. ARE TEETH PROCURED LOCALLY TO SUPPLEMENT DEPOT-PROCURED STOCKS | |
| 5. | |

### B. PROSTHETIC FACILITY NOT ATTACHED

| | |
|---|---|
| 6. NAME OF NEAREST AVAILABLE PROSTHETIC FACILITY | |
| 7. DISTANCE, TIME AND MODE OF TRAVEL TO ABOVE | |
| 8. AVERAGE NUMBER OF PROSTHETIC PATIENTS SENT MONTHLY | |
| 9. NUMBER OF PATIENTS AWAITING PROSTHETIC TREATMENT | |
| 10. ARE ALL ESSENTIAL PROSTHETIC CASES ACCOMMODATED | |
| 11. | |

## PART IV - UTILITIES

| 1. CURRENT | A. VOLTAGE | B. CYCLES |
|---|---|---|
| ☐ AC ☐ DC | | |

2. GAS

☐ NATURAL ☐ COMMERCIAL ☐ BOTTLE ☐ ACETYLENE

## PART V - REMARKS AND RECOMMENDATIONS

*(Confine to equipment and facilities, include planned changes in spaces, arrangement of spaces, contemplated surveys of equipment, shortages due to supply difficulties, etc.)*

| DATE | TYPED OR PRINTED NAME AND GRADE | SIGNATURE |
|---|---|---|
| | | |

## INDIVIDUAL DENTAL OFFICER—DAILY DENTAL SERVICE RECORD

**INSTRUCTION:** This form is provided to individual dental officers to record dental procedures and services accomplished daily for the purpose of accumulating data for completion of the quarterly DENTAL SERVICE REPORT required by (MED-6600-2), on Form DD-477.

| PERIOD REPORTED *(Month and year)* | CLINIC NUMBER | TOTAL DENTAL OFFICER WORKDAYS DURING REPORTING PERIOD | | SUBMITTED BY *(Name of Dental Officer)* |
|---|---|---|---|---|
| | | DENTAL OFFICER WORKDAYS LOST DUE TO COLLATERAL DUTY | | |
| | UNIT OR ROOM NUMBER | DENTAL OFFICER WORKDAYS LOST DUE TO ALL OTHER CAUSES *(Leave, illness, TAD, equipment failure, etc.)* | | |
| | | TOTAL DENTAL OFFICER DAYS WORKED | | |

| PROCEDURE OR SERVICE | DAY | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A. OPERATIVE AND CROWN AND BRIDGE | 1. Amalgam *(One surface)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1. | |
| | 2. Amalgam *(Two or more surfaces)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 2. | |
| | 3. Base Intermediate | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 3. | |
| | 4. Resin | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 4. | |
| | 5. Root Canal Filling *(Teeth)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 5. | |
| | 6. Silicate | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 6. | |
| | 7. Temporary | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 7. | |
| | 8. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 8. | |
| | 9. Gold *(Inlay, foil)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 9. | |
| | 10. Bridge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 10. | |
| | 11. Gold Crown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 11. | |
| | 12. Resin Crown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 12. | |
| | 13. Resin Crown with Metal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 13. | |
| | 14. Other Crowns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 14. | |
| | 15. Crown or Bridge Repair | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 15. | |
| | 16. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 16. | |
| B. PROSTHODONTICS | 17. Denture, Reconst., Reline., Repair | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 17. | |
| | 18. Full Denture | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 18. | |
| | 19. Partial Denture | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 19. | |
| | 20. Other Maxillofacial Appliances | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. | |
| | 21. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 21. | |
| C. ORAL SURGERY | 22. Abscess, Incision and Drainage | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 22. | |
| | 23. Alveolectomy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. | |
| | 24. Apicoectomy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 24. | |
| | 25. Biopsy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 25. | |
| | 26. Cystectomy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 26. | |
| | 27. Fracture Mandible Reduction | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 27. | |
| | 28. Fracture Maxilla Reduction | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 28. | |
| | 29. Fracture *(Other)* Reduction | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 29. | |
| | 30. Root Residual—Removal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 30. | |
| | 31. Tooth Removal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 31. | |
| | 32. Tumors *(All types)* Excision | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 32. | |
| | 33. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. | |
| D. PERIODONTICS AND ORAL HYGIENE | 37. Equilibration | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 37. | |
| | 38. Gingivectomy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 38. | |
| | 39. Gingivitis or Stomatitis Treatment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 39. | |
| | 40. Prophylaxis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 40. | |
| | 41. Scaling *(Periodontal)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 41. | |
| | 42. Caries Prevention Treatment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 42. | |
| | 43. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 43. | |
| E. X-RAY | 44. Intra-Oral Roentgenogram | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 44. | |
| | 45. Extra-Oral Roentgenogram | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 45. | |
| F. OTHER | 46. Examinations *(Types 1, 2 and 3)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 46. | |
| | 47. Orthodontic Treatment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 47. | |
| | 48. Post Operative Treatment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 48. | |
| | 49. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 49. | |
| | 50. Total Sittings | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 50. | |
| | 51. Total Procedures *(Lines 1 - 49)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 51. | |
| | 52. Total Patients Treated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 52. | |

| ISSUED TO: | | | | | | | CASE NUMBER |
|---|---|---|---|---|---|---|---|
| STOCK NUMBER | ISSUED | | RETURNED | | USED | | |
| | dwt | gr | dwt | gr | dwt | gr | |
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| | | | | | | | |
| ISSUED BY: | DATE | RETURNED TO: | | | | DATE | |

**PRECIOUS METAL ISSUE RECORD**

**STATEMENT AND INVENTORY OF PRECIOUS AND SPECIAL DENTAL METALS**

ACTIVITY: ______________________________

| STATEMENT | | | | | | | | | | | | | | | | INVENTORY | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 STOCK NUMBER | 2 UNIT OF ISSUE | 3 BROUGHT FORWARD FROM LAST REPORT | | 4 RECEIVED DURING CURRENT MONTH | | 5 TOTAL BROUGHT FORWARD & RECEIVED | | EXPENDED: 6* MISCELLANEOUS | | EXPENDED: 7 CASES DELIVERED | | 8 BALANCE | | 9 IN VAULT OR SAFE | | 10 IN GOLD ISSUE ROOM | | 11 CASES BEING PROCESSED | | 12 CASES COMPLETED NOT DELIVERED | | 13 BALANCE | |
| | | dwt | gr | dwt | gr | dwt | gr | dwt | gr | dwt | gr | dwt | gr | dwt | gr | dwt | gr | dwt | gr | dwt | gr | dwt | gr |
| 6520-145-0176 | 2 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-145-0349 | 2 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-145-0350 | 2 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-580-0350 | 2 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-580-0450 | 2 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-580-1250 | each | | | | | | | | | | | | | | | | | | | | | | |
| 6520-580-1450 | each | | | | | | | | | | | | | | | | | | | | | | |
| 6520-580-1650 | 10 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-580-2550 | 1 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-580-5250 | 1 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-580-5450 | 1 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-580-5650 | 1 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-580-5850 | 1 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-580-6450 | 4 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-580-6550 | 4 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-580-6650 | 4 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-580-6750 | 4 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-580-6950 | 4 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-817-2517 | 2 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-817-2518 | 2 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-817-2519 | 2 dwt | | | | | | | | | | | | | | | | | | | | | | |
| 6520-826-1301 | each | | | | | | | | | | | | | | | | | | | | | | |
| 6520-890-2170 | 2 dwt | | | | | | | | | | | | | | | | | | | | | | |

14

Submitted for (month) ______________________ 19 ____

Date: ______________________ 19 ____

______________________
*Signature of Dental Officer*

***Explain entries under column 6 on other side of this sheet:***

15

Inventory and Audit completed: ______________________ 19 ____
*Date*

Signatures of Audit Board
1. ______________________
2. ______________________
3. ______________________

16

Date: ______________________ 19 ____ Comment: ______________________

______________________
*Signature of Commanding Officer*

**WORK REQUEST (MAINTENANCE MANAGEMENT)**

*Requestor see Instructions on Reverse Side*

PART I – REQUEST (Filled out by Requestor)

| 1. FROM | 2. REQUEST NO. |
|---|---|
| 3. TO | 4. DATE OF REQUEST |
| 5. REQUEST FOR ☐ COST ESTIMATE ☐ PERFORMANCE OF WORK | 5a. REQUEST WORK START |
| 6. FOR FURTHER INFORMATION CALL | 7. SKETCH/PLAN ATTACHED ☐ YES ☐ NO |

8. DESCRIPTION OF WORK AND JUSTIFICATION *(Including location, type, size, quantity, etc.)*

| 9. FUNDS CHARGEABLE | 10. SIGNATURE *(Requesting Official)* |
|---|---|

PART II – COST ESTIMATE
(Filled out by Maintenance Control Division if estimate requested)

| 11. TO: | 12. ESTIMATE NO. |
|---|---|

| 13. COST ESTIMATE | | 14. SKETCH/PLAN ATTACHED ☐ YES ☐ NO |
|---|---|---|
| a. Labor | $ | 15. |
| b. Material | $ | ☐ APPROVED. PROGRAMMING TO START IN ______ |
| c. Overhead and/or Surcharge | $ | ☐ APPROVED. BASED ON PRESENT WORKLOAD, THIS JOB CAN BE PROGRAMMED TO START IN ______, IF AUTHORIZED BY 25TH OF ______ AND FUNDS ARE MADE AVAILABLE. |
| d. Equipment Rental/Usage | $ | |
| e. Contingency | $ | ☐ DISAPPROVED. *(See Reverse Side)* |
| f. TOTAL | $ | 16. SIGNATURE / 17. DATE |

PART III – ACTION (Filled out by Requestor)

18. TO:

| 19. AUTHORIZATION TO PROCEED IS ATTACHED *(Check one if other than PW funds are involved)* ☐ NAVCOMPT 140 ☐ OTHER | 20. WORK REQUESTED ☐ HAS BEEN CANCELLED ☐ HAS BEEN DEFERRED ☐ WILL BE PERFORMED BY OTHERS |
|---|---|
| 21. SIGNATURE | 22. DATE |

*(See Part IV on Reverse Side)*

## APPENDIX F: PUBLICATIONS THAT ADDRESS STANDARDS FOR DENTAL CARE IN CORRECTIONAL INSTITUTIONS

1. American Correctional Association, Commission on Accreditation for Corrections. Manual of standards for adult correctional institutions. Rockville, Md., The Association, 1977. xxi+95p. (P.49-53). (Available from: Commission on Accreditation for Corrections; 6110 Executive Blvd., Suite 750; Rockville, MD 20852)

2. American Dental Association, Council on Hospital and Institutional Dental Services. Standards for hospital dental services. Chicago, The Association, 1977. 6p. (Available from: Council on Hospital and Institutional Services; American Dental Association; 211 E. Chicago Ave.; Chicago, IL 60611) Note: The Council has been working with the A.M.A. on its standards manual and may have additional documents available in the future.

3. American Medical Association. A.M.A. standards for medical and health services in prisons. 6th draft, revised. Chicago, The Association, 1978. 16p. (p. 7-8). (Available from: American Medical Association; (c/o M.R. Claussen); 535 N. Dearborn; Chicago, IL 60610)

4. American Public Health Association, Jails and Prisons Task Force. Standards for health services in correctional institutions. Washington, D.C., The Association, c.1976. ix + 121 p. (p. 37-48). (Available from: American Public Health Association; 1015 Fifteenth St. N.W.; Washington, DC 20005)

5. Brecher, E.M., and Della Penna, R.D., National Institute of Law Enforcement and Criminal Justice. Health care in correctional institutions: prescriptive package. Washington, D.C., U.S. Government Printing Office, 1975. x + 98 p. (p. 73). (Available from: Superintendent of Documents; U.S. Government Printing Office; Washington, DC 20402; stock number - 027-000-00349-4; price $2.25 per copy)

6. Comptroller General's report to the Congress: a federal strategy is needed to help improve medical and dental care in prisons and jails. Washington, D.C., U.S. General Accounting Office, 1978. viii + 74 p. (Available from: U.S. General Accounting Office; Distribution Section, Room 1518; 441 G. St. N.W.; Washington, DC 20548; stock number - GGD-78-96; no charge for single copy)

## APPENDIX G: WHERE TO ADVERTISE THE AVAILABLE PROFESSIONAL POSITIONS

The following lists of professional journals and state dental societies is provided to assist the correctional health administrator in his efforts to recruit new professional staff. Each of these journals runs classified advertisements for available dental positions and are widely read by members of the dental profession. State dental societies often maintain an employment service for their members and would therefore be a good place to send job announcements.

Other useful agencies to contact during recruitment efforts are dental schools and dental auxilliary training programs and state public health department dental divisions. A full list of these schools and agencies is presented in Appendix H.

