Section VII

Quality Assessment

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Introduction

History

Quality Assessment (QA) in the Indian Health Service dental program began in the late 1960's with the development of criteria to assess technical quality of dental care. These evaluations were originally conducted by Area Dental Officers and later by senior IHS dental clinicians specifically trained as QA evaluators.

Revisions

In 1981 a major revision of the QA document was accomplished. At that time criteria were developed to assess management and community components of dental programs to complement the technical QA criteria. Subsequent to 1981 additional criteria have been developed which address the indirect evaluation of dental care via chart audit, the evaluation of dental disease prevention activities, the evaluation of infection control procedures, and radiologic health and safety. In 1992, the JCAHO subsection was expanded to include examples of important aspects of care, indicators, and a data collection grid to facilitate implementation of the continuous quality improvement monitoring and review process. The prospective and concurrent approach of CQI driven by customer-defined quality complements the retrospective, point-in-time approach of the Technical QA and Chart Review.

After nearly three decades of evaluation, the quality assessment process has become increasingly complex and broad in scope. Consequently, the original format of "in-mouth" review of patients during a "normal" clinic day is no longer entirely adequate to meet present quality assessment needs of all levels of the IHS Dental Program.

QA Methods

To address these multiple areas of need, the current quality assessment documents address five major areas. These include: the technical quality of dental care, dental program management, community involvement, indirect methods of assessing clinical quality, and a section on preparation for JCAHO surveys.

The existence of these multiple documents affords the opportunity to customize the quality assessment process to meet distinct areas of need. Following is a brief description of the five QA formats that are included in this section:

Format A: JCAHO

AMH and AMAC

The JCAHO format for quality assessment consists of meeting the accreditation requirements contained in current issues of the Accreditation Manual for Hospitals (AMH) or the Accreditation Manual for Ambulatory Care (AMAC), which are published annually and revised at least bi-annually by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This format currently focuses on improving organizational performance in an interdepartmental manner, rather than on monitoring and evaluating intradepartmental aspects of care as it has in the past.

Functional Chapters

As of 1996, the AMH and the AMAC were divided into eleven functional chapters, which are themselves divided into Patient-Focused functions and Organization functions. The Patient-Focused functions include Patient Rights and Organization Ethics, Assessment of Patients, Care of Patients, Education of Patients and Family, and Continuity of Care. Organization functions include Improving Organization Performance, Leadership, management of the Environment of Care, Management of Human Resources, Management of Information, and Surveillance, Prevention, and Control of Infection.

Format A gives a brief history and overview of IHS involvement in JCAHO accreditation activities. However, due to the rapid changes that have been occurring in the AMH and AMAC, specific requirements for JCAHO accreditation must be obtained from the most recent issues of the JCAHO manuals.

Format B: Evaluation of Technical Quality of Care

On-Site Reviews

This format consists of the traditional evaluation of clinical quality of care. It involves an on-site visit by a quality of care evaluator and includes the assessment of specific patients scheduled during a "normal" clinic day using the Technical QA Document. When the assessment involves patients being treated by a dental hygienist, the evaluator and hygienist may refer to those criteria marked by an asterisk (*) to indicate criteria applicable to hygienists.

Format C: Chart Review

This format consists of the indirect review of clinical quality of care. A chart review is performed using the criteria found in the "Indirect Review of Clinical Quality and Risk-Management" subsection of Section VII.

Combination of Subsections

An alternate format combines Format B and Format C. It consists of the specific scheduling of patients who have had services completed at an earlier date. Evaluation of these services in conjunction with a review of patient records affords the opportunity to review completed cases as well as records documentation.

Each of these formats should also include a review of laboratory cases.

Format D: Evaluation of Community Involvement

Combined Format

The Evaluation of Community Involvement may be conducted concurrently with review of technical quality of care or reviewed separately. The community and management evaluation documents, while professionally conceived, are not limited exclusively to use by dental professionals. They may be assessed by nondental persons with general background knowledge in these areas. Uses for the documents include orientation of new staff, self-evaluation by individual professionals, establishment of program standards, and assessment of program activities which impact on oral health.

Format E: Evaluation of Management of Oral Health Programs

Use of Evaluation Documents

This evaluation was developed as a measurement of productivity, cost-effectiveness, and appropriateness of dental services delivered in public health dental programs which exist in Tribal and IHS programs. The evaluation and results provide useful measurements as a baseline for changing program emphasis, direction, and plans. Much of this can only be measured by reviewing process indicators which are believed to contribute to effectiveness and efficiency of the program. More specific outcome measurements are derived by reviewing the dental data indicators listed on page VII-102 and VII-

103. Results can be compared to averages from other IHS and Tribal programs and data from contracting patients to private practice.

Considerable latitude exists for using a combination of subsections found in Section VII of the *Oral Health Program Guide* to match situational requirements. Each individual utilizing the document should recognize the dynamic nature of its contents and be encouraged to contribute to its improvement. Future experience in the quality assessment arena will permit and foster continued evolution of the program.

Policies and Responsibilities for Implementing the Quality Assessment System

1. The overall responsibility for the quality of health care in the Area lies with the Area Director, with specific responsibility for quality of dental care falling to the Area Dental Consultant or other senior Dental Program staff. The Chief, Area Contracting Branch is responsible for Tribal/638 program evaluation and may delegate the responsibility for evaluation of the dental component to the ADO. The ADO may delegate this responsibility to other dentists. Other programs implementing this system will have administrative lines of authority which will modify this requirement.

2. Technical evaluation should be performed on each dentist new to the program within the first six months of his/her entering upon duty and thereafter as appropriate. After an initial baseline evaluation, community involvement and management of oral health programs should be reevaluated at least every two or three years. Some programs may prefer to use the results of the technical evaluation every two years in support of privileging, but most of that support should come from provider profiles derived from results of continuous monitoring and review.

3. Private dentists or dental hygienists under IHS contractual agreement working in IHS or Tribal clinics should be evaluated periodically by a trained evaluator, utilizing methodology and evaluation criteria/indicators acceptable to them.

4. The evaluatee must be provided the criteria/indicators and standards for the evaluation prior to the evaluation. No evaluation can be conducted upon services provided or methods employed prior to the time the evaluatee was provided the criteria and standards for the evaluation.

Personal

5. The evaluation will be by personal contact between the evaluator and evaluatee and review of existing records as appropriate.

Administrative Approval

6. Contact with the Service Unit Director or the Tribal Health Administrator is a requirement before the evaluation. A sample letter for follow up of this contact is suggested on pages VII-68 and VII-69.

7. Tact and discretion must be preeminent throughout the evaluation process. The dignity of the evaluatee must be preserved in all instances.

8. When the quality of a service provided is considered questionable by the evaluator, but is not definitely unsatisfactory, the decision must be in favor of the evaluatee and rated satisfactory.

9. Differences in training backgrounds are recognized as sources of potential philosophical differences in criteria for dental procedures performed by dental practitioners. Differences may also arise between the evaluator and evaluatee as to the extent or significance of a deficiency for any criterion. A mechanism is provided for addressing these differences. An example of the process is given on page VII-25, criterion #3, using tooth preparation and restoration as an example. If concurrence of satisfactory or unsatisfactory cannot be agreed upon through discussion between the evaluator and evaluatee, the criterion will not be counted as unsatisfactory. However, the nature of the dispute concerning the criterion will be documented in a narrative summary. Where it is possible that the discussion of the disputed criterion can take place without the evaluatee returning to observe the deficiency, discussion of the disputed criterion will be delayed until the closeout meeting. This process can be applied to any disputed criterion in Section VII.

10. The evaluation must include a confidential closeout meeting where all reports are signed by both the evaluator and evaluatee. Reports for each subsection being evaluated are included at the end of each subsection.

Dissemination of Findings

11. The evaluatee and responsible administrative authorities must be advised of all evaluation findings. Further dissemination of findings must be by mutual consent of the evaluatee and responsible administrative authorities.

Right of

12. The evaluatee has the right of appeal for a reevaluation by the same or a different evaluator.

The Joint Commission on Accreditation of Health Care Organizations

Need for Accreditation

For many years, all Indian Health Service (IHS) facilities have been directed to become accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO). Additionally, all hospitals must be accredited by either the Health Care Financing Administration (HCFA) or the JCAHO in order to collect Medicare reimbursements, which comprise up to one-third of the operating budgets of many IHS facilities. For this reason, as well as the prestige that is conferred on a facility by JCAHO accreditation, many Tribal and Urban programs also choose to seek JCAHO accreditation.

Revision of Criteria

For the past ten years, the JCAHO accreditation criteria have been undergoing rapid and frequent revision. In 1986, the JCAHO embarked on what it calls the "Agenda for Change," which is altering the focus of the survey process from the structure of the health care organization (i.e., the resources available to the organization to provide care) to a focus on the processes that exist within the institution to provide services, and ultimately to a focus on outcome measures. Additionally, the JCAHO had anticipated initiating an Indicator Monitoring System (IMS), with a set of standard indicators that would be monitored by all facilities undergoing accreditation, by the mid 1990's. However, as of this writing, the IMS has not yet been formally adopted, and none of the indicators under development relate to dental programs.

Interdepartmental Emphasis

Since 1990, the Accreditation Manuals for Hospitals (AMH) and for Ambulatory Health Care have changed from departmentalized criteria and Quality Assurance to the concept of Continuous Quality Improvement (CQI) in the 1992 AMH and finally to manuals which are currently organized around important organizational functions and organizational Performance Improvement (1995 AMH and 1996 Ambulatory Health Care Manual). Surveys now focus on inter- rather than intra-departmental activities, so dental programs will have to coordinate their programs with the rest of their facility's in order to pass muster. It is reasonable to assume that these changes will continue into the foreseeable future with each new issuance of the various JCAHO manuals.

IHS Dental Program and JCAHO Accreditation

The information contained in this document is meant to assist IHS Dental Programs in becoming a meaningful part of the accreditation process of the JCAHO. Even though it is difficult to predict how thoroughly a dental program will be evaluated, some historical patterns provide guidance in preparation for future surveys.

Frequently Reviewed Components

Programmatic components which seem to have a higher probability of review include: policy and procedure manuals, in-house quality improvement (now Performance Improvement) programs, infection control protocols, facilities and biomedical maintenance, safety procedures, evidence of staff meetings and inservice training, privileging and credentialing of dental officers, emergency drug kits, nitrous oxide or sedation protocols, and adequacy of documentation of the medical record for dental treatment procedures.

Changes in Review Process

A number of other observations may assist field dental programs in preparation for JCAHO surveys. Hospital-based dental programs seem to receive more attention than those located in outpatient facilities, although this discrepancy has been closing in recent years. The review procedure is becoming more process and outcome oriented, and active ongoing interdepartmental quality improvement is being examined more critically. **It should be noted that the traditional IHS quality of dental care evaluation using IHS Technical Quality of Care documents is not sufficient to meet the requirements for ongoing quality improvement, although it can be an important part of peer review activities in the dental program.**

Assistance for Programs

The actual application of JCAHO standards to IHS Dental Programs will most likely remain variable and subject to change. Area Dental Programs should monitor JCAHO interaction with field programs and to assist field programs in preparation for these accreditation surveys.

JCAHO Survey and Accreditation Process

Ambulatory Care Services

The JCAHO defines hospital-sponsored ambulatory care services as “the delivery of care pertaining to non-emergency, adult, adolescent, and pediatric ambulatory encounters, whether performed through the clinical departments of the hospital or an organized ambulatory program, regardless of the physical location of such services (that

is, within the hospital, on its campus, or at off-campus satellite facilities)." Hospital-sponsored ambulatory care services are provided by one or more organizational unit(s), or components thereof, of the hospital under the responsibility of the governing body. Standards are applied to evaluate a hospital's performance in providing ambulatory care services.

Outpatient Clinics

Those dental clinics residing in a hospital meet the above definition and should comply with the standards in the Accreditation Manual for Hospitals (AMH). Those dental clinics located in outpatient facilities should comply with the standards contained in the Accreditation Manual for Ambulatory Health Care. These may be checked out from the Dental Field Support and Program Development Section, IHS HQ West, Albuquerque, NM (505-248-4175). Most facilities that have applied for accreditation will have a Quality Improvement Coordinator who has copies of these documents.

Use of JCAHO Manuals for Current

Past issuances of the JCAHO section of the OHPG have contained detailed, often step-by-step instructions on how to comply with current JCAHO survey guidelines. Unfortunately, the changes in the JCAHO survey criteria have recently been occurring more quickly than OHPG updates can be prepared and distributed. For this reason, this issuance of the OHPG will not contain detailed instructions on how to attain JCAHO accreditation. Rather, the reader is encouraged to study the most recent copy of the Joint Commission manual that applies to his/her facility (hospital or ambulatory care) to review the most current standards.

Evaluation of the Technical Quality of Care

Oral Diagnosis

A. Patient Records

The patient dental records are part of the patient's primary health care record, and the latter is available for review. *Criterion #1

Method to Assess Criterion: Review of the primary health record.

Note: Criterion #1 does not apply in certain locations where the dental clinic is not attached to an outpatient medical facility. However, the primary health record should still be accessible for review.

The patient's dental health record contains a current (completed within the last year) health questionnaire containing items of specific significance to dental practice. Documentation exists in the patient record that this information was updated annually and reviewed by the dentist at each visit, with documentation of changes or "no changes" in the patient's medical status. *Criterion #2

Method to Assess Criterion: Review the patient dental record for a health questionnaire containing, at a minimum, questions on current M.D. care, recent illnesses, cardiovascular disease (including rheumatic fever), liver disease, diabetes, convulsions/seizures, drug allergies, bleeding tendencies, current medications, harmful habits, pregnancy, blood transfusions, and sexually transmitted diseases.

