

Quality Management Program

PURPOSE

To establish systems and processes within (insert name of health center) that will help assure the provision of high quality oral health care as well as identify any deficiencies in the patient care process as opportunities for performance improvement. The Quality Management Program also establishes, monitors and reports on metrics designed to measure the outcomes of oral health care provided on both an individual and population basis.

PROGRAM OVERVIEW

The Quality Management Program at (*name of clinic*) is based on the report by the Institute of Medicine (IOM). In this report, the IOM urges providers to adopt a shared vision of six specific aims for improvement. These aims are built around the core need for health care to be:

- *Safe*: avoiding injuries to patients from the care that is intended to help them.
- *Effective*: providing services **based on scientific knowledge** to all who could benefit, and refraining from providing services to those not likely to benefit.
- *Patient-centered*: providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.
- *Timely*: reducing waits and sometimes harmful delays for both those who receive and those who give care.
- *Efficient*: avoiding waste, including waste of equipment, supplies, ideas, and energy.
- *Equitable*: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

The Quality Management Program is intended to provide (*insert name of organization*) with a tool to aid in the improvement of quality within our practice. In no way should it be construed as a punitive system. We developed it, for ourselves and our patients, so that we can systematically monitor and improve the care provided as well as the satisfaction of such, by both the patient and ourselves.

(Insert name of health center) will use three approaches as part of its Quality Management Program:

1. Objective dental record peer reviews to examine and evaluate patient documentation against well-defined criteria. To conduct these reviews, the health center will either

utilize staff dentists (who will review charts other than their own) or contract with outside dental professionals. A sample chart audit tool is included in Appendix B.

2. Objective measures to demonstrate improved oral health outcomes (eg, the number of patients who complete Phase I treatment within 12 months of their exam).
3. Subjective patient outcomes assessed via patient satisfaction surveys, which measure the patient's perception of the care experience and results of that care.

DEFINITIONS

In order to be clear about the structure, process and goals of the program, all significant terms will be defined. To begin, the following definitions are offered:

Quality of Care

Quality of care reflects a desired degree of excellence in the provision of health care. Though quality is a subjective attribute, various characteristics usually associated with the health care delivery process are thought to be determinants of quality. These include: structural adequacy, access and availability, technical abilities of practitioners, practitioner communication skills and attitudes, documentation of services provided, coordination and follow-up, patient commitment and adherence to a therapeutic regimen, patient satisfaction, and clinical outcomes. JCAHO provides the following criteria:

- Efficacy: Is the care/procedure useful?
- Appropriateness: Is it right for this patient?
- Accessibility: If right, can this patient get it?
- Acceptability: If right and available, does this patient want it?
- Effectiveness: Is it carried out well?
- Efficiency: Is it carried out in a cost-effective way?
- Continuity: Did it progress without interruption, with appropriate follow up, exchange of information and referral?

Quality Assurance (QA)

A formal set of activities that measure the kind and degree of excellence of health care services provided. Quality assurance includes both a measurement phase (quality assessment) and corrective actions (quality improvement) to remedy any deficiencies identified through the quality assessment process.

Quality Measurement (QM)

The measurement phase in a quality assurance program, in which pre-established criteria or standards for professional performance, with respect to patient, administrative, and support services, are compared against the health care actually provided. The medical record is used as documentation of the care provided.

Quality Improvement (QI)

A formal, ongoing process of identifying problems in health care delivery, testing solutions to those problems, and continually monitoring the solutions for improvement. QI is a common feature of total quality management (TQM) programs. Generally, an organization undertakes QI to achieve continual improvement in the quality of operations and elimination of waste in all functions of the organization through design and redesign processes. The aim of QI is elimination of variations or "defects" in health care delivery through elimination of their causes.

Outcomes Measurement

The process of systematically tracking a patient's clinical treatment and responses to that treatment using generally accepted outcomes measures, or *quality indicators*, such as mortality, morbidity, disability, functional status, recovery, and patient satisfaction.

PROGRAM STRUCTURE

The Dental Director is responsible for the Quality Management Program. He/she will report all QA/QI activities and results to the overall health center quality committee and governing body. He/she will also assure that:

- There is a written description of the Quality Management Program that outlines program structure and design.
- The Quality Management Program is reviewed annually and updated as necessary.
- The Dental Director has substantial involvement in QA/QI activities.
- The staff dentists participate in QA/QI activities.
- Resources dedicated to the program are adequate to meet needs.
- There are contemporaneous (created at the time of the activity is being conducted) records reflecting QA/QI activities.
- There is an annual QI work plan, or schedule of activities, that includes the following:
 - Objectives, scope, and planned projects or activities for the year;
 - Planned monitoring of previously identified issues, including tracking of issues over time
 - Planned evaluation of the QI plan.

