UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

SCHOOL OF DENTISTRY

DENTAL FACULTY PRACTICE

POLICY MANUAL

March 1970
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(Revised June 2014)
(Revised April 2016)

Note:

All items which are marked with an asterisk in this document are included in the Division of Health Affairs Rules, Regulations and Policies.
(Revised Effective April 1, 1997)

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1. PURPOSES AND OBJECTIVES

1.1. Mission

The Dental Faculty Practice (hereinafter referred to as “DFP”) at the University of North Carolina at Chapel Hill is a group dental practice whose clinicians are faculty at the School of Dentistry. Those clinicians provide general and specialty dental and maxillofacial treatment in a unique clinical setting. The clinical team consists of caring and competent clinical assistants, hygienists, clerical and financial personnel, and laboratory technicians. Because the faculty are active clinicians, educators and researchers, they are committed to providing state-of-the-art care for DFP patients.

1.2. General Purposes

The purposes of the DFP are to enable the faculty of the School to maintain their clinical competency, to provide dental care and to generate income that supports faculty salaries and provides fringe benefits.

1.3. Objectives of the DFP

The objectives of the DFP are to provide:

(a) dental services;

(b) an opportunity for the faculty to engage in patient treatment;

(c) a site for referring patients, who have special, complex or multidisciplinary needs, by the dental and other health-care practitioners of the state, region, nation and world;

(d) salary support for Practice members;

(e) fringe benefits for Practice members.

1.4. Group Practice

The DFP embodies the spirit of a group effort towards patient care and includes all recognized dental disciplines and specialties. Ideally, when more than one discipline or specialty is involved then the treatment plan, sequencing of procedures, and the follow-up care will be a coordinated effort among all concerned. Each individual DFP member will be responsible for the direct patient care provided. The Dean, and the department Chair and/or group Director assume indirect responsibility in that they certify the qualifications of departmental or group Practice members and oversee quality assurance measures.
*1.5.  **Management and Use of Income**

The University will maintain DFP trust fund accounts for the deposit of all DFP professional income and the disbursement of all DFP expenditures. All professional income, which includes all fees for DFP members' diagnosis and treatment of patients and patient consultation services, will be billed and collected by the DFP and deposited in the DFP trust fund accounts.

1.6.  **Limitation of Income for Full-Time Faculty Member**

The President of the University and the Board of Governors establish ceilings for the total incomes of the faculty members within the School. The sources of salaries for faculty are State appropriated funds, income from clinical practice, and from other professional activities. The Dean of the School establishes with the Chair of the DFP Board (a licensed dentist as appointed by the Dean) and with department Chairs/group Directors each faculty member's salary. In no case shall the combined earnings of a faculty member exceed the approved University salary ceilings.

*1.7.  **Qualifications and Stipulations for Practice Members**

Practice members must meet the following qualifications:

(a) be full-time members of the School faculty, and/or be Faculty members participating in the phased retirement program, and/or be part-time faculty who have previously participated in DFP as a full member;

(b) possess a DDS, DMD, or equivalent dental degree. The Executive Board may approve special multi-disciplinary team professionals who participate in patient care on a continuing basis;

(c) furnish proof of North Carolina State licensure in accordance with the rules and regulations of the North Carolina State Board of Dental Examiners;

(d) may be on probation, as a new Practice member, for a period of up to three years and will be reviewed annually by the DFP Executive Board for continued participation;

(e) must demonstrate a desire to practice. Practice members are subject to review by the DFP Executive Board. (Refer to Section 1.8).

*1.8.  **Definition of Practice Member Status, Relationship of Status to Fringe Benefits and Payment Source**

Participation in the Practice is subject to the University Conflict of Interest Policies and must be approved by the Dean of the UNC at Chapel Hill School of Dentistry.

The Faculty Practice is responsible for all Faculty Practice costs of operation, which are deemed to include: Faculty distributions, dental supplies, facility rental charges, support personnel, equipment, instruments and supplies, billing and account costs, collection fees, professional liability insurance and other costs incurred in the operation of the Practice.

The Faculty Practice is fully owned and operated by UNC at Chapel Hill School of Dentistry. Resources, equipment and all materials of the Practice are considered state owned.
All income and distribution thereof to practitioners participating in the Faculty Practice shall be calculated on the basis of net revenue (actual collections plus non-operating income minus total departmental and faculty expenses).

Upon resignation or termination from the School of Dentistry, or upon termination as a Dental Faculty member participant, the former Member will cease to receive salary distributions from the Practice. Salary distributions are not owed for procedures performed prior to the date of the resignation or termination, but not collected or distributed.

Dismissal from the Practice due to a disciplinary action, including a determination that the member violated any Federal, State, University, School of Dentistry or Faculty Practice policy or procedure will also cease distribution from the Practice.

*1.8.1. **Active Practice Member**

An active Practice member has met the qualifications established in Section 1.7. and is actively engaged in patient care not fewer than four hours or more than twenty hours per week.

*1.8.2. **Inactive Practice Member**

As of July 1, 2004, any new Practice member may become inactive in the DFP by meeting the following qualification:

**Disability:** A statement by a physician is required indicating that the Practice member in question should not engage in the private practice of dentistry. Continuation of this status would be contingent on an annual signed statement by a physician. In order to qualify for disability inactivity, the Practice member must have been a full member of the Practice for a minimum of one year.

Individual requests for inactive status must be submitted in writing to the department Chair or group Director and forwarded with a recommendation to the DFP Board for consideration.

Once a Practice member has been approved for inactive status, Level I of fringe benefits (Refer to Appendix 3) will be paid from the Doctors’ Fund. Level II and Level III of fringe benefits can be paid from the associated department or group at the discretion of the department Chair or group Director, provided that the Practice member remains a full-time faculty member.

Once a Practice member is granted inactive status, he/she is ineligible to continue patient care in the DFP for compensation.

*1.8.3. **Probationary Member**

Faculty members who become part of the Dental Faculty Practice for the first time are probationary members. Upon recommendation by the probationary member’s DFP Executive Board representative, the DFP Executive Board will consider the probationary member for full membership. Probationary members will be reviewed annually by both their department/group and the DFP Executive Board. Parameters evaluated will include, but are not be limited to, productivity, timeliness of care, accuracy and completeness of records, treatment documentation, patient and staff interaction, compliance with DFP policies and
attendance. The probationary period can extend up to three years. During any probationary period, probationary members may not vote on the probationary status of any DFP participant or financial decisions of the group/department and DFP.

1.8.4. **Full Member**

A full member is an active Practice member who has been recommended for full membership by his/her department or group DFP Executive Board representative following a probationary period and approved by the DFP Executive Board. The member must have been a probationary member for a minimum of one year (12 months) to be considered for full membership. Full members will have voting rights. As stated in the University of North Carolina at Chapel Hill School of Dentistry Dental Faculty Practice Plan, “In order to maintain active membership, all members must demonstrate a desire to practice at a satisfactory level of financial productivity and be subject to review by the Executive Board.” This review may occur any time after becoming a full member. For the review, their productivity, in addition to the following, may be taken into consideration: timeliness of care, accuracy and completeness of records, treatment documentation, patient and staff interaction, compliance with DFP policy and attendance.

*1.8.5. **Practice Members on Leave**

A Practice member on leave of absence may, with his/her department's/group's approval, receive fringe benefits at the expense of the department/group or other funds identified by the department Chair or group Director.

1.8.5.1 **Practice Members on Military Leave**

In the event that a DFP member at the UNC School of Dentistry is called to active military duty, the following policies will be in effect:

(a) Following activation, the faculty member will receive paid military leave for whatever period of time is dictated by the State, US government, or the University;

(b) The DFP portion of the Practice member's salary will be paid from discretionary sources for that time period;

(c) If the Practice member elects to use vacation time in addition to or instead of the military leave, the Practice member's department/group will pay that portion of the salary the Practice member receives from the DFP;

(d) Following military activation the Practice member will receive medical health insurance benefits through the military. He/she will continue to receive all other Level I benefits up to a period of 1 year. The Practice member must be fully approved and in good standing. Level I of benefits will be paid from the Doctors’ Fund;

(e) Level II and III benefits are given at the discretion of the department Chair or group Director depending upon the financial status of the practicing group. If granted, Level II and III benefits will be paid by the practicing department/group; and,
University benefits are addressed by the University.

### 1.8.6. **Phased Retirement Practice Members**

Fringe benefits for phased retirement Practice members are the same as those provided to active Practice members at all levels and contingent upon the approval of the department Chair/group Director. These benefits end when phased retirement ends except for dental services as listed under section 1.8.7. Phased retirement Practice members are not entitled to continue receiving the Optional Retirement Contribution on their DFP salary.

### *1.8.7. **Retired Practice Members**

Practice benefits are extended only to those participating in the Practice or as authorized by the Dean to receive benefits. No Department Chair or DFP participant is authorized to extend those benefits to non DFP participants. Retiree benefits are defined in Appendix A3, Retired Participants A.

### *1.8.8. **Practice Members Who Assume Administrative Posts**

The DFP Executive Board may extend Level I fringe benefits to faculty members who have had direct clinical and/or administrative responsibilities in the Practice and who then assume administrative posts not directly related to the Practice. The Level I fringe benefits are continued based upon the recommendation of the Dean and payable from the Dean's Fund.

### 1.9. **Governing Documents of the DFP**

Practice members will be governed by the following:

(a) the Division of Health Affairs Rules, Regulations, and Policies; (Refer to Appendix 1)

(b) applicable policies and procedures of the University of North Carolina School of Dentistry, including but not limited to the Policy on Infection Control; (Refer to Appendix 2)

(c) the DFP Policy Manual (The Policy Manual). The Policy Manual will govern the overall operation of the Practice. The entire Policy Manual or any part of the Policy Manual may be amended at any regular or special meeting of the DFP Executive Board under the same rules as any other motion. Motions to amend will not be admitted to the floor at any meeting unless properly referenced; such changes must be written and circulated to DFP Executive Board members two weeks before a scheduled meeting. Changes in policies that are also included in the Division of Health Affairs Rules, Regulations and Policies (those marked with *) must be forwarded to the Chancellor for review and action before activation.

(d) the current DFP by-laws or operating policies supersedes previous DFP by-laws or operating policies entered into by the Faculty Practice members, at any time.

### 1.10. **Failure of Practice Members to Comply with Policies**

A Practice member who fails to comply with policies adopted by the DFP Executive Board and the policies reflected in The Policy Manual will forfeit all privileges, including benefits and further participation in the Practice. Enforcement of this provision will occur at the discretion of the Dean.
2. ORGANIZATIONAL AND ADMINISTRATIVE STRUCTURE

2.1. Organizational Structure

As a function of the School in the University, the ultimate responsibility for the Practice rests with the University, particularly the Division of Health Affairs. The direct responsibility for the Practice rests with the Dean of the School and the respective DFP department Chairs and group Directors. The DFP Executive Board is given the power to govern and conduct the Practice in all matters. The DFP Executive Board powers of governance are subject to the approval of the Dean of the School and within the limits of the University and Division of Health Affairs Rules and Regulations. The administrative responsibility for the day-to-day operation of the Practice is delegated to the Director of the Practice, and the Executive Committee of the DFP Executive Board of the Practice.

2.2. DFP Administrative Structure

Dean
DFP Executive Board (Refer to Section 2.3.)
Executive Committee (Refer to Section 2.4.)
Director* (Refer to Section 2.5.)
Business Officer* (refer to Section 2.6.)

*Ex officio non-voting member of DFP Executive Board
Chair of the DFP Executive Board votes in the instance of a tie vote.

2.3. Executive Board

The Executive Board (hereinafter referred to as the DFP Board) will be the policy-making and governing body of the DFP. The DFP Board consists of one elected Practice member from each department/group, the Chair of the DFP Board (a licensed dentist as appointed by the Dean), Vice Chair of the DFP Board (DFP Director), the Business Officer and a representative from Patient Accounts. A department/group representative must be an active and full Practice member with a minimum of two years of clinical experience within the Practice. A representative may serve an unlimited number of times.

2.3.1. Chair of the DFP Board

The Chair of the DFP Board will be appointed at the Dean’s discretion. The Chair of the DFP Board is a non-voting member except on the occasion of a tie vote when he/she may vote to break the tie.

2.3.2. Vice Chair of the DFP Board

The Vice Chair of the Board will be the Director. The Vice Chair of the DFP Board will be a non-voting member of the DFP Board.

*2.3.3. Authority and Duties of the DFP Board and its Officers

The DFP Board will have the power to establish the governing policies of the DFP within the limits of the University's Division of Health Affairs Rules and Regulations and subject to the approval of the Dean of the School.
The Dean will take no policy action in matters affecting the Practice before consultation and discussion with the DFP Board.

The DFP Board and each of the departmental/group representatives are obliged to best serve the interests of the entire Practice, not that of individual departments/groups.

2.3.3.1. Duties of the Chair of the DFP Board

The Chair of the DFP Board will:

(a) preside at all meetings of the DFP Board;

(b) be a non-voting member of the DFP Board except in the instance of a tie vote;

(c) be the Vice Chair of the Executive Committee;

(d) study, plan, advise, and act in the role of a special consultant to the Director and Practice members concerning all internal Practice affairs;

(e) have the power to act on all matters that are not in conflict with the Policy Manual;

(f) appoint committees as needed.

2.3.3.2. Duties of the Vice Chair of the DFP Board

The Vice Chair of the DFP Board will:

(a) be a member and attend all meetings of the DFP Board;

(b) preside at Executive Committee meetings as Chair;

(c) be the Director of the DFP.

2.3.4. Elections

2.3.4.1. Provisions for Annual Elections

An election will be held annually in May to elect representatives to the DFP Board. Practice members must be a full member and have a minimum of two years active service in DFP to be eligible for election to the DFP Board.

2.3.4.2. Election Mechanism

DFP Board representatives from each department/group will be selected by secret ballot of the active full Practice members in each respective department/group. Ballots listing the names of eligible Practice members will be distributed once a year, no later than May 1, by the Business Officer. Sealed ballots must be returned to the Business Officer no later than May 15. The
Business Officer will count and report the results to the Chair of the DFP Board.

2.3.4.3. Run-Off or Tie Votes

Elections will be decided by a majority vote of the voting representatives (full member of the group). In those instances that a majority vote is not established, a run-off election will be held between the two Practice members (including ties) receiving the most votes on the ballot. The ballot for the run-off election will be distributed within two days of the initial count and allowing a maximum of three working days for the return.

2.3.5. Term of Office

Departmental/group representatives will be elected for a two-year term; terms begin on July 1. Approximately one half of the DFP Board will be elected each year.

2.3.5.1. Filling Vacancies

A DFP Board representative vacancy is filled by the respective department/group conducting a special election. The vacancy for the unfinished term will be filled at the next annual DFP Board election.

2.3.6. DFP Board Meetings

2.3.6.1. Regular Meetings

The DFP Board will meet bimonthly. The bimonthly meetings will occur for a maximum of two hours unless a majority of the voting members in attendance vote to extend the meeting. Alterations in this schedule may be made with approval by the DFP Board.

2.3.6.2. Additional Meetings

The Chair of the DFP Board may call additional meetings by giving two weeks advance written notice and convening a majority of the voting department/group representatives at such meetings. The Chair of the DFP Board may call emergency DFP Board meetings without two weeks advance written notice. Emergency DFP Board meetings can be held without a majority of representatives in attendance.

2.3.6.3. Attendance

Each representative will be expected to attend all DFP Board meetings. Any representative unable to attend a meeting must notify the Director of the DFP and/pr Business Officer, in writing whenever possible, at least twenty-four hours before the meeting and must provide the name of the substitute; the substitute must be a faculty member from the same department/group as the absent representative. It is preferable that the substitute be a former representative of the DFP Board or be eligible for DFP Board membership.
2.3.6.4. **Quorum**

A quorum of the DFP Board consists of a simple majority of the voting members. Voting members are regularly elected representatives or their substitutes and the Chair of the DFP Board (Refer to Section 2.3.1.). A majority vote amongst the representatives who are present must occur for a motion to carry. The Chair of the DFP Board or presiding officer may vote to break a tie. At the discretion of a majority of the DFP Board, electronic voting can be utilized through secure electronic means to allow timely action on items that occur in the time interval between scheduled meetings.

2.3.7. **Informing Departmental or Group Members of Actions**

Each department/group representative or substitute will communicate to his/her department Chair or group Director those decisions or actions having a direct effect on his/her department/group.

2.3.8. **Minutes**

Minutes of all DFP Board meetings will be distributed to all Practice members and DFP staff members.

2.4. **Executive Committee**

The Executive Committee consists of the Director and Business Officer of DFP, the Chair of the DFP Board and two members-at-large (Refer to Section 2.4.2.). The Director will serve as the Chair of the Executive Committee.

2.4.1. **Duties of the Executive Committee**

The Executive Committee:

(a) will meet at least once a month or at the call of the Chair of the DFP Board. The Executive Committee will keep the Practice members informed of its actions by appropriate written reports;

(b) will assist in the day-to-day operation of the Practice;

(c) may recommend policy changes to the DFP Board.

2.4.2. **Election of Members-At-Large**

The DFP Board will elect two members-at-large to the Executive Committee from among the DFP Board membership. The election will occur at the first DFP Board meeting of the new fiscal year. Length of term will be for two years. A vacancy on the Executive Committee is filled by the Chair of the DFP Board, given the approval of the DFP Board, appointing an eligible member-at-large from the DFP Board.

2.5. **Director**

The Director will be appointed by the Dean. Selection of a Director will involve consultation with, and the concurrence of, the DFP Board.
2.5.1. **Duties of the Director of the DFP**

In consultation with the Chair of the DFP Board, and with the assistance of the Business Officer, the Director will:

(a) monitor the patient accounts receivable system and the collections activities, and distribute appropriate financial reports to group representatives and/or Practice members;

(b) periodically analyze the financial status of the Practice and report findings, recommendations, and suggestions for expense reduction to the Chair of the DFP Board (a licensed dentist as appointed by the Dean);

(c) organize and oversee the Administrative Office SPA personnel in the Dental Practice;

(d) have final approval over hiring of Administrative Office SPA employees and supervise the Business Officer as he/she assists in this function;

(e) supervise the management of grievances, the administration of SPAG regulations, the Fair Labor Standards Act, and the Wage and Hour Law;

(f) orient new doctors to the various systems, operations and policies of the Practice;

(g) be responsible for reporting the results of the annual election of DFP Board members;

(h) supervise the assignment of operatories to Practice members in accordance with department schedules;

(i) be responsible for the remodeling, maintenance, and security of all Practice facilities under the direction of the Chair of the DFP Board (a licensed dentist as appointed by the Dean);

(j) be responsible for control of patient flow and the preservation of good public relations throughout the Practice;

(k) develop and implement various systems of a financial and non-financial nature to meet the needs of the Practice;

(l) be directly responsible to the Dean for all operations of the Practice as related to the Practice, the School, and the University;

(m) serve as Vice Chair of the DFP Board and Chair of the Executive Committee;

(n) establish Practice holidays;

(o) conduct evaluation of new faculty Practice members at the conclusion of each probationary year and inform the DFP Board as to the results of evaluation for the DFP Board to then decide on status;

(p) monitor compliance with all policies and procedures established for Practice staff and Practice members.
2.6. **Business Officer**

The Business Officer will be a non-faculty SPA staff member.

2.6.1 **Duties of the Business Officer of the DFP**

In consultation with and the assistance of the Director, the Business Officer will:

(a) directly organize and manage the Administrative Office and the Front Desk SPA personnel in the Dental Practice;

(b) review and create personnel descriptions for the Administrative Office and the Front Desk SPA personnel in the Dental Practice;

(c) serve as a non-voting member of the DFP Board and the Executive Committee;

(d) be directly responsible to the Director;

(e) monitor the patient accounts receivable system and the collections activities, and distribute appropriate financial reports to group representatives and/or Practice members;

(f) oversee the administration of the DFP University Trust Fund including, with the Director’s approval and using University channels, investing any excess cash in the DFP Trust Fund and reconciling DFP financial records to the University’s records for the DFP Trust Fund;

(g) monitor room utilization and create monthly reports for the Director;

(h) be available to counsel newly hired Staff members;

(i) oversee and process patient dismissals;

(j) review all DFP Administrative purchase orders;

(k) register all new Practice members for DFP benefits;

(l) oversee the preparation and distribution of DFP financial reports including, but not limited to, monthly operating reports for each of the departments and groups in the Practice and for the Dean.
3. DEPARTMENT/GROUP AND PRACTICE MEMBER RESPONSIBILITIES

*3.1. Department Chairs and Group Directors

The department Chair or group Director will assume responsibility for implementing, maintaining, and evaluating the Practice activity of the members of his/her department/group. The department Chair or group Director may delegate this responsibility to another member of the department/group and must delegate if the department Chair or group Director is not an active DFP member. (Directors for groups not synonymous with academic departments will be designated by the Chair of the DFP Executive Board upon consultation with the members of the group). Ultimate responsibility for leadership in all aspects of Practice activity resides with the department Chair or group Director. Each department Chair and group Director responsibilities include, but are not limited to, the:

*(a) quality and quantity of services rendered to patients;

*(b) Practice member’s activities, including scheduling, patient management, use of supplies, profit or loss, production, problems with patients, employees, management, or facilities;

(c) adequate and timely communication with Practice members about yearly production goals, production accomplished and patient accounts status;

*(d) relationships with other departments or treatment areas;

(e) ensuring that all Practice members from the department/group are acting to preserve the soundness of departmental/group accounts. See Section 1.8.4 for review of full non financially productive members. All departmental/group efforts are collective, including the financial accounting.

*3.2. Faculty Practice Members

Individual Practice members are responsible for all aspects of the direct patient care they provide. In addition, Practice members are also collectively responsible for supporting departmental/group efforts to provide the best possible dental health care for each patient in the Practice. Practice member responsibilities will include, but not be limited to, the following:

(a) supporting department/group fiscal efforts.

(b) exercising judgment in treating patients in the light of his/her experience and capabilities, and referring patients that require specialized treatment to the appropriate specialist.

(c) assuring that the sequence of treatment is continued beyond his/her services by arranging the appropriate referrals.

(d) remaining thoroughly familiar with the procedures and policies of the Practice, and abiding by those procedures and policies.

(e) informing his or her patients of the professional fee for services to be rendered and that payment is due upon completion of that service, unless alternative arrangements are made in advance. Practice members should refer patients to the Patient Accounting Office for arrangements other than the standard financial policy of the DFP. Practice members should notify the Patient Accounting Office when they become aware of changes in the patient's ability to pay.
meeting scheduled time commitments and keeping patient appointments.

3.3. **Types of Practice**

There will be three different types of practice in the DFP. The classification scheme is guided by American Dental Association descriptions/definitions.

