

UCONN

SCHOOL OF DENTAL MEDICINE

CLINIC MANUAL

2015

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INTRODUCTION

The University of Connecticut School of Dental Medicine offers comprehensive dental care provided by predoctoral dental students in multidisciplinary clinics or by postdoctoral dental residents receiving advanced training under the supervision of licensed clinical faculty. University Dentists, a faculty group practice, also provides comprehensive and specialized care for patients wishing to be treated by faculty.

The Clinic Manual gathers into one publication the principal policies and procedures for the management and care of patients in the School's predoctoral and postdoctoral clinics. Selected policies and procedures may also be adopted by University Dentists.

The Dental Clinics operate under specific policies adopted by the Clinical Affairs Committee [CAC]; some policies may have been approved and adopted by its predecessor, the Executive Committee of the Dental Staff [ECDS]. The Dental Clinics also follow policies adopted by UConn Health and UConn Health-John Dempsey Hospital when appropriate.

PATIENT CARE

Student providers are expected to greet all patients promptly for scheduled appointments. In circumstances where there is an unforeseen delay, patients should be informed as soon as possible. Providers are expected to communicate issues interfering with the timely delivery of care to responsible faculty and patient care coordinators. Patients should be seen in a timely manner unless there are unique circumstances, such as medical issues, patient vacations or work related commitments. It is the policy of the clinics that assigned patients should be seen at a minimum of once every forty-five (45) days to ensure appropriate continuity and progress of comprehensive care. Any lapse in continuity of care must be appropriately documented in the patient record.

PATIENT REGISTRATION AND SCHEDULING

All patients of the Dental Clinics must be issued a patient identification number (TOO#) during the patient registration process on or before their initial visit to the UConn Health Center. The patient identification number is also known as the medical record number (MRN). An electronic database record containing demographic information is created and an identification number is permanently assigned to the patient in IDX, the health center's patient information system. The Dental Clinic's information management system, axiUm, will automatically interface with IDX to populate the patient demographic database. Additional demographic information will be added directly through axiUm, including dental insurance information. The MRN is the medico-legal method that identifies patients in all areas of UConn Health and is required prior to the provision of any care in the dental clinics.

Scheduling of patients is the responsibility of the clinical reception staff. Predoctoral dental students will work with clinic reception staff to ensure appropriate scheduling of their assigned patients. Postdoctoral residents in specific training programs may be granted the authority and information system security to schedule patients directly.

The following is the School of Dental Medicine's policy pertaining to scheduled appointments. Strict compliance with the policy must be adhered to for every patient visit:

Patients are expected to be responsible and diligent in keeping scheduled appointments. If a patient fails to keep two consecutive appointments or three non-consecutive appointments without due notice to the provider, further treatment in the clinic may be denied. All missed or broken appointments must be appropriately documented in the electronic patient record and in the appointment module of the information system. Patients should receive warning letters reminding them of the missed appointment policy. Patients shall be given final opportunities to continue their treatment or be removed as an active patient in the program.

Patients are expected to be on time for their appointments. Reciprocally, providers are expected to be on time for their patient's appointment. If a patient arrives more than twenty (20) minutes late for a scheduled appointment, the patient may be denied treatment for that visit. The determination if a patient may be treated following a late arrival must be made in consultation with the supervising faculty preceptors; the determination should be made in consideration of the planned treatment.

DENTAL CLINICS

The Dental Clinics in the School of Dental Medicine include:

At the University of Connecticut Health Center (Farmington)

Dental Clinic 1	Postdoctoral Prosthodontics Predoctoral Periodontics Predoctoral Treatment Planning
Dental Clinic 2	Postdoctoral Endodontics Predoctoral Endodontics Predoctoral Treatment Planning
Dental Clinic 3	Predoctoral Operative Dentistry Predoctoral Treatment Planning Predoctoral Periodontics
Dental Clinic 4	Predoctoral Prosthodontics Predoctoral Treatment Planning Predoctoral Periodontics
Dental Clinic 5	Advanced Education in General Dentistry Dental Emergency Service
Dental Clinic 6	Advanced Education in General Dentistry University Dentists
Dental Clinic 7	Unassigned
Dental Clinic 8	Postdoctoral Oral & Maxillofacial Surgery Predoctoral Oral & Maxillofacial Surgery University Dentists (Oral & Maxillofacial Surgery)
Dental Clinic 9	Screening Oral Diagnosis/Oral Medicine
Dental Clinic M	Postdoctoral Periodontics University Dentists (Implant)
Outpatient Pavilion	Postdoctoral Orthodontics Predoctoral Orthodontics University Dentists (Orthodontics)

At extramural sites:

Connecticut Children’s Medical Center	Postdoctoral Pediatric Dentistry Predoctoral Pediatric Dentistry
UConn Health Partners-Kane Street	Postdoctoral Pediatric Dentistry Predoctoral Pediatric Dentistry
Bank of America/Burgdorf Health Center	Postdoctoral Pediatric Dentistry Predoctoral Pediatric Dentistry

All clinical assignments and discipline allocations are subject to change according to patient care and educational needs. Clinical schedules will be established by the Clinical Affairs Committee and posted and distributed by the Office of Dental Clinical Affairs. The schedule is established to ensure appropriate availability of faculty preceptors for each clinical discipline.

All predoctoral student care must be scheduled in the appropriate clinic according to the posted schedule. The availability of clinic chairs will be appropriately reflected within the scheduling module of axiUm. Every effort must be made to ensure that patients are scheduled in the appropriate clinic based upon the planned treatment discipline. Deviations from the established schedule may be made only with the approval of the predoctoral clinic director, a patient care coordinator, or the Senior Associate Dean for Education and Patient Care.

STANDARDS OF CARE

Consistent with its mission, the School of Dental Medicine is committed to providing high quality, comprehensive oral healthcare. The Standards of Care document is intended to be a source of information for students, residents, faculty and staff engaged in patient care. In addition, it serves as a guide for evaluating the quality of care as part of the School of Dental Medicine's Quality Measurement and Improvement (QMI) program.

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.

PATIENT INFORMATION AND SCHOOL OF DENTAL MEDICINE TREATMENT POLICY

A patient information packet, explaining School of Dental Medicine clinic policies, including patient rights and responsibilities as well as the treatment policies of the School, will be provided to each patient at their initial screening appointment. The information is also available on the School's website and available at all reception areas. Student and resident providers should be familiar with the information provided and ensure that their patients have received and understand the information.

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

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.

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.

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.

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.

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.

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.

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

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.

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

Patient's Responsibilities

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.

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.

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

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

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.

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

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

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

PATIENT SELECTION AND ACCEPTANCE

Patients are evaluated for acceptance into the School of Dental Medicine dental clinics at an initial *screening* appointment. All patients must be screened prior to assignment for comprehensive care into the predoctoral clinical program. Postdoctoral residency programs may elect to accept patients directly into their patient care programs without an initial screening appointment; such assignments are generally limited to patients requesting limited care or patients referred to a particular program by another healthcare provider.

At the screening visit, a faculty member determines a patient's global dental and medical status, their appropriateness for treatment by either a predoctoral or postdoctoral student is evaluated, their ability to meet the responsibilities of a patient of the clinical programs is assessed, and their ability to fulfill financial obligations is reviewed. All patients presenting for screening may not be accepted into the clinical programs. If a patient's needs cannot be appropriately met, or if the patient's desires for care are contrary to the fundamental principles of patient-centered care as defined by the School of Dental Medicine, the patient may not be accepted for treatment. The School of Dental Medicine is unable to provide a referral to a specific provider if the patient cannot be accepted for treatment.

