ORAL HEALTH AND WELLNESS PROGRAM

TECHNICAL ASSISTANCE GUIDE

Foreword

The Job Corps oral health and wellness program is a required program element that must be in place and functioning at a level that meets students' basic needs. Operating requirements for the oral health and wellness program are specified in the Policy and Requirements Handbook (PRH), Chapter 6.10, Section R2.

This Technical Assistance Guide (TAG) contains no additional requirements but offers technical assistance, suggestions, and guidance to assist Job Corps center operators in complying with the requirements of the PRH and to implement Federal Regulations 20 CFR 638.510 for oral health care at all Job Corps centers.

TAGs offer suggested approaches and methods for delivering various aspects of the program and contain expert advice, proven implementation strategies, and best practices that can be used to enhance program performance and delivery. The purpose of this TAG is to provide Center Directors and health personnel, especially center dentists, at all Job Corps centers, with technical assistance to ensure provision of adequate and appropriate oral health care for all students.

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SECTION 1: OVERVIEW

The negative consequences of poor oral health and its effect on speech, eating, self-esteem, social interaction, education, career achievement, and emotional state have been well documented. "More than 51 million school hours are lost each year to dental-related illness. Employed adults lose more than 164 million hours of work each year due to dental disease or dental visits."[1] Obviously, oral health and wellness is crucial to uninterrupted education and training. Good oral health is essential to employment readiness.

1.0 Oral Health and Wellness

Oral health is an integral component of general physical health. Many systemic diseases and conditions have oral manifestations. Conversely, oral diseases and conditions can cause some systemic diseases and conditions. Oral health affects overall health and quality of life. The broadened concept of *oral health* parallels the broadened concept of health. As defined by the World Health Organization, the definition of *health* is a complete state of physical, mental, and social well-being, and not just the absence of infirmity.

The Surgeon General's Report on oral health found that "oral diseases and disorders in and of themselves affect health and well-being throughout life. The burden of oral problems is extensive. Common dental diseases and other oral infections may undermine self-image and self-esteem, discourage normal social interaction, and lead to chronic stress and depression as well as incur great financial cost. They may also interfere with vital functions such as breathing, eating, swallowing, and speaking and with activities of daily living such as work, school, and family interactions.... We see ourselves, and others see us, in terms of the face we present to the world. Diminish that image in any way and we risk the loss of self-esteem and well-being."[2]

The dimension of wellness added to oral health bolsters self-esteem and well-being. Wellness practices include oral health promotional behaviors such as eating nutritiously, practicing good oral hygiene, and making appropriate visits to the dentist.

An oral health and wellness lifestyle dictates that students reduce their risk for oral disease, maintain their teeth in good repair, and take preventative measures to reduce the risk of orofacial trauma.

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[1] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

[2] Ibid.

1.1 The Connection to Employability

The social and economic impact of oral disease in terms of lost days and years of productive work is substantial. Acute and chronic dental problems leading to restricted activity and work loss can jeopardize job performance and security.

Unhealthy conditions of the teeth, gums, jaw, lips, and tongue can have deleterious psychological and physical effects on a student's ability to succeed in Job Corps and in later life. Toothaches, unattractive appearance, inability to chew properly because of multiple missing teeth, and bad breath can also be impairments to social interaction, job training, and employment.

Optimal oral health and wellness is a critical prerequisite to successful training and employment. Moreover, oral health and wellness can promote social and employability skills. For example, at the pivotal time in a job interview, presenting a pleasing, self-confident smile could convince the prospective employer that the student could do the job, would perform with pride, and would be a pleasant coworker.

1.2 The Oral Health and Wellness Program Philosophy

Job Corps employs a training approach that prepares youth for employment. Similarly, Job Corps employs a holistic wellness approach that integrates students' overall well-being, employability skills, and optimal health status through a combination of on-center health services and related health programs to prepare students for stable, long-term employment. Oral health and wellness is key to undistracted learning, speaking and an attractive appearance, as well as to uninterrupted training and work attendance.

The oral health and wellness program is designed to increase students' awareness of their own personal responsibility in achieving and maintaining oral health and wellness. The philosophy of the Job Corps policy regarding oral health is based upon the following precepts and truisms:

- Oral health status is integral to students' general physical health status and vice versa. Students cannot be healthy without good oral health.
- Optimal oral health plays an important role in interpersonal and social relationships.
- Certain oral conditions, when left untreated, present major psychosocial barriers to students' well-being and prevent students from adapting completely to Job Corps and the workplace.
- Optimal oral health is the personal responsibility of each student. One task of a Job Corps center is to make students aware of this responsibility and encourage them to assume it.

- Job placement upon completion of training is often influenced by a full complement of teeth in good repair and free from gum disease.

- Oral diseases involving the teeth and supporting structures cause a significant amount of absenteeism from training and jobs.

- Perception of the condition and appearance of one's teeth can affect self-confidence and self-esteem.

- Safe and effective disease prevention measures exist that everyone can adopt to improve oral health and prevent oral disease.

The determination, dedication, diligence, and attitude that it takes to achieve oral health and wellness is translatable to seeking employment, maintaining employment, and succeeding in the workplace.

1.3 Program Purpose and Objectives

Many students have not had the benefit of routine oral care prior to entering Job Corps. The suboptimal oral health status of many entering students is attributable to their previous lack of access to oral care and preventive services. As a result, many students arrive on center with a tremendous need for restorative care and oral health promotional skills training.

The PRH stipulates that centers provide basic dental services to assist students in attaining and maintaining optimal health and wellness while they are in Job Corps. In the course of obtaining oral health and wellness services, students learn:

- About the center's health care delivery system and how to seek on- center health care

- How and when to access community health services

- About wellness concepts and the steps to take to maintain personal wellness

- About their individual oral condition and prescribed treatment

- About appropriate lifestyle choices

- How to take personal responsibility for maintaining optimal health

- How employability skills can be applied in the course of obtaining oral health and wellness services

- That optimal oral health and wellness is a prerequisite to employment readiness

SECTION 2: COMPONENTS OF AN ORAL HEALTH AND WELLNESS PROGRAM

The components of a center oral health and wellness program include:

- Cursory oral examination and history
- Mandatory oral examination
- Emergency oral care
- Routine restorative oral care
- Periodontal care and oral prophylaxis
- Oral health and wellness checkups
- Off-center oral health services
- Infection control
- Safety and health
- Oral health care for pregnant students
- Oral health and wellness education
- Continuous quality improvement
- Customer relations and outreach

Appendix A provides an overview of each program component. In addition, Appendixes B and C provide resource information that can be useful in supporting the oral health and wellness program. Appendix B contains suggested reference materials (books, CD-ROMs, and teaching aids) and Appendix C contains a list of wellness-related Web sites.

2.0 Cursory Oral Examination and History

The cursory oral examination and history are part of the cursory health evaluation to be completed within 48 hours of a student's arrival on center.[3] The purpose of the cursory oral examination is to determine whether the entering student has oral signs of a communicable disease or of an acute oral condition that requires immediate diagnosis and treatment. This examination is not intended as a screening for separation from Job Corps, nor is it a substitute for the mandatory oral examination.

The dental assistant or a qualified health and wellness center staff member takes the history and performs the cursory oral examination. The services of a dentist are neither required nor appropriate for this examination. However, health and wellness staff should review the examination technique and the content of the examination with the center dentist at least annually. Serious oral conditions must be referred to the center dentist immediately.

[3] The cursory oral examination may be omitted if the entrance physical examination is conducted within 72 hours of a student's arrival on center; the oral examination is included as part of the entrance physical examination.

2.0.1 Procedures for Cursory Oral Examination and History

A brief oral health history is obtained from the student to determine the presence of any condition that might cause pain or swelling in the near future (e.g., recent tooth fracture) or of current conditions such as bleeding, swelling, or pain during the past 3 days.

The examination of the mouth and throat includes visual observation for the following conditions:

- Inflamed/swollen tonsils or pharynx
- Lesions (abnormalities) on lips, tongue, gums (gingiva), or other soft tissues
- Bleeding
- Swelling of mouth, cheeks, jaws
- Loose or fractured teeth
- Grossly decayed teeth, lack of teeth

The cursory oral examination can be performed in areas other than the dental suite. Normally, this examination is conducted with a clean mouth mirror or tongue depressor and a flashlight for better illumination. Health personnel should wear gloves, masks, and eye protection during the cursory oral examination.

A student with any suspect condition should immediately be referred to the center dentist for further evaluation, treatment, and follow up. Suspect conditions include soft tissue swelling or lesions.

Students referred to the center dentist for further evaluation may receive a mandatory oral examination at the time emergency treatment is rendered, depending on the dentist's professional judgment. No other definitive treatment should be started until the student is rescheduled for routine oral health care between the 45th to 75th day after enrollment (depending on when the mandatory oral examination is usually performed at the center).

2.0.2 Procedures for Students with Orthodontic Appliances

No center should provide orthodontic care to a student from its health budget because of the excessive cost, the long treatment period, and the repeated visits involved. Consequently, admissions counselors should not admit and centers should not retain students wearing orthodontic appliances (i.e., braces, bands, headgear) except under specific conditions.

In the event that a student arrives on center wearing an orthodontic appliance, the student may stay on center if health and wellness staff determine immediately that one of the following two conditions applies:

- The student (or parent/guardian) has presented a statement from his/her current orthodontist indicating that active treatment has been completed and that the

appliances are retained only for stabilization of teeth in their current position. In such cases, the center has no responsibility for providing additional funds toward continuing the student's orthodontic treatment.

- The student (or parent/guardian) has provided documented evidence that a treatment plan is in place for continued care, care will be obtained at a facility easily accessible to the center, the time lost to obtain the care will not significantly interfere with the student's education or training, and the cost of continued treatment and treatment-related transportation will be borne by an outside agency (e.g., department of human resources or social services agency), student, parent, or legal guardian.

If neither condition applies and the student qualifies, a medical separation with reinstatement rights[4] may be granted. The student would be reinstated when he/she is no longer under active orthodontic treatment or when the treatment is completed.

2.0.3 Procedures for Pregnant Students

Health staff should refer pregnant students to the oral health and wellness program as soon as possible after they arrive on center or receive their pregnancy test results. Procedures for providing oral health care to pregnant students are discussed in Section 2.9.

2.1 Mandatory Oral Examination

All students must receive a clinical oral examination between their 45th and 75th day on center. The examination may occur earlier if a student has an oral emergency. At the time of the mandatory oral examination, as at all other times, a student with any emergent condition must receive timely, appropriate care or referral (see Section 2.2). Evaluation of the students' oral health status requires reviewing their medical history, obtaining a relevant oral health history, and conducting a thorough clinical and radiographic examination with evaluation of extraoral and intraoral structures. During the examination, it is a good practice for the dentist to explain to students the procedures being conducted so that students are aware of proper examination techniques.

The dentist determines the urgency and type of oral health care needed based on the examination findings. A minimum of four bitewing x-rays is required. Additional x-rays considered necessary for immediate diagnostic purposes or to assign priority classification can also be ordered. However, because of program cost constraints, routine extraoral x-rays should be ordered only when they are a *necessary* adjunct to bitewing x-rays and can be reimbursed at the cost of four bitewing x-rays.

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[4] Reinstatement is a resumption of the previous enrollment, not a new enrollment, and is effective the date the student physically reports back to the center.

A dentist must complete the mandatory oral examination. When a hygienist conducts any aspect of the examination, the center dentist must document his/her review of the charting and establish the treatment plan as part of the oral health and wellness plan and priority classification.

As part of the oral examination, the extraoral structures should be examined and evaluated. The center dentist should refer students with lesions that look highly suspicious to an oral surgeon. Intraoral tissues and structures, including the oral mucosa, muscles of mastication, lips, floor of mouth, tongue, salivary glands, palate, and the oropharynx should be examined and evaluated. Teeth and their replacements should be examined and evaluated. The examination should include observation of missing teeth, condition of restorations, caries, tooth mobility, and signs of parafunctional habits. The presence and distribution of plaque and calculus should be determined. Periodontal soft tissues, probing depths, and the presence of bleeding on probing should be evaluated and noted.

A thorough oral examination can also identify signs of nutritional deficiencies as well as some systemic diseases such as microbial infections, immune disorders, injuries, and some cancers.[5] The dentist should document these findings in the oral health record and verify that students with nutritional deficiencies and systemic diseases are under the care of a provider or make a referral.

2.1.1 Documentation of the Examination Results

Examination documentation must include:

- All relevant findings
- A classification of the student's oral health condition as Priority 1 (P1), Priority 2 (P2), Priority 3 (P3), Priority 4A (P4A), or Priority 4B (P4B), as described in Section 3
- A preliminary treatment plan as part of the oral health and wellness plan that establishes priorities for providing comprehensive oral health care (within program constraints) and lists specific services to be rendered on specific teeth
- A discussion of any proposed oral care with the student and whether the student accepts or declines the proposed oral care

Mandatory oral examination data must be recorded in the oral health record on the standard form (SF) 603 or SF 521 and SF 603A, which is maintained as part of the student's permanent health record. When necessary, oral health records may only be separated temporarily from the student's health record when necessary for short periods

[5] U.S. Department of Health and Human Services. *Oral Health in America. A Report of the Surgeon General—Executive Summary.*

of time. The student's oral classification is entered on the SF 603 in section 1, space number 3. (Appendix D provides sample copies of SF 603, 603A, and 521.) Alternatively, the student's oral classification is entered on SF 521 in Section 8. Only standard Job Corps abbreviations and acronyms should be used on forms and in chart entries so they are understandable to anyone reading them. Appendix E provides standard Job Corps dental abbreviations used to fill out forms and chart in oral health records.

2.1.2 The Mandatory Oral Examination as an Interactive Process

The examination record should document the interactive process that takes place between the dentist and the student. Based on the results of the examination, a diagnosis and proposed treatment plan should be presented to the student. The student should be informed of any disease process, treatment options, potential complications, expected results, and student responsibility in treatment. Consequences of nontreatment should also be explained to the student.

Quality indicators (provided in the PRH) are used to measure the quality of health-related services provided to students. An effective interaction between the dentist and student will ensure that the oral health and wellness program meets the quality indicator "students demonstrate a clear understanding of their individual health condition and treatment prescribed" [PRH-6: 6.10 (Q2)]. Conversations with students about their oral health status should occur in a private setting so that confidentiality is protected. Sufficient time should be provided for questions and discussion with students.

Different ethnic groups view health and disease through unique cultural perspectives. Language differences may influence successful communication. The oral health team members will encounter students who are different from them in terms of culture, race, ethnicity, gender, sexual orientation, and family background. Providing culturally competent care depends on the team's ability to be sensitive to and embrace these differences. Cultural competency demands the mastery of knowledge, attitudes, and skills that facilitate communication with diverse students.

Job Corps accommodates students with sensory, physical, cognitive, and affective disabilities. The oral health team should consult with the student's counselor, mental health consultant (if assigned), Center Director's designee (CDD), and other appropriate staff to determine the best strategies for helping such students maximize benefit from the oral health and wellness program. The team should consult with the CDD for information on handling students with disabilities. The team can also visit the Job Corps Web-based tutorial to obtain additional information related to students with disabilities (http://www.jobcorpshealth.com/disability/). The site provides information on the different types of disabilities common to Job Corps students and effective strategies for interacting with students with varying abilities.

Students may make judgments about their dentists' competence based on a feeling of connectedness to the dentist rather than on any actual objective demonstration of the

dentist's skill. As important as speaking is effective listening. Listening to students is a form of nonverbal communication that may convince them that the dentist understands them and is concerned about them.

Students have a right to an explanation of all subsequent treatment to be rendered. The explanation must be in simple language the student can understand and should include proposed treatment, alternatives (including that of nontreatment), and the benefits, possible side effects, and risks associated with each alternative.
As oral care is voluntary, the student may revoke consent at any time prior to the procedure. Documentation of the student's agreement may consist of a progress note entered into the record summarizing the points covered with the student regarding the specific procedures and his/her verbal consent to proceed with treatment.

2.1.3 Oral Health and Wellness Plan

A personal and practical oral health and wellness plan is critical to helping a student understand his/her role in attaining and maintaining oral health and wellness. The plan should delineate the student's responsibilities and the oral health and wellness team's responsibilities. The plan should be created after the mandatory oral examination when the student is made aware of his/her oral health status. At a minimum, it should contain the dentist's treatment plan and the number of oral care appointments necessary to achieve good oral health, as well as the home care regimen, oral disease prevention practices, and oral health promotional practices that the student agrees to follow. The oral health and wellness goals should be related to employment readiness, and the plan should be accessible to any staff members who need to refer to it and the student should receive a copy of the plan.

2.2 Emergency Oral Care

From the first day on center, each student is eligible for prompt emergency care on a 24-hour basis for the relief of acute conditions. Emergency care should be provided whenever a student needs any of the following:

- Relief for severe oral or craniofacial pain
- Control of swelling involving the cheek, mouth, or jaws
- Control of persistent bleeding from the mouth
- Treatment for trauma resulting in loose or fractured teeth, subluxation or avulsion of teeth, fractured bone, or soft tissue injury
- Treatment for acute infections

Professionally accepted procedures deemed necessary for diagnosis and relief of acute conditions may include, but are not limited to, the following:

- X-rays of the involved areas, when indicated
- Pulp vitality tests
- Extractions
- Incision of pericoronal gingiva
- Incision and drainage of abscesses (intraoral or extraoral)
- Treatment of fractures
- Repair of traumatic wounds
- Palliative treatment for periodontal abscess and acute necrotizing ulcerative gingivitis
- Caries or pulp removal

When deemed necessary, therapeutic drugs or medications can be prescribed.

When an examination is performed for a specific problem or an emergency, records appropriate for the condition should be developed. At the dentist's discretion, a mandatory oral examination may be performed. However, no other definitive treatment besides the emergency treatment should be started until the student is rescheduled for routine oral health care after 45 days on center.

Emergency care providers may include the center dentist, health and wellness personnel (within the scope of their license or job description), and other dental providers in the community. Thus, the Center Director or his/her designee, in consultation with the dentist, needs to develop written standing orders (see Section 5.0) that define emergency care procedures to cover situations in which the center dentist is not available to provide emergency oral care.

2.3 Routine Restorative Oral Care

The center must make routine restorative oral care available to students, however, these procedures are nonmandatory; that is, they are voluntary on the students' part [PRH-6: Exhibit 6-4, page 2]. The dentist should ask students at the beginning of each visit if they are experiencing pain. If students respond affirmative, then the pain should be assessed and managed. Pain management may require analgesics and/or palliative procedures. Students who seek routine restorative oral care are treated according to their priority classification (see Section 3.2, System of Classifying Oral Pathology, to determine priority classification). All students with P1 classifications must be treated first for their Priority 1 (P1) conditions. Students classified P2, P3, P4A, P4B, P5A, and P5B must be treated next in that order.

Students who obtain P1-specific oral procedures are reclassified to P2 or a lesser priority. Students with a P1 classification must receive oral care before additional treatment is rendered to reclassified students. (For examples of restorative procedures, see Section 3.3).

The treatment schedule will change frequently, for at least two reasons:

- When new students are classified, oral health and wellness team members need to review the oral care scheduling sequence to ensure that students with a P1 classification are treated first.

- If a student is likely to complete the training program or be transferred soon after 90 days, health and wellness staff should schedule treatment so it will be completed before the student leaves the center.

Students consenting to treatment should be held accountable for keeping their appointments. In cases of missed appointments and treatment refusal, a health staff or oral health team member should make a notation in the oral health record (SF 603).

The oral health team should be sensitive to the role that cultural values play in care utilization patterns and diminished oral health acceptability.

Although care beyond the mandatory oral examination is voluntary, a health and wellness center quality indicator is “students’ health status will be maintained or improved while they are at Job Corps" [PRH-6: 6.10 (Q3)]. As dental caries are a form of progressive oral disease, the only way the oral health and wellness program can meet the health status quality indicator is for students to follow through with treatment for oral disease.

The oral health team should devise measures to encourage students to obtain treatment and preventive services. Job Corps students typically have not had prior access to oral health care and primary prevention.[6] Consequently, they are at high risk for oral disease. The oral health and wellness program provides them access to oral health care and promotes oral health and wellness.

2.4 Periodontal Care and Oral Prophylaxis

Periodontal care is considered a primary procedure; that is nonmandatory or voluntary on the students’ part [PRH-6: Exhibit 6-4, page 2]. Nevertheless, to the extent that students exhibit periodontal disease, centers are responsible for addressing it because it impedes maintaining students' wellness status. Nonsurgical strategies exist for

[6] As defined in the Surgeon General’s report on oral health, primary prevention includes appropriate diet, nutrition, oral hygiene, and health-promoting behaviors, including the appropriate use of professional services.

addressing periodontal therapy. Oral prophylaxes assist in maintaining periodontal health. Visits for periodontal care and oral prophylaxes should include a strong emphasis on periodontal and general hygiene home care. From an employability standpoint, signs of periodontal disease—including offensive breath, inflamed gums, bleeding gums, and visible calculus (tartar)—are barriers to employment. These barriers can only be eliminated by professional treatment.

2.5 Oral Health and Wellness Checkups

Oral health and wellness checkups after the mandatory oral examination are voluntary but the team should make every effort to create incentives for students to look forward to obtaining them. By scheduling checkups, the team challenges the perception that oral health and wellness visits are largely to correct problems rather than as an opportunity for oral health promotion as well as early oral disease detection.

The center dentist should select a time frame to recall students for a checkup. The time frame will depend on the backlog of oral care needed at the center. Alternatively, checkups may be scheduled based on the individual oral disease risk assessment of students.

Checkups assess how students are progressing with the oral health and wellness plan developed at the time of the mandatory oral examination and allow an opportunity to conduct a clinical examination for early detection of oral disease. Depending on the availability of dental hygiene services, the checkup may be performed by the dental hygienist and combined with oral prophylaxis and necessary x-rays.

