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Federal Bureau of Prisons

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Dental Services

/s/
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1. **PURPOSE AND SCOPE**

To stabilize and maintain the inmate population's oral health. Dental care will be conservative, providing necessary treatment for the greatest number of inmates within available resources.

a. **Summary of Changes**

Policy Rescinded
PS 6400.02 Dental Services (1/15/05)

Section 2a refers to National Chief Dentist. This term replaces Chief Dentist.

Section 2a, fifth bullet, identifies the National Chief Dentist as the privileging granting authority for the Regional Chief Dentist.

Section 2b refers to Regional Chief Dentists. This term replaces Regional Dental Consultants.

Section 2c describes options for facilities during the temporary absence of a dentist.

Section 3 eliminates the need for a local Policies and Procedures Manual. An Institution Supplement is required to describe the nuances of local programs.

Section 3a(1) stipulates restorative and surgical procedures will not be performed without a dental assistant.

Section 3b refers to clinical privileges and competency assessments.

Section 3c references quality management data collection by IOP Coordinators.

Section 4 describes the inmate apprenticeship program and the limitations on the enrolled inmates.

Section 5 references the Electronic Medical Record (EMR). This replaces the paper-based Health Record. Data Management worksheets and reports (daily, monthly, and quarterly) are no longer required. Wait lists for routine care are maintained on the Dental Wait Routine Treatment List Module in EMR.

Section 6a refers to the general population and access to care: failed appointments,transfers, and inmate release.

Section 7 introduces Preventive Oral Health guidance.

Section 8b refers to Admissions and Orientation (A&O) examinations being within 30 calendar days of arrival in all BOP facilities. This replaces the 14-day standard. All A&O examinations are performed by a dentist.

Section 8b refers to the A&O examination authorizing a hygiene appointment for up to 18 months.

Sections 8d&e introduce limited examination and oral health assessment. Periodic examination terminology is no longer referenced.

Section 9c(5) requires RCD preauthorization for prosthetics; full and partial dentures will be authorized for inmates with sentences greater than 3 years. Inmates with sentences less than 3 years who may present with unusual circumstances will be considered on a case-by-case basis by the RCD.

Section 9f introduces orthodontic consent for removal.

Section 10b refers to dental triage. Dental triage is allowed at the Health Services Unit's discretion per the institutional mission or dentist resource availability. Dentists must conduct dental sick call to evaluate and treat urgent complaints.

Section 11 defines four priority levels based on acuity.

Section 12 details the dental Utilization Review Process. The Regional Chief Dentist is the final approving authority for dental specialty care.

Section 13. Laboratory Services are to be provided by the National contracted vendor when one is available. Regional Vocational Dental Laboratories are no longer utilized.

b. **Program Objectives.** The expected result of this program is: Necessary dental care will be provided to inmates by health care providers, who provide quality care consistent with evidence-based practice and in accordance with professional standards.

2. ORGANIZATION

a. **National Chief Dentist**. Bureau dental programs are under the direction of the Bureau's Chief of Dental Programs (National Chief Dentist). The Medical Director privileges and supervises the National Chief Dentist. The National Chief Dentist:

- Establishes national program goals and clinical scope of dental care.
- Sets objectives for providing professional and administrative direction to Bureau dental programs.
- Recruits qualified dentists and auxiliary personnel.
- Represents the Bureau's dental services as necessary with other government agencies or professional groups.
- Grants clinical privileges to Regional Chief Dentists and Institution Chief Dental Officers.

b. **Regional Dental Services**. The National Chief Dentist directly supervises, provides work assignments, and grants privileges to a Regional Chief Dentist (RCD) for each region. The RCD:

- Provides professional direction for institution dental staff within the region and provides policy guidance to institution executive staff, the Regional Health Systems Administrator, Regional Medical Directors, and other Regional Office administrators.
- Oversees the provision of temporary direct patient care to understaffed facilities in his/her assigned region and in shortage areas determined by the National Chief Dentist.
- Serves as the point of contact in dental matters pertaining to clinical care, mentoring and training, policy, recruitment, clinic construction, legal issues, program reviews, and clinical peer reviews.
- Oversees institutional dental programs as Acting Chief Dentist when there is a vacancy in the institution Chief Dentist position.
- Will be responsible for the Dental Utilization Review process.

- Referred to as Regional Chief Dentist (formerly the Regional Dental Consultant [RDC]).

c. **Institution Dental Services**. Per the Office of Quality Management (OQM), the Bureau's Medical Director is the privilege granting authority for Chief Dental Officers (CDO). This authority is delegated to the Bureau's National Chief Dentist, who has privileging authority for the entire dental program. See the current Program Statement **Health Care Provider Credential Verification, Privileges, and Practice Agreement Program.**

Each institution has a CDO, which is a managerial, non-bargaining-unit position. In the absence of a CDO, a staff dentist, with his/her consent, may be temporarily promoted to CDO consistent with HRM policy. If the Staff Dental Officer (SDO) declines the temporary promotion, the RCD will serve as the Acting CDO. If there is no dentist on staff, the RCD is granted temporary Acting CDO privileges and oversees the dental program.

To ensure there is no interruption for dental services, contracting of local dentists, hygienists, and dental assistants will be a priority for vacancies greater than 3 months. See the current Program Statement **Health Care Provider Credential Verification, Privileges, and Practice Agreement Program** for full privileging requirements.

The CDO is under the supervision of the Associate Warden (AW) or Clinical Director (CD). This is a local decision. Supervision of the CDO cannot be delegated below the CD.

The CDO supervises all dental staff and determines all clinical dental staff assignments. The CDO provides clinical feedback to Business Office contracting officers for all contract dental clinical staff.

Clinical dental decisions are the responsibility of the treating dentist(s).

The CDO provides regular information regarding inventory needs and dental budget requirements to the Health Services Administrator (HSA), who has budget and procurement oversight for the Dental Clinic. See the current Program Statement **Health Services Administration.**

d. **Options During the Temporary Absence of the Dentist.** During periods when a dentist is not available (annual refresher training, Annual Leave, CME, etc.), the local HSA or designee will arrange one of the following options:

- **Contracting (Amend Existing Contract).** Incorporate a requirement for temporary Dentist back-up coverage in the comprehensive medical contract.

