UCONN

SCHOOL OF DENTAL MEDICINE

Quality Measurement and Improvement Manual

INTRODUCTION

Purpose of the Manual

For all providers (predoctoral, postdoctoral, and faculty) and support staff to understand the School of Dental Medicine's Quality Assurance (QA)/ Quality Measurement and Improvement (QMI) processes and activities.
An understanding of the underlying principles of quality assurance provides for improved patient care and education.

Definition of Quality Assurance

Quality Assurance includes all activities that ensure that the care provided to patients is of high quality. Quality of care, defined by the Health Center, is the degree to which patient services increase the probability of desired outcomes and reduce the probability of undesired outcomes, given the current state of knowledge. Because knowledge evolves, the probability of desired outcomes can be influenced; patient care quality, therefore, is not static, but, rather, dynamic.

QUALITY MEASUREMENT AND IMPROVEMENT (QMI) COMMITTEE

Charges to the Quality Measurement and Improvement Committee

1. Implement a formally organized sequence of activities using "indicators" and "criteria" to assess quality of care delivered in the School's outpatient areas. There should be an ongoing, systematic and routine collection of data, rather than time-limited audits
2. Evaluate data to assess quality of care, recommend actions, which the Committee feels would remedy deficiencies, and assist in the implementation of these plans
3. Conduct reassessments to determine that the recommended actions have been implemented and have achieved the desired results
4. As appropriate, coordinate activities with the Clinical Affairs Committee
5. Prepare an annual report to be included in the annual report of the Office of Clinical Affairs
6. Perform other charges as assigned by the Dean

The Committee will incorporate the following key concepts regarding evaluations of patient care quality

1. Structures, processes (i.e., services) and outcomes of care will serve as the focus of attention when examining issues related to patient care quality
2. Structures and processes of care only affect the probability of outcomes of care; they are not sufficient to guarantee those outcomes, which are dependent on many other variables (e.g., patient risk, severity-of-illness, compliance with treatment, unknown causes)
3. Because the probability of outcomes can be improved (e.g. with increases in knowledge), patient care quality is not viewed as a static "acceptable" level; rather, it is subject to continuous improvement

Composition of Quality Measurement and Improvement Committee

1. Faculty representatives from the disciplines and programs responsible for the delivery of clinical services in the School's outpatient clinics. This includes the Director of Quality Measurement and Improvement and Planning (Chair), Senior Associate Dean of Education and Patient Care (Ex-officio), Predoctoral Clinic Director, Advanced Education in General Dentistry Program, Director of Burgdorf UCHC Pediatric Dental Clinic
2. Support staff with responsibilities related to clinical services which include the Patient Care Coordinators and Dental Clinic Managers
3. Student representative

STANDARDS OF CARE -Adopted October 2013

Standard: Each patient will be informed of the Patient Bill of Rights.

Standard: Patients will be treated in a safe environment.

Standard: Patients seeking comprehensive care will be provided with a comprehensive exam and an individualized risk assessment.

Standard: A proposed dental treatment plan and financial plan will be reviewed and approved by the patient.

Standard: A medical and dental history will be obtained as part of the initial evaluation of each patient.

Standard: Informed consent will be obtained from the patient prior to the initiation of care.

Standard: An entry in the electronic health record will be completed by the provider for each visit.

Standard: Treatment will be rendered in a logical and orderly fashion. Standard: Care will be delivered in a timely manner.

Standard: Patients will be offered continued oral health services following completion of active care.

Standard: Patients will have access to emergency care.

Standard: Patients will be satisfied with the care that they receive.

Standard: Patient information will be maintained in an appropriate manner to maintain confidentiality.

STANDARDS OF CARE ASSESSMENT PROCESSES

STANDARDS OF CARE -Adopted October 2013

Standard: *Each patient will be informed of the Patient Bill of Rights*
Indicator: All patients will be informed of the Patient Bill of Rights
Measure: 1. At Screening visit, patients are given the Patient Bill of Rights.
2. The Patient Bill of Rights is posted in the Dental Clinics and SDM Website.
3. Patient Satisfaction Survey

