### STANDARD 5 – PATIENT CARE SERVICES

<table>
<thead>
<tr>
<th>5-1</th>
<th>The dental school must conduct a formal system of quality assurance for the patient care program that demonstrates evidence of:</th>
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<td>a. standards of care that are patient-centered, focused on comprehensive care and written in a format that facilitates assessment with measureable criteria;</td>
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<td>b. an ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of the care provided;</td>
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<td>c. mechanisms to determine the cause(s) of treatment deficiencies; and</td>
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<td>d. patient review policies, procedures, outcomes and corrective measures</td>
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**The University at Buffalo, School of Dental Medicine is in compliance with Standard 5-1.**

**Quality Assurance Program**

The School of Dental Medicine employs an organized, structured and formal Quality Assurance Program (Appendix 4.8). The purpose of the program is to ensure that the patient care provided within the School of Dental Medicine’s educational programs meets or exceeds the standards (parameters) of care as promulgated by the American Dental Association and the New York State Department of Health. Specifically, the School of Dental Medicine’s Quality Assurance Plan is designed to:

- a. Ensure quality patient care
- b. Maintain professional accountability
- c. Provide systematic monitoring and evaluation of dental services
- d. Meet regulatory and statutory requirements
- e. Maintain a data acquisition system
- f. Utilize collected data to implement and document changes
- g. Provide school-wide visibility to trends and outcomes
- h. Annually assess the Quality Assurance Plan

The organizational structure of the Quality Assurance Plan is depicted in Figure 5.1.
NOTE: the number in parentheses refers to the number of indicators for that area
The primary responsibility for the Quality Assurance Plan rests with the Dean. Operationally, the Dean has delegated the responsibility for oversight and management of all quality assurance activities to the Quality Assurance Committee, chaired by the Associate Dean for Clinical Affairs. This group is also charged with implementation of appropriate improvement initiatives.

The Quality Assurance Committee has selected 12 central indicators and 23 specific discipline / department indicators to assess patient care in the school (Appendix 2.28, Appendices K and L). For each indicator, there is a designated threshold that the Quality Assurance Committee monitors. For example, one of the Pediatric and Community Dentistry indicators is that "85% of the patients placed on preventive therapy (recall) returned or had been contacted for service no later than 2 months after they are due." In addition to the data summaries of the central indicators and the discipline / departmental indicators, there are additional clinical reports, generated from the clinic management information system, Picasso (Appendix 1.5), utilized to assist with the assessment of patient care quality (Appendix 2.31, Master List of Clinical Reports, available on-site).

Data on the central indicators and the discipline / departmental indicators are collected monthly and are managed by the Quality Assurance Coordinator. The Quality Assurance Coordinator evaluates the collected data at least once a semester to identify areas of deficiency (Appendix 5.1). If the designated threshold is not achieved for a central indicator or a discipline / departmental indicator, an action plan is formulated to improve performance in that area in order to achieve the designated threshold (Appendix 5.2). If the designated threshold is achieved for a central indicator or a discipline / departmental indicator for a year, it is considered functionally stable. The Quality Assurance Committee, along with the designated course directors or discipline director(s), may then continue to monitor that indicator or replace it with a new related indicator in order to assess other areas of patient care.

Quality assurance yearly summary data are made available to dental school personnel via the school's intranet. All personnel viewing the QA summaries are encouraged to send comments or questions to the Quality Assurance Committee. Quality assurance initiatives are made available to the public via the school's "Quality Counts" newsletter published annually and available in all patient waiting rooms (Appendix 4.9).

The Quality Assurance Committee also has a role in ensuring adequate credentialing and training for patient care providers. Training in infection control and HIPAA regulations is available on the school’s intranet. Continuing education programs are offered throughout the year with faculty enrichment programs usually occurring in mid-June, and university orientation programs usually at the start of the academic year in August. Session topics are varied and include reviews and updates on outcomes, trends and new policies and procedures.
The school uses the American Dental Association’s "Dental Practice Parameters" as an aid in clinical decision, diagnosis and treatment. The faculty and the Clinical Group Directors regularly monitor adherence to these parameters. School of Dental Medicine discipline-specific parameters of care as described in the clinical discipline course syllabi, CLD 831/832 and CLD 841/842 – Comprehensive Care Clinic I/II and III/IV, and as outlined by the Clinical Practical Examinations (Appendix 2.27), are consistent with and expand on the ADA Dental Practice Parameters. There are 18 discipline-specific Clinical Practical Examinations (CPEs), each with its own set of attributes outlining the parameter of care in that area. Faculty members evaluate the student’s CPE using the discipline-defined standards of care for that procedure. Students must complete the third year battery of CPEs in order to be advanced into the fourth year and they must complete the fourth year battery of CPEs in order to graduate. Each clinical discipline is represented by a faculty member known as a "Discipline Monitor" or Discipline Director, who works with the Clinical Group Directors to monitor standards of care.

The school's standards of care for comprehensive patient treatment in the clinical group practice model were developed through an iterative process involving the Associate Dean for Clinical Affairs, the Associate Dean for Advanced Education, the Clinic Council, including the Group Directors, the Discipline Directors, Advanced Education Program Directors, the Clinic Management Committee and the faculty. These groups also continually review clinical reports and note changing usage of clinical materials, dental technology and accepted procedures, and modify the CPE’s accordingly. Several new CPE’s have been recently added including one for CPE evaluating patient risk assessment for dental caries, periodontal disease and oral cancer.

The predoctoral clinics are organized into four Clinical Group Practices, two third year and two fourth year, designed to focus on patient-centered comprehensive care. At each patient visit, the student is evaluated for preparation, knowledge of the procedure, and adherence to infection control standards, records management, professionalism, ethics, treatment plan completion, and technical performance. Additional modifications to the group practice model continue to be made. The most recent occurred at the beginning of the 2009-2010 academic year, when the third year clinical groups were moved to the second floor to permit use of this clinic for clinical simulation by the first and second year students.

Continuing review and revision of patient care policies occur through the Clinical Council and the Clinic Management Committee. The Clinical Council meets each semester and is responsible for general policies affecting all clinics and long-range planning. The Clinic Management Committee meets at least monthly, and is responsible for resolving day-to-day clinic issues and developing new clinic policies for the predoctoral clinics. Changes and clarifications from these regular meetings are disseminated in the Clinic Newsletter (Appendix 5.3). Any policy requiring significant curricular change is referred to the Curriculum Committee for approval.
The school's clinical standards, policies and procedures of patient care are published in the Clinic Manual, which is reviewed and revised annually (Appendix 2.28). These standards, policies and procedures are formally reviewed with the students during their clinic orientation sessions held just prior to the beginning of the fall semester and with the faculty and staff during their calibration sessions. The Clinic Manual is accessible online and a hard copy is located in each main clinic area.

The school's parameters and standards of care are used to assess the quality of patient care and they also form the basis for the school's quality assurance plan in the areas of record reviews, patient surveys, and follow-up patient examinations (Appendix 5.4, Appendix 5.5, Appendix 5.6). Computerized reports to the Patient Manager and Dental Care Coordinators, detailing the timeliness of patient assignments, treatment, ongoing care and patient recalls, have been implemented based on standards of care. The school's Coordinator of Patient Services/Patient Advocate conducts ongoing patient surveys based on Quality Assurance indicators to ascertain patient satisfaction and student compliance with patient-centered comprehensive care. The survey results are communicated to both the Clinical Council and Clinic Management Committee for review and appropriate action.

b. on ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of the care provided

The School of Dental Medicine audits a representative sample of active comprehensive care patient records on a continuing basis. Similar audit processes are used in both the predoctoral and advanced education program clinics (Appendix 2.28, Appendices C-G).

The predoctoral patient record audit is performed by a chart auditor (clinical staff member). The goal is to audit a representative sample (~50%) of records in every predoctoral student's patient family.