3.3.1. **Generalist**

A generalist Practice member is one who may choose to deliver an expanded scope of dental services within the Generalist group.

3.3.2. **Limited**

A limited Practice member is one who limits his/her practice to certain aspects of dentistry, but does not possess specialty qualifications or credentials. The classification will include the following areas of dental practice as well as others approved by the DFP Board as the need arises:

(a) Craniofacial/Geriatric-Hospital Dentistry;

(b) Operative Dentistry;

(c) Orofacial Pain.

3.3.2.1. **Limitation of Service**

Practice will be limited to the field or area of dentistry designated by the department/group with exceptions noted.

Exceptions to "Limited" Practice are recognized for those Practice members from restorative disciplines or additional procedures within restorative disciplines. Other exceptions may occur with the consent of the respective department Chair/group Director.

3.3.3. **Specialist**

A specialist Practice member is one who holds specialty qualifications and credentials and chooses to limit his/her practice to that specialty area. The classification of these specialists will include the following areas of dental practice and others approved by the DFP Board:

(a) Oral and Maxillofacial Surgery;

(b) Periodontology;

(c) Pediatric Dentistry;

(d) Endodontics;

(e) Orthodontics;

(f) Pathology;

(g) Prosthodontics;
3.4. **Department/Group Inter-Relationships**

The Director in consultation with the department Chair or group Director will assign Operatories to the departments/groups.

An operatory that is unscheduled and vacant may be used by a faculty member from some other department/group for emergency treatment with the permission of the department Chair, group Director, or his/her representative for the assigned operatory.

3.5. **Schedules**

The department Chair or group Director will submit the schedules of the Practice members to the Administrative Support Associate Supervisor at the DFP Front Desk sixty days before the beginning of each semester. The on-call/emergency-call schedules will be submitted to the Chair of the DFP Board (a licensed dentist as appointed by the Dean), sixty days before the beginning of each semester.

3.6. **Surgically Placed Dental Implants**

Practice members wanting to surgically place dental implants will undergo a credentialing process which will be evaluated by the DFP Implant Advisory Committee upon recommendation of his/her department chair/group director. The Implant Advisory Committee is composed of a DFP member from Periodontology, Prosthodontics and Oral Maxillofacial Surgery as well as the Director of the DFP (Chair of the committee) and the Business Officer of the DFP. The credentialing process will require that the practice member develop a portfolio which will be submitted to his/her department chair/group director for their review. Upon successful review, the department chair/group director will forward to the Chair of the Implant Advisory Committee for their evaluation. Quality assurance will be the responsibility of the participant's department chair or group director. See Section 1.10 of the DFP Policy Manual for failure to comply with DFP policies.

Included in the portfolio will be documentation of the following if applicable:

1) Surgically placed dental implant training in an academic setting
   a. Name of school
   b. Hours of training
      i. Clinical
      ii. Didactic
   c. Type (s) and number of surgically placed dental implants
   d. Training received for other associated surgical dental implant procedures (bone grafting, sinus lift, etc.)

2) Surgically placed dental implant training courses attended
   a. Name of Sponsor
   b. Hours of training
i. Clinical
ii. Didactic

c. Type(s) and number of surgically placed dental implants

d. Training received for other associated surgical dental implant procedures (bone grafting, sinus lift, etc.)

3) Other non-program related experience in surgical implant placement

   a. Type(s) of surgically placed dental implants
   
   b. Number of surgically placed dental implants

4) Other information that may be pertinent.
4. RULES AND REGULATIONS PERTAINING TO INDIVIDUAL PRACTICE MEMBERS

*4.1. Time that May Be Devoted to the DFP

Clinical faculty are expected to participate in patient treatment services in the DFP for a minimum of 8 hours and a maximum of 10 hours per week. The department Chair or group Director may with the consent of the Practice members involved, assign Practice members to schedule patients in the DFP a minimum of four and a maximum of 20 hours per week. A department Chair or group Director can extend these hours at his/her discretion.

Patients are scheduled for appointments during hours of operation as set by the DFP Board. Except for extenuating circumstances and/or emergency treatment, a Practice member will schedule his/her appointments in accordance with his/her schedule. A Practice member may make up scheduled time lost due to illness, vacation, absence to attend dental meetings, and absence due to other legitimate reasons.

4.1.1. Time for Extenuating Circumstances

In addition to the hours normally scheduled in accordance with the Division of Health Affairs Rules, Regulations, and Policies (as amended in July 1978), time is allotted for dental service (dental treatment or consultation) for patients due to extenuating circumstances. Patients may receive dental care in cases of presenting themselves for treatment at DFP, or have traveled a long distance, or the patient’s situation warrants attention for the best interest of the patient, the School, and the University.

4.2. Third-Party Presence in a Treatment Area

For legal and safety reasons, no patient will receive treatment in a DFP treatment area unless at least one other person is present, along with the Practice member and the patient.

4.3. Closed-Door Policy

Except for extenuating circumstances, Practice members will not hold appointments with patients with an individual operatory door closed unless a third person is present.

4.4. Patient Records

Practice member(s), or their designee(s), involved in a specific patient’s treatment are the only persons who may make written treatment entries into that patient’s chart. A Practice member must personally verify his/her treatment entries by signing in a timely manner (10 days) his/her treatment entries or co-signing his/her designees’ treatment entries.

4.5. DFP Security when not Officially Open

Any Practice member operating in a treatment area when the DFP is not officially open is responsible for the security in that DFP area.

4.6. New Practice Member Orientation

All new Practice members will meet with the Director for orientation to policies and procedures. All new Practice members will meet with the Business Officer to register for all appropriate DFP benefits.
4.7. **Terminating Practice Members**

A terminating Practice member will insure that his/her current patients have been charged for all services performed, received written notice that the Practice member is leaving the DFP, and informed patients of the options for their continued treatment at DFP.

4.8. **Management of New Patients**

4.8.1. **Direct Referral**

A direct referral is a patient referred by a personal communication. A direct patient referral may come from a telephone call, or a letter to a specific dentist, group, or specialty of the Practice.

The receptionist would refer those patients designated as direct referrals, after conducting an initial interview, directly to the dentist, group or specialty area for care. When new patients request the services of a specific Practice member, every effort should be made to comply with that request.

4.8.2. **Non-Direct Referral Patients**

The receptionist will assign all new patients, other than the direct referral patients, to a department/group and to a Practice member based upon the patient’s chief complaint and the current availability status and schedules of Practice members.

4.9. **Patient Admissions**

4.9.1. **Eligibility and Restrictions**

Any person may be considered for acceptance to become a patient in the Practice through a direct referral from a dentist or physician for specific treatment or as a self-referral. Acceptance is at the discretion of the practice member. The following sections detail the circumstances that disallow persons from becoming DFP patients (Refer to Sections 4.9.1.1. through 4.9.2).

4.9.1.1. **Transferring Between Student Clinics and DFP**

Any person who received treatment in the student clinics during the past twelve months before requesting treatment in the DFP, is ineligible for consultation, diagnosis, or treatment in the DFP. A Practice member can approve the transfer of a patient from the student clinic to the DFP if the following exceptional circumstances apply:

(a) Students are not available for treatment.

(b) The proposed treatment is beyond the professional capacity of students.

(c) The individual patient’s needs or the nature of treatment demand that treatment be accelerated.

(d) The patient’s treatment needs no longer coincide with the students’ educational needs.
4.9.1.2. **Inactive or Delinquent Patients**

Any patient that has not had an appointment in the past six months and has a delinquent account balance should be on an established payment plan or pay the account in full before receiving further diagnosis and/or treatment with the exception of emergency care.

4.9.2. **Treatment Restrictions for Referred Patients**

Each referred patient shall be diagnosed and treated for the referred condition only. After treatment has been completed a referred patient will be directed to return to his/her referring dentist.

4.10. **Interdepartmental Referrals**

Each patient of the Practice must have a DFP primary care provider. The primary provider is responsible for coordinating patient treatment, among the DFP departments/groups, to best meet an individual patient’s needs. The primary provider may be the initial consulting DFP member or another Practice member as agreed upon among the Practice members providing treatment. When another Practice member refers a patient for further treatment, the referring Practice member will make definitive arrangements for future treatment. If alternate treatment arrangements cannot be made, the patient will be referred to an outside practitioner for the specific service required.

To arrange an internal transfer of a patient, the referring Practice member indicates the reason for the transfer in the patient’s record. The Practice member receiving the patient will make appropriate record entries in that patient’s record. The Practice member receiving the referred patient will communicate with the referring Practice member he/she will relate the patient’s diagnosis, the proposed treatment and patient’s response to both. Upon completion of a patient’s treatment, the Practice member who received the referred patient will notify the referring Practice member of the treatment results and future patient management.

4.11. **Patient Dismissal**

A Patient can be dismissed for the following reasons:

(a) habitually canceling appointments (Refer to Section 5.6.1.);

(b) breaking appointments (Refer to Section 5.6.2.);

(c) having delinquent balances that have been sent to collections (Refer to Section 10.6.);

(d) is unwilling to follow the plan of care;

(e) failing to treat staff with courtesy and respect.

4.11.1. **Patient Dismissal Procedure**

A Practice member may dismiss a patient after a 30-days notification period. The dismissal letter must be sent to the patient by Certified Mail - Return Receipt Requested (Refer to Section 4.11.2)

A sample copy of this dismissal letter and the Returned Receipt will be filed in the patient's record. Sample dismissal letters are available in the Administrative Office.
Communication with patients concerning dismissal, for non-compliance or collections, should be routed through the Business Officer in order to alert appointment clerks, to accomplish chart flagging, and to remove patients from the recall list.

4.12. Due Process in the Dismissal of Patients

The following steps in dismissing patients must be followed through with the Business Officer:

(a) A brochure is sent to all new patients informing them of the patient dismissal policy.

(b) A warning letter can be sent to a patient before a final dismissal letter provided that the warning letter directs the patient to contact the Practice within a specified period of time to avoid dismissal.

(c) A Practice member can give a patient a verbal warning while the patient is in the dental chair before sending a final dismissal letter. The Practice member must document a verbal warning in the patient’s record.

(d) A dismissal letter must contain a specific description of treatment needed for any procedure in progress (but only a general statement concerning other necessary treatment) and a provision for a 30-day termination period in the event that emergency care is needed.
5. APPOINTMENT SYSTEM

5.1. Appointment Check-In

All patients must check in at the appropriate reception desk before going to the corresponding operatories.

5.2. Operating Schedule

The DFP Board will determine the hours of operation of the Practice. Practice operations during non-scheduled hours must qualify as emergency cases.

5.3. Appointment Desk Coverage

A receptionist will be present at all hours of operation. The Director of the Practice will determine the receptionists’ work hours.

5.4. Appointment Control

All appointments must be entered into the DFP appointment systems.

5.5. Room Utilization Monitoring

The Business Officer monitors room utilization by creating a monthly report for the Director as needed.

5.6. Cancellations and Broken Appointments

5.6.1. Cancellations

The DFP defines cancellation as advance notification to the Practice of the patient’s inability to be present for a scheduled appointment, when the notification occurs at least twenty-four hours before the scheduled appointment time. Practice members and their assistants should attempt to assist with the filling of canceled appointments.

5.6.2. Broken Appointments

A broken appointment occurs when a patient fails to appear for a scheduled appointment without proper notification or cancels a scheduled appointment with fewer than twenty-four hours advance notification. Practice members may charge patients, at their discretion, a broken-appointment fee.

5.7. Recall System

A dental hygienist or an individual dentist may recall patients using the established recall protocols. The DFP Administrative Office will assist this process by using the EPR data base.

5.8. Practice Member Absence Procedure

Each Practice member must provide written notification of any planned absences that will occur during their scheduled Practice hours to the personnel (receptionists or assistants) who schedule his/her appointments; written notification should be done as far in advance of the planned absence as possible. In the case of illness, personal emergency, or other
unplanned absence, the Practice member must ensure that the personnel who are responsible for scheduling his/her appointments are properly notified and instructed.
6. MANAGEMENT OF PATIENTS WITH DENTAL EMERGENCIES

6.1. Patients of Record - Regular Business Hours

Each of DFP’s departments and groups must develop an emergency protocol and create a written record of the emergency protocol. It is the responsibility of Practice members to examine and/or treat, during regular hours of operation, any DFP patients of record experiencing dental emergencies. In dental emergency cases, all DFP patients of record should be directed to contact the DFP reception staff.

Each DFP department and group must designate an emergency on-call provider schedule and create a written record of this schedule. An annual schedule for emergency coverage must be provided to the Dean’s Office.

In instances when a department or group cannot provide emergency coverage for its patients, this department/group must arrange for another department/group to provide necessary emergency coverage. Once a department/group has secured replacement emergency coverage, that department/group must inform the Processing Unit Supervisor at the DFP Front Desk of the coverage arrangements.

6.2. Patients of Non-Record

If the receptionist can identify the problem, non-registered walk-in or call-in adult patients will be sent to the appropriate department/group.

If the receptionist cannot identify the problem, a non-registered patient will be referred to the Generalist group for diagnosis. If a Generalist Practice member is not available, the patient will be referred to any other available Practice member. If no Practice member is available, the receptionist may refer the patient either to the Student Clinic Urgent Care Service or to a dental care provider outside the School of Dentistry.

Non-registered walk-in or call-in patients, both emergency and non-emergency, fifteen years of age or under will usually be sent to the Pediatric Dentistry Department.

6.3. After-Hours Emergencies

In the event of after-hours dental emergencies, patients of record may be instructed to first contact their DFP primary care provider. Practice members should give their contact information to each of their DFP patients. If patients are unable to reach their DFP primary care provider, patient may be instructed to call the University of North Carolina Hospitals and ask for the dental resident on call; patients should be instructed to identify themselves as patients of record of the DFP. For any DFP patients who call the DFP number after-hours there will be a recorded message giving out the preceding instructions.

6.3.1. Practice Members Treating Patients’ with After-Hours Emergencies

Practice members who wish to treat patients with after-hours emergencies may do so by making one of the following arrangements:

(a) A Practice member with attending privileges at the University of North Carolina Hospitals may arrange to meet his/her patient in the hospital dental clinic and use the on-call dental assistant available there.

(b) A Practice member wishing to treat his/her after-hours emergency patient in the DFP must do so only in the presence of another person.
7. **GENERAL OPERATING RULES**

7.1. **Room Security**

The DFP area is to be secured at the end of each day by the front desk personnel.

7.2. **Maintenance of Facilities and Equipment**

The Director is responsible for maintenance of the facilities and equipment. Any maintenance problems should be reported to the Director or to the Business Officer.

7.3. **Use of Operatories by Faculty Non-Practice Members**

Any full-time member of the clinical faculty of the School who is licensed in North Carolina may use the DFP operatories to treat his/her family provided he/she receives permission from the appropriate department Chair or group Director whose operatory will be used. Treatment activity of this sort must occur during regular working hours only.

7.4. **Telephone Calls**

Telephones are provided in the DFP for official business only. The cost for telephone service, both local and long-distance, will be included in the General Overhead expenses.

7.5. **Personnel Positions**

The Director initiates new personnel positions for the DFP Business Office. All new personnel positions are subject to the approval of the DFP Board.

Dental assistants and hygienists are approved for employment and assessed for salary determination by the Practice members of the employing department or group. The Director and the Business Officer are available to counsel all newly hired staff members.

7.6. **Laboratory Service for Practice Members**

Laboratory services for the DFP may be obtained from the School operated laboratories, or provided by individual Practice members, or commercial laboratories.

7.6.1. **Procedure for Obtaining Services from the School Laboratories**

In keeping with the North Carolina Dental Practice Act, all service requests must include a prescription(s) for the services at the time they are submitted to the laboratory. Technicians will only accept requests for prescribed services.

7.6.2. **Practice Member Performing Lab Work**

Practice members may provide laboratory services for DFP patients. Practice members cannot substitute the time spent doing patient laboratory work for scheduled clinic time treating patients.

All laboratory materials and supplies used by Practice members, especially precious metals and artificial teeth, should be charged to the appropriate DFP departmental/group accounts.
8. **PATIENT RECORDS**

8.1. **Patient Records**

All persons receiving treatment must register and have a record generated, which includes, but is not limited to, the following:

(a) a registration form with basic demographic and financial information;

(b) a medical alert/problem list;

(c) a medical and dental history that is periodically updated as appropriate for patient’s health status;

(d) an initial clinical examination/data base/written diagnosis;

(e) a treatment plan and cost estimation of treatment (Refer to Section 8.8.);

(f) any additional authorized forms as needed (e.g., a Pathology Report).

8.2. **Patient Records Requirements**

8.2.1. **Responsibility of Patient Records Clerks**

The UNC School of Dentistry processing clerks will be directly responsible for the withdrawal of patient records two days before patient treatment or as requested.

8.2.2. **Prompt Return of Records**

All patient records should be returned to the Patient Records room as promptly as possible.

8.3. **Central Record Retention**

Patient records must be retained in accordance with the specifications of the Attorney General of North Carolina.

8.3.1. **Adults**

Patient records of adults (eighteen years or older) will be retained in the patient records room. All inactive records will be transferred to a storage area.

8.3.2. **Minors**

Patient records of minors will be retained for three years after the patient’s eighteenth birthday. If patients are treated after the eighteenth birthday, these patients’ records will be retained for four years after the last treatment date.

8.4. **Patient Records Room Purge**

The Patient Records room will be purged annually in conjunction with the stated guidelines (Refer to Sections 8.3, 8.3.1., and 8.3.2.) A record will be considered inactive when it has been two or more years since the date of the last patient visit.
8.5. **Impounded Records**

Patient Records personnel will clearly mark and retain in a separate file all patient records sent to collections.

8.6. **Release of Information from Dental Records**

8.6.1. **Authorization for Records Release**

In concordance with North Carolina and United States law, all parts of patients’ records are considered confidential. All privileged and confidential patient information can only be released by one of two ways: by court order or by written consent from a patient (or designated responsible party). A written authorization signed by a patient/responsible party must be received before DFP will release that patient's confidential record/information.

8.6.2. **Retention of Original Patient Records**

The original copies of patient’s records will only be released by court order either to the patient, to a non-Practice provider, or to an outside party. A patient providing proper authorization, for the release of his/her records, will be provided with copies of those records.

8.6.3. **Fee for Record Duplication**

The DFP will assess and receive payment before the release of duplicated materials.

8.7. **Patient Correspondence**

All Practice members will submit copies of any patient correspondence to Patient Records for filing and/or scanning in the patient's records.

8.8. **Treatment Planning**

8.8.1. **Requirement for a Written Treatment Plan**

Practice members proposing an individualized treatment plan for their patients must enter it into the electronic patient record.

The Practice member initiating a treatment plan must inform the patient of the estimated cost of all proposed treatment.

8.8.2. **Fee Estimates for Proposed Treatment Planned**

A Practice member, initiating an electronic treatment plan, must provide each patient with a written statement of the estimated total cost of all his or her proposed treatment. After a Practice member has presented the treatment plan and a patient has accepted the plan, both the Practice member and the patient must sign the treatment plan.

8.8.3. **Consent Form**

After a Practice member has presented a treatment plan to a patient and the patient has accepted the plan; the Practice member, the patient and a witness must sign a consent form before beginning any treatment.
9. **FEES**

9.1. **Depositing of Fees Collected**

All fees collected in the Practice will be deposited into a special fund established by the University.

9.2. **Record Keeping of Patient Accounts**

Patient Accounts will be responsible for accurate recording and filing of all fees charged to patient accounts, done under the leadership of the Associate Dean for Finance for the School and in coordination with the Director of the DFP.

9.3. **Fee Schedules**

At the request of the Director of the DFP, department Chairs and group Directors will submit a written schedule of fees for the dental procedures administered by their respective department/group. Fee schedules will follow these guidelines:

(a) Each department/group schedule will provide the following: Complete Codes and Description of Procedures and fees to be charged for each;

(b) The Executive Committee must pre-approve any changes to fee schedules to ensure consistency in fees throughout the Practice;

(c) Fees charged for all procedures will conform to approved policies and schedules;

(d) The DFP Administration Office will maintain a file of all current fee schedules and shall circulate copies of the same to every Practice member as necessary;

(e) Fee schedules are to be available for patient inspection in the Patient Accounts Office and may be examined on request;

(f) The Executive Committee will review the fee schedules annually.

9.4. **Charging Fees**

Fees shall be charged by the following methods:

(a) Fees will be charged through the treatment module of the Electronic Patient Record (EPR).

(b) Practice members must enter all non-standard fee(s) in EPR at the time of treatment/service.

(c) Fees charged to patients sponsored by agencies will be full fee and may be written off by the Patient Accounts Office for the amount not collected from the specific agency.

(d) Practice members may submit fees as each procedure is completed, at the time of assessment of a laboratory fee, or at any other time during the treatment.

*(e) Any patient seated for any treatment must have a charge entered, even if the charge is zero, and a chart entry must be made. Patients shall be instructed to stop at the reception desk for their walkout statement.*
9.5. **Patient Discounts**

In general, Practice members giving discounts for dental services are discouraged in the Practice. If a Practice member abuses this clause, he/she will be counseled by his/her department Chair or group Director.

9.6. **Bartering**

Practice members are prohibited from bartering dental services in any manner that is not producing income for the Practice.
10. **PATIENT ACCOUNTS**

The Patient Accounts Office of the DFP operates in accordance with the following policies.

10.1. **Authority of the Patient Accounts Office**

The Patient Accounts Office, under the direction of the Associate Dean for Finance for the UNC School of Dentistry, is responsible for managing and maintaining the patient accounting system.

10.1.1. **Reports Generated by the Patient Accounts Office**

The Practice uses an automatic data processing system for the administration of patient accounts.

The Practice produces various records for use by the administration and for internal management purposes. These items are subject to review by the Executive Committee. Current reports include but are not limited to:

(a) Statements of each patient’s account balance, which are mailed at the beginning of each month to the designated responsible party for each patient.

(b) Department Aged Analysis reports, which are distributed every month to each of the department Chairs or to a department’s/group’s designated representative.

10.2. **Legal Requirements Regarding Payment Obligations**

Only patients who are persons 18 years of age and over may sign any official documents of the Practice. A parent or legal guardian must sign all documents for any patient less than 18 years of age. Exception to this policy occurs in the case of a verifiable emancipated minor.

10.3. **Types of Patient Accounts**

The DFP operates under the policy of fee for service requiring that payment is due at the time service is rendered. Other types of accounts may be created before the initiation of treatment.

10.3.1. **Payment-Plan Account**

Because an initial down payment is based on estimated fees, a treatment plan form stating the estimated fees should be completed, dated and signed by the Practice member presenting the treatment plan and the patient.

(a) Payment plans should be established before beginning treatment.

(b) Payment plans must be signed and dated by both a financial counselor in the Patient Accounts Office and by the patient or responsible party.