Standard: *Patients will be treated in a safe environment.*
Indicator: The Dental Clinics will operate under approved infection control and safety parameters. Providers will comply with universal precautions for infection control.
Measure: 1. Infection Control is a component of the student evaluation.
2. Infection Control monitoring in the clinic
3. Infection Control Audit
a. Environment of Care
b. Adherence to Infection Control Guidelines
Indicator: All providers involved with patient care will be certified in basic life support.
Measure: 1. Copies of Basic Life Support Cards Maintained by Administrative Coordinator

Standard: *Patients seeking comprehensive care will be provided with a comprehensive exam and an individualized risk assessment.*
Indicator: All patients seeking comprehensive care will be provided with a comprehensive exam and individualized risk assessment.
Measure: 1. Analytical Audit
2. Procedural Audit

Standard: *A proposed dental treatment plan and financial plan will be reviewed and approved by the patient.*
Indicator: All patients will have approved a treatment plan prior to the initiation of care.
Measure: 1. Procedural audit

Standard: *A medical and dental history will be obtained will be obtained as part of the initial evaluation of each patient.*
Indicator: All patients will have a medical and dental history documented at the initial visit.
Measure: 1. Analytical visit

Standard: *Informed consent will be obtained from the patient prior to the initiation of care.*
Indicator: Informed consent will be obtained from the patient prior to the initiation of care.
Measure: 1. Procedural Audit

Standard: *An entry in the electronic health record will be completed by the provider for each visit.*

Indicator: Entries in the electronic health record will be completed for each patient visit.

Measure: 1. Procedural Audit

Standard: *Treatment will be rendered in a logical and orderly fashion.*

Indicator: Patients will have their treatment rendered in a logical and orderly fashion.

Measure: 1. Analytical Audit
2. Focused Review: Appropriate Sequence of Phase I Reevaluation

Standard: *Care will be delivered in a timely manner.*

Indicator: All patients will be seen at least once every 45 days.

Measure: 1. >45 Day Data
2. Procedural Audit

Indicator: A treatment plan will be proposed to the patient in a reasonable time frame from the initial visit.

Measure: 1. Focused Reviews-Number of visits to treatment plan
Interval between screening & presentation/acceptance of treatment plan

Standard: *Patients will be offered continued oral health services following completion of active care.*

Indicator: Patients will be offered oral health services following completion of active care.

Measure: 1. OHM program is offered to patients

Standard: *Patients will have access to emergency care.*

Indicator: All patients will have access to emergency services.

Measure: 1. Emergency dental services will be available 24 hours per day, 7 days a week at the School of Dental Medicine or John Dempsey Hospital.

Standard: *Patients will be satisfied with the care that they receive.*

Indicator: Patients will be satisfied with the care that they receive.

Measure: 1. Patient Satisfaction Survey-Annual
2. Patient Satisfaction Survey-Maintenance

Standard: *Patient Information will be maintained in an appropriate manner to maintain confidentiality.*

Indicator: Patient information will be maintained in an appropriate manner to maintain confidentiality.

Measure: 1. Secured record room that is attended or locked.
2. Axium software system security reports
3. Records of provider HIPAA training

PATIENT BILL OF RIGHTS

The faculty and staff of the University of Connecticut School of Dental Medicine are here to provide patients with the best dental treatment possible. We recognize that a personal relationship between the treating dentist and the patient is essential for the provision of care. We believe that patients have entrusted us with their dental care, and therefore, have a right to receive certain considerations from the School of Dental Medicine. Patients also have the right to know the rules of the School of Dental Medicine and the regulations that apply to their conduct as a patient.

Patient's Rights

1.) The patient has the right to the most appropriate care the School can provide for their problem, without regard to race, sex, national origin, color, religion, age or disability.

2.) The patient has the right to be treated kindly and respectfully by all personnel; to be addressed by their proper name and without undue familiarity; and to be assured that their individuality will be respected.

3.) The patient has the right to know which members of the health care team (dental student, dental hygiene student, graduate dentist and/or faculty member) are directly responsible for their care, including their names.

4.) The patient has the right to ask their dental provider and other members of the health care team questions and to receive answers from them concerning their dental condition, treatment and plans for care.

5.) The patient has the right to discuss any treatment, procedure, or operation planned for them with members of the health care team, so that the patient may understand the purpose, probable results and/or alternatives and risks involved before consenting to the agreed upon treatment plan.

6.) The patient has the right to know what we feel is the optimal treatment plan for them as well as the right to ask us to scale down the optimal plan to fit within their financial or time constraints, if possible.