**Predoctoral Program Patient Records Audit Protocol**

**Chart Auditor Responsibilities**

The student's list of assigned patients or, Patient Family Summary (Appendix 2.61), is obtained from the clinic management system and the patient records are obtained from the chart room. The charts are reviewed and deficiencies are noted on the Chart Audit Form (Appendix 2.28, Appendix C). During the records audit, the chart auditor examines each chart for the items listed on the Chart Audit Form. These items include signed consent forms, treatment plans, and progress notes; completed patient information; completed medical history; medical history updates within one year; completed initial examination and findings; completed treatment plan; and radiographs properly identified, mounted and dated. Following completion of the audit, the progress notes page and the back cover of the patient record are stamped with a red “Chart Audit”. A red “R” is also stamped if the record requires remediation(s). The patient record and the chart audit form are returned to the student.
Student Responsibilities
The student is given approximately one month to correct any deficiencies and return the chart and the chart audit form to the chart auditor. The chart auditor reviews the remediated record and gives final approval. Students not in compliance are subject to loss of clinical privileges and/or are referred to the Judicial Council.

According to the senior outprocessing protocol (Appendix 2.20), "...all audits must be completed and reviewed prior to the issuance of your diploma..." To assure this, fourth year student records are audited first, usually at the beginning of the fall semester, followed by the third year student records. Once the audit of the third year student records has been completed, a pre-graduation audit of the fourth year student records occurs.

Several of the indicators used in the School of Dental Medicine Quality Assurance Plan (Appendix 2.28, Appendices K and L) are evaluated using data derived from the record audits. For example, "Records of active patients will have an updated medical history at each appointment" and "Records of active patients will have a signed and dated consent to treatment form" are quality assurance indicators used by the school and evaluated during the record audits.

The audit process enhances faculty, staff and student awareness of quality assurance and the need for accurate records (Appendix 5.6). As deficiencies are revealed by the chart audits, corrective actions are taken. For example, it was noted that in the event of a medical emergency, patient medications were not readily accessible in a single location in the chart. To correct this deficiency, a separate form listing medications and emergency and physician contact information was added to the chart. This change reduced the number of chart audit deficiencies in this area. As another example, additions were made to the chart audit procedure to assess compliance with Health Insurance Portability and Accountability Act (HIPAA) regulations. Compliance has been consistently high. The school is moving towards adopting a comprehensive electronic oral health record, and the chart audit procedure will be revised to accommodate this change.

c. mechanisms to determine the cause(s) of treatment deficiencies

Deficiencies in the process of patient treatment and in individual treatment procedures are identified through a multi-stage review by the Clinical Group Directors, clinical faculty, Dental Care Coordinators, Patient Manager, Discipline Directors, the Coordinator of Patient Services, the Patient Care Compliance Coordinator and the Counseling, Advocacy, Referrals, Education, and Service (C.A.R.E.S.) program staff. This review is facilitated by the school's clinic information management system, aka Picasso (Appendix 1.5). Areas reviewed include treatment planning and sequencing, daily treatment, the patient record, treatment progress, laboratory work, financial ledger and completed treatment.
All School of Dental Medicine patients must have an approved comprehensive treatment plan prior to initiating treatment, with the exception of emergency and limited care. The initial patient visit for comprehensive oral exam and data collection (medical history, dental history, initial findings, radiographic examination, additional diagnostic tests, problems list, etc.) follows a standardized protocol designed to ensure completeness (Appendix 5.7). Based on this assessment, a treatment plan is developed that addresses treatment needs. This process is required for all new patients and is reviewed at least annually or when patients are reassigned to another provider. The treatment plan is only changed or modified when there are changes in the patient’s oral health status and/or financial situation. Patients are advised of the benefit(s) and risk(s) of any change in the treatment plan.

To minimize lapses in treatment sequencing, patients are assigned to individual students as part of their patient families. Students are generally expected to complete a patient's treatment prior to graduation. For treatment that cannot be completed prior to graduation, there is a formal end-of-year review (Appendix 2.20) that includes an agreement between the student, faculty and patient as to what will be completed prior to graduation. The patient is then transferred to another student to complete the remainder of the treatment.

d. patient review policies, procedures, outcomes and corrective measures

Individuals Involved in Monitoring and Supervision of Patient Treatment

Clinical Group Directors - There are four senior faculty members, each with administrative and clinical responsibility for approximately 45 students assigned to each clinical group. The Clinical Group Directors ensure that students are assigned patients whose treatment needs include all the experiences and procedures that allow the student to achieve competency. The Clinical Group Directors, in conjunction with the Dental Care Coordinators, monitor patient treatment and student progress in completing the treatment for their assigned patients. They also counsel students having difficulty in achieving competence in one or more areas.

Clinical Faculty - These include both full-time and part-time faculty members, both general dentists and specialists, who directly supervise dental treatment.

Dental Care Coordinators - They are two full-time staff members (a registered dental hygienist and a certified dental assistant) who monitor patient treatment and student progress and assist the Group Directors in tracking student activities. They meet with each student on a regular basis review patient and treatment progress. They also determine if a patient should be discharged.

Patient Manager - A full-time staff member who, in conjunction with the Group Directors and Dental Care Coordinators, assigns patients to students based on treatment needs, reassigns cases from one student to another, arranges a final case review and is responsible completing the forms for patient case completion.
**Discipline Directors** – Individual faculty members are assigned to monitor student progress in operative dentistry, periodontics, endodontics, oral diagnostic sciences, fixed prosthodontics and removable prosthodontics.

**Coordinator of Patient Services** - Currently a registered dental hygienist with over 20 years experience acts as a liaison between patients and their providers. The coordinator surveys patients to assess their satisfaction with treatment and their overall experience at the school, and is active in providing people in the community increased access to oral health care through outreach activities.

**Social Workers** - The school employs two full-time social workers, each with a Master’s degree in Social Work (MSW), for its Counseling, Advocacy, Referrals, Education and Service (C.A.R.E.S.) program (Appendix 2.30). This is a unique award-winning partnership between the Schools of Dental Medicine and Social Work to enhance the oral health and overall well-being of the school’s patients. The social workers coordinate the C.A.R.E.S. program, supervise MSW field education interns, and participate in the predoctoral education program. The Department of Pediatric and Community Dentistry employs an additional half-time individual with an MSW to provide the same services to families of the school’s pediatric patients.

**Monitoring and Supervision Process**

**Patient Care**
The Clinical Group Directors and the clinical faculty supervise patient treatment. At the beginning of each appointment, the faculty supervisor and student clinician review the Activity Tracking Form (ATF) (Appendix 2.60) which lists the completed treatment, the treatment in progress and the treatment to be done.

Each month, the Dental Care Coordinators meet with each student in the clinical groups to review his or her overall productivity and productivity within each clinical discipline. They provide the data to both the Clinical Group Directors and the Discipline Directors (Appendix 2.61). The Patient Manager assigns patients whose treatment needs include all of the experiences that allow students to achieve competency. Assignments are made based on the treatment needs identified at the initial patient screening appointment. Students must complete a specified number of procedures (pre-requisites) within each discipline prior to attempting the Clinical Practical Examinations (Appendix 2.27). Endodontic cases are individually evaluated and assigned by the Department of Periodontics and Endodontics, to ensure that patients are treated in a timely manner. To ensure a variety of clinical experiences, the Patient Manager and Dental Care Coordinators review the number and kind of procedures that each student has performed or has in progress. If the student is progressing in a satisfactory manner, the student and respective Group Director are informed. The Discipline Directors track and evaluate student progress.
within the individual disciplines. If the student’s progress is less than satisfactory, the student is contacted and counseled accordingly.