1. Addresses of Professional Journals

Classified Advertising Editor
Journal of the American Dental Association
2111 East Chicago Avenue
Chicago, Illinois 60611

Employment Service, Classified Advertising Department
American Journal of Public Health (American Public Health Association)
1015 Fifteenth Street, N.W.
Washington, D.C. 20005

Dental Hygiene
Classified Advertising Department
American Dental Hygienists' Association
Suite 3400
444 North Michigan Avenue
Chicago, Illinois 60611

Mrs. Janet W. Jester, Publisher and Advertising Manager
Journal of Public Health Dentistry (American Association of Public Health Dentists)
2209 Lawrence Drive
Raleigh, North Carolina 27603

Health Services Placement
Military Medicine
Association of Military Surgeons of the United States (includes dentists)
10605 Concord Street, Suite 306
P.O. Box 104
Kensington, Maryland 20795

Employment Service
C.O.A. Bulletin
The Commissioned Officers Association of the United States Public Health Service
1750 Pennsylvania Avenue, N.W.
Washington, D.C. 20006

Classified Advertisement, Publications Assistant
Journal of Dental Education
American Association of Dental Schools
1625 Massachusetts Avenue, N.W.
Washington, D.C. 20036

2. Addresses of Constituent (state) dental societies of the A.D.A.

Alabama
Alabama Dental Association
836 Washington Avenue
Montgomery, Alabama 36104

Alaska
Alaska Dental Society
Central Office
P.O. Box 3-487
Anchorage, Alaska 99501

Arizona
Arizona State Dental Association
Suite 320
3800 North Central Avenue
Phoenix, Arizona 85012

Arkansas
Arkansas State Dental Association
P.O. Box 337
Arkadelphia, Arkansas 71923

California
California Dental Association
P.O. Box 91258
Tishman Airport Center
Los Angeles, California 90009

Colorado
Colorado Dental Association
Suite 580
The Galleria Tower 1
720 South Colorado Boulevard
Denver, Colorado 80222

Connecticut
Connecticut State Dental Association
60 Washington Street
Hartford, Connecticut 06106

Delaware
    Delaware State Dental Society
    1925 Lovering Avenue
    Wilmington, Delaware 19806

District of Columbia
    District of Columbia Dental Society
    4300 Fordham Road, N.W.
    Washington, D.C. 20016

Florida
    Florida Dental Association
    3021 Swann Avenue
    Tampa, Florida 33609

Georgia
    Georgia Dental Association
    Suite 112
    2951 Flowers Road, South
    Atlanta, Georgia 30341

Hawaii
    Hawaii Dental Association
    Suite 605
    1000 Bishop Street
    Honolulu, Hawaii 96813

Idaho
    Idaho State Dental Association
    1487 West Hays
    Boise, Idaho 83702

Illinois
    Illinois State Dental Society
    P.O. Box 376
    524 South Fifth Street
    Springfield, Illinois 62705

Indiana
    Indiana Dental Association
    402 Jefferson Building
    One Virginia Avenue
    Indianapolis, Indiana 46204

Iowa
    Iowa Dental Association
    333 Insurance Exchange Building
    Des Moines, Iowa 50309

Kansas
    Kansas State Dental Association
    4301 Huntoon
    Topeka, Kansas 66604

Kentucky
Kentucky Dental Association
1940 Princeton Drive
Louisville, Kentucky 40205

Louisiana
Louisiana Dental Association
Suite 216
Gallery Building
4141 Veterans Boulevard
Metairie, Louisiana 70002

Maine
Maine Dental Association
63A Main Street
Springvale, Maine 04083

Maryland
Maryland State Dental Association
Airport Investment Building
793 Elkridge Landing Road
Linthicum, Maryland 21090

Massachusetts
Massachusetts Dental Society
36 Washington Street
Wellesley Hills, Massachusetts 02181

Michigan
Michigan Dental Association
230 North Washington Square
Lansing, Michigan 48933

Minnesota
Minnesota Dental Association
2236 Marshall Avenue
St. Paul, Minnesota 55104

Mississippi
Mississippi Dental Association
1746 Lelia Drive
Jackson, Mississippi 39216

Missouri
Missouri Dental Association
101 West McCarthy Street
Jefferson City, Missouri 65101

Montana
Montana Dental Association
P.O. Box 513
Butte, Montana 59701

CONTINUED

4 OF 5

Nebraska
Nebraska Dental Association
Suite 1007
134 South 13th Street
Lincoln, Nebraska 68508

Nevada
Nevada Dental Association
P.O. Box 1598
Carson City, Nevada 89701

New Hampshire
New Hampshire Dental Society
Six Loudon Road
Concord, New Hampshire 03301

New Jersey
New Jersey Dental Association
One Dental Plaza
North Brunswick, New Jersey 08902

New Mexico
New Mexico Dental Association
8501-D Candelaria, N.E.
Albuquerque, New Mexico 87112

New York
Dental Society of the State of New York
30 East 42nd Street
New York, New York 10017

North Carolina
North Carolina Dental Society
2414 Wycliff Road
Raleigh, North Carolina 27607

North Dakota
North Dakota Dental Association
Room 2
420 North Fourth Street
Bismarck, North Dakota 58501

Ohio
Ohio Dental Association
Neil House Motor Hotel, Suite 207
41 South High Street
Columbus, Ohio 43215

Oklahoma
Oklahoma Dental Association
629 N.W. Expressway
Oklahoma City, Oklahoma 73118

5

Oregon
Oregon Dental Association
0235 S.W. Boundary Street
Portland, Oregon 97201

Pennsylvania
Pennsylvania Dental Association
P.O. Box 3341
Harrisburg, Pennsylvania 17105

Puerto Rico
Colegio de Cirujanos Dentistas de Puerto Rico
P.O. Box 9023
Santurce, Puerto Rico 00908

Rhode Island
Rhode Island Dental Association
Suite 703
170 Westminster Street
Providence, Rhode Island 02903

South Carolina
South Carolina Dental Association
723 Queen Street
Columbia, South Carolina 29205

South Dakota
South Dakota Dental Association
P.O. Box 1194
Pierre, South Dakota 57501

Tennessee
Tennessee Dental Association
P.O. Box 120188
2104 Sunset Pl.
Nashville, Tennessee 37212

Texas
Texas Dental Association
1946 South Interregional Highway
Austin, Texas 78704

Utah
Utah Dental Association
63 East Stratford Avenue
Salt Lake City, Utah 84115

Vermont
Vermont State Dental Society
132 Church Street
Burlington, Vermont 05401

Virginia
Virginia Dental Association
Suite 423
2015 Staples Mill Road
Richmond, Virginia 23230

Washington
    Washington State Dental Association
    P.O. Box 9824
    Seattle, Washington 98109

West Virginia
    West Virginia Dental Association
    P.O.Box 1946
    Suite 1303
    Kanawha Valley Building
    Charleston, West Virginia 25327

Wisconsin
    Wisconsin Dental Association
    Suite 523-530
    633 West Wisconsin Avenue
    Milwaukee, Wisconsin 53202

Wyoming
    Wyoming Dental Association
    640 Avenue G
    Powell, Wyoming 82435

# APPENDIX H: ADDRESSES OF IMPORTANT AGENCIES, INSTITUTIONS, AND ORGANIZATIONS

1. Schools of Dentistry: (by state) *indicates that school also maintains dental auxiliary training program(s)

Alabama

School of Dentistry, University of Alabama*
1919 Seventh Ave. S
Birmingham, AL 35294

California

School of Dentistry, Loma Linda University*
Loma Linda, CA 92354

School of Dentistry, University of
California at Los Angeles
Center for Health Sciences
Los Angeles, CA 90024

School of Dentistry, University of Southern California*
925 W. 34th St.
Los Angeles, CA 90007

School of Dentistry, University of California
San Francisco*
San Francisco, CA 94143

School of Dentistry, University of the Pacific
2155 Webster St.
San Francisco, CA 94115

Colorado

School of Dentistry, University of Colorado*
Medical Center
4200 E. Ninth Ave.
Denver, CO 80262

Connecticut

School of Dental Medicine, The University of
Connecticut
Health Center
263 Farmington Ave.
Farmington, CT 06032

District of Columbia

School of Dentistry, Georgetown University
3900 Reservoir Rd., N.W.
Washington, D.C. 20007

College of Dentistry, Howard University*
600 W. St., N.W.
Washington, D.C. 20059

Florida

College of Dentistry, University of Florida
J. Hillis Miller Health Center
Gainesville, FL 32610

Georgia

School of Dentistry, Emory University
1462 Clifton Rd., N.E.
Atlanta, GA 30322

School of Dentistry, Medical College of Georgia*
Augusta, GA 30902

Illinois

College of Dentistry, University of Illinois*
801 S. Paulina St.
Chicago, IL 60612

School of Dental Medicine, Southern Illinois University
Edwardsville, IL 62025

Northwestern University Dental School*
240 E. Huron St.
Chicago, IL 60611

School of Dentistry, Loyola University of Chicago*
2160 S. First Ave.
Maywood, IL 60153

Indiana

School of Dentistry, Indiana University*
1121 W. Michigan St.
Indianapolis, IN 46202

Iowa

College of Dentistry, The University of Iowa*
Dental Bldg.
Iowa City, IA 52242

Kentucky

College of Dentistry, University of Kentucky*
800 S. Limestone
Medical center
Lexington, KY 40506

School of Dentistry, University of Louisville*
Health Sciences Center
P.O. Box 35260
Louisville, KY 40232

Louisiana

School of Dentistry, Louisiana State University*
Medical Center
1100 Florida Ave., Bldg 101
New Orleans, LA 70119

Maryland

Baltimore College of Dental Surgery, University of Maryland*
666 W. Baltimore St.
Baltimore, MD 21201

Massachusetts

Harvard School of Dental Medicine
188 Longwood Ave.
Boston, MA 02115

School of Dental Medicine, Tufts University*
One Kneeland St.
Boston, MA 02111

School of Graduate Dentistry, Boston University*
100 E. Newton St.
Boston, MA 02118

Michigan

School of Dentistry, The University of Michigan*
Ann Arbor, MI 48109

School of Dentistry, University of Detroit*
2985 e. Jefferson Ave.
Detroit, MI 48207

Minnesota

School of Dentistry, University of Minnesota*
515 S.E. Delaware St.
Minneapolis, MN 55455

Mississippi

School of Dentistry, The University of Mississippi*
Medical Center
2500 N. State St.
Jackson, MS 39216

Missouri

School of Dentistry, University of Missouri at Kansas City*
650 E. 25th St.
Kansas City, MO 64108

School of Dental Medicine, Washington University
4559 Scott Ave.
St. Louis, MO 63110

Nebraska

College of Dentistry, University of Nebraska*
40th and Holdrege
Lincoln, NE 68583

Boyne School of Dental Medicine, Creighton University
2500 California St.
Omaha, NE 68178

New Jersey

College of Medicine and Dentistry of New Jersey,
New Jersey Dental School*
100 Bergen St.
Newark, NJ 07103

School of Dentistry, Fairleigh Dickinson University*
110 Fuller Pl.
Hackensack, NJ 07601

New York

School of Dentistry, State University of New York at
Buffalo*
Farber Hall
3435 Main St.
Buffalo, NY 14214

School of Dental Medicine, State University of
New York at Stony Brook
Health Sciences Center
Stony Brook, NY 11794

School of Dental and Oral Surgery, Columbia University*
630 W. 168th St.
New York, NY 10032

College of Dentistry, New York University*
421 First Ave.
New York, NY 10010

North Carolina

School of Dentistry, University of North Carolina*
P.O. Box 750
Chapel Hill, NC 27514

Ohio

School of Dentistry, Case Western Reserve University
2123 Abington Rd.
Cleveland, Ohio 44106

College of Dentistry, The Ohio State University*
305 W. 12th Ave.
Columbus, OH 43210

Oklahoma

College of Dentistry, University of Oklahoma*
Health Sciences Center
P.O. Box 26901
Oklahoma City, OK 73190

School of Dentistry, Oral Roberts University
7777 S. Lewis Ave.
Tulsa, OK 74136

Oregon

School of Dentistry, University of Oregon*
Health Sciences Center
611 S.W. Campus Dr.
Sam Jackson Park
Portland, OR 97201

Pennsylvania

School of Dental Medicine, University of Pennsylvania*
4001 W. Spruce St.
Philadelphia, PA 19104

School of Dentistry, Temple University*
3223 Broad St.
Philadelphia, PA 19140

School of Dental Medicine, University of Pittsburg*
3501 Terrace St.
Pittsburgh, PA 15261

Puerto Rico

School of Dentistry, University of Puerto Rico*
San Juan, PR 00905

South Carolina

College of Dental Medicine, Medical University of South Carolina*
171 Ashley Ave.
Charleston, SC 29403

Tennessee

College of Dentistry, University of Tennessee*
875 Union Ave.
Memphis, TN 38163

School of Dentistry, Meharry Medical College*
1005 18th Ave., N.
Nashville, TN 37208

Texas

Baylor College of Dentistry*
3302 Gaston Ave.
Dallas, TX 75246

The University of Texas Dental Branch*
6516 John Freeman Ave.
Houston, TX 77025

The University of Texas Health Sciences Center at San Antonio Dental School
7703 Floyd Curl Dr.
San Antonio, TX 78229

Virginia

School of Dentistry, Medical College of Virginia*
Virginia Commonwealth University
Box 637, MCV Station
Richmond, VA 23298

Washington

School of Dentistry, University of Washington*
Health Sciences Bldg., SC62
Seattle WA 98195

West Virginia

School of Dentistry, West Virginia University*
The Medical Center
Morgantown, 26506

Wisconsin

School of Dentistry, Marquette University*
604 N. 16th St.
Milwaukee, WI 53233

APPENDIX H - continued

Source: American Dental Association, Council on Dental Education, Division of Educational Measurements. Annual report: dental auxiliary education (1978/79). Chicago, The Association, 1979. 35p. (p. 4-9).

2A. INSTITUTIONS CONDUCTING DENTAL HYGIENE EDUCATION PROGRAMS.

