

CODA Accreditation Self-Study

2026

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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. (SADIRAH)

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 form(s). (KETUL)

The school of Dental Hygiene gives diversified preventative and therapeutic dental hygiene services within the scope of practice for licensed dental hygienists. All services are delivered in a proper educational setting under the supervision of licensed dental hygiene faculty and consulting dentists. The David and Sofia Konikoff Dental Care Facility provide clinical services like medical and dental history overview, comprehensive oral health assessments, periodontal charting and risk assessment, vital signs assessment and risk evaluation, extraoral and intraoral examinations, radiographic services (periapical, bitewings, panoramic as indicated). Dental charting, Dental prophylaxis, non-surgical periodontal therapy (scaling and root planning), local anesthesia administration, periodontal maintenance, desensitizing agents, application of topical fluoride (varnish/gel) are also included as a part of clinical service. Nutritional and tobacco cessation counseling, sealant placement, patient education and oral hygiene instruction, silver diamine fluoride application (if mentioned within scope) and Caries risk assessment are also included as a part of clinical services. In general, the treatment is provided based on individualized patient assessment and in accordance with evidence-based standards of care. Services which are outside the scope of dental hygiene that are not provided in the facility and require formal approval include extractions, restorative dentistry, endodontics, prosthodontics, orthodontics, implants, and complex oral surgery. Patients are made aware of the scope and limitations of services verbally and in writing during the initial appointment and via the Introduction Letter to Patients.

Exhibit 3: Current Clinical Services Form

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

During the initial appointment, students are required to complete a comprehensive assessment that includes a review of medical and dental history, oral examination, periodontal evaluation, dental charting, assessment of human needs, and determination of radiographs on their patients. Based on these findings, a treatment plan is developed in Axium (the University's electronic health record system) and reviewed with the supervising faculty and dentist to ensure it meets standards of care and patient safety. The proposed treatment, alternatives, risks, and benefits are clearly explained to the patient, and appropriate informed consent and radiology consent or refusal forms are signed. A printed treatment estimate is provided, and payment is collected by the office manager. If needed services fall outside the scope of care, such as

restorative fillings, extractions, oral surgery (including implants or third molars extractions), prosthodontics, advanced periodontal therapy, or medical clearance for conditions like uncontrolled hypertension, a written referral form is issued to the appropriate dental or medical provider, as the Old Dominion School of Dental Hygiene does not provide restorative treatment.

- Exhibit 4: Radiology Refusal Form
- Exhibit 5: Informed Consent Form
- Exhibit 6: Physician Consultation Forms
- Exhibit 7: Dental Referral Procedure Form

4. Describe how the dental hygiene treatment plans are presented and approved by faculty. (JOANIE)

Dental hygiene treatment plans are developed by student clinicians after completing all required assessments, including health history, oral evaluation, periodontal charting, radiographic needs, and other diagnostic data. The student enters the proposed treatment plan into Axiom, ensuring that procedures are correctly coded, sequenced and organized according to patient needs and the dental hygiene scope of practice. Before the plan is shared with the patient, licensed dental hygiene faculty review and approve it. Faculty verify the accuracy of the assessment findings, evaluate the appropriateness of recommended services, confirm proper phrasing and sequencing, and ensure that the plan reflects current standards of care. Approval is documented electronically through the faculty card swipe in Axiom. 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 continue to monitor and reapprove plan modifications at subsequent visits as needed.