Patients may be referred for a radiographic examination following the screening appointment. In general, patients accepted for treatment in the predoctoral program must have a radiographic examination prior to assignment to a student provider. The nature of the radiographic examination will be based upon the clinical findings and shall be based upon ALARA principles in accordance with presenting selection criteria. The most common baseline radiographic examination will be a panoramic examination supplemented by bitewing radiographs; however, the radiographic examination will vary based upon the patient's unique presentation. Patients may provide the School with dental radiographs taken elsewhere, but radiographs provided to the School will be assessed for their diagnostic quality and appropriateness.

Records of patients accepted into the predoctoral program will be reviewed by the predoctoral clinic director and/or her designees who are actively involved in the management of the predoctoral patient families. Patients will be assigned to primary providers by the predoctoral clinical director or her designees, who may also assign the patient to one or more secondary providers for the efficient delivery of care. All assignments are based upon the global assessment made during the screening appointment and the educational needs of the students.

A complete and thorough treatment plan must be prepared for all patients following screening and acceptance. A sequential treatment plan must be completed prior to the initiation of any treatment, except for emergency care. Only after a comprehensive treatment plan has been discussed and approved by the patient, discipline based faculty, the predoctoral director or designees, and patient financial services, can the student begin treatment. In some instances, such as where final treatment cannot be determined until Phase I treatment has been completed, a Phase I only treatment plan is developed prior to the determination of need for additional, definitive Phase II care. All treatment plans, including those not accepted by the patient, should be appropriately documented within the patient record in axiUm.

All planned treatment must be entered into the clinical information management system (axiUm) and approved by the patient, provider and patient financial services. The executed treatment estimate serves as a guide to the patient's agreed-upon treatment and also as the basis for general consent for treatment; it also serves as a basis for a payment arrangement. Specific procedures may also require-specific consent prior to the initiation of care.

TREATMENT SUPERVISION

Each clinical procedure performed on a patient by a predoctoral student provider must be supervised by a licensed clinical faculty preceptor, or by a postdoctoral resident authorized to function as a clinical preceptor by their respective program director based upon their training and qualifications. This includes any and all treatment provided to another student, friend or family member. The provision of unsupervised care by a predoctoral student is expressly forbidden by School of Dental Medicine policy and UConn Health Center regulations; student providers may not provide unsupervised care under the regulations of the Connecticut State dental practice act. Violations of this policy will result in the student's immediate dismissal from the clinics and may result in further disciplinary action. Postdoctoral residents may be authorized to provide care either under direct or indirect supervision of faculty.

A faculty preceptor's authorization is required prior to a student initiating a clinical procedure on a patient. A faculty preceptor must be present until all work is completed and the patient has been dismissed from the clinic. A faculty preceptor may delegate specific supervisory functions to a postdoctoral resident. Predoctoral students must comply with regular clinic operating hours at all times to allow for proper faculty preceptor supervision.

All clinical procedures should be planned to permit adequate time at the conclusion of the clinical session to complete all necessary documentation and data entry. In general, it is recommended that care be completed a minimum of twenty (20) minutes prior to the scheduled end of a clinic session.

PREDOCTORAL CLINICS

The School of Dental Medicine's predoctoral student clinics are organized into one practice group comprised of third and fourth year students. The Predoctoral Clinic Director is assisted by four Patient Care Coordinators. The Predoctoral Clinic Director and the Patient Care Coordinators monitor all patient management, care delivery and student progress. The Predoctoral Clinic Director bears responsibility for the care of all patients assigned to predoctoral students. At the discretion of the Predoctoral Clinic Director, patients may be assigned to a primary care provider and to a variable number of secondary care providers. The majority of comprehensive care patients will receive the majority of their care by a single provider, however there are circumstances in which multiple providers facilitates the delivery of timely, appropriate and comprehensive care independent from individual student progress and availability. The predoctoral clinic structure encourages and supports "clinic partners" between Year 3 and Year 4 students; patients may be concurrently treated by Year 3 and Year 4 students, with each student providing care commensurate with their level of training. Students are assigned to the predoctoral clinic in Year 1 so that clinical experiences throughout the four year curriculum may be integrated and coordinated.

Patients may receive treatment from both predoctoral student and postdoctoral resident providers. If a patient or record of the predoctoral student clinic is referred to one or more postdoctoral residency programs for specific therapy, the patient's primary student provider retains responsibility for the coordination of care. If a patient is a patient of record of one of the postdoctoral residency programs and is referred to a predoctoral student provider for specific care, the assigned resident retains responsibility for the coordination of care. Patients may not be referred into or out of the predoctoral student clinic program without the involvement of the Predoctoral Clinic Director.

MANAGEMENT OF DENTAL EMERGENCIES

Patients of record of the School of Dental Medicine presenting with acute dental emergencies will be managed by their primary assigned area. Patients of record of the predoctoral student clinical program will be treated by the assigned provider; if the assigned provider is unavailable due to other patient care obligations or scheduling, another student provider will provide the emergency care as directed by the Predoctoral Clinic Director or a Patient Care Coordinator. If a patient has both an assigned primary and secondary provider(s), one of the assigned providers will manage the emergent issue if available.

Patients of record presenting with dental emergencies while the predoctoral student clinic is not in session will be managed by the School of Dental Medicine's Dental Emergency Service. Primary responsibility for the Dental Emergency Service is a component of the School's Advanced Education in General Dentistry residency program.

Unassigned patients (not currently patients of record) are seen by the Dental Emergency Service. The service provides 24 hour, 7 day per week coverage for the diagnosis and management of all dental emergencies. Emergency dental care during evenings, weekends and holidays is provided by the service through the Emergency Department of John Dempsey Hospital at the UConn Health Center.

If a patient of record contacts a predoctoral student provider and reports an acute dental emergency outside of regular clinic hours, the student should contact the resident on-call and discuss the patient's chief complaint. A student may elect to be present during the off-hours care of their patient, but may not provide the actual care unless a faculty preceptor is available and present.

Standard fees for the emergency evaluation will be waived for patients of record, but charges for additional diagnostic tests, including radiographs, and the actual procedures performed will be made.

STUDENT EVALUATION SYSTEM

The School of Dental Medicine provides care based upon patient needs, not on institutional or student requirements. Student advancement in the clinical domain is determined by an experience monitoring system and successful completion of competency based evaluations. The experience monitoring system provides experience credits (RVUs) for completed procedures and for completion of patient cares and re-evaluations. All procedures are proportionally weighted based upon estimates of the number of clinical hours that a student should require, on an average, to complete the procedure.

Students will be provided with a report on their experience credits on a regular basis as a component of the Academic Performance Committee reports.

Students will be evaluated in the domains of practice management, patient management, and professionalism on an ongoing basis through the use of daily global evaluations. The cumulative review of daily global evaluations is the responsibility of all clinical disciplines and the respective Academic Performance Committees.

PATIENT FINANCIAL SERVICES

Policies related to patient financial transactions must be followed during the treatment of all patients cared for by predoctoral students and postdoctoral residents in the School of Dental Medicine clinics. All predoctoral students, postdoctoral residents, and clinical faculty preceptors are responsible for implementing the policies.

Patients treated at the University of Connecticut School of Dental Medicine dental clinics pay fees for dental care at reduced rates because of the additional time required to deliver the care. In general, fees for care provided by predoctoral student will be appropriately 33-50% of prevailing community (UCR, or usual, customary and reasonable rates) while fees for care provided by postdoctoral residents will be approximately 50-67% of prevailing UCR rates.

Patient financial arrangements related to care must be agreed upon prior to all limited or comprehensive care and adhered to by students, residents and faculty during the course of treatment.

SCHOOL OF DENTAL MEDICINE TREATMENT FEES

The School of Dental Medicine clinics currently maintain four fee schedules: (1) predoctoral clinic fees – patients under the age of 21; (2) predoctoral clinic fees – patients 21 years of age and older; (3) postdoctoral clinic fees – patients under the age of 21; (4) postdoctoral clinic fees – patients 21 years of age and older.