All entries in the patient dental record are recorded in ink. *Criterion #3

Method to Assess Criterion: Review of patient dental record.

All entries recorded in the patient dental record follow instructions for completing Form IHS 42-1. Services rendered are recorded on the Dental Progress Notes (Form IHS 42-2) in sufficient detail to determine: date of *Criterion #4

service, tooth/teeth, quadrant/sextant, type of local anesthetic, local anesthetic dosage in milligrams, name and dosage of other drugs administered, materials used, complications, provider (signature and degree), procedure code, and fee, if applicable. Universally understood symbols or a key are provided in clinic protocols for understanding the recording. Abbreviations used are approved by the Medical Staff.

Method to Assess Criterion: Review of patient dental record.

Criterion #5

For emergency visits the SOAP (or similar) format will be used in sufficient detail to document chief complaint, objective findings, diagnosis, and treatment plan.

Method to Assess Criterion: Chart review.

B. Examination and Diagnosis

Criterion #1

Existing hard and soft tissue findings obtained by clinical and radiographic examination are recorded in patient's dental record.

Method to Assess Criterion: Immediately following the completion of the clinical examination provided by the attending dentist, the examiner refers to the patient's dental record and clinically examines the same patient. The same light, mouth mirror, and explorer used by attending dentist are used by the examiner. Determine if radiographic findings are identified and recorded.

Criterion #2

Other diagnostic aids such as pulp testing, cytology, biopsy, or blood pressure screening are used when indicated.

Method to Assess Criterion: Review patient dental record for appropriate use of other diagnostic aids.

Criterion #3

Diagnosis is consistent with findings.

Method to Assess Criterion: Chart review.

Criterion #4

A plan of treatment is available in the patient dental record and follows, in general, the following order:

a. Relief of pain and discomfort, including nonelective surgery.

b. Elimination of infection and factors predisposing to pathologic conditions.

c. Thorough prophylaxis, instruction in oral hygiene, and other oral disease preventive therapies.

d. Treatment of caries.

e. Non-surgical periodontal treatment which is incremental and based on assessment of the patient.

f. Elective care.

g. Documentation of patient acceptance of treatment plan, including signed consent by patient, parent, or legal guardian.

h. Scheduling of minimum of appointments to complete treatment.

Method to Assess Criterion: In evaluating the plan of treatment, take into account the choice of treatment, the types of restorations, and the age, sex, and general health of the patient. The plan should reflect progressive changes in the patient's dental status as each phase of treatment is to be completed. The plan should be sufficiently flexible so that it may be altered to accommodate unanticipated results of previous treatment. The plan should be considered tentative and subject to modification throughout the course of treatment. Any changes in the treatment plan require documentation.

Treatment plan is consistent with diagnosis. Criterion #5

Method to Assess Criterion: Chart review.

C. Radiographs

All radiographic exposures shall be ordered by the dentist according to patient conditions, or meet written criteria for type and frequency described in the clinic policy. The types and frequency of radiographs should meet the following broad classifications: Criterion #1

a. Initial Adult:

An initial radiographic examination, consisting of posterior bitewings supplemented with anterior and/or posterior films and/or panoramic radiographs, as required by oral conditions, is recommended for all individuals *15 years old and older.* Panoramic or full-mouth intraoral radiographic films are appropriate when the patient presents with clinical evidence of generalized dental disease or a history of extensive dental treatment.

b. Initial Child:

Prior to the eruption of the first permanent tooth, bitewing films (where interproximal surfaces cannot be visually inspected) are supplemented with anterior and posterior periapical films, as required by oral conditions. Individualized radiographic examinations consist of a periapical/occlusal or panoramic examination when clinical evidence or history indicate the need for additional radiographic examination. A full-mouth radiographic exam (panoramic or intraoral periapical) is performed *beginning at age 9.*

c. Recall:

1. Bite-wings and/or periapical radiographs should be taken at intervals as required by the patient's general condition.

2. In the absence of specific indications for more frequent radiographs, a panoramic radiograph or full-mouth intraoral periapical series should not be taken more often then once every five years.

d. Emergency Examination:

An appropriate diagnostic radiographic examination of the area in question.

Method to Assess Criterion: Review of patient dental record, clinic policy manual, and observation.

Dental radiographs are dated, mounted, identified with the patient's name and chart number, and contained in the patient's dental record.

Method to Assess Criterion: Review of patient record, with specific attention to mounting and labeling of existing radiographs, and by observation of mounting and labeling of new radiographs after processing.

Density and contrast of radiographs are such that anatomical hard and soft tissue landmarks can be differentiated.

Radiographic image size is not distorted in the area of the mouth under study.

Radiographs disclose no overlapping of image in the area of the mouth under study, except where tooth alignment does not permit open contacts. *Criterion #5

Radiographs disclose no cone-cutting. *Criterion #6

Bitewing radiographs include the distal surface of the erupted cuspids and mesial surface of the most posterior erupted teeth. *Criterion #7

Method to Assess Criteria #3 to #7: Assess the radiographs taken on patients present in the clinic during the evaluation visit and/or review radiographs taken within the previous six months, selected randomly from the files. The radiographs should be viewed with a radiographic illuminator (view box). Apply the applicable criteria to each radiograph and determine diagnostic acceptability. The anatomy in the area under study should be visible and of diagnostic quality. Criterion #5 is not applicable for the permanent dentition, unless the patient is in the clinic for observation of the dentition to rule out crowded teeth as a cause of overlapping.

Note: If a radiograph has a deficiency which does not compromise the diagnostic value, the radiograph will be considered acceptable. However, the deficiency should be pointed out to the evaluatee.

D. Radiological Protection

All dental auxiliaries who take radiographs will be currently certified in radiology. *Criterion #1

Method to Assess Criterion: Observe posting of current certificate or review documentation showing that auxiliaries are certified.

Lead protective devices are used on each patient during all exposures.

Method to Assess Criterion: Observe directly whether the lead protective devices are placed in a manner that will protect the patient.

The tube housing or cone shall be stationary and positioned in close proximity to the film positioning device or skin of the patient when the exposure is made.

Method to Assess Criterion: Observe directly whether the tube housing or cone is stationary and within 1/4" or less of the film positioning device or skin of the patient when exposure is made. Also, observe processed radiographs for evidence of blurred images from movement of the tube head.

*Criterion #4 **During exposure, radiographic film is not held in position by attending staff.**

Method to Assess Criterion: Directly observe whether attending dental staff is holding film in position during exposure.

*Criterion #5 **During exposure, tube housing or cone is not held by attending staff or patient.**

Method to Assess Criterion: Directly observe whether attending staff or patient is holding the tube housing or cone during exposure.

*Criterion #6 **Operator is at least six feet from patient and not in the path of the primary beam or stands behind protective barrier during exposure.**

Method to Assess Criterion: Directly observe the distance and location of the operator when the x-ray machine is activated.

*Criterion #7 **Only necessary persons are allowed in radiographic area during exposure.**

Method to Assess Criterion: Directly observe whether unnecessary persons are in the x-ray area during exposure.

*Criterion #8 **A warning signal is given prior to pushing the x-ray activator button.**

Method to Access Criterion: Directly observe whether operator calls out "x-ray" or gives some other warning prior to activation of machine.

Dosimeters (film badges) are worn by all dentists, hygienists, and dental assistants.

Method to Access Criterion: Directly observe whether a dosimeter is worn by each dental staff member.

Protective devices are properly stored to reduce creasing and damage.

Method to Assess Criterion: Directly observe whether lead protective devices are properly stored to reduce creasing and damage.

Radiological reports are maintained: quarterly report of dosimetry, annual calibration of radiologic equipment, annual evaluation of patient lead protective devices.

Method to Assess Criterion: Directly observe whether reports are on file and current.

Prevention

*Criterion #1

The patient dental record contains an individualized disease prevention plan based on the patient's status and risk factors:

a. Systemic fluoride
b. Professionally-applied topical fluoride
c. Self-applied topical fluoride
d. Fluoride toothpaste
e. Pit and fissure sealants
f. Preventive periodontal treatment
g. Tobacco counseling
h. OHI and other health education
i. Recall

Method to Assess Criterion: Review of dental record for the above information.

*Criterion #2

Oral health education and self-care instructions are provided and are consistent with needs identified in the individualized prevention assessment.

Method to Assess Criterion: Observe what the patient is told during the appointment. If communication cannot be observed, question the patient about what they were told during the visit and ask if appropriate home-care aids were recommended (e.g., fluoride toothpaste, fluoride rinses, floss, Perio Aid, Proxabrush, floss threaders). Special instructions are given to patients with special needs and/or physical handicaps. Ask the patient to demonstrate flossing and brushing technique as taught by the provider.

*Criterion #3

Each dental prophylaxis provided meets the following standards:

a. The presence of plaque and calculus is demonstrated to the patient or parent before prophylaxis begins. Use of a disclosing solution is recommended.

b. All plaque and other soft debris are removed from tooth surfaces (includes flossing of interproximal surfaces to demonstrate plaque removal for the patient and/or parent).

c. All coronal calculus is removed (includes all supragingival calculus and subgingival calculus up to 3 mm. below gingival crest).

d. Each patient indicated for prophylaxis receives toothbrush prophylaxis unless rubber cup is required to accomplish stain removal.

Method to Assess Criterion: Observe whether prophylaxis procedures being provided are explained to the patient by the attending dental staff person. Following the completion of the prophylaxis, assess the quality of the procedure by inspection of the teeth using mouth mirror, explorer, and adequate light.

Persons with one or more new smooth-surface carious lesions, or whose prophylaxis includes a rubber cup polishing, will be given a professionally-applied topical fluoride application. A schedule of up to four applications per year may be followed, based on the presence of moderating factors listed below. Use currently accepted criteria found in Section IV of the *IHS Oral Health Program Guide* for determining the frequency of professionally-applied fluorides.

*Criterion #4

Note: Professionally-applied topical gel treatments are not recommended for patients under five years of age.

Method to Assess Criterion: Chart review, including review of documentation of any moderating factors, and/or direct observation.

Note: Moderating factors for caries risk include: age, present caries activity, past caries activity, exposure to other sources of fluoride, sugar intake and frequency, amount of plaque, dental anatomy, medications, and family history.

Sealants are placed on susceptible unrestored or incipient carious pit and fissure surfaces of permanent first and second molars within two years of eruption.

Criterion #5

Method to Assess Criterion: Chart review or direct observation. Criteria for the use of pit and fissure sealants include: Seal if deep, narrow pits and fissures, or other occlusal lesions are present. Do not seal if broad, well-coalesced pits and fissures, or frank caries are present. Frank caries is defined as gross cavitation with a break in the enamel, softness, and usually discoloration.

All sealants placed meet the following standards:

a. Adequate isolation of teeth is achieved for placement of sealants.

    1. If four-handed technique is used, isolation with cotton rolls or Dri-Aids is acceptable.

    2. If two-handed technique is used, proper isolation requires rubber dam or Vac-Ejector.

b. Adequate etching and rinsing techniques are used prior to application of sealant.

    1. Etching solution is applied for 15 to 30 seconds to achieve a frosted appearance.

    2. Etched surfaces are rinsed for at least 15 to 30 seconds to remove etching solution and precipitate.

c. Sealants exhibit adequate retention by remaining intact following a reasonable effort to remove with an explorer.

d. No overt occlusal interferences are present due to placement of the sealants.

Method to Assess Criterion: Direct observation.

*Criterion #7

Patients who are tobacco users are asked if they want to quit using tobacco.

Method to Assess Criterion: Observe the patient record for evidence that all patients are asked if they use tobacco and documentation that tobacco users have been asked if they want to quit using tobacco.

Criterion #8

Tobacco cessation counseling is recommended for patients who indicate they want assistance in quitting tobacco.

Method to Assess Criterion: Observe the primary health record to determine that the patient who wants counseling has been counseled by the dental staff or has been referred for counseling, unless it is documented that the patient requests deferment of counseling.

Each patient is placed in a recall program based on his/her individual risks rather than arbitrary time intervals. The patient's recall category is consistent with the diagnosis, treatment received, and medical condition, e.g., diabetes, rampant caries, pregnancy, and perio status.

Method to Assess Criterion: Review of dental record.

Restorative (Exclusive of Full Cast Restorations)

Treatment is explained to the patient (parent/guardian) before services begin.

Method to Assess Criterion: Observe whether the attending dentist or dental assistant explains to the patient (parent/guardian) the planned treatment services for that visit before those treatment services begin.

Rubber dam isolation is utilized unless contraindicated. There is documentation of the reason for non-use in the chart.

Method to Assess Criterion: Direct observation. All rubber dam clamps must be positively blocked (i.e., throat pack, ligation, rubber dam) from swallowing or aspiration.

Tooth preparation and restoration are designed to promote success and patient satisfaction.

Method to Assess Criterion: Ask the patient if he/she has experienced any problems with previous restorations, e.g, difficulty flossing, food impaction, or unusual discomfort. At a minimum, the following aspects of the restoration are observed by direct observation:

a. Caries removal
b. Preparation design
c. Base placement
d. Contacts
e. Marginal ridge
f. Lack of overhangs
g. Embrasure
h. Contour
i. Occlusal anatomy
j. Restorative material

Note: Any aspect of the restoration deemed by the evaluator as being unsatisfactory to the extent of promoting failure of the restoration will be identified to the evaluatee. If the evaluatee

disputes the evaluator's conclusion that the deficiency is cause for considering the restoration to be unsatisfactory, there will be a discussion of the deficiency identified. If concurrence between the evaluatee and evaluator cannot be reached after discussion, the disputed restoration will not be counted as unsatisfactory. However, the nature of the dispute will be noted in a narrative summary.

