THE UNIVERSITY OF IOWA
COLLEGE OF DENTISTRY & DENTAL CLINICS

Clerkship Directors Committee
Minutes – Oct 27, 2017

Members Present: Drs. Nidhi Handoo (Chair), Kecia Leary, Terry J. Lindquist, David M. Bohnenkamp, Justine L. Kolker, Sherry R. Timmons, Mike Kanellis, Ms. Joni Yoder, Ms. Becky Todd, Emillie Kenne (D4), Brittanie Lucas (D3), and Katherine Sislow (D3)

Absent: Drs. Paula Weistroffer, Ronald Elvers, John Warren, Saulo L. Sousa Melo, William J. Synan, Bruno Das Neves Cavalcanti, David C. Holmes, Lily T. Garcia, Prof. Marsha Cunningham-Ford, Ms. Michelle Krupp

Meeting called to order at 12:05pm.

I. **Approval of September 22, 2017 minutes** – Dr. Handoo
Tabled – no quorum

II. **Department Standards of Care & Record Audits** – Dr. Kanellis & Ms. Yoder (See Attachment)

A. Dr. Kanellis and Ms. Yoder spoke on Department Standards of Care and Record Audits. With accreditation coming up Dr. Kanellis and his team have really been looking at CODA Standard 5 – Patient Care, (5.3) addresses on-going continuous quality of improvement program within patient care. Each clerkship director received information and Dr. Kanellis requests that each clerkship director update their departmental Standards of Care and Audit Questions by December 1, 2017.

B. Ms. Yoder performs annual audits of D3 clinics (with the exception of the Department of Orthodontics & Division of Oral & Maxillofacial Radiology) with the students during the D3 and D4 Quality Assurance courses. The clerkship directors requested to be informed when their department is being audited, so the clerkship director can be present if possible; at a minimum, clerkship directors want the feedback. Audits are scheduled next for November 2017; records are selected randomly. If issues are identified, Ms. Yoder helps the students fix the errors during the audit. If a non-fixable error is found, it is used as a learning opportunity.
- Dr. Leary suggested that Pediatric Dentistry can include audit questions to include orthodontics.
- Clerkship directors should have information in their clerkship handbook regarding how patient progress notes should be recorded.
- During the audit process, when problems are found within the departments, they are not being shared with the clerkship directors. Moving forward, this has been made a priority to ensure changes can be made to ensure consistency among rotations. It was discussed that the audits should be looked at to find any gaps in the overall clerkship learning.

ACTION ITEM: Ms. Joni Yoder will be placing audit data from the last few years into department audit folders on the shared drive.

III. **Additional Comments**

A. Dr. Kanellis spoke on the opioid misuse issue, in a recent email communication.

B. Dr. Kanellis spoke on the California Licensure Exam and approval for use by the Iowa Dental Board. He clarified that CoD students can participate. The California Licensure Exam/portfolio is unique and not to be confused with portfolios that are created in certain classes. The California Licensure Exam is a collective of clinical testing to meet requirement for licensure; these clinical tests require more time and are more difficult when compared to the CRDTS clinical testing. More information is forthcoming. The terminology used for this portfolio licensure exam is not to be confused with the CoD Procedural Assessment of a Skill Set (P.A.S.S.).

C. Dr. Kolker would like more information regarding StartCheck since she was not involved in the original discussion. She stated that it would be hard for Operative Dentistry to use a StartCheck template used by other departments.
   - Dr. Kanellis informed the committee that the pop-ups in regards to StartCheck are customizable. The "red box" visible in AxiUm with the student's name, remains red until there is a faculty approval/swipe. The other "red box" was a part of the *meaningful use standard*, and needs to be updated.
   - There is a need for consistency in recording patient's blood pressure as described in the policy. The committee was informed that a lot of the students are purchasing their own blood pressure cuffs due to the lack of cuffs available to them at any given time. P
   - Larry Newman, nurse practitioner available on Thursdays; he can be reached at anytime by email. He specializes in helping patients get the proper care for their medical issues, especially management of diabetes and high blood pressure. Dr. Newman can help patients find resources in their hometown.

FUTURE AGENDA ITEMS: Further discussion on StartCheck; Dr. Newman presentation; Blood pressure policy

D. Dr. Lindquist brought up that survey crowns are not being accepted by DW plans and wanted to inform the rest of the group

