CODA Accreditation Self-Study

2026

Gene W. Hirschfeld School of Dental Hygiene

Old Dominion University

4608 Hampton Blvd.

Norfolk, VA 23529

(757) 683-3338

Faculty Members:

Sadirah Beck, Faculty Leader

Joanie Byant

Ketul Dave

Kyla Rigby

Lily Salazar

Naketa Stoudemire

Table of Contents:

STANDARD 6 – PATIENT CARE SERVICES

6-1 The program must have policies and mechanisms in place that inform patients, verbally and in writing, about their comprehensive treatment needs. Patients accepted for dental hygiene care must be advised of the scope of dental hygiene care available at the dental hygiene facilities.

Intent:

All dental hygiene patients should receive appropriate care that assures their right as a patient is protected. Patients should be advised of their treatment needs and the scope of care available at the training facility and appropriately referred for procedures that cannot be provided by the program. This Standard applies to all program sites where clinical education is provided.

Narrative Response and Documentation:

1. **Describe procedures used to accept patients for treatment in the program's clinic.**
   The David and Sofia Konikoff Dental Care Facility follows established protocols for accepting patients into its program to ensure compliance with accreditation standards. Appointments for dental hygiene care are scheduled by the office manager prior to appointment times in order of request or by individual students. Patients are waitlisted when necessary, and the list is accessed when appointments become available. Patients must be at least five years of age, and patients under 18 are required to be accompanied by a guardian. An introductory letter is given to prospective patients outlining clinic policies, services, patient rights, and expectations. Prior to care, patients must complete required documentation, including acknowledgement of clinic policies, informed consent letter, HIPAA privacy form, payment policy, and guardian consent when applicable. The David and Sofia Konikoff Dental Care Facility operates as a reduced-fee clinic and does not require dental insurance for admittance. Fees are determined based on the patient's assessed dental hygiene needs and must be paid in full prior to the initiation of services. Initial appointments involve comprehensive assessments, including medical and dental histories confirmed by faculty. When indicated, a physician consultation form is required before the initiation of invasive procedures. These protocols ensure patient eligibility and adherence to the standards of a supervised educational dental hygiene setting.

   - Exhibit 1: Introduction Letter to Patients

2. **Describe the scope of dental hygiene care available at the program's facility. As an exhibit, include the current clinical services forms(s).**
   The Old Dominion University Dental Hygiene Clinic provides diversified preventative and therapeutic dental hygiene services within the dental hygiene

legal scope of practice. All services are delivered in a proper educational setting under the supervision of licensed dental hygiene faculty and consulting dentists. Preventive services include a comprehensive review of medical and dental histories with documentation of vital signs, followed by a complete oral health assessment. This assessment encompasses extraoral and intraoral examinations, dental charting, periodontal evaluation, radiographic imaging, caries risk assessment, nutritional counseling, smoking-cessation counseling, fluoride application, sealant placement, and the development of an individualized treatment plan. Therapeutic services provided include dental prophylaxis, nonsurgical periodontal therapy, administration of local anesthesia, silver diamine fluoride application, and laser-assisted periodontal therapy. All treatment is provided based on individualized patient assessment and in accordance with evidence-based standards of care.

- Exhibit 2: Clinical Services Form

3. **Explain the mechanism by which patients are advised for their treatment needs and referred for procedures that cannot be provided by the program.**

   During a patient's initial appointment, students complete a comprehensive assessment. This includes a review of medical and dental history, an oral examination, periodontal evaluation, dental charting, radiographs if indicated, and a human needs assessment. Based on these findings, the development of an individualized treatment plan is completed. All findings and resulting treatment plans are documented in the program's electronic health record system, Axium. The plan is reviewed and confirmed by the supervising dental hygienist and dentist to ensure it meets the standards of care and prioritizes patient needs and safety. The proposed treatment, its alternatives, benefits, and risks are explained to the patient. The appropriate informed consent and radiology consent or refusal forms are obtained, a printed treatment estimate is generated by the student, and payment is collected by the office manager. If recommended services fall outside of the scope of care provided by the program, a written referral is issued to the patient to be given to a dental or medical provider by the patient. Such instances could include dental restorative fillings, extractions, oral surgery, implants, prosthodontics, advanced periodontal therapy, or medical indications like uncontrolled hypertension or uncontrolled diabetes.