COORDINATION WITH OTHER MANAGEMENT ACTIVITY

The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QA/QI activity will be documented and reported to appropriate individuals within the organization.

- QA information will be used in re-contracting, re-credentialing and annual performance evaluations.
- QA activities will be coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of patient complaints and grievances.
- There will be a linkage between QA and other management functions such as feedback to providers and patient education.

SCOPE AND CONTENT

There will be an ongoing Quality Management Program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and service provided to patients, and to pursue opportunities for improvement.

The scope of the Quality Management program will be comprehensive and includes both the quality of clinical care and the quality of service.

Patients may offer suggestions for improving the quality of care and/or the patient experience of care.

The monitoring and evaluation of clinical issues will reflect the population served by the dental program and/or health center in terms of age groups, disease categories, and risk status.

IMPORTANT ASPECTS OF CARE AND SERVICE

The Quality Management process will use a variety of mechanisms to identify important areas for improvement and to set meaningful priorities.

- The monitoring and evaluation of important aspects of care and service include high-volume, high-risk services, and the care of acute and chronic conditions.
- The practice will adopt and use practice guidelines or explicit criteria that are based on reasonable scientific evidence and reviewed by the Professional Advisory Panel of the governing body.
- There will be an annual review of the practice guidelines and they will be updated as needed.
- Performance will be assessed against the guidelines.
- There will be an evaluation of the continuity and coordination of care that patients receive.
- There will be an evaluation to detect underutilization as well as overutilization of services.

ACCESS TO CARE AND SERVICE

There will be guidelines established for the availability of dental professionals and access to routine, urgent, and emergency care. Performance on these dimensions of access will be assessed against these standards.

MEASUREMENT AND IMPROVEMENT

The practice will use measurements, QA data collection, and analysis to track quality improvement.

- Quality indicators that are objective, measurable, and based on current knowledge and clinical experience will be used to monitor and evaluate each important aspect of care and service identified.
- Performance goals and/or benchmarking will be established for each indicator.
- Appropriate methods and frequency of data collection will be used for each indicator.
- Data collected through monitoring and evaluation activities will be analyzed.

CHART AUDITS

Chart audits will be conducted on a quarterly basis for all providers (dentists and hygienists). The chart audit process is outlined in Appendix A, and the audit tool is included as Appendix B.

CHARTING REQUIREMENTS

General Guidelines:

Adult Chart Notes

All adult patients (18 or older) of record must have the following in their chart notes:

1. Either a new medical history or a note stating “medical history reviewed”; and
2. An approval note signifying that the dentist has read/edited the note and approves its content
3. The patient’s chief complaint
4. A recording of the patient’s perception of the amount of pain they are in (based on a 0-10 scale, with 10 being excruciating pain)
5. A intraoral and extraoral exam performed and documented
6. An initial/recall exam with recording of both the hard and soft tissue findings
7. A sequenced treatment plan
8. Blood pressure updated once per year or more often as needed
9. Radiographs taken in accordance with the ADA guidelines:
http://www.ada.org/~media/ADA/Member%20Center/Files/Dental_Radiographic_Examinations_2012.ashx
10. Complete medical history with alerts for any medical issues that could affect the dental care provided. The history needs to be reviewed at each appointment with a new history completed once per year.
11. A completed periodontal charting once per year with a periodontal diagnosis
12. Signed consents for the following procedures:
 - Root canals
 - Any surgical procedures
 - Nitrous oxide/ Oral Sedation/ GA
13. Type and amount of anesthetic used
14. Description of the procedure(s) completed including all materials used
15. All medications prescribed including the name of the drug, amount prescribed and directions for use
16. A note to indicate that post-op or pre-op instructions were given
17. A signed treatment note

Children Chart Notes

All children patients (younger than 18) of record must have the following in their chart notes:

1. Parental/guardian verbal consent for treatment.
2. Either a new medical history or a note stating “medical history reviewed with guardian”; and
3. An approval note signifying that the dentist has read/edited the note and approves its content
4. The patient’s chief complaint
5. A recording of the patient’s perception of the amount of pain they are in (based on a 0-10 scale, with 10 being excruciating pain)
6. A intraoral and extraoral exam performed and documented
7. An initial/ recall exam with recording of both the hard and soft tissue findings.
8. A sequenced treatment plan
9. Blood pressure only as needed (e.g.- sedation appointments or specific medical issues)

10. Radiographs taken in accordance with the ADA guidelines: [http://www.ada.org/~media/ADA/Member%20Center/Files/Dental Radiographic Examinations 2012.ashx](http://www.ada.org/~media/ADA/Member%20Center/Files/Dental_Radiographic_Examinations_2012.ashx). If radiographs are not possible (e.g. - very young or uncooperative children), there should be a note indicating this.
11. Complete medical history with alerts for any medical issues that could affect the dental care provided. The history needs to be reviewed at each appointment with a new history completed once per year.
12. A description of their periodontal condition and a periodontal diagnosis.
13. A completed PSR score for children with no deciduous teeth once per year with a periodontal diagnosis
14. Signed consents for the following procedures:
 - Root canals
 - Any surgical procedures
 - Nitrous oxide/ Oral Sedation/ GA
15. Type and amount of anesthetic used
16. Description of the procedure(s) completed including all materials used
17. All medications prescribed including the name of the drug, amount prescribed and directions for use
18. A note to indicate that post-op or pre-op instructions were given.
19. A signed treatment note

Emergency Chart Notes

All Dental Emergency Patient chart notes must include the following:

1. A complete medical history with alerts for any medical issues that could affect the dental care provided.
2. The patient's description of pain.
3. All diagnostic tests required to diagnosis the problem (e.g. – EPT, cold/heat sensitivity, percussion, mobility, swelling/fistula)
4. All radiographs needed to diagnose the problem. The apex of the root must be visible on any periapical film.
5. A specific diagnosis based on subjective and objective findings
6. A complete description of any procedure done during the appointment
7. All medications prescribed including the name of the drug, amount prescribed and directions for use.

ACTION AND FOLLOW-UP

The (*insert name of clinic*) will take action to improve quality and assess the effectiveness of these actions through systematic follow-up.

- The results of the evaluations will be used to improve clinical care and service.
- There will be a systematic method of tracking areas identified for improvement to assure that appropriate action is taken.
- There will be follow-up on identified issues to ensure that actions for improvement have been effective.

EFFECTIVENESS OF THE QUALITY MANAGEMENT PROGRAM

The governing body will evaluate the overall effectiveness of the Quality Management Program. There will be an annual written report on quality, including a report of completed QA activities, trending of clinical and service indicators and other performance data, and demonstrated improvements in quality.

An evaluation will be made as to whether QA activities have contributed to improvement in the care and service provided to patients.

APPENDIX A: GUIDELINES FOR COMPLETING THE QUARTERLY CHART REVIEW FORM

(Insert name of program) conducts quarterly chart audits in which all of our dentists participate. At the beginning of each quarter, each dentist will be assigned a provider to be reviewed and a date by which the chart audits will be completed.

This chart audit is not designed to identify individual dentist's quality of care issues. If quality concerns are found, the provider needs to report those to the dental director for an in depth analysis. This review is designed to identify QA trends and adherence to dental program risk management policies.

The following guidelines are designed to help the reviewer understand what to look for during the chart audit and to calibrate all reviewers for more consistent results.

PATIENT CHART #:

Access the indicated provider's schedule and pick 10 charts at random done within the past 2 months. Pick at least 4 exams, 2 emergency patient charts and 4 restorative charts (fillings, endo, surgery etc).

DATE OF PATIENT VISIT:

List the date for the treatment note that you have selected. If this is an emergency treatment, you will need to review that chart entry and any other chart entry related to this emergency procedure (i.e. all follow-ups). If the entry selected is a part of a patient's routine care, you will need to review all entries up to the most recent exam.