7.) The patient has the right to request an appointment to have their record reviewed by a faculty member who is familiar with their treatment.

8.) The patient has the right to receive an estimate of the cost of dental treatment and to be informed of changes in the total cost, if changes in their treatment plan occur.

9.) The patient has the right to withdraw consent and to discontinue participation in the treatment or activity at any time.

Patient's Responsibilities

1.) The patient shall provide, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters pertaining to his or her health. The patient has the responsibility to report unexpected changes in his or her condition to the responsible practitioner.

2.) The patient shall make it known to the appropriate practitioner whether he or she clearly understands the course of treatment and what is expected of him or her.

3.) The patient is responsible for following the recommended instructions given by the practitioner including follow-up treatment instructions.

4.) The patient is responsible for his or her actions if he or she refuses treatment or does not follow the instructions of the practitioner.

5.) The patient is responsible for keeping appointments, and when unable to do so for any reason, to notify the practitioner or the School of Dental Medicine.

6.) The patient (or the legally responsible party) is responsible for assuming that the financial obligation is fulfilled as treatment is performed.

7.) The patient is responsible for being considerate of the rights of other persons and the School of Dental Medicine.

8.) The patient should expect the School of Dental Medicine to provide only those services that the attending practitioners determine to be appropriate.

QUALITY MEASUREMENT AND IMPROVEMENT PROCESSES

A. Patient Record Audits
   I. Random Record Audits
      a. Record Review Audits: Auditor Assessment
      b. Record Review Audits: Student Self-Assessment
   2. Record Audit
      a. Treatment Plan: Auditor Assessment
      b. Treatment Plan: Student Self-Assessment
   3. Record Audit
      a. OHM/Transfer: Auditor Assessment
      b. OHM/Transfer: Student Self-Assessment

B. Patient Reviews
   1. Treatment Plan
   2. Phase I Reevaluation
   3. Exit/Phase II Evaluation

C. Patient Satisfaction Surveys
   1. Annual
   2. Exit

D. Focused Reviews

   Focused Reviews are conducted on an as needed basis when issues requiring further investigation are identified via record audits, patient satisfaction surveys, or QMI Committee meetings.

E. Education

F. Patient Relations Database

RANDOM RECORD AUDITS - RECORD REVIEW INDICATION

Predoctoral patient records will be audited and evaluated randomly during the treatment process.

PURPOSE

To ensure that the care provided to patients is of high quality. The following Standards of Care are assessed:

Standard: *Patients seeking comprehensive care will be provided with a comprehensive exam and an individualized risk assessment.*

Indicator: All patients seeking comprehensive care will be provided with a comprehensive exam and individualized risk assessment.

Measure: I. Analytical Audit

Q2 Was the medical history documented at the initial exam?

Q3 Are there appropriate entries for recommendations for medical management?

Q5 Is there a follow-up to the medical consult request?

Q6 Is there adequate documentation with regards to dental findings?

Q9 Is there adequate documentation with regards to diagnosis?

Q10 Is there adequate documentation with regards to problems?

Q11 Is there adequate documentation with regards to radiographic findings?

Q12 Does the treatment plan outline a logical sequence of treatment for the patient?

II. Procedural Audit

Q2 Is the caries risk assessment completed?

Q3 Is the periodontal risk assessment completed?

Standard: *A proposed dental treatment plan and financial plan will be reviewed and approved by the patient.*

Indicator: All patients will have approved a treatment plan prior to the initiation of care.

Measure: I. Procedural Audit

Q4 Has the treatment plan been accepted and signed by the patient indicating informed consent for the initial plan of treatment?

Q5 Have updates to the treatment plan been accepted and signed by the patient indicating informed consent for the initial plan of treatment?

Standard: *A medical and dental history will be obtained as part of the initial evaluation of each patient.*

Indicator: All patients will have a medical and dental history documented at the initial visit.

Measure: I. Analytical Audit
- Q2 Was the medical history documented at the initial exam?
- Q4 Are there appropriate entries for recommendations for medical management?
- Q5 Is there a follow-up to the medical consult request?
- Q8 Is there adequate documentation with regards to dental findings?
- Q9 Is there adequate documentation with regards to diagnosis?
- Q10 Is there adequate documentation with regards to problems?
- Q11 Is there adequate documentation with regards to radiographic findings?