   - Exhibit 3: Radiology Refusal Form
   - Exhibit 4: Informed Consent Form
   - Exhibit 5: Physician Consultation Forms
   - Exhibit 6: Dental Referral Form

4. **Describe how the dental hygiene treatment plans are presented and approved by faculty.**
   Dental hygiene treatment plans are developed by student clinicians after completing the required comprehensive assessment. Following this, the student

enters the proposed treatment plan into Axium, ensuring all procedures are coded correctly, sequenced in an appropriate order, and completed according to the patient's individual needs and dental hygiene scope of practice. Prior to presentation to the patient, the plan is reviewed and approved by the supervising licensed dental hygiene faculty. This is done to confirm accuracy of assessment findings, evaluate the appropriateness of recommended services, confirm proper phasing and sequencing, and ensure that the plan reflects current standards of care. Faculty approval is documented electronically through an electronic signature completed by a faculty identification card swipe that translates to Axium. Once approved by the faculty, the student presents the treatment plan to the patient, explains recommended procedures, alternatives, risks, fees, and the anticipated number of appointments, and obtains informed consent. Faculty continues to monitor and reapprove plan modifications at subsequent visits as needed.

- Exhibit 7: Treatment Plan Form

5. **Explain the program's recall policies and procedures.**
   The program maintains a structured recall system that supports continuity of patient care, student competency development, and clinic efficiency. Students are responsible for managing their assigned patients through consistent, professional, and confidential communication, as well as timely follow-up. At the initial appointment, students evaluate the patient's oral health status to determine an appropriate reappointment interval based on their clinical findings and the patient's individual care needs. To maintain continuity of care, reappointments are scheduled prior to the patient's dismissal. Students must provide the patient with an appointment card and enter the scheduled visit into their scheduling calendar located in Axium using the correct appointment code. Students are responsible for confirming all appointments directly with the patient one day prior and maintaining accurate schedules in Axium. When patients cancel appointments, students are required to contact the patient, attempt to reschedule, and document all communication in the patient record including, the date and time of contact. In the case of habitual cancellations or broken appointments, this may result in the patient's inactivation of care. Patients are informed that services may discontinue after two occurrences. This will result in the mailing of an inactivation letter to the patient's address. If the student is unable to contact the patient, a no phone call letter will be mailed, followed by an inactivation letter if the patient does not contact within the required two weeks. Recall intervals are determined based on the patient's oral health needs and must reflect a time period. Periodontal patients are scheduled based on a 3-to-4-month recall, while healthy patients are appropriate for longer intervals, such as 6 months.

   - Exhibit 8: No Phone Call Letter
   - Exhibit 9: Inactivation Letter

6. **As an exhibit, include a blank initial patient screening form.**

- Exhibit 10: Patient Screening Form

7. **As an exhibit, include a blank client consent form, physician's consultation form and dental referral form.**

    - Exhibit 11: Informed Consent Form
    - Exhibit 12: Physician Consultation Form
    - Exhibit 13: Dental Referral Form

6-2 **The program must have a formal written patient care quality assurance plan that allows for a continuous systematic review of patient care standards. The quality assurance plan must be applied at least annually and include:**

a) standards of care that are patient-centered, focused on comprehensive care, and written in a format that facilitates assessment with measurable criteria;

b) an ongoing audit of a representative sample of patient records to assess the appropriateness, necessity and quality of the care provided;

c) mechanisms to determine the cause of treatment deficiencies;

d) patient review policies, procedure, outcomes and corrective measures.

Intent:

The program should have a system in place for continuous review of established standards of patient care. Findings should be used to modify outcomes and assessed in an on-going manner. This Standard applies to all program sites where clinical education is provided.

