UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

RODNEY FUSSELL, GARY ROBERTS, and JAMES LOVE Plaintiffs, v. REGINALD WILKINSON, KAY NORTHRUP, BRUCE MARTIN, PEDRO OBREGON, MONA PARKS, VICKI WARE, JAMES MCWEENEY, and CINDY LAWSON Defendants.	:	Case No. C-1-03-704 (SSB) **AGREEMENT ON DENTAL CARE**

AGREEMENT ON DENTAL CARE
FUSSELL V. WILKINSON
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AGREEMENT ON DENTAL CARE

A. General Provisions

In accordance with the Stipulation For Injunctive Relief (Nov. 16, 2005) at Section FF: Dental, the parties to said Stipulation hereby reach agreement on the provision of dental services and care to all inmates housed within the custody of the Ohio Department of Rehabilitation & Corrections (ODRC).

By entering into this Agreement on dental care and services the parties intend to resolve all claims to such services and care.

In accordance with Paragraph 113 of said Stipulation, the parties selected as a Dental Investigation Team (DIT) the following experts in dentistry to engage in a detailed study of dental care services within ODRC: Nicholas S. Makrides, DMD, MA, MPH; Donald T. Sauter, DDS, MPA; and, Jay D. Shulman, DMD, MA, MSPH.

On May 22, 2006, in compliance with the Stipulation, the members of the DIT presented the parties and Fred Cohen, Independent Consultant (IC) with a Report detailing their investigation, findings, and recommendations as to dental care services within the ODRC.

As required by Paragraph 113, the DIT included recommendations for needed change in their Report. The parties, joined by the IC, have studied such recommendations, then met and discussed them and reached basic agreement on October 6, 2006. On January 9, 2007 the parties, again joined by the I.C., met in Columbus, Ohio and resolved all remaining differences, reaching a final agreement which is contained in this document and denominated, “Agreement on Dental Care.”

The details of said Agreement are incorporated herein and, as stated in Paragraph 113, they "are incorporated into this Stipulation and become binding and enforceable in the same fashion as all other provisions contained herein."

All provisions of the Stipulation relating to grievances, oversight, dispute resolution and modification, enforcement, attorneys' fees, construction, and any other provisions not specifically and expressly limited to medical care are incorporated by reference into this Agreement.

B. Composition of Document

The parties agree that Donald T. Sauter, DDS, MPA and Jay D. Shulman, DMD, MA, MSPH shall be appointed as members of the Dental Oversight Committee (DOC), which shall now become a subcommittee of the Medical Oversight Committee (MOC) and subject to the direction of the I.C.

C. Effective Date

The "date of this Agreement" or "effective date of this Agreement" shall be the date this dental Agreement is filed with the Court.

D. Orientation on Access to Care

The language of the Fussell Stipulation, Paragraph 55 relating to orientation on access to care is hereby incorporated here with the term "dental" substituted for medical.

E. Posting

A summary of the terms of this Agreement shall be posted in prominent locations within each facility encompassed by this Agreement. Multiple copies of the Agreement shall be available for inmate review and photocopying in each such facility.

F. Basic Goals for Dental Care

The basic goals of the dental program incorporated here are to identify dental problems at intake and thereafter, provide relief from pain, eliminate infection and disease, restore and maintain functioning, and provide preventive information and opportunity for inmates to engage in preventive measures.

G. Juvenile Inmates

The parties agree that juveniles, defined as persons in the physical custody of ODRC and under the age of eighteen (18), have special dental needs particularly in the area of preventive care and maintenance. ODRC will conduct a study of such needs and prepare a Report to be completed within twelve (12) months of the date of this Agreement with recommendations for specific action to be taken responsive to such Report.

Following review and discussion with the parties, the I.C. will determine the actions to be taken, including timeframes for their initiation and completion.

H. Dental Administration

There shall be one full-time Director of Dental Services and one full-time Assistant Director of Dental Services.

The parties agree that ODRC will change the present organizational chart so that the Dental Director reports directly to the Chief of the Bureau of Medical Services.

I. Policy & Procedure (P & P)

ODRC will review and propose changes as needed to all of its dental P & P and present the results of such review to class counsel and the IC not later than six (6) months after the date of this Agreement.

Class counsel and the IC shall have one (1) month thereafter to review the proposed P & P and to register any objections or suggestions. Any disagreements about P & P that cannot be resolved by the parties shall be referred to the IC, whose decision shall by final and binding.

The P & P will include the mandates of Paragraph 111 of the Stipulation.

J. Staffing

DENTISTS:

The parties agree that ODRC will provide one full-time properly licensed and privileged staff dentist for every twelve-hundred (1200) inmates. This ratio shall be used to create a general pool of dentists with the precise distribution of these dentists to be determined by ODRC. To the extent that a dentist has non-clinical responsibilities as described in the job description, the non-clinical aspect shall not count towards the staffing ratio.

To the extent feasible, ODRC agrees to fill each FTE dentist position with a single dentist. Where this is not possible, the FTE shall be accomplished with no more than two dentists. In extraordinary circumstances ODRC may ask the MOC for a waiver of the "two dentists per FTE" requirement and supply a full statement of reasons therefore. Class counsel shall be informed and have an opportunity to be heard regarding any such requests and will be informed regarding the disposition thereof.

The number of dentists generated by this ratio and the subsequent distribution shall be the subject of a staffing study conducted by the MOC under the supervision of the IC. The study will address the issues of inmate ready access to dental care, the

quality of such care, whether the ratio adopted has generated too few or too many dentists and other matters directly related to the impact of such staffing.

