OVERVIEW OF RECOMMENDATIONS BY DENTAL EXPERT, JAY D. SHULMAN, DMD, MA, MSPH, WITHIN THE SANTA CLARA COUNTY DEPARTMENT OF CORRECTION

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Introduction

On December 15, 2016, the Board of Supervisors approved an agreement with Sabot Consulting to administer a comprehensive gap analysis to assess and evaluate the provision of health care within the Santa Clara County Department of Correction (DOC). I retained five consultants to conduct the gap analysis and that work is still in progress. In an effort to keep the County updated on the progress of the gap analysis as the information becomes available, I have already provided the recommendations of the Suicide Prevention Consultant, Lindsay M. Hayes, and I am now providing information from Dr. Jay Shulman, who recently completed his assessment of the DOC's dental program.

Qualifications

Dr. Shulman has been a dentist for over 44 years and has had careers in the military, dental education, and correctional dentistry consulting. He is certified by the American Board of Dental Public Health, one of the nine specialties recognized by the American Dental Association. Moreover, he has extensive experience auditing and managing educational, military, and correctional dentistry programs.

During his 22-year military career, he served as the Army Surgeon General's Dental Public Health Consultant and wrote dental public health policy, procedures, and technical guidance. He has written 56 peer-reviewed articles and three book chapters. Dr. Shulman was Director of the Graduate Program in Dental Public Health at Baylor College of Dentistry where he was a faculty member for 15 years, and after retiring from his academic position he remains on faculty as Adjunct Professor, Department of Periodontics. Dr. Shulman has served as a correctional dentistry consultant, court expert / representative, and expert witness several times since 2005. As a court expert in two major class action settlements involving prisoner dental care, he developed an audit process based on the review of clinical records and performed system-wide audits of programs in California (roughly 170,000 inmates in 33 institutions) and Ohio (roughly 50,000 inmates in 30 institutions) over a multi-year period.

Assessment Methodology and Standards

Dr. Shulman conducted a four-day site visit of the Santa Clara County Jail dental clinics between January 4 and 7, 2016. He reviewed the DOC policies and procedures, grievances, inmate dental charts, jail population data; interviewed dental, other health care, and custody staff; and reviewed the scientific and correctional literature concerning correctional dental care. (See Bibliography)

Dr. Shulman advocates for the standards described below for a dental program in correctional facilities. As it relates to scope of services, Dr. Shulman notes that the focus of correctional dentistry is the control of acute and chronic dental pain, stabilization of dental pathology, and maintenance or restoration of function. Dental treatment should not be limited to extractions and should include restorations (fillings). The provision of dental care in a correctional setting is similar to that in public health settings such as a community health center, with emphasis placed on prevention and restoration of function. However, the standard for quality is the same as it is in the community at large. The scope of services may be conditioned

on the length of an inmate's incarceration, with short-term inmates receiving less extensive treatment.

Santa Clara County Jail Population

Dr. Shulman noted that The *Criminal Justice Realignment Act of 2011* made significant changes to the sentencing and supervision of persons convicted of felony offenses; one of the most significant changes being the place where the sentence for certain crimes are to be served. As a result, the inmate populations of county jails and the median sentence lengths have increased, turning transitory jails into hybrid jail/prison facilities. The provision of health care in county jails has been substantially impacted since 2011 since the longer sentences carry with them a responsibility for providing more comprehensive care.

Dr. Shulman noted that it is not unusual for dental care provided to short-stay inmates in jails to be restricted to treating conditions associated with pain (*i.e.*, Urgent Care), while treatment for non-painful conditions (*i.e.*, Routine Care) is not provided – even to sentenced inmates. However, inmates with longer stays require a larger array of dental services. Consequently, Dr. Shulman finds that jails must be prepared to provide longer-term inmates with the dental services that would have been provided if they were incarcerated in the California Department of Corrections and Rehabilitation (CDCR).

In evaluating the DOC, Dr. Shulman noted that the Main Jail Complex houses men at all custody levels. The Elmwood Complex houses minimum and medium custody men and women at all custody levels. Table 1 shows the January 6 population for these facilities.

January 6, 2016 Census	
Facilities:	Population:
Main Jail Complex	1,253
Main Jail North	893
Main Jail South	360
Elmwood Complex	2,290
Men	1,835
Correctional Center for Women (CCW)	443
Total	3,534

In 2015, the DOC reported 81,849 bookings of which 79 percent were released within one month, 86 percent within two months, and 95 percent within six months. At the end of December 2015, 27 percent of the 3,639 inmates were sentenced. Of the inmates with release dates, 855 (88%) had a release date less than six months.

Recommendations

Dr. Shulman conducted an assessment of the DOC's dental program and provided the following recommendations as to how the program should evolve to meet the challenges of realignment.

A. Dental Program

1. Leadership

The physicians and dentists (and dental assistants) currently report to the Chief Medical Officer, who reports to the Executive Director of the Santa Clara Valley Health and Hospital System (SCVHHS). Nurses and non-clinical personnel currently report to the Director of Custody Health, who reports to the Executive Director of the Santa Clara Valley Health and Hospital System (SCVHHS). Dr. Schulman recommends that the Sheriff's Office retain an experienced correctional health care administrator to monitor the provision of health services and coordinate the interaction between health care and custody.