Narrative Response and Documentation:

1. **Describe the program's formal written patient care quality assurance plan.** The Quality Assurance Program is designed to ensure that established standards of care are consistently met while maintaining a safe clinical environment for patients, students, and faculty. This information-based process works to identify, evaluate, and address potential oversights found within patient electronic health records and radiographic records. This is conducted through ongoing monitoring methods such as patient chart audits, radiographic reviews, incident report analysis, sterilization and infection control monitoring, patient satisfaction surveys, and computerized tracking of treatment progress to prevent patient abandonment.

2. **Describe the process to review a representative sample of patient records.** The program completes a formal, systematic patient record audit process as a part of the quality assurance program. This is done to ensure compliance with the established standards of care, documentation, and record-keeping requirements.

Record selection for the review takes place annually by selecting a sample of patient records, including periodontal therapy, prophylaxis, periodontal maintenance, pediatric, and medically compromised patients. To ensure objectivity, records are randomly selected from both completed and active cases, as well as varying in patient classifications. Records are assessed utilizing a Standard Patient Record Audit Form to assess completeness and accuracy of histories, periodontal charting, risk assessments, radiographs, faculty approvals, treatment planning, informed consent, referrals, follow-ups, and HIPAA compliance. Audit findings are summarized in a Quality Assurance report, discrepancies are categorized, and trends are analyzed to identify reoccurring issues. Corrective actions may include chart corrections, faculty-student remediation, clinical re-evaluations, policy revisions, and faculty calibration to ensure continuous monitoring and improvement of patient care quality.

3. **As an exhibit, include the patient record audit form.**

    - Exhibit 14: Patient Record Audit Form
    - Exhibit 15: Chart Audit Review Report

4. **Describe how patient treatment deficiencies are identified and corrected.**
   As a part of the program's quality assurance program, faculty complete monthly audits of patient charts and radiographic records. When a deficiency is identified, the faculty member originally involved in the patient's treatment must complete the revision. The responsible faculty member then meets with the student provider to review and correct the error. All corrections are documented as a service rendered note in the patient's chart. Patients with incomplete treatment due to a deficiency are reappointed to complete their care. If the patient's treatment was completed, the patient is contacted and asked to return to complete their care. If the patient refuses to return, the refusal is documented in the patient's chart. This process ensures patient care is thorough, completed, and deficiencies are addressed and corrected.

5. **Identify the policies and procedures used to track completed patients and ensure active patients are completed.**
   To prevent patient abandonment and ensure completion of care, the program uses the Clinical Evaluation System (CES) to monitor treatment as planned, in progress, or completed. Monthly reports are conducted to identify incomplete cases. Students are required to review any outstanding treatment needs and report updates to the Clinic Director. All patient treatment information is documented and verified in Axium, where missed appointments and cancellations are recorded the same day for legal compliance. Students are to maintain an updated patient log within a shared Google document accessible to the office manager, allowing for ongoing monitoring of patient numbers and treatment progress. Further oversight is provided through middle and end-of-semester clinical conferences with faculty advisors providing additional accountability and case review. If a patient decides to terminate treatment, a formal letter is issued documenting the decision prior to

the patient being removed from the active system. Frequent meetings between the office manager and clinical affairs supervisor, centered on payment audits, ensure that pending services are properly documented. Students are responsible for ensuring appropriate patient communication to prevent patient abandonment and potential legal consequences, while faculty closely monitor their progress to identify and correct any errors.

6. **Identify any changes made to clinic policies and/or procedures based on quality assurance program outcomes. As an exhibit, include the quality assurance reports.**
   When deficiencies are identified, faculty collaborate with students to correct errors, provide additional treatment if needed, notify or reappoint patients when appropriate, and document all actions taken. Recurring issues are addressed through faculty review and remedial training to improve clinical consistency and quality of care. At the end of each semester, quality assurance reports are generated to help faculty and students identify patterns of concern and implement corrective actions that support continuous improvement in patient care.