The results of this study shall be completed and distributed at the end of the second year of this

Agreement and serve as the basis for any necessary or desirable adjustments. In the event that the parties cannot agree on the findings and staffing implications, the matter shall be referred to the IC for final and binding resolution.

DENTAL HYGIENISTS:

The parties agree that ODRC will provide a total of twenty-four (24) licensed dental hygienists in accordance with Appendix C, "Dental Phases" attached hereto.

DENTAL ASSISTANTS:

The parties agree that ODRC will provide one full-time dental assistant for every full time dentist and an additional dental assistant for each clinic. Further, Reception Centers will be allocated an additional dental assistant. Dental Assistants who do not possess a current Radiology Certificate will have nine months from the signing of this Agreement to obtain such Certificate.

K. Dental Operatories and Equipment

Except for each facility designated as a reception center, each full-time dentist shall have at least two complete dental operatories as defined herein. Where there is a compelling reason for modification of this standard, the Defendant shall present such reason or reasons to class counsel and the IC.

The parties shall attempt to informally resolve any differences on this issue but failure to do so will lead to a final and binding decision by the IC.

The equipment minimally necessary for each operatory or for access by each dentist are listed in Appendix A, attached hereto.

L. Dental Screenings

All inmates shall be screened by an appropriately trained, mid-level practitioner (MLP) or a person with greater qualifications within seven (7) days of admission to the ODRC. Inmates with Category 1 or 2 dental problems shall be stabilized or palliated by a dentist, physician, or appropriately trained MLP within twenty-four (24) hours.

M. Mandatory Initial Dental Examination (MIDE)

A MIDE shall be performed by a dentist on each inmate within ninety (90) days of admission to the ODRC.

The MIDE exam shall include a panoramic radiograph for all and be conducted in accordance with the relevant standard of care. This examination shall record all oral disease to include; 1) oral cancer in hard and soft tissues, 2) periodontal disease as determined by Periodontal Screening and Recording (PSR), 3) caries, 4) Temporomandibular Disorders (TMD), and 5) oral facial abnormalities that could indicate other systemic disease processes.

Meaningful oral health education and self-care instruction shall be provided during this visit as well. Procedures to access acute and non-acute dental care shall be reviewed with the inmate at this time.

Reception inmates shall receive free of charge dental product packets consisting of ADA approved dental floss, toothpaste, and toothbrushes sufficient to sustain the inmates during the reception period.

N. Oral Cancer

The ODRC Dental Director shall develop, with the assistance of a trained Oral Pathologist, a tool to measure and calibrate the competency of all ODRC dentists in conducting oral cancer screening examinations. This tool shall be submitted to the DOC and Class Counsel for review and comment no later than six (6) months after the date of this Agreement.

Any biopsy tissues harvested and sent for microscopic examination shall be tracked through use of a log in the dental department and said log shall include at least the following:

1. Date the biopsy was conducted
2. Preliminary differential diagnosis
3. Biopsy site
4. Copy of the consultation with readable name of the surgeon and his contact phone number; and
5. Copy of the final biopsy report

Dental records policy shall be modified to be consistent with the needs of this tracking system. ODRC Dental Records P&P shall be rewritten to ensure that a copy of all consultations initiated by a dentist be provided to the dental clinic and filed within the medical and dental records. Dental procedures will be modified to reflect the above within ninety (90) days of the date of this Agreement. Dental P & P will be modified to reflect the above within six (6) months of the date of this Agreement.

The ODRC Dental Director shall ensure through appropriate P & P and the Q.A. program that dentists perform a thorough oral soft tissue examination and document it

appropriately. Moreover, within six (6) months of the date of this Agreement a system shall be put into place to ensure that: 1) a copy of the biopsy results is placed in the dental chart; 2) there is a follow-up for inmates who have had biopsies with equivocal histologic diagnoses; and 3) within ninety (90) days of the date of this Agreement, ODRC shall establish a Tissue Committee to ensure that inmates diagnosed with oral cancer receive prompt follow-up and treatment.

O. Urgent Care

A dental condition that is not life threatening, but will interfere with chewing, sleeping and the ability to comfortably conduct one's daily activities will be considered urgent. Inmates needing urgent care will be eligible to receive it within 24 hours of registering their request with appropriate ODRC staff as described in the P & P.

P. Emergency Care

A dental emergency requires hospital emergency-level care and includes facial fractures, uncontrolled bleeding, and infections not responsive to antibiotic therapy.

P & P on point will further specify a dental emergency and describe appropriate coordination measures with medical emergencies

Q. Routine Care

Every inmate in the custody of ODRC is eligible for a routine dental examination, cleaning, and continuing oral health education at the end of each twelve (12)-month period of incarceration. Inmate orientation will specify and clarify this opportunity indicating clearly and precisely how and when appointments for routine care shall be made through verbal instruction and a written description in the Inmate Orientation Handbook.

R. Levels of Clinical Care

The parties agree that the ODRC dental system shall strive to provide a quality of care that is 1) consistent with generally accepted professional standards, and 2) at an appropriate level of care.

Appendix B, entitled "Clinical Care" and attached and incorporated into this Agreement, describes four (4) levels of care in greater detail than the preceding paragraphs. Appendix B shall be construed as providing authoritative guidelines for the interpretation and implementation of areas of care otherwise described herein and for the review and revision of the P & P on point.