CHART REVIEW:

The Reviewer will have 3 choices to fill out for the QA items listed:

No Issues Found:

This choice indicates that the dentist adhered to our risk management policies

Needs Improvement:

This choice simply indicates that the reviewer could not find the evidence that the QA indicator was adhered to and that there is no obvious reason why it should not be in the notes. It does not automatically mean that there is a quality of care concern

N/A

This choice does not apply. i.e. The category 'Sedation protocols followed' would be marked N/A for a chart where no sedation was done

1. Orders appropriate/ dx radiographs

Refer to the *ADA Guidelines For Prescribing Dental Radiographs* found at http://www.ada.org/~media/ADA/Member%20Center/Files/Dental_Radiographic_Examinations_2012.ashx

No Issues Found:

- The #s of radiographs taken were based on the risk of the patient and the national guidelines. The quality of the films is high enough to diagnose the patient's needs.
- There were not enough films taken but there is a reasonable explanation in chart notes. or an obvious reason for this i.e. 3 year old patient with behavior issues
- The radiographs are not diagnostic but there are obvious reasons for that (age)

Needs Improvement (examples):

- The appropriate # of radiographs taken to diagnose the tooth or dentition were not present. Examples:
 1. You typically cannot accurately diagnose a new child patient with deeply decayed teeth using just 2 BWs and an anterior PA.
 2. There is an adult initial exam where a complete series of x-rays or a panoramic film was not taken.
- The films are not diagnostic.
- There are overlapped BWs for a patient that has no behavioral issues. A film in a series can be overlapped if the other films show those surfaces. When assessing the films, remember that it is difficult to get perfect films all the time and we want to retake as few as films as needed for patient safety.
- The apex of the tooth is not present for surgical or endodontic procedures

N/A:

- No radiographs were taken

2. Radiographic dx appropriate

This section reviews the dentist's diagnosis of teeth and bony lesions and other issues that could be assessed from a radiograph. We all diagnose slightly different based on our experience and the risk of the patient. Before you call a missed diagnosis, try and pick lesions that are obvious and clearly should have been marked.

No Issues Found (examples):

- All decay or bony lesions were diagnosed correctly
- There are grey areas where one dentist will call decay and another will not. Many times it is the assessed risk that determines treatment. This is why it is important for the dentist to mark watches for those where he or she believes something may be present but decides to wait on treatment. If a dentist marked watches on a tooth that you feel could have been marked as decay, you can mark 'no issues found'

Needs Improvement (examples):

Make sure to list the specific teeth or bony areas that you feel were misdiagnosed.

- All the radiographic teeth lesions were not identified in the exam.
- All the radiographic bone lesions were not identified in the exam.
- Interproximal lesions are called for restoration that cannot be seen on the radiograph

- Overhangs are not diagnosed
- Crown open margins are not diagnosed

N/A:

- No radiographs were taken

3. Sequenced treatment plan present and appropriate

All initial or recall exams must have a sequenced treatment plan that details all the needs of the patient.

No Issues Found:

- After a review of the radiographs and chart notes, all the procedures needed were listed. Missing teeth need to be treatment planned for replacement unless the notes indicate that the patient does not want them replaced.
- There is a sequenced treatment plan
- Treatment alternatives are listed.

Needs Improvement (examples):

- The treatment plan is not appropriate, inadequate or missing procedures given the needs of the patient
- The treatment planned is not sequenced in a logical manner

4. Periodontal charting present

Periodontal charting is required for all patients 18 years and older for each exam, initial and recall, completed

No Issues Found:

- The periodontal charting is present, up to date and filled out completely

Needs Improvement (examples):

- A periodontal chart is present but not current
- There is no periodontal charting present in the treatment record

5. Diagnosis is present for all emergency exams and supported by the documentation

This category covers diagnosis and what is needed for an appropriate and accurate diagnosis.

No Issues Found:

- There is a reasonable diagnosis present in the treatment notes
- There were enough clinical tests listed to make a reasonable diagnosis. Remember that a radiograph that shows a large apical lesion and a destroyed crown may need no other diagnostic tests but a tooth with decay close to the nerve and no periapical lesions may need a full array of tests.

Needs Improvement (examples):

- The diagnosis is not reasonable given the tests recorded
- The diagnosis is not a true diagnosis. i.e. dental pain vs irreversible pulpitis
- There are not enough diagnostic tests listed to arrive at a reasonable diagnosis.
- The symptoms do not match the diagnosis
- There is an emergency encounter with no listed diagnosis

6. Appropriate clinical judgment used

This category covers the judgment the dentist uses over the general course of treatment including the treatment plan, medications given, antibiotic premeds given appropriately, etc. The clinical decisions made should be logical and reasonable and serve the patient well.