Esthetics of anterior restorations satisfy the requirement for concealment and/or harmony of the restoration.

Method to Assess Criterion: The anterior restoration should be esthetically acceptable, and not displeasing to the patient. Ask the patient to comment on the appearance of anterior restorations.

Instructions concerning restorative care are given to the patient (parent/guardian) postoperatively, and services planned for the next appointment are explained.

Method to Assess Criterion: Observe whether instructions concerning restorative care and an explanation of the services planned for the next appointment are given to the patient (parent/guardian) by the attending dentist or the dental auxiliary prior to dismissal of the patient.

Pediatric Dentistry

A. Treatment Planning in the Primary Dentition

All carious teeth are addressed in the treatment plan.

Method to Assess Criterion: Chart review.

All primary posterior teeth with three or more carious surfaces, or teeth receiving pulp therapy, are restored with stainless steel crowns, unless a reason for not using a stainless steel crown is noted.

Method to Assess Criterion: Chart review and direct observation.

Pulp therapy procedures performed in the primary dentition are consistent with the diagnosis. The diagnosis is supported by documentation of the findings in the patient's chart.

Method to Assess Criterion: Review of progress notes and radiographs.

Primary teeth receiving pulpectomy treatment shall have a postoperative periapical radiograph.

Method to Assess Criterion: Review chart and radiographs.

B. Behavior Management of Sedation Patients

The child's behavior and type of restraint techniques (verbal, physical, and/or chemical), if used for patients less than six years of age, is documented in the chart.

Method to Assess Criterion: Chart review. The Frankl Scale is offered on the following page as only one example of behavior documentation which may be used.

FRANKL'S RATING SCALE
Categories of Behavior

Rating 1: **Definitely Negative (- -).** Refuses treatment, cries forcefully, is fearful, or portrays any other overt evidence of extreme negativism.

Rating 2: **Negative (-).** Is reluctant to accept treatment, is uncooperative, portrays some evidence of negative attitude but not pronounced, that is, sullen or withdrawn.

Rating 3: **Positive (+).** Accepts treatment, at times is cautious but willing to comply with the dentist, but follows the dentist's directions cooperatively.

Rating 4: **Definitely Positive (++).** Has good rapport with the dentist, interested in the dental procedures, laughs and enjoys the situation.

Only behavior management techniques in which the dentist is trained and privileged are used.

Method to Assess Criterion: Direct observation and review of charts. Review of hospital or facility privileges for approval of privileges for the type of sedation being used or documented in the dental record as having been used.

Documentation of informed consent is present when chemical restraints (including nitrous oxide and/or other sedation) and physical restraints (including Hand Over Mouth, mouth props, and wraps) are used.

Method to Assess Criterion: Direct observation and chart review.

The response to behavior management techniques, if used for patients less than six years of age, is noted in the progress notes.

Method to Assess Criterion: Direct observation and chart review.

All sedations must conform to the guidelines published in Section V of the *Oral Health Program Guide.*

Method to Assess Criterion: Review of documentation in the Dental Progress Notes (42-2) or the Dental Outpatient Sedation Record (IHS-831) if used. A review of the documentation should address the following:

a. Is the consent statement signed by the parent/guardian?

b. Is the type and amount of local anesthetic recorded?

c. Is the amount of each sedative drug used recorded?

d. Is the indication for the use of sedation recorded on the sedation record or in the progress notes?

e. Has the patient complied with the preoperative NPO instructions?

f. Is there evidence that a physical assessment was done, i.e., that the patient is healthy, current medications are noted, and the airway is not obstructed?

g. Were the respiratory and circulatory systems monitored continuously and findings recorded at an interval no longer than 15 minutes?

h. Were the patient's condition and time of discharge noted?

If any one of these requirements are absent from the documentation, the criterion for sedation is considered unsatisfactory.

Note: The form IHS-831 is not required, but is strongly recommended. This form can facilitate complete documentation of monitoring when more than visual monitoring is required with certain dosages and combinations of drugs described in Section V of the *Oral Health Program Guide.* If the IHS-831 is used, all the second copies (pink) should be maintained as a log.

C. Space Maintenance

A space maintainer is placed when primary molars are prematurely lost prior to normal exfoliation, or reason for non-provision of a spacer is noted.

Method to Assess Criterion: Chart review. Determine whether indications or contraindications for placement of a space maintainer are documented in the dental record.

Arrangements are made for recall examinations for patients with spacers.

Criterion #2

Method to Assess Criterion: Review the patient record for arrangements made for recall examination for patients with spacers.

The space-maintaining appliance spans the edentulous area adequately, allows for normal eruption of the permanent tooth, and does not impinge upon soft tissue. Orthodontic band-type space maintainers exhibit smooth marginal adaptation and adequate cementation.

Method to Assess Criterion: Direct observation.

Endodontics

A. Pulpcapping/Pulpotomy

Pulp capping/pulpotomy procedures for permanent teeth are consistent with the diagnosis and have a good prognosis. Direct pulp capping/pulpotomy of permanent teeth is done only on the very young tooth with open apices and incomplete root formation, for the purpose of apexogenesis. All teeth are closely monitored for evidence of success or failure.

Method to Assess Criterion: Recorded findings support an assumption of normal pulp apical to the exposure/canal orifice(s) with a non-contaminated field. A pulp cap assumes an uncontaminated mechanical exposure of less than one millimeter in diameter. Radiographs of the involved permanent tooth reveal incomplete roots with open apices and no evidence of apical pathology. Documentation exists that patient has been placed on active recall.

B. Root Canal Therapy

Findings confirming the diagnosis and ruling out competing diagnoses are recorded on the patient's dental record and include a preoperative radiograph.

Method to Assess Criterion: Observe the patient's dental record and determine whether documentation for the diagnosis is recorded, including the availability of a preoperative radiograph. History, clinical symptoms, and possible pulp and periradicular test results are noted in the patient's dental record.

Postoperative radiograph(s) is to be available following fill. Each case has proper radiographic documentation. A *minimum* of two radiographs, a preoperative and postoperative film, are required. Working length and master cone films are strongly recommended.

Method to Assess Criterion: Observe the patient's dental record and determine if preoperative and postoperative radiographs were made.

Documentation of the fill follows guidelines in the *IHS Clinical Specialties in Dentistry* manual.

Method to Assess Criterion: Observe patient record for working length(s), reference points, and type of filling material and sealer. Postoperative instructions and recommended follow-up care must also be documented upon obturation.

Removal of coronal tooth structure is minimal but provides adequate access to pulp chamber and allows straight line access to the root canal system.

Method to Assess Criterion: Observe the preoperative and postoperative radiographs to determine that the endodontic filling materials conform to the original size and shape of the pulp chamber and root canal. Observe working length and postoperative radiographs to determine whether sufficient coronal tooth structure was removed to allow straight line access to the root canal system.

Formocresol is not routinely used as a medicament in permanent teeth.

Method to Assess Criterion: Observe patient record for name of medication used.

A postoperative radiograph indicates complete obturation of all root canals within 2 mm of, and not beyond, the radiographic apex, using non-resorbable filling material and a non-staining sealer (permanent teeth).

Note: N_2 and root canal pastes of similar composition do not have the acceptance of the ADA, nor are they approved for use by the FDA; therefore, their use is not currently indicated in the treatment of IHS patients.

Method to Assess Criterion: Observe the routine preoperative and postoperative radiographs and determine the adequacy of the obturation with a solid core primary filling material. Determine if filling material is within 2mm of the radiograph apex and not beyond.

Note: Observe the clinic supply for non-resorbable, non-staining sealer availability and patient dental records to see that the type of root canal sealer is recorded.

Criterion #7

Esthetic restorative material is used on all lingual access preparations in anterior teeth.

Method to Assess Criterion: Direct observation, radiograph, or review of patient's dental record.

A cusp-protecting restoration is used on posterior permanent teeth when either marginal ridge is violated or when remaining enamel structure is unsupported by dentin and lacks strength.

Method to Assess Criterion: Direct observation, radiograph, or review of patient's dental record for provision of cusp-protecting restoration.

A rubber dam is placed to isolate the operating area and act as a barrier to prevent aspiration or swallowing of root canal instruments.

Method to Assess Criterion: Observe endodontic procedures and note availability of rubber dam supplies in the clinic.

Periodontics

The record contains a written diagnosis by ADA-Case Type (Gingivitis, Early Periodontitis, Moderate Periodontitis, and Advanced Periodontitis) and recording of CPITN scores (0,1,2,3, or 4) determined by probing and radiographic evidence of pre-existing conditions. The initial recorded diagnosis is acceptable for the findings.

The diagnosis should be consistent with existing conditions observed in the mouth and/or documented. When definitive periodontal therapy is planned for patients with CPITN of 3 or greater, a periodontal work-up should be conducted. This includes probing pocket depths, radiographic evaluation, furca involvement, mobility, occlusal evaluation, and plaque retentive features. *If definitive periodontal services are not planned, the periodontal work-up should not be conducted.*

Method to Assess Criterion: Chart review and/or direct examination of the patient.

All dentate patients 15 years or older being provided routine dental care are informed of their periodontal status, treatment needs, opportunities for self-care, and have a description of periodontal treatment planned. If a full scope of periodontal services is not available at the particular clinic, a chart notation should be made that the patient has been informed of his/her need for treatment at another facility.

Method to Assess Criterion: Observe the patient record to determine whether patients were informed of their periodontal status and treatment needs consistent with their CPITN and periodontal assessment.

Periodontal treatment is documented, and consistent with, the need indicated by the initial diagnosis.

Method to Assess Criterion: Observe records of patients having all planned treatment completed within the last year to determine if the appropriate treatment plan was provided for sextants with CPITN scores of 2, 3, or 4, i.e., prophylaxis, supra and subgingival cleaning, surgical and/or non-surgical treatment.

Communication with the patient is professional and on a level so that the patient understands the educational information and accepts scaling and

root planing procedures. The provider is attentive to the patient's comfort level.

Method to Assess Criterion: Observe the patient and the provider's interaction during the procedure and note if levels of agreement or disagreement are acceptable. Question the patient to determine if the treatment was acceptable and tolerable.

Supragingival and subgingival cleaning are performed adequately.

Method to Assess Criterion: Observe the patient immediately following the procedure to determine if the contents of the pocket have been debrided and that irregularities and roughness of the root surface adjacent to the pocket have been removed and smoothed. Determine whether tissue trauma from scaling procedures is within acceptable limits.

Hygienists who administer local anesthesia are appropriately certified to do so.

Method to Assess Criterion: Question the hygienist about training and certification in local anesthesia. Review clinic records to verify certification.

The hygienist's progress notes and referrals are countersigned by a dentist. The hygienist's signature alone is adequate only if covered by standing orders in the clinic policy and procedure manual.

Method to Assess Criterion: Review the dental progress notes for countersignature, or verify that standing orders exist in the clinic policy and procedure manual.

A screening exit exam will be included in all treatment plans for routine patients examined with CPITN scores of 2, 3, or 4.

Method to Assess Criterion: Observe the patient record for the presence of an exit exam in the treatment plan, or a final CPITN for those completed patients who were initially diagnosed with any CPITN scores of 2, 3, or 4.

The patient is placed on a recall based on patient's disease status.

Method to Assess Criterion: Observe the patient record for documentation of plans for recall. Discuss the clinic recall policy with the clinic staff.

Periodontal surgery has been effective.

Criterion #10

Method to Assess Criterion: Observe the patient postoperatively to determine that periodontal pockets have been eliminated, the gingivae have been contoured to a morphologic and physiologic form, and deformities in the alveolar bone have been corrected to a physiologic form. Probe all sulcular areas with a calibrated periodontal probe to determine whether sulcus depths have been reduced (probe no sooner than 2 months post-surgery).

In the assessment, compare the pretreatment dental record findings with the post-treatment results.

Mucogingival surgery has been effective.

Method to Assess Criterion: Observe the patient postoperatively to determine that an increased zone of attached gingivae has been attained, undesirable muscle pull on the marginal gingivae has been dissipated, and/or the vestibular fornix has been deepened to allow for maintenance of health of the periodontium.

In the assessment, compare the pretreatment dental record findings with the post-treatment results.

Removable Prosthodontics

Pretreatment full-arch radiographs are available for all removable prosthetic patients (occlusal, panographic, or full mouth intraoral series).

Method to Assess Criterion: Review dental record.

The overall oral condition and the condition of selected abutment teeth promote success of the prosthetic case.

Method to Assess Criterion: A review of the radiographs, clinical exam, endodontic status, and perio charting will be used to determine the overall oral health and the probability of long-term success of abutment teeth selected to support a removable prosthetic appliance.

The appearance of the denture is esthetically acceptable to patient and examiner.

Method to Assess Criterion: The denture harmonizes with the patient's facial appearance. The positioning, shape, and shade of the teeth appear natural. Vertical dimension is within normal range. The acrylic base material is in good condition. Clasps are not unnecessarily visible. The patient expresses satisfaction with appearance of the prosthesis. Documentation should be made in the chart as to the patient's acceptance of the esthetic appearance of the prosthesis.

Stability/retention is acceptable.

Method to Assess Criterion:

a. Ask patient if dentures stay in place while eating and speaking. The stability/retention of the prosthesis is consistent with the limitations imposed by the ridge anatomy present.

b. *Full denture test:* Place forefinger on incisal edge of either maxillary or mandibular denture with sufficient force to blanch the finger. If denture becomes dislodged, it is considered to lack retention/stability.

c. *Partial denture test:* Place forefinger on any segment of partial denture framework and press firmly. If partial denture becomes dislodged or tips, it is considered to lack retention.