(c) A payment plan may be based upon estimated fees and/or an account balance. A Practice member initiating a treatment plan should emphasize to patients that charges for treatment are subject to
change. The Practice member should direct the patient to the Patient Accounts Office with a copy of the treatment estimate.

(d) The Practice member must inform both the patient and the Patient Accounts Office whenever additional procedures are to be added to those originally included in the payment plan. Additions can be made to the payment plan by renegotiating the plan with the Patient Accounts Office.

(e) Each payment plan must be written on an approved Truth in Lending Form.

(f) Unless otherwise designated by a department/group, a down payment is 25% of treatment charges with 6 months to complete payment.

10.3.2. **Insurance Accounts**

The DFP will accept insurance payment assignment and will only process insurance claims for services rendered in the following cases:

(a) UNC Physicians and Associates participants and their immediate family members;

(b) Oral and Maxillofacial Surgery patient services – the insurance claims are filed by the Oral and Maxillofacial Surgery group;

(c) Oral and Maxillofacial Pathology services – the insurance claims are filed by the Oral and Maxillofacial Pathology Group;

(d) UNC Craniofacial Center patients – the insurance claims are filed by the Craniofacial Center;

(e) Pediatric and adult general anesthesia patients treated in the Operating Room (O.R.);

(f) Medicare/Medicaid/North Carolina Health Choice patients;

(g) Worker’s compensation patients;

(h) Vocational rehabilitation patients;

(i) Agency-sponsored patients whose agencies require direct payment to the Practice;

(j) Oral and Maxillofacial Radiology services for Oral and Maxillofacial Surgery patients – the insurance claims are filed by the Oral and Maxillofacial Surgery group.

10.3.3. **Doctors’ Fund Account**

The Director of the DFP will review all requests for payment from the Doctors’ Fund and the Director’s approval must be received before beginning that patient’s treatment. Practice members with approved Doctors’ Fund payment will create a walkout statement after each appointment that clearly states the reason for payment from the Doctors’ fund. The walkout statement will be directly transmitted to the Director.
10.3.4. **Paper Transfer Accounts**

Practice members who provide dental services to DFP colleagues and their families are credited for these dental services after internal paper transfers are completed. A walkout statement with the charges noted must be created as the record for any internal paper transfer. The paper transfer process is done in accordance with the Level I of Fringe Benefits Policy of the DFP (Refer to Appendix 3).

10.4. **Collection of Accounts**

Payment is expected at the time of service unless alternative arrangements have been made.

(a) All checks and money orders shall be made payable to the DFP.

(b) Checks made payable to a specific Practice member will be endorsed as “Pay to Dental Faculty Practice – UNC”, signed by the Practice member, and forwarded promptly to the Cashier.

(c) All money received will be credited in the order of services rendered with the exception of insurance payments that can be identified as payments for specific services. A Practice member who has provided on-going recall services that are not included in a payment plan will be duly credited for these recall services.

(d) A returned check fee will be charged for all returned checks. The Executive Committee will determine each year the returned check fee.

10.5. **Collection of Delinquent Accounts**

An account is considered delinquent when the patient’s account balance is over 30 days past due. Unless alternative arrangements have been made, delinquent accounts are processed for collections as follows:

(a) A first collection notice and statement will be sent to the responsible party when any part of the patient’s account balance is 30 days delinquent. A finance charge, not to exceed 1% per month, will be added to any account balance not paid within 30 days of the statement date.

(b) A final collection notice and statement will be sent when any part of a patient’s account balance is 60 days past due.

(c) The Patient Accounts Office will compile each month a list of all accounts that are 90 days in arrears and for which the debtor has not made financial arrangements to satisfy the obligation. This list of longstanding delinquent accounts will be sent to the Practice members who provided services on these accounts; after the Practice members have added their signatures authorizing the transmittal these accounts will be sent to a collection agency. If there is no response from the practice member within 30 days, the account will go to collections and the patient dismissed.

(d) North Carolina State employees with patient accounts in arrears may be subject to collection through the State Employee Debt Collection Act (SEDCA per the 1979 North Carolina General Assembly).
(e) A patient whose account is in arrears can have a “write-off” authorized by the Practice member who provided services. A “write-off” is considered a fee adjustment and is no longer collectable. Practice members should not routinely authorize “write-offs” because of a patient’s inability to pay.

(f) Accounts returned from a collection agency to the DFP deemed not collectable, will be adjusted as bad debt. These accounts will then be sent to the North Carolina Department of Revenue for collection in accordance with the Set Off Debt Collection Act (SODCA per the 1979 North Carolina General Assembly).

10.6. **Financial Locking of Accounts**

Patients’ accounts will be financially locked upon being transmitted to a collection agency. A financial lock will be noted in a patient’s electronic record. All financially locked accounts will remain locked until the balance is cleared. A patient with financially locked account status will not receive treatment except when the following provisions are met:

(a) All outstanding account balances are paid in full.

(b) The DFP is required to provide emergency treatment for all patients of record. The DFP is not obligated to provide any treatment when a written patient dismissal notice has been placed and an entry written into a patient’s record, and both are dated 30 days before the patient seeks treatment.

10.6.1. **Satisfied Financially Locked Accounts**

When a financially locked account has been paid in full by the patient or a responsible party, or has been collected in full by a collection agency the Patient Accounts Office may authorize the restoration of credit privileges and the financially locked designation will be removed from the patient electronic record. Financially locked accounts that have been brought to a zero balance as a result of a “write-off” or bad debt are not eligible for restoration of credit unless the write-off occurred for reasons of professional courtesy or other legitimate fee-adjustment reasons.

10.7. **Practice Member Obligations Relative to Patient Accounts**

Practice members will:

(a) enter all charges into the Electronic Patient Record at the time of service;

(b) not interfere with collection processes unless there are valid extenuating circumstances. When extenuating circumstances exist, Practice members will inform the Patient Accounts Office who will then resolve the matter.

(c) furnish assistance in the collection of patients’ delinquent accounts when requested by the Patient Accounts Office.

10.8. **Practice Members’ Responsibilities Involving Approved Third-Party Insurance**

Practice members’ responsibilities involving third-party payments include:

(a) providing treatment that requires preauthorization only after the preauthorization has been approved;
(b) submitting all third-party payments to the Patient Accounts Office for processing.

(c) transmitting any and all third-party correspondence, related data, and necessary directions to the Patient Accounts Office;

(d) assisting the Patient Accounts Office with third-party processing as required, in particular any requests for additional information necessary to complete claims processing;

(e) providing third-party data required to process claims of patients who received dental services in the UNC Hospital facilities.

10.9. **Practice Members Responsibilities Involving Agency-Sponsored Patients**

Practice members are responsible for the following aspects of processing agency-sponsored patients:

(a) consulting with the Patient Accounts Office to determine the level of benefits available to each agency-sponsored patient;

(b) becoming familiar with the regulations for each patient's sponsoring agency and complying with those regulations that are on file in the Patient Accounts Office;

(c) neither accepting nor requesting agency-sponsored patients for examination or treatment until thoroughly acquainted with the regulations of the involved agency;

(d) informing the Patient Accounts Office when treatment of an agency-sponsored patient is completed;

(e) notifying any agency-sponsored patient of any services recommended in his/her treatment plan that are not included/authorized by his/her sponsoring agency. Financial arrangements for all unauthorized or non-covered services must be pre-arranged before a patient can receive those services.

(f) accepting the involved agency's fee as full payment for authorized services rendered without recourse to the patient unless agency rules permit pursuing additional collections.

10.10. **Patient Responsibilities Relating to Insurance**

Patients are responsible for the filing of their own dental insurance claims unless they are covered by an approved agency or arrangements have been made before treatment. Instructions to patients for filing insurance claims are included on each walk-out statement. Agency sponsored patients are responsible for providing an insurance card to the front desk staff. A photocopy of this card will be made and sent to the Patient Accounts Office.

10.11. **Patient Accounts Office Responsibilities Relating to Approved Third Party Insurance**

The Patient Accounts Office is responsible for the following aspects of processing patient insurance information for those patients with approved insurance assignment:

(a) processing all third-party documents;
(b) maintaining complete records for each patient for all third-party transactions. Third-party records are considered complete when the records include: dates of filing, charge amounts, payments received, and other related data.

(c) filing pre-authorizations with third parties and notifying the appropriate Practice member(s) when approval notifications are received;

(d) posting payment from all third parties to the patient’s account and completing any appropriate adjustment;

(e) answering all inquiries about processing third-party claims and payments;

(f) informing each patient and/or responsible party of his/her obligation and responsibility in processing third-party insurance claims;

(g) informing the respective insurance carrier of any known discrepancies, errors, omissions, or items requiring attention concerning third-party payments;

(h) informing patients of non-covered portions of treatment and obtaining a completed waiver form from the patients so that they can be billed;

(i) billing patients for non-covered portions of treatment.

10.12. Patient Accounts Office Responsibilities Relating to Agency-Sponsored Patients

The Patient Accounts Office is responsible for the following aspects of processing agency-sponsored information for those patients with agency sponsorship:

(a) processing all agency documents;

(b) maintaining complete records for each patient for all agency transactions. Agency records are considered complete when the records include the dates of filing, the charge amounts, the payments received, and other related data.

(c) filing pre-authorizations with agencies and notifying the appropriate Practice member(s) when approval notifications are received;

(d) posting payment from all agencies to the patient’s account and completing any appropriate adjustment;

(e) answering all inquiries about processing agencies claims and payments;

(f) informing each patient and/or responsible party of his/her obligation and responsibility in processing agency claims;

(h) informing the respective agency of any known discrepancies, errors, omissions or items requiring attention concerning agency payments;

(i) informing patients of non-covered portions of treatment and obtaining a completed waiver form from the patients so that they can be billed.

(j) billing patients for non-covered portions of treatment.
11. **EXPENSES**

11.1. **General Overhead Expenses**

General Overhead expenses are those costs incurred in the Practice that cannot be identified with individual departments/groups. All administration costs are included in General Overhead expenses:

Each department/group will pay its proportionate share of the general overhead.

General Overhead expenses include the following:

(a) DFP administrative staff salaries, which includes the Patient Accounts Office, the Front Desk, and the Administration Office;

(b) DFP administrative supplies and equipment;

(c) data processing services and other computer services;

(d) roving dental assistant salaries;

(e) roving dental hygienist salaries;

(f) telephone monthly rent and toll charges;

(g) rent;

(h) laundry;

(i) salaries for other positions, as approved by the DFP Board;

(j) magazine subscriptions;

(k) postage;

(l) miscellaneous administrative costs;

(m) specified, common clinical expenses.

(n) University administrative fee

11.1.1. **Allocation of General Overhead Expense**

The balanced collections formula, as approved by the DFP Board on July 24th, 2002, will be used to determine the department/group allocation of General Overhead and investment income. Only the DFP Board has the authority to amend the approved General Overhead budget or to alter allocations for an individual department/group. Allocations of general overhead and investment income will be evaluated annually. Each of the departments/groups contributes to the monthly General Overhead expenses.

SODCA collections (Refer to Section 10.5(f)) received for patient accounts will be credited to the General Overhead account. The collection monies will then be divided between the General Overhead account and the relevant department/group account at the rate of 40% and 60%,
respectively. This policy will be reviewed if a new collection policy is implemented.

11.2. **Supplies and Materials**

11.2.1. **Obtaining Supplies and Materials**

All supplies and materials will be processed through the University channels.

The method and forms used to obtain supplies and materials will be the same as those in the School of Dentistry. The University small order policy must not be violated. Administrative Office staff members are available to advise Practice members on ordering policies. Methods to obtain supplies and materials are as follows:

(a) Supplies and materials may be requisitioned from the Dental Storeroom or purchased from sources outside of the School. Supplies and materials do not include capital equipment. Practice members should order only necessary items in the quantity needed.

(b) A Practice Member must approve all Practice supplies and materials before an order is filled. The Business Officer of the DFP must review all orders.

(c) Practice members and/or dental assistants may obtain supplies from the Storeroom by completing the Storeroom requisition and submitting the form to the staff at the Storeroom window. The person receiving the supplies must submit a requisition form with his/her signature in the appropriate place on the form labeled “received by”. The Storeroom will transmit a signed copy of each “Storeroom Requisition” form submitted, for which the order was filled by the Storeroom, to the Administration Office. The Administration Office will charge the supplies to the appropriate department/group or to the Practice as General Overhead;

(d) After the Administration Office receives the supply order for outside purchases, using the Small Order Procedure, a proper University form will be prepared for review and approval by the Business Officer of the DFP.

11.2.2. **Charging Accounts**

Expenditures for supplies and materials will be charged directly to the department/group operating account.

11.3. **Dental Assistants**

Dental assistants are to be employed by departments or groups, except for roving dental assistants.

11.3.1. **Charges for Dental Assistant Salaries**

Charges for dental assistant salaries will be allocated as follows:
(a) The dental assistant salaries are charged to departments/groups based on the number of dental assistant hours assigned to each department/group. The actual cost for dental assistants assigned to more than one department/group, including all employer paid benefits, are pro rated according to allocated time in those departments/groups.

(b) The salaries of roving dental assistants, whose time is not assigned to specific department/group, are charged to General Overhead.

11.4. **Dental Hygienists**

Full-time (non-faculty) or part-time (faculty or non-faculty) dental hygienists are to be employed by departments/groups. It is the responsibility of the department/group to supervise the hygienists in their employ and to insure that a dentist examines patients as appropriate. Each hygienist is responsible for informing the patients they treat of the recall system at DFP. Patients can be added into the recall appointment system, on a voluntary basis, by their hygienist.

All fees collected for services of the hygienist will be credited to the specific department/group employing them. Salaries and expenses of the dental hygienists will be charged against the specific department/group employing them.

11.4.1 **Charges for Dental Hygienist Salaries**

Charges for dental hygienist salaries will be allocated as follows:

(a) The dental hygienist salaries are charged to departments/groups based on the number of dental hygienist hours assigned to each department/group. The actual cost for dental hygienists assigned to more than one department/groups, including all employer paid benefits, are pro rated according to allocated time in those departments/groups.

(b) The salaries of roving dental hygienists, whose time is not assigned to specific departments/groups, are charged to General Overhead.

11.5. **Laboratory Cost Allocation**

Laboratory costs will be allocated to the individuals and to the departments/groups.

(a) Practice members will be charged only for laboratory services actually received. All lab work to be performed in the laboratories must be requested on a properly completed prescription. Prescriptions will be filed in the respective laboratory for reference;

(b) A separate reserve account will be maintained in the Practice Trust Fund for the purpose of tracking laboratory technicians’ salaries paid by the DFP as compared to laboratory services (labor) performed for the DFP. Credit will be applied for all lab service fees charged and debit will be applied for technicians salaries and monies reimbursed to the School of Dentistry for supplies, materials, and equipment utilization. The expense is reflected on the Statement of Financial Condition monthly report as Lab Labor Variance.

(c) The Administration Office will route all commercial laboratory invoices received on to the appropriate Practice member for approval. The approved invoices will be returned to the Administration Office for payment. The invoice amount will be
charged to the department/group operating account of the respective Practice member.

11.6. **Administrative Fund Assessment**

An assessment of 3% of Collections is charged to each department/group. The assessment provides unrestricted funds for the Dean and for special and non-recurring expenses. The 3% assessment is considered an operating expense of the Practice.

The funds will be distributed in the following manner:

(a) 1% transferred to Doctors' Fund (Refer to Section 13.4);

(b) 1% transferred to Dean's Fund (Refer to Section 13.5);

(c) 1% paid to the Dean's Discretionary Trust Fund to provide unrestricted funds for the School Administration.

11.7. **Miscellaneous Practice Members’ Expenses**

Miscellaneous expenses include fringe benefits and other elective items, which are not essential for daily operation of the Practice. Except for persons in those groups noted in 1.7.(b), non-Practice members of the DFP are not eligible to receive DFP fringe benefits. Fringe benefits are paid to eligible persons, from the appropriate departmental/group fund balances. For distributing General Overhead expenses, miscellaneous expenses are considered non-operating and are excluded from determinations of net operating income. (Refer to Appendix 3)

*11.8. Fringe Benefits – (Refer to Appendix 3)*

11.8.1. **Annual Review of Fringe Benefits**

The Benefits Committee reviews and approves the DFP fringe benefits package annually. The Benefits Committee forwards any recommendations to the DFP Board for approval, and the DFP Board approved package is submitted to the Dean. After the fringe benefits package has been approved by the Dean, it is then sent to the Vice Provost of Health Affairs for approval, as required by the Health Affairs Rules, Regulations and Policies. (Refer to Appendix 3)

*11.9. Other Miscellaneous Expenses*

The Chair of the DFP Board may authorize payment of any miscellaneous expenses that have been approved by a department Chair or group Director and which are not included in the expenses described in Section 11.

11.10. **Non-Operating Transactions**

Non-operating transactions include:

(a) adjustments made between departments/groups;

(b) dental care for family members;

(c) quarterly AHEC contributions;
(d) salary supplements;
(e) salary supplement assessments;
(f) supplemental retirement;
(g) supplemental retirement assessment
(h) miscellaneous income.
12. **PRACTICE MEMBERS' SALARY CHARGES**

*12.1. **Salary Determination**

The salary of an individual Practice member is determined on a fixed annual basis by the Dean. A percentage of a Practice member’s salary may be charged to the Practice. The Dean and the Chair of the Practice member's department or the group Director will determine the amount each Practice member will contribute from his/her Practice generated income into his/her own salary. The amount a Practice member contributes to his/her own salary and the amount the DFP contributes to a faculty member's salary is contingent upon the continuing availability of funds.

12.2. **Charging Accounts - Practice Members’ Salaries**

Salary commitments can be approved for payment out of projected revenue and/or the Dean's Fund. Each month the current charges prorated from an annual amount, are collected from all of the departments/groups and/or the Dean's Fund, and used for payments to Practice members in the department/group. Salary support from the Dean's Fund may be transferred back to department/group salary expense accounts to offset salary charges.

12.3. **Dean’s Fund (Refer to Section 13.5)**

The Health Affairs Rules, Regulations, and Policies include provisions for department Chairs/group Directors to allot up to 66.67% of the department/group annual fund balance to the Dean’s Fund for salary allocation.

12.3.1. **Additional Salary Allocation**

A department Chair or group Director may request from the Dean additional salary allocations for Practice members of his/her department/group. The potential amount of salary allocation from the Dean is dependent on the amount of funding available for this usage. The availability of additional salary allocations for any Practice member is contingent upon continued employment at the UNC School of Dentistry. Additional salary allocations are not available as lump sum payments.

12.3.2. **Salary Commitments**

Whenever a salary commitment is made available from a group's fund balance, an additional sum from the fund balance is retained for use by the Dean. The sum retained is equivalent to 2% of the first $5,000.00, 5% of the next $5,000 and 10% of all funds allocated above $10,000.

The total salary for any state employee cannot exceed the salary cap for a given rank and in concordance with the standards approved by the University Board of Governors.

Each faculty member is notified what portion of his/her total annual salary derives from DFP funds.

12.3.3. **Payment of A Probationary Member’s Salary**

The process of underwriting probationary Practice member salaries during the first year of employment by the DFP follows these guidelines:
(a) Departments/groups may request faculty salary support through the DFP for part of the first year’s salary support of a probationary Practice member from the DFP Director. The DFP Director has the authority to allocate salary support payments from the Doctors’ Reserve Fund. Salaries paid by this arrangement are intended for those probationary Practice members without other offsetting funding sources available to them.

(b) A probationary Practice member is not eligible for DFP salary supplement for the first year.

(c) Salary support is for the first 4 months after the probationary Practice member is placed on DFP funding. Departmental DFP funding provides salary support after the initial 4 month period.
13. **TRUST FUND ACCOUNT AND FUND BALANCES**

*13.1. University Trust Fund*

The DFP will maintain a separate University Trust Fund (13900) to account for all financial transactions of the Practice. The DFP’s Business Officer and the Administration Office staff will administer the DFP’s University Trust Fund; processing all receipts and expenditures of the Practice through this account.

The Business Officer and the Administration Office staff members will design and maintain books and journals to facilitate the reconciliation of total trust funds with records in the University Trust Fund Office. Each month the Administration Office will reconcile the DFP financial records to the University records. Prompt investigation will occur of any discrepancies between the records.

The Business Officer of the DFP will invest with the Director’s approval and using University channels, any excess cash in the Trust Fund.

*13.1.1. Investment Earnings*

Interest income earned will be allocated according to the balanced collections formula. (Refer to Section 11.1.1)

13.2. **Creation of Additional Fund Balances**

The Director and the Business Officer may establish, for administrative control purposes, additional fund balance categories.

13.3. **Department/Group Funds**

The department/group Fund Balance is the sum of all the departmental and group account balances.

*13.3.1. Source of Funds*

The sources of trust funds are:

(a) excess of income over expenses from patient care;

(b) allocated investment income credits (Refer to Section 13.1.1);

(c) transfers from other equity accounts.

*13.3.2. Use of Funds*

Department/group trust funds will be used for:

(a) Level I, II, and III benefits;

(b) additional Practice member salary;

(c) transfers to other equity accounts;

(d) operating expenses;

(e) miscellaneous expenses.
13.3.3. **Authorizations**

All salaries that are charged to a department's/group's Fund balance, including the salaries of allied dental personnel and Practice members, result from negotiations between the School of Dentistry, Human Resources Office, and a department Chair or group Director. Other charges are defined elsewhere in this manual. (Refer to Sections 12.1-12.3 and 11.8-11.11)

*13.4. Doctors' Fund*

A fund balance identified as the “Doctors' Fund” will be maintained as a Practice Account.

13.4.1. **Source of Funds**

The sources of funds for the Doctors’ Fund are:

(a) assessment to Practice members. Departments/groups will be assessed a fixed percentage of their collections each month for transfer to the Doctors’ Fund. The DFP Board will determine the rate of assessment.

(b) investment income credits;

(c) receipts from sources outside the Practice such as transfers from other trust funds, contributions and gifts, etc.

13.4.2. **Use of Funds**

The Doctors’ Fund will be used for:

(a) replacement and/or purchase of new equipment (Refer to Section 12.3.3.);

(b) payment, as approved, for up to 4 months of salary support for probationary Practice members (Refer to Section 12.3.3.);

(c) renovations and alterations;

(d) re-treatment of patients previously treated by inactive or disabled Practice members;

(e) fringe benefits for inactive Practice members as approved by the DFP Board;

(f) any other special or non-recurring expenditure approved by the DFP Board.

13.4.3. **Doctors’ Fund Authorizations**

The Chair of the DFP Board must approve before any charges are submitted to the Doctors’ Fund including for re-treatment charges, inactive Practice member benefits, and the payment of probationary Practice member salaries. The DFP Board must approve before all other types of
charges are submitted to the Doctors’ Fund. The DFP Board members must each receive a written request, for non-salary funding, two weeks before a DFP Board meeting.