Students formally review their entire patient family at least twice a year with the Group Director and the Dental Care Coordinators. Reviews occur more frequently if a student has not provided care for a patient within a certain time period, if the student has low productivity in general or within a specific discipline, or if there is a deficiency in the care provided.

All patients receive a Patient Information Booklet (Appendix 2.34) at their initial screening appointment. If patients have any concerns about their care, they can discuss this with their assigned student, faculty involved in treatment and the appropriate Group Director. If the concern is unresolved, the patient may be referred to the Coordinator of Patient Services, who can then review the care provided with the student, faculty directly involved in that patient’s care, the appropriate Group Director and, if necessary, the Associate Dean for Clinical Affairs.

Patients who experience barriers to care may also be referred to the C.A.R.E.S. Program (Appendix 2.30). C.A.R.E.S. staff (social workers and masters of social work graduate students) contact each referred patient as soon as possible and may meet a patient during his/her dental appointment, speak to him/her over the phone or make a specific appointment to meet privately. Each patient signs a consent form and completes an intake form. These questionnaires have received Health Sciences Institutional Review Board approval for use as a research instrument. Social workers offer referral resources, support and assistance with psychosocial issues that impede access to dental services. Examples include Medicaid or grant applications, donated dental services, transportation arrangements, and referrals to physicians, counselor/mental health professionals, lethality assessment/crisis assistance, nutrition assistance and assistance with legal issues.

The masters of social work interns are monitored and supervised by the Director and Assistant Director. Before interns are permitted contact with patients, they receive orientation and individual/group instruction. Following this, students observe one or both of the C.A.R.E.S. directors with a patient. Interns are periodically observed with patients to ensure quality of care. Each intern receives one hour of one-on-one supervision weekly and C.A.R.E.S. directors review interns’ notes on a regular basis. In addition, one of the C.A.R.E.S. directors is always oncall.

Laboratory Evaluation Process
All prosthetic laboratory work receives a second evaluation by a clinical faculty member in the Department of Restorative Dentistry, in addition to the initial evaluation performed by the clinical faculty member supervising the case. The Fixed Prosthodontics Laboratory Work Authorization form (Appendix 5.8) has a section for quality control. The faculty member reviewing the laboratory work evaluates 21 different quality control items, including tooth preparation and die preparation. When a submitted case is deemed inadequate, it is returned to the student for correction and must be reapproved.
by the clinical faculty supervising the case prior to resubmission. A database is maintained containing the results of these reviews. Similar evaluation occurs for removable prosthodontics cases. Upon receipt of labwork that has been submitted to an outside laboratory for processing, a technical support quality control form is completed for any fixed and/or removable prosthodontic lab request. This information is compiled and reported to the chair of the Department of Restorative Dentistry for his review.

Case Completion Process
Upon completion of a patient’s initial treatment plan, the patient is placed on recall. A Predoctoral Case Completion Form (Appendix 2.28, Appendix H) is completed by the student and reviewed by a clinical faculty member and processed by the patient manager. Any treatment not completed is noted on the Predoctoral Case Completion Form, along with an explanation, e.g., cost, time, patient refusal, etc. Two to three months after this evaluation, the patient is scheduled for a Final Case Review (Appendix 2.28, Appendix T), at which time the patient receives an examination and an oral prophylaxis. A student and clinical faculty member not involved in previous treatment determine whether the treatment is acceptable, if there are outstanding treatment needs, if treatment was rendered in a timely fashion and whether the patient is satisfied. When treatment deficiencies are noted or additional treatment is indicated, the patient is either assigned to the original provider or, if the student has graduated, to a new student. The school’s Quality Assurance Coordinator tracks all Final Case Reviews (Appendix 5.4).

The school’s quality assurance program is undergoing a major re-evaluation. The current process will remain in place while a new process is designed to align the school’s recently revised goal, objective, and outcomes measures.

Summary
As a result of the self-study, it was recommended that limited treatment, emergency treatment and recall patient records should be audited using the predoctoral comprehensive active treatment audit process as a model. This suggestion has yet to be acted upon as it may require the hiring and training of additional clinical staff. A second recommendation involved the quality assurance process. The data collection for the Quality Assurance Plan is currently the primary responsibility of Quality Assurance Coordinator. Because it is an extremely labor-intensive task, more efficient methods of data collection are being reviewed.

Supportive Documentation:
Course Syllabi CLD 831, CLD 832, CLD 841, CLD 842
Appendix 1.5 The SDM Electronic Oral Health Record (EoHR) Overview
Appendix 2.20 2010 Senior Outprocessing Form
Appendix 2.27 Clinical Practical Examination (CPE) Assessment Forms
Appendix 2.28 Clinic Manual, Appendices, C, D, E, F, G, H, K, L, T
Appendix 2.30 C.A.R.E.S. Program
Appendix 2.31 Summary of Student’s Clinical Accomplishments
The University at Buffalo School of Dental Medicine is in compliance with Standard 5-2.

Comprehensive Care

Since the 1970’s, the University at Buffalo School of Dental Medicine’s philosophy is focused on educating students to provide comprehensive patient care. Third and fourth year students function in comprehensive care clinics, are assigned to one of four clinical practice groups and are responsible for oral health care for individuals in their assigned patient families (Appendix 2.28).

Third year students are assigned to one of two clinical teaching groups on the Squire Hall second floor clinic on Mondays, Wednesdays and Fridays. Fourth year students are assigned to one of two clinical teaching groups on the Squire Hall first floor clinic Mondays through Fridays. Each of the four clinical practice groups is comprised of approximately 45 students. Approximately four full-time faculty members from the Department of Restorative Dentistry with expertise in operative dentistry and removable and fixed prosthodontics are assigned to each group. Faculty from the Departments of Periodontics and Endodontics and Oral Diagnostic Sciences are also assigned to each group. Each clinical practice group is supported by a senior dental assistant, dental assistants, a Dental Care Coordinator and the Practice Manager, and is managed by a Clinical Group Director.
The second floor clinic schedule allows for clinical simulation by first and second year students on Tuesdays and Thursdays. The recent separation of the third and fourth year students, which has occurred within the past year, also allows clinical faculty to focus on the specific needs of students in that year.

In addition to the third and fourth year classes, the school’s clinical teaching groups involve the first and second year students, thereby providing clinical experiences to students through all four years of the curriculum (consistent with the goals of the school’s comprehensive curriculum review). In the CLD 813/25/828 - Integrated Dental Practice I/II/III courses, first year students are paired with a third year student dentist for approximately one clinical session per month in the spring semester. Second year students are paired with a fourth year student dentist one clinical session per month for both the fall and spring semesters. This allows first and second year students to assist their upper classmen with dental procedures, interact with patients, faculty and staff, and become familiar with the school’s clinical operations, patient record documentation and computerized patient management system (Course Syllabi, CLD 813, 825, 828).

Faculty supervising patient screening provide a preliminary assessment of the patient’s oral health care needs. This information is reviewed by the Patient Manager, who consults with the Dental Care Coordinators and, if necessary, the Group Director, and assigns the patient to an appropriate student based on both the patient’s and the student’s needs.

With limited defined exceptions (see below), all patients assigned to predoctoral students receive comprehensive care. Third year students must complete discipline-based clinical course requirements in addition to fulfilling overall clinical requirements (Course Syllabi, CLD 831/832 - Comprehensive Care Clinic I/III) in order to ensure adequate experiences in fixed and removable prosthodontics (Course Syllabi, RDN 834 – Indirect Restorations Clinic I/II, RDN 839 – Removable Prosthodontics Clinic I), endodontics (Course Syllabi, PER 836/837 – Endodontics Clinics I/II), operative dentistry (Course Syllabi, RDN 836 – Direct Restorations Clinic I/II), oral diagnostic sciences (Course Syllabi, ODS 837/838 – Clinical Diagnosis I/II), and periodontics (PER 833/834 – Periodontics Clinic I/II). Fourth year students complete only overall clinical requirements (Course Syllabi, CLD 841/842 - Comprehensive Care Clinic III/IV).