- **Contracting (Establish Separate Contract).** Contract with a firm that is capable of providing temporary Dentist services using open market procurement procedures or existing Federal Supply Schedules (FSS). The current Program Statement **Bureau of Prisons Acquisition Policy**, Part 37, stipulates various requirements relating to using private sector temporary services. The Chief Executive Officer and Regional Director must approve a written justification prior to the acquisition.
- **Interagency Agreements.** Establish an interagency agreement with another Government agency (e.g., VA or DOD) to provide Dentist coverage on an "as needed" basis.
- **TDY Within the Bureau.** TDY by a Medical Asset Support Team (MAST) dentist or a volunteer dentist from another institution with the approval of the RCD.
- **Use PHS Officers from Outside the Bureau.** Secure TDY assistance from PHS officers assigned to other Government agencies. (The institution needing the Dentist is responsible for travel, lodging, and per diem.)

3. DENTAL CLINIC ADMINISTRATIVE PROCEDURES

The CDO is responsible for ensuring that there is a local Institution Supplement on dental health care. The National Program Statement provides greater continuity of care and treatment Bureau-wide; the Institution Supplement provides dental program clarification as it applies to the specific institution and its mission. The Institution Supplement is updated annually and amended to reflect local and/or national policy changes.

The CDO periodically reviews the Inmate's Admission and Orientation (A&O) Handbook to ensure that information about the dental program is correct. The handbook should include the following information: the dental clinic hours of operation, access to care (sick call protocol and national dental routine waiting list), method to request continued care when transferring, inmate co-pay policy, availability of commissary items, and any applicable local dental policies.

a. **Staffing.** The CDO must be knowledgeable about both Office of Personnel Management (OPM) and U.S. Public Health Service (PHS) personnel systems.

The BOP Health Services Division establishes staffing guidelines for dental clinics. Generally, each institution should have one dentist for every 1,000 inmates. Staffing guidelines may vary by institution, depending on the mission. Requests for modification to an institution's dental staffing are submitted to the National Chief Dentist for consultation with the National Health Services Administrator.

(1) **Auxiliary Personnel**. Auxiliary dental personnel consist of dental assistants (DA) and registered dental hygienists (RDH). Team composition will vary by the institution's mission. Auxiliary personnel are essential to an efficient, productive, and secure dental service unit.

Institutions will provide one DA for each clinical dentist. Restorative and surgical procedures are not performed without a dental assistant. Routine use of a dentist or registered dental hygienist as a dental assistant is inappropriate

Dental hygienists are an important adjunct to the oral health program. Each institution should have one RDH. Additional hygienists are added based on the mission, size of population, or Central Office staffing guidelines. Hygienists should be encouraged to establish prevention programs, provide patient education, and support the dental program.

(2) **Continuing Dental Education**. Dental staff maintain their professional skills and current unrestricted licensure through continuing dental education programs. Fund allocation is listed in the current Program Statement **Health Services Administration**.

(3) **COSTEP/Student Interns**. Local institutions may employ students who have entered into an agreement with the PHS's Commissioned Officers Student Extern Program (COSTEP) for short-term engagements. This program is subject to Central Office funding.

Institutions may establish training agreements with local professional schools to use student interns in various capacities. The Memorandum of Understanding (MOU) must be in writing and subject to annual review. MOU templates are available on Sallyport. A copy is sent to the National Chief Dentist for review before starting or when renewing the program.

Students must provide care under supervision. The patient is notified of the provider's student status before each treatment encounter; written consent documenting this notification using the Consent For Treatment By Student Dentist/Hygienist (BP-A1080) will be entered in the EMR. Inmates refusing treatment by a student should be rescheduled for the staff provider at the earliest appointment available. Electronic Medical Record (EMR) entries are co-signed by the supervising dentist or reviewed by the hygienist for hygiene students only. Staff participation in preceptor programs is voluntary.

b. **Clinical Privileges**. The extent of privileges granted depends on the practitioner's education, training, and experience. All dental staff must work within their current privilege statements and practice agreements, and within the scope of their professional license. Protocols may be negotiated locally if necessary.

Dental assistants and hygienists, staff or contract, must have signed practice protocols and/or agreements on file. Both disciplines undergo competency assessments by a Chief Dental Officer every two years. See the current Program Statement **Health Care Provider Credential Verification, Privileges, and Practice Agreement Program**.

c. **Quality Management (QM).** The CDO will be familiar with the current Program Statement **Health Services Quality Improvement** and will attend the IOP meetings. The IOP Coordinator conducts studies of dental operations and collects the pertinent data.

d. **Facility Management**. A clean and properly functioning dental clinic is essential to provide high-quality dental services in a safe and timely manner. The CDO maintains dental facilities at a high standard of sanitation, minimizing the opportunity for cross-contamination. The CDO or designee ensures that all equipment works properly.

The CDO ensures that dental clinic equipment is included in the Health Services Unit preventive maintenance program of bi-yearly safety inspections according to the current Program Statement **Patient Care**. X-ray units are inspected and calibrated, and protective aprons/shields are inspected according to the current Program Statement **Patient Care**.

e. **Intra-oral Metal Removal**. Precious metal (gold) and base metal that is removed from the inmate's mouth will be autoclaved, placed in an envelope, and marked with the patient's name, number, date, and description of the item. The Inmate Personal Property Record (BP-A0383) will be used. The autoclaved item and form will be taken to the Inmate Systems Management (ISM) department for disposition as the inmate's personal property. A copy of the form will be placed in the EMR Document Manager. Refer to the current Program Statement **Property Management Manual**.

Non-precious alloys may be discarded as biohazardous waste in an appropriate biohazard container. Those containing amalgam should be handled as amalgam waste in accordance with state and local municipality requirements. Amalgam-containing items (i.e., tooth or crown) in this category should be subjected to high-level disinfection or cold sterilization instead of autoclaving.

4. INMATE APPRENTICESHIP PROGRAM

If inmates are used as chair-side dental assistants, they must be enrolled in, or have completed, the Department of Labor Dental Assistant Apprenticeship Program, or a similar certification program in the local community approved by the institution's education department. Other inmate workers (orderlies, those processing instruments, etc.) do not have to be enrolled in a program.

The Inmate Dental Assistant Apprenticeship Program is an educational job skills program to assist in reentry initiatives. This program is not intended to replace the need for dental assistant employees.