2. Scope of Services

The Inmate Orientation and Rulebook currently advises inmates that emergency dental care is provided for all inmates; that if inmates require dental care, they should submit a dental request form to the nurse at the morning pill call; and that if they have a dental emergency they should notify an officer immediately. Santa Clara County Adult Custody Dental Policy addresses the scope of services:

> Dentists who provide services to adult custody inmates work under the guidelines provided by the state of California under Title 15, and by the Institute of Medical Quality. These guidelines state that dental care is provided for the immediate welfare of each patient and is not intended to correct years of dental neglect, and that treatment should not be limited to extractions of teeth. The types of services provided to each inmate are determined at the discretion of the treating dentist based on the aforementioned guidelines and each patient's particular presentation.

Dr. Shulman recommends that the scope of services be broadened for longer-term inmates and be based on the dental priority codes (DPC) used by CDCR which categorize treatment needs as DPC 1 (Urgent Care), DPC 2 (Interceptive Care), DPC 3 (Routine Rehabilitative Care), DPC 4 (No Dental Care Needed), and DPC 5 (Special Needs Care).

a. Urgent Care

Dr. Shulman recommends that Urgent Care be sub-divided based on a condition's acuity. Conditions characterized with sudden onset and severe pain should be treated within 24 hours. Sub-acute hard or soft tissue conditions that are likely to become acute without early intervention should be treated within 30 days. Conditions requiring treatment for unusual hard or soft tissue pathology should be treated within 60 days. Dr. Shulman recommends that Urgent Care be made available to all inmates.

b. Interceptive Care

Dr. Shulman recommends that inmates requiring Interceptive Care be treated within 120 days. Interceptive Care comprises treatment of (asymptomatic) advanced caries, moderate or

advanced periodontal pathology, and fabricating dentures for inmates who are edentulous or are essentially edentulous. Dr. Shulman recommends that Interceptive Care be available to inmates who have six months or longer left in their sentences or inmates who are not adjudicated but who are likely to be in custody for at least six months.

c. Routine Care

Dr. Shulman recommends that Routine Care be provided within 12 months. Routine Care comprises making partial dentures for inmates who have inadequate posterior teeth to chew a regular diet and restoring decayed or fractured teeth with definitive restorative materials or transitional crowns. Dr. Shulman recommends that Routine Care be available to inmates who have 12 months or longer left in their sentences or those who are not adjudicated but likely to be in custody for at least 12 months.

To determine the number of inmates who would be eligible for non-urgent care, Dr. Shulman recommends that the DOC develop a valid decision rule to prospectively identify long-term inmates.

3. Staffing

The Dental Program is currently staffed by a Dental Director, who is a 0.8 full-time equivalent (FTE) at the DOC (she is also a 0.2 FTE at the County's Juvenile Hall); two 0.5 FTE staff dentists; and one 0.1 FTE dentist; for a total of 1.9 dentist FTEs. There are currently 2.5 dental assistant FTEs and no dental hygienists on the staff. The inmate-to-dentist ratio (based on a 3,500 census) is 1,842:1.

Dr. Shulman recommends the Dental Program Director spend a full 1.0 FTE at the Jail. He also recommends that personnel be increased in phases as follows:

Phase 1—Urgent Care

Dr. Shulman recommends that initially an additional 1.5 dentist and dental assistant FTEs will be needed for Urgent Care waiting times to reach a steady state goal of three days for three months. If the goal is not met, additional FTEs will be required until a steady state is reached for three months.

Phase 2—Interceptive Care

Once the Urgent Care steady state has been achieved, Dr. Shulman recommends that sufficient staff should be hired to provide Interceptive Care to inmates with at least six months left on their sentence or those who are not adjudicated but are expected to be incarcerated at least six months. This phase should end three months after a steady state has been achieved, as long as the Urgent Care goal continues to be met.

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Phase 3—Routine Rehabilitative Care

Once the Interceptive Care steady state has been achieved, Dr. Shulman recommends sufficient staff (to include a part-time dental hygienist) be hired to provide Routine Rehabilitative Care to inmates with at least 12 months left on their sentence or those who are not adjudicated but are expected to be incarcerated at least 12 months. Staffing is presumed to be stable three months after the Routine Rehabilitative Care goal is met, as long as the Urgent and Interceptive Care goals continue to be met. Depending on the number of clinical staff required to achieve a steady state, it may be necessary to extend clinic hours.

4. Policies and Procedures

Dr. Shulman recommends that the current dental-care policies be revised as follows:

- Dental policies and procedures should be rewritten to address a wider scope of services (e.g., oral self-care, periodontal diagnosis and non-surgical treatment, denture fabrication and repair, restorations, and routine care), and clinical administrative procedures (e.g., record keeping and workload reporting). The Policies and Procedures should be modeled on those used by CDCR, especially with respect to the DPC system.