S. ODRC Dental Review Board

Within ninety (90) days of the date of this agreement, ODRC shall establish a Dental Review Board (DRB) composed of the ODRC Dental Director, or the Assistant Dental Director, one (1) ODRC dentist, and one (1) Certified Laboratory Technician. The DRB will adopt a procedure to review all cases that fall outside the guidelines established in the P & P. Clinical information about each case shall be sent to the DRB prior to the next monthly meeting. A form shall be included to describe the inmate's needs/requests and contain relevant information about: length of stay, how long the treatment should take to complete, estimated cost, whether the treatment should be provided in-house, and the recommendation of the referring dentist. Mounted dental diagnostic casts (where relevant) and the justification packet should be evaluated. The ODRC Dental Director will coordinate the clinical information for distribution to the DRB.

The MOC will monitor the performance of the DRB particularly with regard to the quality of specimens arriving at the laboratory and then reach an opinion on the capability of the DRB to adequately perform its assigned functions without a prosthodontist serving on the DRB.

T. Broken Appointments

ODRC agrees to keep a record of all broken dental appointments and on a regular basis ascertain the most frequent reasons for such broken appointments.

Each institution, at least annually during the life of this Agreement, will prepare an action plan designed to reduce the number of such broken appointments. Such plan will be reviewed and subject to comment by class counsel and the DOC.

U. Oral Health Education

The parties agree that the oral health needs of the inmate population are significant with inmates presenting with more decayed and missing teeth and more periodontal problems than non-prison populations.

Non-reception facilities shall make basic oral health materials available for purchase at a reasonable price. Indigent inmates shall be provided the items described in Section L, *supra*, at no cost.

V. Periodontal Diagnosis and Treatment

The ODRC Dental Director shall develop P & P for periodontal diagnosis that requires use of the Periodontal Screening & Recording (PSR) and treatment and education measures responsive to the score obtained from the periodontal probe.

Inmates with chronic medical diseases that put them at increased risk for morbidity, particularly HIV and Diabetes, shall be placed on a priority list. Particular attention should be paid to periodontal disease diagnosis and treatment.

W. Quality Assurance

A Quality Assurance (Q.A.) program shall be developed no later than six (6) months from the date of the Agreement by the ODRC Dental Director to monitor compliance with dental policy and procedure, equipment use and maintenance, dental records and proper documentation, dental radiograph quality, the allocation and quality of removable prosthetics, inmate-patient satisfaction with dental care, and compliance with metrics to be developed as to extraction to filling ratios focusing particularly on the extraction of critical teeth salvageable by root canal (endodontic) treatment.

X. Peer Review

Within six (6) months of the signing of this Agreement, the ODRC shall develop a clinically oriented peer review program which, at a minimum, will review ODRC dentists every two (2) years. All clinicians granted provisional credentials will have a peer review completed within ninety (90) days of the start of clinical services. Clinicians found to have concerns at the time of provisional peer review, shall have an additional peer review completed within the next ninety (90) days. The peer review program will include metrics developed by ODRC for evaluating dentist quality and a thorough record review. Peer Review program metrics shall be submitted to DOC and Class Counsel within 90 days of the date of this Agreement for comment prior to formal adoption. This program shall, at a minimum, involve the ODRC Dental Director or his designee examining randomly selected patients treated by each licensed practitioner. This system

shall have thresholds by which deficiencies in treatment quality or appropriateness can be corrected.

Y. Medical History and Consultations

The parties agree that with regard to dental and medical records the critical issues for patient care are convenient and rapid access to the medical and dental records.

It is ODRC's current plan to implement an electronic medical and dental record system. The parties agree that a pilot program shall be implemented on or before December 31, 2007 and that one (1) year thereafter there shall be full implementation. The Defendant may request extensions from the I.C. on a showing of extenuating circumstances.

As an interim measure until the record system is fully electronic, the Dental Director will devise a system within 180 days of the date of this Agreement, which will be submitted to the DOC and Class Counsel prior to formal implementation allowing those providing dental care to review the patient's health history and current medications, and generate appropriate written consultations to assure necessary precautions are taken prior to providing dental treatment. Appropriate orientation to the structure and interpretation of an ODRC inmate medical/dental record shall be provided by the HCA.

The ODRC Dental Director shall make medical history taking and documentation a priority issue for dental clinic review.

Z. SOAP Format

The ODRC Dental Director shall provide instruction to all dentists within six (6) months of the adoption of this Agreement, at the hiring of new dentists, and annually

thereafter on how to document emergency or essential / urgent dental care visits using the SOAP format and the Dental Director shall make chart review a priority on his site visits.

AA. Dental Charting

The ODRC Dental Director shall provide direction and monitoring to standardize and improve the documentation and completeness of the dental records within six (6) months of this Agreement.

BB. Condition of Dental Equipment

The ODRC Dental Director or his designee shall examine the condition of and quantity of dental equipment, instruments, and supplies yearly to ensure they are consistent with this Agreement and adequate to treat the inmate population. No later than sixty (60) days after the date of this Agreement, there should be an equipment replacement plan based on the age and performance of all equipment.

CC. Credentialing and Privileging

Within six (6) months of this Agreement, the ODRC agrees to develop a comprehensive credentialing and privileging policy. The HCA and ODRC Dental Director shall monitor compliance. Documentation shall be maintained in Central Office with notification provided to the appropriate facility.

DD. Hepatitis B

The HCA shall review and record the immunization status of all dental staff. Documentation of immunization shall be maintained for each dental staff member at Central Office and the institution and be available for review.