Limitations are as follows:

- Inmates will not perform direct patient care, including taking x-rays, impressions, or vital signs. Inmates are not involved in the scheduling process or in determining another inmate's access to dental care.
- No inmate may have access to the Health Record. During an examination, inmates working in the clinic are allowed to do charting on a blank A&O Dental Examination (Initial Clinical Dental Findings) form (BP-A0618), under the direct supervision of a dentist.
- Inmates do not handle prescribed medications or needles. Inmate assistants and workers only handle dental instruments under the supervision of a dental staff member.
- Inmate workers only operate dental equipment (amalgamators, curing lights, autoclaves, etc.) under the supervision of dental staff.
- Inmates who are healthcare professionals in any capacity, with or without an active license and regardless of whether they received a degree, license, or certification, are not allowed to work in the dental clinic in any capacity.
- Inmate workers are screened for HBV, HCV, and HIV infection. Those testing positive may be allowed to work in the dental clinic as a dental assistant with approval of the Clincial Director .
- Testing for bloodborne pathogen infections is done for any clinically suspected new infection.
- Any workplace exposure to bloodborne pathogens will be referred to Health Services clinical medical staff for post-exposure management.
- Inmate dental workers are offered the hepatitis B vaccine per OSHA regulations. See the current Program Statement **Infectious Disease Management**.
- Inmate supervision in the Dental Clinic will be consistent with local Correctional Services policies.

5. DENTAL RECORDS/GENERAL INFORMATION

The EMR is used to document all dental encounters and administrative notes. The EMR is used for maintenance of the Dental Routine Treatment List Module. SENTRY is used to place inmates on call-out or retrieve necessary correctional information only. See the current Program Statement **Health Information Management**.

The following applies:

- The uploading of dental/health records will be done in compliance with the current Program Statement **Health Information Management.**

- Paper charting forms (BP-A0618, A&O Dental Examination [Initial Clinical Dental Findings] are completed, then scanned into the EMR Document Manager under the Dental Examinations section. This is only approved for A&O examinations.
- Forms requiring an inmate's signature are scanned into the appropriate section of the EMR Document Manager utilizing the correct file name protocol per current BEMR Document Manager Guidelines.
- Only forms in English are to be scanned into EMR. Miscellaneous forms, such as an outside specialist's consultation notes, Inmate Personal Property Record (BP-A0383), dental laboratory prescription slips, biopsy reports, etc., are signed, dated, and scanned into the appropriate section of the EMR Document Manager utilizing the correct file name protocol.
- Dental radiographs should be included in EMR. If a Dental Service Unit does not have digital radiography capability, radiographs continue to be filed in a two-part folder stored in Medical Records.
- Some inmates may still have existing paper-based records (which will be maintained until their release); if needed, these are referred to when providing dental treatment, but current and future progress notes are done electronically. Prior notes do not need to be scanned. These records are returned to Medical Records at the end of each day.
- The release of information from the Health Record to an inmate is governed by the current Program Statements **Release of Information** and **Health Information Management**.

6. ACCESS TO DENTAL CARE

a. General Population

(1) **Method.** Access to care must be equitable. Comprehensive dental care may be requested by submitting an Inmate Request to Staff (BP-A0148) form, or any other means authorized by local policy and procedures. Provided the inmate is eligible for care, the date that the initial request is received is used as the entered date on the EMR "Dental Routine Treatment List". This date follows the inmate from one facility to another as part of a national wait list. Local institutions do not maintain paper or other electronic wait lists. Inmates must be on the waiting list for care and care will be provided in chronological order; i.e., those waiting the longest will be seen first. Institutions will provide access to comprehensive care for eligible inmates as resources and staff are available.

(2) **Failed Appointments**. Inmate patients may be removed from the dental routine treatment list after two unexcused absences within a 6-month period. It is the dental staff's responsibility to follow the institution's security procedures for "no show" appointments. All inmate "no shows" will require an entry into the health record documenting the absence and action taken.

(3) **Inmate Release**. Medical Records will notify Dental Services of inmates who will be released from BOP custody in any manner (Full Term Release, to a halfway house, etc.). Dental Services should ensure that inmates are removed from the routine treatment list. An inmate returning from a halfway house placement or writ may request to have his/her status on the comprehensive dental care list reactivated. If an inmate returns to BOP custody (either as a violation or new commitment), the inmate can submit a new request for comprehensive dental care and will be added to the waiting list based on this new date.

(4) **Intra-system (BOP to BOP) Transfers.** Medical Records staff will notify medical and dental services of new commitments and transfers who need A&O examinations. This should include inmates transferring in from privately managed correctional facilities. Medical records or other medical support staff may schedule those inmates who have not had a previous A&O for the current commitment for the dentist's A&O exam.

Inmates transferring to a new institution will be seen according to their status on the EMR National Waiting List. The CDO reviews the inmate's previous treatment record and appointments. Treatment is continued per the receiving dentist's updated recommendations and dental schedule.

Dentists at the receiving institution must reconcile any previously ordered dental consultations for transferring inmates. This reconciliation must be done periodically to ensure that necessary care is continued.

The dentist will use a medical hold and advise the inmate if prosthetic or other time-sensitive care has been started and cannot be completed prior to release either to another institution or to a halfway house.

(5) **Medical Co-morbidities.** In rare medical circumstances the CDO or Clinical Director may reprioritize dental treatment for inmates requiring close medical supervision. This may require exemption from established wait list procedures. All medical justifications should be documented in EMR with an accompanying consultation.

b. **Eligibility based on Designation.** Since institutions vary in regard to mission and security level, local provisions can be described in the Institution Supplement. All inmates are entitled to sick call/urgent care.

The dental staff will coordinate with correctional services staff. Inmates will be escorted to the dental clinic by correctional services staff for the management of timely appointments and continuing comprehensive care.

(1) **Pretrial**. At the end of 12 months, pretrial inmates are eligible to receive comprehensive care and can then request to be put on the national waiting list. In rare cases, exceptions will be made on a case-by-case basis, with the advance approval of the Regional Chief Dentist.

(2) **Short-Term Detention.** Comprehensive dental care may be delayed due to short-term temporary detention placements. If an inmate scheduled for comprehensive dental care misses an appointment because of a short-term placement in special housing, he/she resumes being scheduled after returning to general population.

(3) **Long-Term Detention.** Inmates detained in segregation, special housing, or jail units for 12 months or less have access to dental triage/sick call and urgent care. Health care staff assigned to these areas will notify dental services of urgent cases requiring evaluation. Inmates who have been detained for longer than 12 months will be eligible for comprehensive dental care. Inmates permanently designated in long-term, high security units (e.g., ADX) will be eligible for comprehensive dental care in accordance with the National Dental Wait List.