Standard: *Informed consent will be obtained from the patient prior to the initiation of care.*

Indicator: Informed consent will be obtained from the patient prior to the initiation of care.

Measure: I. Procedural Audit
- Q4 Has the treatment plan been accepted and signed by the patient indicating informed consent for the initial plan of treatment?
- Q5 Have updates to the treatment plan been accepted and signed by the patient indicating informed consent for the initial plan of treatment?
- Q8 Do the last three progress notes contain reaffirmation of patient informed consent?

Standard: *An entry in the electronic health record will be completed by the provider for each visit.*

Indicator: Entries in the electronic health record will be completed for each patient visit.

Measure: I. Procedural Audit
- Q10 Is there an entry in the EHR for each visit?

Standard: Treatment will be rendered in a logical and orderly fashion.

Indicator: Patients will have their treatment rendered in a logical and orderly fashion.

Measure: I. Analytical Audit

Q14 Was the Phase I Reevaluation completed in the appropriate sequence?

Q15 Was the Phase II Reevaluation completed?

Q18 Has treatment been completed in a logical sequence?

Standard: Care will delivered in a timely manner.

Indicator: All patients will be seen at least once every 45 days.

Measure: I. Procedural Audit

Q6 Has treatment been completed in a timely manner? (no unexplained intervals of >45 days)

FREQUENCY

Ongoing basis

ANALYSIS

During the record auditing process, the responsible individuals are contacted to rectify deficiencies. This is done electronically from auditor to student. The student then conducts a self-assessment and returns the form back to the auditor. The data is analyzed and discussed with the Predoctoral Clinic Director and the Senior Associate Dean of Education and Patient Care, and the QMI Committee. If necessary, the issues may be forwarded to the Clinical Affairs Subcommittee, via the Senior Associate Dean of Education and Patient Care, or the Dean of the School of Dental Medicine.

RECORD REVIEW

Analytical Audit

1.) Are radiographs taken at recommended intervals?
2.) Was the medical history documented at the initial exam?
3.) Has the medical history been updated appropriately?
4.) Are there appropriate entries for recommendations for medical management?
5.) Is there follow-up to the medical consult request?
6.) Is there evidence of proper follow-up and management for significant medical problems?
7.) Has an identified oral lesion been followed up?
8.) Is there adequate documentation with regards to dental findings?
9.) Is there adequate documentation with regards to diagnosis?
10.) Is there adequate documentation with regards to prognosis?
11.) Is there adequate documentation with regards to radiographic findings?
12.) Does the treatment plan outline a logical sequence of treatment for the patient?
13.) Did the patient receive appropriate preventive care during treatment?
14.) Was the Phase I Reevaluation completed in the appropriate sequence?
15.) Was the Phase II Reevaluation completed?
16.) Do the last three progress notes contain drug/medication administration?
17.) Was there a post-op visit after a surgical procedure?
18.) Has treatment been completed in a logical sequence?
19.) Based on the information, has the quality of care been adequate?

Procedural Audit

1.) Has the HIPAA form been updated within the last 6 months?
2.) Is the caries risk assessment completed?
3.) Is the periodontal risk assessment completed?
4.) Has the treatment plan been accepted and signed by the patient indicating informed consent for the initial plan of treatment?
5.) Have updates to the treatment plan been accepted and signed by the patient indicating informed consent for changes in treatment?
6.) Has treatment been completed in a timely manner? (no unexplained intervals of >45 days)
7.) Do the last three progress notes contain faculty approval?
8.) Do the last three progress notes contain reaffirmation of patient informed consent?
9.) Does the completed procedure code match care recorded in the progress notes?
10.) Is there an entry in the EH R for each visit?

RECORD AUDIT -TREATMENT PLAN

INDICATION

Record Audit -Treatment Plan are completed for all predoctoral comprehensive care patients that are treatment planned.

PURPOSE

To ensure that the care provided to patients is of high quality. The following Standards of Care are assessed:

Standard: Patients seeking comprehensive care will be provided with a comprehensive exam and an individualized risk assessment.

Indicator: All patients seeking comprehensive care will be provided with a comprehensive exam and individualized risk assessment.