All patients receive a comprehensive oral examination, including a medical and dental history, clinical examination of both hard and soft tissues and, if indicated, diagnostic impressions and intraoral, and extraoral radiographs. A comprehensive problem list is formulated from this information and a sequential treatment plan is developed categorized into: (1) urgent care; (2) disease control; and/or (3) remedial provision of form and function.

The patient, student and supervising faculty review the preliminary treatment plan and, if acceptable to all, their agreement is acknowledged by signing and dating the treatment plan in the chart. Patients are presented with alternative treatment plans, when
appropriate, based on treatment preferences, financial considerations, patient availability and/or other considerations.

The school’s commitment to comprehensive patient care is promulgated in the following documents and in the following ways, including but not limited to the:

- **School's Goal I.4** which is to "Ensure clinical education includes a broad, quality student experience providing comprehensive patient care improving oral health."
- **Patient Rights and Responsibilities** (Appendix 2.28, Appendix S) document which states that, “You have the right to…receive emergency, incremental and total care…”
- **Patient Information Booklet** (Appendix 2.34) states that, “The UB School of Dental Medicine is committed to providing you with the best quality comprehensive dental care available.” This booklet is given to all patients at their initial screening appointment and their receipt in indicated by their initials on the patient record.
- **Formal Comprehensive Treatment Plan** (Appendix 5.9) which is developed for each patient assigned to a student for comprehensive care. The patient’s signature acknowledges his/her acceptance of the treatment plan.
- **Activity Tracking Form (ATF)** (Appendix 2.60) Progress toward completion of the treatment plan is continually monitored using this form. Treatment completed, in-progress and yet-to-be-completed are listed on this form, which is issued for each patient visit.
- **Dental Care Coordinators Duties and Responsibilities** (Appendix 5.10) which includes performing chart audits and regularly reviewing Picasso reports to ensure that treatment rendered is in accordance with the agreed treatment plans.
- **Coordinator of Patient Services/Patient Advocate** (Appendix 5.11) who is specifically responsible to redress patient concerns and complaints, including those related to delayed treatment or incomplete treatment.
- **Social Workers** (Appendix 2.30) The C.A.R.E.S. program assists patients with psychosocial and socioeconomic issues that may their oral health. They also review case discharge forms to assess patient retention issues.
- **Referral-Reassignment Request** (Appendix 2.28, Appendix U) A request is made via an on-line process to either refer the patient to another predoctoral clinic or reassign patients from the predoctoral program to the Advanced Education Programs when secondary care is performed to complete the patient’s comprehensive treatment. Patients electronically sign this form acknowledging their agreement to be treated in the Advanced Education Programs.
- **Predoctoral Case Completion Form** (Appendix 2.28, Appendix H) The predoctoral case completion form is used when a patient’s treatment has been completed.
- **Case Completion Review Process** is performed for all patients assigned to fourth year students as part of the required senior outprocessing protocol (Appendix 2.20). The case completion review lists the treatment completed, treatment yet-to-be-done and other patient information need to reassign a patient to another provider.
• Case Discharge Form (Appendix 2.28, Appendix A) is used when a patient is discharged from the school. This form is completed and signed by the student and reviewed by a Dental Care Coordinator. If there are any unmet treatment needs, the Coordinator of Patient Services/Patient Advocate will inform the patient in writing.

• Final Case Review Form (Appendix 2.28, Appendix T) is a component of the school’s Quality Assurance Program. Following completion of treatment, a student other than the assigned provider performs a comprehensive oral examination to verify that all of the treatment has been completed and that it meets the standard of care. A clinical faculty member also not involved in the case reviews this as well. The school’s Quality Assurance Coordinator tracks all Final Case Reviews.

The school’s philosophy (refer to Standard 1-1) of comprehensive patient-centered care is emphasized in the guidelines for patient treatment as described in the Clinic Manual (Appendix 2.28), the CLD 831/832 and 841/842 – Comprehensive Care Clinic I/II and III/IV course syllabi and the CLD 835/838 and CLD 845/853 - Treatment Planning and Cases I/II and III/IV course syllabi (Course Syllabi).

Limited Care

The vast majority of patients receive comprehensive care. However, there is a small group who receive limited oral health care in specifically delineated situations consistent with either programmatic or community needs (Appendix 2.28, Appendix J). Limited patient care is provided in the following situations:

• Emergency Treatment - Any individual with oral pain contacting the school during normal business hours is offered an appointment within 24 hours. The patient will receive emergency care to evaluate an urgent need and/or relieve pain. These individuals can become active patients of the school and receive comprehensive oral health care if they desire. Limited care in this case is deemed both a positive learning experience for the dental students as well as fulfilling a needed community service (Appendix 2.28, Appendix M)

• Orthodontic Treatment - Individuals seeking orthodontic treatment are registered as School of Dental Medicine patients for treatment in the Orthodontic Clinic. Most of these patients have a general dentist in the community and are only seeking orthodontic treatment. If they don’t have a general dentist in the community, they are offered the opportunity to receive comprehensive patient care at the school. Limited orthodontic treatment in this case fulfills both the needs of the Advanced Educational Program in Orthodontics and Dentofacial Orthognathics and the needs of the community. Each new orthodontic patient completes a Dental Health Status form before the initiation of treatment. The Dental Health Status Form confirms that the patient has had a recent dental examination and prophylaxis and that they do not have carious lesions. The Dental Health Status Form can be completed by the patient’s general dentist or,
if the patient is a patient of the school, by the assigned student’s supervising faculty member.

- **Endodontic Treatment** - Individuals are referred to the school for endodontic treatment by dentists in the community, hospital dental clinics or as self-referrals. "Endodontic only" treatment is provided only when the patient is made aware of the need for subsequent restorative treatment (Appendix 5.12). Limited endodontic treatment facilitates both the predoctoral and the Advanced Educational Program in Endodontics and meets the needs of the community.

- **Oral and Maxillofacial Treatment** - Individuals are referred to the school for oral and maxillofacial treatment by dentists in the community, hospital dental clinics or as self-referrals. "OMFS only" treatment may involve removal of third molars, removal of a tooth or teeth in an acute emergent situation, or other procedures necessary to manage acute, subacute, and/or chronic odontogenic and non-odontogenic orofacial conditions. Limited oral and maxillofacial surgery treatment facilitates both the predoctoral and the Advanced Educational Program in Oral and Maxillofacial Surgery and meets the needs of the community.

- **Orofacial Pain Treatment** - The School of Dental Medicine is a referral center for the treatment of orofacial pain, including pain related to temporomandibular dysfunction. Limited orofacial pain treatment facilitates exposure to the predoctoral students and experience for those students/residents in advanced education programs at the school.

**Supportive Documentation:**

- **Course Syllabi**
  - CLD 831, CLD 832, CLD 835, CLD 838, CLD 841, CLD 842, CLD 845, CLD 853, ODS 837, ODS 838, RDN 813, RDN 834, RDN 836, RDN 839, PER 833, PER 834
- **Appendix 2.20**
  - 2010 Senior Outprocessing Form
- **Appendix 2.28**
  - Clinic Manual, Appendices A, H, J, M, S, T, U
- **Appendix 2.30**
  - C.A.R.E.S. Information
- **Appendix 2.34**
  - Patient Information Booklet
- **Appendix 2.60**
  - Activity Tracking Form (ATF)
- **Appendix 5.9**
  - Example of Comprehensive Treatment Plan
- **Appendix 5.10**
  - Dental Care Coordinator Duties and Responsibilities
- **Appendix 5.11**
  - Coordinator of Patient Services Duties and Responsibilities
- **Appendix 5.12**
  - Limited Care Treatment Form
- **On-Site**
  - Patient Records
Standard 5 – Patient Care Services

5-3 The dental school must have developed and distributed to all appropriate students, faculty, and staff and to each patient a written statement of patients' rights.