American Dental Association Current Dental Terminology (CDT) coding is used to establish the coding within the clinic fee schedules. Certain clinic codes are internal codes, created specifically for the purposes of the School's clinics. Such internal codes will be cross-coded or tied to CDT codes for billing purposes.

School of Dental Medicine fee schedules are evaluated and revised on an annual basis or when deemed necessary by the Clinical Affairs Committee, or at any time the CDT is updated. Fee schedules are updated and uploaded to axiUm on an ongoing basis. Fee schedules are available from the Office of Dental Clinical Affairs or the Patient Financial Services office.

CPT Codes, as well as ICD9 (ICD-10 as of October 1, 2015) are maintained within axiUm for the purposes of billing specific procedures as medical procedures. In general, medical coding is only permissible for specific conditions and procedures managed by credentialed faculty providers in Oral & Maxillofacial Surgery, Oral & Maxillofacial Radiology and Oral Pathology.

A dental procedure in progress at the time of a fee schedule change is billed at the fee in effect at the documented time the procedure was initiated. All financial arrangement, treatment plans, and financial contracts include a statement that the agreed upon fees are subject to change.

FINANCIAL ARRANGEMENTS

Patient treatment plans and patient care agreements must be signed by each patient prior to all care except for emergency care. A provide must not commence treatment without a fully executed treatment plan and associated cash agreement.

POLICY ON FINANCIAL RESPONSIBILITY FOR PATIENT CARE

It is imperative that a treatment plan be completed and discussed with all patients prior to the delivery of comprehensive or limited care. A treatment plan serves not only as a guide to the patient's agreed-upon treatment, but also as a basis for financial agreement.

With the exception of emergency care, no treatment may commence without a valid treatment plan in place.

All predoctoral and postdoctoral student provides assume financial responsibility for any and all treatment provided by them on their respective patients in the absence of a signed, fully executed treatment plan.

All financial liabilities must be cleared prior to completion of the predoctoral or postdoctoral program.

Approved by ECDS	May 4, 2005
Implementation	July 1, 2005

PAYMENT OF FEES

The School of Dental Medicine clinics operate with the general policy that dental care must be paid for at the time of treatment. Payment can be made in the form of cash, check, MasterCard or Visa. Partial prepayments (50%) are required for limited care procedures, all procedures involving laboratory costs, and endodontic treatment. Extended payments plans are offered for comprehensive orthodontic treatment and for extensive treatment plans with prior approval by the Predoctoral Clinic Director or the respective postdoctoral residency program and the Senior Associate Dean for Education and Patient Care. Patient Service Representatives are available to discuss financial arrangements with patients during normal clinic business hours.

THIRD PARTY PAYERS

The School of Dental Medicine directly participates with Medicaid, Medicare, and multiple private third party payers. Patient Financial Services will directly bill third party payers on behalf of patients. For patients with insurance coverage for which the School cannot directly bill, Patient Financial Services will provide a record of treatment to any patient who may then submit a claim for direct reimbursement.

FEE REDUCTION AND EXEMPTION POLICY

Most School of Dental Medicine predoctoral and postdoctoral clinic fees are less than the usual, customary and reasonable fees for the region. Fee waivers and reductions in the stated fees will be managed on an individual basis and a determination made by the Predoctoral Clinic Director or the respective postdoctoral residency program director. All fee reductions and waivers must be approved by the Senior Associate Dean for Education and Patient Care.

Fee adjustments will generally fall into one of the following categories:

Educational: fees may be reduced or waived in a limited number of circumstances when the treatment is unusual or unique in nature and valuable to the training program or while not unusual, of specific teaching value. Fees may also be waived or reduced in situations when a service is not covered by a third party payer, however the service is essential or critical to provide quality, continuity of care.

Boards: fees may be reduced or waived in circumstances when the treatment indicated is appropriate for specific examination scenarios and the patient would not otherwise be capable of paying for the service.

Post-treatment: fees may be reduced or waived in circumstances where treatment of services were rendered and because of extenuating circumstances, further direct retreatment (redo) or secondary treatment (redress) may be required.

POLICY ON INDIVIDUALS WITH FINANCIAL HARDSHIP

The University of Connecticut School of Dental Medicine provides dental services at significantly reduced rates. Fees are required to maintain quality of patient care and to cover basic expenses in maintaining the teaching programs. The School, as a component of UConn Health, offers a Charity Care program for patients who meet certain eligibility requirements and have medically necessary care needs. Patients must apply for Charity Care with Patient Financial Services to be considered. The Charity Care policies do not provide for a reduction of fees for complete comprehensive care and only applies to dental treatment that is considered to be medically necessary.

SUSPENSION OF CARE OF PATIENTS WITH OUTSTANDING BALANCES

Patients are expected to remain current on their financial responsibilities. Patients with outstanding balances will be referred to Patient Financial Services for counseling. Should a patient's balance become excessive with no recent payment history (i.e. greater than \$500 with no payments for greater than 30 days), further treatment may be postponed. All decisions to postpone or suspend care because of an outstanding balance must be made by the supervisor of Patient Financial Services, in consultation with the assigned provider, the Predoctoral Clinic Director or respective postdoctoral residency program director, and when indicated, the Senior Associate Dean for Education and Patient Care.

CLINICAL HOURS OF OPERATION

Regular clinic hours of predoctoral and postdoctoral dental clinics are Monday through Friday, from 9 am – noon and from 1 pm – 5pm. On certain days of the week, afternoon clinic session for the predoctoral clinic may begin at 2 pm to accommodate didactic sessions and administrative functions. Hours of operation for facilities outside of the main Farmington site of UConn Health.

Regular clinic hours of postdoctoral dental clinics may be modified or altered by the respective residency program director to accommodate the educational program.

Hours of operation are subject to change to address patient care and educational programs.

No patient treatment is permitted outside of a regularly scheduled clinic session unless specific prior arrangements have been made by a responsible faculty member.

CLINIC ATTIRE

It is the responsibility of each predoctoral dental student, postdoctoral resident, staff, and faculty preceptor to maintain proper dress and a well-groomed, professional appearance. All apparel worn by students, residents, staff and faculty in the clinical area must consist of either professional clothing or appropriate scrubs. Scrub uniforms must be deemed accepted by the clinic administration. If scrubs are worn outside the immediately clinical area, they should be covered by a white coat/laboratory coat.

All individuals involved in clinical treatment must wear clean protective apparel; protective apparel is defined as School of Dental Medicine approved personal protective equipment (PPE)/precaution garments. All individuals involved in patient care must routinely wear precaution garments to prevent occupational exposures and to prevent soiling of street clothing whenever contact with any blood, saliva, bodily fluids, or aerosol is anticipated. Precaution garments must not be worn outside the immediate clinic area and may not be worn in public areas. Immediate clinic area is defined as dental operatories, the immediate surrounding clinical area, and the associated service corridors. Reception areas, restrooms, offices, general traffic corridors, lobbies, waiting rooms, record room, and patient financial services are not immediate clinic areas.

Jeans, tee-shirts, shorts, sandals, or unprofessional sneakers are never acceptable, are not professional attire, and therefore must never be worn in the clinical areas.

Anyone in violation of the attire policy will be dismissed from the clinics.

CREDENTIALING OF CLINIC PARTICIPANTS

Each predoctoral student, postdoctoral resident, clinical faculty preceptor, and clinical staff member who has direct contact with patients in clinic are to be credentialed through the Office of Dental Clinical Affairs. Predoctoral student credentialing includes acceptable progress through the curriculum as determined by the Academic Performance Committees along with compliance with infection control, basic life support, and bloodborne pathogen training. Postdoctoral resident credentialing includes acceptable progress through the residency program (as defined by the respective program) and compliance with infection control, basic life support, and bloodborne pathogen training, along with compliance with health center and state regulations which may vary amongst residency programs. Faculty credentialing ensures compliance with requirements for professional licensure, basic life support, infection control, and bloodborne pathogen training, and compliance with health center and state regulations.