Students who decline treatment at the time of their mandatory oral examination should be invited to obtain a periodic oral health and wellness checkup. As students progress in their training, they may decide to obtain treatment and may need an invitation to return to the dental suite. At the time of the checkup, students with P1 conditions should be scheduled for treatment immediately and the oral health and wellness plan should be updated.

The oral health team should be thoroughly familiar with other programs on center and community resources. They should support and encourage students to achieve their training and employment goals and should structure checkups in a fashion that allows students to exhibit and practice the skills, knowledge, and attitudes they have acquired in their quest to become employable.

When students keep their checkup appointments, the center can demonstrate its efforts to maintain or improve students' health status while they are at Job Corps [PRH-6: 6.10 (Q3)]. Regular visits give the team members the opportunity to provide preventative services, make early diagnosis, and treat oral conditions.

2.6 Off-Center Oral Health Services

Off-center oral health services often require extraordinary expenditures and always require referral agreements and a preauthorization process. They encompass:

- Necessary oral procedures beyond the center dentist's scope of practice that require a specialist (complicated oral surgery, some molar endodontics)

- Emergency oral care that cannot be handled through standing orders when the center dentist is not available (see Section 2.2)

2.6.1 Deciding Whether to Authorize Specialized Services

Dentists are responsible for advising the health and wellness manager (HWM) about students who need to be referred, how each student will benefit from the referral, and the approximate cost involved. This information is the starting point for the decision-making process.

Four factors will influence decisions for approval of P4A[7] services:

- **Priority rankings of other students—**The provision of P4A treatment depends on whether the center is able to provide oral care to all students classified as P1, P2, and P3. Even then, limited resources will force decisions toward those services that are more appropriate for students with the most urgent needs.

- **Likelihood that the special treatment will enhance employability—**P4A treatment can enhance a student's employability and social acceptability, which are part of the Job Corps mission. Thus, as a student nears completion of the program, some P4A procedures involving tooth replacement may be necessary services for a student's well-being and success.

- **Cost—**Oral health and wellness budgets are limited and centers must minimize P4A services. These expenditures should not exceed $500 per student without the Center Director's approval.

- **Scope of the procedure—**Some oral care is so complex that it is beyond the scope of the Job Corps oral health and wellness program.

Examples of procedures that are too expensive or complex include routine extraction of symptomatic impacted third molars, general anesthesia for exodontia, and use of nitrous oxide.

Specialized oral care must be authorized before care is provided. The decision to

[7]See Section 3 for a detailed description of the priority classification system. The classification system determines priority rankings for students.

authorize care at the center's expense should be made by the individual responsible for the center's oral health and wellness budget.

The RDC may be consulted if the center has questions about the validity or necessity of a referral. The RDC will consider budget constraints and the number of students with more urgent needs and will not recommend off-center care for procedures that can be performed competently by the center dentist or that are cost-prohibitive for the Job Corps oral health and wellness program. The decision-making process may involve the Regional Office program/project manager if a specific dollar amount is exceeded (except in emergencies).

Before providing specialized oral care with center funds, every attempt should be made to obtain it at no cost to the center through local agencies (e.g., state vocational rehabilitation, department of social services, medicaid). Under certain circumstances, a medical separation may be available [PRH-6: 6.4 (R4) and 6.12 (R11)].

2.6.2 Establishing Referral Arrangements

The dentist's role includes assisting the HWM in securing appropriate referral arrangements within budget limitations. Before any services are rendered, the center dentist needs to:

- Identify a local specialist and, if needed, arrange for the RDC to review the specialist's qualifications
- Request that the specialist submit fee schedule or financial reimbursement plan for a range of off-center services
- Develop or arrange for a service agreement

2.6.3 Conveying Information to the Specialist

Health and wellness staff members are responsible for conveying certain information to the specialist before service is provided. When treating Job Corps students, specialists need to know the requirements for:

- Minimizing the amount of time students are out of class or training
- Adhering to the guidelines for analgesics
- Maintaining a complete record (for inclusion in the student's health record) of procedures rendered, including prescribing or dispensing medication
- Performing only the procedures for which students are referred

- Monitoring the progress of each referred student and either providing or arranging for required post-operative care

2.6.4 Monitoring and Technical Assistance for Specialized Services

The RDC will monitor specialized oral care referrals to ensure that they are appropriate and are not excessive. Monitoring may involve working with the HWM or Center Director to analyze utilization patterns and costs and review of individual cases. Monitoring occurs during periodic on-center assessments, as follow up on past assessment recommendations, or at the Center Director's request.

The RDC also provides technical assistance based on problems identified in the assessment or at the Center Director's or dentist's request. The assistance targets specific center needs and may cover diverse topics (e.g., development of a practical mechanism for prior authorization of referrals, development of alternative treatment plans for specific cases).

2.6.5 Recommending Medical Separations for Oral Health Reasons

The dentist advises center staff (Center Director, physician, HWM, health and wellness staff) on all oral health-related matters, including the advisability of student medical separations for dental reasons. A student is separated for medical reasons when his/her health condition precludes participation in the Job Corps program or its necessary resolution is beyond budget constraints. In addition, a student is separated for administrative reasons if the mandatory oral examination is refused. Medical separation requirements are described in the PRH [PRH-6: 6.4 (R4) and 6.12 (R11)].

The center dentist needs to document the student's oral health condition before a decision is made regarding eligibility for reinstatement if the condition is resolved. Oral health referrals must be provided for separated students.

A student who receives a medical separation with reinstatement rights must:

- Provide documentation that the medical condition is resolved and he/she is able to participate in the program

- Return within 180 days from the separation date

Medical separations for oral health reasons are minimal when students meet the quality indicator that "students consider scope and limitations of the Job Corps health program, and utilize available health services appropriately" [PRH-6: 6.12 (Q1)].

2.6.6 Community Resources

Students who decline on-center care should be provided with a list of community dental clinics, dentists who may be willing to make payment arrangements, dentists who accept government insurance, local dental schools, and local dental hygiene schools. Wherever possible, any information that can assist the students in making wise consumer choices should be provided. The list of community resources should also be available when students leave the center.

2.7 Infection Control

The dentist has primary responsibility for instituting measures to control exposure to infection and cross contamination. The dentist, assisted by the Center Director, must provide oral health and wellness staff with practical methods to reduce occupational exposure to infectious disease and cross contamination to students in the dental suite.

An infection control program for the oral health and wellness team should contain at least five components:

- **Vaccination—**Offer vaccination against hepatitis B virus (HBV) to oral health team members who are center employees because of their job classification.

- **Protective Measures—**Wear rubber gloves, masks, and protective eye devices during all procedures and protective garments when clothing is likely to be soiled with blood or other body fluids.

- **Bloodborne Pathogen Exposure Control Plan—**Each center is required to maintain a bloodborne pathogen exposure control plan that is in compliance with the Occupational Safety and Health Administration (OSHA) Occupational Exposure to Bloodborne Pathogens: Final Rule (29 CFR Part 1910.1030). Center employees must comply with the plan. In addition, the oral health and wellness program should have infection control guidelines that include appropriate procedures to protect dental patients as well as all oral health team members, whether employers or employees, from occupational transmission of infectious diseases. The center dentist should determine which written infection control guidelines will be used by the oral health team and ensure that the team's practices are consistent with whatever written guidelines they adopt. Appendix F contains sample infection control guidelines.

- **Airborne Pathogen Control—**Use masks to prevent the transmission of airborne communicable diseases.

- **Barrier and Sterilization Protocols—**Use surface disinfectants, barriers, and sterilization techniques to prevent cross contamination; disinfect and sterilize equipment and instruments to prevent cross contamination from instruments

used to treat students.

The following suggestions are offered as practical methods to prevent the oral health team from spreading infectious diseases and from cross-contaminating patients:

- Review and update the medical portion of the health record at each visit

- Recirculate instruments properly according to established guidelines and office protocol. The protocol should describe the flow of instruments as they pass:

  (a) From a dirty area
  (b) To a clean area
  (c) To a packaging area
  (d) To the sterilization area
  (e) To the storage area

- Use biological indicators on a weekly basis to test the effectiveness of the sterilization equipment

- Disinfect or cover hard surfaces properly

- Follow established infection control protocols regarding instruments and work areas

- Prohibit eating food, drinking beverages, and applying cosmetics or lip balm in potentially contaminated areas

- Follow generally accepted practices in the critical area of personal hand washing and hand care

Appendix F contains the infection control guidelines.[8] They neither substitute for professional judgment nor establish a standard of care.

2.8 Safety and Health

The center should have a safety and occupational health program that complies with current OSHA standards and Department of Labor regulations, policies, and procedures. Some parts of the plan are relevant to the oral health and wellness program:

[8]These guidelines are reprinted with the permission of the American Dental Association and the Organization for Safety and Asepsis Procedures (OSAP). OSAP is a nonprofit organization providing information and education on dental infection control and office safety. For more information, please call (800) 298-6727.

- Hazard communication plan (see discussion below)

- Personal protective equipment for students and staff; students eyes should be protected from chemical splashes and injury from dropped instruments or other objects while they are undergoing treatment.

To ensure personal safety, prevent accidents, and minimize back strain and injury, oral health and wellness team members should pay special attention to proper body alignment, balance, and movement.

2.8.1 X-ray Equipment and Radiation Hazards

When using x-ray equipment, oral health team members must ensure minimum exposure and danger to the patient and themselves. They must keep others out of the range of exposure. This requires being knowledgeable about many technical factors and clinical considerations, understanding their relative importance, and being aware of the dangers involved in the appropriate use of x-ray equipment.

The dentist's professional judgment is the basis for determining the extent of patient exposure, the need for dental radiographic examination, the procedures to be employed, and the frequency of x-ray equipment use. Such judgment is developed through sound training, experience, and continuing education. Where appropriate and legal, the dentist may delegate some determinations to a dental hygienist or dental assistant.

Center staff who operate x-ray equipment must take certain precautions:

- Use a leaded apron to shield all students who are exposed to x-rays.

- Consult with the center dentist prior to exposing a pregnant student to x-rays. The nurse should note the pregnancy diagnosis in the oral health record and also inform oral health staff when pregnant students are scheduled for care (see Section 2.9).

- Ensure that x-ray equipment complies with applicable state laws regarding exposure protection, radiation leakage, and periodic inspections.

The dentist should address questions concerning x-ray equipment and its safe use to the RDC and the local city or county health department or other state and local agencies that monitor compliance of x-ray equipment.

2.8.2 Hazardous Waste and Hazardous Chemical Products

Centers must conform with federal, state, local, and Job Corps regulations regarding:

- Generating, storing, and disposing of hazardous waste
- Storing, labeling, and using chemical products

Each center should have a comprehensive hazard communication program that includes:

- Organizing and maintaining up-to-date materials safety data sheets (MSDS) on all hazardous chemical products purchased or used by the center

- Placing clearly readable identifying labels securely on all incoming containers of hazardous chemical products; such labels are not to be removed or defaced

- Providing proper training and instruction to all users of hazardous chemical products, including identification of such products and the specific hazards associated with such products

- Establishing and approving a chemical products purchase list

The center dentist should ensure that the HWM is aware of all hazardous materials used in the dental suite. Copies of all data sheets should be contained in the MSDS binder located in the health and wellness center and accessible to all health and wellness staff. The oral health and wellness team should review the binder periodically to ensure that it contains current data sheets.

2.8.3 Safety and Occupational Health Inspections

The dental suite, as part of the health and wellness center, should be inspected monthly or more regularly for safety and occupational health deficiencies. Any deficiencies identified during the inspections must be corrected promptly. The center safety officer should maintain records of inspections and actions taken to correct deficiencies. If a safety and occupational health deficiency is identified before the regular inspection, oral health staff should report it to the HWM and safety officer immediately.

2.8.4 Orofacial Injury Prevention

One purpose of recreation and leisure-time programs is to provide students with opportunities to participate in enjoyable and safe activities. The opportunity becomes a liability when students sustain orofacial injuries in contact sports. Orofacial injuries include dental avulsions; dental fractures; dental luxations; lacerations or contusions to the gums, cheeks, tongue, lips; and jaw injuries. Lacerations and contusions may be considered less significant at the time of injury; however, they are often associated with delayed dental consequences.

The dentist should educate the Center Director and recreation supervisor about the risk of students sustaining orofacial injuries if they participate in contact sports (soccer, wrestling, football, and basketball). Students should also be informed about orofacial injury risks and how to reduce the effects of orofacial injuries.[9] Health personnel should examine injured students and the dentist should be consulted before the student resumes athletic activity.

2.9 Oral Health Care for Pregnant Students

The dentist should coordinate the oral health and wellness program with the center's family planning and reproductive health program. Prompt access to oral health care and oral health promotion must be provided for pregnant students.

Health and wellness center staff should refer pregnant students to the dentist when they enter Job Corps immediately following the cursory oral examination or immediately upon diagnosis of pregnancy. The dentist should then provide prompt evaluation and treatment when it is safe for the fetus. Dental caries are an infectious disease; a mother can transmit caries-causing bacteria to her fetus. Treatment for caries will reduce the pregnant student's caries-causing bacterial count. If necessary, the dentist should consult with the center physician before treatment. Extreme precaution must be taken to eliminate the dangers involved in inappropriate exposure to x-rays as outlined in Section 2.8.1.

The dentist should also ensure that preventive oral health services are delivered to pregnant students. Maintaining good oral health during pregnancy is the best prevention against developing gingival changes. These changes (such as enlargement, inflammation, and localized conditions known as *pregnancy tumors*) occur most frequently in pregnant women with poor oral hygiene because of a rise in hormone levels during pregnancy that can exaggerate reactions to the irritants in plaque. The dental hygienist should monitor the pregnant students' oral hygiene and provide reinforcement for home oral hygiene regularly. Pregnant students can avoid oral health problems with reasonable and proper care during pregnancy.

2.10 Oral Health and Wellness Philosophy

Oral health and physical health are inseparable. For example, research has suggested relationships between severe gum disease and serious health conditions such as heart disease, stroke, complications from diabetes, and even effects on pregnancy outcomes such as pre-term, low birth weight babies.[10] Obviously, good oral health leads to better overall physical health. Furthermore, through a thorough oral examination, oral health

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[9] Providing head and mouth gear is not the oral health and wellness program's responsibility.

[10] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General—Executive Summary.*

providers may identify signs of systemic conditions or diseases such as diabetes, cancer, heart disease, kidney disease, and immune deficiencies.

Health is physical, mental, and social well-being, and not just the absence of illness. Similarly, the broadened meaning of oral health encompasses well-being or wellness. A wellness approach to oral care encompasses the whole person—not just the oral disease; an individual's attitudes, habits, and lifestyle are just as important as oral care when it comes to oral disease prevention and elimination. The mandatory oral examination offers the opportunity to identify and diagnose serious diseases and health conditions early, thus aiding the achievement or maintenance of optimum health. The mandatory oral examination also offers the opportunity to inquire about eating, drinking, smoking, and hygiene habits that may affect the students' oral health status. In addition, insight into the psychosocial factors that impact the students' decisions about their oral health will aid the team in customizing their approach to care.

Wellness implies a team approach in which the student cooperates with the oral health and wellness team. Oral disease cannot be successfully controlled or eliminated and oral health education cannot be fully embraced until the student willingly cooperates with the team provider. Cooperation is aided by good communication. Students are far more likely to follow home-care recommendations and comply with oral health and wellness program policies when they enjoy a good rapport with the team.

Oral health and wellness does not imply perfect health. Oral health and wellness incorporates optimal health; that is, the most favorable degree or level of health possible within program and student constraints. Oral health and wellness incorporates an optimal health status, obtainable under specific conditions with the added dimension of well-being. The oral health and wellness thrust emphasizes caring for the total person, making appropriate lifestyle choices, and ensuring the quality of the provider-patient partnership. In the wellness paradigm, the provider is a facilitator and a teacher in addition to being a caregiver.

2.10.1 Oral Health and Wellness Education

Oral health and wellness education is ongoing. It begins during the student's earliest encounters with health and wellness staff and continues at every oral health visit. During the introduction to health and wellness services, students learn about:

- The center's oral health and wellness program including the services offered, hours of operation, and procedures for seeking on-center oral health care

- The center's expectation that they practice good oral hygiene

- The reasons why they should responsibly seek oral health services and the importance of keeping appointments

- The effects good oral health can have on improving total health

- The concept of wellness and how oral health and wellness relates to total wellness and employability

The students' introduction to health and wellness services provides a good opportunity to meet the PRH quality indicators that "students are aware of the center's health care delivery system and understand how to seek on-center health care" [PRH-6: 6.10 (Q1)].

2.10.2 Wellness Education

Wellness education is designed to enhance student employability by providing them with information about practices that lead to good physical, mental, and emotional health [PRH-3: 3.19]. The center dentist should provide consultation as requested. Oral health and wellness team input in wellness education may help students to understand and articulate appropriate lifestyle choices for oral health and wellness and reinforce students' responsibility for maintaining good oral health [PRH-6: 6.11 (Q1, Q2)].

The center dentist could provide useful input from an oral health perspective in the following wellness topics:

- Health education and the decision-making model
- Emotional and social well-being
- Consumer health
- Nutrition and fitness

The center dentist's input could help students learn how and when to access community oral health services as well as demonstrate their basic knowledge of the steps to take to maintain personal optimal oral health and wellness [PRH-3: 3.19 (Q1, Q2)]. The mouth reflects the status of general health and wellness; it may be helpful to give examples of oral-systemic disease connections. Students should also learn as part of their wellness education how oral health relates to overall wellness, quality of life, and employability.

2.10.3 Chairside Education

Providing patient chairside education during the course of treatment should be part of all oral health care visits and should be the responsibility of every oral health team member. The dental hygienist should provide education during the oral prophylaxis by commenting on what is detected during the examination, as well as after the prophylaxis when providing oral hygiene instruction and reviewing self-care techniques. The dentist should provide education during the mandatory oral examination, wellness checkups, and hygiene checkups as well as before, during, and after restorative procedures. The dental assistant should provide education with the dentist and dental hygienist as well as while alone with students. For example, the dental assistant may find it useful to mount students' x-rays in front of them as an opportunity to educate them about their restorations and other elements on the x-rays that are discernible to the untrained eye.

Chairside preventive services should include:

- Providing an introduction to the advantages of preventive oral health care

- Providing instructions in proper oral hygiene techniques and the use of oral hygiene self-care devices (e.g., a suitable toothbrush, fluoride toothpaste, dental floss, oral rinses, etc.)

- Providing oral prophylaxis by the dentist or dental hygienist

- Explaining the causes of oral disease and its progression

- Reinforcing the value of oral health and wellness and its relationship to well-being and quality of life including employment opportunities

- Discussing how acquiring the skills, knowledge, and attitudes that promote oral health and wellness also promote employability

- Providing an opportunity for students to practice skills that make them employable

- Discussing personal responsibility for achieving/maintaining oral health and wellness

- Discussing appropriate lifestyle choices related to oral health and wellness

Reinforcement is important at every oral health visit. Every contact with students should serve as an opportunity for team members to provide oral health education and increase student knowledge.

When students feel they are valued and their best interests are considered, they are more likely to relax and relinquish control issues that can affect their receptiveness and cooperation. Their willingness to give up control without giving away their personal power can improve cooperation and strengthen the desire to achieve and maintain lifelong oral health and wellness.

2.10.4 Education on the Hazards and Risks of Tobacco Use

Tobacco use contributes to many diseases and disorders. For example, it is a risk factor for periodontal disease, candidiasis, and dental caries. Major risk factors for oral cancer in the United States are from using cigarettes and other tobacco products. Oral cancer generally involves the lips, tongue, pharynx, and oral cavity. These cancers are among the most debilitating and disfiguring. Alcohol and tobacco users have a higher risk for developing oral cancers than do individuals who use only tobacco.[11] Thus,

primary prevention of oral cancer includes avoiding the use of tobacco products and decreasing consumption of alcoholic beverages. To that end, each Job Corps center has a trainee employee assistance program (TEAP) and tobacco use prevention program (TUPP) [PRH-6: 6.11 (R1, R3)].

Because of their accessibility to students, the oral health and wellness team should help students understand the risks associated with smoking and help combat the glamour associated with smoking that lures so many young people, including Job Corps students, to form the habit despite its well-known dangers.

Tobacco smoke contains nicotine and other elements that undermine the health of arteries and many organs. The chances of developing gum disease increase by 50 percent among smokers. Nicotine is also a highly addictive drug. In addition to cigarette smoking, smokeless tobacco, bidis, and cigars lure young people.

Smokeless Tobacco

The growing use of smokeless tobacco (snuff and chewing tobacco) is of great concern nationally. Staff in some Job Corps centers have observed a substantial increase in smokeless tobacco use in recent years, particularly among males. Many users are unaware of possible harmful effects. The center must educate students and staff about the relationship between smokeless tobacco and serious health risks, including cancer; smokeless tobacco is not a safe alternative to smoking.

Scientific evidence has shown that using smokeless tobacco is causally related to oral and pharyngeal cancer; smokeless tobacco is rendered carcinogenic when sugar is added during the curing process. The risk of developing oral cancer is four times greater among smokeless tobacco users than among nonusers. Smokeless tobacco causes a number of oral health problems including gingival recession, tooth abrasion, and discolored teeth. It also retards healing of oral wounds. A long-term health hazard associated with using smokeless tobacco is oral leukoplakia (white patches in the mouth which are sometimes forerunners to cancer).

Centers can obtain more information about smokeless tobacco hazards and intervention programs from local chapters of the American Cancer Society, American Heart Association, American Lung Association, and Nicotine Anonymous World Services (12-step plan). Many local chapters will also conduct cessation programs on center.