ALABAMA
University of Alabama, School of Dentistry
Dental Hygiene Program
1919 - 7th Avenue South
Birmingham, 35294

ALASKA
Anchorage Community College
Dental Hygiene Program
University of Alaska
3221 Providence Drive
Anchorage, 99504

ARIZONA
Northern Arizona University
Dental Hygiene Department
Box 15065
Flagstaff, 86011

Phoenix College
Dental Hygiene Program
1202 W. Thomas Road
Phoenix, 85013

ARKANSAS
University of Arkansas for Medical Sciences
Dental Hygiene Program
Suite 820, University Tower Building
Little Rock, 72204

CALIFORNIA
Cabrillo College
Dental Hygiene Program
6500 Soquel Drive
Aptos, 95003

Cerritos College
Dental Hygiene Department
11110 E. Alondra Boulevard
Norwalk, 90650

Chabot College
Dental Hygiene Program
25555 Hesperian Boulevard
Hayward, 94545

Cypress College
Dental Hygiene Program
9200 Valley View
Cypress, 90630

Diablo Valley College
Dental Hygiene Program
321 Golf Club Road
Pleasant Hill, 94523

Foothill Community College
Dental Hygiene Program
12345 El Monte Road
Los Altos, 94022

Fresno City College
Dental Hygiene Program
1101 East University
Fresno, 93741

Loma Linda University
School of Dentistry
Department of Dental Hygiene
Loma Linda, 92354

CALIFORNIA cont'd
Los Angeles Community College
Dental Hygiene Program
4800 Freshman Drive
Culver City, 90230

Pasadena City College
Dental Hygiene Program
1570 East Colorado Boulevard
Pasadena, 91106

Sacramento City College
Dental Hygiene Program
3835 Freeport Boulevard
Sacramento, 95822

University of California
School of Dentistry
Division of Dental Hygiene
San Francisco, 94143

University of Southern California
Department of Dental Hygiene
925 West 34th Street
Los Angeles, 90007

COLORADO
Colorado Northwestern Community College
Dental Hygiene Program
P. O. Box 638
Rangely 81648

University of Colorado
School of Dentistry
Dental Hygiene Program
4200 East Ninth Avenue
Denver, 80262

University of Southern Colorado
Dental Hygiene Program
415 Harrison Avenue
Pueblo, 81004

CONNECTICUT
Tunxis Community College
Dental Hygiene Program
Route 6 & 177
Farmington, 06032

University of Bridgeport
Fones School of Dental Hygiene
30 Hazel Street
Bridgeport, 06602

DELAWARE
Delaware Technical and Community College
Dental Hygiene Program
333 Shipley Street
Wilmington, 19801

DISTRICT OF COLUMBIA
Howard University
College of Dentistry
Dental Hygiene Program
600 "W" Street, N. W.
Washington, 20059

FLORIDA
Florida Junior College
Dental Hygiene Program
4501 Capper Road
Jacksonville, 32218

FLORIDA cont'd
Miami-Dade Community College
Dental Hygiene Program
Medical Center Campus
950 N. W. 20th Street
Miami, 33127

Palm Beach Junior College
Dental Hygiene Program
4200 South Congress Avenue
Lake Worth, 33461

Pensacola Junior College
Dental Hygiene Program
5555 Highway 98 West
Pensacola, 32507

St. Petersburg Junior College
Department of Dental Hygiene
P. O. Box 13489
St. Petersburg, 33733

Santa Fe Community College
Dental Hygiene Program
3000 N. W. 83rd Street
Gainesville 32601

Tallahassee Community College
Dental Hygiene Program
444 Appleyard Drive
Tallahassee, 32304

Valencia Community College
Dental Hygiene Program
1800 S. Kirkman Road
Orlando, 32802

GEORGIA
Albany Junior College
Department of Dental Hygiene
2400 Gillionville Road
Albany, 31707

Armstrong State College
Department of Dental Hygiene
11935 Abercorn Street
Savannah, 31406

Clayton Junior College
Department of Dental Hygiene
P. O. Box 285
Morrow, 30260

Columbus College
Dental Hygiene Program
Algonquin Drive
Columbus, 31907

DeKalb Community College
Dental Hygiene Program
1995 Womack Road
Dunwoody, 30338

Macon Junior College
Dental Hygiene Program
5357 Raley Road
Macon, 31206

Medical College of Georgia
Dental Hygiene Program
Dept. of Assoc. Dental Sciences
1120 Fifteenth
Augusta, 30901

Source: American Dental Association, Council on Dental Education, Division of Educational Measurements. Annual report: dental auxiliary education (1978/79). Chicago, The Association, 1979. 35p. (p. 4-9).

## 2A. INSTITUTIONS CONDUCTING DENTAL HYGIENE EDUCATION PROGRAMS, CONTINUED

HAWAII
University of Hawaii-Manoa
Department of Dental Hygiene
2528 The Mall
Honolulu, 96822

IDAHO
Idaho State University
Department of Dental Hygiene
Corner of 8th and Terry Streets
Pocatello, 83209

ILLINOIS
Illinois Central College
Dental Hygiene Program
P. O. Box 2400
East Peoria, 61635

Lake Land College
School of Dental Hygiene
South Route 45
Mattoon, 61938

Loyola University
School of Dentistry
Dental Hygiene Program
2160 South First Avenue
Maywood, 60153

Northwestern University Dental School
Dental Hygiene Program
240 East Huron
Chicago, 60611

Parkland College
Dental Hygiene Program
2400 West Bradley
Champaign, 61820

Prairie State College
Dental Hygiene Program
200 East 197th Street
Chicago Heights, 60411

Southern Illinois University
School of Technical Careers
Dental Hygiene Program
Carbondale, 62901

William Rainey Harper College
Dental Hygiene Program
Algonquin and Roselle Roads
Palatine, 60067

INDIANA
Indiana State University at Evansville
Department of Dental Hygiene
8600 University Boulevard
Evansville, 47712

Indiana University - Northwest Campus
Dental Auxiliary Education
3223 Broadway
Gary, 46408

Indiana University-Purdue at Fort Wayne
Dental Hygiene Program
2101 Coliseum Boulevard East
Fort Wayne, 46805

INDIANA cont'd
Indiana University
School of Denitstry
Dental Hygiene Program
1121 West Michigan Street
Indianapolis, 46202

Indiana University at South Bend
Dental Hygiene Program
Dental Auxiliary Education
1700 Mishawaka Avenue
South Bend, 46615

IOWA
Des Moines Area Community College
Dental Hygiene Program
2006 Ankeny Boulevard
Ankeny, 50021

Hawkeye Institute of Technology
Dental Hygiene Program
2800 Falls Avenue
Waterloo, 50701

University of Iowa
Department of Dental Hygiene
Iowa City, 52242

KANSAS
Johnson County Community College
Dental Hygiene Program
College Boulevard at Quivira Road
Overland Park, 66210

Wichita State University
Department of Dental Hygiene
1842 North Yale
Wichita, 67208

KENTUCKY
University of Kentucky
Lexington Technical Institute
Dental Hygiene Program
Cooper Drive
Lexington, 40506

University of Kentucky
Paducah Community College
Dental Hygiene Program
P. O. Box 1380
Paducah, 42001

University of Kentucky
Somerset Community College
Dental Hygiene Program
Monticello Street
Somerset, 42501

University of Louisville
School of Dentistry
Curriculum in Dental Hygiene
Health Sciences Center
P. O. Box 35260
Louisville, 40232

Western Kentucky University
Department of Dental Hygiene
College Heights
Bowling Green, 42101

LOUISIANA
Louisiana State University
School of Dentistry
Department of Dental Hygiene
1100 Florida Avenue
New Orleans, 70119

Loyola University
Department of Dental Hygiene
6363 St. Charles Street
New Orleans, 70118

Northeast Louisiana University
Curriculum of Dental Hygiene
700 University Avenue
Monroe, 71209

MAINE
University of Maine at Orono
Bangor Community College
Dental Hygiene Program
Lincoln Hall
Bangor, 04401

Westbrook College
Department of Dental Hygiene
716 Stevens Avenue
Portland, 04103

MARYLAND
Allegany Community College
Dental Hygiene Program
P. O. Box 1695
Willowbrook Road
Cumberland, 21502

Community College of Baltimore
Dental Hygiene Program
2901 Liberty Heights Avenue
Baltimore, 21215

University of Maryland
Department of Dental Hygiene
Baltimore Coll. of Dent. Surgery
666 West Baltimore Street
Baltimore, 21201

MASSACHUSETTS
Bristol Community College
Dental Hygiene Program
777 Elsbree Street
Fall River, 02720

Cape Cod Community College
Dental Hygiene Program
Route 132
West Barnstable, 02668

Forsyth Schl. of Dental Hygienists
Dental Center
140 The Fenway
Boston, 02115

Middlesex Community College
Dental Hygiene Program
Springs Road
Bedford, 01730

Quinsigamond Community College
Dental Hygiene Program
670 West Boylston Street
Worchester, 01606

Source: American Dental Association, Council on Dental Education, Division of Educational Measurements. Annual report: dental auxiliary education (1978/79). Chicago, The Association, 1979. 35p. (p. 4-9).

2A. INSTITUTIONS CONDUCTING DENTAL HYGIENE EDUCATION PROGRAMS. CONTINUED

MASSACHUSETTS cont'd
Springfield Technical Community College
Dental Hygiene Department
One Armory Square
Springfield, 01105

MICHIGAN
Charles Stewart Mott Community College
Dental Hygiene Program
1401 East Court Street
Flint, 48503

Ferris State College
Dental Hygiene Progrsm
901 South State Street
Big Rapids, 49307

Grand Rapids Junior College
Dental Hygiene Program
143 Bostwick, N. E.
Grand Rapids, 49503

Kalamazoo Valley Community College
Dental Hygiene Program
6767 West "O" Avenue
Kalamazoo, 49009

Kellogg Community College
Dental Hygiene Program
450 North Avenue
Battle Creek, 49016

Lansing Community College
Dental Hygiene Program
419 North Capitol Avenue
P. O. Box 40010
Lansing, 48901

Oakland Community College
Dental Hygiene Program
7350 Cooley Lake Road
Union Lake, 48085

University of Detroit
Department of Dental Hygiene
2985 East Jefferson Avenue
Detroit, 48207

University of Michigan
Curriculum in Dental Hygiene
1011 North University
Ann Arbor, 48109

MINNESOTA
Mankato State University
Dental Hygiene Program
Box 81, MSU
Mankato, 56001

Normandale Community College
Dental Hygiene Program
9700 Frances Avenue South
Bloomington, 55431

University of Minnesota
Program in Dental Hygiene
515 Delaware Street, S. E.
Minneapolis, 55455

University of Minnesota-Duluth
Dental Hygiene Program
2400 Oakland Street
Duluth, 55812

MISSISSIPPI
Merdian Junior College
Dental Hygiene Program
5500 Highway 19 North
Meridian, 39301

Northeast Mississippi Junior College
Dental Hygiene Program
Cunningham Boulevard
Booneville, 38829

University of Mississippi Medical Center
Department of Dental Hygiene
2500 North State Street
Jackson, 39216

MISSOURI
Missouri Southern State College
Dental Programs
Newman and Duquesne Roads
Joplin, 64801

St. Louis Community College at Forest Park
Dental Hygiene Program
5600 Oakland Avenue
St. Louis, 63110

University of Missouri at Kansas City
Division of Dental Hygiene
650 East 25th Street
Kansas City, 64108

MONTANA
Carroll College
Department of Dental Hygiene
Benton Avenue
Helena, 59601

NEBRASKA
Central Technical Community College
Dental Hygiene Program
P. O. Box 1024
Hastings, 68901

University of Nebraska-Lincoln
College of Dentistry
Dental Hygiene Program
40th and Holdrege
Lincoln, 68583

NEVADA
Clark County Community College
Dental Hygiene Program
3200 East Cheyenne
North Las Vegas, 89030

NEW HAMPSHIRE
New Hampshire Technical Institute
Dental Hygiene Department
Fan Road
Concord, 03301

NEW JERSEY
Bergen Community College
Dental Hygiene Program
400 Paramus Road
Paramus, 07652

Camden County College
Dental Hygiene Program
College Drive
Blackwood, 08012

NEW JERSEY cont'd
Col. of Med. & Dent. of New Jersey
Prog. in the Allied Hlth. Professions
Dental Hygiene Program
100 Bergen Street
Newark, 07103

Fairleigh Dickinson University
Division of Dental Hygiene
110 Fuller Place
Hackensack, 07601

Middlesex County College
Department of Dental Hygiene
Woodbridge Avenue & Mill Rd.
Edison, 08817

Union County Technical Insti.
Dental Hygiene Program
1776 Raritan Road
Scotch Plaines, 07076

NEW MEXICO
University of New Mexico
Dental Hygiene Program
Albuquerque, 87131

NEW YORK
Broome Community College
Dental Hygiene Program
Upper Front Street
Binghamton, 13902

Columbia University
Division of Dental Hygiene
630 West 168th Street
New York, 10032

Erie Community College
North Campus
Dental Hygiene Curriculum
Main St. & Youngs Rd. (Amhurst)
Buffalo, 14221

Hostos Community College
Department of Dental Hygiene
475 Grand Concorse
Bronx, 10451

Hudson Valley Community College
Department of Dental Hygiene
80 Vandenburgh
Troy, 12180

Monroe Community College
Department of Dental Hygiene
1000 East Henrietta Road
Rochester, 14623

New York City Community College
Dental Hygiene Department
300 Jay Street
Brooklyn, 11201

Onondaga Community College
Dental Hygiene Department
Route 173
Syracuse, 13215

Orange County Community College
Dental Hygiene Program
115 South Street
Middletown, 10940

Source: American Dental Association, Council on Dental Education, Division of Educational Measurements. Annual report: dental auxiliary education (1978/79). Chicago, The Association, 1979. 35p. (p. 4-9).

## 2A. INSTITUTIONS CONDUCTING DENTAL HYGIENE EDUCATION PROGRAMS, CONTINUED

NEW YORK cont'd
State University of New York at Farmingdale
Department of Dental Hygiene
Melville Road
Farmingdale, 11735

NORTH CAROLINA
Asheville-Buncombe Technical Institute
Department of Dental Hygiene
340 Victoria Road
Asheville, 28801

Central Piedmont Community College
Dental Hygiene Program
P. O. Box 4009
Charlotte, 28204

Coastal Carolina Community College
Department of Dental Hygiene
444 Western Boulevard
Jacksonville, 28540

Fayetteville Technical Institute
Dental Hygiene Program
2201 Hull Road, P. O. Box 35236
Fayetteville, 28303

Guilford Technical Institute
School of Dental Hygiene
P. O. Box 309
Jamestown, 27282

University of North Carolina
Curriculum for Dental Hygiene
School of Dentistry, 211H
Chapel Hill, 27514

Wayne Community College
Dental Auxiliary Programs
Dental Hygiene Program
Caller Box 8002
Goldsboro, 27530

NORTH DAKOTA
North Dakota State School of Science
Dental Hygiene Program
Wahpeton, 58075

OHIO
Cuyahoga Community College
Dental Hygiene Program
2900 Community College Avenue
Cleveland, 44115

Lakeland Community College
Associate in Applied Science, Dental Hygiene
Route 306 & I-90
Mentor, 44060

Lima Technical College
Dental Hygiene Program
4240 Campus Drive
Lima, 45804

Michael J. Owens Technical College
Department of Dental Hygiene
Caller No. 10,000
Oregon Road
Toledo, 43699

OHIO cont'd
Ohio State University
Division of Dental Hygiene
305 West 12th Avenue
Columbus, 43210

Shawnee State College, North Campus
Dental Hygiene Program
940 Second Street
Portsmouth, 45662

Sinclair Community College
Dental Hygiene Program
444 West Third Street
Dayton, 45402

University of Cincinnati
Raymond Walters College
Dental Hygiene Program
9555 Plainfield Road
Cincinnati, 45236

Youngstown State University
Dental Hygiene Program
410 Wick Avenue
Youngstown, 44555

OKLAHOMA
Oscar Rose Junior College
Department of Dental Hygiene
6420 S. E. 15th Street
Midwest City, 73110

University of Oklahoma
Health Sciences Center
College of Dentistry
Department of Dental Hygiene
P. O. Box 26901
Oklahoma City, 73190

OREGON
Lane Community College
Dental Hygiene Program
400 East 30th Avenue
Box 1-E
Eugene, 97405

Mt. Hood Community College
Dental Hygiene Program
26000 S. E. Stark Street
Gresham, 97030