Flange of prosthetic appliance adapts to the soft tissue borders of the oral cavity.

Method to Assess Criterion: Gently retract lip to minimum degree that will allow you to observe whether flange of prosthetic appliance approximates the soft tissue borders. Note if dentures spring away from borders or lift up.

Note: Not applicable when anatomic conditions make the assessment unfeasible. The reason(s) should be stated in the patient's dental record.

Occlusion is acceptable.

Method to Assess Criterion:

a. *Check centric relation:* Close patient's jaw into centric relation (and/or acceptable habit position) by placing thumb on patient's chin and gently directing mandible to the most posterior position, with patient closing slowly at the same time. Note whether simultaneous bilateral contact of the teeth occurs, and whether substantially all of the teeth on each side touch. If not, or if shifting or sliding occurs, then occlusion is considered to be inadequate.

   Note: For all tooth-borne removable partial dentures, the point of reference is centric occlusion (functional occlusion).

b. *Check eccentric relation:* Ask patient to close and move jaw in all directions. Observe eccentric premature contact or lack of balancing contact on teeth from canine posteriorly and note any instability resulting from the eccentric relationship of the prosthesis. (Eccentric relation is considered adequate if none are noted.)

c. *Check occluding material:* Determine if unglazed porcelain occlusal or incisal surfaces are contacting enamel, gold, alloy, or composite resin. If so, rapid wear of the softer occluding surface will occur and occlusion must be considered unacceptable.

Criterion #7

Vertical dimension and anterior tooth arrangement are acceptable.

Method to Assess Criterion:

a. *Check "S" sounds:* Ask patient to say key words, such as Mississippi, sixty-six, whiskey, seventy-seven. When making "S" sounds, teeth should not contact. If so, appliance(s) is (are) considered inadequate.

b. *Check "F" and "V" sounds:* Ask patient to say key words, such as forty-four, fine food, vim and vigor, Vivian. When making "F" and "V" sounds, the incisal edges of #8 and #9 teeth should contact the wet-dry line of lower lip.

c. Ask patient if teeth seem too long or too short.

All "Cardinal Rules" of partial denture construction are met.

Method to Assess Criterion:

a. *Rest seats (depth):* Ask patient to remove partial denture. Observe clearance for rest seats with patient in centric occlusion. If unable to visualize, then place utility wax in patient's mouth and have patient close to centric occlusion. Remove wax and insert periodontal probe through wax in central area of identified rest seats until point of probe is exposed evenly with wax surface of opposite side. Determine visually whether wax in rest seat area is 1 to 1 1/2 mm thick.

b. *Rest seat (width):* Observe whether rest seats approximate one-third the width of the tooth (except in cingulum rests), and are positioned at a 90 degree angle to long axis of abutment tooth.

c. *Partial denture base:* Inspect removed partial denture and determine whether base material covers all supporting areas. Ask patient to replace partial denture in mouth and then use mouth mirror to observe whether retromolar pad(s) or tuberosity(ies) are completely covered without impingement of soft tissues in flange areas.

d. *Arms of clasps in undercut zones:* Attempt to dislodge partial denture from each abutment tooth by placing finger

under retentive clasp and applying firm force occlusally. If there is no resistance to the force, then retention is considered inadequate. If too much force is required, excessive mobility of the tooth occurs, or if the patient expresses difficulty in removing it, then retention may be excessive.

e. *Guiding planes:* Visually determine whether all guiding planes on abutment teeth are reasonably parallel to one another.

f. *Abutment teeth:* Observe that abutment teeth are in a good state of repair and well-polished.

g. *The tissue-bearing area:* Note any areas of tissue impingement, inflammation, or hypertrophy related to the partial denture. The partial denture should not have caused any apparent tissue damage.

All pertinent information concerning the prosthesis is recorded in the health progress notes. This must include shade, mould, and lab used. Also include lab fee quoted to the patient if applicable. A copy of the lab prescriptions (work orders) should be kept on file in chronological order.

Method to Assess Criterion: Review progress notes and lab files.

Fixed Prosthodontics

A. Crowns (all types)

Note: A crown is unacceptable *only* if the examiner recommends replacement of the crown due to one or more deficiencies noted in the following criteria:

Smooth marginal adaptation.

Method to Assess Criterion: Inspect the margins of the crown to determine if the marginal adaptation is acceptable. The marginal adaptation of the crown should be considered unacceptable if gingival irritation or blanching of the tissues is being caused by the crown or if the smaller end of the #17 explorer can be inserted between the inner surface of the crown and immediate tooth surface.

Occlusal functions are acceptable.

Method of Assess Criterion: Use articulating paper to assess premature contacts in centric and eccentric relations. Also observe whether there are heavy wear facets (or shiny areas) on any occluding surface by using mouth mirror and/or direct observation. If supraocclusion or infraocclusion was planned, it must be noted in the patient's dental record. Question the patient: "Does this give you any discomfort or pain when you eat? Does it seem higher than your other teeth?"

Contact is present.

Method to Assess Criterion: The contacts with the proximal teeth should be in the occlusal 1/3 of the proximal space and tight. Dental floss should pass through without tearing or shredding.

Crown contour is physiologic.

Method to Assess Criterion: Inspect the external contours of its cross-arch analog, if a natural tooth. If the mate is not present or grossly restored, utilize the contours of the tooth most nearly

representative of the test tooth. Compare with the aid of mouth mirror:

a. buccogingival contour
b. linguogingival contour
c. marginal ridge contour
d. embrasure spaces to ensure that they have a v-shape which avoids tissue impingement
e. total buccolingual width

The health of the tissue around the restored tooth (teeth) should not differ significantly from other tissue in the mouth four weeks after cementation.

Crowned, endodontically treated teeth have healthy characteristics which promote long-term success of the case.

Method to Assess Criterion: Review the radiographs, clinical exam record, endodontic status, perio charting, clinical appearance of the crowned tooth.

Porcelain shade blends favorably with remaining dentition.

Method to Assess Criterion: Under natural light, inspect the crown with its cross-arch analog using a Trubyte Bioform 24 button shade guide or Vita Lumen shade guide. If the mate is not present or is not a natural tooth, compare shades to the adjacent natural or opposing teeth. Shade blend should be within one shade of the matching button.

B. Fixed Bridges

Crowned abutments meet criteria #2, #4, and #6 listed under "A. Crowns (all types)"

Method to Assess Criterion: Refer to item "A. Crowns (all types)" of this document and apply the stated criteria and respective methods to be used for assessing whether the criteria are met.

Pontic(s) meet(s) the principles of form and tissue adaptation.

Method to Assess Criterion: Observe the form of pontic(s) by using mouth mirror and/or direct observation. Determine if:

a. Facio-lingual width of the pontic(s) approximate(s) two-thirds of the normal width of the replaced teeth.

b. Facial contour of the pontic(s) approximate(s) the normal contour of the replaced teeth.

c. Gingival contour approximates the alveolar process and mucosa. Pontic is convex, enabling self-cleansing capability. Consider *concave* (ridge-lapped) pontics unacceptable. Thread dental floss through the embrasure and pass the floss mesiodistally between the apex of the pontic and the mucosa of the alveolar process. For pontic to be considered acceptable, the floss should pass freely without impingement or bleeding of involved tissues.

Solder joints meet principles of adequate strength.

Method to Assess Criterion: Use mouth mirror and/or direct observation and apply the following principles for determining adequate strength.

a. Facio-lingual size of the solder joint should be about one-half of the facio-lingual width of the existing pontic.

b. The occlusal gingival side of the solder joint should be about one-half of the distance from the occlusal (incisal) edge of the pontic to its gingival base.

The overall oral condition and periodontal structures of abutment teeth are adequate to support the prosthetic appliance(s).

Method to Assess Criterion: Clinically observe abutment teeth and review the radiographs, clinical exam record, endodontic status, and perio charting. Observe that the patient's prosthetic service(s) received is compatible with the overall periodontal health and caries control, and that it promotes long-term success.

Esthetics are acceptable to the patient and examiner.

Method to Assess Criterion: Question the patient: “Are you satisfied with the appearance of the bridge?” Determine in your own mind whether the existing porcelain surfaces of the pontic and crowns are in harmony with the remaining natural teeth. Determine whether there is unsightly show of metal when smiling and talking.

Occlusal functions are acceptable.

Criterion #6

Method to Assess Criterion: Observe centric and eccentric movements; use articulating paper to assess premature contacts in centric and eccentric relations. Also, observe whether there are heavy wear facets (or shiny areas) on any occluding surface of the bridge by using mouth mirror and/or direct observation. Question the patient: “Does the bridge give you any discomfort or pain when you eat?”

Oral Surgery

A. Indirect Evaluation of Extractions/Surgical Procedures

The diagnosis leading to extraction or other surgical procedures is written in the dental record and is consistent with clinical findings.

Method to Assess Criterion: Observe the patient's dental record and determine whether documentation for the diagnosis is recorded, including the availability of a preoperative radiograph. History, clinical symptoms, including temperature and soft tissue findings, and possible pulp test results are noted in the patient's dental record.

Appropriate diagnostic preoperative x-ray(s) is/are available in the patient's dental record.

Method to Assess Criterion: Review of radiograph to assess presence of the entire tooth, including apex of root(s) and surrounding anatomy.

All postoperative complications receive appropriate follow-up treatment.

Method to Assess Criterion: Chart review. Specifically note use of culture and sensitivity tests, antibiotic regimens, I & D procedures, and recording of patient temperature.

All pathology reports based on cytology or biopsy are present in the patient records.

Method to Assess Criterion: Review patient's dental and/or medical record. Results must be recorded in the patient's progress notes by the dentist. When a tissue biopsy is performed, the patient record must include documentation of indications for biopsy, a copy of the pathology report, and evidence that the patient was notified of the results and received proper follow up. An additional "Biopsy Log" may be kept.

Appropriate preoperative systemic antibiotic therapy is provided patients requiring such, as specified by the American Heart Association.

Method to Assess Criterion: Review of patient primary health record. Observe that these patients have documentation and/or consultation to rule out need for antibiotic prophylaxis. If a prescription is written, it is documented that the patient has complied with regimen.

B. Direct Observation of Surgical Extractions

Standard principals of flap design have been accomplished, e.g., occlusal portion of flap design to extend at least one tooth adjacent to the interdental papilla both mesially and distally from the tooth to be extracted (exception to this would be extraction of the most distal tooth in the arch). Vertical incisions extend obliquely so that the base of the flap is wider than its margin, and the tissue of the retracted flap is not mutilated or torn.

Method to Assess Criterion: Observe the surgical flap procedure on patients present in the clinic receiving this service, or observe the flap design of revisit patients who receive this service and are present in the clinic for postoperative follow-up or suture removal.

Pathologic tissue is completely removed. There is no evidence of residual periapical or periodontal pathology, including root fragments at the surgical site, unless removal is contraindicated.

Alveolar margin is smoothed, and displaced fragments of the alveolus and foreign particles are removed.

Method to Assess Criteria #2 and #3: The examiner assesses these criteria by appropriate instrumentation and palpation, including a postoperative radiograph of the operative site when deemed necessary. On patients present in the clinic for postoperative follow-up or suture removal, the examiner may assess these criteria by palpation of the operative site and by viewing a postoperative radiograph. If root tips have been left, documentation exists for the decision, including postsurgical radiographs, and documentation exists that the patient has been informed and there is provision for recall.

Soft tissue flap is repositioned into anatomical position and maintained there with suture or gauze pressure pack.

Method to Assess Criterion: Inspect the surgical flap site to make certain the soft tissue is repositioned appropriately over alveolar bone without excessive tension.

Oral and written instructions concerning postoperative care of surgical or extraction services are given to patient (parent/guardian) and documented in the record.

Method to Assess Criterion: Observe whether oral and written instructions concerning postoperative care of surgical and/or extraction sites are given to the patient before dismissal.

Informed consent is obtained for oral surgery procedures. This should include a discussion of risks, benefits, and alternatives to treatment.

Method to Assess Criterion: Review patient record for the presence of formal consent form indicating procedure, risks, benefits and treatment alternatives, patient's signature, dentist's name, and date.

All use of conscious sedation for oral surgical procedures is performed under guidelines listed in the *IHS Oral Health Program Guide,* Section V.

Method to Assess Criterion: Review the clinic's *Policy and Procedure Manual* and the *IHS Oral Health Program Guide* for a conscious sedation protocol. See that all providers are properly credentialed for procedures they perform, that adequate emergency back-up is available, that there is proper CPR/ACLS certification, and that the proper monitoring equipment is utilized. This may include the pulse oximeter, EKG, and blood pressure device. Also note that proper informed consent is present for sedation and that there is adequate patient recovery and escort service available.

Orthodontics

The dental record contains documentation that patients (and/or their guardian) ages 6 to 20 have been advised of their orthodontic status and the availability of treatment at the IHS/Tribal facility or the need to seek private care.

Method to Assess Criterion: Chart review.

Practitioners providing interceptive and corrective orthodontic care who have not completed long term training in orthodontics can demonstrate a program of systematic review of selected cases by an orthodontic consultant. Practitioners providing orthodontic care have been granted privileges to provide that care and have documented training to support the level of privileges requested.

Method to Assess Criterion: Review the log of orthodontic patients for evidence of review of selected cases by an orthodontic consultant. Review practitioner's request for privileges and supporting documentation.

