Science Foundation Team: Strategy for completion of task

- Have a clear understanding of our goals: to design an outstanding science foundation curriculum for the UM School of Dentistry + to develop a feasible implementation plan for this curriculum
- Each one of us is responsibility of ensuring that we keep moving forward and towards this outcome
- Identify what is working in the curriculum & maintain it
- Identify what is not working in the curriculum & transform it
- Empower people to make decisions under the principles of our collective vision for the curriculum
  - We should not micromanage the process
  - We should not tell faculty what to teach – the content experts should make these decisions - but we will work together with faculty on the number of hours required for each course.
Science Foundation Team (SFT): Principles

- **Underlying Principle**: “Teach what a dentist needs to know”.
- **Excellence**!
- **Critical thinking** applied to diagnosis, treatment planning, and treatment.
- **Work on independent decision making**
- **Provide tools for self-assessment and life long learning**.
- **Integration** of the science foundation with preclinical and clinical experiences
- **Flexibility** to create some (limited) level of individualization of the curriculum - pathways, electives, possibility of “testing-out” from disciplines
- **De-compress** the delivery of content in the classroom
- **Curriculum**: sustainable, continuous outcome assessment/development.
**Vision**

- **Integrative courses (multidisciplinary)**
  - Cell & Molec. Biology
  - Infection & Immunity
  - Anatomies (HN, dental)
  - Genetics & Development

- **Systems**

- **Parallel Themes**
  - Oral Health Sciences (normal, disease)
  - Grand rounds: 1 patient, 1 clinician, 1 basic scientist
  - Case studies: Online, smaller groups, outside the classroom

- **Clinic**

**Time:**
- Year 1
- Year 4
Vision

Integrative courses (multidisciplinary)

Systems

Parallel Themes

Oral Health Sciences (normal, disease, treatment)

Grand rounds: 1 patient, 1 clinician, 1 basic scientist

Case studies: Online, smaller groups, outside the classroom

Clinic

Clinical foundation

Year 1

Year 4

Time:

Cell & Molec. Biology

Infection & Immunity

Anatomies (HN, dental)

Genetics & Development
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Vision

Integrative courses
(multidisciplinary)

Systems

Time:
Year 4
Year 1

Oral Health Sciences
(normal, disease, treatment)

Grand rounds: 1 patient, 1 clinician, 1 basic scientist

Case studies: Online, smaller groups, outside the classroom

Clinical foundation

Clinic

Parallel Themes

Cell & Molec. Biology
Infection & Immunity
Anatomies (HN, dental)
Genetics & Development
UM School of Dentistry: Current IMS II and IMS IV

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**SFT Recommendations:**

- Have fewer faculty teaching these courses - more ownership, more accountability, appropriate credit for effort
- Consolidate the content – e.g. reproductive system
- Focus on “what an excellent dentist needs to know”
**Vision**

- **Integrative courses (multidisciplinary)**
- **Systems**

### Year 1
- Cell & Molec. Biology
- Infection & Immunity
- Anatomies (HN, dental)
- Genetics & Development

### Year 4
- Oral Health Sciences (normal, disease)
- Grand rounds: 1 patient, 1 clinician, 1 basic scientist
- Case studies: Online, smaller groups, outside the classroom

**Parallel Themes**
- Infection & Immunity
- Anatomies (HN, dental)
- Genetics & Development
Current Disciplines

Developmental biology of dentition
Microbiology of caries
Microbiology Periodontal Disease
Biology Salivary Gland
Biology Oral Mucosa & Perio
Occlusion/TMJ

Oral facial function
Oral Pathology/Oral Medicine

Health & Disease

Tooth/Periodontium/Bone
Oral mucosa/Skin
Salivary glands
TMJ
Science Foundation: Oral Health Sciences Course

Pathophysiology of the Head and Neck

Oral facial function

Neurobiology (Pain, sensory functions)

Wound healing/Tissue Regeneration

Vascular biology (Angiogenesis, coagulation)

Oral Oncology

Tooth/Periodontium/Bone

Oral mucosa/Skin

Salivary glands

TMJ

Oral/Systemic Interactions?

Inflammation/Infection?