Oregon Institute of Technology
Dental Hygiene Program
Campus Drive
Klamath Falls, 97601

Portland Community College
Dental Hygiene Program
12000 S. W. 49th Avenue
Portland, 97219

University of Oregon Health Sciences Center
Dental Hygiene Program
611 S. W. Campus Drive
Portland, 97201

PENNSYLVANIA
Community College of Philadelphia
Dental Hygiene Program
1600 Spring Garden Street
Philadelphia, 19106

PENNSYLVANIA cont'd
Montgomery County Comm. Col.
Dental Hygiene Program
340 DeKalb Pike
Blue Bell, 19422

Northampton Co. Area Comm. Col.
Dental Hygiene Program
3835 Green Pond Road
Bethlehem, 18017

Temple University
School of Dental Hygiene
3223 North Broad Street
Philadelphia, 19140

Thomas Jefferson University
Department of Dental Hygiene
130 South Ninth Street
Philadelphia, 19107

University of Pennsylvania
Department of Dent. Hygiene
4001 Spruce Street
Philadelphia, 19104

University of Pittsburgh
School of Dental Medicine
Dental Hygiene Program
Terrance and Darragh Streets
Pittsburgh, 15261

Williamsport Area Comm. Col.
Dental Hygiene Program
1005 W. Third Street
Williamsport, 17701

RHODE ISLAND
University of Rhode Island
Department of Dental Hygiene
8 Washburn Hall
Kingston, 02881

SOUTH CAROLINA
Florence-Darlington Technical Education Center
Dental Hygiene Program
P. O. Drawer 8000
Florence, 29501

Greenville Technical College
Dental Hygiene Program
P. O. Box 5616, Station B
Greenville, 29606

Med. U. of South Carolina
Col. of Allied Hlth. Sciences
Dental Hygiene Program
171 Ashley Avenue
Charleston, 29403

Midlands Technical College
Department of Dental Hygiene
P. O. Box Drawer Q
Columbia, 29250

SOUTH DAKOTA
University of South Dakota
Department of Dental Hygiene
East Hall
Vermillion, 57069

**2A.** INSTITUTIONS CONDUCTING DENTAL HYGIENE EDUCATION PROGRAMS, CONTINUED

**Source: American Dental Association, Council on Dental Education, Division of Educational Measurements. Annual report: dental auxiliary education (1978/79). Chicago, The Association, 1979. 35p. (p.4-9).**

TENNESSEE
Chattanooga State Tech. Comm. Col.
Dental Hygiene Program
4501 Amnicola Highway
Chattanooga, 37406

East Tennessee State University
Department of Dental Hygiene
Johnson City, 37601

Meharry Medical College
Tennessee State University
Division of Dental Hygiene
3500 Centennial Boulevard
Nashville, 37203

University of Tennessee
Center of Health Sciences
Dental Hygiene Program
777 Court, Room 519
Memphis, 38163

TEXAS
Amarillo College
Dental Hygiene Program
6232 W. 9th
Amarillo, 79178

Baylor College of Dentistry
Caruth School of Dental Hygiene
3302 Gaston Avenue
Dallas, 75246

Bee County College
Dental Hygiene Program
Route 1
Beeville, 78102

Del Mar College
Dental Hygiene Program
Baldwin at Ayers Streets
Corpus Christi, 78404

El Paso Community College
Dental Hygiene Program
Box 20500
El Paso, 79998

Lamar University
Dental Hygiene Program
P. O. Box 10096
Beaumont, 77710

Midwestern State University
Dental Hygiene Program
3400 Taft Boulevard
Wichita Falls, 76308

Tarrant County Junior College
Dental Hygiene Program
Northeast Campus
828 Harwood Road
Hurst, 76053

Texas Woman's University
Department of Dental Hygiene
P. O. Box 22665-TWU Station
Denton, 76204

Tyler Junior College
Department of Dental Hygiene
Henderson Highway
Tyler, 75701

TEXAS cont'd
University of Texas Dental Branch
Health Sciences Center at Houston
6516 John Freeman Avenue
Houston, 77030

University of Texas
Hlth Sciences Cntr. at San Antonio
Dental Hygiene Program
7703 Floyd Curl Drive
San Antonio, 78284

Wharton County Junior College
Dental Hygiene Program
911 Boling Highway
Wharton, 77488

UTAH
Weber State College
Dental Hygiene Program
3750 Harrison Boulevard
Ogden, 84408

VERMONT
University of Vermont
Program in Dental Hygiene
Room 002 Rowel Building
Burlington, 05401

VIRGINIA
Old Dominion University
Department of Dental Hygiene
Technology Building
Norfolk, 23508

Virginia Commonwealth University
School of Dentistry
Division of Dental Hygiene
MCV Box 637
Richmond, 23298

Virginia Western Community College
Dental Hygiene Program
3095 Colonial Avenue, S. W.
Roanoke, 24015

WASHINGTON
Clark College
Dental Hygiene Program
1800 E. McLoughlin Boulevard
Vancouver 98663

Eastern Washington University
Dental Hygiene Department
Rm. 252 - Paulsen Building
Spokane, 99201

Fort Steilacoom Community College
Dental Hygiene Program
9401 Farwest Drive
Tacoma, 98498

Shoreline Community College
Dental Hygiene Program
16101 Greenwood Avenue, N.
Seattle, 98133

University of Washington
Department of Dental Hygiene
SB-28 Health Sciences Building
Seattle, 98195

WASHINGTON cont'd
Yakima Valley College
Dental Hygiene Program
16th Ave. South at Nob Hill Blvd.
Yakima, 98908

WEST VIRGINIA
West Liberty State College
School of Dental Hygiene
West Liberty, 26074

West Virginia Institute of Tech.
Department of Dental Hygiene
Montgomery, 25136

West Virginia University
Department of Dental Hygiene
Medical Center
Morgantown, 26506

WISCONSIN
Madison Area Technical College
Dental Hygiene Program
211 North Carroll Street
Madison, 53703

Marquette University
Dental Hygiene Program
604 North 16th Street
Milwaukee, 53233

Milwaukee Area Technical College
Dental Hygiene Program
1015 North Sixth Street
Milwaukee, 53202

Northeast Wisconsin Tech. Insti.
Dental Hygiene Program
2740 West Mason Street
Green Bay, 54303

WYOMING
Sheridan College
Department of Dental Hygiene
P. O. Box 1500
Sheridan, 82801

# APPENDIX H - continued

Source: American Dental Association, Council on Dental Education, Division of Educational Measurements. Annual report: dental auxiliary education (1978/79). Chicago, The Association, 1979. 35p. (p.16-22).

## 2B. INSTITUTIONS CONDUCTING DENTAL ASSISTING EDUCATION PROGRAMS,

ALABAMA
Bessemer State Technical College
Dental Assisting Program
P. O. Box 308
Bessemer, 35020

John C. Calhoun Community College
Dental Assisting Program
P. O. Box 2016
Decatur, 35602

James H. Faulkner State Junior College
Dental Assisting Program
Hammond Circle
Bay Minnette, 36507

Trenholm State Tech. College
Dental Assisting Program
1225 Air Base Boulevard
Montgomery, 36108

Wallace State Community College
Dental Assisting Program
P. O. Box 250
Hanceville, 35055

University of Alabama
School of Dentistry
Dental Assisting Program
1916 Ninth Avenue, South
Birmingham, 35294

ALASKA
Anchorage Community College
Dental Assisting Program
2533 Providence Avenue
Anchorage, 99504

ARIZONA
Maricopa Technical College
Dental Assisting Program
106 East Washington Street
Phoenix, 85004

Pima Community College
Dental Assisting Program
2202 West Anklam Road
Tuscon, 85709

ARKANSAS
Pulaski Vocational Technical School
Dental Assisting Program
3000 West Scenic Road
North Little Rock, 72118

CALIFORNIA
College of Alameda
Dental Assisting Program
555 Atlantic Avenue
Alameda, 94501

Bakersfield College
Kern Community College District
Dental Assisting Program
1801 Panorama Drive
Bakersfield, 93305

Cabrillo College
Dental Assisting Program
6500 Soquel Drive
Aptos, 95003

CALIFORNIA cont'd
Central City Occupational Center
Paramedical Branch
Dental Assisting Program
3721 W. Washington Blvd.
Los Angeles, 90018

Cerritos College
Dental Assisting Program
11110 E. Alondra Blvd.
Norwalk, 90650

Chabot College
Dental Assisting Program
25555 Hesperian Boulevard
Hayward, 94545

Chaffey Community College
Dental Assisting Program
5885 Haven Avenue
Alta Loma, 91701

Citrus College
Dental Assisting Program
18824 East Foothill Blvd.
Azusa, 91702

Contra Costa College
Dental Assisting Program
2600 Mission Bell Drive
San Pablo, 94806

Cypress College
Dental Assisting Program
9200 Valley View Street
Cypress, 90630

Diablo Valley College
Dental Assisting Program
321 Golf Club Road
Pleasant Hill, 94523

East Los Angeles Occupational Center
Dental Assisting Program
2100 Marengo Street
Los Angeles, 90033

Eden Vocational Center
San Lorenzo Unified School
Dental Assisting Program
15919 Hesperian Blvd.
San Lorenzo, 94580

Foothill Community College
Dental Assisting Program
12345 El Monte Road
Los Altos Hills, 94022

Grossmont Community College
Dental Assisting Program
8800 Grossmont College Drive
El Cajon, 92020

Allan Hancock College
Dental Assisting Program
800 South College Drive
Santa Maria, 93454

La Puente Valley Adult School
Valley Vocational Center
Dental Assisting Program
15839 East Rowland Street
LaPuente, 91744

CALIFORNIA cont'd
Loma Linda University
School Of Dentistry
Dental Assisting Program
Loma Linda, 92350

Long Beach City College
Dental Assisting Program
4901 East Carson Street
Long Beach, 90808

Los Angeles City College
Dental Assisting Program
855 North Vermont Avenue
Los Angeles, 90029

College of Marin
Dental Assisting Program
Kentfeld, 94904

Merced Community College
Dental Assisting Program
3600 M. Street
Merced, 95304

Modesto Junior College
Dental Assisting Program
435 College Avenue
Modesto, 95350

Monterey Peninsula College
Dental Assisting Program
980 Fremont Avenue
Monterey, 93940

North Valley Occupational Center
Dental Assisting Program
11450 Sharp Avenue
Mission Hills, 91345

Orange Coast College
Dental Assisting Program
2701 Fairview Road
Costa Mesa, 92626

Palomar College
Dental Assisting Program
1140 West Mission Road
San Marcos, 92069

Pasadena City College
Dental Assisting Program
1570 E. Colorado Blvd.
Pasadena, 91106

College of the Redwoods
Dental Assisting Program
Tompkins Hill Road
Eureka, 95501

Reedley College
Dental Assisting Program
995 North Reed Avenue
Reedley, 93654

Rio Hondo College
Dental Assisting Program
3600 Workman Mill Road
Whittier, 90608

Source: American Dental Association, Council on Dental Education, Division of Educational Measurements. Annual report: dental auxiliary education (1978/79). Chicago, The Association, 1979. 35p. (p.16-22).

## 2B. INSTITUTIONS CONDUCTING DENTAL ASSISTING EDUCATION PROGRAMS.

CALIFORNIA cont'd
Sacramento City College
Dental Assisting Program
3835 Freeport Blvd.
Sacramento, 95822

San Diego Mesa College
Dental Assisting Program
7250 Mesa College Drive
San Diego, 92111

City College of San Francisco
Dental Assisting Program
50 Phelan Avenue
San Francisco, 95405

San Jose City College
Dental Assisting Program
2100 Moorpark Avenue
San Jose, 95128

College of San Mateo
Dental Assisting Program
1700 West Hillsdale Blvd.
San Mateo, 94086

Santa Barbara City College
Dental Assisting Program
721 Cliff Drive
Santa Barbara, 93105

Santa Rosa Junior College
Dental Assisting Program
1501 Mendocino Avenue
Santa Rosa, 95401

Simi Valley Adult School
Dental Assisting Program
3150 School Street
Simi Valley, 93065

University of California, Extension
Dental Assisting Program
1100 South Grand Avenue
Los Angeles, 90015

COLORADO
Aurora Technical Center
Dental Assisting Program
500 Buckley Road
Aurora, 80011

Community College of Denver
North Campus
Dental Assisting Program
3645 W. 112th Avenue
Westminster, 80030

Mesa College
Dental Assisting Program
P. O. Box 2647
Grand Junction, 81501

Emily Griffith Opportunity School
Dental Assisting Program
1250 Walton Street
Denver, 80204

Larimer County Vocational-Technical Center
Dental Assisting Program
4616 South Shields
Fort Collins, 80522

COLORADO cont'd
Pikes Peak Community College
Dental Assisting Program
5675 South Academy Blvd.
Colorado Springs, 80906

CONNECTICUT
Albert I. Prince Regional V-T School
Dental Assisting Program
500 Brookfield Street
Hartford, 06106

Windham Regional V-T School
Dental Assisting Program
210 Birch Street
Willimantic, 06226

J. M. Wright V-T School
Dental Assisting Program
Box 1416 Scalzi Park
Stamford, 06905

DELAWARE
Delaware Technical & Community College
Dental Assisting Program
333 Shipley Street
Wilmington, 19801

DISTRICT OF COLUMBIA
Armstrong Adult Education Center
Dental Assisting Program
1st & "O" Streets, N. W.
Washington, 20001

FLORIDA
Brevard Community College
Dental Assisting Program
1519 Clearlake Road
Cocoa, 32912

Broward Community College
Dental Assisting Program
3501 Southwest Davie Road
Fort Lauderdale, 33314

Florida Junior College at Jacksonville
Dental Assisting Program
4501 Capper Road
Jacksonville, 32218

Gulf Coast Community College
Dental Assisting Program
5230 West Highway 98
Panama City, 32405

Lindsey Hopkins Technical Education Center
Dental Assisting Program
1450 Northeast Second Avenue
Miami, 33132

Indian River Community College
Dental Assisting Program
3209 Virginia Avenue
Fort Pierce, 33450

Manatee Area V-T Center
Dental Assisting Program
5603 34th Street, West
Bradenton, 33507

Orange County Vocational School
Dental Assisting Program
325 North Palmetto Avenue
Orlando, 32801

FLORIDA cont'd
Palm Beach Junior College
Dental Assisting Program
4200 Congress Avenue
Lake Worth, 33460

Pensacola Junior College
Dental Assisting Program
P J C West Campus
555 W. Highway 98
Pensacola, 32507

Santa Fe Community College
Dental Assisting Program
3000 N. W. 83 St., I-01
Gainesville, 32601

Southern College
Dental Assisting Program
618 E. South Street
Orlando, 32801

Tomlinson Adult Education Center
Dental Assisting Program
296 Mirror Lake Drive
St. Petersburg, 33701

GEORGIA
The Atlanta Area Technical School
Dental Assisting Program
1560 Stewart Avenue, S. W.
Atlanta, 30310

Augusta Area V-T School
Dental Assisting Program
Affiliated with
Medical College of Georgia
School of Dentistry
1399 Walton Way
Augusta, 30901

HAWAII
Kapiolani Community College
Dental Assisting Program
620 Pensacola Street
Honolulu, 96814

IDAHO
Boise State University
Dental Assisting Program
1907 Campus Drive
Boise, 83707

Eastern Idaho V-T School
Dental Assisting Program
2299 East 17th Street
Idaho Falls, 83401

ILLINOIS
Black Hawk College
Dental Assisting Program
6600 34th Avenue
Moline, 61265

Chicago City College
Loop Campus
Dental Assisting Program
64 East Lake Street
Chicago, 60601

Elgin Community College
Dental Assisting Program
1700 Spartan Drive
Elgin, 60120

**2B.** INSTITUTIONS CONDUCTING DENTAL ASSISTING EDUCATION PROGRAMS.

Source: American Dental Association, Council on Dental Education, Division of Educational Measurements. Annual report: dental auxiliary education (1978/79). Chicago, The Association, 1979. 35p. (p.16-28).