EE. Dental Program Management

Productivity: The ODRC shall create and implement within one (1) year of the date of this Agreement a system for reporting dental procedures and productivity. This system ideally would be electronic but in any event shall use the same format and forms at all institutions. Dental P & P shall state clearly that this reporting is mandatory and accuracy is required.

The ODRC shall create and implement a monitoring system to track compliance with the productivity reporting policy. If dental providers fail to comply with the productivity reporting policy, or are clearly unproductive, administrative steps shall be taken to impose sanctions. The same one (1) year timeframe, as above, applies.

Monitoring Contractors: New contract Requests for Proposals (RFP) shall be written to be consistent with the requirements of ODRC P & P. Dental contractor monitors shall be trained in the use of the contractor monitoring forms and how to initiate action to remedy non-compliance with ODRC P & P.

The ODRC Dental Director shall: 1) use the Contract Monitoring Checklist as a part of his Quality Assurance program; 2) ensure that contractors are held financially accountable for lack of compliance with the provisions of the contract to include compliance with ODRC P&P; and 3) develop P&P for dealing with poor contractor performance.

FF. Staff and Operatory Implementation

The parties agree that the requisite dental staff, including dentists, hygienists, and assistants, will be retained and placed in a coordinated fashion.

ODRC retains the discretion to maintain and improve the current system of contracting for dentists and agrees to study the feasibility of establishing a single-source provider system. ODRC further agrees to inform class counsel and the IC of the progress and direction of such study, which shall be completed with six (6) months of the date of this Agreement.

The Dental Phases 1 through 3 will occur in conjunction with Medical Phases 2 through 4. The specific institutions in Dental Phases 1 through 3 are listed in Appendix C.

APPENDIX A

Necessary Dental Equipment

Operatory
- Chair
- Handpiece delivery unit
- Storage side cabinets

Suction pump and air compressor

Handpieces

Hand instruments

Ultrasonic scalers

Tips for ultrasonic scalers

Adequate sterilization equipment and space

Panorex at reception centers

Adequate film processor (not needed if a clinic has digital x-ray)

Surgical burs and handpieces

Surgical instruments

Curing lights

Triturators

Periapical x-ray machine (digital?)

Laboratory equipment to prepare models
- Model trimmer
- Vibrator
- Articulators to be maintained at the OPI Dental Lab

Blood pressure monitoring equipment

Dental Surveyor

APPENDIX B

Clinical Care: Levels of Care

Achieving an acceptable level of oral health for an inmate population is the preferred goal of any correctional dental system. Toward this end, there must be a plan that includes adequate infrastructure and trained staff along with ongoing monitoring of process and treatment outcomes. Acute pain relief, examinations, fillings, and denture construction fall under different levels of care. An inmate may have a high quality of care at a low level or phase of treatment. The converse may also be true. Therefore there must be two goals for the system: 1) to provide acceptable quality of dental care and 2) to provide an appropriate level of dental care.

Level One

Level 1 is medical stabilization and relief from severe pain and infection. Examples of this are stabilizing patients with maxillofacial fractures, avulsed teeth, bleeding, pain, and acute infections. These patients should be examined immediately.

Infection

Dentoalveolar infections can be life-threatening because of airway obstruction and the possibility of cerebral abscess. Consequently, infection must be identified and treated quickly with consistent follow-up. While the infection can often be temporally stabilized by mid-level providers (MLP), the dental source must be isolated and treated in a timely manner to prevent another acute episode and the colonization of resistant organisms reducing antibiotic efficacy.

Inmates whose complaints suggest a dentoalveolar infection (*e.g.*, pain in conjunction with swelling) should be seen by a dentist, physician, or appropriately trained MLP within 24 hours. Where the complaint includes difficulty in breathing or swallowing, or purulent discharge into the mouth or nose, the inmate should be seen by a dentist, physician, or appropriately trained MLP immediately. MLP's should have documented training in the identifying and stabilizing dentoalveolar infections with antibiotics and analgesics. A dentist must be on call 24 hours every day but need not examine the inmate after hours if after a discussion with the appropriately trained MLP or physician the dentist feels that treating the tooth that is believed to be the focus of the problem can wait for dental sick call. If the dentist does not believe the problem can wait until the next dental clinic the patient shall be referred to the emergency room.

Pain

Pain that interferes with swallowing, eating, or other normal activities requires expeditious (*i.e.*, within 24 hours) treatment by a dentist, physician, or appropriately trained MLP. As with dentoalveolar infections, the inmate may be triaged and stabilized by MLPs or physicians and seen by the dentist at dental sick call. The system must be designed to allow for inmates to be seen within 24 hours for stabilization of their pain and an evaluation of its source. Pain associated with denture irritation can be stabilized by leaving the denture out until the inmate may be seen by a dentist.

Level Two

Level two is primarily associated with the dental daily sick call or other requests for urgent care. Inmates with intermittent or constant pain, an inability to eat, and other dental symptoms that cause discomfort should have access to assessment and the

initiation of treatment within 24 hours by a dentist, physician, or appropriately trained MLP. Examples of Level 2 care are toothaches, infections, and pain of apparent maxillofacial origin.

Level Three

Level 3 is disease control or routine care. The acute problems have been stabilized in Levels 1 and 2. Inmates who enter this level require a comprehensive treatment plan. When an inmate progresses to Level 3, he should be free from infection; and pain that interferes with normal daily activities.

Dental Caries

Carious lesions progress slowly and an early lesion takes several years to progress through the enamel of a permanent tooth.