The following records of each patient undergoing comprehensive orthodontic therapy, which is to be provided only by an orthodontic specialist, are available:

a. Orthodontic examination (including the status of the TMJ), which is updated within six months of initiation of treatment.

b. Full mouth or panoramic x-rays.

c. Study casts with bite registration recording centric occlusion.

d. Cephalometric x-ray with the jaw in centric occlusion.

e. Pretreatment photographs: 1) full face at rest and smiling; 2) right and left profile; 3) right, left, and anterior intra-oral; 4) maxillary occlusal, and mandibular occlusal.

f. Treatment objectives established and recorded prior to treatment.

g. Written informed consent signed by parent/guardian which lists treatment objectives, expected outcome and limitations, patient compliance expected, reasons for discontinuing treatment before completion, and anticipated need for further specialty care.

h. Documentation of appropriately sealed teeth in children under age 14.

i. All other treatment completed (PTC except orthodontics) within the last 6 months.

j. Documentation that compliance with home care has been demonstrated prior to treatment.

Method to Assess Criterion: Review of patient's health record.

Assessment of completed cases must be made in conjunction with the treatment objectives established prior to treatment relative to findings in records and/or posttreatment cast concerning:

a. Molar relationship and cuspid relationship.
b. Changes in cephalometric form.
c. Arch expansion.
d. Axial inclination of anterior and posterior teeth.
e. Interproximal spacing.
f. Rotations.
g. Arch form.
h. Overbite correction.
i. Overjet correction.
j. Soft-tissue profile.

Method to Assess Criterion: Review the hallmarks of a well-treated orthodontic case, which include:

a. Good interdigitation of teeth.
b. Cuspids in Class I relationship.
c. Correction of rotations.
d. Correction of overbite or open bite.
e. Correct esthetic inclination of anterior teeth.
f. Correct root position of teeth (parallel roots).
g. Good arch form.
h. General maintenance of cuspid and molar width.

i. Minimal root resorption.
j. Minimal gingival recession.
k. Minimal occlusal interferences in centric relation, in balancing, and in working movements.
l. Minimal decalcification and no caries associated with the appliance.
m. Accomplishment of treatment objectives.

Orthodontic treatment and orthodontic extractions are preceded by an orthodontic consultation.

Method to Assess Criterion: Review patient dental record for evidence of orthodontic consult.

Adjunctive General Services

A. Drugs

Drugs prescribed for and/or administered to dental outpatients or inpatients are recorded in patient's primary health care record.

Drugs administered or prescribed are consistent with the written diagnosis.

Method to Assess Criteria #1 and #2: Review the described health problem(s) and determine the appropriateness of the prescribed drug(s) and daily dosage. Acceptable references, such as *American Hospital Formulary Service* or *Physicians Desk Reference,* may be used to resolve any differences of opinion.

Appropriate preoperative systemic antibiotic therapy is provided patients requiring such, as specified by the American Heart Association.

Method to Assess Criterion: Review of patient primary health record. Observe that all patients who are at risk for Subacute Bacterial Endocarditis (SBE) have documentation of antibiotic prophylaxis and that at each encounter it is documented that the patient complied with the prescribed antibiotic regimen.

Any untoward reactions to medication(s) are recorded in the primary health record. Any allergies to medication(s) are prominently displayed on the primary health record.

Method to Assess Criterion: Review of patient's primary health record.

When a sedative agent or nitrous oxide is administered, the indication for use, duration, concentration exposure and or dosage, monitored vital signs, any untoward reactions, restraints used, and patient status upon dismissal are recorded in the patient record.

Method to Assess Criterion: Chart review.

Dentists or hygienists who administer sedative drugs (inhaled, oral, intramuscular, or intravenous) can demonstrate that they are appropriately

trained to do so and that dentists have been granted privileges by the medical staff to perform the procedure(s).

Method to Assess Criterion: Review medical privileges and documentation of training in sedation for those dentists who administer sedative drugs. Review standing orders for hygienists and documentation of training in administering nitrous oxide/oxygen sedation.

B. Emergency Care

Basic emergency diagnostic and treatment equipment must be available in case of life-threatening episodes.

Method to Assess Criterion: Observe that any member of the dental staff can promptly locate and bring to the chairside the following equipment:

a. Sphygmomanometer (infant, child, and adult sizes)

b. Stethoscope

c. Ambu-bag and oxygen with mask and bags capable of positive pressure ventilation for infants, children, and adults

d. Oral pharyngeal airways (infant, child, and adult)

e. Emergency drug kit/crash cart as specified in the operations manual of the dental clinic or facility with appropriate dosages for children and adults

Emergency drug kit is up-to-date.

Method to Assess Criterion: Inspect the locked emergency drug kit and assure that expiration dates have not passed on any medications.

The dental staff has received annual CPR training.

Method to Assess Criterion: Current certification card or list of CPR-certified staff should be available.

Criterion #4

A clinic emergency plan exists for management of medical emergencies and is understood by the staff.

Method to Assess Criterion: Inspect the plans and interview staff for basic understanding of plan and procedures. Review documentation that the plan has been reviewed annually and/or question the staff on emergency protocol.

C. Environment

All housekeeping activities have been performed before clinical day begins.

Method to Assess Criterion: Observe the cleanliness and neatness of all areas of the dental clinic. If observation in the morning is not possible, then question the dental staff in accordance with the acceptability of the housekeeping activities being provided. Suggested areas to be considered are cleanliness of floors, walls, furniture, cabinets, dental chairs, dental units, wastebaskets, etc.

Note: The neatness and cleanliness of all working counter top areas are considered to be the responsibility of the dental auxiliary staff. Otherwise, supplies and/or materials may be disposed of accidentally by non-dental housekeeping personnel.

The current copy of the IHS Mercury Hygiene Guidelines (located in Section VI of the *IHS Oral Health Program Guide)* is on file and has been reviewed and/or studied by all dental staff within the current fiscal year.

Method to Assess Criterion: The dental officer will show the examiner a copy of the guidelines, as well as an attached page which contains signatures and dates of all dental staff indicating that they have reviewed the guidelines.

The possibilities of mercury toxicity are minimized by the dental staff through the practice of good mercury hygiene.

Method to Assess Criterion: Observe operations involving mercury transfer and determine whether the work surface is smooth, impervious, and suitably lipped to confine spilled mercury, and whether the floor covering is smooth and impervious. A mercury spill kit is available in the facility.

Scrap amalgam should be stored in a closed, labeled container under appropriate (e.g., x-ray fixer, commercial solution) liquid barrier. Water, mineral oil, or glycerin are not acceptable liquid barriers. Pre-encapsulated silver alloy is utilized to minimize the need to handle free mercury.

Criterion #4

Concentration of mercury vapors in the environment should be below the threshold limit value (TLV) of 0.025 mg Hg/m3, or in compliance with the Area Office of Environmental Health (OEH) policy.

Method to Assess Criterion: Ask to see a copy of the most recent mercury vapor level survey, and the Area OEH policy concerning mercury surveillance for dental clinics. Determine whether the mercury vapor level is below 0.025 mg Hg/m3 and/or if the facility is in compliance with the Area OEH policy.

Nitrous oxide/oxygen administration logs are maintained which permit monitoring of the duration of staff exposure to waste anesthetic gas.

Method to Assess Criterion: Review nitrous oxide/oxygen log.

Concentrations of waste anesthetic gas are within accepted levels.

Method to Assess Criterion: Review copy of most recent certification by the IHS Office of Environmental Health waste gas survey/report or records of local monitoring of nitrous oxide.

D. Infection Control Practices in the Dental Treatment Environment

Criteria for the evaluation of infection control practices are based upon the most recent recommendations of the IHS Dental Services Delivery Committee. The document "Recommended Infection Control Practices for Oral Health Programs Serving Native Americans" serves as a guide for quality assessment purposes. This document can be found in Section VI of the *IHS Oral Health Program Guide*.

An infection control policy for the dental facility has been reviewed and approved by dental and medical staff.

Method to Assess Criterion:

a. A copy of the most recent release of "Recommended Infection Control Practices for Oral Health Programs Serving Native Americans" should be available in the dental clinic. This document should contain the dated signatures of all dental personnel to verify their review of the document, as well as those of the Program Director or Service Unit Director and the Chairman of the Service Unit Infection Control Committee (or Clinical Director).

b. The reasons for any exceptions or significant variations to the recommended practices which the local facility has decided to adopt should be explained in writing, initialed by dental staff, and filed with the policy document.

The requirements of the "OSHA Bloodborne Pathogen Standard" are met by having documentation of an exposure control plan, training, and immunization record.

Method to Assess Criterion: Review of the dental staff, personnel records, and direct observation. Determine whether all dental staff have been given the opportunity to be immunized for hepatitis B and other diseases. Determine whether a surveillance record of the immunization status of each member of the dental staff is available for review. (The record should include sero-testing and dates of Tuberculin tests. Follow-up action is documented for employees with "positive" findings which require attention.)

Those staff members refusing the hepatitis vaccine must be informed of the risks and are required to sign a form stating that the vaccine has been offered and refused. Refusal of vaccine and notation of possible consequences must be recorded.

Written policy should exist to address the management of employees involved in patient care who have acute or chronic infectious conditions, including colds, flu, herpes or other skin infections, and any other known or suspected contagious condition.

Accepted infection control procedures are practiced prior to the delivery of care.

Method to Assess Criterion: Observe the performance of infection control procedures routinely practiced prior to the delivery of care for at least 10 patients, if possible. Evaluate each of the following

components of practice relative to the infection control methods recommended by the Indian Health Service.

Prior to Treatment:

a. *Health history:* A summary of findings is documented on Part II of IHS-42-1 (or other standard form if IHS forms are not used). Significant conditions should be noted clearly in the patient's record and addressed prior to treatment.

b. *Hand washing:* Hands are washed between patient treatment contacts and whenever gloves are changed. Nails are cleaned and without polish, jewelry is removed, and recent wounds are covered.

c. *Protective barriers:* Handles and switches on dental lights, x-ray equipment, patient records and other noncritical items are covered or prepared as recommended in Section VI of the IHS *Oral Health Program Guide.*

Accepted infection control practices are maintained routinely throughout the delivery of care for dental patients.

Method to Assess Criterion: Observe the performance of infection control procedures used routinely during the delivery of care based upon at least 10 patients, if possible. Evaluate each of the following components of practice relative to the infection control methods recommended by the Indian Health Service.

During Treatment:

a. *Protective barriers:* For protection of personnel and patients, gloves must always be worn when touching blood, saliva, or mucous membranes. Gloves must be worn by dental health-care workers when touching bloodsoiled items, body fluids, or secretions, as well as surfaces contaminated with them. Gloves must be worn when examining all oral lesions.

   Surgical masks, in addition to eye protection with solid side shields or chin-length plastic face shields, are mandatory for operator protection when splashing or splattering of blood or other body fluids or solids is likely.

Fluid-resistant gowns must be worn when clothing is likely to be soiled with blood or other body fluids. Home laundering of gowns is prohibited. Gowns should be changed when visibly soiled.

A rubber dam is used unless contraindicated.

b. *Handling of instruments and materials:* Adequate methods are employed to minimize "breaks" in aseptic technique during treatment. Four-handed dentistry is practiced when possible. The unit dose concept is applied and forceps are used to transfer or handle objects involved in treatment, especially when small items are removed from or placed into storage drawers, tray set-ups and other noncritical surfaces.

c. *Patient records:* Adequate measures are taken to minimize the contamination of patient records during and after treatment, especially when entries are made in the record.

Accepted infection control procedures are practiced after the delivery of care.

Method to Assess Criterion: Observe the performance of infection control procedures used routinely after the delivery of care based upon at least 10 patients, if possible. Evaluate each of the following components of practice relative to the infection control methods recommended by the Indian Health Service.

After Treatment:

a. *Operatory decontamination:* Environmental surfaces are disinfected with a suitable germicide before the next patient is seated. This includes the removal of "dirty" instruments and waste materials from the operatory, replacing protective barriers (e.g., headrest and bracket table covers), changing burs and handpieces, disinfecting control switches and other noncritical surfaces, and other measures recommended by the IHS (refer to "Recommended Infection Control Practices for Oral Health Programs Serving Native Americans.") All "sharps" must be placed in an approved sharps container. Biohazardous waste materials must be disposed of in covered refuse containers labeled "BIOHAZARD."

Air/water syringe tips must be autoclaved or disposable and changed between patients.

b. *Use and care of sharp instruments and needles:* Sharp items (needles, scalpel blades, endodontic files, orthodontic wires, and other sharp instruments) must be considered as potentially infective and must be handled with extraordinary care to prevent unintentional injuries. A one-handed technique or mechanical capping device must be used for the recapping of needles.

Disposable syringes and needles, scalpel blades, worn out and broken burs, endodontic files, orthodontic wires, and other disposable sharp items must be placed into puncture-resistant containers located as close as practical to the area in which they were used.

Review of the last 12 months injury reports.

c. *Instrument disinfection/sterilization:* In a designated cleanup area, dirty instruments are adequately cleaned (free of visible debris) before disinfection or heat sterilization methods are used. Persons involved in cleaning and decontaminating instruments must wear heavy rubber gloves to prevent hand injuries and eye protection with solid side shields. The lid should be in place on the ultrasonic cleaner during use to avoid splatter. Heat sensitive tape should be used on bagged or packaged instruments which are to be sterilized. Refer to “Recommended Infection Control Practices for Oral Health Programs Serving Native Americans” for the details of accepted practice regarding external/internal indicators. Sterilizer(s) are monitored on a weekly basis with biologic indicators (review records on file). Disinfection solutions should be diluted and replenished according to product instructions and volume of workload.

d. *Instrument storage:* Disinfected and sterilized instruments are placed in storage using accepted methods. The use of clear plastic autoclave bags is recommended when possible. Sterilized instruments/instrument packs must exhibit an expiration date (refer to “Recommended Infection Control Practices for Oral Health Programs Serving Native Americans” for instrument pack shelf life).

e. *Handpiece sterilization:* All surgical instruments including handpieces (high speed, low speed attachments, and prophy angles) must be used as an alternative.