Bidis

Bidis are an inexpensive, flavored minicigarette that can contain up to five times the amount of nicotine in regular cigarettes. Bidi smoking is purported to be particularly alluring to new and young smokers.

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[11] Maria T. Canto, MS, DDS, MPH; Yoko Kawaguchi, DDS, Ph.D.; Alice M. Horowitz, Ph.D., "Coverage and Quality of Oral Cancer Information in the Popular Press: 1987-98, Journal of the American Association of Public Health Dentistry, Vol. 58, No. 3, 1998.

Cigars

In recent years, there has been a national increase in the number of cigar smokers among youth. Many cigar smokers mistakenly assume they are not at risk for diseases caused by cigarette smoking because they do not inhale or only smoke occasionally. Even though cigars do not carry a health warning like cigarettes, they carry significant health risks:

- Cancer of the mouth, larynx, and esophagus is more common among cigar smokers than among nonsmokers.

- Cigar ingredients can include as many as 23 poisons and 43 carcinogens that enter the bloodstream directly through the mucosal lining of the mouth, so one can be at risk without inhaling.

- Cigars can generate 11 times more carbon monoxide, 7 times more tar, and 4 times more nicotine than a cigarette.

- Abrasive particles in the cigar's outer wrapping can erode teeth.

- Cigar smoking promotes periodontal disease.

When oral health and wellness team members encounter students who smoke, they should educate them about the health risks related to smoking. Students who are interested in smoking cessation should be referred to the center's TUPP. The oral health team should familiarize themselves with the TUPP to assist students in identifying and accessing appropriate health-related programs to meet individual needs [PRH-6: 6.11 (Q3)]. The team can help students plan healthful alternatives to smoking. Students in the TUPP should be encouraged to keep low-calorie, sugar-free snacks handy to resist the urge to smoke and avoid unwanted weight gain.

2.10.5 Education on the Hazards and Risks of Drug Use

Drug use carries with it the potential to induce oral neglect—a barrier to employability. Moreover, drugs have side effects that can be detrimental to the users' oral health. The oral health and wellness team should be familiar with the oral manifestations of drug use. Cannabinoids, including marijuana and hashish, cause dry mouth and throat. So do cocaine; methamphetamines; inhalants; and solvents such as acetone, paint thinners, amyl nitrate, and gases. Habitual use of these drugs and substances can lead to dental decay because they deplete saliva flow. Consequently, habitual drug users likely will have more decayed, missing, and filled teeth.

Drugs such as cocaine, cannabinoids, methamphetamines, and LSD elevate the blood pressure; this can be a problem if students use these drugs before an appointment that requires an injection since commonly used local anesthetics contain vasoconstrictors

that can further elevate blood pressure.

Opiates can cause vomiting and nausea. The acidic content of vomit can erode tooth enamel over time. Heroin causes a high craving for sweets and produces dry mouth. Heroin “cut” with quinine may produce petechiae on the buccal mucous membranes.

The oral health and wellness team should learn to recognize the signs and symptoms of drug use as well as its manifestations in the oral cavity. Team members should understand the zero tolerance policy and how to make referrals to the trainee employee assistance program (TEAP). The oral health and wellness team should also formulate—with the TEAP specialist—a procedure for accepting referrals from TEAP for oral care needs that may have arisen from previous drug use.

The oral health care team can provide preventive and educational support at the chairside and in group settings. TEAP specialists are interested in enlisting the support of all center departments to identify how drug and alcohol use prevention is applicable to their areas. Support for student abstinence is a centerwide responsibility.

2.11 Continuous Quality Improvement

The PRH instructs center health staff to seek feedback from students, employ mechanisms to document quality of care provided, and document quality improvement activities [PRH-6: 6.12 (R15)]. The HWM is charged with overseeing the continuous quality improvement (CQI) process. The center dentist should tap into the health and wellness center’s CQI process rather than create his/her own process. The CQI process involves:

- Adopting an approach to improve performance or outcomes
- Developing measurable objectives
- Implementing the approach for a period of time and monitoring it through data collection
- Analyzing the data to evaluate success of the approach

2.12 Customer Relations and Outreach

Because oral health visits beyond the cursory and mandatory oral examinations are voluntary, the oral health and wellness team should treat students as customers. The team should make oral health services on center attractive, convenient, and rewarding for students. One positive outcome would be a low broken-appointment rate and negligible emergency/walk-in rate. To achieve all of this requires an effective customer relations and outreach approach.

2.12.1 Student Feedback

While the National Office conducts periodic student surveys, their usefulness to the oral health team is limited. The team should collaborate with the HWM to incorporate relevant oral health and wellness program questions into the wellness center surveys and questionnaires. Surveys provide important information about the convenience of oral health and wellness clinic hours, ease in making appointments, and oral health and performance of the oral health team. Samples of student surveys are contained in Appendix G.

2.12.2 Team Support

When oral health and wellness personnel are rightfully empowered so that they work as a team, they will more readily embrace the objective of providing students with extraordinary, high-quality care in a more genuine and consistent manner. All oral health and wellness personnel have a responsibility to contribute to team building, but the dentist is the team leader. The dentist is ultimately responsible for fostering an environment that promotes self-esteem for all team members.

Together everyone achieves more is a truism. The oral health and wellness team should collaborate with other departments and programs on center and in the community whenever possible. The team should identify opportunities for students to contribute to the community through civic and organized events such as health fairs. The team should also identify opportunities in which center/student participation in community cultural and civic events would be valued.

2.12.3 Environment and Ambiance

To be appealing to students, the dental suite should be visibly clean, orderly, and well designed to provide appropriate service. The dental suite should be well decorated. It may include pictures, posters, bulletin boards, and decorations that reflect students' interests, oral health and wellness themes, etc. The furnishings and equipment should be in good condition, suitable for their use, and appropriate for the size of center. Safety hazards should be nonexistent.

Team member/team member, team member/student, student/student, and team member/other center staff interactions should be positive, respectful, and nonjudgmental. Students should feel welcome in the dental suite. Appreciation for their appropriate use of oral health and wellness services should be expressed.

SECTION 3: PRIORITY CLASSIFICATION SYSTEM FOR JOB CORPS STUDENTS

At the time of the mandatory oral examination, the dentist should classify each student according to the most urgent oral care needs [PRH-6: 6.10, R2(c)]. Students are classified using the priority classification system described in this section and their oral classification is recorded in the proper box on standard form 603. Note that emergency oral care needs must be met as soon as they are identified.

The priority system is designed to facilitate the efficient handling of a backlog when treatment needs outweigh the team's ability to provide timely care to everyone or when collective treatment needs threaten to outspend the oral health and wellness program budget. A significant backlog may occur when the program is temporarily reduced because of the departure of a team member or the program experiences a sizable influx of students needing treatment. Sometimes, when the budget permits, program hours can be increased temporarily.

3.0 Priority Classification System Uses

The priority classification system and procedures for assigning priority classification are intended to assist the oral health team in providing care rationally when demand for care outstrips dental and dental hygiene chairside hours. They should always exercise their own professional judgment with each patient. Using the priority classification system to identify students with the most urgent oral health needs allows Job Corps to provide the greatest good for the largest number of students.

The priority system must be used by the dentist or, when oral care is delivered off center, by the HWM or nurse. The priority system is used to:

- Identify students with the most urgent oral health care needs
- Establish the sequence in which students receive treatment
- Determine what treatment is within the scope of the center's immediate capabilities
- Establish the sequence of treatment procedures for each student

3.1 Basis for the Priority Classification System

The priority classification system is based on the following assumptions:

- The system allows for input of new students and reclassification of individual students, when appropriate.
- The provision of emergency oral health care to students is mandatory and supercedes the first level of service in the priority classification system.

- The priority classification system has the flexibility to allow for certain differences in student oral conditions.

- Decisions are forced, as resources become limited, toward those services that are more appropriate for students with the most urgent needs. Specialized oral health services should be monitored; the services provided are those most cost-effective from a time or budget standpoint.

- The priority classification system permits, as funds become available, an orderly and equitable increase in services that require more time, additional specialty care, provider skills, or greater financial expenditure.

3.2 System of Classifying Oral Pathology

3.2.1 Priority 1 (P1)

Students with one or more of the following conditions are placed in the first or highest priority (i.e., they are the first to receive oral treatment):

- Acute oral or craniofacial pain or infection

- Chronic, asymptomatic irreversible pulpitis in salvageable and nonsalvageable teeth

- Oral infection or condition that, if left untreated, will probably become acute and lead to disability or harm to the student

- Undiagnosed or suspect significant oral/pathological condition

- Oral condition (such as lack of all teeth or missing upper anterior teeth) that (1) presents a major psychosocial or physical barrier to the student's well-being; (2) helps the student, if given corrective treatment, adapt to Job Corps and increase employability; (3) compromises oral function; and (4) compromises general health

3.2.2 Priority 2 (P2)

The following conditions place a student in the second priority:

- One or more medium to large nonpainful carious lesions
- Symptomatic, self-limiting oral lesions
- Periodontal disease
- Asymptomatic, fractured teeth
- Broken or ill-fitting prosthodontic appliances
- Teeth containing sedative, temporary, or intermediate restorations
- Salvageable teeth on which pulpotomies or pulpectomies were performed

3.2.3 Priority 3 (P3)

The following conditions place a student in the third priority:

- Gingivitis
- Small carious lesions presenting no imminent threat to the pulp

3.2.4 Priority 4A (P4A)

The following conditions place a student in subcategory A of the fourth priority:

- Missing teeth whose replacement would enhance function and overall oral health, but would not produce psychological or employability barriers as indicated under Priority 1

- Temporary crowns that are likely to cause periodontal damage over time

- Posterior teeth on which endodontic therapy was completed but do not have permanent coronal coverage

- Last oral prophylaxis was received more than one year prior

3.2.5 Priority 4B (P4B)

The following conditions place a student in subcategory B of the fourth priority:

- All restorations and dental prosthetics that are in good condition
- Lack of clinically visible carious lesions or of radiographic evidence of lesions
- Good periodontal/gingival health
- Full dentition
- Last oral prophylaxis was received more than one year prior

3.2.6 Priority 5A (P5A)

The following conditions place a student in subcategory A of the lowest priority:

- Missing teeth whose replacement would enhance function and overall oral health, but would not produce psychological or employability barriers as indicated under Priority 1

- Temporary crowns that are likely to cause periodontal damage over time

- Posterior teeth on which endodontic therapy was completed but do not have permanent coronal coverage

- Last oral prophylaxis was received less than one year prior

3.2.7 Priority 5B (P5B)

The following conditions place a student in subcategory B of the lowest priority:

- All restorations and dental prosthetics are in good condition
- Lack of clinically visible carious lesions or of radiographic evidence of lesions
- Good periodontal/gingival health
- Full dentition
- Last oral prophylaxis was received less than one year prior

3.3 Oral Health Procedures for Each Priority Classification

The oral health and wellness team members are encouraged to perform evidence-based procedures; that is, to use procedures proven to be effective.

This section lists the oral health procedures that are normally provided for the priority conditions defined above.

When a student is reclassified to Priority 4A or 4B, he/she will receive an oral prophylaxis if he/she has not received it in a different priority classification. After the oral prophylaxis, the student's priority classification will change to Priority 5A or 5B for the next year unless an emerging oral health problem prompts a priority reclassification.

3.3.1 Procedures Normally Rendered for Priority 1 Conditions

- X-rays of the involved areas; take appropriate precautions if the student is pregnant

- Tooth extraction

- Excavation and treatment of severely carious teeth that are restorable with intermediate restorative material or permanent fillings

- Biopsy or referral for biopsy of suspicious lesions that persist for 2-4 weeks after the presumed local irritating factors have been eliminated

- Pulpotomies or pulpectomies

- Complete dentures

- Stayplates

- Gross debridement
- Temporary crowns
- Oral hygiene instruction
- Dietary information

3.3.2 Procedures Normally Rendered for Priority 2 Conditions

- Routine posterior fillings
- Routine anterior fillings
- Periodontal treatment within a general practitioner's scope of practice
- Relining of dentures and repair procedures
- Endodontic therapy
- Temporary crowns
- Oral hygiene instruction
- Dietary information

3.3.3 Procedures Normally Rendered for Priority 3 Conditions

- Oral prophylaxis
- Restorations
- Oral hygiene instruction
- Dietary information

3.3.4 Procedures Normally Rendered for Priority 4A Conditions

- Permanent anterior or posterior crowns
- Anterior fixed bridges
- Oral hygiene instruction
- Dietary information
- Periodic oral health and wellness checkups
- Oral prophylaxis

3.3.5 Procedures Normally Rendered for Priority 4B Conditions

- Oral hygiene instruction
- Dietary information
- Periodic oral health and wellness checkups
- Oral Prophylaxis

3.3.6 Procedures Normally Rendered for Priority 5A Conditions

- Permanent anterior or posterior crowns

- Anterior fixed bridges
- Oral hygiene instruction
- Dietary Information
- Periodic oral health and wellness checkups

3.3.7 Procedures Normally Rendered for Priority 5B Conditions

- Oral hygiene instruction
- Dietary information
- Periodic oral health and wellness checkups

3.4 Steps to Implement the Priority Classification System

To ensure the priority system functions as designed, use the following sequence of diagnosis and treatment:

1. Inform students of the thoroughness and importance of the mandatory oral examination.

2. Take bitewing x-rays to prepare for the examination.

3. Perform the oral examination and classify students as P1, P2, P3, P4A, P4B, P5A, or P5B.

   After the mandatory oral examination and classification have been completed, record findings schedule and treat students classified as P1 as soon as possible.

   - Treat all P1 students for P1 conditions before scheduling students with less urgent classifications.

   - Treat only the P1 oral needs of P1 students at this time. Inform students of the reasons for the condition and benefits of treatment.

4. Reclassify P1 students. When P1 oral needs are met, reclassify each P1 student in P2, P3, P4A, P4B, P5A, or P5B as appropriate and record the reclassification.

5. Treat students with P2 classifications the remainder of the time.

6. Interrupt oral treatment of P2 students whenever new P1 students are identified if the treatment schedule prohibits treatment of both P1 and P2 students. New P1 students are identified by either mandatory oral examinations (between the 45th and 75th day of enrollment), by P4 oral health and wellness checkups, or by emergency presentations.

7. Treat students classified in P3 when all P1 and P2 students can be accommodated concomitantly.

8. Integrate treatment of students classified in P4A when P1, P2, and P3 students can be accommodated concomitantly and sufficient funds are budgeted for prosthetics.

9. Place students in P4B when no oral treatment is needed or when the students only need oral prophylaxis and periodic oral health and wellness checkups. If there is a dental hygienist on center, he/she may care for students outside of the priority classification system.

10. Move students classified in P4A into P5A after they receive an oral prophylaxis and keep them in P5A classification for 1 year provided they do not develop a new oral condition that would change their priority classification. After a maximum of 1 year, students will need an oral health and wellness checkup and will be reclassified upon checkup findings or, in the absence of oral findings, will revert to P4A signifying that they need another oral prophylaxis.

11. Move students classified as P4B into P5B after they receive an oral prophylaxis and keep them in P5B classification for 1 year provided they do not develop a new oral condition that would change their priority classification. After a maximum of 1 year, students will need an oral health and wellness checkup and will be reclassified upon checkup findings or, in the absence of oral findings, will revert to P4B signifying that they need another oral prophylaxis.

3.5 Limitations of the Priority Classification System

The priority classification system serves as an overall guide for providing oral care but should not replace the professional judgment of the center dentist. Consideration of factors such as the availability of resources, skills of the provider, the addition of a dental hygienist to the team, and certain differences in patient conditions allow for flexibility in implementing the system. However, repeated or long-term disregard for the priority classification system will weaken the effectiveness of the oral health and wellness program and possibly affect the employability of the students completing the training program.

SECTION 4: ORAL HEALTH AND WELLNESS TEAM MEMBERS—ROLES AND REQUIREMENTS

4.0 Center Dentist

The center dentist is defined as the individual with whom the center has a written agreement for provision of oral health care.[12] Whether care is provided on or off center, each center should designate a center dentist.

4.0.1 Role of the Center Dentist

To implement the PRH requirements, every center dentist should:

- Engage in the most efficient and cost-effective practice of contemporary, evidence-based dentistry possible given available time, resources, and personnel.
- Adhere to the Job Corps policies, procedures, and guidelines.
- Ensure that students acquire the oral health-related skills, knowledge, and attitudes that will make them employable [PRH-3: 3.15 (R1)].
- Ensure that the practice of skills that make students employable is fully integrated into applicable aspects of the oral health and wellness program on center [PRH-3: 3.15 (R2)].

The scope of the dentist's role depends on the center's size and the time available for patient care and administrative or supervisory functions. In general, every center dentist should provide services that aid in developing, implementing, and monitoring the oral health and wellness program. These services include, but are not limited to:

- Advise the Center Director and HWM on all oral health-related matters including staffing requirements, advisability of student medical separations for oral health reasons, cost of special services, and other areas deemed appropriate.
- Assist in coordinating and integrating the oral health and wellness program with other health and wellness components and center activities.
- Develop or ensure compliance with infection control policies and procedures.
- Maintain, safeguard, and ensure the confidentiality of all required medical/oral health records when they are in the dental suite or in the possession of oral health and wellness team members.

[12] By agreement, the dental hygienist may have a separate subcontract with the center or the hygienist may be furnished by the dentist.

- Advise and assist wellness instructors in developing and implementing the oral health-related topics as part of overall wellness instruction.

- Advise the Center Director and HWM on the oral health and wellness budget with regard to specific center needs, including replacing obsolete equipment and using necessary dental supplies and medications.

- Review, sign, and date standing orders for oral health care annually in accordance with TAG Q, Standing Orders.

- Model the following skills while interacting with students:

  (a) Dress appropriately for work

  (b) Be on time

  (c) Listen effectively

  (d) Explain procedures

  (e) Satisfy customers

  (f) Work in teams

  (g) Interact harmoniously, competently, and respectfully with individuals of diverse races, genders, sexes, ages, varying abilities, disabilities, and cultures

  (h) Trouble shoot and problem solve

- Reinforce the center's instruction to students at the chairside in the following employment-related subjects as appropriate and without interrupting the oral health and wellness program's productivity:

  (a) Strategies for succeeding during the first weeks on the job
  (b) Job survival skills
  (c) Community support services

- Enforce appropriate workplace behavior when students are in the dental suite or waiting area.

- Advise and assist the staff member who conducts the student introduction to health services in developing the oral health and wellness program component.

- Create an environment in the dental suite in which students can practice

appropriate social skills.

- Lead the oral health and wellness team in a spirit of cooperation with center policies.

4.0.2 Professional Qualifications

Minimum professional qualifications for all dentists serving Job Corps students are as follows:

- Graduates of an accredited dental school

- License to practice dentistry in the state where the Job Corps center is located whether service is provided on or off center [PRH-5: 5.2 (R4), Exhibit 5-3]

- Copy of current Drug Enforcement Administration registration

- Evidence of current and appropriate levels of malpractice coverage

4.0.3 Competency

The center dentist(s) must have the knowledge and ability to perform competently and deliver quality oral care that provides the full scope of services normally available in a general dental practitioner's office. This includes but is not limited to:

- Diagnosis, including x-rays
- Simple surgical treatment
- Restorative treatment
- Routine endodontic treatment
- Prosthetic treatment
- Routine periodontic treatment
- Chairside preventive oral health services
- Oral health and wellness education

In addition, the dentist should be familiar with basic public health principles in treating special populations.

4.0.4 Background and Experience

Selection of the dentist should be based on the candidate's:

- Current state dental license from state Board of Dentistry

- Past experience with Job Corps or relevant experience that can be applied to Job Corps

- Demonstrated interest in oral health promotion and wellness

- Ability to communicate effectively with staff and students

- Interest in and sensitivity to the oral health problems of disadvantaged individuals from diverse cultural backgrounds and with disabilities

- Awareness of and responsiveness to the problems of addressing the oral health needs of a group rather than an individual

- Demonstrated community involvement

- Acceptance of the Job Corps mission and center goals and ability to determine how the oral health and wellness program can contribute to the mission and goals

Other qualifications also apply, depending on the dentist's role in developing, implementing, and monitoring the oral health and wellness program. These qualifications include:

- Interest or experience in administrative matters such as developing a budget, establishing oral health care priorities, organizing effective health care delivery, and evaluating the oral health and wellness program

- Experience in the delivery of oral health care to diverse populations

- Ability to work effectively with nonhealth personnel and to integrate the oral health and wellness program into the educational, vocational, and residential aspects of the Job Corps program

- Interest in other health-related areas and a willingness to provide technical assistance in the health occupations training programs

- Ability to serve as a good role model for students

- Ability to provide leadership and supervision for the oral health and wellness team

- Ability to demonstrate good social skills

4.0.5 Written Agreement with Center Dentist

Centers must have a written agreement with the dentist to define the expectations of the center and the dentist regarding the scope of services and to plan dental costs. In developing the agreement, the center and the dentist must reach a clear understanding that addresses:

- Adhering to all Job Corps policies, procedures, and guidelines
- Understanding the limitations and priorities of oral health care provided to Job Corps students as defined in the PRH and this TAG
- Establishing the mode and time of payment
- Filing a fee schedule with the center (for an off-center dentist) as part of the agreement (including the anticipated fee schedule or financial reimbursement plan for emergency or specialty referrals)
- Assisting the National and Regional Offices and regional health consultants in monitoring and assessing oral health and wellness services
- Attending regional and national Job Corps workshops for oral health and wellness personnel

A copy of a prototype subcontract[13] for oral health care is included in Appendix H. Use of the prototype is not mandatory, but it is recommended and the prototype can be modified as necessary to fit the center's situation. Technical assistance in developing an agreement and reviewing fee schedules is available from RDCs through the Regional Offices.