No Issues Found:

- You should have the general sense that the patient was treated correctly.
- Cancer screenings/ soft tissue exams should be done on all patients but there is a significant difference from not having done one for a 2 year old vs a 78 year-old smoker so use your judgment to determine compliance.
- The appropriate dental materials were used.

Needs Improvement (examples):

- There are obvious issues such as C&B being started before periodontal care was addressed.
- Primary teeth are being restored even though the roots are mostly resorbed
- Flippers made without any discussion notes of alternative treatment
- Primary 2nd molar extracted on a 6 year-old without any plan for space maintenance
- A patient with rampant caries is not offered home fluoride treatment or any other extra preventive care
- Dental materials not used appropriately. i.e Using a glass ionomer as a permanent restorative material for an MOD adult restoration without any explanation why

7. Blood pressure protocols followed

Refer to Malamed's protocols for blood pressure found in:

http://www.drmalamed.com/downloads/files/bpguidelines_nhli_2003.pdf

No Issues Found:

- All patients 18 and older had a blood pressure done at each exam appointment or more often as needed.

Needs Improvement (examples):

- The blood pressure is missing on a patient that is 18 or older.
- If the BP is high, the BP was not monitored appropriately in subsequent visits.

- A medical referral was not made for a patient with high BP who is not already seeing a physician.
- If the treatment did not match the protocols, there were no treatment notes indicating why the standard was deviated. An example would be an emergency patient with a diastolic reading over 110 but the tooth to be extracted had a plus 2 mobility. Clinical judgment should be used to determine appropriate treatment but that clinical judgment needs to be recorded.

8. Follows charting protocols

The American Dental Association has developed charting criteria that should be adhered to by all dental providers for good risk management and patient care

No Issues Found:

- The chart is complete and appropriately describes what was done in enough detail that any dentist can read it and follow what was done
- The treatment record adheres to the standards of care described by the ADA http://www.raedentalmanagement.com/pdfs/ADA_Dental_Records.pdf
- All required consents are present and appropriately signed by all parties.

Needs Improvement (examples):

- Required consents are missing or unsigned.
- The charting does not adhere to the profession's standards
- The treatment record is difficult or impossible to follow

9. Patient instructions documented

This section deals with the need to properly inform our patients.

No Issues Found:

- All surgery and endodontic patient visits should have a chart note indicating that patient post-op instructions were given.
- All exams should have a note indicating that OHI instructions were given.
- All prosthodontic or space maintenance appliances have documentation that instructions for taking care of appliances were given.

Needs Improvement (examples):

- There are exam appointments and hygiene appointments that do not have a chart note indication that patient prevention/ OHI instructions were given.
- Surgical procedures lack notes indicating that post-op instructions were given

10. Follows medical history protocols

It is critical that the medical history is completely filled out, is accurate and gives enough details to safely treat the patient. The dental treatment, including referrals, is appropriate in reference to the medical history.

No Issues Found:

- All 'yes' questions in the medical section have an accompanying note describing why it was marked yes. Example: a heart murmur marked yes must have a description of the murmur specifically to know the need for an antibiotic premed
- All the required signatures are present (patient, assistant and dentist).
- There is a note in the chart that the medical hx was reviewed for each appointment outside of the one that the medical hx was signed.
- The medical histories are updated in a timely manner (a new form must be completed at least once each year).

Needs Improvement (examples):

- There are questions or sections of the medical hx that were not filled in.
- There are significant findings (any item in the medical history that could affect any dental treatment offered) that are not listed in either the *Pop-up* or *Alerts* boxes in the EDR
- Medical referrals or consults appropriate to the medical history were not done.
- The dental treatment is contrary to what should have been followed due to specific medical conditions.

11. Appropriate use of referral

This section deals with dental referrals and consults that should at least be recommended given the complexity of the dental treatment required. The more serious the condition, the more we are obligated to refer and follow-up the referral even when the patient is not cooperative.

No Issues Found:

- Appropriate dental referrals and consults were made given the complexity of the treatment needed.

Needs Improvement (examples):

- If the periodontal diagnosis was a level 3 or 4, do the chart notes indicate that referral to a periodontist was recommended? If it was, but the patient declined, there is no issue; however, subsequent notes should be present indicating an emphasis to see a specialist. This becomes even more critical the worse the periodontal condition is.
- A referral or consult was made but there is no indication of any follow-up.
- Consult/ referral information is not followed and there is no explanation for this.