Criterion #6

A written schedule should exist which describes general sanitation and housekeeping procedures for the dental facility. Housekeeping services should be available to remove refuse daily and to clean floor coverings (carpeting is not recommended in dental operatories).

Method to Assess Criterion: Review dental clinic policy.

Criterion #7

Incoming or outgoing orthodontic or prosthetic appliances are disinfected, and impressions and casts are handled according to recommended IHS infection control practices for oral health programs.

Method to Assess Criterion: Direct observation. Laboratory instruments and supplies (e.g., rag wheels, case pans, model trimmer, knives, and other frequently used equipment) are disinfected or sterilized according to an acceptable policy.

TECHNICAL QA SUMMARY SHEET -- 1

ORAL DIAGNOSIS

	Satisfactory	Unsatisfactory	Not Applicable*	Area AVG/Standard
A. Patient Records				
1. Dental Record				
2. PMH/1 Year				
3. Record in Ink				
4. 42–1/42–2				
5. SOAP				
B. Exam and Diagnosis				
1. Hard and Soft Tissue				
2. Diagnostic Aids				
3. Diagnosis/Findings				
4. Treatment Plan				
5. Treatment Plan/Diagnosis				
C. Radiographs				
1. X-Ray Exposure Policy				
2. Labeling				
3. Density/Contrast				
4. Distorted				
5. Overlapping				
6. Cone-cut				
7. Distal of Cuspids				
D. Radiological Protection				
1. Certification				
2. Lead Device				
3. Tube Position				
4. Film Not Held/Staff				
5. Tube Not Held/Staff or Pt				
6. Six Feet/Not in Path				
7. Only Necessary Persons				
8. Warning Signal				
9. Dosimeters Worn				
10. Lead Devices Stored				
11. Three Reports				
TOTALS				

*Explain

TECHNICAL QA SUMMARY SHEET -- 2

PREVENTION

	Satisfactory	Unsatisfactory	Not Applicable*	Area AVG/Standard
1. Prevention Plan				
2. OHE/Needs				
3. Prophy				
4. TF/Moderating Factors				
5. Sealants/Molars				
6. Sealant Technique				
7. Tobacco Use/Want to Quit				
8. Referral/Counsel Tobacco				
9. Recall/Individual Risks				
TOTALS				

RESTORATIVE

1. Treatment Explained				
2. Rubber Dam Used				
3. Preparation/Restoration				
4. Esthetics				
5. Postop Instructions				
TOTALS				

PEDIATRIC DENTISTRY

A. TX Plan/TX Pediatric Dentition

1. TX Plan/Carious Teeth				
2. 3+ Surface/SSC/Why Not				
3. Pulp Therapy/Diagnosis				
4. Pulpectomy/Postop Radiog				

B. Behavior Mgt of Ped Patient

1. Behavior/Type Restraint				
2. Dentist Trained/Privileged				
3. Informed Consent				
4. Response to Restraint				
5. Sedation Guidelines OHPG				

C. Space Maintenance

1. Premature Loss/Or Why Not				
2. Recall of Spacers				
3. Spacer Meets Criterion				
TOTALS				

*Explain

TECHNICAL QA SUMMARY SHEET -- 3

ENDODONTICS

	Satisfactory	Unsatisfactory	Not Applicable*	Area AVG/Standard
A. Pulpcapping/Pulpotomy				
1. Procedures/Diagnosis				
B. Root Canal Therapy				
1. Findings/Diagnosis				
2. Pre/Postop Radiographs				
3. Documentation of Fill				
4. Access Minimal				
5. Fill/2mm Apex/Material				
6. Restoration/Anteriors				
7. Restoration/Posterior				
8. Rubber Dam Used				
TOTALS				

PERIODONTICS

1. Written Diagnosis				
2. Routine Pts 15 y.o. Informed				
3. Treatment/Diagnosis				
4. Pt Accepts and Tolerates TX				
5. Supra/Subgingival Cleaning				
6. If LA/Hygienist Certified				
7. Countersign/Standing Order				
8. Screening Exit Exam				
9. Recall/Disease Status				
10. Perio Surgery Effective				
11. MG Surgery Effective				
TOTALS				

REMOVABLE PROSTHODONTICS

1. Radiographs				
2. Abutments/Oral Health				
3. Esthetics				
4. Stability/Retention				
5. Flange Adaptation				
6. Occlusion				
7. VD/Anterior Tooth Arrange				
8. Cardinal Rules of RPD				
9. Lab Info Recorded				
TOTALS				

*Explain

TECHNICAL QA SUMMARY SHEET -- 4

FIXED PROSTHODONTICS

	Satisfactory	Unsatisfactory	Not Applicable*	Area AVG/Standard
A. Crowns (all types)				
1. Margins				
2. Occlusal Functions				
3. Contact				
4. Contour				
5. Crowned Endo Tooth Status				
6. Procelain Shade				
B. Fixed Bridges				
1. Meets Crown Criteria 2,4,6				
2. Pontic Form/Tissue Adapt				
3. Solder Joints				
4. Abutments/Oral Health				
5. Esthetics/Patient/Examiner				
6. Occlusal Functions				
TOTALS				

ORAL SURGERY

A. Indirect Eval Ext/Surg Proc				
1. Written Diagnosis/Findings				
2. Preop Radiographs				
3. Postop Follow-ups TX				
4. Path Reports Present				
5. Appropriate AB Prophy				
B. Direct Observation/Surg Ext				
1. Flap Design				
2. Path Tissue Removed				
3. Alveolar Margin/Root Tips				
4. Flap Reposition/Suture				
5. Oral/Written Instructions				
6. Informed Consent				
7. Sedation/OHPG Guidelines				
TOTALS				

ORTHODONTICS

1. Pts 6–20 Advised of Ortho				
2. Review/Consultant/Privilege				
3. Records for Comprehensive				
4. Assessment/Findings				
5. Ortho Consult Before Tx				
TOTALS				

*Explain

TECHNICAL QA SUMMARY SHEET -- 5

ADJUNCTIVE GENERAL SERVICES

	Satisfactory	Unsatisfactory	Not Applicable*	Area AVG/Standard
A. Drugs				
1. Drugs Recorded				
2. Drugs/Diagnosis				
3. Appropriate AB Prophy				
4. Drug Reactions Recorded				
5. Sedation/N2O Documented				
6. Dentist/Hyg Trained Sedation				
B. Emergency Care				
1. Basic Emergency Equip				
2. Emergency Drug Kit/Dates				
3. Annual CPR Training				
4. Clinic Emergency Plan				
C. Environment				
1. Housekeeping				
2. Hg Hygiene Guidelines				
3. Mercury Hygiene				
4. Hg Vapor Levels/OEH				
5. Nitrous Oxide Log				
6. Waste N2O Levels/OEH				
D. Infection Control Practices				
1. Infection Control Policy				
2. OSHA Std/Records Review				
3. Procedures Prior to Care				
4. Procedures During Care				
5. Procedures After Care				
6. Written Schle/Housekeep				
7. Lab Cases Disinfected				
TOTALS				

*Explain

TECHNICAL QA SUMMARY SHEET -- 6

SUMMARY

Category	Satisfactory	Unsatisfactory	Not Applicable*	Area AVG/Standard
Oral Diagnosis				
Prevention				
Restorative				
Pediatric Dentistry				
Endodontics				
Periodontics				
Removable Prosthodontics				
Fixed Prosthodontics				
Oral Surgery				
Orthodontics				
Adjunctive General Services				
TOTAL				

*Explain

TECHNICAL FEEDBACK FORM
(Provide to Evaluatee at Close-Out Session)

COMPONENT_____

Criterion considered unsatisfactory: _____
Describe deficiencies related to this criterion:

_____
_____
_____
_____

Criterion considered unsatisfactory: _____
Describe deficiencies related to this criterion:

_____
_____
_____
_____

Criterion considered unsatisfactory: _____
Describe deficiencies related to this criterion:

_____
_____
_____
_____

Criterion considered unsatisfactory: _____
Describe deficiencies related to this criterion:

_____
_____
_____
_____

Plan of action for correcting deficiency(ies):

_____
_____
_____
_____
_____
_____
_____
_____

Signatures: _____ _____ _____
Evaluator Evaluatee Date

cc: Service Unit Director/Tribal Health Administrator

SAMPLE LETTER

To: _____
Service Unit Director/Tribal Health Administrator Date

Attn: _____
Dentist/Program Personnel

From: _____
Evaluator

_____
Location Area

Subject: Scheduling and Preparation for Dental Quality Assessment Evaluation Visit.

As previous established in our telephone conversation, I plan to visit and evaluate your Dental Program on:

Date(s)_____ From time:_____ to time: _____

For the convenience of those patients and staff involved, it will be desirable to observe the schedule outline as follows:

Pre-evaluation Conference with dentist and/or appropriate staff Time: _____

Evaluation Time: _____

Post-evaluation Conference with Evaluatee Time: _____

Please contact me if any changes in this schedule need to be made. It is suggested that you review and become familiar with the evaluation criteria that will be reviewed prior to the evaluation. It would also be helpful if indicated file material, lists, data, and minutes of applicable meetings are collected prior to the evaluation visit.

The purpose of the evaluation is to assist you and your staff in the enhancement of dental care available to the local community, as well as identifying your dental program needs. It is meant to be an open and ongoing process contributing to the exchange of information.

I look forward to sharing this educational experience with you.

Name: _____
Evaluator

_____
Title

_____
Location

Additional comments or instructions:

cc: Area Dental Consultant
Chief, Dental Unit/Tribal Dentist

Indirect Review of Clinical Quality and Risk Management (Chart Review)

CHART REVIEW

Service Unit _____ Facility _____

Evaluator _____ Date _____

Chart Number: _____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

	Yes	No

A. Health Questionnaire, Exam, Treatment Plan

1) A health questionnaire has been completed and signed by the patient or legal guardian within the last 12 months.
2) Medical history is updated and so noted at each visit. This is documented with the reviewer's initials, date, and changes or "no change" in medical status.
3) Evidence of soft tissue exam is present, either by listing of abnormalities or designation of "STN" (Soft Tissues Normal) or "WNL" (Within Normal Limits).
4) All hard tissue pathology observable on available radiographs is recorded in the dental records. Documentation that radiographs have been read exists in the patient record.
5) Periodontal status (for patients age 15 and older) and orthodontic status (for patients ages 6 to 20) are noted on the dental exam sheet.
6) Written treatment plan exists for all patients receiving initial or recall dental exams.
7) Treatment plan is easily understood, follows a logical sequence, and includes an exit exam.
8) All entries in the dental record are written in ink (preferably black ink).

Comments, Section A:

Total # Yes _____

Total # No _____

% Yes _____

Yes No

B. Dental Progress Notes (IHS 42-2)

1) Progress notes are legible and clearly describe the treatment provided.
2) Appropriate and legible procedure codes are used for all treatment provided.
3) Each initial patient visit during the fiscal year is coded 0000 and each revisit during that fiscal year is coded 0190.
4) Dental Progress Notes include date of treatment, age and sex of patient, and signature and degree of the provider(s).
5) Progress notes indicate that dental auxiliaries routinely initial the procedures they perform.
6) Dental Progress Notes include a disposition at the end of each visit.
7) Documentation of informed consent is present when physical constraints (including hand-over-mouth, mouth props, or wraps) are used.

Comments, Section B:

Total # Yes _____

Total # No _____

% Yes _____

C. Drugs Administered or Prescribed

1) Drugs administer or prescribed are consistent with the written diagnosis.
2) Drug dosages are within limits recommended by the *Physician's Desk Reference* or *American Hospital Formulary Service.*
3) All drugs and dosages are entered in the medical and/or dental progress notes.
4) Reactions and allergies to drugs are prominently displayed in dental record and on outside of medical chart.

Yes No

5) If the medical history suggests that prophylactic antibiotics may be necessary, determination of need or lack of the need is documented.
6) Patients who need prophylactic antibiotics receive the prophylactic antibiotic regiment currently recommended by the American Heart Association.
7) Documentation exists that the patient complied with the prescribed antibiotic regimen and that the dental procedure began after the recommended time interval.
8) Informed written consent is obtained for patients receiving conscious sedation.

Comments, Section C:

Total # Yes _____

Total # No _____

% Yes _____

D. Radiographs

1) Radiographs are dated and are labeled with name or chart number, and dental assistant initials. (Score per radiograph)
2) Radiographs are of good diagnostic quality with regard to density, contrast, and lack of overlapping, conecutting, or distortion. Bitewings include distal surface of erupted cuspid and mesial surface of the most posterior erupted tooth in each quadrant. (Score per radiograph)
3) The types and frequency of radiographs meet the following broad classifications. (Score per patient)

   a. *Initial Adult*

   An initial radiographic examination, consisting of posterior bitewings supplemented with anterior and/or posterior films and/or panoramic radio-graphs, as required by oral conditions, is recommended for all individuals *15 years old and older.* Panoramic or full-mouth intraoral radiographic films are appropriate when the patient presents with clinical evidence of generalized dental disease or history of extensive dental treatment.