The University at Buffalo School of Dental Medicine is in compliance with Standard 5-3.

The document entitled Patient Rights and Responsibilities (Appendix 2.28, Appendix S) was developed and approved by the school's faculty. This document was updated in July 2009 and includes statements that meet or exceed all of the elements suggested under the intent section of Standard 5-3.

Patient Rights and Responsibilities is included in a booklet entitled “Patient Information, University at Buffalo, The State University of New York, School of Dental Medicine,” (Appendix 2.34). This booklet is given to all patients at their initial screening appointment. The patient is asked to initial and date the front of the patient chart to verify receipt. Patient Rights and Responsibilities is also posted conspicuously at various points in Squire Hall, and is posted on the school's website under “Patient Information Booklet”.

Patient Rights and Responsibilities is distributed to students, faculty and staff as part of the Predoctoral and Advanced Education Clinic Manual (Appendix 2.28) that is reviewed during clinic orientations held at the beginning of each year and specifically to faculty at one of the general faculty meetings (Appendix 2.18). It is emailed to all students, faculty and staff annually and published in the school’s clinic newsletter, which is distributed as both electronic and hard copies throughout the school's community. The Predoctoral and Advanced Education Clinic Manual is also available online at the School of Dental Medicine's intranet site.

Included in the Patient Rights and Responsibilities are the following statements fulfilling the intent of Standard 5-3: "You have the right to:

- Be treated with dignity and respect...
- Receive confidential treatment
- Receive continuous care to completion of planned treatment...
- Receive education, counseling and explanations to your questions.
- Receive complete information about your diagnosis, treatment and prognosis.
- Receive all the information that you need to give informed consent … including possible risks and benefits...
- Refuse examination, treatment or change your mind and be told what effect these actions may have on your health.
- Receive an itemized bill and explanation of all charges."

Supportive Documentation:
Appendix 2.18 2009 Orientation Schedule
5-4 The dental school must ensure that active patients have access to professional services at all times for the diagnosis and management of dental emergencies.

The University at Buffalo School of Dental Medicine is in compliance with Standard 5-4.

Students are responsible for their assigned patients’ dental emergencies. When a dental emergency arises from Monday through Friday, 9:00 am to 4:00 pm, a patient contacts his/her student/resident by calling the main switchboard. If the student/resident is unavailable, the patient contacts Patient Admissions to schedule an emergency appointment. During regularly scheduled clinic hours, patients with dental emergencies are seen in the predoctoral clinical practice group clinics or in the advanced education program clinics, Monday through Friday at 9:30 am and 1:30 pm.

All patients in pain are offered an appointment within 24 hours when clinics are in session. All dental emergency appointments scheduled during regular clinic hours are registered through Patient Admissions (Appendix 2.28). If a patient with a dental emergency is a patient of the school, but not currently assigned to a student/resident, the patient is seen in one of the clinical practice groups by a student assigned to the emergency rotation. If an individual who is not a patient of the school contacts the school with an emergency, he/she is treated according to the availability of emergency appointments and the severity of the dental emergency. Walk-in patients are assigned on a first-come, first served basis. Based on the severity of the emergent situation and/or the availability of appointments, a patient may be referred to one of the school's affiliated hospital dental clinics as well. The patient’s financial status has no bearing on the management of dental emergency care.

At times when the predoctoral clinic is not in session, residents in the Advanced Education in General Dentistry Program manage dental emergencies during regularly scheduled clinic hours. Patients with dental emergencies outside of regularly scheduled dental clinic hours are instructed to contact one of the school's affiliated hospitals: Erie County Medical Center or Women and Children’s Hospital of Buffalo. These hospitals have residents on call 24 hours a day to manage dental emergencies.

Patient information regarding dental emergencies is found in the “Patient Information Booklet” (Appendix 2.34), which each patient receives at his/her new patient screening appointment. It is also available on the school’s website and on the school’s after-hours telephone message.

Supportive Documentation:
Appendix 2.28 Clinic Manual
5-5 All students, faculty and support staff involved in the direct provision of patient care must be continuously recognized in basic life support (B.L.S.), including cardiopulmonary resuscitation, and must be able to manage common medical emergencies.

The University at Buffalo School of Dental Medicine is in compliance with Standard 5-5.

Medical emergencies that occur in the school are managed via the protocol developed by the CODE-5 (Emergency) Committee and published in the Clinic Manual (Appendix 2.28). The red colored CODE-5 phones located throughout Squire Hall are part of a dedicated system of communication to the central switchboard operator. All staff members working as the switchboard operator are trained to follow a specific protocol in the event of a CODE-5 emergency. A CODE-5 emergency call from one of the red CODE-5 phones triggers the following sequence of events:

• the person reporting the emergency states the nature of the emergency, its precise location and requests a CODE-5 announcement.
• the staff in the immediate vicinity retrieves the CODE-5 emergency supplies.
• the switchboard operator announces "CODE-5" and the location over the public address system three times.
• Responders hearing the announcement proceed to the announced location.
• The switchboard operator pages Oral and Maxillofacial Surgery (OMFS) and Oral and Diagnostic Sciences (ODS) faculty.
• The switchboard operator telephones the Department of Oral and Maxillofacial Surgery directly to inform them that there is a CODE-5 emergency and its specific location.
• The switchboard operator will standby ready to call Campus Police to activate a 911 Emergency call if directed to do so by emergency responders. If the emergency requires transport of the affected individual to a medical center, the operator will contact Campus Police, who will call for additional emergency personnel. Campus Police will then meet the emergency personnel at the campus entrance and escort them to the school.
• If a 911 Emergency call is made, school responders provide supportive and, if necessary, interventive care until additional rescue personnel arrive.
• Following the CODE-5, personnel (those directly involved, i.e., responders and witnesses) complete a School of Dental Medicine Medical Emergency/First Aid/Code-5 Report Form (Appendix 2.28, Appendix Q) in a timely manner.
• Response to any after-hours emergency is handled via the University at Buffalo Campus Police or the 911 emergency system. The Campus Police maintain a
24 hours and 7 days per week emergency system (716-829-2222) and respond by mobile patrols (Appendix 5.13).

- A debriefing of each CODE-5 occurs at the bi-monthly meeting of the CODE-5 Committee (CODE-5 Meeting Minutes, available on-site).

The CODE-5 Committee meets bi-monthly to review all medical emergencies and Incident Reports (Appendix 5.14) and formally update the CODE-5 protocol as necessary. Periodic reminders concerning CODE-5 protocol or changes in protocol are published and distributed school-wide via the clinic newsletter and by other electronic communications.

UB Student Health Services personnel hold annual mock CODE-5 sessions for dental students before they begin patient care (Appendix 2.63). The University at Buffalo Human Resources Department also offers a course to become familiar with Automated External Defibrillators (AED) equipment and an overview of cardiac emergency preparedness (Appendix 5.15).

Medical emergency equipment is strategically located in each clinic and prominently marked with a green and white "Emergency Equipment Storage" sign. The exact locations are listed and mapped in the Clinic Manual (Appendix 2.28, pg. 31). Each emergency kit contains oxygen, sphygmomonometer, stethoscope, oropharyngeal airway and a sealed emergency drug kit. Automated external defibrillators are located in 15 locations throughout the school and one is located in the Mobile Dental Unit. Locations are reviewed during mock CODE-5 training sessions.

The Department of Oral and Maxillofacial Surgery has an Advanced Cardiac Life Support emergency kit that includes a manual defibrillator / EKG, portable suction, endotracheal tubes, laryngoscope, IV fluids, IV infusion kit and an extensive emergency drug kit. These expanded kits are dedicated to use by the faculty and the Oral and Maxillofacial Surgery residents who are currently certified in Advanced Cardiac Life Support.