QUALITY MEASUREMENTS AND IMPROVEMENT

Quality assurance includes all activities that ensure that the quality of care provided to patients is of high quality. Quality of care is the degree to which patient services increased the probability of desired outcomes and reduce the probability of undesired outcomes. The Quality Measurements and Improvement Committee is charged with the implementation of activities to assess the quality of care provided in the clinical areas, evaluation of data to assess care, reassessment of data following implementation of corrective actions, and the development of process improvement.

A variety of quality measurement and improvement activities are conducted by faculty and staff on an ongoing basis. Patient satisfaction surveys are administered to patients to monitor the degree to which patients' expectations regarding various aspects of patient care are being met. Individual student record audits are conducted by faculty and QMI committee staff to assess compliance with record keeping requirements (procedural audits) and the adequacy of patient care (analytical audits). Focused reviews using information obtained from record audits and/or information obtained from other data sources are conducted to monitor and evaluate performance in specific aspects of clinical care. Results of these activities are discussed at monthly QMI meeting and, when necessary, are referred to the Clinical Affairs Committee or appropriate members of the faculty or administration for the development or modification of policies and procedures.

RISK MANAGEMENT

One of the most important elements of appropriate dental claims management is effective incident reporting. The Senior Associate Dean for Education and Patient Care has responsibility for risk management for the School of Dental Medicine patient care activities. The Senior Associate Dean, the Director of QMI, and the Director of Risk Management of UConn Health must be made aware of any incident involving a patient that could potentially lead to legal action. Responsibility for reporting an incident rests with every member of the School of Dental Medicine community – provider, faculty member, or staff member, who witness, discovers, or has direct knowledge of a reportable incident or occurrence.

Events which should be reported as incidents include, but are not limited to, any unfavorable outcome which a layman might attribute to poor care – this includes cases in which it is certain that there was no problem with the care; any serious lapse in the quality of care regardless of outcome; and any patient threat of legal action.

Any serious incident, such as a major complication from a treatment procedure, or any aggressive comment or threat by a patient regarding legal action should be reported as once to the Senior Associate Dean, Director of QMI, Predoctoral Clinic Director, residency Program Director, Patient Care Coordinator, or any member of the administration. This policy includes all incidents related to care involving students, residents, staff and preceptors of the School of Dental Medicine, even when the care has been delivered at extramural or affiliated sites.

In all cases, a risk identification report must be completed. Risk identification reports are filed through the institution's Safety Intelligence™ site [formerly known as the Patient Safety Net®]. The QMI Director manages the Safety Intelligence activities for the School of Dental Medicine and can provide guidance to any individual who needs to access the system for reporting purposes.

All students, faculty and employees of the School are personally indemnified from any action resulting from the performance of assigned duties and responsibilities, as long as they are not reckless or wanton in nature. The Senior Associate Dean for Education and Patient Care can provide additional information on the liability and malpractice protections afforded to the members of the School community upon request.

Protection of the institution's resources, faculty, students and staff relies upon strict adherence to the risk management policies described above.

PATIENT RECORD MANAGEMENT

Policies and procedures for the management of patient records are intended to assure accurate documentation of care and correspondence related to care, as well as to provide a legal and risk management support document for the School of Dental Medicine.

axiUm[®] is the School of Dental Medicine's comprehensive clinical information management system. It was designed exclusively for use in dental schools and its functions include clinical appointment management and scheduling, patient financial activity and billing, student grading and evaluation, electronic prescription management, and electronic health records. axiUm also hosts the MiPacs digital imaging platform.

Each axiUm use is assigned to a particular "user level" or group that defines the "rights," "permissions," and security within axiUm. axiUm users utilize their assigned network user name and password to access the system via the active directory system. The "rights" and "permissions" are defined by those functions that are necessary to perform their job or role within the School.

The School of Dental Medicine ceased using paper-based records/charts in July of 2013 with the implementation of axiUm as its clinical information management system. Paper-based charts are maintained for historical information for a period of two years in the onsite record room and can be retrieved from remote storage as needed beyond that period. During the 2013-2014 academic year, all paper-based charts were retrieved and delivered to the respective clinical areas as determined by the daily appointment schedules for the purposes of providing historical reference. Effective July 1, 2014, paper-based records are only retrieved upon specific written request by the provider. It is recommended that providers determine if content of the paper-based record (all or selected components) are indicated for scanning into the axiUm record. Only content that is directly related to ongoing and current care, or content that is regularly accessed, should be scanned into the electronic health record since all historical information is retrievable in 24 hours or less.

Records of patient treated by predoctoral students, postdoctoral residents, and faculty are the property of the School of Dental Medicine and are the responsibility of the assigned provider(s). Information contained within a patient record is confidential and must never be released or disclosed to anyone without the patient's (or patient's legal representative) written release, except for use by those School of Dental Medicine personnel who are directly involved with the care of the patient and others for the purposes of billing and healthcare operations. Properly executed release, in accordance with UConn Health policies on the authorization for release of information, is required prior to releasing or disclosure of any information.

Additional information on the security and privacy of protected health information can be found at: http://www.policies.uhc.edu/area/hipaa_privacy.html.

ACCESS AND SECURITY

Access to the axiUm clinical information management system can be both on-site and through secured remote access. All users must comply with School and health center policies, which comply with local, state and federal statutory and regulatory requirements. All users have the responsibility to protect the security of their usernames and passwords. All users must maintain the confidentiality of information to which he/she is given access and accept accountability for all activities associated with the use of his/her individual account. Failure to comply with policies may result in disciplinary action, up to and including dismissal from the School and termination of employment.

RECORD REVIEW

The Office of Clinical Affairs, through the Quality Measurements and Improvement Committee, is responsible for record reviews and audits as defined by the QMI processes. The School conducts a formal system of quality assurance for the patient care program which includes an ongoing review of a representative sample of patient records to assess the appropriateness and quality of care provided.

RECORD KEEPING

Patient records are an essential component of the delivery of competent and quality oral healthcare. All records must be authentic, accurate and objective. Providers shall document all significant patient communication, as well as all diagnostic and treatment services. Radiographs, photographs, consultations, correspondence, and notations relating to patient care shall be retained as part of the record. A medical history shall be recorded in axiUm for every patient prior to the initiation of care and it should be signed electronically by the patient. The medical history, as well as medication and allergy information, shall be updated on an ongoing basis through the medical history form or through the update modality.

A current treatment plan and signed patient consent is required for all comprehensive care patients. Diagnostic and emergency services may be rendered during the development of a treatment plan, however, a general consent to treat must be executed prior to the delivery of any care.

All appointments are managed through axiUm. As such, it is not critical to add additional documentation of cancelled or broken appointments, but it is beneficial and recommended to do so. All progress or treatment notes entered by predoctoral students must be properly approved by a supervising faculty member.

All record entries shall be made within 24-48 hours of the patient visit or encounter.

INFECTION CONTROL

Compliance with Guidelines

All clinical dental faculty, staff, predoctoral students and postdoctoral residents operating in the School of Dental Medicine's clinical facilities must comply with the Infection Control Guidelines of the School of Dental Medicine and of UConn Health.

Guidelines

All clinical dental faculty, staff, predoctoral students and postdoctoral residents functioning in the School of Dental Medicine's clinical facilities must be familiar with the School's Infection Control Program Information and Policy Manual, UConn Health's Infection Control Manual and the Policy for the Control of Employee Occupational exposures to Bloodborne Pathogens and Exposure Control Plan. These documents, along with updates are available through the School of Dental Medicine and UConn Health website and email public folders.

Absence of Policy

Current recommendations and guidelines of UConn Health's Infection Control Policy will apply where an absence of specific School of Dental Medicine policy exists.