13.4.4. **Protocol to Request to Use Doctor’s Fund**

At the close of the fiscal year, any amount over a minimum balance of $200,000 in the Doctors’ Fund may be used to help support DFP Departments/Groups with equipment purchases. Departments/Groups should submit reimbursement expense requests through their Board representative for DFP Board consideration. Requests will be reviewed at the first Board meeting of the fiscal year.

*13.5. **Dean's Fund**

A Fund Balance reserve identified as "Dean's Fund" will be maintained as a Practice Trust Fund Account.

13.5.1. **Source of Funds**

The sources of funds for the Dean’s Fund are:

(a) assessment of a fixed percentage of each department's collections each month. The DFP Board will determine the rate to assess the collections of the departments and groups (Refer to Section 11.7.);

(b) assessments on portions of those DFP salaries derived from departments/groups at the rate of 2% of the first $5,000, 5% of the next $5,000 and 10% of all money in excess of $10,000 (Refer to Section 12.3.3);

(c) Assessments on supplemental retirement contributions;

(d) voluntary contributions (transfers) from active Practice members and/or department/group pools (Refer to Section 12.3);

(e) Investment income credits;

(f) receipts from sources outside the Practice transferred from other trust funds, contributions and gifts, etc.

*13.5.2. **Use of Funds**

The Dean’s fund monies may be used anywhere within the School and for any purpose, which the Dean deems necessary.

13.5.3. **Authorization**

Charges against this fund will be by the Dean's directive.

13.6. **Dean's Discretionary Fund**

The Dean's Discretionary Fund is a separate University Trust Fund that provides unrestricted funds for the School administration, as determined by the Dean, and is administered by the Dean’s Office.
13.6.1. Source of Funds

The assessment to Practice members is one source of funds for the Dean’s Discretionary Funds. A fixed percentage is assessed to each department's/group’s monthly collections and transferred to the Dean’s Discretionary Fund. The DFP Board may petition the Dean for change in the percentage assessed.

13.6.2. Use of Funds

Charges against this fund will be by the Dean’s Directive.

13.6.3. Authorization

The Dean must authorize the release of any monies to be taken from the Dean’s Discretionary Fund. The Dean must authorize before any requests for monies from the Dean’s Discretionary Fund are granted. The Dean's office will field all requests for information on additional funding sources and will receive all requests for the Dean’s Discretionary Fund monies.
14. **FINANCIAL REPORTS**

*14.1. Explanation of Income and Expenses*

For departmental/group balance purposes, income is based on revenue and non-operating income. Expenses are charged once the amounts are determined.

*14.2. Income Defined*

Practice Income is composed of all the Practice members’ receipts accrued while acting as DFP representatives and practicing dentistry (see Section 1.5.) within the School of Dentistry, UNC hospitals, or other approved locations. All such income must be deposited in the departmental/group operating account.

*14.3. Responsibility for Reports*

The Business Officer is responsible for the preparing of DFP financial reports, using departments'/groups' financial records, and distributing the reports.

*14.3.1. Monthly Operating Reports*

The Business Officer is responsible for the preparation of monthly operating reports for each department/group and for the distribution of the relevant report to the Chair of that department or Director of that group.

The monthly operating reports for each department/group will include financial data collected during the month previous, the current billing month and through to the ending date for collections.
APPENDIX A1

THE UNIVERSITY OF NORTH CAROLINA

AT

CHAPEL HILL

DIVISION OF HEALTH AFFAIRS

RULES, REGULATIONS, AND POLICIES
(Revised effective April 1, 1997)
INTRODUCTION

Until March 10, 1972, the Executive Committee of the former Board of Trustees of the University of North Carolina exercised the authority to promulgate Rules, Regulations, and Policies of the Division of Health Affairs of the University of North Carolina at Chapel Hill. By Resolution adopted on that date, the Executive Committee authorized the Chancellor of the University of North Carolina at Chapel Hill "to amend (by addition, deletion, or modification) or to repeal (in whole or in part) the Rules, Regulations, and Policies of the Division of Health Affairs of the University of North Carolina at Chapel Hill."

Following a careful review, then Chancellor Ferebee Taylor authorized a revision of the Rules, Regulations, and Policies effective July 1, 1978. Again following a thorough review, a pursuant to the authorization referred to above, I have approved and do hereby promulgate revised Rules, Regulations, and Policies of the Division of Health Affairs of The University of North Carolina at Chapel Hill, as set forth herein, to be effective on and after April 1, 1997.

Michael Hooker
Chancellor
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APPENDIX A: UNC PHYSICIANS AND ASSOCIATES
APPENDIX B: DENTAL FACULTY PRACTICE PLAN
1. **ORGANIZATION AND FUNCTION**

Section 1-1. **Division of Health Affairs**

The Division of Health Affairs in the University of North Carolina at Chapel Hill includes the Schools of Dentistry, Medicine, Nursing, Pharmacy, and Public Health; the Health Sciences Library; and related Institutes, Centers, and Special Offices. The composition of the Division is subject to change by the Chancellor.

The Deans of the Schools, the Director of the Health Sciences Library, and the Directors of the Institutes, Centers, and Special Offices (other than those who report to a Dean or a Department Chairman) shall be responsible and accountable to the Vice Provost for Health Affairs. The Vice Provost for Health Affairs shall be responsible and accountable to the Provost and interim to the Chancellor.

Section 1-2. **Deans and Administrative Boards of Schools**

The Deans of each School shall have duties as specified in The Faculty Code of University Government, and each School shall have an Administrative Board as prescribed in said Faculty Code.

Section 1-3. **Health Sciences Library**

The Director of the Health Sciences Library shall be the chief administrative officer of the library for the Division of Health Affairs and shall be responsible and accountable to the Vice Provost for Health Affairs. The Director of the Health Sciences Library shall be advised by a standing committee appointed by the Vice Provost.

The Health Sciences Library shall be a separate administrative unit within the Division of Health Affairs, and it shall serve all schools and other units in the Division as well as the University of North Carolina Hospitals. Although independent of the University Library, the Health Sciences Library shall maintain a close working relationship with the University Library.

Section 1-4. **University of North Carolina Hospitals**

The University of North Carolina Hospitals are governed by a Board of Directors as provided in the N.C.G.S. 116-37. The Board of Governors of the University of North Carolina is responsible for appointing nine of the 12 members of the Hospitals’ Board of Directors; the other three are ex officio members from the University at Chapel Hill: The Vice Provost for Health Affairs, the Vice Provost for Administration and the Dean of the School of Medicine.

The Division of Health Affairs maintains a close working relationship with the University of North Carolina Hospitals, which provide the major clinical framework for education and learning experiences for students and trainees within the Division and whose regular medical and dental staff consists entirely of University faculty members in the Schools of Medicine and Dentistry.

2. **ACADEMIC FREEDOM, TENURE, AND ACADEMIC DUE PROCESS**

The provisions of the Trustee Policies and Regulations Governing Academic Tenure in The University of North Carolina at Chapel Hill are incorporated herein by reference.
3. CONSTITUTIONS AND BYLAWS

The faculty of any School within the Division of Health Affairs may, following a review and approval by the Vice Provost for Health Affairs, adopt such constitutions and bylaws as may be deemed necessary for the effective administration of the School concerned, provided that such documents shall not be inconsistent with applicable laws, policies, and regulations of the State or the University, including the following:

- The Code of the University of North Carolina
- The Board of Governors Delegations of Duty and Authority to Boards of Trustees
- Bylaws of the Board of Trustees of The University of North Carolina at Chapel Hill
- Trustee Policies and Regulations Governing Academic Tenure in The University of North Carolina at Chapel Hill
- The Faculty Code of University Government
- Division of Health Affairs Rules, Regulations, and Policies

4. POLICY AND PROCEDURE ON INTER-SCHOOL INSTRUCTION

Section 4-1. Instruction in Inter-School Courses

Instructional programs organized by a School for another School, and involving the provision of special or additional courses in which students from the other school will participate, may be undertaken only on the basis of a written understanding between the Schools concerned, possibly including provision for the School whose students are to receive instruction by faculty of another School to make available funds adequate to implement the agreed-upon program.

5. SALARY CEILINGS AND SOURCES

Upon recommendation of the Chancellor on the advice of the Dean and after consultation with the Vice Provost for Health Affairs, the President of The University of North Carolina (with the approval of the Board of Governors, or a Committee of same, when required) establishes ceilings on the total salaries of members of the faculties of the Schools of Dentistry, Medicine, and Public Health. Funds to pay salaries within those ceilings may come from State-appropriated funds, income from patient-care services, monies from contracts and grants, and benefactions. The salary ceilings are reviewed periodically. No member of the faculty or staff subject to a practice plan may receive payment in excess of the person's approved salary for the provision of patient care services whether or not carried out in the course and scope of employment (including, but not limited to, direct patient care, patient care consultation, chart review, expert witness testimony, depositions, etc.). Faculty members of the Schools of Nursing and Pharmacy are limited to maximum salary levels as authorized by the UNC Board of Governors as “point-of-reference” levels.
6. INCOME-PRODUCING PROFESSIONAL ACTIVITIES OF FACULTY AND PROFESSIONAL STAFF MEMBERS

Section 6-1. General

Professional activities of members of the faculty and professional staff within the Division of Health Affairs may fall into any of the following three categories: (1) participation in the institutional programs of the University; (2) provision of patient care services by a member of the faculty or staff subject to a practice plan, the fees from which shall be handled as provided in Section 6-2 below; and (3) outside professional activities (other than the provision of patient care services for a member of the faculty or staff subject to a practice plan whether or not carried out in the course and scope of employment), payments for which shall be handled as provided in Section 6-3 below. University salaries constitute the consideration for professional activities in category one and for members of the faculty or staff subject to a practice plan, category two.

Section 6-2. Patient Care Service Plans

All fees charged and collected for the provision of patient care services provided at any time and any place by members of the faculties and professional staffs of the Schools of Medicine and Dentistry subject to their practice plans shall be deposited in appropriate University trust fund accounts and shall be handled in accordance with the provisions of faculty practice plans approved by the Chancellor. The approved UNC Physicians and Associates and Dental Faculty Practice Plan are incorporated herein as Appendix A and Appendix B, respectively.

Section 6-3. Outside Professional Activities

Outside professional activities of members of the faculty and professional staff of the Division of Health Affairs are those meeting the following criteria: (1) The activities are undertaken not for or through the University or through University of North Carolina Hospitals; and (2) the activities are undertaken in addition to, and not as a part of, the activities for which the individual is paid University compensation. Such outside activities may include lectures, symposia, and consultative services. For persons subject to a practice plan, to the extent that such outside activities include the provision of patient care services, payment for such activities should be handled as provided in Section 6-2 above.

Payment for outside activities is to be construed as income to the individual and not to the University. Such activities are to be undertaken only in compliance with and pursuant to the Board of Governors’ Policy Statement on External Professional Activities of Faculty and Other Professional Staff. As required by the Policy on External Professional Activities, members of the faculty and professional staff may undertake outside professional activities as described above, provided that:

(1) In each case, pursuant to that Policy such outside activity shall be subject to review and approval by the appropriate Department Chair, and under conditions described in the Policy, by the Dean. Requests to engage in such activity must be submitted on the "Notice of Intent" form prescribed by the Board of Governors.

(2) External professional activities for pay are to be undertaken only if they do not:
   (a) interfere with the primary obligations of the individual to carry out all University duties and responsibilities in a timely and effective manner; or
   (b) create a conflict of interest with the individual’s University duties and responsibilities; or
   (c) involve any inappropriate use or exploitation of University facilities, equipment, personnel, or other resources; or
(d) make any use of the name of The University of North Carolina or any of its constituent institutions for any purpose other than professional identification; or

(e) claim any University or Institutional responsibility for the conduct or outcome of such activities.

When a contribution or assignment is made to a University, School, department, or other unit from earnings received for such outside activity, such payment shall be deposited in an appropriate University trust fund account and may be expended for purposes authorized by University regulations governing the use of such funds.

7. **CONTRACTS AND AGREEMENTS**

Nothing herein shall be construed to alter the terms and conditions of any existing contract or agreement between The University of North Carolina at Chapel Hill (on behalf of operating units of its Division of Health Affairs) and any other entity for the provision of services to or by the University. University State-appropriated accounts, and contract and grant accounts, which incur the direct expense of providing such services shall be reimbursed from monies received as payment for the provision of such services under the terms of any contract or agreement now existing or hereafter executed.
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I. INTRODUCTION

In 1952, when the School of Medicine became a four-year school and the North Carolina Memorial Hospital opened, the medical service plan at The University of North Carolina at Chapel Hill was established as the Private Patient Service to provide a setting for the clinical faculty of the School of Medicine to provide patient-care services to patients at the North Carolina Memorial Hospital and to bill patients on a fee-for-service basis. That medical service plan was established and subsequently operated under the Rules, Regulations, and Policies of the Division of Health Affairs of The University of North Carolina at Chapel Hill.

In 1978, The Medical Faculty Practice Plan was established under the Rules, Regulations, and Policies of the Division of Health Affairs of The University of North Carolina at Chapel Hill as a successor to the Private Patient Service. The Medical Faculty Practice Plan of 1978 set forth policies and regulations for billing, collecting, budgeting and expenditure of professional fees generated by the faculty of the School of Medicine, and for the management and use of such professional fee funds.

The Medical Faculty Practice Plan was revised effective February 1, 1986, and was again revised and renamed UNC Physicians and Associates effective July 1, 1990. As part of the Rules, Regulations, and Policies of the Division of Health Affairs of The University of North Carolina at Chapel Hill, this Appendix sets forth policies and regulations for a group practice of medicine among the faculty of the School of Medicine, including billing, collecting, budgeting and expenditures of professional fees; management and use of professional fee funds; and practice management. UNC Physicians and Associates is the administrative unit within the School of Medicine which is responsible for planning, organizing, and coordinating all patient care activities of the faculty which are not primarily the responsibility of individual departments of the School of Medicine, the Dean of the School of Medicine, the Associate Dean for Clinical Affairs, the Executive Committee of the Medical Staff of the University of North Carolina Hospitals, or the Area Health Education Centers.

The plan of 1990, as revised in 1996, governing the UNC Physicians and Associates is a successor to the medical service plan heretofore designated the Medical Faculty Practice Plans of 1978 and 1986 and the Private Patient Service, and all agreements and contracts in the name of the Private Patient Service or the Medical Faculty Practice Plan shall be valid and part of UNC Physicians and Associates unless specifically changed within this document. However, all negotiations, agreements, contracts and activities of the UNC Physicians and Associates from the effective date of this document are subject to the policies and procedures set forth herein and in the Rules, Regulations, and Policies of the Division of Health Affairs.

It is recognized that UNC Physicians and Associates, in providing for the effective group practice management of the faculty of the School of Medicine of The University of North Carolina at Chapel Hill, including the management of professional fee income, should serve the following purposes:

1. to maintain a level of excellence in the quality of medical faculty members recruited and appointed by The University of North Carolina at Chapel Hill;
2. to support a clinical setting conducive to the proper clinic, and education of medical students, graduate students, house staff, and allied health students;
3. to maintain an educational and patient-care relationship with the University of North Carolina Hospitals consistent with medical staff bylaws of that teaching, hospital;
4. to permit faculty of the School of Medicine to be responsive, as appropriate, to the needs of patients throughout the State of North Carolina;
5. to assure high standards of communication between the faculty and non-faculty referring physicians, both within and outside the State of North Carolina;
6. to provide an administrative structure to recommend alternative health care financing and delivery systems to determine the appropriateness of faculty participation in such programs;
7. to maintain a leadership position in the delivery of health care throughout the State of North Carolina consistent with the responsibilities and objectives of The University of North Carolina at Chapel Hill;
(8.) to provide the necessary funding, in addition to State appropriations and other funds, to attract and retain highly qualified faculty members to carry out the teaching, research, patient care, and public service responsibilities of the School of Medicine;

(9.) to provide funding for the maintenance of faculty compensation as nearly as possible competitive with compensation levels of similar faculty at comparable academic medical centers in the United States; to provide financial support for the educational, research, and public service programs of the School of Medicine of The University of North Carolina at Chapel Hill;

(10.) to assist the School of Medicine Administration and Department Chairs in maintaining proper balance among the teaching, research, patient care, and public service responsibilities of faculty members;

(11.) to promote superior standards of patient care through the use of sound and innovative techniques in the delivery of health care services; and

(12.) to provide practice management services not available through the departments of the School of Medicine or through the University of North Carolina Hospitals.

II. MEMBERSHIP

Upon appointment to the faculty of the School of Medicine, as a condition of employment and until termination of membership in that faculty, the following full-time or part-time faculty members who are properly licensed to practice medicine in the State of North Carolina or who provide other health care services are automatically members of UNC Physicians and Associates.

(1) Members
   (a) the Dean and all clinical department chairs;
   (b) all members of the full-time clinical faculty; and
   (c) all other members of the clinical faculty who conduct the majority of their clinical practice at the University of North Carolina Hospitals.

(1) Associate Members
Other clinical faculty of the School of Medicine who are not members as defined above and who render patient care at the University of North Carolina Hospitals.

(3) Courtesy Staff
Members of the courtesy staff at the University of North Carolina Hospitals shall not be eligible to be members of the UNC Physicians and Associates.

The privilege of providing clinical services and generating professional income at the University of North Carolina Hospitals by members of UNC Physicians and Associates is contingent upon appropriate appointment to the medical staff of the University of North Carolina Hospitals in accordance with the rules, regulations, and bylaws of the medical staff of the University of North Carolina Hospitals.

There shall be an annual meeting of the UNC Physicians and Associates membership. Each member as defined in Item II-I above shall have voting privileges in those matters brought before UNC Physicians and Associates membership for decision and approval.
III. ORGANIZATIONAL STRUCTURE

The Dean of the School of Medicine shall be responsible to the Chancellor, through the Provost and Vice Provost for Health Affairs, for the administration, operation, and management of UNC Physicians and Associates. In the discharge of this responsibility the Dean shall be assisted by a UNC Physicians and Associates Board and an Executive Committee of the UNC Physicians & Associates Board.

(1) The UNC Physicians and Associates Board shall have the responsibilities delineated below and shall consist of:

(a) the Dean of the School of Medicine or his designee, as chair;
(b) the Chairs of the Clinical Departments of the School of Medicine, the Associate Dean for Clinical Affairs of the School of Medicine, the Chair of UNC Physicians and Associates Executive Committee, the Executive Director of the University of North Carolina Hospitals and the Medical Co-Director of the UNC Health Plan;
(c) five elected full-time members of UNC Physicians and Associates elected in the following manner: two members elected by the combined membership of the Departments of Anesthesiology, Obstetrics and Gynecology, Ophthalmology, Orthopedics and Surgery, two members elected by the combined membership of the Departments of Dermatology, Family Medicine, Medicine, Neurology, Pediatrics, Physical Medicine and Rehabilitation and Psychiatry; and one member elected by the combined membership of the Departments of Emergency Medicine, Pathology and Laboratory Medicine, Radiology and Radiation Oncology. (These elected members shall serve terms of three years and may be re-elected but can serve no more than two terms consecutively. Not more than one member of any department shall be elected to serve on the Board at any one time.); and
(d) the Executive Director of UNC Physicians and Associates, the Senior Associate Dean of the School of Medicine, the Director of the North Carolina Area Health Education Centers Program, and the Chair of the Department of Medical Allied Health Professions, as ex-officio and non-voting members.

(1) The UNC Physicians and Associates Board shall advise the Dean of the School of Medicine on matters relating to the management and operation of UNC Physicians and Associates. To that end, the Board shall:

(a) recommend rules and procedures for elections and the filling of vacancies in the membership of the Board and the Executive Committee of UNC Physicians and Associates;
(b) review and recommend approval of the operating budget of the Administrative Office of UNC Physicians and Associates;
(c) review a summary of clinical departments’ proposed annual budgets relating to professional fee income and expenditures (the Board will have no responsibility for establishing or recommending the salaries of individual faculty members);
(d) receive recommendations from members of UNC Physicians and Associates and take appropriate action in advising the Dean of the School of Medicine;
(e) advise the Dean of the School of Medicine on matters pertaining to the effective and efficient operation of UNC Physicians and Associates including billing, collection, accounting and statistical reporting, fringe benefits, professional liability insurance, practice management, clinical contracts and contract payment review, clinical construction and renovations, managed care, and other alternative systems for financing and delivering health care, market analysis, relations with referring physicians, and other matters of direct interest to the faculty practice;
(f) participate on behalf of UNC Physicians and Associates in cooperation with the Office of the Dean and the administration of the University of North Carolina Hospitals in negotiations with outside agencies that affect or regulate medical practice;

(g) receive quarterly financial reports from the Executive Director of UNC Physicians and Associates;

(a) meet at least quarterly to discuss the activities of UNC Physicians and Associates (the Dean or his designee shall call the meetings and circulate agenda for the meetings. Items may be placed on the agenda at the request of any Board member);

(b) establish standing subcommittees including UNC Physicians and Associates members as needed to provide ongoing review of matters pertaining to the operation of UNC Physicians and Associates; and

(c) recommend UNC Physicians and Associates faculty representatives for appointment to those joint committees of the School of Medicine and the University of North Carolina Hospitals, dealing, with issues of faculty practice.

(1) The Executive Committee of the UNC Physicians & Associates Board shall provide frequent and active direction and advice to UNC Physicians and Associates by meeting at least monthly. This committee shall have the responsibility for reviewing immediate and long-term issues affecting UNC Physicians and Associates. On issues of long-term or major significance, the Executive Committee will make recommendations to the UNC Physicians and Associates Board for approval or modification. The Executive Committee may nominate members to standing subcommittees and ad hoc committees dealing with matters pertaining to the operations of UNC Physicians and Associates for approval by the UNC Physicians and Associates Board.

The UNC Physicians and Associates Executive Committee shall consist of:

(a) a chair from UNC Physicians and Associates membership nominated by the Board and appointed by the Dean, serving, up to a five-year term as determined by the Dean;

(b) four members of the Board including at least one member who was elected at large to the Board, serving repeatable terms of three years, but with no more than one individual elected from the departments listed in 2(c);

(d) the Chairs of the Departments of Family Medicine, Medicine, Obstetrics and Gynecology, Pediatrics and Surgery;

(e) the Executive Director of UNC Hospitals serving as an ex-officio and voting member;

(f) the Medical/Co-Director of the UNC Health Plan serving as an ex-officio and voting member;

(g) the Associate Dean for Clinical Affairs of the School of Medicine, serving as an ex-officio and non-voting member;

(h) the Executive Director of UNC Physicians and Associates serving, as an ex-officio and non-voting member;

(i) the Senior Associate Dean of the School of Medicine serving as an ex-officio and non-voting member.