- The policy regarding prescribing inmates dental prosthesis should be rewritten.

- The Refusal of Care Form should be rewritten to fit the educational level of the typical inmate and should describe the specific treatment that has been recommended and is being refused, as well as the specific consequences of declining the treatment.

- A policy should be developed to address dental floss and other interdental cleaning devices. The policy should also address the circumstances when use of such devices will be denied for security reasons.

- A policy should be developed to treat inmates who have fixed orthodontic appliances.

- The policy on the Security of Dental Instruments should be revised to specify a role for custody.

- A policy should be developed that specifies treatment timelines.

- A policy should be developed to address when inmates who are expected to remain in custody for six months or more will be provided dentures. The policy should also address when soft diets will be prescribed to inmates who experience chewing difficulty due substantial tooth loss.

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5. Quality Improvement

Dr. Shulman recommends that two studies be performed: (1) a study to identify underlying reasons for the high dental-appointment refusal rate and explore methods to reduce it; and (2) a study to assess whether inmates who admit to dental problems at intake receive appropriate referral. Dr. Shulman also recommends that patient encounters, the number of dental sick call visits, wait times to see the dentist, and workload data be collected from the dental clinics and reported.

B. Facilities

The Main Jail Complex is currently served by a one-chair dental clinic located in the North Building. The Elmwood Complex has two dental clinics, the Men's Clinic and the Women's Clinic.

Dr. Shulman makes the following recommendations with regard to the facilities:

1. Panoramic Radiographs

Neither of the clinics have a panoramic radiograph device. Inmates deemed to need a panoramic radiograph are sent to a County health clinic off-site.

In preparation for the Interceptive Care Phase (Phase 2), Dr. Shulman highly recommends taking panoramic x-rays of long-term inmates who request a dental examination. Consequently, he recommends that a panoramic device, which he estimates costs $25,000, be available to inmates at Elmwood and at Main Jail as well as trained dental assistants, which is not a full-time position, to operate them.

2. Modify Dental Clinics and Clinic Schedules

Dr. Shulman recommends that the DOC consider the feasibility of expanding one of the clinics at Elmwood or identifying space for a larger clinic due to his proposal to increase staffing and clinic hours.

As Interceptive and Routine Rehabilitative Care are introduced, Dr. Shulman notes that there will be a need to make study models and do minor denture repairs and adjustments. He recommends identifying a dedicated space for a small laboratory that is outside the patient treatment area.

Dr. Shulman recommends that the construction plan for the new jail be evaluated to make sure that there is sufficient space for clinical operations as well as for inmate holding. In addition, he suggests that the clinic contain adequate counter space for proper instrument cleaning and disinfection, adequate wheelchair access, sufficient storage space for supplies, and at least two dental operatories. Moreover, the clinic should contain a small dental lab for minor denture repairs and pouring and trimming study models.

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C. Clinic Administration

1. Record Keeping

Dr. Shulman recommends that dental treatment provided to inmates be recorded using the American Dental Association's Code on Dental Procedures and Nomenclature. Dental progress notes are currently maintained in a paper chart, while other data entered by dentists, such as medication orders, are entered in the electronic medical record. Dr. Shulman recommends that the tooth diagram currently used on the paper chart be changed, but noted that this issue may become moot if an electronic dental record (EDR) is purchased. Dr. Shulman also recommends that the dental component not be part of a commercial EDR (which generally does not serve the unique needs of dentistry) but rather an off-the-shelf dental system that can interface with the EDR.

2. Workload Reporting

Dr. Shulman recommends that the principal evaluation metric for the dental program be changed from the number of patient encounters to the number of procedures (using CDT codes) that dentists do on a daily basis. Consequently, it is critical that any EDR be designed with the capability to produce management and productivity reports using CDT codes. In addition, the EDR should be sufficiently flexible to track DPC codes. Dr. Shulman notes that this can be done initially using a manual (paper) system that is completed after each appointment and totaled at the end of the day. This system can be migrated to Microsoft Excel, and later be produced by the EDR.

D. Security

Dr. Shulman recommends that the number of Custody Officers be increased to facilitate inmate transport to the dental clinic. Currently, only one dentist is present in the Elmwood clinics, which have two chairs. If increasing treatment capacity requires these clinics to be staffed by two dentists (or a dentist and a dental hygienist), Dr. Shulman notes that holding cell capacity will have to be increased; or alternatively, the frequency of inmate transport will have to be increased to ensure that inmates with incompatible custody levels are not scheduled for the same clinic period. Dr. Shulman notes that the frequency of transport may also reduce refusals. Dr. Shulman also recommends that Custody Officers be given responsibility to oversee dental tool control in the dental clinics for security reasons.

E. Monitoring

Dr. Shulman recommends that after the final steady state is reached as referred to above, the DOC develop a monitoring plan to ensure that the changed dental program is truly stable and maintains the minimum standard of care. A critical first step will be developing an Audit Tool and developing the process for collecting the data necessary for the audit. Dr. Shulman also recommends that the DOC develop a process for self-assessments that can be validated by a disinterested monitor.

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