Measure: I. Analytical Audit

- Q2 Was the medical history documented at the initial exam?
- Q4 Are there appropriate entries for recommendations for medical management?
- Q5 Is there a follow-up to the medical consult request?
- Q8 Is there adequate documentation with regards to dental findings?
- Q9 Is there adequate documentation with regards to diagnosis?
- Q10 Is there adequate documentation with regards to problems?
- Q 11 Is there adequate documentation with regards to radiographic findings?
- Q12 Does the treatment plan outline a logical sequence of treatment for the patient?

II. Procedural Audit

- Q2 Is the caries risk assessment completed?
- Q3 Is the periodontal risk assessment completed?

Standard: A proposed dental treatment plan and financial plan will be reviewed and approved by the patient.

Indicator: All patients will have approved a treatment plan prior to the initiation of care.

Measure: I. Procedural Audit

- Q4 Has the treatment plan been accepted and signed by the patient indicating informed consent for the initial plan of treatment?

Standard: *A medical and dental history will be obtained as part of the initial evaluation of each patient.*

Indicator: All patients will have a medical and dental history documented at the initial visit.

Measure: I. Analytical Audit

- Q2 Was the medical history documented at the initial exam?
- Q4 Are there appropriate entries for recommendations for medical management?
- Q5 Is there a follow-up to the medical consult request?
- Q8 Is there adequate documentation with regards to dental findings?
- Q9 Is there adequate documentation with regards to diagnosis?
- Q10 Is there adequate documentation with regards to problems?
- Q11 Is there adequate documentation with regards to radiographic findings?

Standard: *Informed consent will be obtained from the patient prior to the initiation of care.*

Indicator: Informed consent will be obtained from the patient prior to the initiation of care

Measure: I. Procedural Audit

- Q4 Has the treatment plan been accepted and signed by the patient indicating informed consent for the initial plan of treatment?

FREQUENCY

Ongoing basis

ANALYSIS

This is a self-auditing instrument used by students. It is utilized to ensure patient care standards, and are evaluated randomly by the predoctoral clinic director or faculty auditors. They may also be included in the random record audits. By completion of the instrument, the student provider is attesting to the accurate completion of the patient record. Once the student conducts a self- assessment, the audit form is sent electronically to the faculty auditor. The faculty audits the record and informs the student electronically of any deficiencies that were identified.

TREATMENT PLAN AUDIT

1.) Was the medical history documented at the initial exam?
2.) Are there appropriate entries for recommendations for medical management?
3.) Is there follow-up to the medical consult request?
4.) Is there evidence of proper follow-up and management for significant medical problems?
5.) Has an identified oral lesion been followed up?
6.) Is there adequate documentation with regards to dental findings?
7.) Is there adequate documentation with regards to diagnosis?
8.) Is there adequate documentation with regards to prognosis?
9.) Is there adequate documentation with regards to radiographic findings?
10.) Does the treatment plan outline a logical sequence of treatment for the patient?
11) Is there a patient signature on the HIPAA form?
12.) Is the caries risk assessment completed?
13.) Is the periodontal risk assessment completed?
14.) Has the treatment plan been accepted and signed by the patient indicating informed consent for the initial plan of treatment?

RECORD AUDIT -TRANSFER/OHM

INDICATION

Record Audit Transfer/OHM are completed for all predoctoral comprehensive care patients upon completion of their treatment.

PURPOSE

To ensure that the care provided to patients is of high quality. The following Standards of Care are assessed:

Standard: Patients seeking comprehensive care will be provided with a comprehensive exam and an individualized risk assessment.

Indicator: All patients seeking comprehensive care will be provided with a comprehensive exam and individualized risk assessment.

Measure: I. Procedural Audit

Q2 Is the caries risk assessment completed?

Q3 Is the periodontal risk assessment completed?

Standard: A proposed dental treatment plan and financial plan will be reviewed and approved by the patient.

Indicator: All patients will have approved a treatment plan prior to the initiation of care.

Measure: I. Procedural Audit

Q5 Have updates to the treatment plan been accepted and signed by the patient indicating informed consent for the initial plan of treatment?

Standard: Informed consent will be obtained from the patient prior to the initiation of care.

Indicator: Informed consent will be obtained from the patient prior to the initiation of care.

Measure: I. Procedural Audit

Q5 Have updates to the treatment plan been accepted and signed by the patient indicating informed consent for the initial plan of treatment?

Q8 Do the last three progress notes contain reaffirmation of patient informed consent?