Thus, if existing carious lesions can be stabilized, an inmate with three (3) years or less to serve has a low probability of having caries (decay) break though into the dentin and pulp chamber. As used in this agreement the term "years to serve" means years to an expected Expiration of Stated Term, to a Projected Release Date or an equivalent calculation, but does not refer to mere eligibility for discretionary release.

Stabilizing open carious lesions with glass ionomer or other resin-based, restorative material using a conservative restorative approach reduces the total bacteriologic load (TBL) and thus the incidence of new carious lesions.

For inmates with three (3) years or less to serve, teeth with caries may be stabilized using resin modified glass ionomer materials or other resin-based, restorative materials. In operative dentistry a dentist will generally remove all decay and place an amalgam (silver alloy) or a light cured reinforced composite resin filling. This generally

requires the use of local anesthesia and preparing (drilling) an appropriately shaped pattern in the tooth, base placement, placement of pins or Intracoronal retention features, and or acid etching and bonding. This type of direct filling procedures may take 30 minutes to one hour.

Another approach to stabilizing dental caries is to remove only the soft decay with hand instruments and some light rotary instrumentation (anesthesia is generally not required) and place a resin modified glass ionomer (RMGI) material providing there is adequate physical retention for the material. Unlike "silver fillings", RMGI bonds to the dentin allowing for additional retention to supplement the mechanical retention of the cavity preparation. The literature has shown that this treatment arrests the progression of the caries. While this is not a definitive restoration, it is capable of stabilizing a tooth for several years. This conservative approach can stabilize the tooth until the inmate is released or until the inmate's oral health has improved at which time Level 4 treatment could be provided.

For longer-term inmates, teeth would be restored more extensively with silver amalgam or composite resin fillings. In patients at high risk for caries, fluoride, and chlorhexadene (an antimicrobial rinse) therapy should be used to reduce the TBL of caries-producing organisms. Both these restorative or dental disease control procedures can be of high quality and help to bring patients to an acceptable level of care for their stay in the correctional system.

Level 3 is where asymptomatic non-restorable teeth will be removed (with proper consent). If the teeth are in need of root canal therapy, they will be stabilized on a case-

by-case basis following guidelines related to the importance of the tooth to the overall function of the dentition.

Scaling and root planning the teeth to stabilize the periodontium is another Level 3 need. This dental cleaning must remove all the calculus/tartar along with polishing the teeth and providing hands-on oral hygiene education.

Periodontal Disease

Based on the results of the PSR performed at the MIDE, many patients will need to be seen by a dental hygienist to scale and remove hard deposits from the roots of the teeth to allow for long term healing and control of inflammation and infection. There appears to be a close association between periodontal disease and some chronic diseases such as diabetes and HIV. Inmates with those chronic diseases that put them at particular risk should be offered the opportunity to be examined yearly for periodontal disease and given some priority in seeing the dental hygienist due to their compromised healing response.

Level Four

Level 4 care is to generally be reserved for the longer-term population; inmates who will likely be in ODRC custody for more than three (3) years.

Endodontics

Root canal therapy is considered to be Level 4 care once the infection and pain are controlled. Root canal therapy will be limited to those cases with compelling reasons for saving a particular tooth. In those very limited instances where the dentist performing the service feels that endodontics is warranted, this service may be provided in accordance with the following criteria: a) The dentist must evaluate the total oral health

of the inmate and there must be excellent oral hygiene and periodontal health, b) the tooth must be in occlusion, c) low caries risk is noted, and d) there is sufficient clinical crown, such that a full-coverage, cast restoration is not anticipated.

Prosthodontic Treatment

If the inmate does not have occlusion of at least the maxillary and mandibular second bicuspids as well as the anterior teeth, some type of partial or full denture should be considered. Prosthodontic (denture) treatment is Level 4 care. Thus, the inmate's length of sentence must be considered. Full and partial dentures are Level 4 care. While these treatments are desirable for all who fit the diagnosis, they are often not necessary to prevent pain or significantly improve chewing function. A soft diet shall be made available for inmates whose difficulty chewing interferes with proper nutrition.

Partially edentulous inmates must have their mouths fully prepared prior to fabrication of a removable partial denture. This preparation may require a surgical procedure to ensure that the maxillary and mandibular ridges on which the dentures will rest have a physiologic shape. This would mandate eligibility for Level 3 care to be able to progress to Level 4. For dental prostheses to be wearable there must be supporting structures that can keep them stable under the forces of chewing and speaking. The occlusion (bite) must be carefully recorded to keep the finished denture in harmony with the patient's jaw position and chewing cycle.

P & P shall describe in detail the fitting and preparation of dentures for those inmates found eligible for this level of care. The MOC shall carefully monitor all issues related to eligibility decisions and the quality of prosthodontic devices.

Removable Prosthetics

P & P shall provide criteria for a dentist to decide whether and when an inmate qualifies for removable partial dentures. These criteria shall be based on inmate need, sentence length, and the condition of the inmate's supporting structures and commitment to good oral self care.