Craniofacial Growth & Development?
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## Oral Health Sciences (45 hours)

- Pathophysiology of the Head & Neck (overview)

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### Half-term (7-8 weeks)

- 15 hours – 2 hour/week
- 30 hours – 4 hour/week
- 45 hours – 6 hour/week
- 60 hours – 8 hour/week
- 75 hours – 10 hour/week
- 90 hours – 12 hour/week
- 115 hours – 14 hour/week
- 130 hours – 16 hour/week
- 145 hours – 18 hour/week
- 160 hours – 20 hour/week
Science Foundation: Fall, D1

Disciplines
- Cell & Molec Biol (45 h)
- Infection & Immunity (30 h)
- Biomaterials I (30 h)
- Radiology (30 h)
- Behavioral Sciences (30 h)

Grand Rounds
- Pathophysiology head & neck
- Tooth/Periodontium/Bone

Oral Health Sciences (60 h)
- Pathophysiology head & neck
- Tooth/Periodontium/Bone

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Full-term (15 weeks)
- 15 hours – 1 hour/week
- 30 hours – 2 hours/week
- 45 hours – 3 hours/week
- 60 hours – 4 hours/week
- 75 hours – 5 hours/week
- 90 hours – 6 hours/week
- 115 hours – 7 hours/week
- 130 hours – 8 hours/week
- 145 hours – 9 hours/week
- 160 hours – 10 hours/week
### Science Foundation: Winter, D1

#### Disciplines

- Genetics/Development (30 h)
- Systems I (IMS II) (160 h)
- Biomaterials II (15 h)

#### Grand Rounds

- Tooth/Periodontium/Bone
- TMJ

#### Oral Health Sciences (60 h)

- Tooth/Periodontium/Bone
- TMJ

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**Full-term (15 weeks)**

- 15 hours – 1 hour/week
- 30 hours – 2 hours/week
- 45 hours – 3 hours/week
- 60 hours – 4 hours/week
- 75 hours – 5 hours/week
- 90 hours – 6 hours/week
- 115 hours – 7 hours/week
- 130 hours – 8 hours/week
- 145 hours – 9 hours/week
- 160 hours – 10 hours/week
## Science Foundation: Spring, D1

### Disciplines
- Systems (IMS IV) (60 h)
- Epid Oral Disease (15 h)
- Nutrition (8 h)

### Grand Rounds
- Oral Mucosa/Skin
- Salivary gland

### Oral Health Sciences (~ 30 h)
- Oral Mucosa/Skin
- Salivary gland

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### Half-term (7-8 weeks)
- 15 hours – 2 hour/week
- 30 hours – 4 hours/week
- 45 hours – 6 hours/week
- 60 hours – 8 hours/week
- 75 hours – 10 hours/week
- 90 hours – 12 hours/week
- 115 hours – 14 hours/week
- 130 hours – 16 hours/week
- 145 hours – 18 hours/week
- 160 hours – 20 hours/week
Science Foundation Team: Next steps

1. SFT suggests potential names of faculty for each discipline/course, and submit these names to VIT;
2. VIT add/subtract names and then communicate with Chairs;
3. Chairs approve/disapprove names and let faculty know that they will be contacted by the SFT about developing a new course, or critically looking at the content of current courses.
4. Faculty are empowered to make the decisions about the content of their courses. However, faculty should keep in mind that the goal is to deliver excellent and updated content that “a dentist needs to know”. Hopefully in this process the faculty will identify means of maximizing efficiencies and reducing the overall time necessary to deliver this content by eliminating redundancies, identifying content that could be delivered via Grand Rounds/Case Studies, and by eliminating things that are “nice to know”. It is imperative that faculty realizes that we can only create flexibility in the curriculum if we reduce the time that the students spend in the classroom (and laboratories).
5. SFT will then review the course outline provided by the faculty, work with the faculty (if necessary), and then submit the course outline to VIT/curriculum cmte/Associate Dean for Academic Affairs for review/approval.
Science Foundation Team: Next steps

- Stepwise implementation of new curriculum: While we need to think globally in the four years of dental school to develop the (new) curriculum, the SFT recommends that the implementation of the (new) curriculum is done in a stepwise mode, i.e. implement changes one year at a time, minimizing as much as much as we can the disruption for the students that are currently enrolled in dental school. This would make the process more manageable, it would reduce anxieties from the students that are currently enrolled, and would allow us to learn from the experience and make necessary adjustments as we move along.
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Other recommended courses: Physiology, histology, anatomy, social sciences, communication, business, fine arts, philosophy, and psychology.
Science Foundation: Oral Health Sciences Course