Standard: An entry in the electronic health record will be completed by the provider for each visit.

Indicator: Entries in the electronic health record will be completed for each patient visit.

Measure: I. Procedural Audit

Q10 Is there an entry in the EHR for each visit?

Standard: *Treatment will be rendered in a logical and orderly fashion.*

Indicator: Patients will have their treatment rendered in a logical and orderly fashion.

Measure: I. Analytical Audit
Q14 Was the Phase I Reevaluation completed in the appropriate sequence?
Q15 Was the Phase II Reevaluation completed?
Q18 Has treatment been completed in a logical sequence?

Standard: *Care will be delivered in a timely manner.*

Indicator: All patients will be seen at least once every 45 days

Measure: I. Procedural Audit
Q6 Has treatment been completed in a timely manner?
(no unexplained intervals of >45 days)

FREQUENCY

Ongoing basis

ANALYSIS

This is a self-auditing instrument used by students. It is utilized to ensure patient care standards, and are evaluated randomly by assigned faculty auditors. They may also be included in the random record audit. By completion of the instrument, the student provider is attesting to the accurate completion of the patient record. Once the student conducts a self-assessment, the audit form is sent electronically to the faculty auditor. The faculty audits the record and informs the student electronically of any deficiencies that were identified.

TRANSFER/OHM AUDIT

1.) Is there evidence of proper follow-up and management for significant medical problems?
2.) Has the Medical History been updated appropriately?
3.) Has an identified oral lesion been followed up?
4.) Is the caries risk assessment completed?
5.) Is the periodontal risk assessment completed?
6.) Are radiographs taken at recommended intervals?
7.) Is there adequate documentation with regards to radiographic findings?
8.) Did the patient receive appropriate preventive care during treatment?
9.) Was the Phase I Reevaluation completed in the appropriate sequence?
10.) Was the Phase II Reevaluation completed?
11.) Has treatment been completed in a logical sequence?
12.) Based on the information, has the quality of care been adequate?
13.) Do the last three progress notes contain drug/medication administration?
14.) Have updates to the treatment plan been accepted and signed by the patient indicating informed consent for changes in treatment?
15.) Has treatment been completed in a timely manner? (no unexplained intervals of >45 days)
16.) Do the last three progress notes contain faculty approval?
17.) Do the last three progress notes contain reaffirmation of patient informed consent?
18.) Do the last three progress notes contain prescription documentation?
19.) Does the completed procedure code match care recorded in the progress notes?
20.) Is there an entry in the EHR for each visit?

PATIENT REVIEW- TREATMENT PLAN

INDICATION

All comprehensive care patients in the predoctoral clinics will be examined and evaluated by faculty; overall treatment plan will be reviewed predoctoral clinic director or assigned faculty.

PURPOSE

To ensure that the care provided to patients is of high quality. The following Standards of Care are assessed:

Standard: Patients seeking comprehensive care will be provided with a comprehensive exam and an individualized risk assessment.

Indicator: All patients seeking comprehensive care will be provided with a comprehensive exam and individualized risk assessment.

Measure:

Analytical Audit

Q2 Was the medical history documented at the initial exam?

Q4 Are there appropriate entries for recommendations for medical management?

Q5 Is there a follow-up to the medical consult request?

Q8 Is there adequate documentation with regards to dental findings?

Q9 Is there adequate documentation with regards to diagnosis?

Q10 Is there adequate documentation with regards to problems?

Q11 Is there adequate documentation with regards to radiographic findings?

Q12 Does the treatment plan outline a logical sequence of treatment for the patient?

II. Procedural Audit

Q2 Is the caries risk assessment completed?

Q3 Is the periodontal risk assessment completed?

Standard: A proposed dental treatment plan and financial plan will be reviewed and approved by the patient.

Indicator: All patients will have approved a treatment plan prior to the initiation of care.

Measure: I. Procedural Audit

Q4 Has the treatment plan been accepted and signed by the patient indicating informed consent for the initial plan of treatment

Q5 Have updates to the treatment plan been accepted and signed by the patient indicating informed consent for the initial plan of treatment?

Standard: *A medical and dental history will be obtained as part of the initial evaluation of each patient.*

Indicator: All patients will have a medical and dental history documented at the initial visit.