(4) **BOP General Population Inmates.** All permanently designated inmates are eligible for comprehensive dental care. This includes inmates designated to detention, jail, and contract facilities. Inmates designated to community corrections facilities (Residential Reentry Centers) are eligibile for emergency care only.

7. PREVENTIVE ORAL HEALTH

a. **Oral Health Education**. Preventive dental health care starts at the Admissions and Orientation (A&O) examination. Personal oral hygiene is essential to good oral health promotion/disease prevention. Oral health information/education is provided to all inmates during the A&O examination and each subsequent dental visit.

Dental staff promote the understanding of the relationship between dental plaque and the development and progress of oral and systemic diseases. Patient education includes information on the relationship between oral diseases and tobacco products, alcohol, and other drugs.

Dental staff should take every opportunity to provide oral health and hygiene information to the institution population (pamphlets, video presentations in waiting areas, booklets, A&O orientation, etc.).

The techniques for brushing and interdental aids will be reviewed at A&O and hygiene appointments. Issues of diet and nutrition will be discussed, reviewing the relationship of food intake (substances and frequency), plaque formation, and dental pathology.

b. **Requirement for Adequate and Proper Oral Hygiene**. The dental hygiene program is responsible for ensuring that inmates can demonstrate adequate and proper oral hygiene. The treating dentist may discontinue comprehensive dental care any time it becomes apparent the inmate is not practicing proper oral hygiene. These inmates will still have access to urgent care through sick call.

c. **Oral Hygiene Products**. The CDO ensures that the institution Commissary has toothbrushes, floss or suitable substitutes, fluoride dentifrices, denture adhesives, denture baths/cups, etc. CDOs should refer to the Interdental Aid Resource Guide. Inmates may be provided oral health specialty products as needed that are not otherwise available in the commissary. Indigent inmates will be provided items available per the Institution Supplement on a schedule deemed appropriate by dental staff.

8. DENTAL EXAMINATIONS

a. **Intake Screening**. Inmates respond to questions regarding their oral health status as part of medical intake screening. A self-reporting process is documented in the EMR Intake Screening. Dental problems identified are assessed by medical staff and referred to dental staff if indicated. See the current Program Statement **Patient Care**.

b. **Admission and Orientation (A&O) Examination**. Medical records staff will determine the admission and release status of the inmate and schedule inmates for an A&O examination.

The A&O examination is performed upon admission for an inmate's current incarceration within 30 calendar days of arrival. Intrasystem transfers (BOP to BOP) need not be re-examined. An A&O exam must be performed on inmates who have been released from BOP custody but have been readmitted on a new commitment or violation. Inmates returning from a halfway house placement or writ do not require a new A&O examination if they have had one for their current commitment.

The Dental A&O clinical examination is performed by a dentist and cannot be delegated to auxiliary dental staff or a non-dentist. It includes:

- An EMR Dental Health History Encounter.
- A head and neck/soft tissue examination.
- An examination of the hard and soft tissue of the oral cavity by illuminator light, mouth mirror, and explorer in a clinical setting, charting existing dental restorations, caries, missing teeth, occlusion classification, oral hygiene rating, and other requirements on the A&O Dental Examination (Initial Clinical Dental Findings) form (BP-A0618) and the EMR A&O

Examination Encounter. The charting guide used for A&O Examinations is posted on Sallyport.

- An assessment of the inmate's periodontal condition using the Community Periodontal Index of Treatment Needs (CPITN). The CPITN guide is available on the National Chief Dentist's Sallyport webpage.
- X-rays for diagnostic purposes, which can be taken if deemed necessary by the dentist.
- Intraoral photographs as necessary.

The inmate is informed of the clinical findings at the time of the examination, provided education on oral hygiene, advised of caries risk, informed about the availability of oral care items in the commissary, and instructed how to access treatment. Oral hygiene literature (English and Spanish) is offered during this process. The brochure will provide information regarding access to dental care/services, time of clinic operation, and oral health information to include pictures or illustrations demonstrating proper hygiene technique. A template pamphlet will be available on Sallyport.

The recorded dental findings are used in prioritizing care. Patients must submit a request to staff in order to be added to the dental Routine Treatment List. Patients that have received their A&O exam can be authorized for hygiene appointments up to 18 months from the date of the A&O examination.

c. **Treatment Planning Examination**. Complete examinations performed by the dentist after the A&O Examination are Treatment Planning Examinations. These examinations enable the practitioner to assess risk, diagnose oral disease, and develop and document a treatment plan. The examination is completed before providing non-urgent treatment and is a thorough and complete visual and tactile examination. It will determine the basis for dental treatment, continued dental maintenance, and frequency of future dental appointments, including continued recall hygiene appointments. Inmates who have not been seen by the dental hygienist within the 18-month A&O Examination authorization will have a Treatment Planning Examination prior to initiating periodontal or hygiene treatment. The purpose of these diagnostic examinations includes determining baseline findings, monitoring an inmate's diagnostic changes during and after dental treatment, as well as the need for supplemental care.

A treatment planning exam can include:

- An EMR health history review and inmate compliance review.
- A head and neck/soft tissue examination.
- A periodontal examination or CPITN assessment.
- Review of the screening examination findings.
- Radiographs and their interpretation, as deemed clinically indicated by the treating provider.

- Updated clinical findings and a detailed treatment plan will be entered into the treatment planning screen of EMR, prioritizing care as necessary.
- Caries risk assessment.
- Documentation of oral health education.
- Consultations and laboratory tests deemed necessary.
- Intraoral photographs as needed.

d. **Limited Examination**. A Limited Examination is performed on sick call appointments where the provider is focusing only on the patient's chief complaint. This is not a substitute for a Treatment Planning Examination.

e. **Oral Health Assessment.** An Oral Health Assessment, conducted by the registered dental hygienist, is part of the dental hygiene encounter and includes elements that describe the oral condition. This is not a diagnostic examination and therefore is not intended to replace the Treatment Planning Examination.

9. COMPREHENSIVE DENTAL CARE (NON-URGENT DENTAL CARE)

This care includes non-urgent treatment procedures identified on the Treatment Planning Examination. Inmates' need for care is based on individual considerations, including the need for treatment, follow-up, and dental hygiene recalls. The treating dentist may discontinue care at any time if it becomes apparent the inmate is not practicing proper oral hygiene. This will be documented in EMR. Inmates will still have access to emergency dental care (e.g., to treat infection, pain, etc.)