(1) An Executive Director shall direct the administrative operations of UNC Physicians and Associates. The Executive Director shall be appointed by the Dean of the School of Medicine with the advice of the Board of UNC Physicians and Associates and shall be responsible to the Dean for the administration and fiscal management of UNC Physicians and Associates. The Executive Director will work in coordination with appropriate Department Chairs on matters pertaining to UNC Physicians and Associates activities.

The Executive Director will assure that a written business procedures manual is prepared and kept up to date and that the business activities are conducted in accordance with written policies and procedures.
IV. MANAGEMENT AND USE OF INCOME

The University shall maintain accounts for UNC Physicians and Associates for the deposit of all its members' professional fees and contractual income derived from patient care and the disbursement of all expenditures. All professional fees from patient care activities of the UNC Physicians & Associates members, whether earned at the University of North Carolina campus or in other approved locations, shall be billed, collected, budgeted, and expended through UNC Physicians & Associates; except that professional fee income generated through clinical practice at Area Health Education Center (AHEC)'s shall be billed, collected, budgeted, and expended by the Area Health Education Centers. All professional fees from patient care services by all other health care providers employed by the School of Medicine shall also be billed, collected, budgeted and expended through UNC Physicians and Associates provided that the services of these other health care providers are conducted in the course and scope of their University employment. Absent prior written approval to the contrary by the Dean of the School of Medicine, that portion of professional fees from patient care activities of associate members which result from clinical practice at the University of North Carolina Hospitals shall be billed, collected, budgeted and expended through LJNC Physicians & Associates. With prior written approval of the Dean of the School of Medicine, department chairs may develop arrangements through which associate members may directly bill and collect from patients admitted to UNC Hospitals from their office-based practices. All such arrangements must include prior written provisions requiring that the associate member provide monthly, auditable billing reports, accessible to School of Medicine employees designated by the Dean and in a form acceptable to the Dean.

Professional income and fees shall mean all collected fees derived from patient care services including but not limited to direct patient care, patient care consultations, chart review, expert witness testimony, depositions, and any other patient-care services rendered directly to patients or institutions. All professional income, as defined, will be deposited in the University of North Carolina Physicians trust fund accounts of The University of North Carolina at Chapel Hill collection of patient accounting data, charges, and other information relating to the billing, collecting, and disbursement of professional fees will be handled under the administrative direction of the Executive Director of UNC Physicians and Associates.

In the event that The University of North Carolina at Chapel Hill enters into agreements on behalf of the School of Medicine with the University of North Carolina Hospitals or with hospitals, institutions, clinics, or programs affiliated with the School of Medicine (including State agencies in such fields as mental health, public health, and corrections) whereby direct patient-care services may be provided to said agencies by members of UNC Physicians & Associates, payment received for direct patient-care activities pursuant to such agreements shall be remitted to UNC Physicians and Associates (except where such arrangements are made through Area Health Education Centers) and shall be deposited into appropriate departmental trust fund accounts.

Annually, a budget of UNC Physicians and Associates income and - expenditures shall be prepared and referred by the Dean of the School of Medicine to the Chancellor for approval with the advice of the Provost, the Vice Provost for Health Affairs and the Executive Vice Chancellor. Budget changes shall be prepared in a manner consistent with University procedures and shall be subject to the same approval. Annual income and expense budgets will be prepared for UNC Physicians and Associates administrative and other general costs of operations as well as for departmental programs. Accounting and reporting systems will utilize the University's chart of accounts and object codes insofar as practicable. Income and expenses will be processed in a manner compatible with Generally accepted University accounting procedures.

Monthly accounting reports will be prepared by the University fiscal office and provided to UNC Physicians and Associates administrative offices. The Executive Director of UNC Physicians and Associates, with the advice and assistance of the University fiscal office, will prepare financial reports and analyses for the Dean and UNC Physicians and Associates for forwarding to the Vice Provost for Health Affairs, the Provost, the Executive Vice Chancellor and the Chancellor. All financial reports and analyses will be part of the official records of The University of North Carolina at Chapel Hill.
Funds received as payment for professional services provided under UNC Physicians and Associates shall be expended, in accordance with approved budgets, as follows:

1. For UNC Physicians and Associates Administrative Costs and Other Costs of Operations

The Executive Director will prepare an annual proposed budget for administrative and other costs of operations for review and approval of the Dean.

Administrative costs shall include (1) salary and fringe benefits of administrative office staff, (2) cost of space, equipment supplies, and operational expenses of the administrative offices, (3) information systems services and (4) all other costs of clinical operations and support. To provide funds for payment of such costs, the clinical departments shall be assessed a proportionate part of UNC Physicians and Associates administrative costs. The method of apportionment of administrative costs shall be established by the Dean with the advice of the UNC Physicians and Associates Board.

Other costs of operations, as used in this subsection (1), include only the amounts payable directly by the clinical departments or under approved contractual agreements with the University of North Carolina Hospitals for ambulatory care space, administrative and patient-care staff, supplies, and equipment. These costs will be charged directly to the departments using the services.

2. For Medical School Trust Fund Transfers

After deduction of UNC Physicians and Associates administrative costs and other costs of operations, 7.5% of all professional fees collected shall be deposited in the Medical School Trust Fund except that the distribution from patient income of associate members derived from their direct billing of patients admitted to UNC Hospitals shall be up to 5.0% as determined by the Dean. The Medical School Trust Fund is established to provide a funding source for activities of the Medical School in achieving overall objectives for which other fund sources are inadequate or unavailable. The uses of these funds may include support of the budget or operational fund of any Department or School of Medicine projects. The 7.5% distribution will be made monthly from the net receipts following the payment of the administrative costs and other costs of operations of UNC Physicians and Associates. The distribution from associate members will be calculated against their total receipts, without deduction of billing or operating costs.

3. For Departmental Operating Funds

For each clinical department, a Departmental Operating Fund shall be established to receive collections for professional services following deductions for administrative costs and other costs of operations and transfers to the Medical School Trust Fund.

The Departmental Operating Fund shall be managed by the Department Chair and may be utilized for funding those activities which contribute to the well-being of the Department and School in areas of teaching, research, patient care, and public service.

An annual budget shall be prepared by each Department Chair outlining planned expenditures from UNC Physicians and Associates Departmental Operating Fund. Such budgets shall be coordinated through the office of the Executive Director of UNC Physicians and Associates and shall be accompanied by a detailed annual departmental revenues (charges) budget and a departmental annual cash flow budget.

Each Department Chair shall submit the proposed annual Departmental Operating Fund budget to the Dean for review, approval, and inclusion in the proposed annual budget for UNC Physicians and Associates. The Dean of the School of Medicine shall present the proposed annual budget of UNC Physicians & Associates to the Chancellor through the Executive Vice Chancellor, Provost and Vice Provost for Health Affairs.
At the end of each fiscal year, if the balance in any Departmental Operating Fund exceeds the budgeted annual expenditures for the ensuing year by more than 50%, the balance in excess of 150% of budgeted annual expenditures may be transferred by the Dean to the Medical School Trust Fund account.

Funds deposited into Departmental Operating Funds may be expended on approved budgeted items which serve to maintain and/or improve the departmental capabilities in the areas of teaching, research, patient care, and public service. Such expenditures include only the following:

(a) faculty salaries and fringe benefits;
(b) professional liability insurance premiums and contributions to related self-insurance trust funds;
(c) licenses and privilege taxes;
(d) expenses incurred as a result of appropriate professional travel, attendance at meetings, and operational costs of the department in accordance with approved budgets;
(e) medical society dues in accordance with departmental policy;
(f) equipment and laboratories for departmental activities;
(g) other expenditures recommended by the UNC Physicians and Associates Board. endorsed by the Dean of the School of Medicine, and properly approved as budgeted expenditures for programs of the department;
(h) business-related expenses incurred hosting professional visitors, including recruitment expenses for prospective faculty and staff. Such anticipated expenses shall be approved in advance by the Department Chair;
(i) costs of departmental meetings of faculty and staff for purposes of discussing, modifying, or otherwise achieving departmental goals and objectives. Such professional meetings shall be approved in advance by the Department Chair. Expenditures of funds shall be limited to business-related expenses of the faculty and staff,
(j) payments due under terms of contractual agreements entered into with the University of North Carolina Hospitals or other State agencies or other entities. (Contractual agreements require approval of the Executive Vice Chancellor of the University of North Carolina at Chapel Hill or his designee.);
(k) expenditures for awards and prizes in recognition of outstanding service or achievement shall be properly established in an approved category of awards and prizes agreed upon in advance by the Department Chair and the Dean;
(l) transfers of funds to other departmental trust fund accounts when appropriate and authorized in the annual budget for UNC Physicians & Associates.

Should a deficit in a Departmental Operating Fund develop or be anticipated, the following steps will be initiated:

(a) all expenditures except salaries, fringe benefits, and encumbered expenses shall be suspended until the deficit is resolved;
(b) the Executive Director of UNC Physicians and Associates and the affected Department Chair shall prepare an analysis of the situation and provide to the Dean of the School of Medicine a plan for resolution of the deficit.

Departmental Operating Funds or any other funds may not be used:

(a) to pay salary and fringe benefit amounts in excess of the levels established and approved by The University of North Carolina at Chapel Hill; or
(b) to fund items which would be construed as non-business or personal in nature.

V. **FACULTY SALARIES AND FRINGE BENEFITS**

The annual salary of each faculty member is recommended by the School of Medicine and approved by the University. Though the salary may be paid from one or more sources, the faculty member's salary from all sources cannot exceed faculty salary ceilings established annually by the University of North Carolina Board of Governors. The mechanism for payment of salaries to faculty in clinical departments is set forth in the compensation plan document approved by the University of North Carolina Board of Governors on January 12, 1996.

A supplemental fringe benefit program may be maintained by UNC Physicians & Associates. The supplemental fringe benefit program will be designed (when combined with the prevailing salary levels) to achieve a level of total compensation that as nearly as possible will be competitive with the total compensation of medical faculties of comparable university medical centers nationally.

The UNC Physicians & Associates fringe benefit program shall be developed and revised as needed by the UNC Physicians and Associates Executive Committee and Board in coordination with the Executive Director of UNC Physicians and Associates and submitted to the Dean of the School of Medicine for review and approval. The UNC Physicians & Associates fringe benefit program shall be supported by evidence of financial feasibility and evidence of the need for the proposed fringe benefits to maintain faculty compensation at a level as nearly as possible competitive with medical faculties nationally.

The proposed annual UNC Physicians & Associates budget shall be accompanied by an analysis of the proposed UNC Physicians & Associates fringe benefits program. The Dean shall submit annually the proposed fringe benefits program to the Chancellor for approval with the advice of the Provost, the Vice Provost for Health Affairs and the Executive Vice Chancellor.

VI. **LEGAL COUNSEL**

If it should at any time be deemed necessary or advisable for UNC Physicians and Associates to secure private legal counsel or representation, such legal services may be secured only in accordance with applicable provisions of N.C.G.S. 147-71.

VII. **OUTSIDE CONSULTING SERVICES**

If it should at any time be deemed necessary or advisable for UNC Physicians and Associates to secure the services of outside consultants for such purposes as operation of accounting audits, planning, organizational analysis, and system review, such services may be secured only in accordance with applicable provision of N.C.G.S. 143-64.20 et seq.

VIII. **AMENDMENTS**

Proposals for amending, this Appendix may be made to the Chancellor by the Dean of the School of Medicine, the Provost, the Vice Provost for Health Affairs or by the Executive Vice Chancellor so that necessary or advisable revision may be considered.
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I. **INTRODUCTION**

When the clinical facilities of the School of Dentistry were completed in 1952, there was established, under the Rules, Regulations, and Policies of the Division of Health Affairs of The University of North Carolina at Chapel Hill, an Intramural Program for the provision of patient care services by full-time dental faculty members. This was the first such program in a dental school, and its growth and development have produced a model now duplicated in many other dental schools. This dental service program has enabled the School of Dentistry to attract and retain outstanding faculty in competition with dental schools throughout the nation and to provide selected patient-care services in addition to, and as an extension of, the School's instructional and research missions. The delivery of patient care by its faculty members is and has been an essential and compatible function of the School of Dentistry of The University of North Carolina at Chapel Hill. This Dental Faculty Practice Plan provides the framework for the operation of the Dental Faculty Practice as successor to the Intramural Program of the School of Dentistry; like its predecessor, it is operated in compliance with all applicable laws, regulations, and policies of the State and the University and the code of ethics of the North Carolina Dental Society.

The purpose of the Dental Faculty Practice is to enable and encourage the faculty of the School of Dentistry to maintain clinical competency by providing dental care for selected patients, to afford a setting for student instruction in private practice techniques, and to facilitate research on problems of dental care and treatment. The Dental Faculty Practice is a group effort of the faculty of the School of Dentistry in the provision of patient care, and, while individual faculty members are always responsible for the direct patient care they provide, the responsibility to assure optimum dental care for each patient rests with the Dean, the Department Chairs, and the faculty of the School.

This Dental Faculty Practice Plan, as a part of the Rules, Regulations, and Policies of the Division of Health Affairs of The University of North Carolina at Chapel Hill, sets forth policies and regulations for the billing, collecting, budgeting, and expenditure of professional fees generated by the faculty of the School of Dentistry and for the management and use of such professional fees.
II. MEMBERSHIP

(1) Active

Eligibility for active membership in the Dental Faculty Practice is limited to those persons who are full-time members of the faculty of the School of Dentistry, possesses a D.D.S., D.M.D., or equivalent degree, and are licensed to practice dentistry in the State of North Carolina. Additionally, other health care professionals such as psychologists and physical therapists who are members of multi-disciplinary departments may be participants of the Practice. New participants of the Dental Faculty Practice will be probationary members for a period of one year and will then be reviewed by the Executive Board (see below) for continued active membership. In order to maintain active membership, all members must demonstrate a desire to practice at a satisfactory level of productivity and be subject to review by the Executive Board. In addition, a full-time faculty member who is an administrator with direct involvement in the administration of the Dental Faculty Practice may qualify as a member without meeting the other criteria for active membership.

(2) Inactive

On recommendation of the Department Chairs and Dean, and with the approval of the Executive Board in each individual case, active members may become inactive members of the Dental Faculty Practice by reason of:

(a) completion of 20 years of satisfactory membership in the Dental Faculty Practice or its predecessor (the Intramural Program) with no more than two years remaining before becoming eligible for full retirement benefits under the State Retirement System; or
(b) physical and/or emotional disability, evidenced by a physician's signed statement that the individual should not engage in the practice of dentistry - continuation of this status is contingent on annual submission of a physician's signed statement of continued disability. In order to qualify for inactive membership, the individual must have been an active member for at least one year. All requests for inactive membership are to be submitted by the Department Chair or the Dean for action on each individual request by the Executive Board. The payment of certain fringe benefits for inactive members will be continued by the Dental Faculty Practice so long as the member remains a full-time faculty member of the School.

The payment of fringe benefits for an active or inactive member while on leave of absence may be continued from departmental Dental Faculty Practice funds at the discretion of the member's Department.

(3) Regulations Pertaining to Members

Faculty members are individually responsible for all aspects of the direct patient care they provide and, in addition, are responsible for cooperative efforts to ensure that the best possible dental health care is provided in their Departments to each patient treated. In order to satisfy the "Purposes" and "Objectives" of the Dental Faculty Practice, each department has an obligation and a commitment to assign clinical participants to treat patients in the DFP for an aggregate number of hours each week equivalent to at least 8 hours, but not to exceed 10 hours, per
departmental participant. Emergency on-call coverage must be scheduled for all times for all departments.

To satisfy this aggregate commitment, the departmental chairperson or group director may, with the consent of the participants involved, assign participants to schedule patients in the DFP a minimum of four and a maximum of 20 hours per week. When circumstances warrant, these hours can be extended at the discretion of the departmental chairperson or group director. All hours are to be scheduled, and the optional additional hours will not necessarily include assignment of a dental assistant. Except in unusual circumstances, including emergencies, patient appointments are not to be made outside of the regular weekday scheduling hours.

Each Dental Faculty Practice member is responsible for remaining thoroughly familiar with and abiding by the policies and procedures of the Dental Faculty Practice Plan. Failure to comply with those policies and procedures will result, at the discretion of the Dean, in the forfeiture of all privileges and benefits of membership in the Dental Practice.

III. ORGANIZATIONAL STRUCTURE

The Dean of the School of Dentistry shall be responsible to the Chancellor, through the Vice Provost for Health Affairs, for the administration, operation, and management of the Dental Faculty Practice. In the discharge of this responsibility, the Dean shall be assisted by:

(1) The Executive Board of the Dental Faculty Practice, which shall consist of:
   (a) a Chair, who shall be the Associate/Assistant Dean for Administrative Affairs of the School of Dentistry;
   (b) a Vice Chair who will serve his term the year after he has served a term as the At Large Member of the Executive Committee. The At-Large Member will be elected annually by the Executive Board from among, the active members of the Dental Faculty Practice;
   (c) one Member-at-Large elected by and from each of the School's Departments; and
   (d) one Member-at-Large elected from each of the School's operating units which is not organized as a department of the School.
   (e) the Director and Assistant Director, who are appointed by the Chair of the Board and are non-voting members of the Board; selection of the Director must be made in consultation with the concurrence of the Executive Board.

Members-at-Large shall be elected annually in May to serve two-year terms beginning July 1; six Members-at-Large shall be elected in even-numbered years and six in odd numbered years. Each elected Member-at-Large shall be a member of the Dental Faculty Practice who has completed at least two years as an active member of the Dental Faculty Practice (or its predecessor). Any vacancy occurring among the board's elected Members-at-Large shall be filled by a special election in the affected departmental group to serve for the remainder of the unexpired term.

The duties and responsibilities of the Executive Board shall be to make recommendations to the Dean on policy matters concerning effective operation of the Dental Faculty Practice, and the Dean will take no action on policy matters without prior consultation with the Executive Board.
(1) The Executive Committee of the Executive Board, which shall consist of the Chair of the Board, the Vice Chairman of the Board, the Director and Assistant Director of the Dental Faculty Practice and At-large Member(s) as elected by the Executive Board.

The duties and responsibilities of the Executive Committee shall be those assigned by the Executive Board with the concurrence of the Dean of the School of Dentistry. The Executive Committee shall hold meetings at least monthly, and shall keep the members of the Dental Faculty Practice informed of its actions by appropriate written reports.

(2) The Department Chairs of the clinical Departments of the School, each of whom shall have the same responsibility in his Department for the provision, delivery, and evaluation of patient-care services as he has for departmental instruction and research. Although a Department Chair may delegate to another member of his Department the coordination of departmental patient-care services, and must so delegate if he/she is not an active DFP participant, he shall retain ultimate responsibility for the quality and quantity of patient-care service, for the appropriateness of his faculty members’ schedules, for provision of patient-care services, for faculty members’ patient-care activities such as patient management, use of supplies and facilities, productivity, and relationships with patients, staff employees, and administrative management, and for relationships with other Departments and patient treatment areas. Additionally, he is responsible for communicating appropriate information to all members of his department concerning desired and achieved productivity. All departmental efforts are to be pooled, including the financial accounting.

(3) A Director and Assistant Director of the Dental Faculty Practice who shall be appointed by the Dean upon recommendation by the Executive Board through the Assistant Dean for Administration as the Chair of the Board.

IV. MANAGEMENT AND USE OF INCOME

The University shall maintain Dental Faculty Practice trust fund accounts for the deposit of all Dental Faculty Practice professional income and the disbursement of all Dental Faculty Practice expenditures. The Dental Faculty Practice trust fund accounts (and any sub-accounts thereof) shall not be utilized for the deposit of any other income or the disbursement of any other expenditures. All professional income (which includes all fees for Dental Faculty Practice members’ diagnosis and treatment of patients, patient consultation services, or any other patient care services rendered directly to patients or to institutions, but excludes honoraria, royalties, fees for occasional lectures, military pay, and editorial fees) shall be billed and collected by the Dental Faculty Practice and deposited in the Dental Faculty Practice trust fund accounts. The collection of patient accounting data, charges, and other information relating to billing collecting, and recording of professional fees will be performed under the administrative direction of the Dental Faculty Practice Director, who shall be responsible for the maintenance of satisfactory financial records.

Annually, a budget for Dental Faculty Practice income and expenditures will be prepared and submitted by the Dean for approval by the Chancellor with the advice of the Vice-Provost for Health Affairs and the Vice Chancellor for Business and Finance. Budget changes shall be prepared in a manner consistent with University procedures and be subject to the same approval. The accounting and reporting system will utilize the University’s chart of accounts and object codes insofar as practicable, and income and expense transactions will be processed in a manner consistent with generally accepted
University accounting procedures. All expenditures from the Dental Faculty Practice trust fund accounts will be processed on the appropriate forms of The University of North Carolina at Chapel Hill and approved by the Dean or the Assistant Dean for Administration.

Accounting reports similar to those Prepared for State appropriations will be prepared by the University Fiscal Office monthly and provided to the Dental Faculty Practice Director for the use of the Dean and the Chair of the Executive Board. The accounting reports are official records of The University of North Carolina at Chapel Hill, and records maintained by the Dental Faculty Practice will be reconciled to those accounting reports.

The fund balance in the Dental Faculty Practice trust fund accounts shall be divided into sub-accounts, the balance in each sub-account at any time being that amount determined by the School of Dentistry to be necessary or advisable. Those sub-accounts shall include the following, and other sub-accounts may be established as found by the School of Dentistry to be necessary or expedient.

1. The Departmental Fund, comprising the total of the separately identified individual departmental balances. Expenditures from the Departmental Fund may be made for approved budget items which serve to maintain and/or improve departmental capabilities in the areas of teaching, research, patient care, and public service; and such expenditures shall include payment of the direct clinical operating costs and the indirect administrative costs incurred in the delivery of patient care. Such expenditures may also include the payment of faculty salaries and fringe benefits within approved limits and of other expenses as follows:

   Level I benefits: are available to all participants regardless of departmental DFP financial status.

   Level II benefits: (A) are available to all of a department's participants upon the chair/group director's approval when the department's fund balance is positive; (B) are available to individual participants even when the departmental DFP financial status is negative if (1) the computation of the participant's quarterly collections are in excess of the individual's share of departmental expenses or the individual's per capita share of the pooled group, (2) the respective chair/group director approves the request, and (3) the DFP Director approves the request.

   Level III benefits: are available to participants only if, 1) the departmental DFP financial status is positive; 2) the computation of the participant's quarterly collections are in excess of the individual's share of departmental expenses or the individual's-per capita share of the pooled group, and 3) the respective chair/group director approves the request. Fund balances are reviewed bi-annually at the end of May and November. Departments having a negative fund balance at these times will be restricted to Level I benefits except in the narrow case described under Level II(B). Additionally, departments/groups may not expend more than two thirds of a positive fund balance to pay Level II/III benefits except as noted in Level II(B) above.