Purpose and Rationale

The purpose of these guidelines is to minimize risk of cross-infection between patients and between patients and dental personnel.

The University of Connecticut School of Dental Medicine recognizes and concurs with current guidelines, statutes, and regulations for infection control, including the use of universal precautions, as published by the US Department of Health and Human Services Centers for Disease Control, the US Department of Labor Occupational Safety and Health Administration, the American Dental Association, the Connecticut State Dental Association, and the Connecticut Department of Public Health. The School of Dental Medicine abides by all policies and statements as described in the Health Center's Policy for the Control of Employee Exposure to Bloodborne Pathogen and Exposure Control Plan and the School's Infection Control Program Information and Policy Manual.

Dental health care workers are exposed to the blood and saliva of patients which may contain a wide variety of pathogens capable of transmitting infection. Infections may be transmitted by blood or saliva through direct contact, droplets, or aerosols. Because all infected patients cannot be identified by history, physical examination or readily available laboratory tests, all clinical faculty, staff, predoctoral students, and postdoctoral residents must manage all patients as if they are infectious and adhere rigorously to universal infection control precautions in order to minimize the risk of exposure.

General Procedures (An Overview)

The following procedure must be considered routine for all patient care activities:

- a. **Medical history:** a complete medical history must be obtained initially and updated for all patients at each subsequent visit. Specific questions concerning infections and current illnesses must be included.
- b. **Minimize hazards of infection:** all procedures involving blood or potentially infectious materials shall be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets.
- c. **Gloves:** disposable gloves must be worn when contact with blood, saliva, mucous membranes, non-intact skin, or potentially infectious materials can be reasonably anticipated. Gloves must be changed between each patient. Gloves shall not be used if they are peeling, cracked, discolored, punctured, torn, or when their ability to function as a barrier is compromised. Gloves shall not be washed or disinfected for reuse. Immediately after removing gloves, or any other personal protective equipment, hands or other skin surfaces must be washed thoroughly with an appropriate soap. Gloves may not be worn outside of the immediate treatment area. Any surface that may have been touched by gloves must be appropriately disinfected.
- d. **Masks and face/eye protection:** masks in combination with eye protection devices, such as goggles or glasses with solid side shields, or chin length face shields, shall be worn whenever splashes, spray, splatter or droplets of blood, saliva, or potentially hazardous or infectious materials may be generated and eye, nose or mouth contamination can be reasonably anticipated. Masks must be discarded immediately after treating each patient and prior to leaving the immediate clinical area or when they become damp or soiled, whichever comes first. Eye protection devices and face shields should be removed prior to leaving the immediate clinical area. Masks should never be dangled around the neck or left in place after leaving the operatory. When removing the mask, it should be handled by the elastic or cloth tie strings and not by the mask itself. All patients should wear safety glasses or their own personal glasses when receiving dental treatment. Safety glasses for this purpose are available in each clinical area. Safety glasses must be thoroughly cleaned or disinfected after each use.
- e. **Personal protective clothing (protective body clothing):** appropriate protective barrier clothing such as, but not limited to, gowns, lab coats, clinic jackets, or similar outer garments shall be worn in occupational exposure situations. The type and characteristics of this clothing will depend upon the task and the anticipated degree of exposure. Personal protective clothing is considered appropriate only if it does not permit blood or potentially infectious materials to pass through to or reach the healthcare worker's skin or clothing under normal conditions of use and for the duration of time which the personal protective equipment (PPE) is to be used. If the garment is penetrated by blood or potentially infectious materials, it must be removed immediately or as soon as possible. All contaminated laundry must be handled using universal precautions and must be removed prior to leaving the immediate clinical area. Cloth and disposable PPE gowns are available throughout the clinical areas. Cloth PPE gowns may be worn until they are visibly soiled, at which time they must be changed.
- f. **Surgical caps and shoecovers:** surgical caps and shoecovers are not considered to be required PPE for routine dental care. Surgical caps and/or shoecovers must only be worn in instances where gross contamination is anticipated. Caps and shoecovers must be removed prior to leaving the immediate clinical areas.

- g. **Care and disposal of protective equipment:** when personal protective equipment is removed, it must be placed in an appropriately designated area or contained for storage, washing, decontamination or disposal.
- h. **Use of rubber dam:** use of the rubber dam to minimize the formation of droplets, splatter, and aerosols is recommended whenever appropriate.

Exposure to Blood or Body Fluids

Exposure to blood or body fluids by needlestick, laceration, mucous membrane splash, or other accident can pose a serious occupational problem for healthcare workers. The main risk is the possible transmission of viruses, including HIV, hepatitis B, or hepatitis C. If a healthcare worker is exposed to blood or body fluids in the above manner, her/she should immediately and thoroughly clean the affected area and seek medical attention immediately or as soon as patient care reasonably allows:

Needlestick or puncture wound: immediately remove gloves and wash the contaminated areas with an antimicrobial soap and water

Eye or mucosal membrane contact: proceed to the nearest eye wash station and wash the area with copious water

Non-intact skin contact: wash skin thoroughly with an antimicrobial soap

A dental clinic administrator, trained in the management of exposures, must be contact immediately. The post-exposure administrator will explain the incident to the patients and will request that the patient be tested following source patient protocols. The administrator will provide all of the necessary documentation and forms for laboratory testing and will direct the patient accordingly.

The exposed healthcare worker must seek medical attention from Employee Health. If the exposure occurs outside the hours of 8 am – 4:30 pm, Monday through Friday, the worker should report to the Emergency Department.

School of Dental Medicine employees must report the injury to Human Resources; all others must report the incident to Public Safety.

Handwashing

Handwashing is the single most effective mechanism to prevent or reduce the risk of disease transmission.

Dental healthcare workers must wash hands before and after treating each patient, before donning gloves, after removal of gloves, and after barehanded touching of inanimate objects possibly contaminated by any blood, saliva or bodily secretions. Hands must be immediately washed when gloves are torn, cut or punctured. Gloves should be removed as soon as patient safety permits.

All dental health care workers with exudative lesions or weeping dermatitis, particularly on the hands, should refrain from direct patient care and from handling dental care equipment or supplies until the condition resolves.

Use and Care of Sharps

All healthcare workers should take precautions to prevent injuries caused by needles, scalpels and other sharp instruments during patient care, when cleaning instruments and disposing of needles, and when handling sharp instruments following their use. To prevent needlestick injuries, needles must never be recapped, purposely bent, broken by hand, or otherwise manipulated by hand. Contaminated sharps must be discarded immediately or as soon as feasible in containers that are closable, puncture resistant, leak-proof and labeled in accordance with regulatory standards. When no other alternative is feasible or when such action is required by a specific dental procedure, recapping or needle removal must be accomplished through the use of a mechanical device or one-handed technique.

Handling of Extracted Teeth

CDC recommendations for infection control practices in dentistry state that the handling of extracted teeth used in dental educational setting differs from giving patients their own extracted teeth. Several states allow patients to keep such teeth because these teeth are not considered to be regulated (pathologic) waste or because the removed body part (tooth) becomes the property of the patient and does not enter the waste system.

Since the State of Connecticut does not have written guidelines or policies regarding extracted teeth, teeth may be returned to patient upon their request after completing the following procedures:

1. Teeth must be first cleaned of loosely adherent tissue or debris by gently scrubbing with detergent and water
2. Teeth should be wrapped in gauze squares which have been thoroughly saturated in a fresh solution of sodium hypochlorite diluted 1:10 with water and placed in a sealed Ziploc-type bag. Personnel handling extracted teeth should do so wearing necessary PPE. Patients, parents and/or guardians should be advised that for infection control and safety reasons, the teeth are wrapped in sodium hypochlorite solution and should not be handled by children until they have been thoroughly rinsed.
3. Providers must document in the patient record that the extracted teeth were given to the patient, parent or guardian upon their request and that the appropriate infection control procedures were followed.