The P & P shall address:

- Fabrication of temporary partial dentures
- Fabrication of cast framework partial dentures
- Fabrication of complete dentures and immediate dentures
- Denture repairs
- Denture remakes
- Dental review board
- Quality of impressions, casts and interocclusal records

APPENDIX C[1]

Inst.	Phase
ACI/OCF	1
CMC/FPRC	1
CRC	1
LorCI	1
MCI	1
NCCI	1
ORW	1
ToCI	1
Inst.	**Phase**
BECI	2
DCI/MEPRC	2
GCI	2
LeCI	2
LoCI	2
NCI	2
NEPRC	2
OSP	2
SCI	2
WCI	2
Inst.	**Phase**
CCI	3
HCF	3
LaeCI	3
MaCI	3
ManCI	3
NCCTF	3
PCI	3
RiCI	3
RCI	3
SOCF	3
TCI	3

*** Dentists – DRC will employ one (1) full-time properly licensed and privileged staff dentist for every 1200 inmates. This ratio shall be used to create a general pool of dentists with the precise distribution of these dentists to be determined by ODRC.**

*** Dental Hygienists (RDH) – DRC will provide a total of twenty-four (24) licensed dental hygienists. This ratio shall be used to create a general pool of hygienists with the precise distribution of these dentists to be determined by ODRC.**

*** Dental Assistants (DA) – DRC will provide one (1) full-time dental assistant for every full-time dentist and an additional dental assistant for each clinic. Reception Centers will be allocated an additional dental assistant.**

[1] Please see *Fussell* Stipulation, Appendix E for DRC Facility and Staffing Legend.

Dental Stipulation Glossary

Abutment Teeth are adjacent to edentulous areas and support fixed or removable partial dentures. A prosthesis rests and is anchored to the abutment tooth as a bridge anchored to its abutments.

Active Biologicals are microorganisms that are used to test whether a **Steam Sterilizer** is operating at the appropriate temperature, pressure, and time cycle.

Acute/Urgent Care is care directed at the alleviation of orofacial pain, swelling, bleeding, and infection. Circumstances that are life-threatening should be treated as medical emergencies

An **Autoclave** or **Steam Sterilizer** is a decontamination device powered by electricity that is used to pressure and steam-sterilize dental instruments.

A **Biopsy** is the surgical sampling or excision of tissues suspected of being pathologic. This is followed by histologic examination by a pathologist.

A **Bite Wing X-ray** is an intraoral radiograph that shows the crowns and part of the roots of the posterior (back) teeth. It is used to diagnose dental caries, subgingival calculus, defective restorations, and periodontal bone loss.

Bloodborne Pathogens are pathogenic microorganisms that are present in human blood that can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

The **Bloodborne Pathogens Protocol** is a set of instructions issued by the Centers for Disease Control and Prevention (CDC) to guide health care facilities in the controlling the spread of infectious disease during medical and dental treatment.

A **Cast Framework Removable Partial Denture** is a prosthesis that replaces teeth in a partially dentate arch and clips/clasps and rests on the natural teeth that remain. The cast framework allows the forces of chewing to be directed to the remaining natural supporting teeth (**Abutment Teeth**) in such a way as to preserve their periodontal health.

Category 1 Care is a term used in ODRC 68-MED-12 to define emergency care. ODRC 68-MED-12 defines a dental emergency as a serious, disabling condition of the teeth or surrounding tissues, manifested by severe symptoms that occur suddenly or unexpectedly.

Category 2 Care is a term used in ODRC 68-MED-12 to define essential care. ODRC 68-MED-12 defines **Category 2 Care** as the treatment of conditions of an urgent nature, such as grossly decayed teeth and/or significant pain.

A **Cavity** is a defect in tooth enamel caused by decomposition (demineralization) of enamel due to exposure to acidic byproducts of oral bacteria.

Comprehensive Dental Treatment is dental treatment provided by following a well-formulated **Dental Treatment Plan**. This **Treatment Plan** should be based on a thorough intraoral examination, a carefully taken and reviewed health history, a review of diagnostic x-rays, and an interview with the patient. The goal of this treatment is a dental disease-free oral cavity and a patient educated about the causes, cures and preventive strategies to maintain oral health.

A **Custom Impression Tray** is a dental impression tray made on a plaster model of the patient's mouth. It is used to carry and mold impression material around oral structures which will support dental prostheses

A **Dentoalveolar Infection** is an infection associated with the teeth and surrounding bone.

Dental Amalgam / "Silver" Filling is a direct filling material consisting of various metals formulated to solidify. **Dental Amalgam** is condensed into a cavity preparation (pattern drilled into the tooth) after **Dental Caries** has been removed. The filling material restores the chewing surfaces and tooth contacts.

A **Dental Assistant** assists the dentist in performing comprehensive care. The **Dental Assistant** also responsible for disinfecting and sterilizing equipment and instruments that are used and contaminated during dental procedures. Often **Dental Assistants** will keep the appointment schedules and perform other clerical work necessary for the day to day operation of the clinic. Depending on a state's **Dental Practice Act**, a **Dental Assistant** who has had the appropriate training (**Radiology Certificate**) may expose dental radiographs.

Dental Calculus (Tartar) is the hard deposits that form on the teeth secondary in incomplete dental plaque removal. These deposits must be removed by direct contact with sharp hand instruments or an ultrasonic scaler.

Dental Caries is a chronic infection of tooth enamel characterized by a loss of mineralized structure resulting in a **Cavity**.

A **Dental Cast/Model Trimmer** is a device that uses a rotating abrasive disk and water to shape portions of dental casts.

Dental Casts are models made of a gypsum product that serve as a rigid representation of patient's hard and soft tissues used in mastication or to support a denture base. This model is most commonly used as a base for the fabrication of a fixed or removable prosthesis.

A **Dental Chair** is power reclining chair used to hold and position the patient during a dental procedure. It is a component of a **Dental Operatory**.