Current Disciplines

Developmental biology of dentition
Microbiology of caries
Microbiology of Periodontal Disease
Biology Salivary Gland
Biology of Oral Mucosa & Periodontium
  Occlusion/TMJ
Oral facial function
Oral Pathology

Pathophysiology of the Head & Neck

Neurobiology (Pain, sensory functions)
  Vascular biology (Angiogenesis, coagulation)
Wound healing/Tissue Regeneration
  Oncogenesis

Inflammation/Infection?
  Development?
Vision

Integrative courses (multidisciplinary)

Systems

Integrated Oral Health Sciences (normal, disease, treatment)

Grand rounds: 1 patient, 1 clinician, 1 basic scientist

Case studies: Online, smaller groups, outside the classroom

Clinical foundation

Clinic

Year 4

Year 1

Time:

Cell & Molec Biology

Infection & Immunity

Genetics?

Anatomies (HN, dental)
New Basic Sciences Curriculum (2010-):
Working Template for 1st Semester

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<thead>
<tr>
<th>Basic Sciences</th>
<th>Basic Sciences (New curriculum)</th>
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<td>Head &amp; neck anatomy (July, Year 1)</td>
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<tr>
<td>Developmental Biology</td>
<td>Microbiology/Immunology</td>
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<td>Biochemistry*</td>
<td>Craniofacial growth &amp; development</td>
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<td>Genetics</td>
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<td>Cell Molecular Biology*</td>
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<td>Histology**</td>
<td>Pharmacology</td>
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<td>Physiology**</td>
<td>Critical Thinking/Logic</td>
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<td>Pathology</td>
<td>General embryology (online)</td>
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Prerequisites for admission
* Required courses
**Recommended courses
What science foundation a dentist needs to have?

Working Template for 1st Semester

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<th>Hours/week (tentative)</th>
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<tr>
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Prerequisites for admission

* Required courses
**Recommended courses
Discuss in more depth the oral health & disease course, and what contents should be included there.

- Oral cavity as a system? – Jan Hu
- “Integrated Oral Health Sciences” – Jan Hu
- Should we consider to include the course on development of the dentition, the oral mucosa, the salivary gland course as components (themes) of the oral health & disease (or IOHS) course?
- Would this be a good place to teach fundamental concepts as, for example, inflammation, wound healing, tissue regeneration?
- Content of the course for the first semester
- Concept for the course: content in parallel with contents of grand rounds & case studies; 2-year cycles?; pairing D1/D3 and D2/D4?; having the didactic content for D3/D4 online for review before grand rounds/case studies? Have some form of evaluating D3/D4s?
Several faculty: Compression of schedule (in several instances, more than 1 lecture/day on the same topic) – no time for students to “digest” content

Oveda: Microbiology works better as discipline.

Helena: Molecular biology works better as a discipline.

Jim Simmer: No noticeable difference after biochemistry became pre-requisite. Would envision possibility of testing out of course. Make all lectures online and fully accessible to other faculty.

Lopatin: Need for coordination of content among faculty.

Matt Velkey: Current student performance is very low. Would like to have a first run with the students on general/basic histology. Talked about access to technology, i.e. each student with a laptop and internet connection in classroom. Histology laboratory (faculty would be available to staff it). Online testing increases flexibility – opens up time in the curriculum (weekends?)

Renny: Pointed out critical thinking and becoming self-learners as a critical component of the new curriculum. Will require change in testing – test periodically through curriculum, testing for critical thinking/self-learning.
Vision

Integrative courses (multidisciplinary)

Systems

Time:

Year 4

Year 1

Parallel Themes

Oral Health Sciences (normal, disease, treatment)

Grand rounds: 1 patient, 1 clinician, 1 basic scientist

Case studies: Online, smaller groups, outside the classroom

Clinical foundation

Cell & Molec. Biology

Infection & Immunity

Anatomies (HN, dental)

Genetics & Development
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<th>Added Pillars (disciplines)</th>
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<td>Infection &amp; Immunity</td>
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<tr>
<td>Anatomies (HN, Dental)</td>
<td></td>
<td>Oral facial function</td>
</tr>
<tr>
<td>Introduction to profession</td>
<td></td>
<td>Oral Pathology</td>
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<td>Nutrition</td>
</tr>
</tbody>
</table>
Science Foundation: Oral Health Sciences Course

Current Disciplines

Developmental biology of dentition
Microbiology of caries
Microbiology of Periodontal Disease
Biology Salivary Gland
Biology of Oral Mucosa & Periodontium
   Occlusion/TMJ
Oral facial function
   Oral Pathology
Science Foundation Team (SFT)

- **Members:** Vesa Kaartinen, Ronald Heys, Eric Krukonis, David Brzezinski, Jan Hu, Carol-Anne Murdoch-Kinch (co-Chair), Jacques Nör (co-Chair).