   - Exhibit 16: Radiographic Quality Assurance Report
   - Exhibit 17: Incident Report Forms
   - Exhibit 18: Chart Audit Review Report
   - Exhibit 19: Sterilization Log Report
   - Exhibit 20: Patient Satisfaction Survey Results Report
   - Exhibit 21: Weekly and monthly Patient Billing Account Audit
   - Exhibit 22: Student List of "Planned" and "In Progress" Treatments

7. **Discuss how the program assesses patients' perceptions of quality of care. Describe the mechanisms to handle patient complaints. As an exhibit, include the patient satisfaction survey instruments and data results.**
   The program assesses patients' perceptions of quality of care through the confidential Patient Satisfaction Survey identified in the Patient Bill of Rights. This serves as the formal mechanism for patients to provide feedback, comments, or concerns about their treatment. The Patient Satisfaction Survey results are compiled into a semester report that is reviewed by faculty and students to identify patterns of strengths or deficiencies and to guide continuous quality improvement. The HIPAA Privacy Form outlines the process for submitting complaints related to privacy or access to health information, allowing patients to file concerns with the Director of Clinical Affairs or the U.S. Department of Health and Human Services without fear of retaliation. The Commission on Dental Accreditation Complaints Policy provides an additional external avenue for submitting concerns related to the program's compliance with accreditation standards. Together, these mechanisms ensure that patient feedback is collected systematically and that complaints are addressed promptly, transparently, and in accordance with institutional, federal, and accreditation requirements.

   - Exhibit 23: Patient Satisfaction Survey

- Exhibit 24: Patient Satisfaction Survey Results Report
- Exhibit 25: Patient Bill of Rights
- Exhibit 26: HIPAA Privacy Form
- Exhibit 27: CODA Complaints Policy

6-3 The use of quantitative criteria for student advancement and graduation must not compromise the delivery of comprehensive dental hygiene patient care.

Intent:

The need for students to satisfactorily complete specific clinical requirements prior to advancement and graduation should not adversely affect the health and care of patients

Narrative Response and Documentation:

1. **Describe policies and procedures relative to patient assignment strategies.** While scheduling patient care, students may personally recruit patients, be assigned community patients by the office manager, or schedule patients who are due for their recare appointments. Students are encouraged to recruit and schedule personally recruited patients throughout the clinical program. Documents and marketing tools are provided to students to recruit patients. The office manager is responsible for compiling a new patient wait list for patients seeking appointments through the clinic. This document is detailed with relevant information, such as the date of the patient's last dental appointment and previously identified difficulty level. This allows students to determine whether a prospective patient meets their clinical requirements. Depending on the student's semester of training, faculty members assess patients to ensure alignment with the student's current skill level. For cases involving advanced periodontal conditions or heavy calculus classifications, junior students are permitted one designated teaching case per semester. If the case is too advanced, the patient is transferred to a senior student. Senior students may also complete one ungraded case per semester. Teaching cases allows for more focused instruction time for difficult cases.

    - Exhibit 28: Patient Recruitment Form

2. **Discuss all efforts made to ensure students can complete clinical patient requirements.**

    Each student is assigned to a clinic advisor and is required to meet for advising sessions on their progress in completing clinical patient requirements. Students are required to schedule a mid-semester advising session to review their progress halfway through the semester. If a student is falling behind on requirements, a mid-semester advising letter is issued with a time frame to complete requirements. At the end of the semester, all students meet with the clinic director for a review

of their level of completion of clinical patient requirements and their grades. It is the student's responsibility to schedule meetings and come prepared with advising forms complete. Make-up clinic sessions are available for students to schedule, upon approval by the clinic director, in cases of absence or need. In the spring semester of senior year, students who have not met all requirements are enrolled in the summer term to complete remaining requirements and subsequently graduate.

6-4 The program must develop and distribute a written statement of patients' rights to all patients, appropriate students, faculty, and staff.