Hiring/subcontracting oral health professionals is subject to prior approval by the Regional Office. The Regional Office will consult with the RDC and National Office as necessary. The Center Director should send a signed copy of the agreement along with a copy of the health professional’s resume, current state board license, professional liability coverage certificate, and medication prescribing license to the Regional Office at least 1 month before the subcontract is scheduled to be implemented or renewed.

[13] Civilian conservation centers (operated by the federal government) contract with health professionals; contract centers (operated by private corporations that are awarded the contract to operate the center by the Department of Labor) subcontract with health professionals. Large centers employ full-time dentists whose role and responsibilities should be defined in a prototype agreement; these dentists are not under contract. The term “subcontract” as used here refers to any of these agreements between a center and a dentist.

4.0.6 Secondary Subcontracting

The dentist (prime subcontractor) has primary responsibility for implementing the oral health and wellness program and may be technically assisted by the RDCs and/or the National Office. The dentist agrees to perform all work personally and not to delegate any professional responsibilities set forth in the agreement (subcontract) to another part-time dentist (as a secondary subcontractor[14]) except under the following conditions:

- The Center Director provides prior approval
- The Regional Director in consultation with the RDC reviews the professional qualifications of the secondary subcontractor(s)

Regional Office approval must be obtained prior to subcontracting with a secondary part-time dentist.

The center dentist may delegate any responsibilities set forth in their agreement to appropriate qualified nondentists within the constraints defined in the center dental standing orders and center operating procedures or subcontract.

4.1 Dental Auxiliary Staff

4.1.1 Role and Qualifications of the Dental Assistant

The dentist or the center should provide at least one dental assistant for each dentist engaged. The use of a chairside dental assistant greatly enhances the dentist's productivity. In addition to assisting the dentist, the assistant may provide oral health education, perform clerical work,[15] and provide authorized emergency oral health care under standing orders. The dentist's time on center should be spent providing professional services rather than on recordkeeping, instrument recirculation, and other tasks that can be done more cost effectively by a dental assistant.

Dental assistants do not have to be licensed or registered by the state; however, they *may* have completed a recognized training program and be *certified* by the state for their skill level. A certified dental assistant is preferred because a trained individual is more valuable to the center and serves as a role model for students who may be considering allied health occupations in dentistry. Some states require that dental assistants demonstrate proficiency in the use of x-rays and be certified to that effect.

[14] The term "secondary subcontractor" as used here includes any part-time dentist to whom the center dentist delegates any professional responsibilities. This includes a dentist who assumes responsibility for specialty or emergency care as well as any dentist who provides routine oral care.

[15] The center dentist should coordinate support from the health and wellness center staff when the dental assistant is at the chairside for prolonged periods of time and cannot tend to clerical tasks (e.g., making appointments) that should not be postponed.

4.1.2 Role and Qualifications of the Dental Hygienist

Depending upon the center's best interest, the dental hygienist can be an independent subcontractor, an employee of the dentist, or an employee of the center. Dental hygienists can treat some forms of gum disease and teach students techniques for preventing gum disease. Depending on specific state laws, a hygienist may perform some of the duties that the dentist performs, with varying degrees of independence, such as cleaning teeth by scaling, using ultrasonic devices, injecting patients, performing oral examinations, and charting.

The presence of a hygienist offers two primary benefits:

- The dentist has more available time to provide restorative clinical services
- The hygienist is able to provide more in-depth oral health promotion and wellness information to students

All students should routinely receive an oral prophylaxis by a dentist or dental hygienist. Oral prophylaxis and other preventive services should be considered separately from the priority system when the available staffing hours and the dental hygienist's schedule allow sufficient time for treatment of all students.

4.1.3 Staffing Requirements

Determining realistic staffing requirements for dental assistant and dental hygienist coverage is complex. The dentist, in consultation with the Center Director and RDC, bases the staffing configuration on a professional assessment of needs. Factors that influence this decision include the center's financial capability and size, ability of the health and wellness center to provide clerical support, and ability to recruit staff. (The minimum dental staffing requirements are delineated in PRH-6, Exhibit 6-5.) The RDC is available to provide technical assistance on staffing patterns.

The highest priority for all centers, particularly those with minimal coverage by a dentist and dental assistant, is to secure at least some coverage by a dental hygienist. This is the most cost-effective way to expand the capability of the oral health and wellness program to treat more students.

SECTION 5: STANDING ORDERS FOR ORAL AND CRANIOFACIAL CARE

Each center must prepare standing orders and keep them readily available in the health and wellness center [PRH-6: 6.12 (R9)]. TAG Q, Standing Orders, outlines the different points to consider and steps to take when health and nonhealth staff are presented with student health problems.

5.0 <u>Health Staff</u>

The standing orders for health staff that concern oral care should include:

- Managing pain in teeth or jaws
- Managing oral bleeding
- Managing dental infection

5.1 <u>Nonhealth Staff</u>

In the absence of health staff, nonhealth staff may need to provide a student's initial health care. In small or medium-sized centers, a nurse may be on duty only a limited number of hours each day or not at all during evenings, nights, and weekends. Even in centers with full coverage, emergencies occur away from the health and wellness center and a nonhealth staff member may be the first one at the scene. The nonhealth standing orders for dental use should include:

- Managing pain in teeth or jaws
- Managing oral bleeding
- Dealing with injury to face, jaws, or teeth

Nonhealth standing orders should be available for appropriate staff.

5.2 <u>Annual Review</u>

Although the center physician is responsible for reviewing and signing all standing orders annually, it is appropriate for the center dentist to review and sign the dental standing orders [PRH-6: 6.12 (R9)]. The dentist must ensure that current dental standing orders are issued and maintained in accordance with TAG Q. The dentist must also sign and date every order. After discussion, the dentist, Center Director, and staff person responsible for health and wellness center services may want to adopt or tailor any or all of the standing orders in TAG Q.

SECTION 6: DOCUMENTATION

6.0 The Health Record

The oral health record (SF 603 and SF 603A) must be kept as part of the student's record in the health folder. The complete student health record must be accessible to dentists and other health care providers. All information in the records is considered confidential. The center dentist must maintain, safeguard, and ensure the confidentiality of all required oral health records.

The oral health portion of the health record should contain:

- SF 603 or SF 521 and, as necessary, SF 603A
- Mounted x-rays
- Consultation requests
- Oral health and wellness plan
- Copies of dental laboratory orders and prescriptions
- Summaries of off-center and emergency oral health care

The signed consent form (form 653) should be included in the student health record by the time the student arrives on center. The oral health team member should review the complete health record before a dental visit to confirm that it contains form 653. The form serves as authorization for basic routine health care, including oral care.

Health and wellness center staff responsibilities include completing oral health records for on-center care, supplying off-center dentists with forms and tracking their return, and maintaining the student health record that contains the oral health record.

Documentation for oral health care should include:

- **Cursory oral examination—**Record findings either on the cursory medical history form and cursory medical examination guide or on SF 600 in the student's health record.
- **Mandatory oral examination**—Record results of the examination on SF 603 or SF 521. SF 603 and SF 521 were designed for the Department of Defense and some items will not apply to Job Corps (such as item 8, Grade, or item 10, Component, on SF 603). However, the form applies to Job Corps use in most instances and should be filled out as completely as possible.

- **Student's oral health status and care provided while in Job Corps—**Maintain a complete, accurate record of oral health status and services on SF 603 and SF 603A (see Appendix D) and, where applicable, on SF 600. Include medication, prescriptions, and orders for dental laboratory procedures on these standard forms.

Use standard Job Corps dental abbreviations to complete forms (see Appendix E); write out terms not included on the list.

The Job Corps National Office and regional dental consultants (RDCs) are responsible for ensuring that students receive high-quality care. RDCs use thorough record reviews to ascertain the quality of care being provided, determine whether oral health care is being recorded on the proper forms, and confirm that center oral health care guidelines comply with the PRH.

6.1 Reporting Requirements

The number of mandatory oral examinations are reported by the center on the monthly health services utilization statistics report. This report should be maintained on center for internal management purposes.

6.2 Productivity Indicators

Low productivity is an ineffective and costly use of the limited resources available for Job Corps oral health and wellness programs. To ensure that centers incur maximum benefit from their oral health and wellness programs, the National Office—with input from RDCs and center staff—developed and validated basic indicators to measure program productivity. These indicators help define the minimum work output of dental productivity considered acceptable for Job Corps and take into account the scope of oral health services provided, the facilities, and the staffing guidelines.

Productivity indicators are a management tool for assessing program productivity and cost effectiveness. The four productivity indicators and the recommended guidelines for each are:

- **Mandatory Oral (and Recall) Examinations Per Hour—**This guideline suggests that a center should experience a mandatory oral examination rate equal to 4.0 examinations per hour.

  A rate less than 4.0 examinations per hour may indicate insufficient use of the dentist's scheduled time. Centers that do not meet this guideline should examine appointment scheduling procedures as well as the number of hours and days per week the dentist is scheduled to work.

- **Other Dentist and Dental Hygienist Visits Per Hour—**This guideline suggests that a center should experience a visitation rate equal to approximately 1.5

student visits per hour. This includes all visits for routine, emergency, and preventive care administered by the dentist and the dental hygienist but excludes mandatory oral examinations and referrals.

A rate less than 1.5 student visits per hour may result in reduced availability of care and unnecessary treatment delays for the majority of students.

- **Broken Appointment Rate—**This guideline suggests that centers maintain a rate of less than 15 percent for broken appointments. Centers are considered to be in compliance with this guideline if they achieve a rate of less than 15 percent.

  A rate greater than 15 percent may indicate a need to review program staffing patterns and scheduling methods as well as the effectiveness of sanctions for broken appointments. High AWOL rates may also contribute to broken appointments. Another factor that may cause a high broken-appointment rate is dental equipment malfunctions that necessitate rescheduling appointments. Centers must establish incentives for students to keep appointments to maintain a low broken-appointment rate.

- **Emergency/Walk-in Visit Rate—**This guideline suggests that centers maintain a rate of less than 25 percent for emergency/walk-in visits, which includes all unplanned encounters between students and the dentist.

  A rate greater than 25 percent may indicate a need to review the appointment scheduling and referral process used by nonhealth staff to refer students to the oral health and wellness program without consulting health staff.

Some centers enhance compliance with the four productivity indicators by instituting reminder systems and penalties. For example, some centers:

- Give students individual reminder slips for the next visit during their current appointment or send a reminder slip just before their next scheduled appointment

- Implement a consistent centerwide policy that assesses penalty fees for missing appointments (fines do not exceed more than $5 per pay period)

When students miss an appointment for a mandatory oral examination or any other oral health service, an oral health team member should follow up to ensure that they receive treatment at another time (as resources allow). Requiring follow up creates an opportunity to explore reasons for missing the appointment and ways that the student and center can reduce broken appointment rates.

Centers collect the following data to determine productivity indicators:

- Dentist hours worked each day on mandatory oral examinations and other dental visits

- Dental hygienist chairside hours worked each day
- Total number of dentist and dental hygienist appointments
- Total number of dentist and dental hygienist visits
- Total number of dentist emergency/walk-in visits
- Total number of broken appointments

Appendix I contains the data log sheet and instructions for determining productivity calculations. An oral health and wellness team member should fill out the data log sheet daily; the log is held until an RHC visits the center. Center personnel should collect data during the first month of each quarter. When the RHC visits the center, he/she will work with the center to analyze the data and determine how to correct problems. The RHC will:

- Calculate productivity and compare it to the indicators for minimum acceptable levels of performance
- Discuss the findings and any needed corrective action with center personnel
- Use other productivity input when needed (for example, the number and type of oral health procedures) to ascertain the causes for low productivity
- Include the productivity data in the report submitted to the National and Regional Offices

6.3 Oral Health Outcomes

The PRH details the expected oral health outcome that students' oral health status will be maintained or improved while they are in Job Corps. The priority classification system promotes positive oral health outcomes by guiding the sequence of services rendered to each student. The system also promotes aggregate oral health outcomes by determining which students receive care first.

The oral health team should collect, maintain, tabulate, and analyze oral health outcome data the first month of each quarter to assess their progress in helping students meet the expected oral health outcome. The information collected should be kept on center for review during RHC visits. Appendix J contains the oral health outcome data sheets and instructions for their completion.

The breakdown of priorities at the time of the mandatory oral examination will show the prevalence and severity of oral disease among entering Job Corps students. The breakdown of priorities at the time of oral health and wellness checkups will show if the

oral health status among students has improved during their stay in Job Corps. During the care phase, the breakdown of priorities will give insight into whether students' oral health status is being maintained, improving, or declining during their stay in Job Corps.

The dentist should analyze the results and undertake continuous quality improvement activities as necessary to improve oral health outcomes.

SECTION 7: DENTAL SUITE EQUIPMENT AND SUPPLIES

The dentist must be able to work efficiently and effectively. The dental suite and equipment should enhance rendering care. Consequently, the standards for Job Corps on-center dental suites and equipment should be comparable to those for off-center private practices.

7.0 Standards for the Basic Configuration of Dental Suites, Equipment, and Supplies

On-center dental suites should use a minimum of two chairs for efficient and cost-effective practice of contemporary dentistry. Job Corps standards for major dental equipment are directed toward providing treatment to active adolescents and young adults.

Job Corps centers must provide the necessary equipment and supplies for routine and emergency delivery of oral health services on center. All such equipment must comply with federal and state requirements. Standardized use of major dental equipment simplifies the design and construction of dental suites. Periodically the National Office publishes and distributes an updated list of major dental equipment to be used in all Job Corps dental suites on center.

7.1 Equipment Replacement, Renovation, and Construction

Replacing obsolete dental equipment and renovating dental suites occurs when and if financial resources allow. Such decisions are facilitated by careful documentation of problems and needs during Regional Office assessments, RHC site visits, and facilities surveys. On-center dentists also contribute significantly to the decision-making process. Normally, the HWM—with input from the dentist—advises the Center Director on the oral health and wellness budget regarding specific facility and equipment needs. The dentist may need to document special concerns in writing, especially when a technical explanation will clarify the nature of the request.

When asked to prioritize requests, the dentist should address those needs that are vital to protect student health and safety or eliminate down time that severely hampers the dentist's productivity. For example, failure to replace or repair the dental handpiece contributes to significant down time in the dental suite.

7.2 Procuring Dental Equipment and Supplies

Equipment and supplies necessary to operate and maintain dental suites and programs efficiently should be procured from the most appropriate and least expensive sources. This means centers need to pursue government excess first, other federal supply sources second, and nongovernment sources third. Only limited amounts of supplies and equipment should be obtained from nongovernment sources.

Whenever possible, centers need to procure serviceable federal government excess property and equipment. Required items that cannot be obtained from government excess should be purchased from federal supply sources, such as:

- Veterans Administration
- Defense Supply Agency
- Public Health Service
- General Services Administration

Each center should have a standard operating procedure for procuring supplies on a timely basis. The oral health and wellness team should follow the relevant standard operating procedure on their center to obtain dental supplies. The HWM should monitor the health and wellness center budget as well as coordinate the timely and cost-effective acquisition of needed dental supplies.

7.3 Dental Laboratory Services

The dentist is responsible for identifying a competent dental laboratory service in the community for center use. Criteria for evaluating a laboratory include the quality of work, responsiveness to need for timely pick-up and delivery of laboratory work, and competitive prices.

Centers can request technical assistance from the RDC in identifying competent dental laboratories.

SECTION 8: TECHNICAL ASSISTANCE, ASSESSMENT, AND MONITORING

8.0 Technical Assistance Scope and Process

The National Office is responsible for developing, implementing, and monitoring oral health and wellness program policies. Each Job Corps Regional Office has RHCs (dental, medical, nursing, and mental health) who assist in carrying out these responsibilities and provide technical assistance to Job Corps centers and the Regional Office. The RHCs assess center operations and provide assistance through on-site visits and by telephone.

RHCs may conduct on-center program assessments, provide technical assistance, or conduct monitoring visits at the request of the National or Regional Office to ensure achievement of program goals and objectives and delivery of quality services. Centers can also request technical assistance from the RDC by contacting their Regional Office project/program manager or the RDC.

8.1 Regional Dental Consultant Support and Assistance

The RDC is involved in a wide range of supportive activities at the center, regional, and national levels. Areas in which assistance and advice are most frequently sought include:

- Screen Job Corps applicants who indicate oral health problems on their application
- Provide technical assistance to center and Regional Office staff (the RDC is available to assist center staff in developing procedures targeted to the center's specific needs; the consultant can share successful approaches used by other centers and advise centers on proposed corrective actions)
- Recruit center dentists or assist Regional Office and center staff in recruitment efforts
- Assess the professional qualifications of dentists, dental hygienists, and secondary subcontractors
- Consult with the Regional Office during the approval process of dental subcontracts
- Advise centers on matters such as cost containment, fees, and salaries for auxiliary staff
- Advise centers on staffing requirements for dentist, dental hygienist, and dental assistant positions

- Train oral health and wellness staff and assist national, regional, and center staff in providing training
- Monitor off-center oral health care and outside specialty referrals for their effect on the budget during the center assessment
- Assist center staff with analyzing productivity data and patterns and identifying corrective actions
- Recommend the selection of new dental equipment
- Determine the feasibility of on-center dental suites
- Review facility designs for new construction or dental suite modifications
- Investigate significant dental-related incidents at the request of the National Office

The RDC frequently provides assistance by telephone and e-mail since most questions do not require a center visit. The RDC also provides assistance on site during center assessments and technical assistance visits.

8.2 Center Program Assessment Process

RHCs participate as team members when Regional Office staff conduct center program assessments on an annual or biennial basis, depending on the severity of center concerns. These assessments serve to ensure that the Job Corps health and wellness center services and health-related program components deliver the outcomes and quality indicators prescribed in the PRH. Appendix K contains self-assessments that the oral health and wellness team can use to help prepare for the program quality assessment as well as the standards and compliance review.

The center assessment process generally occurs as follows:

(1) **Pre-site Analysis—**The Regional Office conducts a pre-site analysis to determine whether outcomes have been met. When outcomes have been met, the assessment team will focus on selective requirements involving integrity issues (integrity issues relate to financial resources and data systems). The pre-site analysis determines the type of assessment that best serves the needs of the center and the model of the assessment that will be used. Center operators may be asked to conduct a self-assessment to prepare for the arrival of the Regional Office program assessment team.

(2) **On-site Assessment—**When the team arrives at the center, they will verify issues identified during the pre-site analysis and verify targeted outcomes and quality indicators. The team will also review documents and interview staff,

students, local community connections, etc.

(3) **Brief-out Dialogue—**Before leaving the center, the team will share assessment results and the quality rating with the center operator and staff to create an environment in which improvements that are needed can be clarified and priorities can be established.

(4) **Issuance of Formal Report—**After the assessment, the Regional Office issues a formal report detailing the assessment results, center ratings, and areas requiring improvement.

(5) **Corrective Action Plan—**The center operator should submit a corrective action plan to respond to problems identified during the assessment and suggest ideas for improvement.

(6) **Follow Up and Monitoring—**The center operator, the program/project manager and the management team should provide regular follow up and monitor corrective action plans.

8.3 Oral Health and Wellness Program Assessment

Oral health team members should be prepared to describe to the assessment team the oral health and wellness program goals, performance expectations and standards, ways in which their individual performance contributes to the overall accomplishment of program and center goals, and their continuous quality improvement activities.

During a center program assessment, the RHCs focus on the concerns identified during the pre-site analysis to customize the assessment process to resolve concerns and support continuous quality improvement. This may include the following activities:

- Examine quality indicators—the connection between program requirements and outcomes
- Evaluate the oral health and wellness program productivity from the perspective of cost versus quantity/quality of treatment
- Investigate how the oral health and wellness program contributes to student outcomes, especially employability
- Examine the extent to which the oral health and wellness program is integrated with health and wellness center services and other Job Corps program components
- Determine the extent to which corrective actions taken for continuous quality improvement are producing the desired effect

- Determine the extent to which students are able to demonstrate the oral health and wellness skills they have mastered

- Organize and conduct student focus groups

- Provide oral health and wellness program assessment feedback to the assessment team

The RHC assesses the quality of oral health services provided by the center and the appropriateness of specified treatment plans through such activities as record reviews, staff interviews, student interviews, student focus groups, and observations of dental suite activities.

APPENDIX A

OVERVIEW OF ORAL HEALTH AND WELLNESS PROGRAM COMPONENTS

Overview of Oral Health and Wellness Program Components

SECTION	COMPONENT	PURPOSE	WHEN	PROVIDER
2.0	Cursory Oral Examination and History	Identify oral signs of communicable disease or acute oral condition. Obtain brief oral health history. Determine whether students with orthodontic appliances meet treatment status conditions for retention in Job Corps. Enhance student employability and acceptability.	During cursory health evaluation (in the first 48 hours on center)	Health and wellness staff (e.g., nurse who conducts the cursory health evaluation, dental assistant, or physician as part of entrance physical examination)
2.1	Mandatory Oral Examination	Determine priority classification. Determine oral health status. Develop preliminary treatment plan. Enhance student employability and acceptability.	Between 45th and 75th day on center (or as part of emergency treatment before the 45th day)	Center dentist
2.2	Emergency Oral Care	Relieve acute conditions. Enhance student employability and acceptability.	As needed	Center dentist, dental assistant, or other staff as defined by center standing orders
2.3	Routine Restorative Oral Care	Treat conditions per the treatment plan. Promote optimum oral health Move students to lower priority classifications. Enhance student employability and acceptability.	Per timetable in the treatment plan	Center dentist
2.4	Periodontal Care and Oral Prophylaxis	Maintain or improve periodontal status. Enhance student employability and acceptability.	Per timetable in treatment plan according to the priority classification	Dental hygienist (preferably) or center dentist
2.5	Oral Health and Wellness Checkups	Review with students their success in reaching the goal of optimum oral health and wellness. Reinforce the relationship between optimum oral health and employability. Enhance student employability and acceptability.	Per timetable in the treatment plan	Center dentist
2.6	Off-Center Oral Health Services	Provide necessary oral procedures beyond the center dentist's scope of practice. Provide some Priority 3 services. Enhance student employability and acceptability.	As authorized	Off-center dental specialist
2.7	Infection Control	Reduce risk of transmitting infectious diseases. Enhance student employability and acceptability.	Every oral health visit	Center dentist, hygienist, and dental assistant
2.8	Safety and Health	Reduce risk of exposure to hazardous chemicals and a hazardous environment.	Every oral health visit	Center staff, center safety officer
2.9	Oral Health Care for Pregnant Students	Provide preventive services and safe care.	Immediately upon diagnosis of pregnancy	Center Dentist
2.10	Oral Health and Wellness Philosophy	Address the whole person and not just the oral cavity. Build student knowledge and skills in oral health care practices. Enhance student employability and acceptability.	Orientation Every oral health visit	Center dentist, hygienist, and dental assistant
2.11	Continuous Quality Improvement	Develop innovative approaches to measurably improve the oral health and wellness program. Enhance student employability and acceptability.	Routinely	Oral health and wellness staff
2.12	Customer Relations and Outreach	Promote oral health and wellness program. Promote optimum oral health and employability. Enhance student employability and acceptability.	Surveys, group presentations, every oral health visit, committee meetings	Health and wellness staff, oral health and wellness team

APPENDIX B

SUGGESTED RESOURCE PUBLICATIONS

Birn, H. and Winther Je, *Manual of Minor Oral Surgery: A Step-by-Step Atlas*, W. B. Saunders Company.