- **Charge:** Design a curriculum that empowers the graduating dentist in using scientific methods and evidence that informs diagnosis, treatment planning, and patient care.

- **Underlying Principle:** “Teach what a dentist needs to know”.

- **UM Dental School Graduate:** Our graduate should know how to think critically about clinical problems, and how to access and apply new knowledge, with the ultimate goal of making sound and ethical clinical decisions.
UM School of Dentistry: Current Basic Sciences Curriculum

<table>
<thead>
<tr>
<th>Basic Sciences (General)</th>
<th>Basic Sciences (Dental)</th>
<th>Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anatomy**</td>
<td>Head &amp; Neck Anatomy</td>
<td>Nervous system</td>
</tr>
<tr>
<td>Developmental Biology</td>
<td>Craniofacial growth</td>
<td>Cardiovascular system</td>
</tr>
<tr>
<td>Microbiology*/Immunology</td>
<td>Oral Pathology</td>
<td>Respiratory system</td>
</tr>
<tr>
<td>Biochemistry*</td>
<td>Oral mucosa</td>
<td>Renal system</td>
</tr>
<tr>
<td>Genetics</td>
<td>Salivary glands</td>
<td>Endocrine system</td>
</tr>
<tr>
<td>Cell Molecular Biology*</td>
<td>Sensory/motor/pain</td>
<td>Gastrointestinal system</td>
</tr>
<tr>
<td>Histology**</td>
<td>Pharmacology</td>
<td>Musculoskeletal system</td>
</tr>
<tr>
<td>Physiology**</td>
<td>Biomaterial Sciences</td>
<td>Reproductive system</td>
</tr>
<tr>
<td>Pathology</td>
<td>Behavioral Sciences</td>
<td>Skin &amp; Integument</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hematology</td>
</tr>
</tbody>
</table>

Prerequisites for admission
* Required courses
**Recommended courses

Inflammation?
Wound healing?
Tissue regeneration?
Cancer biology?
Clinical Sciences Foundation Team
Meeting Notes, 10-1-09, 7-8 a.m., room 1397

Overall goals
- Timeliness of learning relative to application
- Problem solving – patient applications
- Integration – minimize isolation of disciplines
- Students take responsibility

Suggested approaches
Organize curricular content by competencies rather than by disciplines?
  - Utilize competency matrix as a way of looking at and sorting existing content from courses?

  Create a new matrix – courses by competency, application and class year
  Expand to include knowledge, attitudes, behaviors (and levels)

Do we over-emphasize content relative to the problem solving skills that we seek?
  “Spoon feeding” based on student demands

  No regular requirement that students actually solve problems except IN CLINIC (sometimes) and during the OSCE exam

  Teaching= telling
  passive (fill the vessel)

  vs

  Learning = discovery
  active (take ownership)

  Pedagogies of engagement – requiring students to “work with it”

What measures to assure the achievements that we seek?

How to adapt the application of the “knowledge base” in clinical disciplines to courses
  Reduce emphasis on repetition (preclinic techniques) in favor of exercises to apply choices and grade product quality

  Early learners may benefit from exposure to a comp care seminar-type experience that includes an enhanced discussion that is richer in terms of the basis underlying the clinical decisions that are made

Communication between current working teams needs to be enhanced
Clinic Issues Meeting  
September 9, 2009

Present: Dr. Ron Heys, Gary Sweier, Georgia Kasko  
D4: Manny Carranza, Sara Arnold, Mike White, Nathan Martzke  
D3: Jon Heckman, Johnna Daniels, Goron Topalo  
D2: Ezio Novelli, Mike Wierenga, Steve Davis, Hillary Mendillo  
DH: Ann Bunek, Michelle Uekiha, Sylvana Fanelli  

Gary Sweier welcomed students and explained that Dr. Stefanac was due to return from Louisville last night when his flight was cancelled. Gary led the meeting in Dr. Stefanac’s absence.