   Detailed benefits lists specified for each fiscal year shall be forwarded to the Office of the Vice Provost for Health Affairs for approval prior to the beginning of each fiscal year. Upon approval by the Vice Provost, an annual detail of benefits is sent to all participants.

2. The Doctors' Fund which shall be maintained by assessment of a fixed percentage of each department's Dental Faculty Practice collections each month.
The rate of such assessment shall be as determined from time to time by the Executive Board. Expenditures from the Doctors' Fund may be made, with the prior approval in each case of the Executive Board (except, for re-treatment of patients, and to offset unearned portion of clinical base salary during the first year of participation, the approval of the Chair of the Executive Board), for repair and/or purchase of equipment, renovations and alterations, re-treatment of patients previously treated by inactive or disabled Dental Faculty Practice members, to offset unearned portion of clinical base salary during the first year of participation, other special or non-recurring expenditures, and faculty fringe benefits within approved limits.

(3) The Dean's Trust Fund, which shall be maintained by assessment of a fixed percentage of each department's Dental Faculty Practice collections each month. The rate of such assessment will be as determined from time to time by the Executive Board. Also credited to this sub-account shall be any department-approved budgeted transfers from departmental Dental Faculty Practice balances. Expenditures from the Dean's Fund may be made, with the approval of the Dean and notification to the Chair of the Executive Board, for any School of Dentistry purpose that the Dean deems to be necessary and directly or indirectly beneficial to the Dental Faculty Practice.

(4) The Dean's Discretionary Fund shall be a separately maintained University trust fund account. A percentage of departmental Dental Faculty Practice collections may, with the approval of the Executive Board, be transferred to the Dean's Research and Education Fund to provide funds to support needs and objectives of the School of Dentistry. The Board may petition the Dean for a change in the percentage assessment. The percentage to be so transferred at any time will be as determined by the Executive Board.

Dental Faculty Practice funds or any other funds may be used:
(a) to pay salary and fringe benefit amounts in excess of the levels established and approved by The University of North Carolina at Chapel Hill; or
(b) to fund items which would be construed as non-business or personal in nature.

V. FACULTY SALARIES AND FRINGE BENEFITS

The annual salary of each faculty member is established by the University, and the sources for payment of such salaries may include Dental Faculty Practice funds. The portion of each Dental Faculty Practice member's salary to be paid from Dental Faculty Practice funds is determined by the Chair of the Executive Board in consultation with the Dean and the member's Department Chair, and that amount may be changed from time to time in the same manner. A faculty member's salary from all sources cannot exceed the total amount established for the individual by the University. The types and level of fringe benefit programs paid for from Dental Faculty Practice funds shall be recommended to the Dean by the Dental Faculty Practice Executive Board with evidence of financial feasibility and evidence of need for the proposed fringe benefits to maintain faculty compensation at a level as nearly as possible competitive with dental faculties nationally. The Dean shall submit annually the proposed fringe benefits program to the Chancellor for approval with the advice of the Vice Provost for Health Affairs and the Vice Chancellor for Business and Finance.
VI. **LEGAL COUNSEL**

If it should at any time be deemed necessary or advisable for the Dental Faculty Practice to secure private legal counsel or representation, such legal services may be secured only in accordance with applicable provisions of N.C.G.S. 147-17.

VII. **OUTSIDE CONSULTING SERVICES**

If it should at any time be deemed necessary or advisable for the Dental Faculty Practice to secure the services of outside consultants for such purposes as operation or accounting audits, planning, organizational analysis, and system review, such services may be secured only in accordance with applicable provisions of N.C.G.S. 143-64.20 et seq.

VIII. **AMENDMENTS**

Proposals for amending this Dental Faculty Practice Plan may be made to the Chancellor by the Dean of the School of Dentistry (on request of the Executive Board of the Dental Faculty Practice), or by the Vice Provost for Health Affairs, or by the Vice Chancellor for Business and Finance so that necessary or advisable revisions may be considered.
University of North Carolina
at Chapel Hill

School of Dentistry

Infection Control Manual

Effective: September 18, 2002
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Section I: Introduction

Infection control is a priority consideration in dental practice. Publicity of diseases such as AIDS and hepatitis has resulted in increased numbers of patients viewing the dental environment as a potential source for infection. Dentists and allied dental personnel have also become increasingly concerned about their own safety. Consequently, infection control policies and procedures must ensure confidence as well as provide protection for both the public and the care providers.

The School of Dentistry is committed to utilizing the most current research and technology to maintain an infection control program that is practical while meeting regulatory requirements. It is an imperative, ethical duty for all faculty, staff, and students to learn and practice the policies and procedures described in this manual.

Section II: General Policy Provisions

A. The School of Dentistry subscribes to the policy statement adopted by the American Association of Dental Schools, March 1991, which states, "Chief administrative officers of dental education institutions must establish and enforce written preclinical, clinical, and laboratory protocols to ensure adequate asepsis, infection and hazard control, and hazardous-waste disposal. These protocols should be consistent with current federal, state, and/or local guidelines, and must be provided to all faculty, students and appropriate support staff. To protect faculty, students, staff and patients from the possibility of cross-contamination and infection, asepsis protocols must include policies requiring the availability and use of gloves, masks, and protective eye wear by faculty, staff, and students in clinical situations and where appropriate, in preclinical situations."

B. All employed persons and enrolled students of the School of Dentistry, who are engaged in or may become engaged in patient care activities, shall be treated in a manner and shall conduct him or herself in accordance with the University of North Carolina at Chapel Hill Policy on HIV-infected and HBV-infected Employees and Students, issued 8 April 1992, included as Appendix A of the Bloodborne Pathogens Exposure Control Plan.

C. All dental personnel are ethically obligated to provide patient care with compassion and respect for human dignity. No dental personnel may ethically refuse to provide dental care solely because the patient has, or may have, an infectious disease, such as human immunodeficiency virus (HIV) infection, acquired immunodeficiency syndrome (AIDS), or hepatitis B infection.

D. All research personnel and clinical laboratory supervisors shall recognize their responsibility for implementing University guidelines to protect laboratory workers from hazards incumbent in handling human blood, secretions, specimens, tissues and materials contaminated with blood or secretions.
E. Hepatitis B or AIDS testing cannot be required for anyone except in the event of an exposure incident. For patients whose medical signs or symptoms are consistent with hepatitis B, AIDS, or other infectious disease, with or without associated medical history, appropriate referral for medical consultation and follow-up should be made.

F. Confidentiality of results of such testing and related diagnosis is essential and is the individual responsibility of each School of Dentistry employee and student who has access to this information. This information may be shared in confidence only with others providing direct health care to the patient (based on N.C. Public Health Law). When an HIV positive patient is referred to other health care professionals, the referring doctor is responsible for communicating the patient's medical status.

G. Notification of patients who have been treated by faculty, staff or students who have tested seropositive for AIDS or who have been diagnosed with AIDS, HIV infection, HBV infection or some other infectious disease, shall be conducted in accordance with the University policy issued 8 April 1992. (Appendix A of the Bloodborne Pathogens Exposure Control Plan).

H. The School of Dentistry will carefully observe the infection control guidelines published by the U.S. Public Health Service, for preventing possible transmission of infectious diseases.

I. Directors of each clinical and laboratory unit are charged with responsibility for conducting annual evaluations for compliance with Infection Control Manual in their area of responsibility. Records documenting dates of evaluations and findings shall be maintained and submitted for Infection Control Committee review. Infection Control Concern Report forms will be available in each unit as a method for reporting possible problems with infection control procedures and policies. Patients, faculty, staff and students should submit these forms to the Chair of the Infection Control Committee for evaluation and management in conjunction with the Program Director.

Section III: Clinical Attire and Barrier Protection Procedures

A. Instructors and providers of patient care are required to wear clean clinical overgarments, approved by the Infection Control Committee, each day in clinical areas. Clinical attire that has been soiled with blood and/or opim (other potential infectious materials) must be exchanged for clean attire before encounter with another patient.

B. Wearing of clinical overgarments is restricted to designated clinical facilities. Under no circumstances should gowns be worn outside the clinical areas. Clinical overgarments visibly soiled with blood and/or opim must not be worn outside the clinical area where treatment was rendered. Contaminated overgarments should be placed in the laundry container available in the clinical area, prior to leaving the clinic.
C. Disposable treatment gloves must be worn in performing and/or assisting in all intra-oral procedures. In addition, treatment gloves must be worn:

1. When opening exposed intra-oral X-ray film packets in the darkroom. (See Section X for details and exceptions.)
2. In laboratory settings when there is a possibility of exposure to blood and/or opim.
3. When handling equipment, instruments, and other items which have been contaminated with blood and/or opim, prior to being disinfected.

D. Jewelry must be removed from hands and fingernails should be trimmed sufficiently to prevent puncture of gloves. Long hair should be neatly styled/combed so as to not fall into the operator's field of vision or touch patient's face.

E. Sterile gloves must be worn in performing and/or assisting in all surgical procedures.

F. Hands must be thoroughly washed with antiseptic hand soap before gloves are put on and after they are removed. Also, hands and other skin surfaces must be thoroughly washed with antiseptic soap whenever contact with blood and other potentially infectious materials has occurred.

G. Any patient care provider with an exposed area of weeping dermatitis or a draining lesion will not treat and/or examine patients until the condition is resolved.

H. Disposable treatment gloves must not be worn outside the clinical area where treatment is rendered.

I. Treatment gloves must not be washed or disinfected for re-use with another patient.

J. Disposable mask and protective eye covering with solid side shields, or a face shield, must be worn during clinical examinations and chairside consultations in addition to any clinical procedure involving the generation of aerosols or spatter of blood or saliva. This applies to assisting personnel as well as to persons providing direct patient care. The disposable mask should be changed between patients or when visibly soiled. Protective eyewear should be disinfected between patients when visibly soiled/contaminated.

K. Instructors supervising patient care procedures, necessitating mucosal contact or contact with contaminated instruments, are required to change gloves between patients or use disposable overgloves.

L. Clean gloves, overgloves, or paper towels should be used to touch drawer handles, chairs, and non-sterile items to avoid contaminating those items.
M. Whenever preparing an anesthetic needle for intraoral use, obtain and install a protective shield on the needle sheath. All needles shall be used with a protective shield. Use the shield to support the empty needle sheath at an angle to provide easy one-handed resheathing of the needle. Re-capping of anesthetic needles is only permitted with the use of a protective shield by means of a one-handed technique.

N. Do not pass a syringe with an unsheathed, contaminated needle between clinician and assistant or vise versa. The clinician should always re-sheath the needle using a one-handed technique.

O. The School of Dentistry considers the safety of its patients to be of paramount importance. Eye protection is an essential component of our safety program. Therefore, patients are required to wear protective eyewear during any treatment that might involve use of sharp instruments or result in flying debris. The treating faculty, staff or student will provide this eyewear to the patient when necessary. Patients who prefer to wear their own glasses should be discouraged from doing so, since their glasses will not have side shields. Eyewear must be disinfected after each use.

Section IV: Preparation and Disinfection of Operatories

A. Clean-up and aseptic preparation of operatory is required according to the protocol outlined below, immediately following each patient encounter. Adherence to these procedures will insure that all operatories will be left in an aseptic and sanitary condition and that minimal preparation of the operatory will be required before seating a new patient.

B. Use plastic covers for the bracket tray, dental chair, air/water syringes, handpieces, and suction hose handles and accessory arm. These covers provide the most effective protection from chemicals and microbes. Items so covered do not require surface disinfection after patient treatment unless the integrity of the cover has been compromised.

C. Preparation of operatories shall be performed in accordance with the following sequence of activities.

1. Each operatory shall be stocked with the following items:
   a. paper towels
   b. liquid antiseptic hand soap
   c. bottle of disinfectant

2. Within each clinical area, the following items are available:
   a. plastic covers for bracket tables, dental chairs, air/water syringes, handpieces, suction hose handles and accessory arm.
b. foil for lamp handles

c. disposable treatment gloves and masks

d. patient napkins

e. disposable tray covers

f. disposable saliva ejectors and suction tips

g. cotton rolls, gauze, etc.

h. protective needle shields

i. leak-proof, puncture-resistant container for sharps disposal

3. Upon entering the operatory, place the foot pedal on the floor, place full water bottle on unit, turn on the main switch and lower the dental chair.

4. Wash hands with antiseptic soap, lather and rinse; repeat. Use a paper towel to avoid direct contact with the faucet handles. Put on disposable treatment gloves.

5. Push suction tip, air/water syringe and saliva ejector through the small plastic cover so that the tips protrude through the cover.

6. Test air/water syringe and suction to ensure unit activates. If plastic cover blocks activator switch in holder, simply pull plastic away from switch. Flush water through air/water syringe and handpiece for 30 seconds.

7. Re-hang handpiece hoses and air/water syringe in their supports.

8. Place disposable napkin on surface of mobile cabinet. Set out sealed instrument cassette and supplies for the entire treatment procedure on the covered bracket table and covered mobile cabinet. Remove disposable gloves. Remove radiographs and information from the patient chart. Place in appropriate location in the operatory.

9. Seat the patient in the operatory. Patient use of an antiseptic mouthwash is recommended prior to treatment for reduction in patient oral bacterial count.

10. Review medical history and check blood pressure.

11. Put on mask and eye covering in accordance with Section 3, I. Wash hands, put on disposable treatment gloves. Open sealed instrument cassette without contaminating instruments. Leave slow, color-change sterilization indicator strip on the tray with instruments. Retain paper instrument cassette wrap.
D. Clean-up and disinfecting of the operatory shall be performed according to the following sequence of activities after dismissing the patient from the operatory. Do not disinfect surfaces and items covered with plastic drape unless the plastic cover was torn during treatment.

1. Wash hands with antiseptic hand soap. Rinse, dry, and put on disposable treatment gloves. With needle shield in place, remove covered needle from anesthetic syringe. Discard needle, anesthetic carpules, and all other sharp disposable items into leak-proof, puncture-resistant container. Place cotton rolls, air/water syringe tip, and other disposable items from the bracket table into the inverted plastic covering the dental chair and discard.

2. Account for all instruments originally found on the cassette. Verify that the patient's social security number is written on the sterilization tag. Return instrument cassette to paper wrap and set aside.

3. Dispense disinfectant into a paper towel, wipe any used bottles and containers. Wipe dry with paper towel.

4. Remove hoses. Remove handpiece and follow protocol in Section VII, H. Remove and discard plastic covers from air/water syringe, handpiece hoses, and suction hose from the supports on the unit. Discard suction and saliva ejector tips. Place three towels in the seat of the dental chair. Lay air/water syringe, handpiece hose, and suction hose ends on paper towel on the dental chair and wipe with disinfectant.

5. Invert, remove, and discard plastic drape from bracket table. Remove and discard the lamp handle foil and the patient napkin covering mobile cabinet.

6. Remove handpiece and follow protocol in Section 4, H.

7. Wet paper towel with disinfectant and wipe lamp switch, lamp face, and controls that were not covered with plastic drape. Wipe surface of the mobile cabinet, uncovered arms of dental chair, exposed drawer handles, radiographic view box and switch. Discard wet paper towels.

8. Wipe faucet handles, sink counter top, and trash disposal openings with disinfectant and wipe dry with paper towel. Discard towel, wipe areas with disinfectant, and leave damp.

9. Wipe items of clinical equipment to be returned to the dispensary with disinfectant. Let stand for 3 minutes, then wipe dry.

10. Remove treatment gloves according to technique described in Section 5, F. Discard in operatory trash bin. Wash hands with antiseptic hand soap, rinse, and dry with paper towel.

11. Place a clean saliva ejector, air/water syringe tip and suction tip into their hoses and cover with plastic drapes.
12. Re-bag the accessory arm.

13. Re-hang the hoses in their supports.

14. Cover the back of the dental chair with plastic drape. Cover lamp handles with foil. Cover the bracket table with plastic drape and place paper tray cover on top.

15. Raise the dental chair to its highest position. Hang up the foot pedal on the dental unit or lay in patient chair on paper towel. Turn off the main switch.

16. Empty water bottle and invert (turn upside-down) on paper towel.

17. Return disinfected items to the dispensary with gloved hands. Submit instruments to the dispensary for sterilization. See Section 7.

E. Contaminated equipment will be decontaminated, if possible, prior to being returned to storage servicing or shipping for service. Equipment that cannot be adequately decontaminated will be tagged as a Biohazard.

F. Housekeeping workers will wear appropriate personal protective equipment during cleaning of areas potentially contaminated with infectious materials.

Section V: Maintaining the Chain of Asepsis and Limiting Contamination

A. Only items and surfaces that have been properly disinfected and/or sterilized constitute the patient's "chain of asepsis." Contact with other items or surfaces during or prior to treatment constitutes contamination and requires changing of disposable treatment gloves before proceeding with treatment.

B. Dental personnel should minimize the field of contamination by avoiding contact with objects such as patient records, telephones and cabinets during treatment procedures.

C. One area of the operatory should be considered clean and kept separate for the placement of patient records, radiographs, paperwork and writing instruments. Items in this area should only be handled without gloves or with clean gloves. Radiographs and material needed for viewing during treatment should be retrieved from the patient’s record prior to patient contact, or removed with clean gloves after patient contact. Gloves should be removed prior to handling telephones or making chart entries. Care must be taken and plans must be made in making chart entries to avoid contamination. Entries may be made when gloves are contaminated by using aluminum foil covering the pen and a clean towel over the chart page upon which to rest the hand when writing. Notes may be made on a piece of paper separate from the chart and later transcribed onto the chart when hands are clean.
D. Remove gloves, wash hands, and put on clean gloves if the chain of asepsis is broken for any reason.

E. Instruments and materials that have fallen outside the "chain of asepsis" during treatment should be placed in the operatory sink for later scrubbing and disinfection.

F. To remove contaminated gloves, mask, and eye covering, the following technique should be followed:

1. To avoid skin contamination when removing gloves, with gloved fingers of the right hand, pinch a large enough area of the left glove near the inner wrist to pull off and invert the glove. Then, insert a bare finger inside the other cuff without touching the soiled surface of the glove, to pull it off, inverting it also. Discard into the operatory trash receptacle.

   NOTE: (NEVER discard gloves or masks on the operatory floor, or outside the operatory/treatment area.)

2. After discarding gloves, wash hands thoroughly with antiseptic hand soap, rinse, and dry with paper towel.

3. Then, remove mask by the rubber band at the sides (facial portion may be contaminated) and discard in the operatory trash receptacle.

4. Masks should be changed every hour when treating the same patient and between the treatment of patients. Soiled masks should be removed and discarded rather than worn around the neck where contamination may spread to neck and clothes.

5. Protective eye covering with solid side shields should be removed, sprayed with disinfectant, and wiped dry with a clean towel.

G. Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in patient care areas, dental laboratories, sterilization areas, and in other areas where there is a potential for occupational exposure to bloodborne pathogens.

Section VI: Handling Needles and Sharps:

General Policy

Departments and dental care providers within UNC School of Dentistry will use proper handling and disposal of sharps as outlined below.

North Carolina Waste Management

Sharps are considered medical waste. The North Carolina Solid and Hazardous Waste Management Branch has developed rules relating to the disposal of regulated medical
waste. Within the School of Dentistry, the following are considered regulated medical waste: Human tissue, and blood products (including blood, serum, plasma). Incineration or sanitary sewers are appropriate means to discard those items. Sharps as defined include, but are not limited to, needles, syringes with attached needles, capillary tubes, slides and cover slips, scalpel blades and the sharps included in the Dental Tray. Sharp items may be incinerated or placed into the sanitary landfill after placement in a rigid puncture-proof container.

Policy for Handling Needles and Sharps

1. The healthcare provider will obtain a new sheath-guard/prop card with every new needle. Attach the card before attaching the needle to the syringe. All needles are to remain in the sheath until use. After use, the needle will be returned to the sheath-guard/prop until further use or disposal. The card is for one-handled re-sheathing of needles.

2. Do not bend needles for disposal. Only irrigating syringe needles used for endodontics may be carefully bent with needle forceps.

3. Use the Sharps Disposal Canister located in each operatory to discard all used needles, blades (removed with needle forceps), wire or other sharps for disposal.

4. If the canister is full, bring another canister to the site to discard the sharp(s).

Policy for Disposal of Dental Sharps

1. All used needle disposal syringes, scalpel blades, anesthetic carpules, and other sharp disposable items, must be placed in covered, puncture-resistant, leak-proof containers, labeled as Biohazard. When full, the containers are taken to a specified area in the basement of Tarrson Hall, located near Central Sterilization.

2. These materials are picked up on a monthly basis by the contracted medical waste facility.

Section VII: Sterilization and Disinfection of Instruments

A. Only properly sterilized or single-use instruments may be used in patient treatment.

B. All instruments must be submitted for sterilization promptly following use in patient care.

C. Prior to being sterilized, all instruments must be cleaned. Ultrasonic or mechanical cleaning should be used whenever feasible instead of cleaning by hand. Cleaning will be accomplished only in the Central Sterilization facility unless instruments are sterilized and repackaged on site for sterilization in individual sterilers.
D. Only instruments that have been cleaned of debris, disinfected, and dry may be submitted for sterilization in accordance with the procedures below:

1. For dry heat sterilization (used in DFP):
   a. Put on heavy-duty utility gloves. Preferably, rinse, ultrasonically clean, and rinse instruments again. Otherwise, with heavy gloves, scrub debris from a few instruments at a time using hot water, disinfectant, and a scrub brush. **Avoid squeezing sharp ends of double-ended instruments that can penetrate heavy gloves.** Dry instruments thoroughly with paper towel.
   b. Process no more than 22 clean and dry instruments in a heavy bag.
   c. Date and sign a slow-color-change indicator strip and place with instruments.
   d. Fold and seal bag with sterilization tape.
   e. Submit instruments for sterilization at appropriate location.
   f. Perforated metal alginate trays must be scrubbed free of debris, disinfected, and dried thoroughly.
   g. No more than 12 clean and dry alginate trays should be placed in paper bag along with a dated and signed slow-color-change strip. The bag must be sealed with sterilization tape and then submitted for sterilization.
   h. Do not overload sterilizer. Place bags a finger's width apart on the shelves.

2. For Steam Autoclaving Sterilization:
   a. Follow the same procedure as for Dry-Heat Sterilization, for instruments that are sterilized within the clinical unit.
   b. In some areas, but not in student operatories, instruments to be submitted to the Central Sterilization Unit, also must be scrubbed free of debris, disinfected, dried, and placed in the instrument tray.
   c. In the student clinics, the tray should be returned to the paper bag in which it was received, for submission to be cleaned and re-sterilized. Individual instruments must be returned to the bubble pack in which they were received, for submission to be re-sterilized.