- Exhibit 8: Treatment Plan Form

5. Explain the program's recall policies and procedures. (KYLA)

The program maintains a structured recall system that supports continuity of patient care, student competency development, and clinic efficiency. Students manage their assigned patients through consistent, confidential communication and timely follow-up. At the initial appointment, students assess the patient's oral health needs and determine appropriate recall intervals based on individual periodontal status, caries risk, and treatment plans. Recall intervals must reflect a specific time interval based on the patient's oral health needs. Periodontal patients generally require more frequent recare (such as 3- or 4-month intervals), while healthy patients may be appropriate for longer intervals such as 6 months. Reappointments are scheduled before the patient is dismissed to ensure appropriate continuity of care, and students must provide the patient with an appointment card and enter the next visit into the electronic scheduler using the appropriate appointment code. Students are responsible for confirming all appointments directly with the patient one day prior and maintaining accurate schedules in the electronic system. When patients cancel appointments, students are required to contact the patient, attempt to reschedule, and document all communication in the patient record. Habitual

cancellations or broken appointments may result in patient inactivation following the program's documented procedures, including informing the patient that clinic services may be terminated after the second occurrence and issuing a No Phone Call Letter followed by an Inactivation Letter within two weeks.

- Exhibit ? : No Phone Call Letter
- Exhibit ? : Inactivation Letter

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

- Exhibit ? : Patient Screening Form

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

- Exhibit ? : Informed consent form
- Exhibit ? : Physician consultation form
- Exhibit ? : 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. (NAKETA)

The Quality Assurance Program is designed to ensure that established standards of care are consistently met while maintaining a safe clinical environment for patients and providers. This information-based system works to identify, evaluate, and correct potential problems in patient

treatment through ongoing monitoring methods such as patient chart audits, radiographic grading reviews, incident report analysis, sterilization and infection control monitoring, patient satisfaction surveys, and computerized tracking of treatment progress to prevent patient abandonment. Every patient is evaluated before and after treatment, and faculty review all services provided to confirm proper implementation and documentation of care.

2. Describe the process to review a representative sample of patient records. (KETUL)

The program keeps a formal, systematic patient record audit process as part of the Quality Assurance (QA) plan. This is done to ensure compliance with the established standards of care and documentation requirements. Record Selection Process takes place by annually selecting a sample of patient records. The sample has patients from different classifications such as periodontal therapy, prophylaxis, maintenance cases, pediatric patients, and medically compromised patients. To ensure objectivity, records are selected randomly from completed and active cases. A systematic sample patient records are annually reviewed for maintaining systematic quality assurance. Records are assessed by a Standard Patient Record Audit Form. The purpose of it is to ensure accuracy and completeness of dental/medical histories, comprehensive periodontal charting, documentation of vital signs and risk assessments, radiographic justification and interpretation, faculty approval documentation (Axium electronic signature), evidence-based treatment planning. Also, it ensures proper sequencing and completion of planned treatment, informed consent documentation, referral documentation when needed, recall documentation and follow-up notes, and compliance with HIPAA and documentation standards. For Evaluation and reporting purposes, Audit findings are compiled into a QA Summary report; Discrepancies are categorized for example – documentation error, clinical judgement issue, incomplete treatment, sequencing issue, etc. Trends are analyzed to identify recurring concerns and results are presented during faculty meetings and incorporated into semester QA reports. When discrepancies are figured out, corrective actions include Immediate chart correction (if documentation is omitted), Faculty student remediation session, Clinical re-evaluation of patients if required, Policy revision or faculty calibration discussion. This type of structured audit mechanism ensures continuous monitoring of patient care quality.

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. To ensure objectivity, records are randomly selected from both completed and active cases, as well as, varying in patient classifications.

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

Exhibit 11: Patient Record Audit Form

Exhibit 12: Chart Audit Review Report

4. Describe how patient treatment deficiencies are identified and corrected. (SADIRAH)

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 services rendered note in the patient's chart. Patients with incomplete treatment due to a deficiency are reappointed to complete their care. In the event that 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. (LILY)

To prevent patient abandonment and ensure completion of care, the program uses the Clinical Evaluation System (CES) to track treatments categorized as planned, in progress, or completed. Monthly reports identify incomplete cases, and students must review outstanding treatments and report updates to the Clinic Director. All patient information is documented and verified in Axiom, where missed appointments and cancellations are recorded the same day for legal compliance. Students also maintain an updated patient log in a shared Google document accessible to the office manager to monitor patient numbers and treatment progress. Mid- and end-of-semester clinical conferences with faculty advisors provide additional oversight and accountability. If a patient decides to discontinue treatment, a formal letter is sent documenting the decision before the patient is removed from the active system. Regular meetings between the office manager and clinical affairs supervisor, along with payment audits, further ensure that pending services are properly documented. Ultimately, students are responsible for appropriate follow-up to prevent patient abandonment and potential legal consequences.