N/A

This is routine care and no referrals or consults are needed

12. Follows protocols for patient vital signs

While vital signs (pulse, respiration, SPO2, temperature etc) are not taken on every patient, there are times where it is absolutely critical to the health of the patient. The more

complex the patient's medical history is, the more you should expect to see various vital signs taken at each appointment. Since we already have a section on blood pressure, this part only deals with the other vital signs we collect at times.

No Issues Found:

- All patient vital information required for safe and effective treatment is present and updated.

Needs Improvement (examples):

- Vital signs were taken but not properly followed up.
- There was no temperature taken for a patient presenting with a cellulitis.
- Medications prescribed for a child but no weight is listed

13. Appropriate use of medication

Any medications used in the clinic, directed for use or prescribed must be the appropriate medication and in the right dosage and strength.

No Issues Found:

- All medications are appropriate and in the correct dose and strength
- All prescriptions written show the exact medication name, the amount given and the directions for taking the medication in the treatment notes.

Needs Improvement (examples):

- Medications prescribed or used are contraindicated from the medical history.
- If an antibiotic premed was needed, it was prescribed in an inappropriate manner or was not the best medication for the targeted issue
- The medications and dosages prescribed are not appropriate for the treatment performed.
- A medication was clearly called for and not prescribed

N/A

No medications were prescribed or needed

14. Sedation Protocols followed

(_____ Health Center) has specific policies that must be followed for all sedation appointments. Sedation includes every sedation modality nitrous oxide alone to GA.

No Issues Found:

- All (_____ Health Center) sedation protocols were followed

Needs Improvement (examples):

- The protocols described in (_____ Health Center) sedation protocols were not adhered to

N/A

No sedation was done at this appointment

15. Appropriate emergency follow-up done

Ensure that acute care patients receive follow-up care and instructions as needed to resolve any initial pain and swelling or complications that arise from treatment. This also includes follow-up needed for biopsies either done by the dental clinic or referred out.

No Issues Found:

- The patient has been appropriately followed until the emergency situation has been resolved or the biopsy results have been delivered to the patient and appropriate action taken.

Needs Improvement (examples):

The more complicated the emergency procedure, the more complete the follow-up should be.

- It is not clear in the treatment notes that the patient's pain and/or infection has been appropriately followed up. A cellulitis patient that is given a prescription must be followed through until we know the infection has subsided.
- Biopsy results were not tracked and appropriately followed. The more serious the potential diagnosis is, the greater ethical and legal responsibility we have to bring the patient back even if the patient is not cooperative in keeping their appointments.

N/A

There were no emergency issues in this chart entry

16. Correct billing procedures followed

The health center must adhere to all Medicaid and insurance billing instructions, and all providers must code correctly to avoid any issues of fraudulent billing practices.

No Issues Found:

- All services provided in the visit were coded appropriately

Needs Improvement (examples):

- *You will need to review your state's Medicaid billing instructions to ensure that all appropriate billing procedures are being followed.*
- *Procedures are up-coded (i.e. a routine extraction is charged out as a surgical extraction)*
- *Procedures are incorrectly coded or the provider is using old CDT codes that have been deleted. (consider using the "Coding with Confidence" to familiarize yourself with proper coding.)*

APPENDIX B: QUARTERLY DENTAL CHART AUDIT TOOL

Dentist: _____ Patient Chart # _____ Date of Patient visit _____

Note: This review applies to the most recent treatment episode provided by the Clinician being evaluated. You may however need to review chart notes from the last exam forward to answer the questions below correctly. Explain any comments or suggestions in space below and return confidentially to the Dental Director

	Outstanding	Satisfactory	Needs Improvement	NA
Orders appropriate/ dx radiographs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiographic dx appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sequenced treatment plan present and appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal charting present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnosis present for all emergency exams and supported by documentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appropriate clinical judgment used	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure protocols followed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follows charting protocols	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient post-op instructions documented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follows medical hx protocols	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appropriate use of referral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follows protocols for patient vital signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appropriate use of medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedation protocols followed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appropriate emergency follow-up done	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Correct billing procedures followed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Handwriting legible (if paper charts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Overall chart rating:

- Outstanding (all sections rated outstanding)
- Satisfactory (all sections rated outstanding or satisfactory)
- Unsatisfactory (at least one needs improvement)

Comments:

Reviewing Dentist Signature _____ **Date of review** _____