The BOP scope of comprehensive dental care includes:

a. **Diagnostic Procedures**:

- Radiographs.
- Clinical examinations (Treatment Plan Exam): diagnostic assessment of current oral health.
- Head and neck/soft tissue examination
- Oral disease risk assessment.

b. **Preventive Services**:

- Dental prophylaxis (hygiene appointment), as determined by the dentist's prescriptive recommendations. Hygiene recall appointments are subject to a dentist's updated clinical examination.
- Periodontal therapy.

- Oral hygiene instruction.
- Preventive dentistry procedures.

c. **Routine Dental Procedures**:

(1) **Tooth-borne restorative procedures:**

- Amalgam and composite/resin fillings.
- Temporary crowns (stainless steel, polycarbonate).

(2) **Temporo-Mandibular Joint (TMJ) Disorders.** This includes management of myofascial pain, internal derangement of the disc, or arthritis within the joint.

(3) **Endodontic Treatment (root canal therapy).** Root canal therapy may be completed when the dentist deems it clinically indicated. Endodontic procedures are considered invasive; therefore, the consent forms must be used and the Universal Protocol must be followed in its entirety.

This treatment is not undertaken if any of the following conditions are present:

- The tooth is a third molar.
- Inadequate oral hygiene.
- The tooth is periodontally compromised.
- High caries rate.
- The tooth requires extensive restoration.
- Missing teeth in the same arch that can be replaced with a removable prosthesis.
- The opposing tooth is missing.
- Other teeth in the same arch are of questionable prognosis.
- The tooth is not essential to maintain the integrity of the arch.

(4) **Oral Surgery**. Basic surgical procedures (extractions, alveoplasty, biopsy, etc.) are considered invasive; therefore, the consent forms must be used and the Universal Protocol must be followed in its entirety:

- Vital signs, at a minimum blood pressure and pulse, are taken and documented before the invasive procedure and during the appointment. Each dentist will have an automated vital signs monitor.
- X-rays must be current (six months or less) and should be of diagnostic quality.
- The tooth being extracted should be clearly visible on the radiograph, to include the apices
- Bitewing x-rays are generally unacceptable, unless vertical views include the apices.

- Inmates must be informed of biopsy findings; this notification encounter must be documented.

(5) **Dental Prostheses.** Full dentures, partial dentures, obturators, and splint therapy may be provided if clinically indicated; prosthodontics (full and partial dentures) is a component of the comprehensive dental treatment plan. All prosthetics are to be approved by the RCD.

The replacement of teeth is a lower priority than relief of pain and treatment of active dental/oral disease and should be initiated only after all active disease has been treated and risk is managed. Full and partial dentures will be authorized for inmates with sentences greater than 3 years. Inmates with sentences less than 3 years who may present with unusual circumstances will be considered on a case-by-case basis by the RCD.

A Removable Partial Denture (RPD) must be justified by a lack of teeth for adequate mastication and should be deferred if any of the following conditions are present:

- Poor periodontal health.
- Poor oral hygiene.
- Non-restorable teeth present.
- Chronic infection.
- Active caries.
- Restorations not completed.
- Eight or more posterior teeth in occlusion, including bicuspid occlusion.
- The inmate has less than six months remaining in a BOP correctional facility.

Prosthetics (transitional, temporary, cast, or acrylic) or therapeutic splints are initiated only after periodontal, surgical, and restorative treatment is completed, and the patient maintains a periodontally healthy environment that will help improve clinical outcomes. If the patient does not maintain proper oral hygiene, the treating dentist may discontinue treatment until home care improves. Documentation of oral hygiene evaluation(s) is maintained in EMR, accompanied by specific oral hygiene instructions provided to help the patient improve his/her oral condition.

In cases of anterior tooth loss secondary to non-sport-related trauma while in BOP custody, transitional partial dentures (generally a cosmetic procedure) can be fabricated only after approval by the RCD.

Immediate dentures are not appropriate in a public health setting, as they are resource-intensive and are a cosmetic interim procedure for well-fitting dentures.

d. **Advanced Dental Treatment**. Accessory treatment is generally considered elective and extends beyond the scope of routine dental care in a public health setting. These procedures include but are not limited to:

- Orthodontic tooth movement (traditional or Invisalign) or orthodontic retainers.
- Fixed cast prosthodontics (single or multiple units, to include resin-bonded prostheses).
- Dental implants and/or implant restorations.
- Edentulous ridge augmentation.
- Orthognathic surgery.
- Second molar endodontics.
- Vital and non-vital bleaching.
- Cosmetic dentistry procedures such as "tooth whitening" or facial veneers.
- Periodontal surgery (e.g., grafts, flaps).
- Apicoectomies or retrograde fillings.

If the CDO determines such treatment may be indicated, a consultation with a BOP specialist can be made. However, the RCD is the approving authority and proposed procedures in this section are subject to Utilization Review (UR) approval before initiation.

e. **Specialty Services**. If dental services require dental specialist assistance, arrangements are made through the HSA after the UR approval by the RCD. The dentist prepares a consultation request using EMR for each referral to an outside dentist or specialist. Upon returning from the specialist, a dentist must review the consultation report and note in EMR. See Utilization Review Section.

f. **Continuation of Outside Treatment**. The Bureau is not responsible for completing dental care or therapy initiated prior to incarceration. Care is provided as policy dictates and resources allow. Ordinarily, inmates cannot be seen by outside providers, regardless of ability to pay for these services. See the current Program Statement **Patient Care**.

Fixed or removable prosthetics fabricated as part of outside care may be sent to the CDO for delivery. However, the inmate is informed that the Bureau is not responsible for any unsatisfactory prosthesis from an outside source.

The dentist makes the judgment as to the acceptability of these appliances. If the prosthesis/ appliance is deemed inadequate; he/she will not make adjustments and it is returned at the inmate's expense.

Orthodontic treatment is not in the scope of practice of Bureau dental services. Inmates who enter custody while in orthodontic treatment by a private practitioner have two options:

- Fixed appliances (brackets, bands, arch-wire, etc.) may remain and serve as a retainer to maintain current tooth position.
- Alternatively, the patient may request removal of all orthodontic appliances. In doing so, he/she accepts that any progress in orthodontic movement may relapse. The Consent for Removal of Orthodontic Appliances (BP-A1041) shall be completed and placed in EMR under the Document Manager/Dental Consent Form section.