Each emergency kit is inspected quarterly by the Associate Dean for Clinical Affairs, the Assistant Director of Clinical Operations and the Facilities Compliance Officer. During this inspection, the Facilities Compliance Officer checks the drugs for expiration date, the oxygen tanks for fullness, and the equipment for functionality. He/she also maintains a maintenance log that tracks each drug and each piece of emergency equipment. University Facilities test and maintain the Automated External Defibrillators (Automated External Defibrillator (AED) Inspection Tags, available on-site).

The Senior Dental Assistants are responsible for immediately contacting the Assistant Director of Clinical Operations if any of the equipment or supplies have been utilized, are missing and/or if the seal on the emergency drug kit has been broken. The Assistant Director of Clinical Operations arranges for immediate replacement of any used or missing equipment. The school maintains a small supply of replacement emergency drugs and equipment for this purpose.
The school requires all students, clinical faculty and clinical staff who are involved in
direct patient care to be certified in Basic Life Support (BLS). To ensure this, the school
offers the American Heart Association Basic Life Support for Healthcare Providers
course to all students, clinical faculty and clinical staff at least twice a year. In lieu of
this course, BLS certification from other organizations, e.g., US Army certification, is
acceptable.

The school's predoctoral program requires training and certification in the identification
and management of medical emergencies including Basic Life Support (BLS), as
described below:

1. New dental students and residents are certified in BLS during the first year
orientation program (Appendix 2.18). This occurs prior to their first patient
contact. Following this initial certification, students are re-certified every two
years. Students without BLS certification or who have not received a medical
exception are denied patient care privileges.

2. Students receive additional instruction in the identification and management of
medical emergencies common in dental practice in the following required
courses from the Departments of Oral and Maxillofacial Surgery, Oral Diagnostic
Sciences and Restorative Dentistry, including:

   a. OSU 822 - Regional Anesthesia
   b. OSU 831 - Oral Surgery I
   c. OSU 832 - Oral Surgery II
   d. OSU 835 - Medical Emergencies
   e. ODS 837 - Clinical Diagnosis I
   f. ODS 838 – Clinical Diagnosis II
   g. ODS 840 - Development of Patient Assessment/Management Skills
   h. RDN 842 – Dental Management of the Special Needs Patient

3. All faculty, staff, residents, and continuing students involved in direct patient care
are offered the BLS training (certification) programs at least twice during the
year.

4. Other faculty and staff members are also offered the opportunity to obtain BLS
certification.

Faculty and residents of the Department of Oral and Maxillofacial Surgery are trained in
adult, child and infant Advanced Cardiac Life Support. The school's administration
maintains a database of faculty and staff, and a file copy of resident and student BLS
and ACLS certification status. The database flags individuals requiring re-certification
who are then notified (Records of BLS/ACLS Status, available on-site).

Exceptions to the requirement for BLS certification are made only upon receipt of a
physician's written statement that the person is physically unable to perform BLS. These
individuals must still observe the training and complete the written assignments,
but are excused from the hands-on exercises. The BLS and ACLS certification status database also identifies the persons exempt from BLS certification. The school's administration retains the physician's written exemption statement.

**Supportive Documentation:**
- Course Syllabi: OSU 822, OSU 831, OSU 832, OSU 835, ODS 837, ODS 838, ODS 840, RDN 842
- Appendix 2.18: 2009 Student Orientation Schedule
- Appendix 2.28: Clinic Manual
- Appendix 2.63: Medical Emergency, Mock Code-5 Report
- Appendix 5.13: UBAlert Emergency Information and Resources
- Appendix 5.14: Incident Report Summary
- Appendix 5.15: Public Access to Defibrillation Program
- On-Site: Code-5 Committee Minutes
- On-Site: Automated External Defibrillator Inspection Tags
- On-Site: Records of BLS/ACLS Status

### 5-6 Written policies and procedures must be in place for the safe use of ionizing radiation.

The University at Buffalo School of Dental Medicine is in compliance with Standard 5-6.

The school's written policies and procedures are based on New York State Department of Health requirements, contained in The Radiation Equipment Safety Manual provided by the University at Buffalo Environment, Health and Safety Services (available on-site) for the safe use of ionizing radiation in the dental school clinics. This manual may be accessed at the University at Buffalo website. Policies and procedures, including the radiographic guidelines approved by the American Dental Association, the Food and Drug Administration, the National Council on Radiation Protection and Measurements (NCRP) and dental specialties, are distributed in the Clinic Manual (Appendix 2.28) and the school's clinic newsletter (Appendix 5.16). Lectures discussing the ADA guidelines for prescribing radiographs are given to predoctoral dental students in ODS 820 - Introduction to Diagnostic Imaging and emphasized in the radiology clinic rotations (Course Syllabi, ODS 820 – Introduction to Diagnostic Imaging, ODS 822 – Oral Radiology Clinic I). Notable among these policies and procedures,

"Radiographs must be taken judiciously and only after considering medical, oral and dental histories and clinical findings ... Radiographs must be documented [in the patient record] including the necessity for radiographs, the exposure level, [written and signed order] signature of a licensed dentist indicating approval for exposure, documentation of diagnosis and disposition. Radiology policies...apply to all X-ray equipment and darkrooms..."
In addition to the policies and procedures distributed in the Clinic Manual (Appendix 2.28), policy manuals are maintained in the Radiology Clinic (Appendix 5.17). Radiology faculty and staff, directed by the Director of Oral Radiology, teach and supervise radiologic services during school clinic hours (Appendix 5.18).

In compliance with ALARA (As Low As Reasonably Achievable) and the Guidelines for Radiology and to ensure that students are taking the minimal number of radiographs, the following methods are utilized:

1. An oral examination must be completed before ordering radiographs.
2. The clinical grading system was adjusted so that there is no incentive for a student to take additional radiographs.
3. Faculty members approve each digital radiograph via a swipe card. Students have the ability to save images for faculty approval before they are stored to the DICOM server, which allows faculty to determine if additional views are indicated. (Digital Radiology Manual, available on-site)
4. The number of images for a complete adult dentition full mouth series was reduced to 18. Compared to film, digital radiography reduced the radiation exposure to the school’s patients by lowering the dosage and exposure times. Students are taught to apply ALARA at all times.

Every X-ray unit is checked and calibrated annually either by a dental school radiology technician or by the Director of the Radiology Clinic. The log of these calibrations is maintained in the Radiology Clinic and the updated results are posted on the door of each radiographic operatory (Radiology Calibration Logs, available on-site). Until recently, the University Radiation Safety Officer inspected each X-ray unit every two years. Starting in the fall 2009, the New York State Department of Health has revised the University Radiation Safety Officer’s required inspection to every five years. Each X-ray unit is marked with a yellow, dated sticker certifying successful inspection and compliance with New York State Department of Health requirements.

In 2006 at a cost of over $600,000, the School of Dental Medicine transitioned from film to digital intraoral and extraoral imaging. The transition to digital imaging is complete except in the faculty practice and in certain research projects needing intraoral and extraoral film radiographs. The school continues to use film for full and half-arch occlusal imaging.

Faculty and residents attend digital radiology workshops to facilitate their transition from film to digital imaging. The transition to digital imaging is continuously evolving, with new versions of MiPACs, point of care monitors installed this past academic year at a cost of over $500,000, faculty approval swipe cards, the Sun Ray system and the move toward the Electronic Oral Health Record (Appendix 1.5). Digital radiology is included in the student clinical orientation presentations (Appendix 2.18).