Management of Patients with Tuberculosis

UConn Health has adopted a policy for the control of occupational exposure to TB. Among other requirements, an isolation facility must be used for the management of patients with active TB exposure. Within the School of Dental Medicine, a treatment room (operatory) equipped with the appropriate negative pressure equipment to create an isolation environment is housed within the AEGD clinical facility. Only non-elective and emergent care is provided to patients with active infection or during that period of time the patient is deemed to be potentially infectious.

MANAGEMENT OF MEDICAL EMERGENCIES

In the event that a patient experiences a medical emergency, the provider must remain with the patient and summon assistance immediately from the nearest faculty member. The faculty member will determine if the situation is life threatening or non-life threatening and will initiate the appropriate treatment intervention. The faculty member will determine which other individuals (students, staff, faculty) will assist in stabilizing the patient and assist in the management of the emergency situation.

At all times, the responsible faculty member and provider remain with the patient. The clinical emergency cart should be brought to the area and prepared for use.

Appropriate treatment should be initiated immediately for non-life threatening conditions. If resolution or improvement is not achieved, 7777 should be called for paramedic assistance.

For life threatening emergencies, 7777 should be activated immediately.

When activating the 7777 response team, the nature of the emergency must be reported, as well as the location, the nearest phone extension. Personnel should be directed to the nearest elevators and access points.

Additional information on the management of medical emergencies is available in the emergency guides available in all clinical activities and online.

FIRE EMERGENCIES

Dial 777 to report a fire, smoke or suspected fire related issue. The fire department, police and medical personnel all respond to the report.

Activate the nearest fire alarm if possible and announce a Code Red.

Evacuate the areas if the situation is threatening or if fire is observed; the area should also be evacuated if a public address announcement directs for the location to be evacuated.

A Code Red announcement will be used whenever there is a reported fire at UConn Health. Automated alarms through the clinics will be activated within the clinics.

An order of evacuation requires that all individuals leave the premises. The primary responsibility of all personnel is the safety and security of patients and visitors, in addition to the safety and security of all students, faculty and staff. The location of the nearest fire exits and the locations of assembly stations is posted in each clinical area.

EMERGENCY CLOSING

To minimize confusion about appropriate authority to close components of UConn Health for emergency reasons (i.e. weather related events), all students, residents, faculty and staff should be aware of the following policy and procedures:

- The nature of the health center's activities requires that emergency closing decision be made only by the health center. General announcements from any other State of CT office, including the Governor's Office, do not constitute authorization for any unit to close or any employee to leave work. Employees required to work, when other employees are not, will be compensated accordingly.
- UConn Health's Vice President, or designee, in consultation with appropriate School and health center officials, will decide when circumstances are such that (1) all units of UConn Health will remain open and all students and employees will maintain usual schedules or (2) that only essential services will be conducted.
- Patient care activities in the School of Dental Medicine are considered essential services. If health center operations dictate that only essential operations continue, dental clinic activity will continue as scheduled. The Senior Associate Dean may declare the dental clinical operations non-essential for any emergency event in order to consider the safety and security of patients, students, residents, staff and faculty.
- Decisions for didactic activities may be made independently from patient care activities.
- Emergency closings will be announced and communicated to all units by members of the administration.
- Additional information may always be obtained through the Operational Status Hotline.

FACILITIES, EQUIPMENT AND MATERIALS MANAGEMENT

Dental Instrument, Supply, and Equipment Procurement

An appropriate inventory of equipment, instruments, and supplies required for all of the dental procedures in comprehensive patient care are maintained in the clinics of the School of Dental Medicine.

The standard inventory of supplies and instruments is designed to meet all educational and patient care requirements. These supplies and equipment are dispensed without charge to predoctoral dental students and postdoctoral residents. It is important that supplies be used in an efficient and economical manner with minimal waste. To be able to maintain the policy of supplying all items without charge, certain instruments required special controls to maintain sterility, excessive wear, or damage and minimize loss.

It is the responsibility of all providers to ensure the completeness and integrity of all instrumentation prior to use. Broken or missing instruments should be reported to a clinic staff member immediately so that they may be removed from circulation and replaced.

At the completion of treatment, instruments should be cleaned using available heavy duty rubber gloves and instrument brushes. All instruments must be visibly clean, free of blood, cement or other materials. Instruments must be replaced in the appropriate cassettes prior to sterilization.

Sterilization

Instrument cassettes, large equipment, and instruments and those items which require special handling (e.g. gas or ethylene oxide treatment) are sterilized in the health center's central sterile support area. Cassettes will be delivered to Dental Clinic Central Support and distributed to the respective clinical areas. Small items, individual instrumentation, and handpieces are sterilized within Dental Clinic Central Support.

Reporting of Equipment Malfunction

All equipment malfunctions or problems must be reported immediately to a clinical staff member with a description of the problem encountered. The clinic staff member is responsible for initiating the appropriate service request.

Portable Nitrous Oxide Sedation Units

In order to obtain a portable nitrous oxide sedation unit from Dental Clinic Central Support, it is necessary to present a completed nitrous oxide administration checklist. Instruction in the use of the checklists and instrumentation is provided in the predoctoral and postdoctoral curricula; the checklists are available in each clinical areas. Portable units will not be accepted for return if any of the indicated steps and procedures have not been completed.

ADDITIONAL POLICIES

UNIVERSITY OF CONNECTICUT
SCHOOL OF DENTAL MEDICINE

POLICY ON FINANCIAL RESPONSIBILITY FOR PATIENT CARE

It is imperative that a treatment plan be completed and discussed with all patients prior to the delivery of comprehensive or limited care. A treatment plan serves not only as a guide to the patient's agreed-upon treatment, but also as the basis for financial agreement.

With the exception of emergency care, no treatment may commence without a valid treatment plan in place.

All predoctoral and postdoctoral student providers assume financial responsibility for any and all treatment provided by them on their respective patients in the absence of a signed, fully executed treatment plan.

All financial liabilities must be cleared prior to completion of the predoctoral or postdoctoral program.

Approved by ECDS May 4, 2005
Implementation July 1, 2005

CLINIC ATTIRE POLICY

Required attire for students, staff and faculty who are directly involved in clinical treatment includes clean personal protective apparel. Protective apparel is defined as SDM approved precaution garments. All employees and non-employees at risk must routinely wear precaution garments to prevent skin exposure and soiling of street clothes when contact with blood, saliva or bodily fluids is anticipated. Precaution garments must not be worn outside the immediate clinic areas. Immediate clinic areas is defined as operatories, immediate surrounding clinic area and associated service corridors. Reception areas, restrooms, offices, general traffic corridors, main lobby, record room and financial services are not immediate clinical areas.

All apparel worn by students, staff and faculty must consist of professional attire or scrubs uniforms. If scrubs are worn outside the immediate clinical areas, they must be covered with a white laboratory coat. Scrubs must have an acceptable appearance. Jeans, tee-shirts, shorts, sandals or unapproved sneakers are never acceptable, are not professional in appearance, and therefore must never be worn in the clinical areas. Exceptions or clarifications to the clinic attire policy should have prior approval from the clinic administration.

The following protocol related to the use of precaution garments must be followed to be in compliance with standing infection control procedures:

1. Laundered garments are delivered to the service corridors and are stored in service aisle carts for distribution. Disposable garments may be found in the clinic proper.
2. Providers and staff should obtain appropriate garments from the clinic in which they are providing care.
3. Soiled garments are deposited into the designated hampers in each clinic following the clinic session or when the garment is visibly soiled or contaminated.
4. Laundry bags of soiled garments are to be place in the designated carts in the service aisle by clinic staff.