Yes No

b. *Initial Child (age 1–14)*

Prior to the eruption of the first permanent tooth, bitewing films (if interproximal surfaces cannot be visually inspected) are supplemented with anterior and posterior periapical films, as required by oral conditions. Individualized radiographic examinations consist of a periapical/occlusal or panoramic examination when clinical evidence or history indicate the need for additional radiographic examination. A full-mouth radiographic exam (panoramic or intraoral periapical) is performed *beginning at age 9.*

c. *Recall*

1. Bitewings and/or periapical radiographs are taken at intervals as required by the patient's general condition.
2. In the absence of specific indications for more frequent radiographs, a panoramic radiograph or full-mouth intraoral periapical series is not taken more often than once every five years.

d. *Emergency Examination*

An appropriate diagnostic radiographic examination of the area in question is performed for emergency patients.

Comments, Section D:

Total # Yes _____

Total # No _____

% Yes _____

E. Dental Emergency Treatment

1) "SOAP" or similar format is used for each dental emergency patient to document chief complaint, objective findings, diagnosis, and treatment plan in the patient record.
2) Diagnosis is consistent with subjective and objective findings.

Yes No

3) Treatment is consistent with the diagnosis and is definitive in nature.
4) Evidence of an intraoral screening exam is present for emergency patients, either by listing of abnormalities (e.g., gross caries, periodontal disease, soft tissue lesions) or "WNL" (within normal limits).

Comments, Section E:

Total # Yes _____

Total # No _____

% Yes _____

F. Endodontics

1) Preoperative and postoperative radiographs are available for each tooth receiving endodontic treatment.
2) Findings confirming the diagnosis and ruling out competing diagnoses are entered in the dental record.
3) Postoperative radiograph indicates complete obturation of all root canals to within 2 mm of and not beyond the radiographic apex (refers to primary filling material, not sealer).
4) Dental record indicates that a non-resorbable primary filling material and non-staining sealer are used in the endodontic treatment of a permanent tooth, that a resorbable filling material is used for a primary tooth, and that formocresol is not routinely used in permanent teeth.
5) Working lengths, reference points, and instrument sizes are recorded in the patient record.
6) An esthetic restorative material is used to restore each lingual access preparation.
7) Choice of restoration on each posterior endodontically-treated tooth meets the need for cusp protection (i.e., provision of a crown or a cusp-protecting amalgam restoration).

Yes No

8) Postoperative instructions and recommended follow-up care are documented at the obturation appointment.

Comments, Section F:

Total # Yes _____

Total # No _____

% Yes _____

G. Oral Surgery

1) The diagnosis leading to extraction or other surgical procedure is written in the dental record.
2) The chosen surgical procedure is consistent with the diagnosis.
3) A preoperative radiograph showing the apex of each root is available for all teeth extracted.
4) In the event of untoward outcome or postoperative complications, the dental record indicates appropriate treatment of these complications and arrangements for follow-up treatment.
5) If sutures are placed, type and number are documented.
6) Informed consent includes documentation of discussion of risks, benefits, and alternatives to treatment.
7) All pathology reports and evidence that the patient was notified of appropriate follow-up are present in the patient record.
8) Any documented difficult surgical procedure or untoward outcome has appropriate follow-up arranged.

Comments, Section G:

Total # Yes _____

Total # No _____

% Yes _____

Yes No

H. Pediatric Dentistry/Orthodontics

1) All carious teeth are addressed in the treatment plan.
2) An SSC is provided or planned for each primary molar with three or more carious surfaces or pulp therapy, unless contraindications are documented.
3) When an indirect pulp cap is performed, there is documentation present to support a diagnosis of reversible pulpitis.
4) All primary teeth receiving pulpectomies have preoperative and post-fill periapical radiographs.
5) In cases where rubber dam is not used for restorative procedures, the reason for non-use is documented. (In clinics where there is no evidence of documentation of non-use of the rubber dam, the provider(s) should be questioned as to whether the rubber dam is used for all restorations.)
6) The dental record indicates that space maintenance is provided or planned for each prematurely lost primary molar, or reason for nonprovision is documented, and there is provision for appropriate recall (6 months or less).
7) Documentation of the behavior for all children under the age of 6 is included on the IHS 42-2, as well as behavior management techniques used and their level of effectiveness.
8) Use of sedation is documented by the presence of a completed form IHS-831 or by listing information required in Section V of the *IHS Oral Health Program Guide.*
9) Documentation that patients are informed of need for orthodontic treatment is present.
10) Request for extraction from an orthodontist is documented in the patient record.
11) Pretreatment full mouth or panographic radiographs are available for each patient undergoing orthodontic treatment.
12) Pretreatment study casts are available for each patient receiving orthodontic treatment.

Yes No

13) Orthodontic treatment plan and treatment provided are consistent with pretreatment findings.

Comments, Section H:

Total # Yes _____

Total # No _____

% Yes _____

I. Periodontics

1) The record of patients receiving a complete dental exam contains CPITN/PSR scores and a written diagnosis by ADA-Case Type (Gingivitis, Early Periodontitis, Moderate Periodontitis, or Advanced Periodontitis), based on probing and radiographic evidence.
2) When definitive periodontal therapy is planned for patients with CPITN/PSR of 3 or greater, a periodontal work-up is conducted. This includes probing pocket depths, furca involvement, mobility, and occlusal features, with documentation on form IHS-514.
3) Preoperative radiographs of areas receiving periodontal treatment are present in the dental chart.
4) Diagnosis and treatment plan are consistent with preoperative findings.
5) Dental record contains evidence of patient counseling in home care procedures for all patients receiving periodontal treatment.
6) The hygienist's progress notes and referrals are countersigned by a dentist. The hygienist's signature alone is adequate only if covered by standing orders in the clinic policy and procedure manual.
7) A screening exit exam for patients receiving perio treatment includes a CPITN score.
8) The record indicates that each patient has been placed on a recall which is based on that patient's periodontal disease status and the clinic recall policy.

Yes No

9) All dentate patients 15 years or older being provided routine dental care are informed of the periodontal status, treatment needs, opportunities for self-care, and have a description of periodontal treatment planned. If a full scope of periodontal services is not available at the particular clinic, a chart notation should be made that the patient has been informed of his/her need for treatment at another facility.

Comments, Section I:

Total # Yes _____

Total # No _____

% Yes _____

J. Preventive Dentistry

1) The dental record contains an individualized dental disease prevention plan, including assessment of the following needs:

   a. Systemic fluoride
   b. Professionally-applied topical fluoride
   c. Self-applied topical fluoride
   d. Fluoride toothpaste
   e. Pit and fissure sealants
   f. Preventive periodontal treatment
   g. Tobacco counseling
   h. OHI and other health education
   i. Recall

2) Persons with one or more smooth-surface carious lesions will receive a professionally-applied topical fluoride application. A schedule of up to four applications per year may be followed, based on the presence of moderating factors documented for the patient. Moderating factors include: age, present caries activity, past caries activity, exposure to other sources of fluoride, sugar intake and frequency, amount of plaque, dental anatomy, and family history.

3) Fluoride supplements are offered for each patient under age 16 who does not have access to drinking water containing adequate levels of fluoride.

Yes No

4) Sealants are placed on unrestored, non-carious or incipient carious pit and fissure surfaces of all permanent first and second molars within two years of eruption.
5) The record indicates that patients who are tobacco users are asked if they want to quit using tobacco.
6) The record indicates that tobacco cessation counseling was provided or recommended for patients who indicated that they wanted assistance in quitting tobacco.
7) The patient is placed in a recall program based on his/her individual risks, rather than arbitrary time intervals. The patient's recall category is consistent with the diagnosis, treatment received, and medical condition, e.g., diabetes, rampant caries, pregnancy, and perio status.

Comments, Section J:

Total # Yes _____

Total # No _____

% Yes _____

K. Prosthodontics

1) Preoperative periapical radiographs of fixed bridge or partial denture abutment teeth are present in the dental record.
2) Radiographic and other diagnostic findings indicate that the periodontal condition of the abutment teeth is adequate to support the prosthesis, e.g., Ante's Rule for fixed bridges.
3) Pretreatment full-arch radiographs (occlusal, panographic, or FMX) are available for all full denture patients.
4) Prosthetic treatment plan exists and is consistent with preoperative findings.
5) Shades, moulds, laboratory, and type of metal used for the prosthesis are recorded in the dental chart for future reference.

Yes No

6) Laboratory Rx slips are stored for future reference.

Comments, Section K:

Total # Yes _____

Total # No _____

% Yes _____

L. Restorative Dentistry

1) Restorative materials are used appropriately for satisfactory esthetic results and as accepted for use by the ADA.
2) Recent bitewing radiographs (no older than two years) show absence of obvious overhangs, open margins, or open contacts on restorations previously placed by the dental staff being evaluated.
3) In cases where rubber dam is not used, the reason for non-use is documented. In clinics where there is no evidence of documentation of non-use of the rubber dam, the provider(s) should be questioned as to whether the rubber dam is used for all restorations.

Comments, Section L:

Total # Yes _____

Total # No _____

% Yes _____

SUMMARY OF DENTAL CHART REVIEW

	% Yes or "NA"	Area Average
A. Health Questionnaire, Exam, Tx Plan	_____	_____
B. Dental Progress Notes	_____	_____
C. Drugs Administered or Prescribed	_____	_____
D. Radiographs	_____	_____
E. Dental Emergency Treatment	_____	_____
F. Endodontics	_____	_____
G. Oral Surgery	_____	_____
H. Pedodontics/Orthodontics	_____	_____
I. Periodontics	_____	_____
J. Preventive Dentistry	_____	_____
K. Prosthodontics	_____	_____
L. Restorative Dentistry	_____	_____

(80% is considered satisfactory for each category)

Recommendations from Chart Review:

1.

2.

3.

4.

Signatures: _____ _____ _____
Evaluator Evaluatee Date

cc: Service Unit Director/Tribal Health Administrator

Evaluation of Community Involvement in Oral Health Programs

Introduction

COPC

The Indian Health Service embraces the concept of Community Oriented Primary Care (COPC). In this model, systematic mechanisms describe the health status and needs of a defined population (a "community"). Dental programs are planned in response to, and evaluated by use of, this information. Fundamental elements of this approach include: planning based upon epidemiological methods, universal coverage of the population, and involvement of the population served in health policy decisions.

Primary Preventive Services

In general, universal coverage of the population is possible if broad access to primary preventive services is made available. If such services are effective, a smaller proportion of the population will need secondary preventive services, and still fewer people will need tertiary preventive services. Consequently, service delivery mechanisms are selected to use the most cost-effective method of providing each level of preventive service. It is often appropriate to deliver services outside of the dental clinic to provide broad access to primary prevention.

Continuity of Care

Continuity of care is also an important principle of operation. Whereas it is common to consider continuity of care of individual patients, the COPC approach requires continuity of care throughout the community. Access to and adequacy of lower levels of preventive services must be monitored, and those individuals who continue to be at high risk, in spite of these efforts, should be offered more intensive services.

In addition to this risk assessment and referral component of continuity is the aspect of continuity of care over time. The coordination of efforts and assurance of continuity, despite ever-changing arrays of individuals in social and health care agencies, requires active interdisciplinary linkages. This includes not only the maintenance of information about resources and participants, but also agreement of all parties as to operating protocols and objectives.

Community Involvement

Finally, the identification of problems most significant to the community, the selection of methods most appropriate for the situation, and the development of programs acceptable to the community all require community involvement. Broadly defined, community involvement is participation by the community in those decision-making processes which directly or indirectly affect the oral health of individuals in the community. It is an important aspect of both COPC and Indian self-determination and connotes an interactive process. This interactive process involves the health system in various community activities, as well as involving individuals and groups in the services provided by the health system.

The following criteria address many of the above activities in the community which are known to have a positive influence on oral health:

Crit. #1 An ongoing community water fluoridation program is conducted at the community level. At a minimum this program consists of the following components:

Crit. #1a A Service Unit plan exists and is used to promote, implement, and provide surveillance for fluoridated community water systems which serve a Native American population of at least 25 homes.

Meth. to Det. Review Service Unit Fluoridation Plan annually. This plan should include a list of fluoride-deficient water systems, review of systems status, prioritizing of target systems, and activities planned to promote implementation at targeted sites.

COMMENTS:_____

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Crit. #1b The *Service Unit Fluoridation Committee/Team has met during the past four months and has developed and implemented a plan for increasing or maintaining fluoridation compliance** to at least 75 percent.

Meth. to Det. Review Fluoridation Committee/Team meeting minutes and fluoridation compliance plan.

COMMENTS:_____

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** Any reference to Service Unit fluoridation committees/teams could also refer to Tribal or Urban health committees/teams.*

*** A water system is considered to be in compliance for the year if the time-weighted fluoride concentration, determined by three samples per system per month, is within the optimum range for 9 out of 12 months.*

Crit. #1c The Service Unit Fluoridation Committee/Team assesses the compliance of those community water systems currently mechanically fluoridating their water supply, with a goal to increase coverage to 60 percent of the population (Year 2000 Oral Health Objective).

Meth. to Det. The records of fluoride levels in public drinking waters during the previous 12 months should be reviewed. The number of people and percentage of *total population* having access to optimally fluoridated water for at least 9 of the 12 months should be estimated.

COMMENTS:_____

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Crit. #1d A reliable mechanism exists for testing fluoride levels in the community and individual well water sources.

Meth. to Det. Review of testing and charting system.

COMMENTS:_____

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Note: CDC recommends use of the ion probe for fluoride testing for prescribing fluoride supplements.

Crit. #2 Schools with at least 30 percent American Indian/Alaska Native (AI/AN) enrollment promote school fluoride mouthrinse and/or toothbrushing (with a fluoridated dentifrice) programs for reducing the incidence of dental caries, unless unwarranted due to documented low caries rates.