Removal of any fixed orthodontic appliance requires the patient's written consent, with the understanding that there may be a relapse. The BOP is not responsible for correcting any relapse resulting from the removal.

g. **Refusal of Treatment**. If an inmate refuses part of the recommended treatment plan, the dentist may deny dependent comprehensive care (e.g., the fabrication of a removable partial denture). However, completion of other routine restorative procedures will be continued.

Any refusal of treatment is documented on a Medical Treatment Refusal (BP-A0358), which is accessed through EMR. Please note: Spanish forms are for reference but are not to be entered into EMR. Once the form is completed (signed by the inmate and provider) it becomes part of the medical record per the current Document Manager Guidelines. An inmate may revoke a signed treatment refusal at any time if he/she decides to follow the provider's recommended treatment. This revocation is documented in EMR in an administrative note prior to continuation of treatment.

Inmates signing a refusal for all dental care are removed from the Dental Routine Treatment List but are still eligible for urgent dental care. Should they request placement on the list again, their name will be placed at the bottom of the wait list.

h. **Inmate Restrictions**. Inmates are not entitled to select their own clinician, and are not entitled to dictate the use of selected dental materials. The treating dentist will provide appropriate care to the scheduled inmate. If an inmate refuses all treatment by the assigned dentist, a refusal form will be completed and he/she will be removed from the routine treatment list. The inmate will be eligible only for dental sick call. If he/she requests comprehensive care at a later date, the inmate will be placed at the bottom of the list.

Inmates are not permitted to use their own dentist, whether in the BOP clinic or the dentist's office, whether on a reimbursable or non-reimbursable basis, or whether there was a prior relationship between the inmate and the provider.

10. **URGENT DENTAL CARE (DENTAL SICK CALL PROGRAM)**

a. **Definition.** Urgent dental care includes treatment for relief of severe, acute dental pain, traumatic injuries, and acute infections exhibiting the cardinal signs of infection. This includes a palliative treatment intervention that may include placement of sedative, temporary restorations, extraction of non-restorable teeth, pulpectomy, and gross debridement of symptomatic areas. Urgent dental care may be requested by inmates on a 24-hour basis.

Urgent dental care is the highest priority. Maintaining a wait list for urgent care is prohibited. If dental emergencies occur outside the regular workday, local procedures in the Institution Supplement required by the current Program Statement **Patient Care** will be followed. The patient must be seen by a dentist within 3 business days of the initial clinical encounter. In the absence of a dentist, the inmate will be seen by a prescribing clinician.

b. **Dental Triage**. Dental triage is allowed in facilities to support the dentist. Dental staff can prioritize inmate requests based on urgency when the inmate presents to the sick call clinic.

Dentally trained medical staff can assess the urgency of dental conditions when a dentist is not available or to support the dental program. Examples may include off-shift duty hours, during medical unit rounds, or when the dentist is working at a different facility within a complex. While dental triage may be managed by non-dental providers and interim medications prescribed, this is not a substitute for definitive dental diagnosis and treatment interventions done by a dentist.

When there is no dentist present during regular duty hours, available DAs and RDHs can triage inmates signing up for dental sick call. If a patient reports to dental sick call with acute symptoms (severe pain, obvious swelling) and prescribing medications may be indicated, the following procedures may be instituted:

- The patient may be referred/taken over to a Mid-Level Provider (MLP) or physician. He/she can evaluate the patient, contacting the dentist if he/she is accessible, and prescribe medications for relief of acute symptoms until the patient can be seen by a dentist.
- The DA or RDH should track these inmates and report them to the CDO. Should the institution be without a CDO, dental staff will report these inmates to the RCD. The RCD can review the triage note in the EMR remotely and determine the urgency for and management of definitive care for the chief complaint.

Dental protocols should be used by trained health care staff. Non-dental staff must be trained by the dentist annually to ensure current competency. Training is documented and made available to reviewers and auditors.

c. **Dental Sick Call Clinic**. Complexes and facilities with dentists conduct sick call clinics for assessing urgent inmate dental conditions. Provisional dental treatment is provided to manage acutely symptomatic dental disease. Chronic dental disease management is deferred to the routine dental care program (see Comprehensive Care section).

Patients are diagnosed by a licensed dentist. During staff vacancies at complexes, the Chief Dental Officer or staff dentist establishes a rotation to ensure coverage at each facility within the complex.

Inmate-generated sick call encounters are subject to copayment. Exceptions may include: referrals from another healthcare provider; requests as a result of recent prior treatment (i.e., lost restoration) by a BOP provider; adjustment of dental prostheses recently (up to six months) delivered by a BOP provider.

The placement of a permanent final restoration at sick call should only be considered when a temporary restoration cannot be placed (adequate justification must be made in the progress note). For example, an acutely symptomatic Ellis Class II fractured anterior tooth may require a permanent resin restoration as opposed to a temporary restoration, when retention of the provisional material is questionable. This should be rare, as the placement of permanent restorations requires being identified during a comprehensive examination and subsequent treatment plan.

(1) **Hours.** Dental sick call occurs during regular duty hours as established by the CDO. The inmate is assessed and only urgent dental care is provided during sick call hours. Sick call palliative care is rendered at the time of the initial clinic encounter; follow-up is performed on a case-by-case basis.

(2) **Documentation of Sick Call and Urgent Procedures.** Dental triage/sick call and urgent patient encounters are documented in the EMR using the "SOAP-E" format. The patient's reported pain level/scale and quality (descriptions) of pain must be documented.

- (S) Subjective findings: Symptoms described by patient.
- (O) Objective findings: Results of the clinical exam, x-rays, or tests.
- (A) Assessment: Provisional diagnosis.
- (P) Plan: Planned treatment rendered.
- (E) Education: Post assessment with treatment instruction.