The School of Dental Medicine utilizes PhotoStimuable Phosphorous (PSP) sensors for intraoral digital radiography. PSP sensors are wrapped using a cardboard reinforcement.
shield inside a sealed plastic barrier bag. XCP film positioning devices and other holder/aiming instruments are utilized with the intraoral PSP sensors. Sensors are continuously inspected for scratches and artifacts prior to reuse. Defective, bent or scratched sensors are discarded. Debris from the adhesive used to seal the barrier bags is a common artifact problem with the PSP sensors. This radiopaque adhesive is removed following manufacturer’s guidelines (Digital Radiology Manual, available on-site). The radiology clinic staff generally discards and replaces PSP sensors on a rotating basis, approximately every four to seven months, due to continuous demand. Intraoral digital processing is accomplished using OpTime scanners. The PSP sensors are scanned individually, which is advantageous for quality control. Contaminated or defective PSP sensors are discarded. Scanners are calibrated bi-annually, or more often as needed. Dental repair personnel maintain the scanners by disassembling and cleaning the OpTime units. Every scanner station is equipped with a manual (Digital Radiography Tips, available on-site). This information is also available on the school's intranet site.

Extraoral digital units utilize direct sensors Charge Coupled Device technology. The school uses two digital Panoramic/Cephalometric units. One of these units has Transverse Slice Acquisition (TSA) capability. The school has purchased a Cone Beam 3-D Volume Computerized Tomography unit. Once operational, a board certified Oral and Maxillofacial radiologist will provide overreads for every 3-D volume image captured.

Radiographic facilities are designed to protect patients, students, faculty and staff, and the institution complies with regulations for radiation hygiene and protection as outlined on the University at Buffalo website. The University Radiation Protection Service uses the shielding requirements published by the National Council on Radiation Protection. X-ray rooms in the Radiology Clinic are constructed with lead shielding in the walls, leaded glass for the viewing window and an interlock in the door to disconnect the X-ray unit when the door is open. Adequate darkroom facilities are maintained and faculty and staff monitor proper darkroom practices. Automated developers are cleaned and solutions changed weekly.

Ionizing radiation used in the school's research laboratories is monitored by the University's Office of Radiation Safety as well as by the principal investigators. Radiation Safety's primary goal is to ensure the safe use of radioactive materials and radiation-producing equipment in accordance with the rules, regulations, licenses and permits issued by the New York State Department of Health, the New York State Department of Environmental Conservation and the Nuclear Regulatory Commission. The University's Office of Radiation Safety conducts safety inspections and trains workers in the correct use of radioactive materials and radiation-producing equipment, calibrates radiation survey instruments, monitors external and internal personnel dosimetry, and disposes of radioactive waste.

**Supportive Documentation:**
Course Syllabi ODS 820, ODS 822
The University at Buffalo School of Dental Medicine is in compliance with Standard 5-7.

The school ensures compliance with this standard by directing students, faculty and staff to read, understand and follow the School of Dental Medicine’s Infection and Hazard Control Program Manual, accessible on the school’s Intranet site. The school conducts mandatory annual training sessions for clinical staff (Appendix 5.19) and for students (Appendix 2.18), by monitoring the infection control practices of faculty, staff and students (Appendix 5.20) and publishing monitoring report results in the monthly clinic newsletter (Appendix 5.3).

Asepsis, Infection and Biohazard Control

The school's policies, procedures and strategies for preclinical / clinical / laboratory asepsis and infection and biohazard control are based on Occupational Safety and Health Administration requirements, Centers for Disease Control (CDC) recommendations, Food and Drug Administration (FDA) recommendations, American Dental Association recommendations, New York State Health Department and New York State Education Department mandates, Environmental Protection Agency recommendations, Organization for Safety and Asepsis Procedures (OSAP) strategies and other organizations that provide recommendations for dental practice. The school promotes asepsis and infection and biohazard control procedures in all clinical activities and laboratories. Attention to infection control activities and review of complaints/problems is addressed at the regular meetings of the Infection and Hazard Control Committee (Infection and Hazard Control Committee Minutes, available on-site).

The Infection and Hazard Control Program Manual (Appendix 5.20) is revised and updated periodically by the Infection and Hazard Control Committee (Table 14). The committee is composed of representatives from departments, the clinical disciplines and clinical areas in the school, including predoctoral student representatives. The chair of the Infection and Hazard Control Committee interacts with the University Office of
Environmental Health and Safety to ensure that the school is in compliance with university policies, procedures, rules and regulations. The committee facilitates and oversees compliance training, educational activities and initiatives for all faculty, staff, and students relative to infection control, safety, biohazard control and disposal of hazardous waste. This committee is charged with the following:

1. periodically review all infection control guidelines
2. promulgate new guidelines as necessary
3. develop and offer training programs in infection and hazard control to students, staff and faculty
4. monitor compliance with infection and hazard control guidelines in all clinical areas
5. make recommendations to the Curriculum Committee to incorporate specific material into the curriculum

At the start of each academic year, in-service and educational sessions are provided to the faculty, staff and students that emphasize information relative to new products, procedure changes and issues of concern. To reinforce and emphasize clinical practices, students involved in patient care are required to read and understand the Infection and Hazard Control Program Manual (Appendix 5.20) and to verify this by completing a computer based assessment as a requirement for clinical privileges. In addition, University Employees must complete “Right – to – Know” training from the University Facilities’ Department of Environment Health and Safety.

Enforcement of infection control and biohazard control policies is multifaceted. The preclinical courses include didactic material concerning infection control and safety issues in their laboratory setting as well as directed reference to the school’s Infection and Hazard Control Program Manual. Infection control and safety concepts are enforced by observation and direct counseling by the preclinical faculty during laboratory instruction and student formative and summative faculty evaluations (Course Syllabi, CLD 831 – Comprehensive Care Clinic, Appendix C). Violation of these standards may adversely affect a student’s final grade or they may be denied clinic privileges.

Students are under constant observation for compliance with the school's infection control policy by faculty and staff. Infection control is a required management skill that is formally evaluated by the faculty at the 8-week formative and 16-week summative clinical examinations in the comprehensive care clinical courses (Course Syllabi, CLD 831/832 and CLD 841/842 – Comprehensive Care Clinic I/II and III/IV). An unsatisfactory evaluation in infection control standard may reduce the student’s final grade. Further enforcement of infection control and safety occurs in the grading of all the clinical practical examinations (CPEs) (Appendix 2.27) in that infection control is a graded element of these examinations. Clinical faculty members who observe breaches of infection or safety protocols can immediately cite the student by completing a Clinical Performance/Patient Management Report form (“The Salmon Slip”) (Appendix 2.41). The Clinical Performance/Patient Management Report form specifically lists Infection
Control and Engineering Controls as items that can be cited. These reports are forwarded to the Clinical Group Directors and to the Associate Dean for Clinical Affairs. The Clinical Group Director soon meets with the student and reviews the report. Depending on the seriousness and frequency of the problem, disciplinary remedies may include a reduction of Clinical Productivity Units which may reduce the student’s grade or the student’s clinic privileges may be suspended.

If an infection control or safety violation results in a reportable event, an Incident Report form (Appendix 2.28, Appendix P) must be filed. The Patient Care Compliance Officer receives a copy of the Incident Report and review the incident with the individual student. This includes review of policy and, where appropriate, remediation. Based on the severity of the infraction, the Associate Dean of Clinical Affairs may suspend the student’s clinic privileges and may lower the student’s final course grade.

**Biological and Hazardous Waste Disposal**

The school’s policy for the handling and disposal of regulated medical waste is based on the University at Buffalo Regulated Medical Waste Policy, Information and Disposal Procedures (Appendix 5.21). "Regulated medical waste" is defined in the school’s Infection Control and Hazard Program Manual (Appendix 5.20) as "liquid or semi-liquid blood or saliva; contaminated items that would release blood or saliva as liquid or semi-liquid if compressed; and items that are caked with dried blood or saliva and capable of releasing these materials during handling". Contaminated sharps capable of causing an injury are also considered regulated waste. As regulated medical waste is generated in the clinics, it is placed in an approved, marked waste bag or in the case of contaminated sharps, placed in an appropriately labeled sharps container. Once full, the waste bag or sharps container is taken to the dispensary on that clinic floor. A dispensary staff member forwards the waste to the Central Sterilization area via the dumbwaiter, where it is unloaded and placed in a large, specially marked red bag. This bag is boxed and marked with the proper tracking label and then stored in a designated, appropriately labeled storage cabinet. The waste is picked up weekly by a licensed vendor, currently Stericycle, Inc., under contract with the University (Appendix 5.22).