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. (NAKETA)

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 ? : Radiographic Quality Assurance Report
- Exhibit ? : Incident Report Forms
- Exhibit ? : Chart Audit Review Report
- Exhibit ? Sterilization Log Report
- Exhibit ? : Patient Satisfaction Survey Results Report
- Exhibit ? : Weekly and monthly Patient Billing Account Audit
- Exhibit ? : 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. (KYLA)

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. 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 ? : Patient Satisfaction Survey
- Exhibit ? : Patient Satisfaction Survey Results Report
- Exhibit ? : Patient Bill of Rights
- Exhibit ? : HIPPA Privacy Form
- Exhibit ? : CODA Complaints Policy

Examples of evidence to demonstrate compliance with 6-2 may include:

- documentation of an ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of care provided
- quality assurance policy and procedures
- patient bill of rights
- documentation of policies on scope of care provided, recalls and referrals
- description of the quality assurance process for the patient care program
- samples of outcomes assessment measures that assess patients' perceptions of quality of care, i.e., patient satisfaction surveys and results
- results of patient records review

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. (JENNIFER)

Students are encouraged to recruit and schedule their own patients throughout the 2-year program. Documents and marketing tools are provided via Canvas for students to distribute. There is an option for students to mark "Please Fill" to alert the office manager and student office assistant there is a student who would like help finding a patient for that appointment. Students are expected to compile their own recall list of completed patients throughout the semesters.

The office manager compiles a new patient wait list as well, detailing the last time they had a cleaning or previous difficulty level so students can identify if they will match requirements they need to be met. Faculty is able to assess patients to determine if the student's skill level is appropriate, if a patient would be too challenging, they are rescheduled with the student in senior year. In cases for very challenging periodontal or calculus classification, junior year students are able to have one teaching

case a semester and senior year students are able to have one ungraded case a semester. This allows more focused instruction time for such difficult cases.

- Exhibit X: Policies and Procedures Manual: Patient Recruitment

2. Discuss all efforts made to ensure students can complete clinical patient requirements. (JENNIFER)

Each student is assigned a clinic advisor and are required to meet mid-semester to review progress. At the end of the semester all students meet with the clinic director for a review of 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. As for the spring semester of the student's senior year, if requirements are not met, they will be enrolled in a summer semester to finish 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. **(JOANIE)**
Patients receive this information at their first clinical interaction. During every new or recare appointment, the Office Assistant

provides all new or recare patients with a folder of clinic policies, which includes the Patient Bill of Rights. Patients are instructed to review the information while waiting 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, in which 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 8 - 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. (LILY)

Patient records include demographic data, medical, dental, and pharmacological histories, examination findings, radiographs, consultations, and diagnostic information, all of which are 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, and students may only access records through secure, individualized login credentials and passwords. 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 9: HIPAA policy

Exhibits:

- Exhibit 1:
- Exhibit 2:
- Exhibit 3:
- Exhibit 4: Radiology Refusal Form
- Exhibit 5: Informed Consent Form
- Exhibit 6: Physician Consultation Forms
- Exhibit 7: Dental Referral Procedure Form
- Exhibit 8: Treatment Planning
- Exhibit 7: Radiographic Quality Assurance Report
- Exhibit 7: Incident Report Forms
- Exhibit 7: Chart Audit Review Report
- Exhibit 7: Sterilization Log Report
- Exhibit 7: Patient Satisfaction Survey Results Report
- Exhibit 7: Weekly and monthly Patient Billing Account Audit
- Exhibit 7: Student List of “Planned” and “In Progress” Treatments
- Exhibit 9: Patient Bill of Rights Information Form
- Exhibit 10: HIPAA policy