11. **PRIORITY OF SERVICES**

The Bureau of Prisons defines four priority levels based on acuity that determine the imminence of treatment for inmates. The following categories discuss the priority of dental care, which may change when and by whom dental procedures may be performed.

a. **Emergency Dental Care**. Dental/orofacial conditions that are of an immediate, acute, or grave nature and which, without care, would cause rapid deterioration of the inmate's health, significant irreversible loss of function, or may be life-threatening.

b. **Urgent Dental Care**. Care for dental conditions that are not imminently life-threatening. This includes the management of acute oral disease, ordinarily referred to as sick call care:

- Serious deterioration that may lead to premature death.
- Significant reduction in the possibility of repair later without present treatment.
- Significant pain or discomfort that impairs the inmate's participation in daily activities.

c. **Non-urgent Dental Care**. Care for dental conditions that will generally improve the inmate's quality of life. This includes the management of chronic oral disease, ordinarily referred to as comprehensive dental care.

d. **Limited Value Dental Care**. Care for dental conditions that resolve on their own, treatment that provides little or no clinical value, is expressly for the inmate's convenience, or is beyond the scope of a public health setting. Procedures in this category are usually in the Advanced Dental Treatment section.

12. **DENTAL UTILIZATION REVIEW PROCESS**

Every institution has a Utilization Review Committee (URC). Only Emergency Dental Care referrals are authorized at the institution level when it is essential to sustain life or function and warrants immediate attention. A retrospective review of Emergency Dental Care referrals will be done by the URC and the RCD. Conditions or procedures requiring RCD approval in the Urgent, Non-Urgent, or Limited Value categories will be forwarded directly to the RCD for utilization review.

The UR process is not limited to only outside referral consideration; specialty care provided by contractors within the institution must be preauthorized by the RCD. Dental referrals are forwarded to the RCD or designee for approval; if digital radiographs are not available, films are forwarded by mail or other methods. Relevant factors to consider in approving proposed treatments include:

- The risks and benefits of the treatment.
- Available resources.
- Natural history of the condition.
- The effect of the intervention on inmate's masticatory function and oral health.
- Time remaining on the inmate's sentence.

a. **Recommendations**. The RCD selects the appropriate EMR decision for each case:

- **Approved:** The request granted without modification.
- **Defer**: Additional information is required. The consult has to be resubmitted.
- **Disapproved:** The request for the procedure is denied. Reasons should be documented, such as the procedure is contraindicated due to unacceptable risk to the inmate if it is performed, etc.
- **Follow Up:** No decision, pending additional information.

b. **Decisions**. The CDO or the designated HSU staff will ensure that a written notification of the URC decision is made to the inmate and a copy is placed in the inmate's health record. The reason for the decision should be included, where applicable.

c. **Recommendations From Clinicians External to the BOP**. The CDO is under no obligation to follow an outside dental consultant's or private dentist's recommendations. However, if the recommendations are not followed, the CDO must document his/her justification in the health record.

If a specific intervention is not pursued, the inmate is advised that his/her condition will continue to be monitored and ongoing treatment provided as necessary, and that re-submission of the request will be considered if dentally indicated.

d. **Secondary Reviews**. The CDO can appeal the RCD's UR decision on a case-by-case basis to the National Chief Dentist.

e. **Retrospective Review**. A retrospective review of emergency cases can be conducted by QM staff based on URC findings and as part of the institution Quality Improvement Program.

13. DENTAL LABORATORY SERVICES

If a National Dental Laboratory has been contracted, all dentists must use these services exclusively. Exceptions to this requirement shall be made in writing to the RCD and will be considered on a case-by-case basis. These exceptions will require payment through the local

institution's funding and contracting office. All laboratory slips will be completed by a dentist and scanned into EMR Dental, Other Forms section. Refer to the National Chief Dentist's Sallyport page for further guidance.

14. **PREVENTING MEDICAL EMERGENCIES IN THE DENTAL CLINIC**

a. **Health Evaluation**. The Inmate Health Summary in EMR will be reviewed before any patient encounter, noting all relevant medical information, including diagnoses, encounters, prescriptions, recent vital signs, and laboratory values. All dental patients are interviewed for any changes in their health and their compliance in their medical treatment, as this may alter planned dental treatment. When indicated, updated laboratory tests and vital signs are obtained. Full EMR literacy and familiarity with current BOP Clinical Practice Guidelines (on Sallyport) in all health care sections is expected.

b. **Medical Emergencies**. Each dental department will be prepared to implement emergency medical care procedures. All dental staff, including contractors, must maintain current CPR certification.

c. **Reference Materials**. All clinics will have current reference materials, such as the latest edition of *Dental Management of the Medically Compromised Patient; Little, Falace, Miller & Rhodus; Mosby.*

15. **SPECIAL DIETS**

The treating dentist should consider alternative diets (soft) for inmates for whom nutritional concerns have been documented.

The absence of dentures in a healthy edentulous individual does not warrant a Therapeutic Diet. Nutritional concerns can be addressed to the inmate's primary care practitioner or with a Nutritional Needs assessment through a dietary consult. When prescribed, a blended diet is ordered. Foods will be blended separately and not combined. See current Medical Diets Clinical Practice Guideline.

16. **INTERMAXILLARY FIXATION**

A means of removing fixation is to be readily available to staff who are supervising inmates with intermaxillary fixation. Contact the RCD for guidance/alternatives and coordinate a plan with the institution's Captain.

17. **WORKPLACE SAFETY**

a. **Hazard Communication Program**. A written Hazard Communication Program is mandated by Title 29, CFR 1910.1200. A copy of this program can be obtained from the institution's Safety Manager and implemented with his/her assistance. Under this program, the following are required:

- A chemical inventory and usage log of flammable liquids. Flammable and corrosive materials are stored and inventoried appropriately in consultation with the institution Safety Manager.
- Safety Data Sheets (SDS) for products used in the unit, located in the Dental Clinic where all employee/inmate workers will have access to them.
- Written documentation of yearly staff/inmate worker training.

b. **Other Safety Requirements**:

- Staff and inmates working in the dental lab and dental clinic wear personal protective equipment (PPE).
- Inmates receiving treatment are provided protective eye wear.
- Documentation of the department's safety orientation is kept in the CDO's office.
- Biohazardous waste is disposed according to Federal and State regulations and as part of Health Services Unit procedures.
- Disposable barrier materials are used to minimize contamination of dental equipment and work surfaces and are to be changed after each patient.
- Dental equipment and work surfaces are decontaminated between patients by a surface disinfectant and following manufacturer's recommendations.
- Durable (reusable) dental instruments are sterilized between each use following manufacturer's recommendations. Although disposing of dental burs is recommended after each procedure, those deemed to be reused should be sterilized in autoclave packages.
- Each autoclave/sterilizer's performance is verified weekly when the clinic has been in use by using biological monitoring systems. Weekly periods where there are no dental services provided (leave, Annual Refresher Training, etc.) are noted in the log.
- Each autoclave must have separate logs for weekly monitoring. The monitor's manufacturer's instructions, including the use of controls, are closely followed; each clinic will identify steps to be taken in the event of a positive spore test, including tracking sterilized instruments generated outside the dental clinic. This protocol will be in the local Institution Supplement.
- Scrap amalgam recovery and recycling will be coordinated between the Environmental Safety Compliance Administrator and Chief Dental Officer in accordance with the current Program Statements **Environmental Management Systems** and **Occupational Safety,**

Environmental Compliance, and Fire Protection, and state and local regulations. Methods of collection will be documented in the dental Institution Supplement.