The New York State Department of Environmental Conservation Chapter 506, Laws of New York, 2002 (Appendix 5.23) regulates the use and recycling of elemental mercury and dental amalgam in dental offices. To comply with these regulations, there was an extensive revision of the operatory drain system in 2008. Chair side cuspidors were removed from all operatories in both Squire and Foster Halls. Multiple amalgam separators were installed and the operatory drainpipes were changed from copper to PVC. Foster Hall received a ‘stand-alone’ amalgam separator for its six operatories.

As part of this accreditation self-study, the school evaluated the quality of the water in its dental units. The ADA states, “drinking water must meet a certain standard for concentrations of contaminants and chemicals.” Additionally, the Centers for Disease Control states, “exposing patients or dental health care personnel to water of uncertain microbiological quality, despite the lack of documented adverse health effects, is
inconsistent with generally accepted infection control practices.” Therefore, at a cost of approximately $70,000, self-contained water systems, which have been installed on all dental units in Squire and Foster Halls, isolate these units from the municipal water supply and allow for both intermittent and continuous chemical treatment of dental unit water lines. All units have been shocked treated with Sterilex Ultra "shock" treatment. Through utilization of this protocol and the continuous delivery of chemical treatment by the ADEC ICX system, SDM dental units deliver treatment water of acceptable microbiologic quality, achieving a target of \(< \text{ or } = 500 \text{ CFU/ml} \). When the self-contained water system bottle is empty, there will be no water flow to devices on the dental unit. A new water treatment tablet is to be added when the self-contained bottle is refilled.

Supportive Documentation:

| Table 14 | Committee Membership |
| Course Syllabi | CLD 831, CLD 832, CLD 841, CLD 842 |
| Appendix 2.18 | 2009 Orientation Schedules |
| Appendix 2.28 | Clinic Manual, Appendix P |
| Appendix 2.41 | Clinic Performance/Patient Management Report Form |
| Appendix 5.3 | Clinic Newsletter, May 2009 |
| Appendix 5.19 | August Calendar for Mandatory Training Sessions |
| Appendix 5.20 | Infection and Hazard Control Program Manual |
| Appendix 5.21 | Interim Guidance on Managing the Regulated Medical Waste |
| Appendix 5.22 | Regulatory Compliance, Biological and Medical Waste |
| Appendix 5.23 | NYState DEC Dental Mercury and Amalgam Law |

5-8 The school’s policies must ensure that the confidentiality of information pertaining to the health status of each patient is strictly maintained.

The University at Buffalo School of Dental Medicine is in compliance with Standard 5-8.

The school maintains the security and confidentiality of all protected health information for all school patients. The school has promulgated reasonable physical, electronic and managerial procedures to safeguard and secure each patient’s Protected Health Information. (Appendix 5.24, Appendix 5.25). In addition, faculty, staff and students are informed of their responsibility for protecting health information and kept abreast of the issue of confidentiality and security of protected health information. They are also informed of changes as a result of the Health Insurance Portability and Accountability Act via the school’s Clinic Newsletter and training seminars. Annual online training is mandatory for all new and continuing students prior to actual patient treatment. Training is also mandatory for all employees of the school whether or not they have direct patient care responsibilities. Tracking completion of this mandate occurs through the online HIPAA training module. An annual HIPAA Privacy self-assessment is submitted to the State University of New York (SUNY) per the request of Systems Administration (Appendix 5.26). This self-assessment ensures that the school is in compliance with.
the regulations. Those who fail to successfully complete HIPAA training are denied clinic privileges.

The State University of New York has developed a position statement regarding privacy practices, "Notice of Privacy Practices" (Appendix 5.24), which is distributed to the school's patients. All patients are asked to sign a written acknowledgment that they received the document at their initial screening appointment. Documentation is retained within the patient record.

The school's clinic information management system, known as Picasso (Appendix 1.5), has an extensive layered security system and follows modern best practices in application security to ensure the highest levels of patient confidentiality and data integrity. The data containing electronic patient information are stored on enterprise class secured servers. The servers are stored in a dedicated, secure room. There is an alarm monitored by the University Campus Police Office and a swipe card access system ensures that only authorized personnel have access to the room. The system logs all activity and a web camera monitors and records all activity in the room. Two layers of firewalls, a perimeter layer as well as a server layer, protect the servers and the data are encrypted as they travel on the network. The students, faculty and staff access the clinic system at point of care terminals using 2-factor authentication via a smart card. The smart card also enables users to "hot-desk," meaning they can pull the card out of the computer and insert it at any other computer and their computer session travels with them. This convenience, as well as the fact that the smart card performs other functions, ensures that the cards always travel with the users and therefore greatly help with ensuring privacy as the computer sessions are never left unattended even for small periods of time. The clinic system is also accessible remotely, and uses a SecureID token for 2-factor authentication. The token is tied to a user account and has the ability to generate a new one-time password every 30 seconds. A user must be in possession of the token and have knowledge of a valid username and password to gain access to the system. Instructions for Secure Picasso Remote Access can be found on the school's intranet site. Each user is assigned access to only that part of the clinic information system consistent with that individual's predetermined role (Appendix 5.27). An individual user's level of access to the clinic information system determines the individual screens and reports that the user may view. Modifications to any user's account are controlled by completion of a Picasso Modification Request Form (Appendix 5.28), and are only granted upon supervisor signature. As additional security measures, user accounts are disabled after successive logon failures and password standards are enforced. All logins/logoffs are monitored within the system.

Most clinic system users access the system using thin client technology, meaning that all data stay on the servers and the user's computer only displays the screen information. Nonetheless, standard practices are followed to ensure the highest level of user workstation security. The users' computers are protected by firewalls, scanned for viruses, and are updated for security fixes regularly. The university also regularly scans all computers for suspicious activities and promptly reports such activity. All reports are investigated and remediated in a timely fashion. The point-of-care computers are
running virtual machines on thin clients, meaning that the computers’ operating system can be quickly refreshed, thus preventing the likelihood of compromise. Users are also encouraged to report any suspicious activity or compromises to the school’s privacy and/or security officers, who monitor two published email addresses.

The written patient record is a repository for much of the patient Protected Health Information. Access to a patient record is limited to only those faculty and/or students who have responsibility for that patient’s care or to staff who are involved in managing that patient’s information. School policy requires that all patient records are stored in the chart room when not being used by faculty, staff or students for direct patient care or for planning care. If the patient record must be used after chart room hours, it is the responsibility of the individual faculty, staff or student who signed out the record to safeguard it in a reasonable manner so as to safeguard the Protected Health Information. Any violation of HIPAA policies and procedures can result in loss of clinic privileges until remediation (re-training) has been successfully completed.

The school was found to be in compliance when audited by the Office of the University Auditor, which based the audit on federal standards, in 2008 (SUNY Audit Report, available on-site).

Supportive Documentation:

Appendix 1.5  The SDM Electronic Oral Health (EoHR) Overview
Appendix 5.24  HIPAA Privacy Policy and Procedure Manual
Appendix 5.25  HIPAA Electronic Data Security Standard
Appendix 5.26  Annual HIPAA Privacy Self-Assessment Report
Appendix 5.27  Picasso Information Access Establishment
Appendix 5.28  Picasso Modification Request
On-Site  SUNY Audit Report