A **Dental Clinic** is a defined space dedicated to the provision of dental care. Typically, it is composed of at least one **Dental Operatory**, a small **Dental Laboratory**, and equipment to expose and develop necessary dental x-rays.

A **Dental Composite Filling** is direct filling material consisting of acrylic resin reinforced with glass particles formulated to solidify on its own or with the application of a specific wavelength of light applied by a hand held source. This dental composite filling is condensed or injected into a void in the tooth designed to remove dental caries, retain the filling material, and restore the chewing surfaces and tooth contacts. This resin is tooth colored and is most often used with the front teeth.

A **Dental Compressor** is a specialized air compressor used to provide air pressure to the **Dental Headpieces** and **Dental Operatory.**

A **Dental Curing Light** is a hand-held light source used to harden certain dental filling materials.

A **Dental Impression** is a negative representation of a patient's teeth and denture bearing areas made with a soft material that becomes rigid after several minutes in the patient's mouth. This dental impression is then filled with a gypsum product to form a plaster or dental stone model of the patient's jaws.

A **Dental Laboratory** is a defined space used to prepare impressions and models for prosthodontic treatment.

Dental Impression Material a flowable paste or putty which becomes rigid when placed in the patient's mouth and is used in a Dental Impression Tray to make a negative mold of the teeth into which dental plaster can be placed to form a model of the patient's mouth.

Dental Impression Tray is a dental instrument shaped like the dental arch and cupped to hold and carry **Dental Impression Material.** These trays can be reusable or disposable.

Dental Hand Instruments are specialized tools used in the mouth and surrounding structures to perform comprehensive dental treatment. These instruments are largely stainless steel or disposable. They are used to cut and shape dental tissues and direct filling restorations

A **Dental Handpiece** is an air-powered dental tool used in conjunction with dental burs and attachments, to perform comprehensive dental treatment.

A **Dental Hygienist** is a licensed professional trained to educate patients about dental disease and oral self care techniques and remove soft and hard deposits from a patient's teeth and tissues. Depending on the **State Dental Practice Act**, a Dental Hygienist may work independently, or under **General** of **Direct Supervision** of a **Dentist.**

Dental Operatory is a term often used to describe the collection of equipment needed for providing comprehensive dental treatment. An **Operatory** or **Dental Operatory** typically contains a dental chair, a dental light, a **Dental Handpiece** delivery system, cabinets for instruments, materials and supplies, a sink, and necessary connection to compressed air, dental vacuum, potable water, electric power, and waste disposal.

Dental Plaque is a tenacious film comprising bacteria, bacterial byproducts, and debris that forms on the teeth continuously. **Dental Plaque** bacteria and byproducts lead to the formation of dental caries, dental calculus/tartar deposits, and periodontal disease. **Dental Plaque** is associated with **Periodontal Disease**.

A **Dental Practice Act** is a state statute that defines the scope of dental and dental hygiene practice and specifies the clinical activities of non-dentists that require **General** or **Direct Supervision**.

Dental (Oral) Prophylaxis the process of cleaning the teeth (removing **Dental Plaque** and calculus) which will include oral hygiene instruction and education, removal of soft and hard deposits, assessment of oral health and polishing of the teeth.

Dental Restoration describes fillings, fixed and removable partial dentures, full dentures, implants or single crowns.

A **Dental Suction Device** is a specialized vacuum pump plumbed into the **Dental Operatory** to allow the dental team to suction oral fluids and particles from a patient's mouth

Dental Treatment Plan is a list of dental procedures to be performed by on a patient with dental disease and or loss of tooth structure and ability to masticate adequately. This Dental Treatment Plan is arranged in an order that guides the dentist to treat the most important problems first and work to improve the supporting structures of the mouth to support more advanced restorative procedures if needed.

A **Dental Vibrator** is a device used to prepare dental casts.

Dentist is licensed professional who is trained to diagnose and treat conditions of the hard and soft tissues of the mouth.

Edentulous means being without teeth.

Endodontic Treatment. See **Root Canal Treatment.**

A **Full/Complete Denture** is a dental prosthesis that rests on an **Edentulous** (toothless) dental arch (jaw) and is retained by suction. The **Full/Complete Denture** replaces all the teeth in that arch required by the patient to chew, speak and allow for acceptable esthetics.

General Supervision means that a dentist has authorized a dental hygienist to perform procedures but need not be present in the treatment facility during the performance of those procedures.

Glass Ionomer Filling describes a resin material that contains fluoride, bonds to the internal structure of a natural tooth and can be flowed or packed into an area of the tooth where caries has been removed to restore the contour, contacts and chewing surfaces of the tooth.

HCA refers to **Health Care Administrator** with the job description provided by the ODRC.

A **Jaw Relationship Record** is a rigid index used to capture the position of a patient's jaws that permits a prosthesis to be fabricated so that the patient's chewing cycle is replicated.

A **Midlevel Practitioner** is a health care worker who is trained to assist physicians in patient diagnosis and treatment. The most common **Midlevel Practitioners** are registered nurses and physician assistants.

Occlusion is the alignment of the teeth of the upper and lower jaws when brought together.

Oral Cancer Screening is a standard portion of a dental examination that examines the hard tissue (radiographically) and soft tissue by visual inspection and palpation to look for signs of oral cancer lesions such as color and texture changes in the oral tissue or abnormal swelling.

Oral Hygiene Instruction or **Oral Self-Care Education** provides the dental patient information on the cause and effects of oral disease, the benefits of oral health, and instruction on the use of the toothbrush, floss, and other oral hygiene aids as necessary to conform to the shape and position of the teeth and fixed dental prostheses and remove dental plaque.