Adopted ECDS 6/13/2001

INFORMED CONSENT POLICY

All consents for care must be signed and placed in the patient record prior to the initiation of treatment. The patient must sign a general consent for examination and general treatment prior to any evaluation; the general consent for treatment is available electronically in axiUm. The treatment plan estimate provides for consent for planned treatment. Specific clinical procedures (i.e. surgical treatment) may require an additional, procedure specific consent process. Written documentation of consent must be signed by all adult patients who possess the capability to participate in the information consent process. For patients who are not of legal age, or those who require a legal guardian, consent for care must be documented and signed by the parent or legal guardian. Documentation of consent may be electronic or paper-based; paper-based consent documents must be scanned and entered into the patient record.

The informed consent process is, in general, valid when all five of the following components are satisfied:

1. **Voluntariness** is a precondition whereby patients must not be coerced into making a decision and must be free from unfair persuasions and inducements.
2. **Information disclosure** includes informing patients of the nature of the procedure, its risks and hazards, anticipated benefits and alternatives and risks and benefits of no treatment.
3. **Competence** indicates that a patient has the capacity to comprehend the disclosed information.
4. **Understanding** assures that once a competent patient is provided with information, he or she will understand it and be able to make a reasoned decision concerning treatment.
5. **Decision** results in the patient accepting (i.e. consenting) or not accepting (e.g. refusing) treatment.

The following is the informed consent policy regarding the management and treatment of dental emergencies in which a minor is involved and is brought to the clinic by someone other than parent or legal guardian. Siblings, friends or any persons other than legal guardian cannot provide consent. In instances where a minor presents as an emergency and is not accompanied by parent or legal guardian, efforts should be made to obtain the consent of the parent or guardian prior to any treatment. Only in situations where life may be at risk may intervention be provided in the absent of consent.

Telephone consent is valid when the following guidelines are observed:

1. The situation falls within the definition of an acute dental emergency. An emergency exists when the patient is experiencing immediate need for medical or dental attention and failure to secure consent for treatment would result in a delay which increases the risk to the patient's health or life.
2. The dental provider makes a conscientious effort to contact one of the parents or guardians. Either parent may grant consent for a minor child except in the case when only one parent has legal custody.
3. A third party, not involved in the direct provision of care, listens to the conversation on the phone and the parent is informed that a third party is involved.
4. The provider explains the situation to parent or guardian and includes all elements required for valid consent.
5. Appropriate documentation is made in the record of the conversation which is acknowledged by the parties involved.

If neither parent nor guardian can be located, notes must be entered in the patient record indicating the nature of the emergency, why immediate care was necessary, the care provided and the fact that all attempts to reach the parent or guardian had been exhausted. In general, if the dental provider is of the opinion that any delay would seriously

compromise the dental or overall health of the patient, he or she may initiate necessary treatment without parental or guardian consent.

Emancipated minors do not require parental or guardian consent. A minor, in the State of Connecticut, is considered to be emancipated if:

- The minor is married
- The minor has military service
- The minor is a parent themselves
- The minor is willingly living apart from parent(s) and managing their own finances and affairs
- A court has determined that it is in the minor's best interests to be independent from the parent(s).

Health care representatives named in advanced directive documents or health care proxy, court appointed conservators or guardians, and individuals with durable power of attorney for health care may all provide consent with appropriate documentation on file.

If a provider has concerns about a patient's ability or competence to participate in the informed consent process, the concerns should be immediately brought to the attention of a faculty member, Predoctoral Clinic Director, Postdoctoral Residency Director, or the Senior Associate Dean. Faculty may consult with the Office of the Attorney General for further clarification and guidance.

Adopted ECDS 12/14/00

**POLICY ON INTERPRETER/LINGUISTIC ACCESS FOR PERSONS WITH
LIMITED ENGLISH PROFICIENCY**

The School of Dental Medicine adopted the policy on interpreter services and linguistic access for persons with limited English proficiency approved by UConn Health. The policy can be found in the JDH Hospital Administrative Manual.

http://nursing.uhc.edu/hosp_admin_manual/docs/08-007.pdf

POLICY ON CARE DELIVERY TO PERSONS WHO ARE DEAF OR HARD OF HEARING

The School of Dental Medicine adopted the policy on the delivery of care to persons who are deaf or hard of hearing. The policy can be found in the JDH Hospital Administrative Manual.

http://nursing.uchc.edu/hosp_admin_manual/docs/08-009.pdf

TISSUE REMOVAL POLICY

All tissues removed during surgical procedures in the School of Dental Medicine clinics must be sent for pathological examination except for the following:

1. Normal, carious or periodontally involved teeth
2. Gingival tissue removed during subgingival debridement of teeth affected by inflammatory periodontal disease and gingival tissue or bone removed during surgical treatment of periodontitis or inflammatory drug induced gingival hyperplasia
3. Pulpal and periapical tissue removed during non-surgical and surgical treatment of pulpitis, pulpal infection and/or necrosis or periapical periodontitis secondary to pulpal disease or failed endodontic therapy
4. Normal bone and soft tissue removed from non-diseased areas

All removed tissues, includes teeth, must be listed and described in progress or operative notes.

Adopted ECDS 3/15/06

MERCURY MANAGEMENT PROCEDURES

The School of Dental Medicine stores, uses and handles dental amalgam in accordance with state and federal law and any best management practices adopted by the State of Connecticut Department of Energy and Environmental Protection.

Dental scrap amalgam and any used, empty, closed amalgam capsules must be placed into a tightly closed, dry, wide mouth screw top container with the label "contact scrap amalgam." The container must be closed when amalgam or capsules are not being added. Any defective capsule that cannot be emptied must also be placed with the scrap amalgam. Amalgam must be disposed of by an approved waste transporter; the Office of Research Safety manages the disposal of waste amalgam.

All suction traps must be changed or cleaned regularly and vacuum and suction lines must be flushed and cleaned according to protocol.

Instruments with amalgam debris, including amalgam carriers, should not be heated over an open flame since it is possible that vapors may be released when heated to temperatures with an open flame.

An amalgam separator was installed on or before December 2003 in compliance with State DEEP regulations.

Approved ECDS 2/21/06

GUIDELINES FOR THE PREVENTION OF INFECTIVE ENDOCARDITIS

The Clinical Affairs Committee has adopted the American Heart Association Guidelines for the Prevention of Infective Endocarditis (IE), which were accepted by the American Dental Association in 2007. The guidelines reflect scientific evidence that the risk of antibiotic associated adverse events exceeds the benefit, if any, from prophylactic antibiotic therapy. The maintenance of optimal oral health and hygiene may reduce the incidence of bacteremia from daily activities and is more important than prophylactic antibiotics for a dental procedure to reduce the risk of IE.

Routine antibiotic prophylaxis is not recommended, except in the following:

Cardiac conditions associated with the highest risk of adverse outcome from endocarditis for which prophylaxis for dental procedures is reasonable includes:

- Prosthetic cardiac valve or prosthetic material for cardiac valve repair
- Previous history of IE
- Certain congenital heart diseases
 - Unrepaired cyanotic CHD
 - Palliative shunts and conduits
 - Repaired CHD with prosthetic material or device during the first 6 months of procedure
 - Repaired CHD with residual defects at site or adjacent to site of prosthetic device
- Cardiac transplantation recipients who developed valvulopathy

All dental procedures that involve the manipulation of the gingival tissue or the periapical region of teeth or perforation of the oral mucosa should involve antibiotic prophylaxis for those patients with cardiac conditions that are associated with the highest risk described above.

The following procedures do not need prophylaxis: routine anesthetic injections through noninfected tissue, dental radiographs, placement of removable prosthodontic or orthodontic appliances, adjustment of orthodontic appliances, placement of orthodontic brackets, shedding of primary teeth, and bleeding from trauma to lips or oral mucosa.

The recommended regimens for dental procedures follow.

Guidelines do not obviate the need for appropriate provider judgment and consultation.