ILLINOIS cont'd

Illinois Valley Community College
Dental Assisting Program
Route One
Oglesby, 61348

Kaskaskia Community College
Dental Assisting Program
Shattuc Road
Centralia, 62801

College of Lake County
Dental Assisting Program
19351 West Washington Boulevard
Grayslake, 60030

Lake Land College
Dental Assisting Program
South Route 45
Mattoon, 61938

Lewis & Clark Community College
Dental Assisting Program
5800 Godfrey, 62035
Godfrey, 62035

Loyola University of Chicago
School of Dentistry
Dental Assisting Education Program
2160 South First Avenue
Maywood, 60153

Morton College
Dental Assisting Program
3801 South Central Avenue
Cicero, 60650

Olney Central College
Dental Assisting Program
305 North West Street
Olney, 62450

Parkland College
Dental Assisting Program
2400 West Bradley
Champaign, 61820

Prairie State College
Dental Assisting Program
202 South Halsted
Chicago Heights, 60411

Robert Morris School
Dental Assisting Program
College Avenue
Carthage, 62321

Rock Valley College
Dental Assisting Program
3301 North Mulford Road
Rockford, 61101

Triton College
Dental Assisting Program
2000 Fifth Avenue
River Grove, 60171

University of Illinois
Paradental Education
801 South Paulina Street
Chicago, 60612

INDIANA

Indiana State University at Evansville
Dental Assisting Program
8600 University Blvd.
Evansville, 47712

Indiana University at Fort Wayne
Dental Assisting Program
2101 Coliseum Blvd., East
Fort Wayne, 46805

Indiana University Northwest
Dental Assisting Program
3223 Broadway
Gary, 46408

Indiana University at South Bend
Dental Assisting Program
1700 Mishawaka Avenue
South Bend, 46615

Indiana University
School of Dentistry
Dental Assisting Program
1121 West Michigan Street
Indianapolis, 46202

Indiana V-T College
Dental Assisting Program
616 Wabash Street
Lafayette, 47905

Professional Careers Institute
Dental Assisting Program
6321 LaPas Trail
Indianapolis, 46268

IOWA

Area One V-T School
Dental Assisting Program
330 Nesler Center
Town Clock Plaza
Dubuque, 52001

Des Moines Area Community College
Dental Assisting Education
2006 S. Ankeny Blvd.
Ankeny, 50021

Hawkeye Institute of Technology
Dental Assisting Program
2800 Falls Avenue
Waterloo, 50701

Iowa Central Community College
Dental Assisting Program
330 Avenue "M"
Fort Dodge, 50501

Iowa Western Community College
Dental Assisting Program
2700 College Road
Council Bluffs, 51501

Kirkwood Community College
Dental Assisting Program
6301 Kirkwood Blvd., S. W.
Cedar Rapids, 52406

Marshalltown Community College
Dental Assisting Program
3700 South Center Street
Marshalltown, 50158

IOWA cont'd

Western Iowa Tch. Comm. Col
Dental Assisting Program
4647 Stone Avenue
Sioux City, 51102

KANSAS

Flint-Hills Area V-T School
Dental Assisting Program
3301 West 18th Street
Emporia, 66801

Haskell Indian Junior College
Dental Assisting Program
USPHS Indian Health Center
Lawrence, 66044

Wichita Area V-T School
Wichita Dental Assisting Schl.
324 North Emporia
Wichita, 67202

KENTUCKY

Fugazzi College
Dental Assisting Program
406 Lafayette Avenue
Lexington, 40502

Jefferson State V-T School
Dental Assisting Program
727 W. Chestnut Street
Louisville, 40203

University of Louisville
School of Dentistry
Dental Assisting Program
501 S. Preston Street
Louisville, 40201

Watterson College
Dental Assisting Program
100 High Rise Drive
Louisville, 40213

LOUISIANA

Louisiana State University
Dental School
Dental Assisting Program
1100 Florida Avenue
New Orleans, 70119

MAINE

Bangor Community College
Dental Assisting Program
Lincoln Hall
Bangor, 04401

MARYLAND

Allegany Community College
Dental Assisting Program
Willowbrook Road
P. O. Box 1695
Cumberland, 21502

Community College of Baltimore
Department of Dental Aux.
2901 Liberty Heights Ave.
Baltimore, 21215

Essex Community College
Dental Assisting Program
7201 Rossville Boulevard
Baltimore, 21237

Source: American Dental Association, Council on Dental Education, Division of Educational Measurements. Annual report: dental auxiliary education (1978/79). Chicago, The Association, 1979. 35p. (p.16-22).

## 2B. INSTITUTIONS CONDUCTING DENTAL ASSISTING EDUCATION PROGRAMS.

MARYLAND cont'd
Frederick Community College
Dental Assisting Program
Route 10
Frederick, 21701

Montgomery Community College
Dental Assisting Program
7600 Takoma Avenue
Takoma Park, 20012

Prince George's Community College
Dental Assisting Program
301 Largo Road
Largo, 20870

MASSACHUSETTS
Assabet Valley Regional Voc. School
Dental Assisting Program
Fitchburg Street
Marlboro, 01752

Blue Hills Regional Tech. Institute
Dental Assisting Program
100 Randolph Street
Canton, 02021

Boston University
School of Graduate Dentistry
Dental Assisting Program
100 East Newton Street
Boston, 02118

Diman Regional Technical Institute
Dental Assisting Program
Stonehaven Road
Fall River, 02723

David Hale Fanning School
of Health Occupations
Dental Assisting Program
251 Belmont Street
Worcester, 01545

Greater Lawrence Regional V-T School
Dental Assisting Program
57 River Road
Andover, 01810

Middlesex Community College
Dental Assiting Program
Springs Road
Bedford, 01730

Charles H. McCann Technical School
Dental Assisting Program
Hodges Crossroad
North Adams, 01247

Mount Ida Junior College
Dental Assistant-Office Manager Program
777 Dedham Street
Newton Centre, 02159

Northeast Metropolitan Reg. Voc. School
Dental Assisting Program
P. O. Box 238- Hemlock Road
Wakefield, 01880

Northeastern-Tufts University
Dental Assisting Program
360 Huntington Avenue
Boston, 02115

MASSACHUSETTS cont'd
Quincy V-T School
Dental Assisting Program
107 Woodward Avenue
Quincy, 02169

Southeastern Regional Tech. Insti.
Dental Assisting Program
250 Foundry Street
South Easton, 02375

Springfield Technical Comm. College
Dental Assisting Program
One Armory Square
Springfield, 01105

Whittier Regional V-T School
Dental Assisting Program
115 Amesbury Line Road
Haverhill, 01830

MICHIGAN
Delta College
Dental Assisting Program
Allied Health Bldg.
University Center, 48710

Ferris State College
Dental Assisting Program
School of Health Sciences & Arts
Swan Hall 104
Big Rapids, 49307

Grand Rapids Junior College
Dental Assisting Cirriculum
143 Bostwick Avenue, N. E.
Grand Rapids, 49503

Kellogg Community College
Dental Auxiliary Education
450 North Avenue
Battle Creek, 49016

Lake Michigan College
Dental Assisting Program
2755 Napier Avenue
Benton Harbor, 49022

Lansing Community College
Dental Auxiliary Programs
419 North Capitol Avenue
Lansing, 48901

Macomb County Community College
Dental Assisting Program
Center Campus
P. O. Box 309
Warren, 48093

C. S. Mott Community College
Dental Assisting Program
1401 East Court Street
Flint, 48503

Muskegon Community College
Dental Assisting Program
221 S. Quaterline Road
Muskegon, 49442

Northwestern Michigan College
Dental Assisting Program
1701 East Front Street
Traverse City, 49684

MICHIGAN cont'd
Oakland Community College
Dental Assisting Program
7350 Cooley Lake Road
Union Lake, 48085

Shaw College at Detroit
Dental Assisting Program
18734 Woodward Avenue
Detroit, 48203

Washtenaw Community Col.
Dental Assisting Department
4800 E. Huron River Drive
Ann Arbor, 48106

Wayne County Comm. Col.
Dental Assisting Program
Greenfield Center
8551 Greenfield
Room 308A
Detroit, 48228

University Detroit
Dental Assisting Program
2985 East Jefferson
Detroit, 482[illegible]

MINNESOTA
Bemidji Area V-T Institute
Dental Assisting Program
Roosevelt Road & Grant Avenue
Bemidji, 56601

Brainerd Area V-T Institute
Dental Assisting Program
300 Quince Street
Brainerd, 56401

Canby Area V-T School
Dental Assisting Program
Highway 68 West
Canby, 56220

Hennepin Technical Center
Dental Assisting Program
9000 N. 77th Avenue
Brooklyn Park, 55445

Hibbing Area V-T Institute
Dental Assisting Program
2900 East Beltline
Hibbing, 55746

Lakeland Med.-Dental Academy
Dental Assisting Program
1402 West Lake Street
Minneapolis, 55408

Mankato State University
Dental Assisting Program
Department of Dental Education
P. O. Box 81
Mankato, 56001

Minnesota Institute of Med. &
Dental Assistants, Inc.
Dental Assisting Program
2915 Wayzata Blvd.
Minneapolis, 55405

2B. INSTITUTIONS CONDUCTING DENTAL ASSISTING EDUCATION PROGRAMS,

Source: American Dental Association, Council on Dental Education, Division of Educational Measurements. Annual report: dental auxiliary education (1978/79). Chicago, The Association, 1979. 35p. (p.16-22).

MINNESOTA cont'd
Moorhead Area V-T Institute
Dental Assisting Program
1900 & 28th Avenue, South
Moorhead, 56560

Normandale Community College
Dental Assisting Program
9700 France Avenue, South
Bloomington, 55431

Rochester Area V-T Institute
Dental Assisting Program
1926 Second Street, S. E.
Rochester, 55901

St. Cloud Area V-T Institute
Dental Assisting Program
1540 Northway Drive
St. Cloud, 56301

University of Minnesota
School of Dentistry
Dental Assisting Department
515 Delaware Street, S. E.
Minneapolis, 55455

916 Area V-T Institute
Dental Assisting Program
3300 Century Avenue, North
White Bear Lake, 55110

MISSISSIPPI
Hinds Junior College
Dental Assisting Program
3925 Sunset Drive
Jackson, 39213

MISSOURI
East Central Junior College
Dental Assisting Program
P. O. Box 529
Union, 63084

Forest Park Community College
Dental Assisting Program
5600 Oakland
St. Louis, 63110

Graff Area V-T Center
Dental Assisting Program
815 North Sherman
Springfield, 65802

Mineral Area College
Dental Assisting Program
Flat River, 63601

Missouri Southern State College
Dental Assisting Program
Newman & Duquesne Roads
Joplin, 64801

Nichols Career Center
Dental Assisting Program
609 Union Street
Jefferson City, 65101

Penn Valley Community College
Dental Assisting Program
3201 Southwest Trafficway
Kansas City, 64111

MISSOURI cont'd
Rolla Area V-T School
Dental Assisting Program
1304 East Tenth Street
Rolla, 65401

St. Louis Community College at Meramec
Dental Assisting Program
11333 Big Bend Blvd.
Kirkwood, 63122

Three Rivers Community College
Dental Assisting Program
507 Vine Street
Popular Bluff, 63901

MONTANA
Great Falls V-T Center
Dental Assisting Program
2100 16th Avenue, South
Great Falls, 59405

NEBRASKA
Central Technical Community College
School of Dental Assisting
Box 1024
Hastings, 68901

Southeast Community College
School of Dental Assisting
Health Occupations Division
1801 South 40th Street
Lincoln, 68506

Mid-Plains Community College
Dental Assisting Program
Intersection I-80 & Highway 83
North Platte, 69101

Metropolitan Tech. Comm. College
Department of Dental Assisting
2909 Edward "Babe" Gomez Ave.
Omaha, 68107

Omaha College of Health Careers
Dental Assisting Program
1052 Park Avenue
Omaha, 68105

NEVADA
Western Nevada Community College
Dental Assisting Program
7000 El Rancho Drive
Sparks, 89431

NEW HAMPSHIRE
New Hampshire Technical Institute
Dental Assisting Program
Fan Road
Concord, 03301

NEW JERSEY
Camden County Voc. & Technical Schools
Dental Assisting Program
P. O. Box 566
Cross Keys Road
Sicklerville, 08081

Camden County College
Box 200, College Drive
Blackwood, 08012

NEW JERSEY cont'd
College of Medicine & Dentistry of New Jersey
Dental Assisting Program
100 Bergen Street
Newark, 07111

Mercer County Comm. Col.
Dental Assisting Program
1200 Old Trenton Road
Trenton, 08690

Middlesex County College
Dental Assisting Program
Woodbridge Ave. & Mill Rd.
Edison, 08817

Union Co. Tech. Institute
Dental Assisting Program
1776 Raritan Road
Scotch Plains, 07076

NEW MEXICO
Eastern New Mexico Univ.
Dental Assisting Program
Roswell Campus
Gillis St. at "C" & "D" Sts.
Roswell, 88201

University of New Mexico
Dental Assisting Program
Building B-2
Albuquerque, 87131

Southwestern Indian Polytechnic Institute
Dental Assisting Program
9169 Coors Road, N. W.
Albuquerque, 87125

NEW YORK
Dutchess Community College
Dental Assisting Program
Pendell Road
Poughkeepsie, 12601

Hudson Valley Comm. Col.
Dental Assisting Program
80 Vandenburgh Avenue
Troy, 12180

State University of New York at Buffalo
Educational Opportunity Ctr.
Dental Assisting Program
465 Washington Street
Buffalo, 14203

New York University
Dental Assisting Program
Dental Center
421 First Avenue
New York, 10012

Niagara County Comm. Col.
Dental Assisting Program
3111 Saunders Settlement Rd.
Sanborn, 14132

Rockland Community College
Dental Assisting Program
10 North Broadway
Nyack, 10960

**2B.** INSTITUTIONS CONDUCTING DENTAL ASSISTING EDUCATION PROGRAMS, CONTINUED

Source: American Dental Association, Council on Dental Education, Division of Educational Measurements. Annual report: dental auxiliary education (1978/79). Chicago, The Association, 1979. 35p. (p.16-22).