Measure: I. Analytical Audit

Q2 Was the medical history documented at the initial exam?

Q4 Are there appropriate entries for recommendations for medical management?

Q5 Is there a follow-up to the medical consult request?

Q8 Is there adequate documentation with regards to dental findings?

Q9 Is there adequate documentation with regards to diagnosis?

Q10 Is there adequate documentation with regards to problems?

Q11 Is there adequate documentation with regards to radiographic findings?

Standard: *Informed consent will be obtained from the patient prior to the initiation of care.*

Indicator: Informed consent will be obtained from the patient prior to the initiation of care.

Measure: I. Procedural Audit

Q4 Has the treatment plan been accepted and signed by the patient indicating informed consent for the initial plan of treatment?

Q5 Have updates to the treatment plan been accepted and signed by the patient indicating informed consent for the initial plan of treatment?

Q8 Do the last three progress notes contain reaffirmation of patient informed consent?

FREQUENCY

Ongoing basis

ANALYSIS

Treatment plans are reviewed by the predoctoral clinic director or assigned faculty. If modifications to the treatment plan are necessary, they are rectified prior to the initiation of care.

PHASE I RE-EVALUATION

INDICATION

All comprehensive care patients in the predoctoral clinics will be examined and evaluated at the completion of Phase I Treatment (disease control).

PURPOSE

To ensure that the care provided to patients is of high quality by assessing the need for further Phase I Treatment prior to the initiation of Phase II Treatment.

The following Standards of Care are assessed:

Standard: *Treatment will be rendered in a logical and orderly fashion.*

Indicator: Patients will have their treatment rendered in a logical and orderly fashion.

Measure:
I. Analytical Audit
Q14 Was the Phase I Reevaluation completed in the appropriate sequence?
Q18 Has treatment been completed in a logical sequence?
II. Focused Review
Appropriate Sequence of Phase I Reevaluation

FREQUENCY

Ongoing basis

ANALYSIS

The data is analyzed and discussed with the QMI Committee.· If necessary, the issues may be forwarded to the Clinical Affairs Committee via the Senior Associate Dean of Education and Patient Care, or the Dean of the School of Dental Medicine.

EXIT/PHASE II EVALUATION

INDICATION

All comprehensive care patients in the predoctoral clinics will be examined and evaluated at the completion of Phase II Treatment.

PURPOSE

To ensure that the care provided to patients is of high quality by assessing the need for further treatment before the patient is transferred into the maintenance phase of treatment.

The following Standards of Care are assessed:

Standard: *Treatment will be rendered in a logical and orderly fashion.*

Indicator: Patients will have their treatment rendered in a logical and orderly fashion.

Measure: Analytical Audit

Q15 Was the Phase II Reevaluation completed?

Q18 Has treatment been completed in a logical Sequence?

Standard: *Patients will be offered continued oral health services following completion of active care.*

Indicator: Patients will be offered oral health services following completion of active care.

Measure: OHM program is offered to patients.

FREQUENCY

Ongoing basis

ANALYSIS

The data is analyzed and discussed with the QMI Committee. If necessary, the issues may be forwarded to the Clinical Affairs Committee via the Senior Associate Dean of Education and Patient Care, or the Dean of the School of Dental Medicine.

EPR Form Code (ASTROT)

Form	Owner Type	Section	Sub-tab	Multiple Forms?	Inactive?
Assessment (Treatment Outcome)	EPR	Clinical Information	Clinical Forms	Yes	No