TABLE 2**Regimens for a dental procedure.**

SITUATION	AGENT	REGIMEN: SINGLE DOSE 30-60 MINUTES BEFORE PROCEDURE	
		Adults	Children
Oral	Amoxicillin	2 grams	50 milligrams per kilogram
Unable to Take Oral Medication	Ampicillin OR Cefazolin or ceftriaxone	2 g IM* or IV† 1 g IM or IV	50 mg/kg IM or IV 50 mg/kg IM or IV
Allergic to Penicillins or Ampicillin Oral	Cephalexin‡ OR Clindamycin OR Azithromycin or clarithromycin	2 g 600 mg 500 mg	50 mg/kg 20 mg/kg 15 mg/kg
Allergic to Penicillins or Ampicillin and Unable to Take Oral Medication	Cefazolin or ceftriaxone§ OR Clindamycin	1 g IM or IV 600 mg IM or IV	50 mg/kg IM or IV 20 mg/kg IM or IV

* IM: Intramuscular.
† IV: Intravenous.
‡ Or other first- or second-generation oral cephalosporin in equivalent adult or pediatric dosage.
§ Cephalosporins should not be used in a person with a history of anaphylaxis, angioedema or urticaria with penicillins or ampicillin.

Excerpted and adapted from the Journal of the American Dental Association 2008; 139 (1) Special Supplement

Approved CAC 6/20/07

GUIDELINES FOR THE MANAGEMENT OF PATIENTS WITH PROSTHETIC JOINTS

The Clinical Affairs Committee adopted the American Dental Association's 2015 recommendation for the clinical management of patients with prosthetic joints.

In general, for patients with prosthetic joint implants, prophylactic antibiotics are not recommended prior to dental procedures to prevent prosthetic joint infection. For patients with a history of complications associated with their joint replacement surgery who are undergoing dental procedures that include gingival manipulation or mucosal incision, prophylactic antibiotics should only be considered after consultation with the patient and the orthopedic surgeon or other provider(s). Risk assessment should be done by the patient's orthopedist or primary care physician and the individual patient's circumstances and preferences should be considered when deciding whether to prescribe prophylactic antibiotics prior to dental treatment.

- There is evidence that dental procedures are not associated with prosthetic joint implant infections
- There is evidence that antibiotics do not prevent prosthetic joint implant infections
- There are potential harms of antibiotics and the benefits may not exceed the harms for most patients

Approved and adopted CAC 1/21/15

RECOMMENDATIONS FOR THE MANAGEMENT OF PATIENTS ON BISPHOSPHONATES

Oncologic Conditions

1. Cancer Patients Prior to Starting Intravenous BP therapy

Complete Oral exam with extraction of non-restorable teeth. All teeth that may require extensive restoration and/or periodontal therapy at the present time or in the future should be thoroughly evaluated and strong consideration should be given for their removal. It is recommended that extractions and/endodontic therapy should be performed at least one week prior to the initiation of BP treatment. Dental prophylaxis, periodontal therapy, and restorative treatment may be performed within a month of initiation of BP administration. Patients with dentures should be checked for any potential areas of irritation and the dentures should be adjusted accordingly.

2a. Cancer Patients without Evidence of ONJ Receiving BP as an adjunct to cancer therapy

Routine prophylaxis, restorative therapy, endodontic therapy and limited scaling/root planning may be performed and should be encouraged. Dentures should be adjusted as above. Patients who have started BP therapy within the past month can have extractions performed. It is recommended that extractions in patients who have been receiving BP therapy for longer than a month should be avoided in favor of endodontic treatment. If no alternatives to extraction exist, treatment should be rendered with the atraumatic procedure as possible. Primary closure of the oral soft tissues should be utilized if possible. There is no evidence that discontinuing BP therapy alters the outcome of oral surgical intervention in these patients. Implant therapy should be avoided in these patients.

2b. Cancer patients without evidence of ONJ receiving Oral or Intravenous BP for treatment or prevention of osteoporosis

There are no studies evaluating the risks of developing ONJ in this specific patient population however since these individuals are often receiving chemotherapeutic and/or immunosuppressive agents it appears likely that these individuals are at an increased risk when compared to patients being treated for benign conditions (Section 2, Benign Conditions Below). Prevention or treatment of osteoporosis may be via oral or yearly IV BP administration that translates to cumulative BP doses that are significantly lower than the patients described in the sections above.

Patients should be encouraged to seek regular dental care on a 6 month basis. Patients in need of elective extractions and/or osseous surgical procedures should have their BP therapy suspended for three months prior and three months following treatment or when tissue healing is adequate. It is not necessary to alter BP treatment in patients receiving routine dental treatment including prophylaxis, restorative procedures, non-surgical endodontic, or orthodontic treatment. In patients requiring emergent treatment, therapy should be rendered without preoperative suspension of BP administration. Furthermore, there is no indication that CTX levels have any value in the timing of delivery of dental treatment in these patients.

Implant failures in this patient population have not been investigated but are likely to be low. It is difficult to make specific recommendations for implant placement in this group of patients based on the paucity of research data. Therefore no alteration in the placement of implants is recommended other than good surgical technique. The practitioner may consider a preference for delayed loading and meticulous soft tissue closure of the implant site in order to allow for optimal implant healing. Patients should be informed that they may be at an increased risk for implant failure when compared to patients on BPs for benign conditions due to the possible increased risk for development of ONJ from chemotherapeutic and/or immunosuppressive agents.

3. Cancer Patients with ONJ receiving BP

At the present time there are no accepted treatments for this condition. Empirical recommendations have been made based on the extent and severity of the lesion although the available staging systems are extremely limited. The majority of experts recommend avoiding surgery as it often resulted in the extension of the lesion. Small and medium size lesions can generally be treated conservatively using a combination of oral antibiotics, antibacterial mouth rinses, and meticulous hygiene practices. Recently several groups have advocated resection and reconstruction of more extensive, symptomatic lesions with good results. Decisions regarding treatment for patients with ONJ should be individualized, weigh all risks and benefits, and be determined by a multidisciplinary team. The majority of evidence does not support discontinuing BP in these patients.

Benign Conditions

(Including but not limited to: Osteoporosis, Osteogenesis Imperfecta, Paget's Disease)

While the incidence/prevalence of ONJ in patients taking BPs for benign conditions is not known it is several orders of magnitude lower than that seen in patients with malignancies. Additionally, most patients who are treated for benign conditions receive lower levels of BPs than those administered for the treatment of skeletally related events associated with bone metastases in patients with malignancies.

1. Patients prior to starting Oral or Intravenous BP therapy

Patients should be encouraged to have regular dental care. In the event that a patient has not received a dental examination within the past several years they should be encouraged to obtain a general dental examination including screening radiographs and cleaning. This should be accomplished within 6 months of the initiation of BP treatment.

2. Patients without Evidence of ONJ Receiving BPs for benign conditions

Patients should be encouraged to seek regular dental care on a 6 month basis. There is no evidence that the delivery of routine dental care should be altered in this patient population. Patients in need of elective extractions and/or osseous surgical procedures should have their BP therapy suspended for three months prior and until initial bony healing (typically 2-3 months) following treatment. It is not necessary to alter BP treatment in patients receiving routine dental treatment including prophylaxis, restorative procedures, non-surgical endodontic, or orthodontic treatment. In patients requiring emergent treatment, therapy should be rendered without preoperative suspension of BP administration. Furthermore, there is no indication that CTX levels have any value in the timing of delivery of dental treatment in these patients.

The number of reported implant failures in this patient population is extremely low and therefore no alteration in the placement of implants is recommended other than good surgical technique. The practitioner may consider a preference for delayed loading and meticulous soft tissue closure of the implant site in order to allow for optimal implant healing.

3. Patients with ONJ receiving BPs for benign conditions

See above treatment for cancer patients with ONJ.

Approved and adopted by Clinical Affairs Committee 5/19/10