NEW YORK cont'd
Suffolk County Community College
Dental Assisting Program
Riverhead Building, Room 116
533 College Road
Selden, 11784

NORTH CAROLINA
Asheville-Buncombe Technical Institute
Dental Assisting Program
340 Victoria Road
Asheville, 28801

Central Piedmont Community College
Dental Assisting Program
Elizabeth Ave. at King's Drive
Charlotte, 28204

Coastal Carolina Community College
Dental Assisting Department
444 Western Boulevard
Jacksonville, 28540

Fayetteville Technical Institute
Dental Assisting Program
P. O. Box 35236
Fayetteville, 28303

Guilford Technical Institute
Dental Assisting Program
P. O. Box 309
Jamestown, 27282

Rowan Technical Institute
Dental Assisting Program
I-85 & Klumac Road
Salisbury, 28144

Technical Institute of Alamance
School of Dental Assisting
P. O. Box 623
Haw River, 27258

University of North Carolina
School of Dentistry
Dental Assisting Program
416 Brauer Hall
Chapel Hill, 27514

University of North Carolina
Independent Study by Extension
121 Abernethy - 002A
Chapel Hill, 27514

Wayne Community College
Dental Assisting Program
Caller Box 8002
Goldsboro, 27530

Western Piedmont Community College
Dental Assisting Program
Burkemont Avenue
Morganton, 28655

NORTH DAKOTA
North Dakota State School of Science
Dental Assisting Program
Wahpeton, 58075

OHIO
[illegible] Addams Vocational School
Dental Assisting Program
[illegible] East [illegible] Street
Cleveland, 44115

OHIO cont'd
Paul C. Hayes Tech. School
Dental Assisting Program
4436 Haugh Road
Grove City, 43123

Jefferson Technical College
Dental Assisting Program
4000 Sunset Boulevard
Steubenville, 43952

OREGON
Blue Mountain Community College
Dental Assisting Program
2411 N. W. Carden
Pendleton, 97801

Chemeketa Community College
Dental Assisting Program
4000 Lancaster Drive, N. E.
Salem, 97309

Lane Community College
Dental Assisting Program
4000 E. 30th Avenue
Eugene, 97405

Linn-Benton Community College
Dental Assisting Program
6500 S. W. Pacific Boulevard
Albany, 97321

Oregon Institute of Technology
Dental Assisting Program
Campus Drive
Kalamath Falls, 96701

Portland Community College
Dental Assisting Program
12000 S. W. 49th Avenue
Portland, 97219

PENNSYLVANIA
Central Montgomery County Area
Technical School
Dental Assisting Program
Plymouth Road & New Hope Street
Norristown, 19401

Community College of Philadelphia
Dental Assisting Program
1600 Spring Garden Street
Philadelphia, 19106

Harcum Junior College
Dental Assisting Program
Montgomery Avenue
Bryn Mawr, 19010

Lehigh County Community College
Dental Assisting Program
2370 Main Street
Schnecksville, 18078

Luzerne County Community College
Dental Assisting Program
Prospect Street & Middle Road
Nanticoke, 18634

Manor Junior College
Dental Assisting Program
Fox Chase Road
Jenkintown, 19046

PENNSYLVANIA cont'd
Mercyhurst College
Dental Assisting Program
501 East 38th Street
Erie, 16546

Murrell Dobbins Area V-T Schl.
Dental Assisting Program
22nd & Lehigh Avenue
Philadelphia, 19132

Northampton County Area
Community College
Dental Assisting Program
3835 Green Pond Road
Bethlehem, 18017

University of Pittsburgh
School of Dental Medicine
Dental Assisting-Oral Hygiene
Terrace & Darragh Streets
Pittsburgh, 15261

RHODE ISLAND
Rhode Island Junior College
Dental Assisting Program
Louisquisset Pike
Lincoln, 02865

SOUTH CAROLINA
Florence-Darlington Tech. Col.
Dental Assisting Program
P. O. Drawer 8000
Florence, 29501

Greenville Technical College
Dental Assistant Program
P. O. Box 5616
Station B
Greenville, 29606

McDuffie Vocational School
Dental Assisting Program
1225 South McDuffie Street
Anderson, 29621

Medical U. of South Carolina
College of Allied Health Sciences
Dental Assisting Program
171 Ashley Avenue
Charleston, 29483

Midlands Technical College
Dental Assisting Program
P. O. Drawer Q
Columbia, 29250

Spartanburg Technical College
Dental Assisting Program
I-85
Spartanburg, 29303

SOUTH DAKOTA
Lake Area V-T Institute
Dental Assisting Program
230 - 11th Street, N. E.
Watertown, 57201

TENNESSEE
Chattanooga St. Tech. Comm. Col.
Dental Assisting Program
4501 Amnicola Highway
Chattanooga, 37406

2B. INSTITUTIONS CONDUCTING DENTAL ASSISTING EDUCATION PROGRAMS, CONTINUED

Source: American Dental Association, Council on Dental Education, Division of Educational Measurements. Annual report: dental auxiliary education (1978/79). Chicago, The Association, 1979. 35p. (p. 16-22).

TENNESSEE cont'd
Knoxville City Schools
Dental Assisting Program
1807 E. Vine Avenue
Knoxville, 37915

Memphis Area V-T School
Dental Assisting Program
620 Mosby Avenue
Memphis, 38105

Volunteer State Community College
Dental Assisting Program
Nashville Pike
Gallatin, 37066

TEXAS
Amarillo College
Dental Assisting Program
6232 West 9th Street
Amarillo, 79178

Austin Community College
Dental Assisting Program
Box 2165
Austin, 78768

Del Mar College
Dental Assisting Program
Baldwin & Ayers
Corpus Christi, 78404

El Centro College
Dental Assisting Program
Main at Lamar Street
Dallas, 75202

El Paso Community College
Dental Assisting Program
P. O. Box 20500
El Paso, 79998

Grayson County College
Dental Assisting Program
6101 Highway 691
Denison, 75020

San Antonio College
Dental Assisting Program
1300 San Pedro Avenue
San Antonio, 78249

School of Health Care Sciences
Dental Assisting Program
Sheppard Air Force Base, 76311

Tarrant County Junior College
Dental Assisting Program
828 Harwood Road
Hurst, 76053

Texas State Technical Institute
Dental Assistant Program
James Connally Campus
Waco, 76705

Texas State Technical Institute
Rolling Plains Campus
Dental Assisting Program
Route 3
Sweetwater, 79556

TEXAS cont'd
Tyler Junior College
Dental Assisting Program
Henderson Highway
Tyler, 75701

University of Texas at Houston
Dental Branch
Dental Assistant Program
6516 John Freeman Avenue
Houston, 77030

University of Texas
Health Science Center at San Antonio
Dental Assisting Program
7703 Floyd Curl Drive
San Antonio, 78284

UTAH
Utah Technical College at Provo
Dental Assisting Program
1395 North 150 East
Provo, 84601

VERMONT
Champlain College
Dental Assisting Program
232 South Willard Street
Burlington, 05401

Green Mountain College
Dental Assisting Program
16 College Street
Poultney, 05764

VIRGINIA
J. Sargeant Reynolds Community College
Dental Assisting Program
108 East Grace Street
P. O. Box 12084
Richmond, 23241

Northern Virginia Community College
Dental Assisting Program
8333 Little River Turnpike
Annandale, 22003

Old Dominion University
Dental Assisting Program
Technology Building
47th Street & Hampton Blvd.
Norfolk, 23508

Virginia Western Community College
Dental Assistant Program
3095 Colonial Avenue, S. W.
Roanoke, 24015

Wytheville Community College
Dental Assisting Program
1000 East Main Street
Wytheville, 24382

WASHINGTON
L. H. Bates V-T Institute
Dental Assisting Program
1101 South Yakima Avenue
Tacoma, 98405

Bellingham V-T Institute
Dental Assisting Program
3028 Lindbergh Avenue
Bellingham, 98225

WASHINGTON cont'd
Clover Park V-T Institute
Dental Assisting Program
4500 Steilacoom Blvd., S. W.
Tacoma, 98498

Edmonds Community College
Dental Assisting Program
20000-68th Avenue, West
Lynwood, 98036

Highline Community College
Dental Assisting Program
Midway, 98031

Kinman Business University
Dental Assisting Department
214 North Wall Street
Spokane, 99201

Olympia Technical Community Col.
Dental Assisting Program
2011 Mottman Road, S. W.
Olympia, 98502

Seattle Central Community College
Dental Assisting Program
1701 Broadway
Seattle, 98122

Spokane Community College
Dental Assisting Program
North 1810 Greene Street
Spokane, 99207

WEST VIRGINIA
Parkersburg Community College
Dental Assisting Program
Route 5, Box 167A
Parkersburg, 26101

WISCONSIN
Blackhawk Technical Institute
Dental Assisting Program
1149 - Fourth Street
Beloit, 53545

Fox Valley Technical Institute
Dental Assisting Program
1825 North Bluemond
Appleton, 54913

Gateway Technical Institute
Dental Assisting Program
3520 - 30th Avenue
Kenosha, 53141

Lakeshore Technical Institute
Dental Assisting Program
1290 North Avenue
Cleveland, 53015

Madison Area Technical College
Dental Assisting Program
211 North Carroll Street
Madison, 53703

Milwaukee Area Technical College
Dental Assisting Program
1015 North 6th Street
Milwaukee, 53203

WISCONSIN cont'd
Northeast Wisconsin Technical Insti.
Dental Assisting Program
2740 West Mason Street
Green Bay, 54303

Western Wisconsin Technical Institute
Dental Assisting Program
Sixth & Vine Streets
La Crosse, 54601

WYOMING
Northern Wyoming Comm. Col. District
Dental Assisting Program
Sheridan College
Sheridan, 82801

PUERTO RICO
University of Puerto Rico
School of Dentistry
Dental Auxiliary Program
Medical Science Campus
G. O. P. Box 5067
San Juan, 00936

# Appendix H - continued

Source: American Dental Association, Council on Dental Education, Division of Educational Measurements. Annual report: dental auxiliary education (1978/79). Chicago, The Association, 1979. 35p. (p.31-2).

## 2C. INSTITUTIONS CONDUCTING DENTAL LABORATORY TECHNOLOGY EDUCATION PROGRAMS.

ALABAMA
Veterans Administration Medical Center
University of Alabama
Dental Lab. Technology Program
700 South 19th Street
Birmingham, 35233

ARIZONA
Pima Community College
Dental Lab. Technology Program
2202 W. Anklam Road
Tucson, 85709

CALIFORNIA
Casa Loma Institute of Technology
Dental Technology Program
12502 Van Nuys Boulevard
Pacoima, 91331

City College of San Francisco
Dental Lab. Technology Program
50 Phelan Avenue
San Francisco, 94112

Diablo Valley College
Dental Technology Program
321 Golf Club Road
Pleasant Hill, 94523

Los Angeles City College
Dental Lab. Technology Program
855 N. Vermont Avenue
Los Angeles, 90029

Merced College
Dental Lab. Technology Program
3600 "M" Street
Merced, 95340

Orange Coast College
Dental Lab. Technology Program
2701 Fairview Road
Costa Mesa, 92626

Pasadena City College
Dental Lab. Technology Program
1570 E. Colorado Blvd.
Pasadena, 91106

Riverside City College
Dental Technology Program
4800 Magnolia Avenue
Riverside, 92506

FLORIDA
Lindsey Hopkins Tech. Educ. Center
Dental Lab. Technology Program
1450 N. E. Second Avenue
Miami, 33132

Palm Beach Junior College
Dental Lab. Technology Program
4200 Congress Avenue
Lake Worth, 33460

Pensacola Junior College
Dental Lab. Technology Program
5555 Highway 98
Pensacola, 32507

Southern College
Dental Lab. Technology Program
618 East South Street
Orlando, 32801

GEORGIA
Atlanta Area Technical School
Dental Lab. Technology Program
1560 Stewart Avenue, S. W.
Atlanta, 30310

Atlanta College of Medical
and Dental Assistants
Dental Lab. Technology Program
1280 W. Peachtree Street, N. W.
Atlanta, 30309

Augusta Area Technical School
Medical College of Georgia
Dental Lab. Technology Program
1120 15th Street
Augusta, 30901

ILLINOIS
Southern Illinois University
School of Technical Careers
Dental Technology Program
F. Bldg., Dental Technology Dept.
Carbondale, 62901

Triton College
Dental Lab. Technology Program
2000 N. Fifth Avenue
River Grove, 60171

INDIANA
Indiana State University of Evansville
Dental Lab. Technology Program
8600 University Boulevard
Evansville, 47712

Indiana University-Purdue University
at Fort Wayne
Dental Lab. Technology Program
2101 Coliseum Boulevard, East
Fort Wayne, 46805

IOWA
Kirkwood Community College
Dental Lab. Technicians Program
6301 Kirkwood Boulevard, S. W.
Cedar Rapids, 52406

KENTUCKY
University of Kentucky
Lexington Technical Institute
Dental Lab. Technology Program
Oswald Bldg., Cooper Drive
Lexington, 40506

LOUISIANA
Louisiana State University
School of Dentistry
Dental Lab. Technology Program
1100 Florida Avenue
New Orleans, 70119

MARYLAND
Community College of Baltimore
Dental Lab. Technology Program
2901 Liberty Heights Avenue
Baltimore, 21215

Montgomery College
Dental Lab. Technology Program
7600 Takoma Avenue
Takoma Park, 20012

MASSACHUSETTS
Middlesex Community College
Dental Lab. Technology Program
Springs Road
Bedford, 01730

Quincy Voc.-Tech. School
Dental Lab. Technology Program
107 Woodward Avenue
Quincy, 02169

MICHIGAN
Ferris State College
School of Allied Health
Dental Lab. Technology Program
Swan Building, Room 203
Big Rapids, 49307

Grand Rapids Junior College
Dental Lab. Technology Program
143 Bostwick, N. E.
Grand Rapids, 49503

MINNESOTA
Suburban Hennepin AVTI 287
Dental Lab. Technician Program
9000 North 77th Avenue
Brooklyn Park, 55445

916 Area Voc.-Tech. Institute
Dental Lab. Technology Program
3300 Century Avenue North
White Bear Lake, 55110

NEBRASKA
Central Tech. Community Col.
Dental Lab. Technology Program
P. O. Box 1024
Hastings, 68901

NEW JERSEY
Union County Technical Institute
Dental Lab. Technician Program
1776 Raritan Road
Scotch Plains, 07076

NEW MEXICO
Southwestern Indian Poly. Insti.
Dental Lab. Technology Program
9169 Coors Road, N. W.
Albuquerque, 87125

NEW YORK
Dutchess Community College
Dental Lab. Technology Program
Pendell Road
Poughkeepsie, 12601

New York City Community Col.
Dental Lab. Technology Program
300 Jay Street
Brooklyn, 11201

NORTH CAROLINA
Durham Technical Institute
Dental Lab. Technician Program
1637 Lawson Street
Durham, 27703

OHIO
Columbus Technical Institute
Dental Lab. Technology Program
550 East Spring Street
Columbus, 43216

Source: American Dental Association, Council on Dental Education, Division of Educational Measurements. Annual report: dental auxiliary education (1978/79). Chicago, The Association, 1979. 35p. (p.31-2).