Operatory. See **Dental Operatory**.

An **Oral Pathologist** is a dental specialist who has completed an American Dental Association-approved training program that deals with the nature, identification, and management of diseases affecting the oral and maxillofacial regions. Oral pathology is a discipline that investigates the causes, processes and effects of these diseases. The practice of oral and maxillofacial pathology includes research, diagnosis of diseases using clinical, radiographic, microscopic, biochemical or other examinations, and management of patients.

Oral Prophylaxis. See **Dental Prophylaxis**.

Oral Self-Care Education. See **Oral Hygiene Instruction**.

A **Panoramic X-ray** is an extraoral radiograph of a patient's entire jaw and surrounding structures in a flat plane. Panoramic radiographs are often used for forensic patient identification and initial screening.

A **Panoramic X-ray Machine** produces an extraoral radiograph of a patient's entire jaw and surrounding structures in a flat plane.

A **Periapical X-ray** is an intraoral radiograph that shows entire teeth in a small segment of the mouth, used to diagnose caries, dentoalveolar infection, periodontal disease, subgingival calculus, some oral pathology, and diseases of the dental pulp.

Periodontal Care is treatment directed at reducing or eliminating **Periodontal Diseases**.

Periodontal Diseases are chronic inflammatory conditions (infections) of the gingiva (gums) and bone

A **Periodontal Infection** is an infection associated with dental soft tissues, teeth and surrounding bone. This condition is a subset of a **Dentoalveolar Infection**.

Periodontal Screening and Recording (PSR) is a process where a calibrated dental probe is used to measure the position of the tissue and bone surrounding the teeth. Specific teeth in each sextant (one sixth of the patient's mouth) are measured and examined. Notations are made of the measurements, presence of dental calculus, and bleeding.

A **Periodontist** is a dentist who has successfully completed American Dental Association-approved advanced training in the diagnosis and treatment of the diseases of the tissues and bone that support the natural teeth.

A **Plaque Index** is a numerical score that summarizes the extent to which a patient has removed **Dental Plaque** from his teeth. A disclosing dye is used to stain plaque that adheres to the teeth. A common Plaque Index is the proportion of tooth surfaces that has plaque.

Prosthodontic Treatment is treatment of the deficiencies in the chewing function of patients who have lost tooth structure or teeth.

A **Prosthodontist** is a dentist who has successfully completed American Dental Association-approved advanced training in the diagnosis and treatment of deficiencies in the chewing function of patients who have lost tooth structure or teeth.

Quality of Care is a measure of the organizational and technical competence of dental care. Adequate or acceptable quality of care is that which meets the technical and scientific standards described in the peer-reviewed dental literature. It is a measure of the extent to which comports with professional standards.

A **Radiology Certificate** is a credential, earned by attending a course and passing an examination that permits a **Dental Assistant** to expose radiographs.

Root Canal (Endodontic) Treatment describes the process of entering a natural tooth to remove infected nerve and blood vessels that reside in canals which run from the crown of the tooth to the end of the root. After the diseased tissue is removed, a neutral filling material placed in the root canal space preventing the loss of the tooth.

Root Planing is the debridement and smoothing of the root surface as part of periodontal treatment performed by a **Dentist** or **Dental Hygienist**.

Scaling is a procedure performed by a dentist or dental hygienist that involves removing mineralized deposits (calculus or tartar) from the tooth. Scaling is a component of an **Oral Prophylaxis.** This is accomplished using both **Dental Hand Instruments** and an **Ultrasonic Scaler.**

Steam Sterilizer. See **Autoclave**.

SOAP Format is a standardized approach to recording patient encounters. SOAP is an acronym for **S**ubjective (patient chief complaint), **O**bjective (clinical findings), **A**ssessment (diagnosis), and **P**lan (treatment).

Silver Filling. See **Dental Amalgam**.

Spore Testing is the process of validating the calibration of a **Steam Sterilizer** by testing its ability to kill **Active Biologicals** such as bacteria and spores (organisms that are difficult to kill). After the organisms are cycled through the **Steam Sterilizer,** they are sent to a laboratory for culturing. The results are retained in a **Spore Test Log.**

A **Spore Test Log** is a record of all **Spore Tests** performed in a **Steam Sterilizer** during a given period.

Stabilization of Dental Caries is a broad term that could describe brief and lengthy restorative procedures whose purpose is to remove caries and restore function. In the context of stabilizing caries in a dental population, stabilization will often consist of removing caries and placing a provisional restoration which may not be prepared with all the characteristics of an end stage restoration

Surface Disinfection is the process of decontaminating exposed areas of a **Dental Operatory** and any equipment which is not used intraorally. This is typically performed by "spray, wipe, spray" technique using an antibiological liquid.

A **Surgical Handpiece** is a special high torque handpiece used in the surgical removal of teeth and surgical procedures on the mandible and maxilla. It is powered by compressed air or gas and is designed so that expelled gas is not directed onto the surgical site.

Tartar. See **Dental Calculus**.

A **Triturator** is a device used to mix direct filling dental materials.

An **Ultrasonic Scaler** is an electronic and water-driven unit used to remove dental calculus (tartar) from teeth while providing and ultrasonic lavage to the teeth. The **Ultrasonic Scaler** will be a wand connected to a tabletop power source or an **Ultrasonic Handpiece** connected directly to the **Dental Operatory.**

Urgent Care. See Acute Care.

An **X-ray Processor** is machine used to develop x-ray film.