Intent:

The primacy of care for the patient should be well-established in the management of the program and clinical facility assuring that the rights of the patient are protected. A written statement of patient rights should include:

a) considerate, respectful and confidential treatment;
b) continuity and completion of treatment;
c) access to complete and current information about his/her condition;
d) advance knowledge of the cost of treatment;
e) informed consent;
f) explanation of recommended treatment, treatment alternatives, the option to refuse treatment, the risk of no treatment, and expected outcomes of various treatments;
g) treatment that meets the standard of care in the profession.

Narrative Response and Documentation:

1. **As an exhibit, provide a copy of the written statement of patients' rights. Describe how the statement is distributed to students, faculty, staff, and patients.**
   Patients receive a copy of the Patient Bill of Rights at their initial clinical appointment. During every new or recare appointment, the office assistant provides all new or recare patients with a folder of clinic policies, including the Patient Bill of Rights. Patients are instructed to review the information while waiting to be seated for their appointment, ensuring they understand their rights before being treated by student providers. The program documents patient acknowledgment of the Patient Bill of Rights through its formal consent process. The signed consent forms are uploaded into AXIUM as part of the permanent health record, ensuring patients have reviewed and received the information and may request copies at any time. Students, faculty, and staff also receive the Patient Bill of Rights through the School of Dental Hygiene Policies and Procedures Manual. The school maintains ongoing oversight of the Patient Bill of Rights through routine quality assurance measures that verify it is consistently

distributed, explained, and documented, with any gaps promptly corrected. The Patient Bill of Rights is also reviewed annually, and updated versions are shared with all stakeholders to ensure continued clarity and alignment with institutional expectations.

- Exhibit 29: Patient Bill of Rights

6-5 The program's policies must ensure that the confidentiality of information pertaining to the health status of each individual patient is strictly maintained.

Intent:

The program should have a system in place to ensure patient confidentiality. All individuals who have access to patient information will ensure patient confidentiality.

Narrative Response and Documentation:

1. **Describe how patient confidentiality is maintained.**
   Patient health records include demographic data, medical, dental, and pharmacological histories, examination findings, radiographs, consultations, and diagnostic information. All patient information is classified as Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA). To safeguard patient identity, each individual is assigned a unique personal identification number. Access to electronic health records is limited to authorized university clinic personnel. Students may only access records through secure, individualized login credentials and passwords of patients that are assigned to their care. All students and employees are required to complete HIPAA training to understand privacy policies and legal responsibilities. Additionally, patients sign a HIPAA consent form authorizing the use and disclosure of their information for treatment, payment, and healthcare operations, ensuring their health information remains confidential and protected.

   - Exhibit 30: HIPAA Privacy Form

Examples of Selected Exhibits:

Exhibit 1: Introduction Letter to Patients
Exhibit 2: Clinical Services Form
Exhibit 3: Radiology Refusal Form
Exhibit 4: Informed Consent Form
Exhibit 5: Physician Consultation Forms
Exhibit 6: Dental Referral Form
Exhibit 7: Treatment Plan Form
Exhibit 8: No Phone Call Letter
Exhibit 9: Inactivation Letter
Exhibit 10: Patient Screening Form
Exhibit 11: Informed Consent Form
Exhibit 12: Physician Consultation Form
Exhibit 13: Dental Referral Form
Exhibit 14: Patient Record Audit Form
Exhibit 15: Chart Audit Review Report
Exhibit 16: Radiographic Quality Assurance Report
Exhibit 17: Incident Report Forms
Exhibit 18: Chart Audit Review Report
Exhibit 19: Sterilization Log Report
Exhibit 20: Patient Satisfaction Survey Results Report
Exhibit 21: Weekly and monthly Patient Billing Account Audit
Exhibit 22: Student List of “Planned” and “In Progress” Treatments
Exhibit 23: Patient Satisfaction Survey
Exhibit 24: Patient Satisfaction Survey Results Report
Exhibit 25: Patient Bill of Rights
Exhibit 26: HIPAA Privacy Form
Exhibit 27: CODA Complaints Policy
Exhibit 28: Patient Recruitment Form
Exhibit 29: Patient Bill of Rights
Exhibit 30: HIPAA Privacy Form