## 2C. INSTUTIONS CONDUCTING DENTAL LABORATORY TECHNOLOGY EDUCATION PROGRAMS, CONTINUED

**OKLAHOMA**
Oscar Rose Junior College
Dental Lab. Technology Program
6420 Southeast Fifteenth Street
Midwest City, 73110

**OREGON**
Portland Community College
Dental Technology Program
12000 S. W. 49th Avenue
Portland, 97219

**PENNSYLVANIA**
Mastbaum Area Voc.-Tech. School
Dental Lab. Technology Program
Frankford Avenue and Clementine Street
Philadelphia, 19134

**SOUTH CAROLINA**
Greenville Technical College
Dental Laboratory Department
Box 5616, Station B
Greenville, 29606

Medical University of South Carolina
Trident Technical College
Dental Lab. Technology Program
171 Ashley Avenue
Charleston, 29403

**SOUTH DAKOTA**
Lake Area Voc.-Tech. Institution
Dental Lab. Technology Program
230 - 11th Street, N. E.
Watertown, 57201

**TENNESSEE**
Cleveland State Community College
Dental Lab. Technician Program
P. O. Box 1205
Cleveland, 37311

**TEXAS**
Academy of Health Sciences
Dental Lab. Technology Program
U. S. Army
Fort-Sam Houston 78234

School of Health Care Sciences
Dental Lab. Tech. Training Program
SHCS/USAF, MSDD
114 Sheppard Air Force Base, 76311

Texas State Technical Institute
Dental Lab. Technology Program
James Connally Campus
Waco, 76705

University of Texas
Health Sciences Center at San Antonio
Dental Lab. Technology Education Program
7703 Floyd Curl Drive
San Antonio, 78284

**VIRGINIA**
J. Sargeant Reynolds Comm. Col.
Dental Lab. Technology Program
P. O. Box 12084
108 East Grace Street
Richmond, 23241

Northern Virginia Comm. College
Dental Lab. Technology Program
8333 Little River Turnpike
Annandale, 22003

**WASHINGTON**
L. H. Bates Voc.-Tech. Institue
Dental Lab. Technicians Program
1101 S. Yakima Avenue
Tacoma, 98405

Seattle Central Community Col.
Dental Lab. Technology Program
1701 Broadway
Seattle, 98155

**WISCONSIN**
Milwaukee Area Technical College
Dental Lab. Technology Program
1015 North Sixth Street
Milwaukee, 53203

APPENDIX H (cont'd.)

3. State Boards of Dental Examiners

Alabama
2308 B. Starmount Circle
Huntsville, AL 35801

Alaska
Department of Commerce and Economic Development
Division of Occupational Licensing
Pouch D
Juneau, AK 99811

Arizona
Rm 419
1645 W. Jefferson
Phoenix, AZ 85007

Arkansas
1018 Donaghey Bldg.
Little Rock, AR 72201

California
Rm A-102
1021 "O" St.
Sacramento, CA 95814

Colorado
128 State Services Bldg.
1525 Sherman St.
Denver, CO 80203

Connecticut
99 Pratt St.
Hartford, CT 06103

Delaware
1905 Delaware Ave.
Wilmington, DE 19806

District of Columbia
Department of Licenses
Rm 109
614 "H" St. N.W.
Washington, DC 20001

Florida
Suite 240
Oakland Bldg.
2009 Apalachee Pkwy.
Tallahassee, FL 32301

Georgia
166 Pryor St. S.W.
Atlanta, GA 30303

Hawaii
Department of Regulatory Agencies
P. O. Box 3469
Honolulu, HI 96801

Idaho
Capitol Bldg.
Boise, ID 83720

Illinois
Department of Registration and Education
State of Illinois Dental Section
Springfield, IL 62706

Indiana
700 N. High School Rd.
Indianapolis, IN 46224

Iowa
State Department of Health
Lucas State Office Bldg.
Des Moines, IA 50319

Kansas
4301 Huntoon
Topeka, KS 66604

Kentucky
2106 Bardstown Rd.
Louisville, KY 40205

Louisiana
505 Saratoga Bldg.
New Orleans, LA 70112

Maine
100 Stoney Ridge
Auburn, ME 04210

Maryland
1318 N. Carolina
Baltimore, MD 21213

Massachusetts
Rm 1508
State Government Ctr.
100 Cambridge St.
Boston, MA 02181

Michigan
Department of Licensing and Regulation
P. O. Box 30018
Lansing, MI 48909

Minnesota
717 SE Delaware
Minneapolis, MN 55414

Mississippi
2485 W. Capitol St.
Jackson, MS 39209

Missouri
P. O. Box 1367
Jefferson City, MO 65102

Montana
Lalonde Bldg.
Helena, MT 59601

Nebraska
301 Centennial Mall South
P. O. Box 95007
Lincoln, NE 68509

Nevada
83 S. Maine
Fallon, NV 89406

New Hampshire
61 S. Spring St.
Concord, NY 03301

New Jersey
150 E. State St.
Trenton, NJ 08608

New Mexico
105 W. Manana
Clovis, NM 88181

New York
99 Washington Ave.
Albany, NY 12230

North Carolina
P. O. Drawer 1030
Raleigh, NC 27602

North Dakota
1209 Fifth Ave. SE
Jamestown, ND 58401

Ohio
Rm 1106
180 E. Broad St.
Columbus, OH 43215

Oklahoma
No. 201
45 Classen Blvd.
Oklahoma City, OK 73112

Oregon
Suite 405
620 S. W. Fifth Ave.
Portland, OR 97204

Pennsylvania
P. O. Box 2649
Harrisburg, PA 17120

Puerto Rico
G.P.O. Box 9342
Santurce, PR 00908

Rhode Island
104 Cannon Bldg.
Providence, RI 02908

South Carolina
1315 Blanding St.
Columbia, SC 29201

South Dakota
Suite 10
821 Jackson Blvd.
Rapid City, SD 57701

Tennessee
Department of Public Health Office Bldg.
Ben Allen Rd.
Nashville, TN 37216

Texas
718 Southwest Tower
Seventh and Brazos Sts.
Austin, TX 78701

Utah
330 E. Fourth St. S.
Salt Lake City, UT 84111

Vermont
10 Bladwin St.
Montpelier, VT 05602

Virginia
No. 453
Seabord Bldg.
3600 W. Broad St.
Richmond, VA 23230

Virgin Islands
Department of Health/Government of the Virgin Islands of the United States
P. O. Box 7309
St. Thomas, VI 00801

Washington
P. O. Box 9649
Olympia, WA 98504

West Virginia
P. O. Drawer 1459
Beckley, WV 25801

Wisconsin
1400 E. Washington Ave.
Madison WI 53702

Wyoming
233 "C" St.
Rock Springs, WY 82901

APPENDIX H (cont'd.)

4. Schools of Public Health and Graduate Public Health Programs

*Denotes schools with programs in dental public health

(NOTE: Correctional health administrators seeking assistance with their dental health program should feel free to contact their nearest school of public health, even if the school has no separate program in dental public health. It is very likely that most, if not all, schools of public health, have public health dentists on their faculty or have dentists enrolled in the advanced degree programs.)

Alabama

University of Alabama at Birmingham*
Department of Public Health
The Medical Center
Birmingham, AL 35294

California

University of California
School of Public Health
19 Earl Warren Hall
Berkeley, CA 94720

University of California at Los Angeles
School of Public Health
Center for the Health Sciences
Los Angeles, CA 90024

Loma Linda University
School of Health
Loma Linda, CA 92354

California State University - Northridge
Department of Health Sciences
Northridge, CA 91324

San Jose State University
Department of Health Science
125 South Seventh St.
San Jose- CA 95114

Connecticut

Yale University
Department of Epidemiology and Public Health
School of Medicine
60 College St.
New Haven, CT 06510

Georgia

Emory University
Master of Community Health Programs
School of Medicine
1518 Clifton Rd.
Atlanta, GA 30322

Hawaii

University of Hawaii
School of Public Health
1960 East - West Rd.
Honolulu, HI 96822

Illinois

University of Illinois
School of Public Health at the Medical Center
Post Office Box 6998
Chicago, IL 60680

Louisiana

Tulane University
School of Public Health and Tropical Medicine
1430 Tulane Ave.
New Orleans, LA 70112

Maryland

The Johns Hopkins University
School of Hygiene and Public Health
615 N. Wolfe St.
Baltimore, MD 21205

Massachusetts

Harvard University
School of Public Health
677 Huntington Ave.
Boston, MA 02115

University of Massachusetts
Division of Public Health
School of Health Sciences
Amherst, MA 01002

Michigan

University of Michigan*
School of Public Health
Ann Arbor, MI 48104

Minnesota

University of Minnesota
School of Public Health
1360 Mayo Memorial Bldg.
412 Union St. S.E.
Minneapolis, MN 55455

Missouri

University of Missouri
Division of Community Health Education
Department of Family and Community Medicine
TD-3W
Room 137
School of Medicine
Columbia, MO 65212

New York

Columbia University
School of Public Health
600 W. 168th St.
New York, NY 10032

Hunter College
Community Health Education Program
Institute for Health Sciences
105 E. 106th St.
New York, NY 10029

New York University
Program in Community Health Education
School of Education
Health, Nursing, and the Arts
Washington Square
New York, NY 10003

University of Rochester
Master of Science in Community Health Program
School of Medicine and Dentistry
601 Elmwood Ave.
Rochester, NY 14642

North Carolina

University of North Carolina*
School of Public Health
Chapel Hill, NC 27514

Oklahoma

University of Oklahoma
School of Public Health
College of Health
Health Sciences Center
P. O. Box 26901
Oklahoma City, OK 73190

Pennsylvania

University of Pittsburgh
Graduate School of Public Health
111 Parran Hall
Pittsburgh, PA 15261

Puerto Rico

University of Puerto Rico
Faculty of Biosocial Sciences and School of Public Health
Medical Sciences Campus
G. P. O. Box 5067
San Juan, PR 00936

South Carolina

University of South Carolina
School of Public Health
Columbia, SC 29208

Tennessee

University of Tennessee
Health and Safety Department
College of Education
Knoxville, TX 37916

Texas

University of Texas - Houston
School of Public Health
P. O. Box 20186
Astrodome Station
Houston, TX 77025

Utah

University of Utah
Master of Science in Community Health
Department of Family and Community Medicine
Medical Center
50 N. Medical Dr.
Salt Lake City, UT 84132

Washington

University of Washington
School of Public Health and Community Medicine
F356d Health Sciences Bldg.
Mail Drop SC-30
Seattle, WA 98195

APPENDIX H (cont'd.)

5. U. S. Public Health Service Regional Offices (for P.H.S. Regional Dental Consultant)

Region I: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

John F. Kennedy Federal Building
Government Center
Boston, MA 02203

Region II: New Jersey, New York, Puerto Rico, Virgin Islands

26 Federal Plaza, Room 1005
New York, NY 10007

Region III: Delaware, Maryland, Pennsylvania, Virginia West Virginia, Washington, D.C.

P. O. Box 13716
Philadelphia, PA 19101

Region IV: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee

50 Seventh St. N.W.
Room 404
Atlanta, GA 30323

Region V: Illinois, Indiana, Minnesota, Michigan, Ohio, Wisconsin

300 S. Wacker Dr.
34th Floor
Chicago, IL 60606

Region VI: Arkansas, Louisiana, New Mexico, Oklahoma, Texas

1114 Commerce St.
Dallas, TX 75202

Region VII: Iowa, Kansas, Missouri, Nebraska

601 E. 12th St.
Kansas City, MO 64106

Region VIII: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming

9017 Federal Office Bldg.
19th and Stout Sts.
Denver, CO 80202

APPENDIX H (cont'd.)