Meth. to Det. Survey dental staff and/or school administrators to determine how many schools have fluoride mouthrinse and/or toothbrushing programs and how many more could be implemented.

COMMENTS:_____

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Crit. #3 A sealant program exists for those schools with at least 30 percent AI/AN enrollment. These programs provide pit and fissure sealants on permanent molars for at least 80 percent of all AI/AN school children six to eight years and 12 to 15 years. An evaluation method for retention of sealants should also be conducted.

Meth. to Det. Review dental data and participate in discussions with dental staff and/or school administrators. Conduct random chart reviews to determine if 80 percent compliance is being met. Review any available retention studies.

COMMENTS:_____

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Crit. #4 Oral health education curricula are provided for schools with at least 30 percent AI/AN enrollment.

Meth. to Det. Survey dental staff and/or school administrators to determine how many schools have oral health education curricula and how many more schools could be included.

COMMENTS:_____

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Crit. #5 Programs have been established to make oral health services available to individuals/families, and target groups at high risk for oral disease. These groups may include diabetics, tobacco users, Head Start children, and other special population groups as identified in the PL 94-437 oral health objectives.

Meth. to Det. Review community health plan and perform chart reviews to determine whether needs of high-risk individuals are addressed. The Community-Based Activity Reporting System (CBARS) can be used to measure preventive activities by target groups.

COMMENTS:_____

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Crit. #6 The dental program has provided oral health in-service training to non-dental health professionals in the past 12 months. An evaluation of the training should be conducted.

Meth. to Det. Review annually the number of presentations to non-dental health professionals and the number of participants. CBARS should be used to provide documentation. An evaluation method to assess appropriateness and effectiveness should also be reviewed.

COMMENTS:_____

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Crit. #7 The dental program participates in community health activities and promotes community-based oral health promotion/disease prevention programs based on the needs of the community. An evaluation is conducted on these programs.

Meth. to Det. Review dental program participation in school-based programs, health fairs, health professions recruitment, community meetings, Head Start functions, etc. CBARS should be used to document these activities. **These activities should support the oral health objectives specified in each Service Unit/Tribal/Urban preventive plan.**

COMMENTS:_____

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Crit. #8 Dental clinic staff have identified and participated in effective primary health care education or services delivery programs, e.g., diabetes, tobacco education, Well Baby, and WIC programs.

Meth. to Det. Review policies and procedures of dental program to assess involvement with other primary health care programs. Ask primary health care program directors if dental program could improve role in education or services delivery. Review any program evaluations.

COMMENTS:_____

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Crit. #9 Local Tribal administration is involved in planning, implementation, and evaluation of oral health promotion/disease prevention programs. Opportunities for local Tribal participation have been presented and explored.

Meth. to Det. Review documents (Tribal health committee meeting minutes and/or correspondence from the dental program) to the Tribe to determine what efforts have been undertaken. Determine that dental program staff have met at least once in the past year with the Tribal health leaders, e.g., Tribal health director, Tribal council, Tribal chairman, or council members. CBARS can also be used to document these efforts.

COMMENTS:_____

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Crit. #10 Community satisfaction assessments have been conducted during the preceding year. Findings have been incorporated into changes in programs and policies.

Meth. to Det. Review data from any available community satisfaction assessments and actions which have resulted from this process.

COMMENTS:_____

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Crit. #11 The Dental Program develops and routinely monitors and evaluates a community-based BBTD/rampant caries prevention program.

Meth. to Det. Review dental prevention plans to assess appropriateness and effectiveness of collaborative efforts. Review annual dental data reports or other surveys to assess the incidence of disease in target population (0-3 years). An annual evaluation method should also be in place. Knowledge, skill, and attitude surveys should be developed with evaluation at regular intervals to assess program progress.

COMMENTS:_____

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Crit. # 12 An annual evaluation process should be implemented for a select number of the criteria.

Meth. to Det. Review evaluation methods and analysis. Discuss findings and how changes have been incorporated into programs.

COMMENTS:_____

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Community Feedback Form

Describe strengths of the community component of the dental program:

Describe any weaknesses of the community component of the dental program:

Recommendations for improving the community component of the dental program:

Signatures:_____ _____ _____

Evaluator Evaluatee Date

cc: Service Unit/Tribal Health Administrator

Evaluation of Management of Oral Health Programs

Introduction

Management Challenges

Management of clinical dental programs in the Indian Health Service presents the clinical manager with a variety of unique challenges. Organizational variability between Areas and Service Units, decentralized management, and Tribal contracting are but a few factors which contribute to the variability present within dental programs which serve American Indians/Alaska Natives. Nonetheless, certain core management elements should serve as a nucleus for the management of these programs.

Format

In this section of the quality assessment document, certain questions are posed to dental managers. These questions generally require a yes/no answer or other short response. It should be noted that there is no mechanism provided to convert the results into a "score." The value of this format lies in its ability to stimulate communication during the review process.

Measurements

This evaluation measures productivity, cost-effectiveness, and appropriateness of dental services delivered in public health dental programs which exist in Tribal, Urban, and IHS programs. These data and calculations are useful as a baseline for determining the present status of the program and for planning and evaluating planned changes in the direction of the program. Much of this can only be measured by reviewing process indicators which are believed to contribute to effectiveness and efficiency of the program. More specific outcome measurements are derived by reviewing the dental data indicators listed on pages VII-100 to VII-102. Results can be compared to averages from other IHS and Tribal programs and data from contracting patients to dentists in private practice.

Review Results

After completion of a management QA review, the evaluator will be able to develop a list of program strengths as well as a list of recommendations to improve program management.

Since this document is intended for review of core elements, it may be necessary to add review elements locally to deal with those

items unique to individual programs.

Yes No

A. Policy and Procedure Manual

1. Does a *Dental Policy and Procedure Manual* exist for the facility?
2. Is the *Dental Policy and Procedure Manual* reviewed annually and updated to reflect current practices?
3. Does the *Dental Policy and Procedure Manual* contain the following items?
   a. Definition of services available
   b. Protocols for referral of routine and emergency procedures to/from other IHS facilities and private offices
   c. Standards and procedures for routine clinic operations or references to supporting documents for the following:
      1) Equipment maintenance schedules, repair policies, and documentation of staff training in safe use of equipment
      2) Handling tissue specimens
      3) Continuing education policies
      4) Credentialing process
      5) Staff privileging
      6) Use of standing orders if used by the clinic
      7) Inventory/procurement procedures
      8) Prescription procedures (inpatient and outpatient)
      9) Infection control protocols
      10) Bloodborne pathogen exposure control plan
      11) Mercury safety, radiological protection procedures, and nitrous oxide policies
      12) Response to medical device recalls and hazard notices

Yes No

d. Definition and responsibilities for determining patient eligibility for direct and CHS care

e. Appointment policies (routine, emergency, deferred, recall, broken, canceled)

f. Statement of regular clinic hours and provisions for after-hours and emergency coverage

g. Written leave policy for commissioned corps commissioned corps, civil service, and/or Tribal employees

h. Protocols for dealing with emergencies (medical, fire, disaster, etc.)

i. Policy for the utilization of dental laboratories

j. Accurate organizational chart representing lines of authority

4. Is there an up-to-date copy of the *IHS Oral Health Program Guide* in the clinic?

5. Is a written “Patient Bill of Rights and Responsibilities” posted?

6. Has a patient satisfaction questionnaire been completed within the last year?

7. Is there a formal mechanism for monitoring patient complaints and resolving complaints to improve care?

8. a. Is a written Service Unit/Tribal dental plan available which includes community and clinical oral health promotion/disease prevention objectives?

   b. Has the Service Unit/Tribal dental plan been updated for the current fiscal year, and has it been reviewed and signed by all Service Unit/Tribal dental staff?

9. Has the Service Unit/Tribal dental plan been presented to the Tribal health board for approval and/or comment?

10. _____Are dental staff meetings held regularly?
    If so, how often? _____

11. Are minutes of previous dental staff meetings available?

12. Has a budget listed by object classes been completed for the current fiscal year?

13. Does the budget include both direct and CHS activities?

	Yes	No
14. Have equipment replacement lists been updated within the past year?		
15. Which facility committees have dental representatives?		

_____

_____

_____

16. Is a protocol in place for orientation of new dental staff and documentation of orientation to dental program and hospital or clinic?		
17. Does each employee have a current and accurate position description?		
18. Does each commissioned officer have a current and updated billet description?		
19. Do current standards of performance exist for each dental employee?		
20. Are all dental assistants currently certified in radiology?		
21. Does each dental officer have a current and unrestricted dental license in at least one state?		
22. Have the training needs of each dental employee been identified for the current fiscal year?		
23. Is the selection of training for employees based on needs identified for the Service Unit/Tribal/Urban program and the individual?		
24. Is in-service dental training available to the dental staff?		
25. Does the clinic have a Hazardous Material Communication Program?		
26. Have employees been trained to handle hazardous materials encountered in the dental clinic environment?		
How is this documented? _____		
27. Is there an OSHA #2203 or similar poster in the dental clinic which contains a summary of the Occupational Safety and Health Act of 1971?		

Yes No

28. Is there evidence of Bloodborne Pathogen Standard training for each employee?

29. Is there a record of employee vaccinations?

30. Is there a record of refusal of HBV immunization when an employee declines immunization?

31. How often are in-house quality assessment reviews performed?

_____

32. When was the last dental program quality of care evaluation or dental program review performed? _____

33. Which components were evaluated?

Clinical_____ Management _____ Community_____

B. Dental Clinic Efficiency

(Discussion with Facility Dental Chief or Tribal Dental Director)

1. Are extracts and exports of DDS data performed for the facility on a regular schedule, or are IHS 42-2 forms completed and mailed to UNICOR on a regular basis?
2. Does the dental chief show an understanding of the IHS Dental Data System and data reports?
3. Is the dental program director (dental chief) aware of trends in the program?
4. Can he/she explain increases or decreases in services by age group, levels of care, or in overall services?
5. Is the dental program director (dental chief) able to demonstrate that information derived from the data system is used to plan the dental program?
6. Are workload/productivity expectations set annually based on the staffing available?
7. Are workload/productivity expectations monitored monthly or quarterly?
8. Were productivity expectations met for the last fiscal year?

	Clinic	Area AVG/ Standard

9. Calculate the following indicators:

   Visits/FTE

   Visits/Operatory

   Services/Visit

   Service Minutes/Visit

   Service Minutes/FTE

   BA Rate (9130/0000+0190+9130-0140)

   Direct Cost/Service Minute

   Contract Cost/Service Minute

   Recommendations from Clinic Efficiency Criteria:

Yes No

C. Data Analysis
(Levels of Care and Appropriateness of Care)

1. If Level I services (emergency care) exceed 40% of total services provided, indicating large unmet dental needs, do Level IV, V, and VI services combined equal less than 5% of total services?
2. Do Level II (primary care) services comprise at least 15% of total services provided, indicating the existence of a clinical prevention program?
3. Do data for Level X services provided (exclusions) reveal the absence of services that should have been identified by another procedure code, representing a different level of care?
4. Does the facility dental chief understand the relationship between the “levels of care” concept and the practice of public health dentistry?
5. Do services provided data reveal the absence of procedures that are not generally recommended in IHS practice, such as gold foil restorations or unilateral removable partial dentures (“Nesbitt” partials)?
6. Does the number of sedative fillings provided (Code 2940) comprise less than 5% of the total number of restorations provided?
7. Do stainless steel crowns comprise at least 80% of primary restorations (excluding composites) involving three or more surfaces, i.e., are less than 20% of these restorations amalgams?
8. What is the ratio of endo access to endo fills?

   Facility Dentist(s) ratio _____
   Service Unit/Tribal Program ratio _____
   Area Dental Program ratio _____
   Ratio recommended by IHS endo specialists _____

9. What is the ratio of pulpotomies to SSCs?

   Facility Dentist(s) ratio _____
   Service Unit/Tribal Program ratio _____
   Area Dental Program ratio _____
   Ratio recommended by IHS pedo specialists _____

Yes No

10. In the opinion of the facility dental chief, is public health dentistry being provided to the service area?

Recommendations from Data Analysis:

_____

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D. Appointment Policies

1. Are written appointment policies available for the following?
   a. Appointments for exams and routine treatment
   b. Dental urgent/emergency treatment (“walk-in” patients)
   c. Broken or canceled appointments and late arrivals
   d. Referred treatment
   e. Deferred treatment
2. Has the broken appointment policy been approved by the Tribal health board and communicated to patients/community?
3. Do appointment policies allow for control of the appointment book so that patients are booked no more than three weeks in advance of appointments?
4. Is the appointment policy adhered to?
5. Is a call list available for patients who can respond on short notice to fill in broken or canceled appointments?

	Yes	No
6. Is there a method to reach high-priority recall patients who do not respond?		
7. Is the recall interval based on each patient's individual disease rates, rather than using arbitrary time intervals?		
8. Are appointment policies available as handouts or posted for public view?		

Recommendations from Appointment Indicators:

MANAGEMENT FEEDBACK FORM

(Provide to Evaluatee at Close-Out Session)

CATEGORY_____

Objective considered unsatisfactory: _____

Describe deficiencies related to this objective:

_____

_____

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_____

Objective considered unsatisfactory: _____

Describe deficiencies related to this objective:

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Objective considered unsatisfactory: _____

Describe deficiencies related to this objective:

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Objective considered unsatisfactory: _____

Describe deficiencies related to this objective:

_____

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MANAGEMENT FEEDBACK FORM, continued

Program strengths:

Plan of action to correct deficiency(ies):

Signatures: _____ _____ _____
Evaluator Evaluatee Date

cc: Service Unit Director/Tribal Health Administrator