	Ans. Type	List/Func.	Ref. Code	Change?
Assessment (Page 1)				
Assessment of Treatment Outcome (Re-Eval)				
Phase I Therapy				
Simple	Yes/No		ASTROT1	Yes
Moderate	Yes/No		ASTROT2	Yes
Complex	Yes/No		ASTROT3	Yes
Phase II Therapy				
Simple	Yes/No		ASTROT4	Yes
Moderate	Yes/No		ASTROT5	Yes
Complex	Yes/No		ASTROT6	Yes
Caries Risk Assessment				
Initial Risk Level				
Low	Yes/No		ASTROT7	Yes
High	Yes/No		ASTROT8	Yes
Present Risk Level				
Low	Yes/No		ASTROT9	Yes
High	Yes/No		ASTROT10	Yes
If High Risk, Caries Risk Assessment Form Completed?				
Completed	List	YNNA		Yes
1. Yes				
2. No				
3. N/A				
If No, please specify	Long Text			Yes
Periodontal Risk Assessment				
1. BOP (%)	List	BOP	ASTROT69	Yes
1. <10% L				
2. 10-25% M				
3. >25% H				
2. Number of pockets >4mm	List	POCKET	ASTROT70	Yes
1. <4 pockets L				
2. 4-8 pockets M				
3. >8 pockets H				
3. Loss of periodontal support/patient's age	List	PLOSS	ASTROT71	Yes
1. <0.5 L				
2. 0.5-1 M				
3. >1.0 H				
4. Diabetes	List	YHNL	ASTROT72	Yes
1. Yes H				
2. No L				
5. Cigarette smoking	List	YHNL	ASTROT73	Yes
1. Yes H				
2. No L				
6. Number of missing teeth	List	MISTTH	ASTROT74	Yes
1. <4 teeth L				
2. 4-8 teeth M				
3. >8 teeth H				
Patients with NO ACTIVE or Hx of Periodontitis				
A high risk patient should have at least 3 of the 6 parameters in the high (H) risk category				
Risk/Management	List	LHP		Yes
1. Low: Recall: 2x/yr				
2. High: Recall: 4x/yr				
Patients with ACTIVE or Hx of Periodontitis				
Instructions to Calculate Risk/Management:				
A low risk patient should have all parameters in low risk (L) categories or only 1 of the 6 parameters in moderate risk				
A moderate risk patient should have 2 or more of the 6 parameters in the moderate (M) category and at most 1 of the 6 parameters in the high category				
A high risk patient should have at least 2 of the 6 parameters in the high (H) risk category				

EPR Form Code (ASTROT)

Form	Owner Type	Section	Sub-tab	Multiple Forms?	Inactive?
Assessment (Treatment Outcome)	EPR	Clinical Information	Clinical Forms	Yes	No

	Ans. Type	List/Func.	Ref. Code	Change?
Risk/Management	List	LMH	ASTROT76	Yes
1. Low: Recall: 2x/yr				
2. Moderate: Recall: 3x/yr				
3. High: Recall: 4x/yr				
Endodontic Follow-Up Data				
Specify Endodontic Follow-Up Data	Spreadsheet		ASTROT30	Yes
Tooth #			ASTROT31	Yes
Follow-up Date			ASTROT32	Yes
Date of obturation			ASTROT33	Yes
Restoration placed			ASTROT34	Yes
Percussion/Palp		PLSMIN	ASTROT35	Yes
Periodontal status			ASTROT36	Yes
Deepest probing/site			ASTROT37	Yes
Sinus tract/root		PLSMIN	ASTROT38	Yes
Discoloration		PLSMIN	ASTROT39	Yes
PA lesion/diam/root			ASTROT40	Yes
Root resorption/root			ASTROT41	Yes
Swelling		PLSMIN	ASTROT42	Yes
Recall outcome:S/F/U			ASTROT43	No
Reason for F or U			ASTROT44	Yes
Further Tx/Follow-up			ASTROT45	Yes
Summary of Treatment Outcome				
Treament plan has been completed?	Yes/No		ASTROT46	Yes
Endodontics	Yes/No		ASTROT47	Yes
Operative	Yes/No		ASTROT48	Yes
Periodontics	Yes/No		ASTROT49	Yes
Prosthodontics	Yes/No		ASTROT50	Yes
Goals of treatment, including chief complaint, have been met?	Yes/No		ASTROT51	Yes
Endodontics	Yes/No		ASTROT52	Yes
Operative	Yes/No		ASTROT53	Yes
Periodontics	Yes/No		ASTROT54	Yes
Prosthodontics	Yes/No		ASTROT55	Yes
Are all answers to both questions above Yes?	Yes/No		ASTROT56	Yes
Phase II Treatment	Yes/No		ASTROT57	Yes
Oral Health Maintenance	Yes/No		ASTROT58	Yes
Recall can be initiated	Yes/No		ASTROT59	Yes
Are any answers to to any questions above No?	Yes/No		ASTROT60	Yes
Additional treatment or management indicated below is necessary:	Long Text		ASTROT61	Yes
Phase II treatment may be initiated or patient discharged although treatment goals have not been met. Provide rationale:	Long Text		ASTROT62	Yes