Region IX: Arizona, California, Guam, Hawaii, Nevada, American Samoa, Trust Territory of the Pacific Islands

30 Fulton St.
San Francisco, CA 94102

Region X: Alaska, Idaho, Oregon, Washington

Arcade Plaza Building
1321 Second Avenue

APPENDIX H (cont'd)

6. Offices of Dental Directors for State Health Departments

Alabama

Bureau of Dental Health
Alabama Department of Public Health
State Office Bldg.
Montgomery, AL 36104

Alaska

Department of Health and Social Service
Division of Public Health
Community Health Section
Pouch H
Juneau, AK 99801

Arizona

Bureau of Dental Health
Arizona State Department of Health Services
1740 West Adams St.
Phoenix, AZ 85007

Arkansas

Bureau of Dental Health
Arkansas State Board of Health
State Health Building
Little Rock, AR 72201

California

Dental Health Unit
Family Health Services Section
Health Protection System
Department of Health
State of California
714 "P" Street
Sacramento, CA 95814

Colorado

Public Health Dentistry Section
Colorado Department of Public Health
4210 East 11th Ave.
Denver, CO 80220

Connecticut

Dental Health Section
Connecticut State Department of Health
79 Elm St.
Hartford, CT 06115

Delaware

Director of Dental Health
Delaware State Board of Health
Dover, DE 19901

District of Columbia

Bureau of Dental Health
Community Health Sciences Administration
Universal Bldg. N., Room 814
1875 Connecticut Ave., N.W.
Washington, D.C. 20009

Florida

Bureau of Dental Health
Florida State Board of Health
P.O. Box 210
1217 Pearl St.
Jacksonville, FL 32201

Georgia

Branch of Dental Health
State Department of Public Health
47 Trinity Ave., S.W.
Atlanta, GA 30303

Hawaii

Division of Dental Health
Department of Health
P.O. Box 3378
Honolulu, HI 96801

Idaho

Dental Health Section
Idaho Department of Health
State House
Boise, ID 83707

Illinois

Division of Dental Health
Illinois Department of Public Health
State Regional Office Bldg.
4500 S. 6th
Springfield, IL 62706

Indiana

Division of Dental Health
Indiana State Board of Health
1330 Michigan St.
Indianapolis, IN 46207

Iowa

Dental Health Division
Iowa State Department of Health
State Office Bldg.
Des Moines, IA 50319

Kansas

Medical-Dental Health Division
Kansas State Department of Health
535 Kansas Ave., 8th Floor
Topeka, KS 66603

Kentucky

Dental Health Branch
Kentucky Department of Human Resources
275 E. Main St.
Frankfort, KY 40601

Louisiana

Division of Dental Health
Louisiana State Department of Health
P.O. Box 60630
New Orleans, LA 70160

Maine

Division of Dental Health
Department of Health and Welfare
State House
Augusta, ME 04330

Maryland

Division of Dental Health
Maryland State Department of Health
310 West Preston St.
Baltimore, MD 21201

Massachusetts

Division of Dental Health
Massachusetts Department of Public Health
600 Washington St.
Boston, MA 02111

Michigan

Division of Public Health Dentistry
Michigan Department of Public Health
3500 North Logan
Lansing, MI 48914

Minnesota

Section of Public Health Education
Minnesota Department of Health
717 Delaware St., S.E.
Minneapolis, MN 55440

Mississippi

Division of Public Health Dentistry
Mississippi State Board of Health
Jackson, MS 39205

Missouri

Bureau of Dental Health
Missouri Division of Health
P.O. Box 570
Jefferson City, MO 65101

Montana

Dental Health Division
Montana State Board of Health
Cogswell Bldg.
Helena, MT 59601

Nebraska

Division of Dental Health
Nebraska Department of Health
Room 404, Lincoln Bldg.
1003 "O" St.
Lincoln, NE 68508

Nevada

Bureau of Dental Health
Nevada Division of Health
201 S. Fall St.
Carson City, NV 89701

New Hampshire

Bureau of Dental Public Health
New Hampshire State Department of Health
State Health Bldg.
61 S. Spring St.
Concord, NH 03301

New Jersey

Dental Health Program
New Jersey State Department of Health
Health Agricultural Bldg.
Box 1540
Trenton, NJ 08625

New Mexico

Dental Health Section
New Mexico Health and Social Services Department
P.O. Box 2348
Sante Fe, NM 87501

New York

Bureau of Dental Health
New York State Department of Health
28 Essex St.
Albany, NY 12206

North Carolina

Dental Health Section
North Carolina Division of Health Services
Department of Human Resources
Box 2091
Raleigh, NC 27602

North Dakota

Division of Dental Health
State Department of Health
420 N. 4th St., Room 2
Bismarck, ND 58501

Ohio

Division of Dental Health
Ohio Department of Health
450 E. Town St.
Columbus, OH 43215

Oklahoma

Dental Health Service
State Department of Health
Northeast 10th St. and Stonewall
P.O. Box 53551
Oklahoma City, OK 73105

Oregon

Dental Health Section
Oregon State Health Division
P.O. Box 231
Portland,OR 97201

Pennsylvania

Division of Dental Health
Commonwealth of Pennsylvania Department of Health
Health and Welfare Bldg.
Harrisburg, PA 17120

Puerto Rico

Assistant Secretary of Health for Oral Health
Puerto Rico Department of Health
1306 Ponce de Leon Ave.
Stop 19
Santurce, PR 00908

Rhode Island

Division of Dental Public Health
Rhode Island Department of Health
75 Davis St.
Providence, RI 02908

South Carolina

Division of Dental Health
South Carolina Department of Health and
Environmental Control
J. Marion Sims Bldg.
2600 Bull St.
Columbia, SC 29201

South Dakota

Division of Dental Health
State Department of Health
Pierre, SD 57501

Tennessee

Division of Dental Health
Tennessee Department of Public Health
Middle Tennessee Chest Disease Hospital
Ben Allen Rd.
Nashville, TN 37216

Texas

Dental Health Section
Texas State Department of Health
1100 West 49th St.
Austin, TX 78756

Utah

Dental Health Section
Utah State Division of Health
44 Medical Dr.
Salt Lake City, UT 84113

Vermont

Dental Division
Vermont Department of Health
39-43 Pearl St.
Burlington, VT 05401

Virginia

Division of Dental Health
Virginia Department of Health
109 Governor St.
Richmond, VA 23219

Washington

Dental Health Section
Washington State Department of Health
Public Health Bldg.
Olympia, WA 98502

West Virginia

Division of Dental Health
West Virginia Department of Health
3rd floor - Suite 318
601 Morris St.
Charleston, WV 25301

Wisconsin

Section of Dental Health
Wisconsin Division of Health
Box 309
Madison, WI 53701

Wyoming

Wyoming Department of Public Health and
Social Services
State Office Bldg.
Cheyenne, WY 82001

APPENDIX H (cont'd.)

7. Organizations with Studies or Manuals of Standards that can apply to Dental Health Programs in Correctional Institutions

American Correctional Association
Commission on Accreditation for Corrections
6110 Executive Blvd.
Suite 750
Rockville, MD 20852

American Dental Association
Council on Hospital and Institutional Services
211 E. Chicago Avenue
Chicago, IL 60611

American Medical Association
Program to Improve Health Care in Correctional Institutions
Division of Medical Practice
535 N. Dearborn
Chicago, IL 60610

American Public Health Association
Jails and Prisons Task Force
1015 Fifteenth St. N.W.
Washington, D.C. 20005

Organizations prompting improvements in correctional health care delivery

American Correctional Health Services Association
c/o Mr. Richard A. Kiel, President
831 West Morgan St.
Raleigh, NC 27603

The Correctional Health Care Program
Collaborating Organizations

Office of Health Care
Michigan Department of Corrections
3222 S. Logan - Logan Center
Lansing, Michigan 48913

Department of Medical Care Organization
School of Public Health
The University of Michigan
109 Observatory Street
Ann Arbor, MI 48109

Department of Community Health Science
Colleges of Human and Osteopathic Medicine
Michigan State University
A106 East Fee Hall
East Lansing, MI 48824

## APPENDIX I: LIST OF SUGGESTED TEXTBOOKS FOR DENTAL REFERENCE LIBRARY (Addresses of Publishers at End of Appendix)

| Reference Book | Publisher |
|---|---|
| SYLLABUS OF COMPLETE DENTURES, by Heartwell | Lea & Febiger, Company |
| SWENSON'S COMPLETE DENTURES, by Boucher | C.V. Mosby Company |
| McCRACKEN'S PARTIAL DENTURE CONSTRUCTION: PRINCIPLE AND TECHNIQUES, by Henderson and Steffel | C.V. Mosby Company |
| MODERN PRACTICE IN CROWN AND BRIDGE PROSTHODONTICS, by Phillips, Johnson, and Dykema | W.B. Saunders |
| ORAL PATHOLOGY, by Shafer, Hine, and Levy | W.B. Saunders |
| EMERGENCIES IN DENTAL PRACTICE, by McCarthy | W.B. Saunders |
| MEDICAL DICTIONARY (ILLUSTRATED), by Dorland | W.B. Saunders |
| CURRENT CLINICAL DENTAL TERMINOLOGY, by Boucher | C.V. Mosby Company |
| COMMUNICATING IN DENTISTRY, by Easlick, Craig, Russell, and Seger | Chas. C. Thomas |
| ORAL SURGERY, by Kruger | C.V. Mosby Company |
| ORAL SURGERY, by Archer | W.B. Saunders |
| SYNOPSIS OF ORAL PATHOLOGY, by Bhasker | C.V. Mosby Company |
| ORAL MEDICINE: DIAGNOSIS AND TREATMENT, by Burket | J.B. Lippincott |
| ORAL ROENTGENOGRAPHIC DIAGNOSIS, by Stafne | W.B. Saunders |
| AN ATLAS OF DENTAL RADIOGRAPHIC ANATOMY, by Kasle | W.B. Saunders |
| ACCEPTED DENTAL THERAPEUTICS, by A.D.A. (lastest edition) | American Dental Assoc. |
| PHYSICIAN'S DESK REFERENCE (latest edition) | Litton Publications (Medical Economics Co.) |
| ADVANCED PERIODONTAL DISEASE: SURGICAL AND PROSTHETIC MANAGEMENT, by Prichard | W.B. Saunders |
| CLINICAL PERIODONTOLOGY, by Glickman | W.B. Saunders |
| OCCLUSION, by Ramfjord and Ash | W.B. Saunders |
| TEXTBOOK OF OPERATIVE DENTISTRY, by Gilmore | C.V. Mosby Company |
| ENDODONTICS, by Ingle | Lea & Febiger, Company |

| Reference Book | Publisher |
| --- | --- |
| CLINICAL PHARMACOLOGY IN DENTAL PRACTICE, by Holroyd | C.V. Mosby Company |
| DENTAL JURISPRUDENCE, by Sarner | W.F. Poe, Assoc. or W.B. Saunders |
| LOCAL ANESTHESIA AND PAIN CONTROL IN DENTAL PRACTICE, by Monheim | C.V. Mosby Company |
| GENERAL ANESTHESIA IN DENTAL PRACTICE, by Monheim | C.V. Mosby Company |
| RELATIVE ANALGESIA IN DENTAL PRACTICE, by Langa | W.B. Saunders |
| THE DENTIST, HIS PRACTICE, AND HIS COMMUNITY, by Young and Striffler | W.B. Saunders |
| THE DENTAL ASSISTANT, by Richardson, Barton, and Brauer | McGraw-Hill Company |
| DENTAL RADIOGRAPHY: AN INTRODUCTION FOR DENTAL HYGIENISTS AND ASSISTANTS, by O'Brien | W.B. Saunders |
| ORAL PATHOLOGY: AN INTRODUCTION TO GENERAL AND ORAL PATHOLOGY FOR HYGIENISTS, by Kerr and Ash | Lea & Febiger Company |
| CURRENT CONCEPTS IN DENTAL HYGIENE, by Boundy and Reynolds | C.V. Mosby |
| ROENTGENOGRAPHIC INTERPRETATION FOR THE DENTIST, by Bhaskar | C.V. Mosby Company |
| ORAL HEALTH, DENTISTRY, AND THE AMERICAN PUBLIC, by Brown | University of Oklahoma Press |

Publisher's Addresses:

Charles C. Thomas, Publisher
301-327 East Lawrence Avenue
Springfield, Illinois 62717

The C.V. Mosby Company
11830 Westline Industrial Drive
St. Louis, Missouri 63141

J.B. Lippincott Company
East Washington Square
Philadelphia, Pennsylvania 19105

Lea and Febiger
Washing Square
Philadelphia, Pennsylvania 19106

Litton Publications
Medical Economics Company
Box 210
Westwood, New Jersey 08675

McGraw-Hill Book Company
1221 Avenue of the Americas
New York, New York 10020

W.F. Poe Associates, Inc.
110 Franklin Street
P.O. Box 1348
Tampa, Florida 33601

University of Oklahoma Press
1005 Asp Avenue
Norman, Oklahoma 73019

Publisher's Addresses continued:

W.B. Saunders Company
P.O. Box 270
Philadelphia, Pennsylvania 19105

American Dental Association
Order Department
211 East Chicago Avenue
Chicago, Illinois 60611

# APPENDIX J: LIST OF RECOMMENDED PROFESSIONAL JOURNALS AND PERIODICALS
(*denotes essential)

*THE JOURNAL OF THE AMERICAN DENTAL ASSOCIATION
American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611

*DENTAL ABSTRACTS
American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611

JOURNAL OF PUBLIC HEALTH DENTISTRY
American Association of Public Health Dentists
2209 Lawrence Drive
Raleigh, North Carolina 27603

*DENTAL CLINICS OF NORTH AMERICA
W.B. Saunders Company
P.O. Box 270
Philadelphia, Pennsylvania 19105

JOURNAL OF HOSPITAL DENTISTRY
American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611

JOURNAL OF ORAL SURGERY
American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611

ORAL SURGERY, ORAL MEDICINE, AND ORAL PATHOLOGY
Circulation Department
The C.V. Mosby Company
11830 Westline Industrial Drive
St. Louis, Missouri 63141

AMERICAN JOURNAL OF PUBLIC HEALTH
American Public Health Association
1015 Fifteenth Street, N.W.
Washington, D. C. 20005

DENTAL HYGIENE
American Dental Hygienist's Association
444 North Michigan Avenue
Chicago, Illinois 60611

The following publications are generally free to practicing dentists:

CLINICAL PREVENTIVE DENTISTRY
J.B. Lippincott Company
East Washington Square
Philadelphia, Pennsylvania 19105

DENTAL ECONOMICS
Dental Economics
P.O. Box 1260
Tulsa, Oklahoma 74101

DENTAL DIMENSIONS
CPC Communications, Inc.
500 West Putnam Avenue
P.O. Box 4010
Greenwich, Connecticut 06830

DENTAL MANAGEMENT
Harcourt Brace Jovanovich Publishing
1 East First Street
Duluth, Minnesota 55802

DENTAL SURVEY
Harcourt Brace Jovanovich Publishing
1 East First Street
Duluth, Minnesota 55802

Ca-A CANCER JOURNAL FOR CLINICIANS
American Cancer Society
777 Third Avenue
New York, New York 10017

END