E. **Instrument Cassettes:** In Student Clinics, clinical cassettes of instruments will be handled as follows:
1. Carefully open the brown paper bag and remove instrument tray, making every effort NOT to tear the bag or damage the tape. Determine if any instruments are missing from the tray. If so, return the cassette to the dispensary for a new one.

2. Carefully write the social security number of the patient onto the brown paper bag.

3. At the completion of patient care, the cassette is placed back into the original brown paper bag. DO NOT SCRUB instruments in the operatory, but remove excess cement and gross accumulations of debris prior to insertion into the bag. PLEASE NOTE: Return instruments in a neat and orderly fashion to avoid bag puncture with contaminated sharps. Placment of the cassette into the bag is best achieved by turning the bag upside down (once the bottom of the bag has been freed of tape), inserting instruments, and tucking end of bag underneath. Extra bags are available at the dispensary as needed.

4. The cassette is then transported with gloved hands to the dispensary where the instruments are counted and checked in. PLEASE NOTE: Transportation of two cassettes simultaneously is permitted, but carrying books, book bags, purses, or other materials while carrying clinical cassettes is not permitted. FAILURE TO FOLLOW THESE RULES MAY RESULT IN LOSS OF CLINICAL PRIVILEGES.

F. **Instrument Storage:** After sterilization, instruments should be stored in their sealed packages until they are used in treatment. Whenever this is not possible, the instruments must be submitted for re-sterilization prior to use in patient care.

G. **Supply Containers:** Dental materials and supplies that are available on mobile carts and storage boxes in the clinical areas, which have been used/contaminated during patient treatment, must be sprayed wet with disinfectant and wiped dry with a paper towel after use.

H. **Handpiece Sterilization:** Sterilization of handpieces is required. The Central Sterilization Unit, which is responsible for all handpiece maintenance and sterilization, follows manufacturer’s cleaning and sterilization directions. Before autoclaving a handpiece, clean internally with Midwest cleaner; clean in washer-decontaminator. Operate handpiece to remove solution; autoclave and re-lubricate. Handpieces are then placed in pre-sterilized peel-pockets and are distributed to dispensaries.

   1. If the handpiece is stiff, fit a bur and rotate it with gloved fingers to start it. Operate the handpiece for 30 seconds or until it works freely. If the handpiece will not function properly, place a note on it with tape and return it to the sterilization center.

   2. Slow speed motors are not sterilized, but are disinfected with alcohol and kept covered with a plastic sleeve during patient care.
Section VIII: Sterilization Monitoring for Individual Sterilizer

Sterilization unit and clinical dental assisting staff shall monitor the effectiveness of sterilization equipment in accordance with the procedures below.

A. A "slow-color-change" chemical indicator strip must be placed in each instrument or surgical pack of each load. For other kinds of loads, one chemical indicator strip per load is sufficient. The strip must be examined when the pack is first opened, and the pack must be rejected if the strip has not changed color. Save the strip and document the fact that it had not changed color.

Assume that the load is not sterile, and reprocess in another sterilizer known to be functioning properly. The problematic sterilizer must be taken off line until repaired and shown to be working by testing negative with at least one spore strip test.

B. Use a spore strip in a randomly selected instrument pack one day each week and send it to the Microbiology Lab for processing. Positive results indicating a problem will be communicated to the person responsible for that sterilizer. Monthly reports will be issued to each sterilization unit.

C. Mark the current date on sterilization tape on the outside of each instrument pack being sterilized.

D. Maintain a daily sterilization record in a notebook:
   1. Attach one piece of sterilization tape and one chemical indicator strip from the day's loads to a weekly calendar sheet. Date and initial both.
   2. Include monthly spore strip reports received from the Microbiology Lab.
   3. Document all problems with sterilizers and all remedial action taken to correct these problems.

E. A report must be sent to the Dean listing any sterilizers for which a spore test is not submitted to the microbiology laboratory.

STERILIZERS: CONSIDERATIONS OF TIMES AND TEMPERATURES

For small sterilizers used in offices, the major causes of failure are operator errors, including overloading and errors in time and pressure settings. However, power failures and mechanical errors are not uncommon.

DO NOT OVERLOAD STERILIZERS. READ THE MANUAL. READ GAUGES. MONITOR STERILIZATION.

1. **STEAM PRESSURE STERILIZATION (AUTOCLAVE):** Steam must circulate and penetrate all packs for the prescribed time. Do not overload or cram packs together. **Package** instruments to protect from contamination during storage. Packaging must not block steam penetration. Leave closed containers on their sides with lids open or ajar.
a. **FOR GRAVITY AIR DISPLACEMENT STEAM AUTOCLAVE:** Air is displaced in the chamber by a flow of steam from a vent in the top of the chamber. 250°F (121°C) at 15 lbs pressure; minimum of 15 minutes for very light loads; allow 20 to 30 min. for a moderate load of wrapped instruments.

b. **PRE-VACUUM or HIGH VACUUM STEAM AUTOCLAVE:** Used mainly in hospitals; a vacuum is pulled in the chamber before allowing steam to flow in. Otherwise operation time, temp., and pressure are the same. This process is considered to be more efficient, but is not available in most portable sterilizers.

c. **FLASH STERILIZATION:** 273°F (134°C) at 30 lbs pressure. Allow a minimum of 7 minutes for a light load and 10 min for a moderate load of wrapped instruments; 3-5 min for an unwrapped instrument. Consult specific times prescribed in the sterilizer manufacturer's manual. **Temperature cycles still must kill biological indicator spores.**

**Cautions:** Time required for the sterilizer to reach temperature is not included in the sterilization times given. Begin timing after sterilizer has reached temperature. Place packs so steam can circulate and penetrate. Crack door at cycle end to let packs dry.

2. **CHEMICAL VAPOR PRESSURE STERILIZATION (CHEMICLAVE):** Alcohol/acetone/formaldehyde vapor must penetrate thin packs and condense on dry instruments to kill spores. Requires: 270°F (131°C) and 20 lbs pressure; about 30 min. total time. Operate according to manufacturer's directions. See Operator's Manual. Also, consult operator's manual about packaging materials.

**Cautions:** Do not skimp on time if timing can be varied. Dry the cleaned instruments well before sterilizing. Use only the wrap prescribed by manufacturer, not cloth. Use only the manufacturer's sterilizer fluid. Avoid breathing vapor. When possible, let sterilizer cool before opening door to reduce fumes. Not suitable for towel packs.

For problem solving, door seal leaks, etc., see operator's manual and/or consult Support Services.

3. **DRY HEAT STERILIZATION (DRYCLAVE):** Basic dry heat ovens are merely heated baking chambers that allow air to circulate by gravity flow (gravity convection). Use only good quality ovens made for professional use. Forced draft (mechanical convection) ovens suitable for clinical use should be selected from well-calibrated equipment with FDA premarket approval or less expensive, high quality, equipment rated for industrial use. Heat must range above 320°F (160°C). Individual dental instruments must actually reach above 320°F for 30 minutes to achieve sterilization. However, much additional time is needed to heat the chamber and instruments to that temperature, depending on the wattage of the unit. An oven thermometer measures only oven temperature, not instrument
temperature. A thermocouple wire and pyrometer are needed to monitor instrument temperature.

a. **MECHANICAL CONVECTION (FAN-OPERATED FORCED DRAFT) OVENS:** May require an additional 0.25-0.5 hours to heat instruments; total time = 45 to 75 min., more or less depending on wattage and load size at a range of 335-345 F. Standardize with a pyrometer and verify with spore tests placed inside of bags.

b. **GRAVITY CONVECTION OVENS (have no fan or blower):** May require 0.5 to 1.5 hours (1-2 hours total time) to heat a lightly wrapped, properly spaced load of instrument packs to sterilization temperature. Time required in use will also depend upon the efficiency of the oven for its size, the size of the load, and how the load is packaged. Sixty to 90 minutes may be required to sterilize a medium load of lightly wrapped instruments in an oven set at a range of 330 to 345 F. Use paper, foil, or high-temp. nylon wrap or bags for dry heat. Prolonged higher temperatures may melt solder that holds instrument tip in place.

Dry heating temperatures fluctuate 5-10 degrees above and below the setting during a cycle, so a "range" rather than a specific temperature must be set. Without careful calibration, more sterilization failures are obtained with ordinary gravity convection dry heat ovens and with home-type mechanical convection ovens than any other type of sterilizer. The only accurate way to calibrate a sterilization cycle in most relatively inexpensive professional medical or professional industrial dry heat ovens is by using an external thermocouple wire attached to a temperature gauge (pyrometer). The sensing end of the wire is extended inside the oven and tied to an instrument in a centrally located pack to measure its exact temperature. Pyrometers are available from scientific supply companies at about $100. For continued use, tie the end of the probe wire to an instrument left in a package in the sterilizer as a control.

**Caution:** Instruments cannot be added during a sterilization cycle without starting timing over. Use special nylon bags, foil or paper wrapped packs, or metal trays for instruments. Place packs/trays at least a centimeter apart to allow heated air to circulate.

4. **"RAPID" DRY HEAT STERILIZATION (USES FORCED DRAFT OR MECHANICAL CONVECTION; COX, DENTRONICS):** Use only equipment with FDA premarket approval. Heat must reach instruments long enough to heat surfaces to oxidize spores. Forced?draft ovens that circulate air with a fan operate at approximately 370?375 F.; using 6 minutes for unwrapped and 12 minutes for wrapped instruments (Cox manufacturing Corp., and Dentronics Corp.).

5. **HOT BEAD DEVICES** are not suitable for sterilization of devices for re-use between patients; they are limited to use for re-disinfecting items during an endodontic treatment.

6. **ETHYLENE OXIDE STERILIZATION (ETO)**
Ethylene oxide sterilization is the most gentle method for sterilizing complex instruments and delicate materials.

Porous or plastic materials require aeration for at least 24 hours before contacting skin or tissues. (See operator's manual). Metal items can be used immediately.

a. Low cost equipment provides 12-hour cycles at room temperature above 68 F. Meets OSHA safety standards and is effective for processing dental instruments. Large chamber sizes hold many instruments or packs and reduce cycle numbers, but are more costly. Manufacturers should be consulted to obtain detailed information and ventilation requirements. (Anderson Products Co, Burlington, NC is the only manufacturer of low cost devices.)

b. Expensive equipment provides shorter cycles of three hours at 120-160 F (50-71 C). (3M Co. makes short cycle devices).

ETO CAUTIONS AND LIMITATIONS:

ETO is not presently validated for handpiece sterilization, but shows promise. Oil can defeat sterilization, so handpieces should be cleaned but not oiled before ETO sterilization.

Room temperature sterilizers: Must remain above 68 F throughout operation.

Gas cannot penetrate closed glass containers at any temperature, or nylon plastic bags at room temperature.

Use only types of packaging specified by the manufacturer. See operator's manual.

Instruments must not be wet, but should be freshly cleaned and damp before processing. Again, consult manufacturer or operator's manual.

Store spores for testing ETO in proper humidity, e.g. in a humidor. See manufacturer's directions.

Disinfection of Impression Materials and Dental Laboratory Procedures:

A. REQUIRED CLINICAL PROCEDURES:

IMPRESSIONS, BITE REGISTRATIONS, APPLIANCES, PROSTHETIC DEVICES AND CASTINGS: After removing any attached cotton materials from the item, rinse with running water to remove saliva, blood, and debris. Disinfect item prior to leaving the operatory, pouring in die stone, or sending to the dental laboratory by either spraying or soaking as follows:
1. Most impression materials and dental items may be either sprayed as described below, or soaked as described later in this section. Do not soak polyether elastomeric impressions or reversible and irreversible hydrocolloid impressions.

2. SPRAYING: Rinse item well under running water and then spray item with Omni or other suitable disinfectant. Leave wet for 3 minutes. Rinse thoroughly under running water, shake gently to remove water, then re-spray with disinfectant. Leave wet for 3 minutes. After 3 minutes, the item may be rinsed and considered disinfected.

3. BAGGING: Place disinfected impression or other dental item in a biohazard-labeled plastic zip-lock or heat-sealed (leak-proof) plastic bag before leaving the operatory. Avoid contaminating the outside of the bag. Wipe the bag with disinfectant if contaminated. For impressions, label the bag as to whether it is merely disinfected (DIS), or has been disinfected and rinsed (OK to pour). (Note that improper rinsing of the disinfectant inhibits the set of the dental stone.)

4. SUBMISSION GUIDELINES: Remove gloves and wash hands prior to carrying or submitting materials to the dental laboratory.

5. RE-ADMISSION GUIDELINES: All prosthetic items to be returned to the patient's mouth from the laboratory are considered clean. Items may be rinsed in a small amount of mouth wash to improve their taste.

6. INTERIM-USE GUIDELINES: See Section VII. All re-usable instruments in high-risk use, such as burs, Tofflemire or other matrix bands and retainers, scissors, hemostats, etc., contaminated during patient treatment, must be sterilized.

   a. The previously-described disinfectant techniques must be used for such items which either cannot be sterilized or are in a low-risk usage category, such as shade guides, laboratory pliers, laboratory knives, etc. If these are handled by gloved hands in the operatory, they must be disinfected prior to being returned to storage.

   b. Other items such as amalgamators, activators, curing lights, brushes, and polycarbonate crowns shall be disinfected prior to being returned to storage.

   c. Contaminated dentures, castings, appliances, or other prosthetic devices being taken by the provider to a remote site for further adjustment must be disinfected prior to leaving the operatory.

   d. Articulators, facebows, and other re-usable items handled by soiled gloved hands but not stored in the operatory, must be disinfected prior to removal.
B. LABORATORY CONSIDERATIONS:

1. Laboratory personnel are required to wear a clean uniform or laboratory jacket/coat. **Personnel receiving cases must also wear disposable treatment gloves.** A disposable mask and protective eyewear are also required when there is the potential for exposure to dust or spatter. Wash hands after removing gloves and whenever changing gloves.

2. Prior to arrival at the dental laboratory, all incoming cases must be properly disinfected and labeled. If there is a question about contamination, the case may be disinfected using a either a soak or spray technique:
   
   a. **SOAK:** 5 minute soak in 1:20 dilution of Clorox, full strength Omni, or other acceptable disinfectant. Polyether materials should not be soaked, but rather sprayed, rinsed, sprayed, and rinsed again after 3 minutes as previously described.
   
   b. Case containers must also be disinfected, and packing materials discarded to avoid cross-contamination.
   
   c. Spray gypsum casts and articulators with disinfectant when contaminated.

3. All outgoing cases must be properly cleaned and placed in a zip-lock bag or appropriate container prior to leaving the laboratory.

4. Contaminated countertops and work surfaces must be cleaned of debris and disinfected daily. After cleaning, spray surfaces with disinfectant, wipe dry with paper towels, and re-spray with disinfectant. Leave surfaces wet.

5. Contaminated ragwheels must be washed thoroughly and sterilized or disinfected in Clorox 1:10 for 20 minutes daily. Use Clorox (1:10) to wet the pumice daily. Caution should be used to avoid spatter on clothes.

6. Contaminated provisional and permanent appliances or prostheses which require ultrasonic cleaning and/or ragwheel polishing must be immersed in Clorox (1:10) for 5 minutes preceding cleaning/polishing.

7. Solid waste materials that are contaminated with blood or saliva must be placed in heavy-duty trash bags and sealed for disposal.
Section IX: Disinfection of Impression Materials and Dental Laboratory Procedures

A. REQUIRED CLINICAL PROCEDURES

IMPRESSIONS, BITE REGISTRATIONS, APPLIANCES, PROSTHETIC DEVICES AND CASTINGS: After removing any attached cotton materials from the item, rinse with running water to remove saliva, blood, and debris. Disinfect item prior to leaving the operatory, pouring in die stone, or sending to the dental laboratory by soaking as follows:

1. Most impression materials and dental items may be soaked as described later in this section. Do not soak polyether elastomeric impressions or reversible and irreversible hydrocolloid impressions.

2. Soaking: Rinse item well under running water and then soak item with 1:10 Clorox, ProPhene Plus, or other suitable disinfectant. Leave for 10 minutes. Rinse thoroughly under running water, shake gently to remove water. The item may be rinsed and considered disinfected.

3. BAGGING: Place disinfected impression or other dental item in a biohazard-labeled plastic zip-lock or heat-sealed (leak-proof) plastic bag before leaving the operatory. Avoid contaminating the outside of the bag. Wipe the bag with disinfectant if contaminated. For impressions, label the bag as to whether it is merely disinfected (DIS), or has been disinfected and rinsed (OK to pour). (Note that improper rinsing of the disinfectant inhibits the set of the dental stone.)

4. SUBMISSION GUIDELINES: Remove gloves and wash hands prior to carrying or submitting materials to the dental laboratory.

5. RE-ADMISSION GUIDELINES: All prosthetic items to be returned to the patient's mouth from the laboratory are considered clean. Items may be rinsed in a small amount of mouth wash to improve their taste.

6. INTERIM-USE GUIDELINES: See Section VII. All re-usable instruments in high-risk use, such as burs, Tofflemire or other matrix bands and retainers, scissors, hemostats, etc., contaminated during patient treatment, must be sterilized.

   a. The previously-described disinfectant techniques must be used for such items which either cannot be sterilized or are in a low-risk usage category, such as shade guides, laboratory pliers, laboratory knives, etc. If these are handled by gloved hands in the operatory, they must be disinfected prior to being returned to storage.
b. Other items such as amalgamators, activators, curing lights, brushes, and polycarbonate crowns shall be disinfected prior to being returned to storage.

c. Contaminated dentures, castings, appliances, or other prosthetic devices being taken by the provider to a remote site for further adjustment must be disinfected prior to leaving the operatory.

d. Articulators, facebows, and other re-usable items handled by soiled gloved hands but not stored in the operatory, must be disinfected prior to removal.

B. LABORATORY CONSIDERATIONS:

1. Laboratory personnel are required to wear a clean uniform or laboratory jacket/coat. Personnel receiving cases must also wear disposable treatment gloves. A disposable mask and protective eyewear are also required when there is the potential for exposure to dust or spatter. Wash hands after removing gloves and whenever changing gloves.

2. Prior to arrival at the dental laboratory, all incoming cases must be properly disinfected and labeled. If there is a question about contamination, the case may be disinfected by soaking.

   a. SOAK: 10 minute soak in 1:10 dilution of Clorox, ProPhene Plus or other acceptable disinfectant. Polyether materials should not be soaked, but rather sprayed, rinsed, sprayed, and rinsed again after 3 minutes as previously described.

   b. Case containers must also be disinfected, and packing materials discarded to avoid cross-contamination.

   c. Soak gypsum casts and articulators with disinfectant when contaminated.

3. All out-going cases must be properly cleaned and placed in a zip-lock bag or appropriate container prior to leaving the laboratory.

4. Contaminated countertops and work surfaces must be cleaned of debris and disinfected daily. After cleaning, wipe surfaces with disinfectant, wipe dry with paper towels, and re-wipe with disinfectant. Leave surfaces wet.

5. Contaminated ragwheels must be washed thoroughly and sterilized or disinfected in Clorox 1:20 for 20 minutes daily. Use Clorox (1:10) to wet the pumice daily. Caution should be used to avoid spatter on clothes.
6. Contaminated provisional and permanent appliances or prostheses which require ultrasonic cleaning and/or ragwheel polishing must be immersed in Clorox (1:20) for 10 minutes preceding cleaning/polishing.

7. Solid waste materials that are contaminated with blood or saliva must be placed in heavy-duty trash bags and sealed for disposal.

Section X: Radiology Service Procedures

Approved clinical attire, treatment gloves, facemasks (when there is the potential for splatter of infectious materials) and other appropriate barrier protection are required when rendering patient care in the Radiology Clinic and in other areas when radiologic examinations are performed.

All waste materials will be disposed in Biohazard receptacles.

General Room Setup:

1. If not present, place a plastic drape on the x-ray tube head, chair back and work space. Place clean foil or plastic covers on the control dials and exposure switch. Select the correct technique factors required for the examination. Cover laptop keyboard with plastic drape if using digital radiography or CCD system.

2. Wash hands and put on clean examination gloves.

3. Obtain the appropriate positioning instruments needed for the examination and place them on the covered work space.

4. Obtain the number of films/ image receptors as per protocol for device used and place them on a formal layout sheet on the covered work space. Set aside a paper towel wet with disinfectant to wipe saliva from the exposed films/ image receptors. Remove and discard gloves.

5. Seat patient. Briefly determine if the patient has any unprotected skin lesions that the lead apron or collar will touch. If so, tape a gauze square over the lesion or place a towel or other protective cover under the apron.

6. Wash hands and put on examination gloves and proceed with exam per receptor protocol.

Receptor Prep/Handling & Processing:

Standard Film:

1. With gloved hands obtain the number of films needed for exam and place on layout sheet.

2. After each exposure wipe saliva off the film packet with a dry paper towel and place them into a paper cup.
3. After all films have been exposed, wipe each film packet with a paper towel wet with disinfectant and place them into a clean paper cup. Remove gloves and wash hands.

4. Take films to darkroom. With gloved hands, open film packets dropping film onto a clean paper towel, discarding contaminated film wraps into trash can and discard lead foil in containers provided.

5. Remove and discard gloves, with clean gloved hands, process films separating double packet film before loading into processor.

6. Should retakes be necessary follow the same procedures in this section. When exam is complete, dismiss patient and follow protocol for room setup.

**Daylight Loader Method:**

1. Follow steps 1-3 above.

2. Put on two pairs of clean gloves, line the bottom of loader with a paper towel and place cup containing films and an empty cup into the daylight loader.

3. Insert hands into loader through ports. Open each packet allowing the film to drop onto the paper towel. Place wraps and foil into appropriate containers.

4. When all packets are opened, remove top pair of gloves and place in the trash paper cup. Separate double film and place into processor.

5. After all films have been processed, remove gloves turning inside out and then withdraw hands from ports. Open daylight loader and remove gloves and trash. Wash hands.

**PSP**

1. Wash hands. With clean ungloved hands, place the number of PSP receptors needed for exam in protective covers and on layout sheet.

2. Proceed with exam. After each exposure, wipe receptor with a dry paper towel and place in a clean paper cup.

3. When exam is finished, wipe each receptor cover with a paper towel wet with disinfectant and place into a clean paper cup. Remove gloves and wash hands.

4. With clean gloved hands, tear open receptor packet and drop receptor into light tight black box.

5. Remove gloves and wash hands.

6. Take box to scanning area and process as per protocol.

7. When scanning is complete, erase image using appropriate method. Re-bag and store receptors in closed container as directed. Wipe off image erasing screen with a disinfectant soaked paper towel.
8. Should retakes be necessary follow the same procedures in this section. When exam is complete, dismiss patient and follow protocol for room setup.