Colby, Robert; Kerr, Donald; Robinson, Hamilton. *Color Atlas of Oral Pathology,* JB Lippencott Company.

Florman, Michael. *Dental Materials Digest.* Odontos Publishing, Inc.

Malamed, Stanley and Sheppard, Gerald. *Handbook of Medical Emergencies in the Dental Office.* The CV Mosby Company. 11830 Westline Industrial Drive, St. Louis, Missouri 63141.

Studevant, Clifford; Barton, Roger; Sockwell, Clarence; Strickland, William. *The Art and Science of Operative Dentistry.* The CV Mosby Company.

Tommasone, Pamela E. *Dental Therapeutic Digest.* Odontos Publishing, Inc.

Torres, Hazel and Ehlich, Ann. *Modern Dental Assisting.* W.B. Saunders Company. The Curtis Center, Independence Square West, Philadelphia, PA 19106. (1990)

Colgate Oral Pharmaceuticals
One Colgate Way
Canton, MA 02021
(800) 346-3767

Community outreach materials

Dental Models & Designs, Inc.
20 Passaic Street
Garfield, NJ 07026
Telephone: (973) 472-8009

Life-like models for patient education and demonstration

National Institute of Dental and Craniofacial Research
31 Center Drive MSC 2190
Building 31/Room 5B-49
Bethesda, MD 20892-2190
Fax: (301) 496-9988

Free pamphlets on oral health care topics in Spanish and English

National Biological Laboratories, Inc.
140-C Tewning Road
Williamsburg, VA 23188
(800) 248-8830
www.nationalbiologicallabs.com

Dental demonstration models and anatomical models for patient and student education

National Oral Health Information Clearinghouse
1 NOHIC Way
Bethesda, MD 20892-3500
(301) 402-7364

The National Oral Health Information Clearinghouse (NOHIC), a service of the National Institute of Dental and Craniofacial Research, helps meet the information needs of special care patients and health care providers. Special care patients are persons with a variety of medical and mental health conditions and disabilities.

NewMentor Group Professional Learning Systems. *Cleaning and Shaping.* NewMentor Group 360 Post Street, Suite 402, San Francisco, CA 94108. (1998)
(CD-ROM; designed to provide comprehensive information about the clinical goals, procedures, methods, and material most effective for endodontic therapy.)

APPENDIX C

INTERNET WEB SITES WITH WELLNESS INFORMATION

American Dental Association: www.ada.org

American Dental Hygienists' Association: www.adha.org

CDC's Oral Health Program: www.cdc.gov/nccdphp/oh/

Healthy People 2010 home page: www.web.health.gov/healthypeople

National Oral Health Information Clearinghouse: www.aerie.com.nohicweb/

Committee on Dental Auxiliaries: www.comda.ca.gov

UCSF Dental Public Health Seminar Series: www.ckm.ucsf.edu/

(The telephone number for the teleconferences is (800) 684-2424; the access code is 1999.)

National Library of Medicine (for free access to Medline, a database of more than nine million references to articles in 3,800 biomedical journals): www.nlm.nih.gov

Surgeon General's Report on Oral Health: www.nidr.nih.gov/sgr/sgr.htm

University of California Environmental Health and Safety: www.ehs.ucdavis.edu

Wellness Web: www.wellweb.com

PubMed (access to the nine million citations in MedLine and other medical research databases free of charge): www.ncbi.nlm.nih.gov/PubMed

Healthy Ideas (encyclopedic site from Prevention Magazine): www.prevention.com

HealthGate (online source of health, wellness, and biomedical information on both alternative and conventional medicine; registration is free): www.healthgate.com

Oral Health America: www.oralhealthamerica.org

The Office of Minority Health Resources Center (community-based organizations and institutions serving racial and ethnic minority groups in the United States can order free resource materials from this office): www.omhrc.gov

APPENDIX D

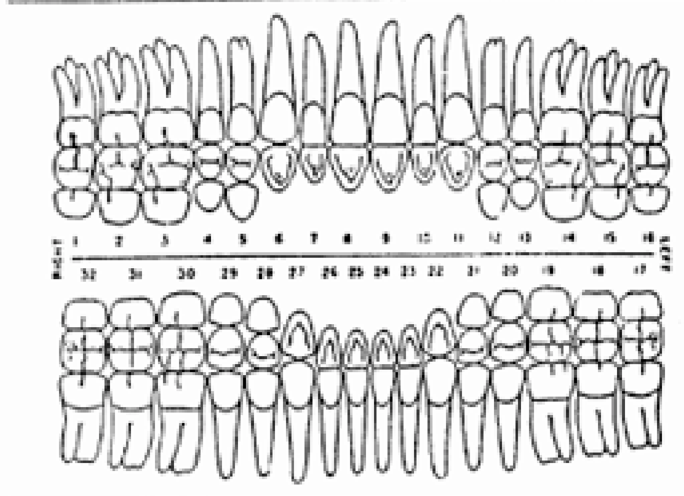
SAMPLE ORAL HEALTH RECORDS
(SF 603, SF 603A, AND SF 521)

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

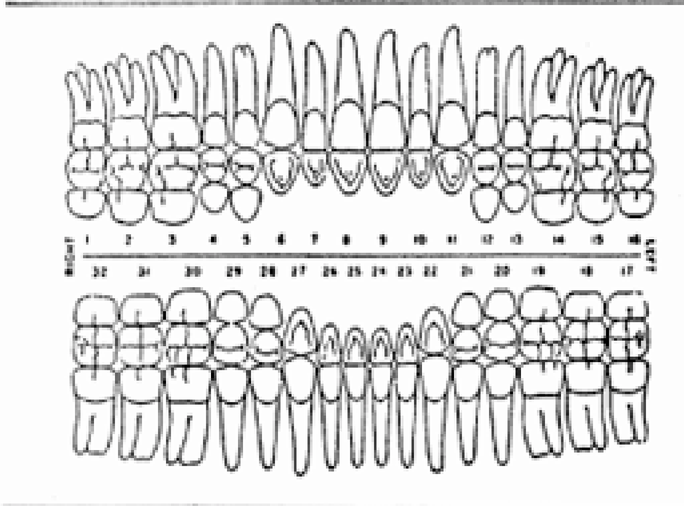


REMARKS

PLACE OF EXAMINATION	DATE

SIGNATURE OF DENTIST COMPLETING THIS SECTION

5. DISEASES, ABNORMALITIES, AND X-RAYS



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.

FPI LEX Printed on Recycled Paper

NSN 7540-00-634-4179

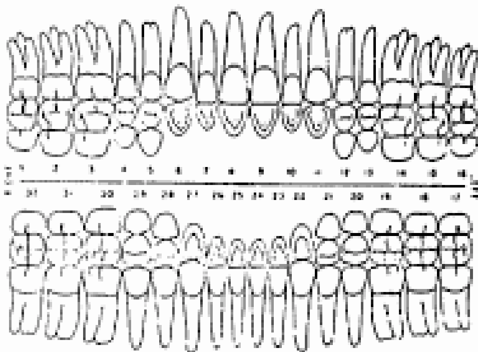
SF 603 10/75
Prescribe By GSA and ICMR
FIRMR (41-CFR) 201-45.505
603-107

Standard Form 603-A

HEALTH RECORD | **DENTAL—Continuation**

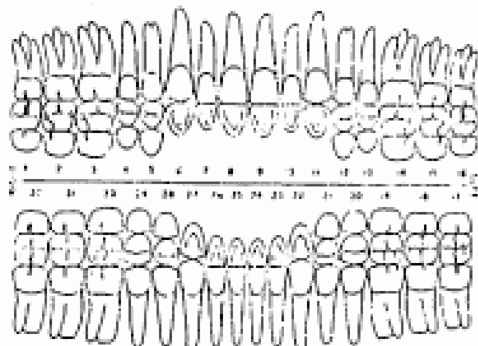
SECTION III. ATTENDANCE RECORD

15. RESTORATIONS AND TREATMENTS (*Completed during service*)



REMARKS

16. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS

17. SERVICES RENDERED

DATE	DIAGNOSIS—TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS

PATIENT'S LAST NAME FIRST NAME MIDDLE NAME

IDENTIFICATION NO

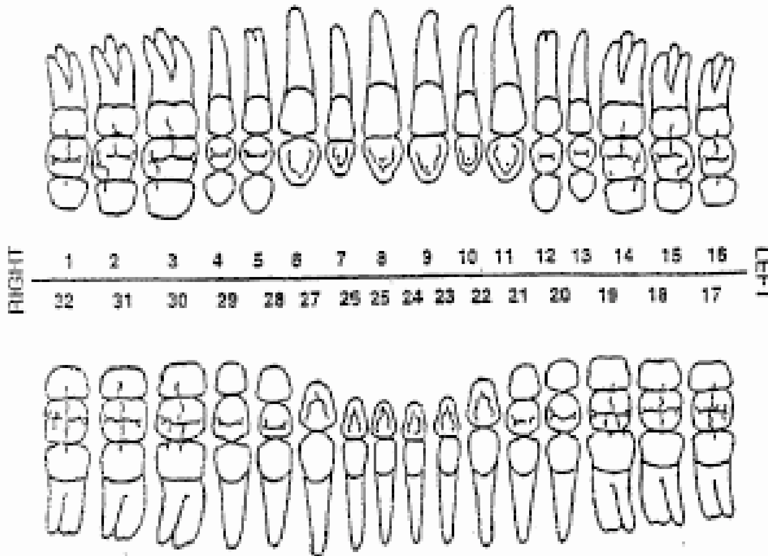
GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR (41 CFR) 201-45.505
OCTOBER 1975

603-205

NSN 7540-00-634-4164

MEDICAL RECORD | DENTAL

1. CHART



2. ROENTGENOGRAMS
☐ PERIAPICAL ☐ BITEWINGS ☐ 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 PHYSICIAN

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; rank; rate; hospital or medical facility)*

22. IDENTIFICATION NO.	23. REGISTER NO.	24. WARD NO.

DENTAL
Medical Record
STANDARD FORM 603 (Rev. 3-84)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

INFORMATION FOR DENTAL SERVICE (To be filled in by referring agency)

25. 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

*U.S. Government Printing Office: 1996 - 404-783/40043

STANDARD FORM 521 (Rev. 3-84) BACK

APPENDIX E

STANDARD JOB CORPS DENTAL ABBREVIATIONS AND ACRONYMS

These standard Job Corps dental abbreviations and acronyms, unless otherwise noted, are excerpted from the American Dental Association's publication _Accepted Dental Abbreviations and Acronyms_, first edition, 1997. Abbreviations are arranged according to the field(s) of dentistry in which they are most likely to be used. Those with wide application are listed under *Common*.

COMMON			
A	Assessment	M	Mesial
Anes	Anesthetic	Man	Mandible, mandibular
Ant	Anterior	Max	Maxilla(ry)
Appt	Appointment	NC	No change in condition
B	Buccal	Neg	Negative
BA	Broken appointment	NKA	No known allergies
Bi	Bicuspid	NPC	No previous complaint
Canc	Cancel(lation)	NS	Nonsmoker
Chk	Checked (observed)	N/S	No show
Chr	Chronic	O	Occlusal
Clr	Clear	OCF	Other clinical findings
C/O	Complaint of	P	Pulpal
Cond	Condition	Porc	Porcelain
D	Distal	Prog	Prognosis
DA	Dental assistant	PS	Past smoker
D/C	Discontinue	Pt	Patient
Decid	Deciduous	ReApp	Reappoint
D/H	Dental history	Recem	Recement(ed)
Emerg	Emergency	Re-eval	Reevaluate
Epin	Epinephrine	Rem	Remove(d)
Eval	Evaluate	RFI	Request for information
Exp	Exposure	R/O	Rule out
F	Facial	SH	Social history
Fx	Fixed	Super	Supernumerary
Frac	Fracture	Sx	Symptoms
HOI	History of present illness	Tb	Toothbrush
HS	Heavy smoker	Temp	Temporary
I	Incisal	Tng	Tongue
Inf	Infected, inflammation	Tx	Treatment
Inj	Injection	UL	Upper left
L	Lingual	UR	Upper right
Les	Lesion	X	Times
LL	Lower left		
LR	Lower right		

EXAMINATION	
BW	Bitewing x-ray
CC	Chief complaint
Def	Defective
Demo	Demonstrate
Dev	Develop
Disc	Discussed
DT	Decayed teeth
Dx	Diagnosis
EOB	Explanation of benefits
Exam	Examination
FOM	Floor of mouth
GMH	General medical history
P-XR	Panographic x-ray

ENDODONTICS	
Abs	Abscess
ENDO	Endodontic
GP	Gutta percha
Ncr	Necrosis
PA	Periapical
PACR	Post-and-core restoration
PAP	Periapical pathology
RC	Root canal
RCT	Root canal treatment

RESTORATIVE	
Abr	Abrasion
Am	Amalgam
B	Base
Bldup	Build up
Car	Caries (carious)
Cav	Cavity
Cem	Cement
Crn	Crown
DBA	Dentin bonding agents
GIC	Glass ionomer cement
Pcap	Pulp cap
POI	Post operative instructions

PERIODONTICS ORAL HYGIENE PREVENTIVE DENTISTRY	
Adj	Adjust(ment)
BOP	Bleeding on probing
Calc	Calculus
Car Prev	Caries prevention
Cur	Curettage
Debrd	Debride
Equil	Equilibration
Fl	Fluoride
Ging	Gingiva(l)
Gtmy	Gingivectomy
NUG	Necrotizing ulcerative gingivitis
OH	Oral hygiene
OHI	Oral hygiene instruction
PA	Periapical
PD	Probing depth
Perio	Periodontal
Plq	Plaque
Poc	Pocket
Prophy	Prophylaxis
RP	Root planing
S	Scale(d) (ing)
STM	Soft tissue management

ORAL SURGERY		PROSTHODONTICS	
Alv	Alveolar	Abut	Abutment
Alvy	Alveolectomy	Adj	Adjust(ed) (ment)
BF	Bone fragment	Appl	Appliance
Bn	Bone, bony	APT	Active periodontal treatment
Bx	Biopsy	Compl	Complete
Ext	Extract(ed) (ion)	Dtr	Denture
Frac	Fracture(d)	Equil	Equilibration
I&D	Incision and drainage	FLD	Full lower denture
Imp	Impacted	FUD	Full upper denture
Irrig	Irrigation	Fx	Fixed
LA	Anesthesia (local)	Imm	Immediate
OS	Oral surgery	Impr	Impression
Su	Suture	Prep	Prepare(d)
Surg	Surgical	RPD	Removable partial denture
		SSC	Stainless steel crown

APPENDIX F

INFECTION CONTROL RECOMMENDATIONS

Infection Control Recommendations for the Dental Office and the Dental Laboratory

ADA Council on Scientific Affairs and ADA Council on Dental Practice

This report is based on the recommendations of the Centers for Disease Control and Prevention and other publications in the medical and dental literature. The recommendations here, which have been accepted by the ADA Council on Scientific Affairs and the ADA Council on Dental Practice, are intended to offer general guidance for dental offices and laboratories on infection control. They are not intended to establish a standard of care or industry custom, nor are they intended to deprive the dentist of the ability to exercise his or her professional judgment.

Dental professionals are exposed to a wide variety of microorganisms in the blood and saliva of patients. These microorganisms may cause infectious diseases such as the common cold, pneumonia, tuberculosis, herpes, hepatitis B and acquired immune deficiency syndrome. The use of effective infection control procedures and universal precautions in the dental office and the dental laboratory will prevent cross-contamination that could extend to dentists, dental office staff, dental technicians and patients.

The American Dental Association has advocated the use of infection control procedures in the dental practice for many years. [1-6] As new information has become available, the Association has disseminated it to the profession and will continue to do so. Currently available Association publications that provide detailed information about infection control and treatment of patients with infectious diseases are Dental Management of the HIV-Infected Patient, [7] Monograph on Safety and Infection Control, [8] Infection Control in the Dental Environment [9] and now this report. The Association has also provided The American Dental Association Regulatory Compliance Manual [10] and a videotape entitled "OSHA: What You Must Know," [11] both designed to help dentists come into compliance with OSHA's Standards on Occupational Exposure to Bloodborne Pathogens and Hazard Communication.

This report is based on the recommendations of the Centers for Disease Control and Prevention [12-15] and other publications in the medical and dental literature. The recommendations in this document have been accepted by the Council on Scientific Affairs and the Council on Dental Practice. The Councils strongly urge practitioners and dental laboratories to comply with these infection control practices. With the enactment of the OSHA Standard on Occupational Exposure to Bloodborne Pathogens in December 1991, [16] many of these infection control procedures are required by law.

Dentists should recognize an important distinction between OSHA requirements and acceptable infection control practices. OSHA has a Congressional mandate to institute workplace procedures that protect the employee and, by law, is able to write regulations and enter the workplace to conduct inspections and impose financial penalties. The 1991 OSHA Standard on Occupational Exposure to Bloodborne Pathogens is thus written to protect employees. OSHA does not have the mandate to institute practices that protect the patient or the employer. The OSHA Standard, although providing some patient and employer protection, does not encompass all the infection control practices recommended by the U.S. Public Health Service (CDC) and the American Dental Association to protect patients, employees and employers from occupational transmission of infectious disease. Conversely, it is also important to note that OSHA

has many requirements in the Bloodborne Pathogen Standard that neither the U.S. Public Health Service nor the Association includes in its infection control recommendations (for example, where contaminated gowns should be laundered, the requirement to retain an employee's medical records for the duration of employment plus 30 years, the requirement that the employer pay for hepatitis B vaccination and for medical follow-up after an exposure incident).

Therefore, although dentists have a legal requirement to comply with the OSHA Standard, the Association believes that they should also be aware of and practice proper infection control procedures designed for the safety of everyone. These infection control procedures are detailed in this report, and also in various publications from the CDC and ADA referenced at the end of this report. Since this document is not intended to cover every aspect of infection control compliance, the dentist, his or her staff and that of dental laboratories should refer to the referenced publications. [2] [6] [15] [16]

Prevention of transmission of infectious diseases

It is generally accepted that the dental health team is far more at risk from the hepatitis B virus, or HBV, than from the human immunodeficiency virus that causes AIDS. However, because of increasing acceptance of the HBV vaccine among practicing dentists in recent years -- 86 percent (American Dental Association Health Screening Program. October 1995. Unpublished data.) -- the risk of HBV infection is generally limited to those who have not been vaccinated. [17] Patients with hepatitis B or who are HBV carriers can be treated safely or with minimal risk of transmission of disease in the dental office when infection control procedures are used. As HIV appears to be much more difficult to transmit than HBV, there is confidence that the same procedures will prevent the transmission of HIV in the dental office. [17-18]

Vaccination against hepatitis B. Dental health care workers are at a greater risk than the general population of acquiring hepatitis B through contact with patients. It is the policy of the ADA that all dentists and their staffs having patient contact should be vaccinated against hepatitis B. [19] The OSHA Standard now requires that employers make the hepatitis B vaccine available to occupationally exposed employees, at the employer's expense, within 10 working days of assignment of tasks that may result in exposure. [16]

Infection control practices for the dental office: Universal Precautions

A thorough medical history should be obtained for all patients at the first visit and updated and reviewed at subsequent visits.
However, since not all patients with infectious diseases can be identified by medical history, physical examination or readily available laboratory tests, the CDC has introduced the concept of universal precautions. [20] This term refers to a method of infection control in which all human blood and certain human body fluids (saliva in dentistry) are treated as if known to be infectious for HIV, HBV and other bloodborne pathogens. Universal precautions means that the same infection control procedures are used for all patients.

Barrier techniques. Gloves. Gloves must be worn when skin contact with body fluids or mucous membranes is anticipated, or when touching items or surfaces that may be

contaminated with these fluids. After contact with each patient, gloves must be removed and hands must be washed and then regloved before treating another patient. Repeated use of a single pair of gloves by disinfecting them between patients is not acceptable. Exposure to disinfectants or other chemicals often causes defects in gloves, thereby diminishing their value as effective barriers. [21] Latex or vinyl gloves should be used for patient examinations and procedures. Heavy rubber gloves, also called utility gloves, should preferably be used for cleaning instruments and environmental surfaces. Dentists should be aware that allergic reactions to latex gloves or the cornstarch powder in gloves have been reported in health care workers and patients. [22-23] To reduce the possibility of such reactions, nylon glove liners for use under latex, rubber or plastic gloves are available. Polyethylene gloves, also known as food-handlers' gloves, may be worn over treatment gloves to prevent contamination of objects such as drawer or light handles or charts.

Protective clothing. Gowns, aprons, lab coats, clinic jackets or similar outer garments, either reusable or disposable, must be worn when clothing or skin is likely to be exposed to body fluids. Professional judgment should be used to determine the degree of exposure anticipated in a given procedure. Protective clothing should be changed when visibly soiled or penetrated by fluids. OSHA requires that these garments not be worn outside the work area and that protective attire be removed and placed in laundry bags or containers that are properly marked after use. Contaminated articles should be laundered using a normal laundry cycle. [13]

Masks. Surgical masks or chin-length plastic face shields must be worn to protect the face, the oral mucosa and the nasal mucosa when spatter of body fluids is anticipated. Masks should be changed when visibly soiled or wet. Face shields should be cleaned when necessary.

Protective eyewear. Protective eyewear in combination with a mask must be worn to protect the eyes when spatter and splash of body fluids are anticipated and a face shield is not chosen. The OSHA Standard specifies that protective eyewear be fitted with solid side shields. [16] Eyewear should be cleaned as necessary.

Limiting contamination. Three principal means of limiting contamination by droplets and spatter are the use of high-volume evacuation, proper patient positioning and rubber dams. Dental personnel should also limit contamination by avoiding contact with objects such as charts, telephones and cabinets during patient treatment procedures. A second pair of disposable gloves, such as food-handlers' gloves, or a sheet of plastic wrap or foil may be used over gloves when it is necessary to prevent contamination of these objects.

Hands. *Hand washing.* Hands must always be washed at the start of each day, before gloving, after removal of gloves and after touching inanimate objects likely to be contaminated by body fluids from patients. For many routine dental procedures, such as examinations and nonsurgical procedures, hand washing with plain soap appears to be adequate, since soap and water will remove transient microorganisms acquired directly or indirectly from patient contact. For surgical procedures, an antimicrobial surgical handscrub should be used. [9] Hand washing facilities should be designed to avoid cross-contamination at the scrub sink from water valve handles and soap dispensers.

Care of hands. Precautions should be taken to avoid hand injuries during procedures. If an injury such as a needlestick occurs or gloves are torn, cut or punctured, gloves

should be removed as soon as is compatible with the patient's safety. Hands should be washed thoroughly and regloved before completing the dental procedure.

Handling of sharp instruments and needles. Needles, scalpel blades and other sharp instruments should be handled carefully to prevent injuries. Syringe needles may be recapped after they are used. If a patient requires multiple injections over time from a single syringe, then the needle should be recapped between each use to avoid the possibility of a needlestick injury. Needles can be safely recapped by placing the cap in a special holder, by using a forceps or other appropriate instrument to grasp the cap or by simply laying the cap on the instrument tray and then guiding the needle into the cap until the cap can be completely seated. Therefore, when recapping, the cap must not be held in the operator's hand, as this poses a great risk of needlestick injury.
Disposable needles should not be bent or broken after use. Needles should not be removed manually from disposable syringes or otherwise handled manually. Forceps or other appropriate instruments may be used to handle sharp items. Disposable syringes, needles, scalpel blades and other sharp items should be discarded into puncture-resistant biohazard (sharps) containers that are easily accessible.

Sterilization and disinfection. Sterilization is the process by which all forms of microorganisms -- including viruses, bacteria, fungi and spores -- are destroyed. Suitable methods of sterilization include the use of steam under pressure (autoclave), dry heat, chemical vapor and ethylene oxide gas (only for instruments that can be thoroughly cleaned and dried). Immersion in a cold chemical sterilant solution instead of the use of physical means of sterilization is not recommended for several reasons:

- sterilization by chemical solutions cannot be monitored biologically;
- instruments sterilized by chemical solutions must be handled aseptically, rinsed in sterile water and dried with sterile towels;
- instruments sterilized by chemical solutions are not wrapped and, therefore, must be used immediately or stored in a sterile container.

Disinfection is generally less lethal to pathogenic organisms than sterilization. The disinfection process leads to a reduction in the level of microbial contamination and covers, depending on the disinfectant used and treatment time, a broad range of activity that may extend from sterility at one extreme to a minimal reduction in microbial contamination at the other. [24]
Disinfection may be accomplished by using a chemical disinfectant according to the directions on the product label. When chemical solutions are used for disinfection, manufacturers' instructions must be followed carefully. Particular attention should be given to dilution requirements (if any), contact time, temperature requirements, antimicrobial activity spectrum and reuse life. A chemical agent for disinfection (other than sodium hypochlorite) in the dental setting must be registered by the Environmental Protection Agency (EPA) as a hospital disinfectant, and must be tuberculocidal. Virucidal efficacy must include, as a minimum, both lipophilic and hydrophilic viruses. Table 1 summarizes appropriate sterilization and disinfection methods for dental instruments, materials and other commonly used items. Consideration should be given to the effect of sterilization or disinfection on materials and instruments. The use of a rust-inhibitor solution on instruments prior to autoclaving can be helpful in avoiding

corrosion problems. Manufacturers should be consulted on appropriate sterilization or disinfection of specific products.

Instruments and equipment. Surgical and other instruments that normally penetrate soft tissue or bone (for example, forceps, scalpels, bone chisels, scalers and surgical burs) must be sterilized after each use or discarded. Instruments that are not intended to penetrate oral soft tissues or bone (such as amalgam condensers and plastic instruments) but that may come into contact with oral tissues should also be sterilized after each use. If, however, sterilization is not feasible because the instrument will be damaged by heat, the instrument should either be discarded or immersed for six to 10 hours in an EPA-registered chemical sterilant according to manufacturers' instructions. If instruments are to be stored after sterilization, they should be wrapped or bagged before sterilizing, using a suitable wrap material such as muslin, clear pouches or paper as recommended by the manufacturer of the sterilizer. The wrap or bag should be sealed with appropriate tape. Pins, staples or paper clips should not be used, as these make holes in the wrap that permit entry of microorganisms. After sterilization, the instruments should be stored in the sealed packages until they are used. Process indicators should be used with each load. Biologi-cal monitors should be used routinely to verify the adequacy of sterilization cycles. Weekly verification should be adequate for most dental practices. [6] [15] [25]
Instruments and equipment that come in contact with intact skin, that may be exposed to spatter or spray of body fluids or that may have been touched by contaminated hands (such as physical measurement devices and amalgamators) should be disinfected. Instruments and equipment intended for sterilization or disinfection procedures must first be carefully prepared. Patient debris and body fluids must be removed from the instruments and surfaces before sterilization or disinfection. This can be done by scrubbing the instruments with hot water and soap or detergent or by using a device such as an ultrasonic cleaner with an appropriate cleaning solution. Dental personnel responsible for handling instruments should wear heavy-duty utility gloves to prevent hand injuries. After cleaning, the instruments should be dried before being wrapped or packaged.

Handpieces. Although no documented cases of disease transmission have been associated with high-speed dental handpieces, low-speed handpiece components used intraorally or prophy angles, sterilization between patients with acceptable methods that ensure internal as well as external sterility is recommended. Acceptable sterilization methods include steam under pressure (autoclave), dry heat or chemical vapor. Ethylene oxide sterilization is not recommended for high-speed dental handpieces, low-speed handpiece components used intraorally or prophy angles. Disposable prophy angles are avail-able and are to be discarded after one-time use.
The manufacturer's instructions must be followed for proper sterilization of handpieces and prophy angles and for the use and maintenance of waterlines and check valves. The first step, before sterilization, is to flush the handpiece with water by running it for 20 to 30 seconds, discharging the water into a sink or container. An ultrasonic cleaner should be used to remove any adherent material, but only if recommended by the handpiece manufacturer. Otherwise, the handpiece should be scrubbed thoroughly with a detergent and hot water. Many manufacturers recommend spraying a cleaner/lubricant into the assembled handpiece before and after sterilization. If in doubt

as to whether a handpiece can be sterilized, contact the manufacturer. Some manufacturers will replace the handpiece components that cannot be sterilized, making the handpiece sterilizable. This is often automatically done when a handpiece is serviced.

Air/water syringes and ultrasonic scalers. Units should be flushed as described for handpieces. These attachments should be sterilized in the same manner as the handpieces, or in accordance with manufacturers' instructions. It is recommended that removable or disposable tips used only one time for one patient be used for these instruments.

X-ray equipment and films. Protective coverings or disinfectants should be used to prevent microbial contamination of position-indicating devices. Intraorally contaminated film packets should be handled in a manner to prevent cross-contamination. Contaminated packets should be opened in the darkroom, using disposable gloves. The films should be dropped out of the packets without touching the films. The contaminated packets should be accumulated in a disposable towel. After all packets have been opened, they should be discarded and the gloves removed. The films can then be processed without contaminating darkroom equipment with microorganisms from the patient. [26] Alternatively, film packets can be placed in protective pouches before use. The uncontaminated packets can then be dropped out of the pouches before processing.

Operatory surfaces. Countertops and dental equipment surfaces such as light handles, X-ray unit heads, amalgamators, cabinet and drawer pulls, tray tables and chair switches are likely to become contaminated with potentially infectious materials during treatment procedures. These surfaces can be either covered or disinfected. Surfaces can be covered with plastic wrap, aluminum foil or impervious-backed absorbent paper. These protective coverings should be changed between patients and when contaminated.
Alternatively, surfaces can be pre-cleaned to remove extraneous organic matter and then disinfected with an EPA-registered disinfectant that is tuberculocidal following manufacturers' instructions. These include certain combination synthetic phenolics and iodophors, phenolic-alcohol combinations and chlorine compounds. A solution of sodium hypochlorite (household bleach) prepared fresh daily is an effective germicide. Concentrations of sodium hypochlorite ranging from 5,000 to 500 parts per million, achieved by diluting household bleach in a ratio ranging from 1:10 to 1:100, is effective, depending on the amount of organic matter (blood and mucus) present on the surface to be cleaned and disinfected. Sodium hypochlorite should be used with caution because it is corrosive to some metals, especially aluminum. Corrosiveness is less of a problem with some commercial disinfectants. Glutaraldehydes of 2 and 3.2 percent strength are not suitable for this purpose. Surfaces should be disinfected between patients, and when they are visibly contaminated by splashes of body fluids.
Housekeeping surfaces, including floors, sinks and related objects, are not likely to be associated with the transmission of infection. Therefore, extraordinary attempts to disinfect these surfaces are not necessary. However, the removal of visible soil and cleaning should be undertaken on a routine basis. Cleaners with germicidal activity may be used.

Impressions, prostheses, casts, wax rims, jaw relation records. Items such as impressions, jaw relation records, casts, prosthetic restorations and devices that have been in the patient's mouth should be properly disinfected prior to shipment to a dental laboratory (Table 2). Disinfected impressions that are sent to the dental laboratory should be labeled as such in order to prevent duplication of the disinfection protocol.

Table 2. Disinfection of Prostheses, Casts, Wax Rims and Jaw Relation Records

Material	Method
Stone Casts	Spray or immerse in hypochlorite or iodophor
Fixed (Metal/Porcelain)	Immerse in glutaraldehyde
Removable Dentures	Immerse in iodophors or chlorine compounds (Acrylic/Porcelain)
Removable Partials	Immerse in iodophors or chlorine compounds (Metal/Acrylic)
Wax Rims/Bites	Spray, wipe, spray with iodophors

Impressions must be rinsed to remove saliva, blood and debris and then disinfected. Impressions can be disinfected by immersion in any compatible disinfecting product. Since the compatibility of an impression material with a disinfectant varies, manufacturers' recommendations for proper disinfection should be followed. [27] The use of disinfectants requiring times of no more than 30 minutes for disinfection is recommended.

Disposal of waste materials. Disposable materials such as gloves, masks, wipes, paper drapes and surface covers that are contaminated with body fluids should be carefully handled with gloves and discarded in sturdy, impervious plastic bags to minimize human contact. Blood, disinfectants and sterilants may be carefully poured into a drain connected to a sanitary sewer system. Care should be taken to ensure compliance with applicable local regulations. It is recommended that drains be flushed or purged each night to reduce bacteria accumulation and growth. Sharp items, such as needles and scalpel blades, should be placed in puncture-resistant containers marked with the biohazard label. Human tissue may be handled in the same manner as sharp items, but should not be placed in the same container. Regulated medical waste (sharps and tissues, for example) should be disposed of according to the requirements established by local or state environmental regulatory agencies.

Practices for the dental laboratory

Dental laboratories should institute appropriate infection control programs. [28] Such programs should be coordinated with the dental office.

Receiving area. A receiving area should be established separate from the production area. Countertops and work surfaces should be cleaned and then disinfected daily with an appropriate surface disinfectant used according to the manufacturer's directions.

Incoming cases. Unless the laboratory employee knows that the case has been disinfected by the dental office, all cases should be disinfected as they are received.

Containers should be sterilized or disinfected after each use. Packing materials should be discarded to avoid cross contamination.

Disposal of waste materials. Solid waste that is soaked or saturated with body fluids should be placed in sealed, sturdy impervious bags. The bag should be disposed of following regulations established by local or state environmental agencies.

Production area. Persons working in the production area should wear a clean uniform or laboratory coat, a face mask, protective eyewear and disposable gloves. Work surfaces and equipment should be kept free of debris and disinfected daily. Any instruments, attachments and materials to be used with new prostheses or appliances should be maintained separately from those to be used with prostheses or appliances that have already been inserted in the mouth. Ragwheels can be washed and autoclaved after each case. Brushes and other equipment should be disinfected at least daily. A small amount of pumice should be dispensed in small disposable containers for individual use on each case. The excess should be discarded. A liquid disinfectant (1:20 sodium hypochlorite solution) can serve as a mixing medium for pumice. [29] Adding three parts green soap to the disinfectant solution will keep the pumice suspended.

Outgoing cases. Each case should be disinfected before it is returned to the dental office. Dentists should be informed about infection control procedures that are used in the dental laboratory.

Office Safety & Asepsis Procedures Research Foundation

September, 1997

Infection Control in Dentistry Guidelines

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Office Safety & Asepsis Procedures Research Foundation
Infection Control In Dentistry Guidelines

September, 1997

These infection control guidelines include appropriate procedures to protect dental patients as well as all dental health care workers (DHCW) whether employers or employees from occupational transmission of infectious diseases (including but not limited to bloodborne pathogens) in the dental office.

1. Universal Precautions

Universal precautions as defined by the Centers for Disease Control and Prevention (CDC) must be used in all patient care in dentistry. This term refers to a set of precautions designed to prevent transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other bloodborne pathogens in health care settings. Under universal precautions, blood and saliva (in dentistry) of all patients are considered potentially infectious for HIV, HBV, and other bloodborne pathogens. Applied universal precautions means that the same infection control procedures for any given dental procedure must be used for all patients. Thus, the required infection control policies and procedures to be used for any given dental procedure are determined by the characteristics of the procedure. Therefore, universal precautions are procedure specific, not patient specific.

Universal precautions do not preclude the use of additional infection control procedures to protect a patient who is so severely medically compromised that these additional precautions are needed to provide for safe treatment of that patient. Patients with active *Mycobacterium* tuberculosis are an example of when infection control procedures beyond universal precautions may be required. Please refer to Section 13 and Appendix A of these Guidelines for information on tuberculosis.

2. Hepatitis B Immunization

All DHCWs who have direct or indirect contact with patients' blood and/or saliva should be immunized with hepatitis B vaccine or show serological evidence of immunity (anti-HBs) to hepatitis B virus infection. The US Occupational Safety & Health Administration (OSHA) requires that the hepatitis B vaccine must be offered to employees at no charge within 10 days of employment. Those who receive the vaccine series should be serologically tested six weeks-six months after the third injection to determine if they have developed immunity. (This testing is not "required" by current OSHA regulations.) Those who have not developed immunity should be serologically evaluated to determine past exposure to HBV or possible need for additional hepatitis B immunizations. For adults and children with normal immune status, the antibody response to properly administered vaccine is excellent, and protection lasts for at least 10 years. Booster doses of vaccine are not routinely recommended, nor is routine serologic testing to assess antibody levels in vaccine recipients necessary during this period unless a person has a documented percutaneous, mucous membrane, or non-intact skin exposure to blood and/or saliva. In these exposure incidents, the latest CDC guidelines should be followed to assess and manage the exposure.

3. Percutaneous Injuries

Percutaneous and permucosal exposure to the blood and other body fluids of dental patients poses the single greatest risk of transmission of HIV, hepatitis B, C and D, and other bloodborne diseases from patient to DHCW. Emphasis should be placed on prevention of these incidents by assessing safer devices and work practices. Review of the dental literature is also useful in determining which practices may be associated with dental exposure incidents.

In spite of efforts to prevent such injuries, every dental practice safety program should include preparation for response to these incidents. Post-exposure management as required by OSHA includes gathering information related to the exposure, offering medical follow-up to the exposed worker, and requesting that the source patient be tested for HIV and hepatitis B and C. It is imperative that the post-exposure management program be in place before an incident occurs. Delay in referral to a qualified medical practitioner in assessing the injury may affect the availability of prophylactic medications that can now be offered to exposed health care workers.

4. Mouth Rinses

A pre-procedure mouth rinse should be used to reduce the number of microbes in the patient's mouth. The mouth rinse should have residual activity to help maintain reduced microbial levels throughout the appointment.

5. Handwashing and Hand Care

The skin of DHCWs' hands harbor resident and transient microorganisms. Most *resident* microorganisms found in the superficial layers of the skin are not highly virulent, but may be responsible for some skin infections. DHCW contact with infected patients is a source of *transient* microorganisms on DHCWs' hands. *Transient* microorganisms pose the greatest risk of cross-infection. Adequate handwashing will remove or inhibit both transient and resident organisms.

DHCWs should wash hands before donning gloves, upon removal of gloves, and after inadvertent barehanded touching of contaminated surfaces or objects.

For most routine procedures, washing with plain soap appears adequate. Use antimicrobial soap for more invasive procedures, such as surgery. For all handwashing, convenient placement of sinks, towels, and soaps will encourage use by workers. When possible, use alternative sink controls such as foot or sensor-activated faucets. Vigorously rubbing lathered hands together under a stream of water for a minimum of ten seconds is adequate for routine handwashing. Thorough rinsing under a stream of water should follow this. Dry hands well before donning gloves. DHCWs with open sores or weeping dermatitis must refrain from direct patient contact and handling of patient care equipment until the condition is resolved.

6. Personal Protective Equipment (PPE)

DHCWs must wear protective attire such as eye wear or a chin-length shield, disposable gloves, a disposable surgical quality mask, and protective clothing when performing procedures capable of causing splash, spatter, or other contact with body fluids, and/or mucous membranes. Protective attire must also be worn when touching items or surfaces that may be contaminated with these fluids, and during other activities that pose a risk of exposure to blood, saliva or tissue.

Gloves are single use items and must not be reused. Single use gloves may not be washed, disinfected or sterilized. They may be rinsed with water only to remove excess powder. Torn or compromised gloves must be replaced immediately. Latex, vinyl or other disposable medical quality gloves may be used for patient exams and procedures. Plastic or foodhandlers' gloves may be worn over contaminated treatment gloves (overgloving) to prevent contamination of clean objects handled during treatment. These overgloves may never be used alone as a hand barrier, or for intraoral patient care procedures. Overgloves must be handled carefully to avoid contamination during handling with contaminated procedure gloves. If overgloves are not used, contaminated procedure gloves should be removed before leaving chairside during patient care and replaced with new gloves upon returning to patient care. Hands must be washed after glove removal and before re-gloving.

Surgical masks that have at least 95% filtration efficiency for particles 3-5 micron in diameter must be worn whenever splash or spatter is anticipated. Masks should be changed for every patient or more often, particularly if heavy spatter is generated during treatment. Some literature suggests masks should be worn a maximum of 20 minutes in areas of high humidity, and a maximum of 60 minutes in dry climates. Masks should be handled by touching the periphery only, avoiding handling of the body of the mask. Masks should not contact the mouth while being worn as the moisture generated will decrease the mask filtration efficiency. A mask should be selected that conforms well to the shape of the face. A faceshield does not substitute for a surgical mask.

Protective eyewear must have solid side-shields and be decontaminated by immersion in a cleaning agent between patients. A faceshield may substitute for protective eye wear. If protective eyewear or a faceshield is used to protect against damage from solid projectiles, the protective eyewear should meet American National Standards Institute (ANSI) Occupational and Educational Eye and Face Protection Standard (Z87.1-1989) and be clearly marked as such.

Protective clothing must have a high neck and protect the arms if splash and spatter are reasonably anticipated. Cotton or cotton/polyester or disposable clinic jackets or lab coats are usually satisfactory attire for routine dental procedures. The type and characteristics of protective clothing depend on the type of exposure anticipated. Gowns or jackets worn as protective attire should be changed at least daily, or more often if visibly soiled. Protective gowns or covers must be removed before leaving the work area. Protective attire may not be taken home and washed by employees. It may be laundered in the office if equipment is available and universal precautions are followed for handling and laundering contaminated attire. Contaminated linens transported away from the office for laundering should be in appropriate bags to prevent leaking, with a biohazard label or appropriately color-coded, unless the laundry facility employees practice universal precautions in the handling of all laundry. Disposable gowns may be used but must be discarded daily, or more often if visibly soiled.

Utility gloves that are puncture-resistant, a mask, protective clothing and protective eyewear must be worn when handling and cleaning contaminated instruments, when performing operatory cleanup, and for surface cleaning and disinfecting. Utility gloves must be discarded if their barrier properties become compromised. Utility gloves, protective eye wear or face shields, and masks must be worn when mixing and/or using chemical sterilants or disinfectants. Used utility gloves must be considered contaminated and handled appropriately until properly disinfected or sterilized.

NOTE: Along with the increased use of latex gloves for infection control purposes has been an increased incidence of latex allergies and other sensitivities. Certain individuals are considered to be at an increased risk of latex sensitivity. These individuals include persons who have had multiple surgeries (especially involving the placement of rubber tubes or drains), spina bifida patients, health care workers, and individuals with other documented allergies. Medical histories should include questions which may alert the DHCW that a patient is latex-sensitive. If a person is found to be sensitive to latex, precautions such as non-latex gloves, non-latex rubber dams, and avoidance of any other latex-containing products should be implemented in the treatment of those patients. Latex-sensitive patients should also be scheduled at the beginning of the day to minimize exposure to latex residue and powder.

DHCWs who experience symptoms consistent with sensitivity including skin rash, itching, or wheezing should seek the advice of a qualified medical professional for diagnosis of the symptoms. Because a variety of materials may be responsible for the sensitivity, including resin materials which may permeate the gloves, self-diagnosis is ill-advised and could increase the risk of a serious allergic response.

7. Instrument Sterilization

Puncture-resistant utility gloves, a mask, protective eyewear, and a protective gown or apron must be worn throughout instrument processing.

Single use disposable items must be disposed after each use. All reusable items that come in contact with the patient's blood, saliva or mucous membranes must be sterilized in an autoclave,

unsaturated chemical vapor sterilizer, dry heat sterilizer (must be FDA-cleared for use as a medical device), or ethylene oxide gas sterilizer before reuse. Ethylene oxide is inappropriate for use with lubricated items such as handpieces, due to failure of the gas to penetrate lubricants.

Sterilization by immersion in a chemical sterilant which has been FDA-cleared for use as a sterilizing agent is only appropriate for those items which may be damaged by the sterilization methods referred to in the paragraph above. Use the concentration, contact time, and temperature stated on the product label to achieve chemical sterilization. The solution should be routinely checked during use with a glutaraldehyde indicator to assure a minimum effective glutaraldehyde concentration. Note that glutaraldehyde cannot be biologically monitored to verify sterilization, nor can items be packaged prior to chemical sterilization.

The procedure for processing reusable instruments begins at chairside. It is important to keep instruments moist to facilitate cleaning. Therefore, if instruments are not immediately processed, they should be placed in a "holding" solution (soapy water or a commercially available surfactant solution) to prevent the drying of blood and debris. All items must be properly cleaned in an ultrasonic cleaning unit or instrument washer. Only cleaners intended for use in an ultrasonic cleaner or instrument washer should be used. Chemical germicides are inappropriate for use with these devices. Hand scrubbing of sharp instruments should be avoided. However, if hand scrubbing or cleaning is required, use a clean long-handled brush and keep instruments submerged while scrubbing to reduce spatter. Brushes should be disposable or autoclavable. Care must be taken to avoid injuries with hand (brush) scrubbing. Instruments must be dry if ethylene oxide gas, dry heat, or unsaturated chemical vapor sterilizers are used. Instruments must be packaged (using proper pouches, bags or wrapped cassettes or packs) before steam, chemical vapor, dry heat or gas sterilization and remain packaged for storage to protect the items from environmental contamination after sterilization. Mark packages with date and sterilizer number for tracking purposes. Note: Do not write with ink directly on paper (wrap or pouches). Autoclave tape, bar code stickers, or writing on plastic side of pouches is acceptable.

8. Handpiece Sterilization

All high-speed handpieces, nose cones, contra-angles, low-speed motors, motor-to-angle adapters and prophylaxis angles (unless disposable prophylaxis angles are used) must be heat sterilized between patients. The cleaning, sterilization and maintenance procedures described by the handpiece manufacturer must be meticulously followed to ensure proper sterilization and maximum longevity from the handpiece.

After patient treatment, flush the water/air lines for 20-30 seconds with the high speed handpieces still attached. Remove the handpieces and thoroughly clean the external/internal surfaces as directed. Package before sterilization, and process through the sterilizer according to the sterilizer and handpiece manufacturers' instructions. If lubrication is indicated by the handpiece manufacturer either before or after sterilization, follow the procedures as outlined by the manufacturer. It is recommended that a separate container of lubricant be reserved for this purpose as a cross-contamination avoidance strategy.

9. Sterilization Monitoring

The use and functioning of heat sterilizers should be biologically monitored at least weekly, or more often if the practice demands it, with appropriate spore tests. Place the spore strips or vials inside a pouch, bag, pack or cassette, and include this package as part of the normal load through a normal sterilizer cycle. Always use a control spore strip or vial (not heat processed but otherwise treated identically to the test strips or vials) with each spore test performed. Additionally, chemical indicators should be used on the inside of each package during every sterilizer load. Accurate records of sterilization monitoring must be maintained. A chemical indicator from inside each pack may be initialed and dated for each day of patient care and kept in a file. The weekly spore test for each heat sterilization unit may be kept in the same file. Biologically monitor whenever there is a change in packaging, following equipment repair; retest after failure and when training new employees.

10. Environmental Surface and Equipment Asepsis

Current CDC Guidelines recommend that all waterlines for syringes and/or handpieces should be turned on and flushed for several minutes with handpieces disconnected at the beginning of the day and 20-30 seconds between patients. However, research has shown this protocol alone to be temporary and inadequate in controlling water contamination.

Sterile cooling and irrigating solutions must be used as an irrigant during surgical procedures. This water must be delivered from a source separate from the dental unit. Dental unit water which contains fewer than 200 CFU/ml of heterotrophic mesophilic bacteria is acceptable for use as a coolant or irrigant for all non-surgical dental procedures. Dental water delivery systems which are fitted with anti-retraction valves must be checked weekly. Alternatively, systems which provide constant positive pressure may be used. Heat sterilized or disposable air/water syringe tips and vacuum tips must be used. All vacuum lines must be flushed after every patient procedure to prevent drying of blood and debris in the lines.

To develop an effective asepsis protocol, operatory surfaces including walls, floors, cabinetry and equipment should be classified and managed under three categories: touch surfaces, transfer surfaces and splash/spatter surfaces.

(a) Touch Surfaces:
Surfaces that are usually touched and contaminated during dental procedures. Examples include dental light handles, dental unit handle and controls, headrest adjustment mechanisms, or dental chair switches.

Touch surfaces should be kept at a minimum. If a surface must or might be touched, it should be cleaned and disinfected, or covered with a barrier that is impervious to liquid. Barriers must be single-use and replaced between patients. Offices should develop a standard procedure for installing and removing barriers that will prevent cross contamination. All office staff responsible for operatory turnover between patients should be trained in this standard procedure. Contaminated barriers must be properly discarded. If a covered touch surface is compromised and becomes visibly contaminated, it should be cleaned and disinfected with an low or intermediate-level disinfectant before applying the barriers for the next patient. Touch surfaces that have been covered with barriers should be cleaned and disinfected at the end of each clinical day. Before the first patient of the next clinical day, new barriers should be installed.

(b) Transfer Surfaces:
Surfaces that are not touched, but which are usually contacted by contaminated instruments. Examples include instrument trays and dental unit handpiece holders. Asepsis for transfer surfaces is the same as for touch surfaces.

(c) Splash, Spatter and Aerosol Surfaces:
All surfaces in the operatory other than touch or transfer surfaces. Splash and spatter surfaces need not be disinfected, but should be cleaned (at least daily, or more often if possible).

11. Laboratory Asepsis

Open communication must exist between the dental office and the dental laboratory concerning infection control protocols and delineation of responsibilities between the office and lab.

Materials, impressions and intra-oral appliances must be cleaned and disinfected before being handled, adjusted, or sent to a dental lab. Personal protective equipment including gown, gloves, mask and protective eyewear should be worn.

Before selecting a disinfecting agent, consult the manufacturers of specific materials as to the stability of their material relative to disinfection agents and procedures. Then, disinfect for the specified length of time with the appropriate chemical (1:10 sodium hypochlorite solution or an EPA-registered, tuberculocidal disinfectant that also kills hydrophilic and lipophilic (enveloped and nonenveloped) viruses). Finally, rinse thoroughly. Do not transfer to laboratory in container containing disinfectant.

If items are properly disinfected before being taken into or sent out to the laboratory, then lab equipment and surfaces should not become contaminated. However, a laboratory that provides services to numerous clients may become subject to contamination from other sources. All items

returned from a commercial laboratory should be considered clean for handling but should be disinfected before placing in a patients' mouth. If laboratory equipment, surfaces and attachments become contaminated with blood or saliva, they must be thoroughly cleaned and then sterilized or disinfected before use on another case.

12. Waste Disposal

a. General

All waste must be disposed according to applicable federal, state and local regulations and recommendations. Generally, blood and /or saliva-tinged items are not regulated waste. Hard and soft tissue and soaked items, that is, blood or saliva can be squeezed out, or blood may flake from the item, are considered regulated medical waste. Always consult the state or local government agency regarding specific exemptions and disposal/treatment requirements.

b. Infectious Disease Hazard (Biohazard) Communication

Containers of regulated medical waste (as defined above) are to be labeled and/or identified in compliance with local regulations. These containers include contaminated sharps containers, contaminated reusable sharps containers (i.e., pans used for holding contaminated instruments), bags of contaminated laundry, specimen containers, and storage containers.

c. Handling and disposing sharps

Place needles and other disposable sharps, such as scalpel blades, orthodontic wires and broken glass into a puncture resistant, leak-proof container that is closable and color-coded or labeled with the biohazard symbol. The container must be located as close as possible to the point of use for immediate disposal. Do not cut, bend, break or remove needles by hand before disposal, and do not remove needles from disposable syringes.

To recap a needle on a non-disposable anesthetic syringe, lay the needle cover on a firm surface and guide the needle into the cover using only one hand; OR use one-handed resheathing with a resheathing device. Alternatively, self-sheathing needles may also be used. If the device is one that is hand-held, it must provide full hand protection for the hand holding the device. When the sharps container is 3/4 full, securely close and treat or dispose according to state and local laws.

d. Non-sharp disposable items

Non-sharp disposable items that are considered regulated waste by state or local laws must be disposed of and/or transported according to specific state and/or local regulations. At a minimum, these items must always be placed in labeled, leak-proof bags or containers. Disposable items that may contain the body fluids of patients, but are not subject to medical waste regulations, such as gloves and patient bibs, should be placed in a lined trash receptacle. Red bags should not be used for non-regulated waste. Check the specific requirements of the local regulatory agency (usually state or county health departments).

13. Tuberculosis

With the reemergence of *Mycobacterium* tuberculosis (TB) infection and active tuberculosis as demonstrated risk factors for health care workers (HCW), consult the following reference "Guidelines for Preventing the Transmission of TB in Health Care Facilities, 1994," CDC. (appendix A)

14. Training

All DHCWs involved in the direct provision of patient care should receive regular training in infection control and safety issues. Training should include coverage of OSHA's pertinent regulations such as the Bloodborne Pathogens and Hazard Communication standards.

15. Other

a. A dental dam and high volume evacuation may be used during dental procedures, when indicated, to minimize the amount of potentially contaminated splash and spatter, and to minimize direct contact with patients' oral mucosa.

b. Ventilation devices such as a one-way CPR airway (e.g., a pocket mask with a one-way valve) or oxygen with bagging capability must be available for those qualified to provide such care.

c. Eating, Drinking, Smoking

Do not eat, drink, smoke, apply cosmetics or lip balm, handle contact lenses or store food or drink in areas of possible exposure to (or storage of) blood, saliva, tissue or other potentially infectious materials. This would include the dental operatory, dental laboratory, sterilization area and darkroom/x-ray processing area.

d. Decontamination of Equipment for Servicing or Maintenance

Contaminated equipment or instruments that are to be repaired on site or shipped for service are first to be cleaned and sterilized or disinfected. If a portion of the equipment cannot be cleaned and sterilized or disinfected, that portion should be identified with a biohazard label and an explanation to those who may handle the contaminated item. Utility gloves, masks and protective eyewear must be worn when routine maintenance is performed on equipment such as replacing filters on suction pumps, etc. Infection control practices/procedures should be communicated to the repair personnel.

e. Radiographic Asepsis

Wear gloves while exposing films in the patient's mouth. Place exposed films in a paper cup. When all films are exposed, remove and discard gloves. Reglove and transport to the darkroom, carefully open the packs and drop the films on a clean surface. Discard the contaminated wrappers, remove and discard the gloves, and process the films.

(1) Daylight loader:

When using an x-ray processor with a daylight loader, extra precautions are required to avoid contamination of the sleeves, and external and internal components of the processor. Place films in a paper cup as they are exposed. When all the films have been taken, remove gloves and place the paper cup containing exposed film packets into the daylight loader. Wearing clean gloves, insert hands through the sleeves of daylight loader. Open all film packets, allowing films to drop onto a clean surface. Do not touch films with gloved hands. Once all the film packets have been opened, discard empty film wrappers, remove gloves and process films with bare hands. For disposal, empty film packets and used gloves may be placed in the paper cup that was originally used to transport films into the daylight loader. If the insides of the insertion sleeves have ever been contaminated, double gloving may be used for protection when removing hands from the daylight loader. One pair of gloves should be removed after opening film packets, leaving a clean pair of gloves for handling films and touching the sleeves of the daylight loader.

(2) Barrier Pack Films

X-ray films packaged in fluid impervious barriers are available. A slight modification of the recommended x-ray and darkroom protocol is indicated. After exposing the film, pull on the edges of the barrier pack, allowing the film to drop into a clean paper cup without contaminating the inner film packet. When all films have been exposed and collected in the cup, remove procedure gloves and take films to the darkroom or daylight loader for processing.

DISCLAIMER

The Office Safety & Asepsis Procedures (OSAP) Research Foundation Infection Control in Dentistry Guidelines updated in September, 1997 are based on the recommendations of the Centers for Disease Control and Prevention and other publications in the dental and medical literature. The guidelines here are intended to offer general guidance on infection control. OSAP assumes no responsibility for actions taken based on the information herein.

Appendix A

POLICY FOR TREATMENT OF DENTAL PATIENTS WITH ACTIVE OR SUSPECTED INFECTION WITH TUBERCULOSIS

A. During initial medical history and periodic updates ask patients about a history of TB disease and symptoms suggestive of TB. Symptoms include chronic cough, coughing blood, night sweats, and weight loss. **Note:** positive TB skin test without symptoms does not indicate **active infection** in most cases.

B. Patients with history and symptoms suggestive of active TB should be promptly referred to a physician for evaluation for possible infectiousness.

C. Elective dental treatment should be postponed until a physician confirms, using recognized diagnostic evaluations, that the patient does not have active tuberculosis.

D. If urgent dental care must be provided for a patient who has, or is suspected of having, active TB infection, TB isolation practices must be implemented. Treatment provided should be limited to the minimal necessary to relieve the patient's immediate pain. Generally, referral to a medical center with proper isolation rooms will be required. Respiratory protection (HEPA-filter masks) must be used by the dental care providers when performing procedures on these patients. The respirators must be fit tested prior to each use.

E. DHCWs with persistent cough and other symptoms suggestive of active TB should be evaluated promptly for TB. The individual should not return to work until a diagnosis of TB has been excluded or until the individual is on therapy and a determination has been made that the worker is not infectious.

from:
Centers for Disease Control and Prevention
Guidelines for Preventing the Transmission of *Mycobacterium* tuberculosis
in Health Care Facilities, 1994.

Appendix A
MMWR, June 7, 1996 Update: Provisional Public Health Service Recommendations For Chemoprophylaxis After Occupational Exposure to HIV

Table 1:

Type of exposure	Source material*	Antiretroviral prophylaxis†	Antiretroviral regimen§
Percutaneous	Blood¶		
	Highest risk	Recommend	ZDV+3TC plus IDV
	Increased risk	Recommend	ZDV+3TC±IDV**
	No increased risk	Offer	ZDV plus 3TC
	Fluid containing visible blood, other potentially infectious fluid††, or tissue	Offer	ZDV plus 3TC
	Other body fluid (e.g., urine)	Not offer	
Mucous membrane	Blood	Offer	ZDV plus 3TC
	Fluid containing visible blood, other potentially infectious fluid††, or tissue	Offer	ZDV±3TC
	Other fluid (e.g., urine)	Not offer	
Skin, increased risk§§	Blood	Offer	ZDV plus 3TC,±IDV**
	Fluid containing visible blood, other potentially infectious fluid††, or tissue	Offer	ZDV±3TC
	Other fluid (e.g., urine)	Not offer	

* Any exposure to concentrated HIV (e.g., in a research laboratory or production facility) is treated as percutaneous exposure to blood with highest risk.

† ***Recommend***-Postexposure prophylaxis (PEP) should be recommended to the exposed worker with counseling (see text).

Offer-PEP should be offered to the exposed worker with counseling (see text).

Not offer-PEP should not be offered because these are not occupational exposures to HIV (1).

§**Regimens**: zidovudine (ZDV), 200 mg three times a day; lamivudine (3TC), 150 mg two times a day; indinavir (IDV), 800 mg three times a day (if IDV is not available, saquinavir may be used, 600 mg three times a day). Prophylaxis is given for four weeks. For full prescribing information, see packet inserts.

¶***Highest risk***-BOTH larger volume of blood (e.g., deep injury with large diameter hollow needle previously in source patients vein or artery, especially involving an injection of source-patients blood) AND blood containing a high titer of HIV (e.g., source with acute retroviral illness or end-stage AIDS; viral load measurements may be considered, but its use in relationship to PEP has nor been evaluated).

Increased risk-EITHER exposure to larger volume of blood OR blood with a higher titer of HIV.

No increased risk-NEITHER exposure to larger volume of blood NOR higher titer of HIV (e.g., solid suture needle injury from source patient with asymptomatic HIV infection).

**Possible toxicity of additional drug may not be warranted. (See text).

††Includes semen; vaginal secretions; cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids.

§§For skin, risk is increased for exposures involving a high titer of HIV, prolonged contact, an extensive area, or an area in which skin integrity is visibly compromised. For skin exposures without increased risk, the risk for drug toxicity outweighs the benefit of PEP.

APPENDIX G

STUDENT SURVEY SAMPLES

Oral Health and Wellness Program Student Satisfaction Survey

Thank you for keeping your oral health and wellness appointment. Please take a few moments to evaluate your visit.

Check *yes* or *no* for the following statements.

YES	NO	STATEMENT
		The oral health and wellness team made me feel welcome when I checked in.
		I did not have to wait long to be treated.
		The oral health and wellness team members were friendly and helpful.
		The oral health and wellness team members care whether or not I keep my appointments.
		I felt comfortable asking questions.
		My questions were answered.
		I understand what was done to my mouth today.
		I know when the oral health and wellness team wants to see me again.
		I know what will be done during my next visit.
		I know what I am supposed to do at home or in my dorm to have a healthy mouth.
		I know what oral health and wellness means.
		I am glad I visited the dental suite today.
		I can explain how oral health and wellness can help me get and keep a job.

Constructive suggestions:

Thank you for taking the time to complete this survey.

JOB CORPS
Oral Health and Wellness Program Survey

Please take a few minutes and fill out this short survey to help us evaluate the quality of your Job Corps oral health and wellness program. Thank you.

1. How long have you been on center? ________________________________ __________

2. Do you know what "oral health and wellness" means?

   YES **NO** **(circle one)**

3. Have you ever visited the wellness center for oral health and wellness care?

   YES **NO** **(circle one)**

If yes, circle the services you received.					
Oral Exam	**Filling**	**Tooth Pulled Out**	**Teeth Cleaning**	**Oral Health Education**	**Other**

4. If you had a problem with your teeth or gums or mouth in general, would you make an appointment to see the dentist on center?

   YES **NO** **(circle one)**

5. Has any member of the oral health and wellness team told you how a healthy mouth can help you get and keep a job?

   YES **NO** **(circle one)**

6. Do you know what you can do to prevent problems in your mouth?

   YES **NO** **(circle one)**

7. Do you have any problems in your mouth?

   YES **NO** **(circle one)**

8. Do you like to smile?

   YES **NO** **(circle one)**

9. Do you know how to make an appointment for oral health and wellness care?

YES **NO** **(circle one)**

APPENDIX H

PROTOTYPE CENTER SUBCONTRACT
FOR CENTER DENTIST

PROTOTYPE
DENTAL PROVIDER SUBCONTRACT

This Agreement is entered into between [the center operator] and [the health care provider] for the purpose of providing dental services as set forth below for the [specific Job Corps center] operated by [the center operator], under Contract number [insert contract number] with the United States Department of Labor.

ARTICLE I: Definitions

A. "Center" as used in this agreement shall mean the [name of the specific Job Corps center], a residential/nonresidential training and education institution located at [center address].

B. "Center Director" as used in this agreement shall mean the individual duly appointed by center operator with responsibility and authority for planning, budgeting, contracting, directing, and operating the entire program at the center.

C. "Center operator" as used in this agreement shall mean the [name of the specific Job Corps center operator].

D. "Students" as used in this agreement shall mean those individuals who are enrolled in the center and entitled to services as hereinafter defined.

E. "Subcontractor" as used in this agreement shall mean [name of health care provider], whose personnel are certified and/or licensed by the state of [name of state] as required.

F. "Department of Labor" as used in this agreement shall mean the United States Department of Labor, Employment and Training Administration (ETA), Office of Job Corps or its designee.

ARTICLE II: Statement of Work/Performance

Pursuant to its contract with the Department of Labor, the center operator is obligated to provide training services and a health and wellness program to students. Therefore, the center operator hereby engages the subcontractor, and the subcontractor hereby agrees to perform services related to the foregoing health and wellness program.

Specifically, the subcontractor agrees to perform the tasks and services set forth in the statement of work that is attached to and hereby incorporated into this agreement as Attachment 1.

ARTICLE III: Staffing Requirements

Subcontractor is responsible for providing all staff necessary to fulfill the aforementioned agreement commitments. In conformity with the Policy and Requirements Handbook (PRH) staffing requirements, the minimum acceptable staff shall be [insert number] [insert dentist(s)/doctor(s)/mental health consultant(s)] for an average of [insert number] hours per week not to exceed [insert number] hours per year and [insert number] [insert additional staff] for an average of [insert number] hours per week not to exceed [insert number] hours per year.

The Center Director shall have the right to request removal and replacement of any staff assigned by the subcontractor as set forth herein. Subcontractor agrees to comply with any such request and the staff member may be replaced by the subcontractor as soon as practical at no cost to the center. "Staff" for the purpose of this article shall mean and include professional and nonprofessional employees of the subcontractor.

The subcontractor shall identify one health professional to assume the responsibilities of the center [insert dentist/physician/mental health consultant]. In addition to the direct health services that shall be provided at the center, the center [insert dentist/physician/mental health consultant] shall oversee the development, implementation, and monitoring of the total center [insert oral, mental, or medical] health and wellness program, which is subject to the approval of the Center Director.

ARTICLE IV: Period of Performance

The parties mutually agree that this agreement shall be in effect from [beginning date of subcontract] through [ending date of subcontract] unless sooner terminated as hereinafter provided. The contract may be extended by [number of] 1-year options. The total duration of this contract will not exceed [number of] years.

ARTICLE V: Compensation/Payment/Limitation

A. Compensation

Remuneration for services rendered will be at the rate of [$____________] dollars per hour for ________________ total hours or ______________hours per week on average.

B. Payment

Payment shall be made within [insert number] days of receipt by the center operator of an acceptable invoice.

C. Limitation

Notwithstanding any other provision in this agreement, the maximum liability of the center operator under this agreement shall not exceed the total amount of [insert dollar amount].

ARTICLE VI: Indemnification and Insurance

The subcontractor does hereby agree to indemnify and hold harmless the center operator; the center; the Department of Labor and their officers, agents, and employees from any claim, action, lawsuit or liability for injury or damage to any person or property arising out of performance of this agreement. The subcontractor is required to maintain a current professional liability policy with a limit of at least [insert dollar figure] per occurrence.

ARTICLE VII: Independent Contractor

This agreement is not intended by the parties to constitute or create a joint venture, partnership, formal business organization of any kind, or employer/employee relationship between the parties, and the rights and obligations of all parties shall be only those expressly set forth herein. Neither party shall have authority to bind the other except to the extent authorized herein. The parties to this agreement shall remain as independent contractors at all times, and neither party shall act as the agent for the other.

Subcontractor shall secure and keep current, at its own expense, all licenses and other certifications required by law or otherwise necessary to fulfill the statement of work. Subcontractor shall be solely and exclusively liable to third parties for all costs incurred by the subcontractor and for all claims of damage against the subcontractor arising out of or based on subcontractor's performance of this agreement, and is responsible for maintaining proper insurance, at the subcontractor's sole expense, to cover any and all such contingencies. Subcontractor shall also assume full responsibility for payment of any and all federal, state, and local taxes or contributions imposed or required under unemployment insurance, social security, and income tax laws, with respect to subcontractor's performance under this agreement.

ARTICLE VIII: Termination of Agreement

This agreement may be terminated by the center operator, Department of Labor, or subcontractor upon [number] days written notice. The notice shall be effective on the same date as duly posted in the United States mail, certified, addressed and postage paid. The notice shall be sent to the center operator at [address], with copies to:

ATTN: Program Manager
U.S. Department of Labor
ETA/Office of Job Corps
[Regional Office address]

To Subcontractor: [Insert name and address of subcontractor]

The center operator also reserves the right to terminate this agreement, in whole or in part, with or without notice, if requested by the Department of Labor.

ARTICLE IX: General Provisions

The parties agree that the following provisions are applicable to this agreement:

A. That the subcontractor agrees to perform its services in accordance with professional standards and policies, procedures, and guidelines as may be established, from time to time, by the Department of Labor and/or the center operator. The subcontractor further agrees and acknowledges that the Department of Labor and the center operator reserve the right to change, modify, alter, and revoke the said polices, procedures, and guidelines.

B. That no services under this agreement shall be delegated or subcontracted without the express written permission of the center operator.

C. That the center operator may at any time, by written order, make reasonable requests for amendments and additions, within the general scope of this agreement, in the definition of services and tasks to be performed, the time, and the place of performance thereof.

D. That the subcontractor shall maintain confidential health records on each student. These records shall be maintained in accordance with all Department of Labor and Job Corps standards and shall be the property of the Department of Labor.

E. That the subcontractor shall make no public statements with respect to this agreement or its work thereunder and shall issue no public statements or advertising or conduct research related thereto without the prior written approval of the Center Director and the Department of Labor.

F. That the subcontractor shall provide the center operator with current copies of professional licenses and insurance certificates.

G. That it is understood and agreed that the services provided by subcontractor are subject to monitoring and review by the Department of Labor.

H. That this agreement is subject to the terms and conditions of the center operators' prime contract and certain provisions contained therein may be applicable to subcontractor. It is hereby understood and agreed that the provisions set forth in Attachment 2, if any, are hereby incorporated into this agreement by reference and shall have the same force and effect as though set out in full text herein.

I. The agreement shall be construed and enforced in accordance with the laws of the state of [insert name of state in which center resides].

J. If any term or provision of this agreement is held to be illegal, invalid, void, and/or unenforceable, for any reason, such term or provision shall be fully severable; this agreement shall be construed and enforced as if such illegal, invalid, void, and/or unenforceable term or provision had never comprised a part of this agreement; and the remaining terms and provisions of this agreement shall remain in full force and effect.

K. This agreement can only be modified in writing executed by each of the parties or their authorized agents.

L. This writing is intended by the parties to be the final expression of their agreement and is a complete and exclusive statement of its terms, and all communications, negotiations, considerations, and representations, whether written or oral, between the parties with respect to the subject matter of this agreement are incorporated. Other than as specifically set forth in this agreement, no representations, understandings, and/or agreements have been made or relied upon in the making of this agreement.

This agreement was executed by the parties hereto this [insert day] day of [insert month], [insert year].

APPROVED*

______________________________	______________________________
Authorized Official (Signature)	Subcontractor (Signature)
______________________________	______________________________
(Name Printed)	(Name Printed)
______________________________	______________________________
Title	Date

*This subcontract should be signed by the appropriate authorized official of the center operator in accordance with the terms of the basic center contract or interagency agreement.

Attachment 1

STATEMENT OF WORK

(Oral Health Services)

Subcontractor shall provide adequate licensed personnel to perform dental services for students, including but not limited to:

1. Providing a mandated oral examination and the development of an oral health and wellness plan between the 45th and 75th day after the student's arrival at the center.

2. Providing a written diagnosis and treatment plan as part of an oral health and wellness plan for each student and obtaining agreement for voluntary care before proceeding with treatment.

3. Establishing treatment according to priority classification and within program constraints.

4. Providing basic dental care, as defined by the Job Corps PRH.

5. Providing oral health education.

6. Establishing an appropriate referral system to ensure the receipt of specialty care as defined in the PRH and within budget constraints.

7. Providing or arranging for 24-hour emergency coverage.

8. Participating in the coordination and integration of the oral health program with the wellness components, center activities, and center-community activities.

9. Maintaining the accuracy and confidentiality of all required oral health and wellness records when they are in the subcontractor's presence.

10. Providing support to the students in acquiring the oral health-related skills, knowledge, and attitudes that will make them employable.

11. Promoting opportunities for the students to practice the skills that will help make them employable.

12. Developing and complying with Job Corps infection control policies and procedures.

13. Reviewing and signing standing orders annually for dental care in accordance with the Technical Assistance Guide on Standing Orders.

14. Enforcing appropriate student workplace behavior when students are in the dental office or waiting area.

15. Arranging appropriate medical separations in conformity with the PRH.

16. Collecting data and preparing reports as required by the Center Director and/or the Department of Labor.

17. Advising/consulting as requested with the Center Director and center staff on oral health and dental programmatic issues.

18. Cooperating with corporate and Regional Office center assessments.

19. Ensuring that regular preventive maintenance is provided to the dental equipment.

Attachment 2.

INCORPORATED CLAUSES

The following contract clauses are hereby incorporated by reference:

APPENDIX I

PROCEDURES FOR REPORTING PRODUCTIVITY INDICATORS

Procedures for Reporting Productivity Indicators
(Oral Health and Wellness Program)

Center Name:						**Month:**			**Year:**	
Date of month	Working hours- oral exams	Working hours- other DDS visits	Working hours- RDH visits	# of DDS appts made (exams and other visits)	# of oral exams completed	# of other DDS visits kept	# of RDH appts made	# of RDH appts kept	# of non-DDS/ non-RDH visits	# of emergency/ walk-in DDS visits
1										
2										
3										
4										
5										
6										
7										
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28										
29										
30										
31										
Total										

(Definitions and Calculations attached)

DEFINITIONS

DDS = Dentist

RDH = Dental Hygienist

Working hours–oral examinations
Actual time spent (in hours) by the dentist on mandatory oral (and recall) examinations.

Working hours–other DDS visits
Actual time spent (in hours) by the dentist providing care during appointments and on an emergency/walk-in basis. This does not include time spent by the dentist on chairside activities or oral examinations.

Working hours–RDH visits
Actual time spent (in hours) by the dental hygienist on dental hygiene procedures and oral health education at the chairside.

# of DDS appointments made (examinations and other DDS visits)
Total number of scheduled appointments made by students for oral examinations and dental procedures administered by the dentists. This does not include emergencies or referrals.

# of oral examinations completed
Total number of visits kept by students for mandatory oral and recalls examinations.

# of other DDS visits kept
Total number of student visits kept by the dentist for dental procedures.

# of RDH appointments made
Total number of scheduled appointments made by students for the dental hygienist.

# of RDH appointments kept
Total number of scheduled appointments kept by students for the dental hygienist.

# of non-DDS/non-RDH visits
Total number of scheduled or unscheduled visits to the dental assistant for X-rays (when the oral examination appointment is on another day), oral health education/instruction, or cursory oral examinations.

# of emergency/walk-in DDS visits
Total number of unscheduled visits by students for evaluation, consultation, or treatment.

PRODUCTIVITY CALCULATIONS

1. Oral examinations meet the productivity standard if the dentist treats 3 students per hour on the average.

   Oral Exam Productivity = $\dfrac{\text{\# of mandatory oral exams completed}}{\text{Working hours–mandatory oral exams}}$

2. Other DDS visits meet the productivity standard if the dentist treats 1.5 students per hour on the average.

   Other DDS Visit Productivity = $\dfrac{\text{\# of other DDS visits kept}}{\text{Working hours–other DDS visits}}$

3. Dental hygiene visits meet the productivity standard if the dental hygienist treats 1 student per hour on the average (assuming the dental hygienist does not have the benefit of a dental assistant).

   RDH Visit Productivity = $\dfrac{\text{\# of RDH appointments kept}}{\text{Working hours–RDH visits}}$

4. The oral health program meets overall productivity standard if the dentist's and dental hygienist's broken appointment rate is no greater than 15 percent. At least 20 percent of the onboard strength should be scheduled for appointments to manage backlog.

   DDS Broken Appointment Rate =

   $$\frac{\text{(\# of DDS appointments made)} - [\text{(\# of oral exams completed)} + \text{(\# of other DDS visits kept)}]}{\text{\# of DDS appointments made}}$$

   RDH Broken Appointment Rate = $\dfrac{\text{(\# of RDH appointments made)} - \text{(\# of RDH appointments kept)}}{\text{\# of RDH appointments made}}$

   When there is a dental hygienist, follow steps (a) to (c) below to calculate the overall oral health program broken appointment rate.

   Weight the dentist and dental hygienist contribution to the broken appointment rate.

   a) RDH Weight = $\dfrac{\text{(RDH working hours per week)}}{\text{(\# dental hygienist hours per week)} + \text{(\# dentist hours per week)}}$

   b) DDS Weight = $\dfrac{\text{(DDS working hours per week)}}{\text{(\# dental hygienist hours per week)} + \text{(\# dentist hours per week)}}$

   c) $\dfrac{\text{(RDH Weight x RDH Broken Appt. Rate)} + \text{(DDS Weight x DDS Broken Appt. Rate)}}{2}$

5. Emergency/walk-in DDS visits meet the productivity standard if they do not exceed 25 percent of the visits made by students during a month.

   Emergency/Walk-in Rate =

   $$\frac{\text{\# emergency/walk-in DDS visits}}{\text{(\# of oral exams completed)} + \text{(\# of other DDS visits kept)} + \text{(\# emergency/walk-in rate)}}$$

APPENDIX J

ORAL HEALTH OUTCOMES

ORAL HEALTH OUTCOMES

STUDENTS' HEALTH STATUS WILL BE MAINTAINED OR IMPROVED WHILE THEY ARE AT JOB CORPS.[16]

Table 1 and Table 2 should be filled out completely the first month of each quarter. These tables should be kept on center for review by the regional health consultants. They should also be used by the oral health and wellness program staff to assess their progress in helping to maintain or to improve the students' oral health status.

1. On Table 1, record the priority classification of each student who receives an oral examination. For each day of the month that the dentist is on center, total the number of students who are classified in each priority at the time of the mandatory oral examination. For each oral health and wellness checkup, total the number of students who are classified in each priority.

   The breakdown by priority classification indicates the prevalence and severity of oral disease among entering Job Corps students and among enrolled Job Corps students at the time of oral examinations.

   A comparison of the overall statistics can give some indication as to whether the oral health status of the Job Corps population is improving over the time they are enrolled in Job Corps. Generally, there should be more students in the lower priority classifications when they return for the oral health and wellness checkup than students presenting for the mandatory oral examination.

2. After the care is provided and the priority classification is determined, note on Table 2 whether priority is higher, lower, or remains unchanged. Also note if the priority classification has changed to 4 or 5 (A or B).

   This table is designed to help indicate the extent to which the provision of oral health services helps to maintain or improve the oral health status among Job Corps students.

[16]PRH Chapter 6.10 Student Health Services, Quality Indicator 3 (July, 2001). Students' oral health status is affected by the oral health services they receive and by their personal oral care practices. Tables 1 and 2 are designed to gather data that determine the contribution of the oral health services to students' oral health status.

Table 1: Priority Classification Status at Conclusion of the Oral Exam Visit

The first month of each quarter, record the priority classification of each mandatory oral examination and periodic oral examination.

Oral Examination

Month and Year: ___________________________ __

	Mandatory Oral Examinations							Oral Health and Wellness Checkups						
Day	**P1**	**P2**	**P3**	**P4A**	**P4B**	**P5A**	**P5B**	**P1**	**P2**	**P3**	**P4A**	**P4B**	**P5A**	**P5B**
1														
2														
3														
4														
5														
6														
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TABLE 1 DEFINITIONS

The priority classification system is described in Section 3.2 of the Oral Health and Wellness Technical Assistance Guide.

Month and Year = the month and year for which the data are recorded.

Mandatory Oral Examinations = the initial oral examination that is conducted between the 45th – 75th day after the students' arrival on center

Oral Health and Wellness Checkups = the voluntary, periodic oral examination that is conducted subsequent to the mandatory oral examination

Day = the day of the month for which data are recorded.

P1 = students classified with oral conditions that place them in the first or highest priority according to the system of classifying oral health status.

P2 = students classified with oral conditions that place them in the second highest priority according to the system of classifying oral health status.

P3 = students classified with oral conditions that place them in the third highest priority according to the system of classifying oral health status.

P4A = students classified with oral conditions that place them in the "A" subcategory of the fourth highest priority according to the system of classifying oral health status.

P4B = students classified with oral conditions that place them in the "B" subcategory of the fourth highest priority according to the system of classifying oral health status.

P5A = students classified with oral conditions that place them in the "A" subcategory of the lowest or fifth highest priority according to the system of classifying oral health status.

P5B = students classified with oral conditions that place them in the "B" subcategory of the lowest or fifth highest priority according to the system of classifying oral health status.

Table 2: Priority Classification Status at Conclusion of Care Visit

Record the effect of care provided by the dentist and dental hygienist on the students' priority classification.

Month and Year: ____________________________

Day	Higher Priority	Lower Priority	Priority Changed To 4 or 5	Priority Unchanged
1				
2				
3				
4				
5				
6				
7				
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TABLE 2 DEFINITIONS

Month and Year = month and year for which data are recorded

Day = the day of the month for which data are recorded.

Higher priority = priority classification as a result of the care provided during the visit is higher than it was at the beginning of the visit. (For example, the priority classification was P2 at the beginning of the visit because the student had one carious lesion that the dentist restored during that visit but the dentist noticed a white lesion on the lateral border of the tongue. The undiagnosed or suspect significant pathological condition placed the student in the P1 classification where he will remain until the lesion is diagnosed and oral cancer is ruled out.)

Lower Priority = priority classification as a result of the care provided during the visit is lower than it was at the beginning of the visit. (For example, the priority classification was P2 at the beginning of the visit but after restoring the upper first molar, the priority classification changed to P4B.)

Priority Changed to 4 or 5 = priority classification went from a higher classification to a priority classification category of 4A, 4B, 5A, or 5B after the student received care. These priority classifications denote that the student is free of oral disease.

Priority Unchanged = at the end of the visit, the student was still in the same priority classification due to other oral conditions.

APPENDIX K

ORAL HEALTH AND WELLNESS PROGRAM SELF-ASSESSMENTS

ORAL HEALTH AND WELLNESS

Program Management and Effectiveness

1. Is care rendered according to the priority classification system?

2. Are the dentist and dental hygienist meeting productivity guidelines?

3. Is the dentist maintaining data on health outcomes?

4. Can the oral health and wellness team define oral health and wellness? Is it consistent with students' and other staff members' notion of oral health and wellness?

5. How are students referred to you if problems are detected during the cursory oral examination?

6. How do students learn about the oral health and wellness program during their first 60 days on center?

7. Is the equipment in good repair and maintained to prevent breakdowns?

8. Are broken appointments a problem?

9. Is at least 20 percent of the onboard strength scheduled for appointments monthly?

10. Do oral health and wellness team members provide basic preventive services and self-care instructions?

11. What other departments on center promote oral health and wellness?

12. Are students surveyed on their opinions about the quality of the oral health and wellness program at least semiannually?

13. Does the oral health and wellness program undertake performance/quality improvement activities?

14. Are the staffing pattern and hours consistent with the guidelines?

15. Is there an inventory control system in place?

16. How are students introduced to the oral health and wellness program?

17. What is the procedure for students to make or cancel appointments?

18. Does the oral health and wellness program have a recall system?

19. Do students obtain oral health and wellness plans and if so what is the process for their creation and oversight?

Environment

1. Are oral health and wellness promotional posters and pamphlets displayed throughout the center?

2. Do the oral health and wellness program infection control practices follow up-to-date written guidelines? Who authored the guidelines?

3. Is the dental suite waiting area pleasant and attractive?

4. How do oral health and wellness personnel function as a team?

5. How does the oral health and wellness team make students feel welcome and appreciated?

6. How are oral health and wellness team members accessible to students outside of appointment time?

Employability

1. Can students articulate how good oral health is important to getting and keeping a job?

2. Is the relationship between oral health and wellness and employability stressed during career preparation?

Community Connections

1. Does the center have arrangements for off-center specialty care providers and an approval process for off-center referrals? What are they?

2. Do specialists receive a consultation request form that they are required to complete as a prerequisite for payment?

PRH-6: 6.10 STUDENT HEALTH SERVICES					
	YES	**NO**	**HOW TO DETERMINE COMPLIANCE**		
			Review Documentation	**Interview**	**Observation**
R2. Dental Program					
a. Are cursory dental examinations performed within 48 hours after the students' arrival on center by trained personnel who have consulted with the center dentist?			1. Student health record (SF 93) 2. Log of cursory exam	1. Dentist and/or health and wellness manager (HWM) 2. Dental staff	
b. Are mandatory oral examinations, including 4 bite-wing x-rays, performed (and recorded on the SF 603 and SF 603A) by the center dentist between the 45th and the 75th day? *Elements to Consider:* *b1-Are treatment plans formulated for each student?* *b2-Are measures being taken to protect students/staff during radiographic procedures?*			1. HMIS data (not completely accurate because of attrition) 2. Student health record/ SF 603 and 603A b1 1. Student health record/ SF 603 and 603A b2 1. Inspection report	1. Dentist and/or HWM	b2 1. Students 2. Dental staff

PRH-6: 6.10 STUDENT HEALTH SERVICES					
	YES	**NO**	**HOW TO DETERMINE COMPLIANCE**		
			Review Documentation	**Interview**	**Observation**
c. Is dental treatment rendered according to the accepted priority system? *Elements to Consider:* *c1-Are dental emergencies responded to in a timely fashion?* *c2-Are students referred to off-center specialists when appropriate?* *c3-Are appropriate barrier protection and infection control procedures being followed, contaminated materials being disposed of properly, and the sterilization procedures being monitored?* *c4-Is dental equipment appropriate and well maintained to support the center's program?*			1. Student health record/ SF 603 and 603A 2. Priority tracking system 3. Dental productivity data c1 1. Student health record/ SF603A 2. Standing order (SO) 3. Center operating procedure (COP) c2 1. Written/verbal agreement with specialists in community 2. Student health record c3 1. Review Bloodborne Pathogen Control Plan 2. COP 3. Logs (disposal of materials, autoclave maintenance)	1. Dentists and/or HWM	c3 1. Autoclave c4 1. Equipment and autoclave
d. Are students with orthodontic appliances managed according to Job Corps requirements?			1. Student health record of students with appliances, indication that someone else is responsible for paying	1. Dentist and/or HWM (Do any students have appliances?)	