18. ORAL PATHOLOGY /BIOPSY SERVICE

The BOP has established a professional collaboration with the National Naval Dental Center for its oral pathology service. While this agreement is in effect, Bureau clinicians are able to obtain radiographic consultation or send their biopsy specimens to Bethesda, Maryland, or San Diego, California.

If necessary, a telephone or fax response may be requested.

Specimen mailing containers and forms can be obtained from:

Chief, Oral Pathology Service
Walter Reed National Military Medical Center
National Naval Dental Center, Bethesda, MD 20014
or
Chief, Oral Pathology Service
Naval Dental Center, San Diego, CA 92136-5147

All biopsy results are reviewed with the patients, initialed by the referring practitioner, and included in the electronic medical record. Biopsy findings are referred to the Tissue Committee per local protocols.

19. SECURITY

The dental clinic presents several security concerns, including oversight of inmates, records, instruments, needles, hazardous chemicals, flammable materials, and computers. The CDO consults with the Chief Correctional Supervisor in developing security measures in the dental clinic:

- Needles, syringes, irrigation syringes, pre-filled syringes, and acid etch syringes/dispensing tips are accounted for using procedures in the current Program Statement **Pharmacy Services**. Strict adherence for needle accountability is expected; sub-stock stored in the clinic will be counted and documented on every manned shift. Although expiration dates are to be monitored, anesthetic carpules are not considered sharps and are not included in the shift inventory requirement.
- Dental burs do not pose a security risk and are not inventoried.

- Class A and B tools are stored and inventoried in accordance with tool control policies. See the current Program Statement **Correctional Services Manual**.
- Dental/surgical instruments cannot be handled as Class B tools; they are not engraved or stored on a shadowboard. Instruments will be stored in their sterile packages in a way that does not compromise the pack's integrity and the sterility of the contents. In the event of packaging of multiple instruments together (e.g., an operative setup), the inventories indicate how many and which instruments are in the package.
- Written inventories (ex: scalpels) are maintained with a method to document/prove accountability. The method and frequency of accountability will be established and may vary depending on the specific mission or needs of the institution. This protocol will be in the local Institution Supplement.
- The inventory of surplus/bulk dental instruments should be verified on a quarterly basis.
- Access to areas where dental instruments are kept should be limited to Dental Staff/contractors, HSA, CD, and supervised inmates. Inmates are not allowed in the dental clinic without staff supervision. All dental staff are responsible for supervising inmates and will conduct pat searches as needed. See the current Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.
- Policy/procedures must be developed with guidance from the institution's Computer Services Manager for computer and information security.
- Consult the RCD when developing security measures in the Dental Clinic.

REFERENCES

Program Statements

P1600.09	Occupational Safety, Environmental Complieance, and Fire Protection (10/31/07)
P1600.10	Environmental Management Systems (12/14/07)
P4100.05	Bureau of Prisons Acquisition Policy (3/3/16)
P4400.05	Property Management Manual (3/13/15)
P4500.11	Trust Fund/Deposit Fund Manual (4/9/15)
P5290.14	Admission and Orientation Program (4/3/03)
P5500.12	Correctional Services Manual (10/10/03)
P5521.06	Searches of Housing Units, Inmates, and Inmate Work Areas (6/4/15)
P5580.08	Personal Property, Inmate (8/22/11)
P6010.05	Health Services Administration (6/26/14)
P6013.01	Health Services Quality Improvement (1/15/05)
P6027.01	Health Care Provider Credential Verification, Privileges, and Practice Agreement Program (1/15/05)
P6031.02	Inmate Copayment Program (8/15/05)
P6031.04	Patient Care (6/3/14)
P6090.04	Health Information Management (3/2/15)

P6190.04 Infectious Disease Management (6/3/14)
P6360.01 Pharmacy Services (1/15/05)
P6370.01 Laboratory Services (1/15/05)

Title 29, CFR 1910.1200 OSHA Hazard Communication Program

BOP Forms

BP-A0148 Inmate Request to Staff
BP-A0358 Medical Treatment Refusal (Rechazo de Tratamiento Médico)
BP-A0383 Inmate Personal Property Record
BP-A0618 A&O Dental Examination (Initial Clinical Dental Findings)
BP-A1041 Consent for Removal of Orthodontic Appliances
BP-A1080 Consent For Treatment By Student Dentist/Hygienist

ACA Standards

- 4th Edition Standards for Adult Correctional Institutions: 4-4196(M), 4-4215(M), 4-4342, 4-4344(M), 4-4345, 4-4347, 4-4350, 4-4351(M), 4-4354(M), 4-4358(M), 4-4360, 4-4361, 4-4362(M), 4-4346, 4-4375, 4-4378(M), 4-4381(M), 4-4382(M) , 4-4392, 4-4393, 4-397(M),4-4398, 4-4410, 4-4410(M), 4-4412, and 4-4427.

- 4rd Edition Performance Based Standards for Adult Local Detention Facilities: 4-ALDF-2D-03(M), 4-ALDF-4B-06, 4-ALDF-4C-01(M),4-ALDF-4C-02, 4-ALDF-4C-03, 4-ALDF-4C-04, 4-ALDF-4C-07, 4-ALDF-4C-08(M), 4-ALDF-4C-18(M), 4-ALDF-4C-20, 4-ALDF-4C-21, 4-ALDF-4C-22(M), 4-ALDF-4C-25, 4-ALDF-4C-35, 4-ALDF-4D-02(M), 4-ALDF-4D-10, 4-ALDF-4D-11, 4-ALDF-4D-15(M), 4-ALDF-4D-16, and 4-ALDF-4D-25(M).

Records Retention Requirements

For guidance on records and information that apply to this program, see the Records and Information Disposition Schedule (RIDS) on Sallyport.