**CCD Receptors:**

1. With clean hands place CCD receptor in protective cover and cover keyboard with plastic drape.

2. Wash hands. With gloved hands proceed with exam.

3. When exam is complete remove gloves and wash hands, dismiss patient. With gloved hands remove protective covers from sensor and keyboard. Wipe sensor and cord with a paper towel wet with disinfectant.

4. Remove gloves and wash hands.

5. Prepare room for next patient as described in room setup.

**Section XI: Exposure Incident Reporting**  
(Student/Faculty/Staff/Resident)

The policies regarding Exposure Incident Reporting are listed on the University of North Carolina Dental School’s website at: [http://www.dent.unc.edu/admin/exposures/](http://www.dent.unc.edu/admin/exposures/)

**Section XII: HBV Immunization and Testing**

A. The School of Dentistry will comply with the OSHA Standard on Bloodborne Pathogens which states, in part, that the employer shall make available at no cost to the employee, the hepatitis B vaccine to all employees who have occupational exposure, and post-exposure evaluation and follow-up to all employees who have had an exposure incident. The School strongly encourages immunization for hepatitis B, as well as for other infectious diseases such as mumps, measles, and rubella.

B. Records of immunizations or documentations of refusal of vaccines will be kept with the personnel records and student records.

C. Students are required (unless medically contraindicated) to be vaccinated against hepatitis B to minimize the risk of hepatitis B infection. Since patient care activities begin during the summer semester of the first year, students should have their vaccination completed prior to that time.

D. Subject: Protocol for referring employees to the University Occupational Health Service for hepatitis B vaccination

**Policy:** All Clinical Research Center and School of Dentistry temporary, probationary, and permanent employees covered under the School’s Bloodborne Pathogen Exposure Control Plan are to be referred to the University Occupational Health Service within 10 working days of initial assignment. Responsibility for initiating the referral process rests...
Section XIII: Education Protocol on Infection Control

A. DUTIES OF EACH DEPARTMENTAL INFECTION CONTROL REPRESENTATIVE

1. Similar to the practice in UNC hospitals, each dental office is currently required to designate a person, dentist or auxiliary, to have major on-site responsibility for exposure/infection control.

2. ASSIGNMENT. Each Chair and/or Clinical Service director will designate an OSHA/Infection Control (OSHA/IC) representative for each clinical facility. The representative should be an auxiliary supervisor, assistant, hygienist, or dentist most able to annually review OSHA and State infection control requirements for that department or service, orient new personnel, and assure that records are kept and reported. Two persons may serve as a team to educate and orient persons in their clinic and department.

3. DUTIES. The departmental OSHA/IC representative must annually update the faculty and staff of the department regarding changes in IC regulations and other IC issues which may be necessary to review.

   The representative shall assist the department chair in monitoring and reinforcing infection control practices in the clinical setting.

   Before a new employee begins clinical work, the departmental OSHA/IC representative must assure that the new employee has been educated on IC matters as noted in section B below, that HB immunization and tuberculin testing have been addressed, and that the employee signs the OSHA form to document training at orientation.

4. TRAINING. Each departmental OSHA/IC representative must attend an OSHA/IC update session each year presented by an OSHA/IC Coordinator for the School or by the Chair of the Infection Control Committee. Attending a program presented by the Hospital or Biological Safety Office for the Campus may also be helpful, however such a program cannot address IC concerns specific to the dental school.

5. COMMUNICATION. The OSHA/IC representatives should maintain communication with the Director of Clinics, the Chair of the Infection Control Committee, and the Coordinator for Infection Control.

6. Departmental OSHA/IC representatives must assure that all employee records are filed in the department. This includes training records, HB immunization records, and tuberculin testing records. Copies of training records go to the Office of Biological Safety and to the Infection Control Committee Chair for recording and central filing.
B. EDUCATION FOR NEW EMPLOYEES WITH CLINICAL DUTIES

1. When an employment position is created in the School of Dentistry, the recruiter (person filling out the Recruitment Requisition form) must identify whether the potential employee will be exposed to bloodborne pathogens, other infectious material, or hazardous chemicals as defined by OSHA. When such exposure is anticipated, the following items apply.

2. The Personnel Department, upon notification of the new employee's start date by the UNC campus Office of Human Resources, will contact the School of Dentistry recruiter and inform him/her of the start date. The recruiter is then responsible for scheduling a meeting between the employee and the departmental OSHA/IC representative prior to patient contact or exposure to bloodborne pathogens.

3. The departmental OSHA/IC representative will then provide a one hour orientation, to include the following:


   b. A review of procedures for handling an employee exposure.

   c. A review of clinical infection control procedures. The employee will receive a copy of the checklist of NC infection control regulations located at the end of this section. The employee will also answer the clinical orientation questions at the end of this section.

   d. Determine whether the person has had an approved OSHA Bloodborne Pathogen Training/DEHNR course or has graduated in the last year from a North Carolina dental program (including dental assisting and dental hygiene programs).

      i. If such experience is confirmed, further personalized training is not needed at this time. The new employee must read a copy of the UNC School of Dentistry's Bloodborne Pathogen Exposure Control Plan and view the video on TB. The departmental copy of the School of Dentistry's Infection Control Documents must be made available to the new employee.

      ii. If such experience (part d. above) cannot be confirmed, the new employee must read a copy of the UNC School of Dentistry's Infection Control Documents (Parts I: Bloodborne Pathogens Exposure Control Plan and DEHNR; Part II: Epidemiology of Major Infections Transmissible in Dentistry; Part III: Infection Control
Manual). The employee will then be tested on the material and must score an 80% correct to meet minimum standards. Employees scoring less than 80% will be asked to reread the material and then be retested until the minimum passing score has been achieved.

iii. If the new employee is from a foreign country or does not have previous knowledge of OSHA, then the new employee must view the OSHA videotape on the Bloodborne Pathogens Standard.

e. Assure that the new employee has started or has made an appointment for their hepatitis B vaccine.

f. Assure that the new employee has seen the tuberculosis (TB) video and made an appointment for their TB test.

g. Assure that the new employee fills out and signs the OSHA training documentation form, which is then given to the Chair of the Infection Control Committee.

C. EDUCATION FOR NEW EMPLOYEES IN THE DENTAL RESEARCH CENTER (OR ANY NEW DRC LABORATORY PERSONNEL)

1. New laboratory personnel in the Dental Research Center (DRC) may be research technicians, dental students, graduate students, research fellows, postdoctoral fellows, or visiting scholars. All of these new personnel are required to be trained by the Laboratory Safety Officer of each laboratory. The Laboratory Safety Officer is designated by (or may be) the principal investigator of that laboratory. The new personnel will be trained according to the Laboratory Safety Plan which is written and updated by the principal investigator and/or the Laboratory Safety Officer as mandated by OSHA. The Laboratory Safety Plan must cover infection control protocols for laboratory specimens such as blood and tissue samples which might harbor human pathogens.

2. When new laboratory personnel have research duties involving oral examinations of human research subjects or potential exposure to the blood or body fluids of a human research subject in a clinical setting, then the Laboratory Safety Officer is required to arrange a meeting of the new personnel with an OSHA/IC representative for training as outlined in II above. The new personnel may be referred to the OSHA/IC representative of the department of the principal investigator or of the clinical area in which the new personnel will be conducting research on human subjects.

3. The DRC will have two of its own OSHA/IC representatives who will verify that the training described above (C.1,2) takes place. The DRC
OSHA/IC representatives will regularly obtain an updated list of DRC laboratory personnel and will ask those personnel about their risk of infectious exposure and their training in matters of infection control. The Laboratory Safety Officers and principal investigators will maintain the updated list of DRC personnel, and will receive a copy of this section (XIII) of the Manual of Infection Control from the DRC OSHA/IC representative.

4. Check List of NC Infection Control regulations that apply to the dental team, including the dentist.

Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses performed only in non exposure-prone areas.

Masks and glasses with side shields are worn during patient treatment and examinations.

Over-gowns are worn by all who work in the operatory; not worn or taken home for cleaning.

Whenever heavily soiled or at least each day, over-gowns are placed in a color coded hamper near the place of use.

Treatment gloves are worn for all oral contact procedures and chair-side assisting.

Treatment gloves are changed for each patient.

Charts, drawers, door knobs, light switches, phones etc. are not contaminated with used treatment gloves.

Soiled/used gloves are not worn to get instruments from drawers without using an additional clean barrier.

Hands washed when gloves changed unless multiple gloves are worn and stripped off one at a time.

Drapes on the unit are changed, suction/water tips are changed, and uncovered surfaces are disinfected after every patient.

A heavy glove is worn on each hand when gathering up and cleaning used instruments, and until the instruments are bagged for sterilization, such as in central sterilization and DFP.

A heavy glove is worn on each hand when cleaning suction traps.
Instruments are ultrasonically cleaned instead of scrubbed whenever possible.

Needles are only resheathed with one handed technique.

Needles are not bent except for canal irrigation.

Sharps are discarded where used (not in clean-up area).

Labeled sharps container: located at each operatory; discarded before over filling.

Unsheathed needles are not passed, or passed in a safe manner.

Hands not inserted down into containers to remove contaminated sharps.

Contaminated broken glass is picked up only with tongs; contaminated spills are cleaned up with disinfectant and paper towels while wearing utility gloves.

Sterilizers are monitored daily with indicator strips, and monitored weekly with biological indicator (spore test).

Sterilizer monitoring and problem-solving records are kept in a note book.

Handpieces are sterilized; water tips disposed of or autoclaved.

Radiographic films and equipment are handled aseptically.

Impressions are cleaned free of blood and debris, disinfected, and sent to lab in a biohazard labeled bag.

Infection Control Documents are kept in a brightly colored binder in a central location.

Questions to be answered by new staff, residents, and clinical faculty regarding the clinic in which they work:

1. Where is the note book located containing the OSHA EXPOSURE CONTROL PLAN?

2. Where is the NEEDLE/SHARPS EXPOSURE PLAN located?

3. Where are the following located?

gowns.... (What gown is permitted in the clinic in order to present a uniform standard of protection and
care to students
and patients?)
launder hampers

Masks
Gloves

4. How or where can protective eyewear be obtained with side shields?
5. Where are needles and needle prop/shields obtained and discarded?
6. How are sterile instruments/handpieces obtained?
7. What procedures are used for repackaging and returning used instruments?
8. How is saliva/blood-contaminated trash discarded?
9. Where are materials located to clean up spills?
10. How do we protect charts?
11. How are radiographic films handled and how is the day-light loader used aseptically?
12. In areas where instruments are cleaned and re-sterilized:

   Where are materials for monitoring sterilization located?

   What sterilization records must be kept in a log book?
13. Where are we allowed to eat, drink, apply cosmetics, lip balm, and store food?
14. Where are first aid kits, oxygen tanks, and disposable resuscitation masks located?
15. Is it permissible to pass unsheathed needles between clinical personnel?
16. Are there any new regulations or concerns that need to be addressed or updated?

Section XIV: Care of the Dental Patient Who is Hepatitis B, Hepatitis C, or HIV Positive

Patients with HBV, HCV, or HIV can be treated confidently in the clinics of the UNC School of Dentistry. In nearly all regards, such patients can be treated as would any other patients, in accordance with the School of Dentistry Manual of Infection Control Manual (revision August 2001). The occupational risk of HBV transmission in dentistry is known and measurable (one in three percutaneous injuries in a non-vaccinated health care worker or patient - 33%), while the risk of HIV transmission is much lower. (one in 250 - 300 injuries - 0.3%). The risk of HCV transmission is approximately 3% following a
percutaneous injury. The following protocols and recommendations should facilitate a practical and low-risk approach to treating a patient with a known transmissible infection.

A. TREATMENT, CONSULTATION, AND REFERRAL:

1. Do not refuse to treat a patient solely on the basis of the presence of a transmissible disease/infection. All patients appreciate professional competence and sensitivity in the handling of their treatment needs.

2. Members of the dental team who will have direct, hands-on contact with the patients should be informed confidentially (in private) of the patient's status. Students should make this communication with supervising faculty and chairside dental assistants prior to, or at the beginning of, a treatment session. The patient's confidentiality must be protected. Breach of confidentiality of health records is a criminal misdemeanor in North Carolina, punishable by up to 2 years in jail and an unlimited fine.

3. When making a referral to a specialist or other practitioner, the referring dentist may directly inform the other practitioner of the patient's HBV or HIV status, according to the N.C. Communicable Disease Laws and Regulations.

4. Contact his/her physician to determine current health status, medications, tuberculin reaction status, T4 cell count (with the date of the count), and any potential harm to the patient that may result from treatment. Enter the patient's diagnosis and T4 cell count in the chart.

5. It is not required that all patients with low T4 cell counts be seen in the hospital dental clinic. Referral should be accomplished on an individual case basis with consideration given to the patient's medical health. When a patient with HIV infection develops a T4 cell count less than 100, intraoral Kaposi's sarcoma, or an oral infection, which does not respond to customary therapy, he/she will require a consultation with, and possible referral to, a hospital dental clinic. Faculty in the DFP may refer patients directly after consulting with a UNC Hospital Dental Clinic Attending. Students should bring the patient's chart to their Attending Faculty who will contact the UNC Hospital Dental Clinic Attending and assist the student in making a referral if indicated.

B. BEFORE AND DURING TREATMENT:

1. Observe standard universal precautions with all patients, regardless of infectious status. As usual, establish a clean operatory area for the chart and uncontaminated instruments.

2. Treatment gloves should always be worn when handling items contaminated with saliva or blood (also when opening intraoral X-ray films).
3. Use standard precautions for treatment procedures. If there are cuts or sores on hands, use double gloves. Only use sterile surgical gloves when performing surgery, not for other procedures.

4. Use a protective sheath prop and the "one hand scoop" technique when recapping anesthetic needle. Do not pass uncapped needles between dentist and assistant. Instead, place it directly onto the instrument tray.

5. Change clinical overgarment before and after treating the patient.

6. Wear a disposable surgical cap when performing surgical procedures or when using a cavitron or a prophy-jet.

7. During surgery, avoid the use of fingers to manipulate suture needles. Use a forceps or other instrument to support the mucosa during suturing and to reorient the suture needle on the needle holder for subsequent stitches. Remove needles from the surgical field prior to tying knots.

8. Access one of the School's autoclavable handpieces to use when treating the patient.

C. AFTER TREATMENT:


2. Disinfect protective eyewear and pen (or change pen cover).

3. Discard contaminated disposable items inside the plastic chair cover and then drop in the operatory trash bin.

4. Place the scrubbed instruments back into the cassette and the paper bag, and turn it in. Place a label of the patient's chart number inside the wrapped instruments.

5. Disinfect impressions and prostheses as usual before transfer to a laboratory. No special labeling is required.

Section XV: Infection Control in the Learning Resource Center

A. While taking intraoral photographs, examination gloves will be worn when retracting the buccal mucosa or performing any procedure involving contact with saliva or a risk of exposure to human pathogens.

B. Hands must be washed when gloves are removed or changed.

C. Used cheek retractors must be dropped into a paper bag with a biohazard label and sent to Central Sterilization for cleaning and sterilization.

D. Contaminated gloves must not be allowed to touch the camera or surroundings.

E. Gowns must be worn in operatories.
F. Gowns must be placed in laundry hampers in clinical areas when soiled or at least once a day.

G. Biohazard labels will be placed on waste containers which receive waste contaminated with saliva or blood.
ACTIVE PARTICIPANTS

Level I benefits are available to all participants regardless of departmental DFP financial status.

Level II benefits: (A) are available to all of a department’s participants upon the chair/group director’s approval when the department’s fund balance is positive; (B) are available to individual participant’s even when the departmental DFP financial status is negative if 1) the computation of the participant’s quarterly collections are in excess of the individual’s share of departmental expenses or the individual’s per capita share of the pooled group; 2) the respective chair/group director approves the request; and 3) the DFP Director approves the request.

Level III benefits: are available to participants only if: 1) the departmental DFP financial status is positive; 2) the computation of the participant’s quarterly collections are in excess of the individual’s share of departmental expenses or the individual’s per capita share of the pooled group, and 3) the respective chair/group director approves the request.

Fund balances are reviewed monthly. Departments having a negative fund balance will be restricted to level I benefits except in the narrow case described under Level II (B). Additionally, departments/groups may not expend more than two-thirds of a positive fund balance to pay Level II/III benefits except as noted in Level II (B) above.

BENEFITS

Level I Benefits (see criteria for qualification above)

A. Term Life Insurance

Coverage: on an active participant, $200,000 to age 65; $130,000 to age 70; $40,000 age 70 and older; on spouse, $10,000; domestic partner*, $10,000; and dependent children, $0 until 14 days; 14 days – 6 mos. $1,000; 6+ mos. $10,000

B. Accidental Death and Dismemberment

1. $200,000 benefit for accidental death or maximum dismemberment of the participant.

2. $100,000 benefit for accidental death or maximum dismemberment of spouse.

3. Graduated benefits for dismemberment between minimum and maximum.

4. Participants may purchase additional AD&D insurance on themselves, spouses and each child through payroll deduction.

• As stated in the Affidavit of Domestic Partnership
DFP Benefits

C. Health Insurance

The health insurance benefit program that is available to all other State employees is provided to DFP participants. This program is administered through the University to whom all inquiries should be directed. Typically, eligible health benefit programs have included the State of North Carolina Comprehensive Plan administered through Blue Cross/Blue Shield.

D. Salary continuance (Disability Insurance) provided by State

1. After one year of service all employees are covered by the State short-term plan. This plan provides a benefit level of 50% of an employee’s total salary (limited to $3,000) per month after a 60-day waiting period. This benefit is payable for up to 365 days after the waiting period. Coordinated with worker’s compensation; additional earnings up to a specified level are permitted. Those in TSER accrue creditable service towards retirement.

2. After five years of service all employees are covered by the State long-term disability plan. Benefits are payable after the conclusion of the short-term period. The benefit level is 65% of total salary (limited to $3,900) per month coordinated with worker’s compensation and social security. Additional earnings up to a specified level are permitted. Those in TSER accrue creditable service towards retirement.

E. Disability Insurance provide by the Dental Faculty Practice.

Upon successful completion of the probationary period (see Section 1.7d.), the participant is enrolled in a group policy established by DFP based on the participant’s annual earned income and carrier’s normal Issue & Participation limits. The benefit amount is 60% of salary up to a $15,000 monthly maximum. Provision for disability coverage is dependent upon availability of insurance underwriting for dentists at an affordable cost to DFP.

F. Retirement contribution on DFP Salary

1. Total salary participates in the University basic retirement program, either State Retirement System or TIAA-ORP. There is a six–percent salary deduction from participants administered through the University.

2. Supplemental retirement Annuity Account for participants who elect an ORP basic retirement plan.

To equalize the employer matching cost between the two basic retirement programs (TSER and ORP), a non-contributory payment will be made into a separate retirement account for participants who choose an ORP basic retirement plan equal to the difference in the employer’s matching cost on the DFP salary.
DFP Benefits

G. Dental Services

For participant, spouse, domestic partner, children of participant spouse or domestic partner, parents of participant, parents-in-law of participant and parents of domestic partner of participant up to $3,000 per year in dental services and electric toothbrushes (purchased through DFP) for a family group. Charges over $3,000 must be approved by the respective Department Chairman. The Practice will provide coverage for a child up to 26 years of age and over 26 years of age if the child is a full time student or legal dependent of a participant.

H. North Carolina License Renewal Fee

I. North Carolina Privilege Tax

J. Malpractice Insurance

Level II Benefits (see criteria for qualification above)

A. Health and Vision Insurance Premium Reimbursement

Monthly premiums deducted through the University payroll may be reimbursed quarterly.

B. American Dental Association and North Carolina Dental Society dues.

Level III Benefits (see criteria for qualification above)

A. Out-of-Pocket Medical Expenses

Reimbursement of out-of-pocket medical expenses for the participant and family up to a maximum amount determined by the individual departments per year. Family is defined as those covered under the Hospital-Medical insurance program (includes prescription drugs and corrective, safety, or telescopic lenses).

B. Supplemental Retirement

Departments with adequate fund balances in their January operating account may elect to make non-contributory payments into individual supplemental retirement annuity accounts which are authorized under section 403(B) of the Internal Revenue Code. An adequate fund balance allows the total remittances for a department/group to not exceed two-thirds of their January fund balance. All eligible members of the Dental Faculty Practice at the UNC-CH School of Dentistry may participate equally, either up to 6.00% of total salary or at a specific dollar amount, with a limit of $30,000 each for the year. Three years in the Dental Faculty Practice is required to be eligible. Companies used for remittances must be on the approved 403B company list with the University of North Carolina at Chapel Hill.
DFP Benefits

C. Dental Services

Reimbursement of out-of-pocket dental expense for minor children residing outside of North Carolina who are tax dependents of the participant are limited to $3,000 when combined with the participant’s yearly Level I dental benefits. The Benefits Committee will consider requests on a case-by-case basis that are supported by the participants chair/group director and make recommendations to the Board of Directors for reimbursement of out-of-pocket dental expenses for immediate family members when dental care is not available to be provided by the DFP.

D. Reimbursement for Long Term Care Insurance premiums, participant only.

E. Reimbursement for UNC Parking permit fee and/or bus pass.

F. Travel – professionally related.

G. Elective equipment, books for participant’s use, other appropriate work-related supplies.

H. Additional dues and subscriptions.

I. Monthly group-term life insurance premium deducted through the University payroll may be reimbursed quarterly.

INACTIVE PARTICIPANTS

Fringe benefits for inactive participants are the same type as provide to active participants at all levels. Please refer to active participant’s section.

PHASED RETIREMENT PARTICIPANTS

Fringe benefits for phased retirement participants are the same type as provided to active participants at all levels with Department Chair/Group Director approval. Phased retirement participants are not entitled to continue receiving the Optional Retirement Contribution on their DFP salary. Please refer to active participant’s section.

RETIRED PARTICIPANTS

A. Dental Services

A retired participant who completed 10 years or more in the Practice is provided up to $3,000 total cost per fiscal year for dental services and electric toothbrushes (purchased through DFP) for self and his/her spouse.

The DFP benefits structure will be reviewed annually and may be amended annually by action of the DFP Board, subject to further approval by the Vice-Provost for Health Affairs.
PARTICIPANT EXIT SHEET

Participant Name:

Participant Department:

Date of Departure:

Keys Turned In To the School: ___________________________ Date:

Keys Turned In To the DFP: ___________________________ Date:

Equipment Turned In To Dept: ___________________________ Date:

Equipment Turned In To DFP: ___________________________ Date:

Do you have patients with work yet to be completed? _____ Yes / No

If yes, have patients been re-assigned? _____ Yes / No

Have all patients been charged? _____ Yes / No

Have all charts been returned to the proper chartroom? _____ Yes / No

Do you have any comments for the School or for the Dental Faculty Practice?

Participant Signature: ___________________________ Date: