Report of the Clinic Model Task Force

(Draft 2/12/09)

This report is the result of the efforts of 10 individuals from throughout the Dugoni School of Dentistry. The members of the group known as the Clinic Model Task Force were the following: Drs. Marc Geissberger, Cindy Lyon, Alan Budenz, Eddie Hayashida, Nader Nadershahi, Peter Hansen, Russ Woodson, Terry Hoover, Faroud Hakim, and Brian Gilmore (student rep). Dr. Hoover agreed to chair this work group. We had weekly three hour afternoon meetings during the month of January 2009 with several sub team meetings over that time in addition. We were charged by administration to look at our current clinical teaching model and make recommendations for the organization/management of our system to address some issues that have surfaced as on-going concerns. These concerns are faculty coverage, student and faculty attendance, differences in teaching between the separate 2nd and 3rd year clinics among others. The discussions were thorough, spirited, and representative of many opinions and views. We started with a careful SWOT analysis of our current system and determined the values we wished to maintain. In the end we accomplished what was asked. The recommendation we are making is that of the entire work group. The changes we recommend will improve on what we are already doing successfully and create a model adaptable to enhancements over time. Further changes and modifications can and will be made as outcomes of the new model are assessed. Our recommendation is the first stage in the direction of a more ideal clinical teaching model which will be achieved as additions are made to the model as funds become available and commitments to facility changes are possible.

The crux of our recommendation is:

- The combining of 2rd and 3nd year students into one teaching model
- All clinic teaching groups (group practices) will include both 2nd and 3rd year students as well as 1st year students (for experiences as determined in their curriculum).
- There will no longer be a separate 2nd year clinic or "2nd year experience." Students now will have two years of clinical practice with their pace of learning and reaching competency in the various disciplines individualized and managed by their GPA's, Faculty Team Leaders, and faculty within the group practices.
- The "generalist" faculty designated as a GPM's in our current 3rd year model are restorative faculty. In the new model the GPM faculty will be expanded through cross training to include ODTP, Emergency, Screening, and Removable faculty as well. This larger corps of GPM's as in our current 3rd year model will supervise all ODTP, restorative, and simple perio. The new model will expand GPM supervision to removable treatment as well.
- Screening and Emergency care services will be provided by the Group Practices
- Simple endo and simple oral surgery supervision may be added as time goes on.
- Periodontal and endodontic specialists will continue to supervise their disciplines in this model with specialists assigned to particular groups.

At the initial stage of implementation of our expanded model:

- There will be four clinic group practices and four GPA's as now. There is some interest in expanding the number GPA's and clinic groups but no consensus exists yet as to the ideal number of groups or the new role of the GPA in these smaller clinical group practices.
- There will be an endodontist and a periodontist assigned to each pair of clinical groups.
- All emergency care and new patient screening will be done in the groups and faculty that would previously have been assigned to supervise these two areas could be included in the main clinic as GPM's.
- Oral surgery and surgical implant placement will continue to be done in our specialty clinics. It is intended, however, that implant restorative be done in the clinic groups under GPM supervision.
- As in the current system, patients are assigned to individual students and remain assigned to the group practice of that student.

In terms of oversight and support:

- Accountability for faculty coverage and faculty teaching evaluation will remain the responsibility of the clinical chairs as it is now. They will be reviewing current policies on absences from clinical teaching responsibilities and making recommendations.
- The Clinical Dean, GPA's, and clinical managers will continue to manage clinic operations.
- It was felt by our group that the instrument distribution system in the clinic currently, although getting better, needs additional improvement if more efficiency in teaching and patient care can be expected.
- Chairs and Academic Dean will continue to be responsible for student competency tracking and will give feedback to GPA's for communication of this information to students.

We believe the new paperless AxiUm System scheduled for deployment this July will assist in tracking of student, faculty and patient attendance. Student daily performance evaluation tracking will provide more consistence student progress information which was a concern discussed by our task force.

There was some discussion about the effectiveness of night clinic sessions as a result of the school hour changes and further study of that issue should continue.

Naturally a proposed clinic model change such as this will require a cross training and financial commitment. The clinical chairs who were part of this task force have committed to the cross training component and are beginning that process in March of this year. The table on the following page details the faculty changes in this proposed model and explains our committee's analysis of additional faculty needed. We believe more faculty is required to properly support curricular changes including the dynamic use of faculty whose responsibilities include both didactic clinic teaching *whether or not the model changes we recommend are instituted.*

Proposed Clinic Model with 4 clinic groups (Group Practices)

students assigned per group

3rd year	40 (with IDS)
2nd year	35 (40 midyear with IDS)
1st year	(35-do not need individual clinic chairs)

students per group each clinic session

3rd year	25
2nd year	10-12
avg	36
	× 4 groups
Total **# students per session**	**144** (approx 147 chairs available)

faculty **per clinic session** in **current model** by discipline

Current model				Proposed model	
12 GPM's	(restorative)	3rd year	these become GPM's in **proposed model** ⇨	20 GPM's	(5 GPM's/group)
2 GPM's	(restorative)	2nd year			
3 ODTP	(dental practice)	2nd year			
1 screen	(dental practice)	B level			
1 emerg	(dental practice)	B level			
2 remov	(removable)	2nd/3rd yr			
2 endo			same number specialty faculty in **proposed model** ⇨	2 endo	(1 per 2 groups)
2-3 perio				2 perio	(1 per 2 groups)
24 faculty current model				**24 faculty proposed model**	

students per session: 147 (assumes all chairs used)
faculty per session: ÷ 24 (with full complement of faculty including specialists)

~ 6 students / all faculty and a 147/20 ~ 7 students / GPM
(these ratios are based on current faculty census)

With input from the clinical chairs on the Task Force, we recommend an additional 4 GPM's per day (one per clinic group). This equates to 20 additional faculty days per week. A day is 2 clinic sessions. The chairs would work with administration as to the allocation of types of faculty hires (which department, # days per week appointment, etc). This additional faculty would account for a proper teaching ratio of students to all floor faculty of 147/28 ~ 5/1 or student to GPM of 147/24 ~6/1. It would also allow enough faculty to allow for unexpected absences, meeting attendance, or staffing of didactic and integrated curriculum needs).

These are the strengths of our current clinic teaching system that this proposed model retains or improves on:

- excellent clinical training
- humanism
- patient centered / quality treatment
- generalist model
- comprehensive patient care
- closer approximation of private practice using specialists for difficult cases as in private practice

These are the issues that this proposed model addresses:

- the perceived weakness of current 2nd year clinical experience
- different and often confusing messages to students and patients because of different departments being responsible for treatment planning and restorative in 2nd year clinic
- improved work environment due to cross training, more communication and collegiality
- improvement of the transfer and continuity of care since 2nd and 3rd year students (also 1st year) work together within same group where patient is assigned
- improve distribution of cases between 2nd and 3rd year students / seniors will complete more complex treatment and juniors will complete recall and simpler procedures
- more efficient use of faculty (e.g. in 2nd year currently restorative faculty not busy early in the year; ODTP faculty not busy late in year because of discipline based assignments)
- faculty absences will be less consequential and more manageable with a larger number of GPM's per group practice

These are the enhancements considered for the proposed new model as we assess its function over time:

- pre distribution of instruments and supplies to units for more efficient use of clinic time
- gradual assumption of patient scheduling by the school instead of students for better patient management and care (patient schedulers assigned to group practices)
    - Phase I – staff schedule recall visits; implant follow up, etc.
    - Phase II – staff schedule all visits
- simple surgical procedures done within the group practices supervised by the GPM's
- staggered clinic sessions for more efficient use of facilities
- assignment of assistants and possibly hygienists to each group
- expansion of the number of groups and GPA's and a evolution of GPA job description
- physical plant changes coordinated with teaching model

These are specific assessments we recommend tracking after initiation of the new model to evaluate the progress and outcomes of our model (others will be added):

- production/ experiences of 2nd year students after one year in clinic versus previous years
- production/ competency of 3rd year students at graduation time under 1st year of this model
- frequency of faculty coverage problems (teaching ratios monitored)
- patient, student, faculty satisfaction data
- individual GPM monthly production
- individual group practice production

Addendum

Theses are the important issues and comments that came back to Dr. Hoover after the Draft Report of the Clinic Model Task Force was circulated to the task force members and Clinic Administration (Dr. Fredekind and the GPA's). These ideas, issues or concerns would all have to be worked out by the implementation body responsible for moving this or any other model change forward.

- A suggestion was made and circulated by a GPA to have each GPA do screening once a week off the main floor thereby freeing up the current screener to work as a GPM. The GPA would assign a screened patient to a student in the GPA's group the same day as the GPA did the screening. The GPA on his screening day could also screen emergency patients after their initial care and assign to appropriate student in the group. **Concern was expressed by several others that taking a GPA off the clinic floor would not be advisable—GPA's doing screening would be helpful but not at the expense of being off the clinic floor (screening should be done in the group on the main clinic floor).**
- Several comments underscored the importance of working out the details of how emergency care and screening would actually occur (e.g. How will patients be distributed evenly to group practices? Where will they check in and complete paperwork? Etc.)
- 7 individuals in the group to whom the draft report was circulated strongly supported additional GPA's and smaller clinic groups. Several of those felt that unless we specifically planned and targeted a date for that expansion, the idea would be forgotten or dropped.
- Details for cross training of GPM's for implant restorative, endo, removable will need to be explained and scheduled.
- Several comments were made that chairs have not really been held accountable for faculty coverage. They are <u>responsible</u> (and ask to continue to be responsible) but not <u>accountable</u>. These comments echoed the theme that until the accountability piece is worked out to <u>everyone's</u> satisfaction, no model change would be wise (e.g. If there are coverage and distribution issues, what is the mechanism for evaluating this, deciding on changes and communicating it to all involved, and if the coverage is not resolved, how is the accountability issue handled?)
- There needs to be more specifics as to "additional improvements" to the instrument distribution system. **The discussion in the task force meetings referenced students waiting in line for instruments as contributing to the slow start of some clinic sessions**.
- The Clinical Dean doesn't feel we need any additional faculty even with the proposed change. He pointed that the main clinic will no longer have access to the eight chairs in the current perio clinic area due to changes to the surgery space. This therefore eliminates 8 chairs from the task force's formula. Endo will continue to use 12 chairs which should also be eliminated from the formula. Removable uses 10 chairs which can also be eliminated since there is no evidence at this time that rem prosth will be incorporated into restorative. Perio faculty usually manage 20 patients each clinic session. That leaves 97 remaining ops covered by 20 GPM's (about 5 students per GPM); going to 24 faculty by adding 4 GPM's per day (about at 4 students per GPM). This assumes all chairs are used. He feels five students per faculty member is easily covered without adding additional faculty. Also, how will the 12 chairs on B level be used in this model? **Actually the task force considered putting special care down on B level and using the current C level chairs now being used by special care to replace those lost by elimination of perio chairs to keep main clinic chair count closer to 147 or 148.**
- More detail requested on tracking student and faculty absences as well as patient, student, and faculty satisfaction data—who does it and when? Shouldn't we start now?
- Several comments bemoaned that this new model does not change current scope of GPA duties in a significant way which is important in the expansion of number of groups, GPA's, etc.

- Support and reporting structure of larger clinical faculty, currently with multiple departments, has yet to be determined. **This likely is an administration/chair level discussion.**
- A comment from the sub team presenting the "patch" of the current model: "please add the development of a student mentoring program to the list of enhancements....[to the new model]. This idea was discussed briefly, being overshadowed by larger issues. Not only will the clinical faculty be supplemented in hands-on supervision of specific procedures [by student mentors], but it would also allow us to encourage future dental educators which we are going to be desperate for in the coming years."
- A sub team of three members of the task force met the week of Feb 9 and looked at the effect of the new model on functioning of Monday and Thurs mornings when there are no 3rd year students in clinic (there are only 2 clinic groups of 2nd years at a time in each clinic session). It was suggested that those mornings with two 2nd year groups present, the faculty teams would consist of two clinic groups of 4 GPM's each with one endo and one perio faculty to cover both teams. This could be accomplished with no additional faculty.
- The latter sub team also discussed our night clinics (Monday and Thursday evenings). A suggestion worth further consideration is allowing only one night clinic per week for both 2nd and 3rd year students. This would increase clinic time and experiences for 2nd year students. It was hoped that cutting night clinic time for 3rd year students would encourage more use of Friday clinics by 3rd years. (No hard data to confirm light Friday clinic utilization but this is an observation mentioned often.)
- Dr. Fredekind is supportive of more GPA's (with a change of scope of duties) and smaller clinic teaching groups but feels AxiUm deployment starting July '09 makes expansion of groups and GPA's not workable for 2009-2010 academic year.