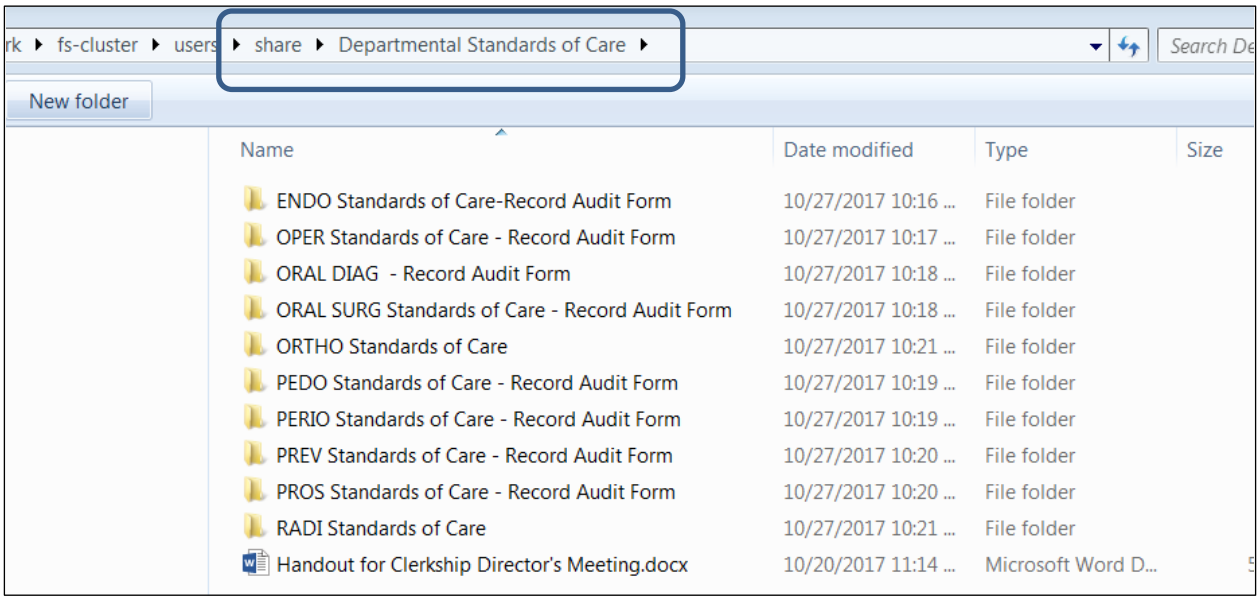
ACTION ITEM: Dr. Kanellis' office is going to look further into why survey crowns are not being accepted.

Next Meeting: **November 17, 2017**

Minutes recorded: Ms. Lauren Moniot

Departmental Standards of Patient Care
Clerkship Director's Meeting
Friday, October 27, 2017

1. Departments need to review and confirm their "Departmental Standards of Patient Care"
    a. Hard copies handed out
    b. Electronic versions on Share Drive under "Departmental Standards of Care"
    c. Please make any changes/updates on the share drive by December 1



2. Departments need to review/revise departmental audit forms to coincide with Departmental Standards of Patient Care
    a. Hard copies handed out
    b. Electronic versions on Share Drive under "Departmental Standards of Care"
    c. Make sure that audit forms include all Departmental Standards of Patient Care, as appropriate

APPENDIX 5-1-1

COLLEGIATE STANDARDS FOR PATIENT CARE

1. A comprehensive care patient receives a comprehensive examination prior to non-emergency treatment.

1.1 A medical and dental history is obtained for each patient.

1.2 Radiographs are sufficient to support the examination and create a treatment plan.

1.3 Head and neck examination, including evaluation of oral and maxillofacial hard and soft tissues, is performed for each patient.

1.4 The initial clinical and radiographic findings are recorded for each patient.

2. A treatment plan is created for the patient based on their problems and treatment objectives.

2.1 The patient's chief complaint is documented.

2.2 A problem list and treatment objectives are developed for each patient.

2.3 A comprehensive treatment plan is developed for each patient.

2.4 Treatment plans are sequenced to control disease before reconstruction begins.

3. The patient receives a treatment plan presentation.

3.1 The patient is provided information about their dental problems and treatment objectives so that he/she can give informed consent.

3.2 A treatment plan with alternatives is presented to the patient.

4. Patient care is delivered using established criteria in a timely manner.

4.1 The patient's chief complaint is addressed.

4.2 Each dentate patient receives preventive or periodontal treatment.

4.3 The patient receives treatment in accordance with departmental standards of care.

4.4 Patient progress towards completion of his/her treatment plan is monitored at regular intervals.

4.5 Patients are encouraged to make appointments in order to receive timely treatment.

4.6 The patient is examined at the completion of a treatment plan.

4.7 Patient satisfaction is monitored and complaints are handled in a timely and appropriate manner.

5. Patients who complete comprehensive care are periodically re-evaluated.

5.1 Patients are offered the opportunity to participate in a recall program.

5.2 The medical history is reviewed for each patient.

5.3 Radiographs sufficient for reevaluation are made for each patient.

5.4 Head and neck examination, including evaluation of oral and maxillofacial hard and soft tissues, is performed for each patient.

5.5 New clinical and radiographic findings detected during the recall appointment are recorded for each patient.

5.6 A list of new problems and treatment options is developed for each patient.