Outstanding issues from last month’s meeting were reviewed. Gary asked if dental chairs were still being moved in the 3Green clinic. Mike White, from 3Blue, reported that dental chairs continue to be moved in his clinic. Dorothy Smith-Fesl

Gary reported that extra glucometers have been purchased and are available at Dispensing on both floors. Also, the plastic composite instrument is now packaged separately and can be checked out from Dispensing.

Gary asked about the new spray disinfectant that is being piloted in 2Green Clinic. According to Sara Arnold, the product is excellent.

Georgia Kasko-
Georgia spoke about the assignment process and the perception of uneven distribution of patients. She reminded students that if an assignment is made designating a discipline (ie Prosth) and the treatment will not be started, students should remove the patient from their patient family. As long as a patient is assigned with specific treatment, further patients with that discipline probably will not be assigned to students already having that discipline. Another reason patient distribution may seem unequal is that students can be placed on hold and will not receive any patient assignments until their PCC releases the hold.

Mike Wieranga-
Mike reported that D2’s don’t know what their clinic requirements are. He also said the D2 MiDent training was ineffective and D2’s have to rely on upper classmen to help with MiDent. Roger Gillie, Sharon Grayden, Lynn Johnson

Johnna Daniels-
Johnna reported that there is a faculty member on 2nd floor who is using her cell phone and tells students to find another faculty member. Johnna gave Georgia the faculty member’s name to share with Dr. Stefanac.

Johnna asked if Dispensing can carry latex free carpules for patients with latex allergies. Currently, Pediatrics carries the carpules. Dr. Stefanac
Sara Arnold

Sara reported that a student from 2Green says that 2nd Floor Info Desk was rude to a patient and student. Georgia asked Sara to ask the student to speak with Jean Thompson.

Sara asked if Dr. Fitzgerald can set up the provider teams so that D2 team members will be available opposite of each other, one in the morning, and the other in the afternoon. Dr. Fitzgerald

Manny Carranza

Manny asked if a MiDent link could be established with commercial lab information. Georgia said she would ask Dental Informatics if this can be done. Georgia Kasko/Roger Gillie

Jon Heckman

Jon asked if students can only refer prophys to a hygiene student once for the CEU credit. Jon was told dental students can refer patients for prophys to more than one hygiene student; the patient can only be referred once as the patient will be assigned to the hygiene student for recall.

Jon also said there is not enough of Perio faculty in 2Blue. Dr. Eber

Mike White

Mike asked if same day referrals could be made without a swipe from a faculty member.

A 3B student who arrives early each day reports that the cleaning crew has been sweeping dust/dirt into a pile and leaving it in the clinic. Dorothy Smith-Fesl

Mike reports that 3Blue is down on Prosth faculty as Dr. Yohn is out. Dr. Sierraalta

Nathan Martzke

Nathan asked if students will be able to delete in MiDent. Georgia responded that students will not be allowed to delete. Dr. Heys said students can’t delete because they could possibly alter case completions needed for graduation. Georgia said that students will soon be given the ability to modify planned treatment in MiDent.

Nathan reported that restorative faculty is sparse in 3Green. Dr. Heys said that Dr. Fitzgerald has a daily listing of restorative faculty coverage in the clinics and that floaters may not be reporting as they should be. Dr. Fitzgerald

Nathan also reported that Endo faculty will complete the start check and then leave the clinic. Dr. Fitzgerald
Ann Bunek

Ann reported that patients are now being charged for fluoride. She asked why the policy changed. **Dr. Stefanac**

Ann asked if students would be able to preorder instruments in MiDent from home. She was told that students will not be given access to the Mident patient management system outside of the dental building. Gary told Ann that Dispensing hopes to be able to handling preorders beginning in December.

Ann asked about 2nd Floor’s policy of taking unappointed chairs by 4 p.m. the day before students have a reserved chair. She said that if the chair is taken and the student is able to get another patient in, they go to the “bottom” of the list for override chairs. **Ann Somppi, Mary Garrelts**

Ann asked students to not cut through patient care areas. She was completing a test case yesterday and 4-5 students cut through, bumping into her.

Michelle Uekihara

Michelle asked if our Medicaid patients could receive a letter from the dental school stating that Medicaid is not longer accepted at the dental school. Georgia told Michelle that Medicaid continues to cover emergency care for patients.

Michelle also said she gets referrals from dental students and the prophy is already completed.

Gary Sweier asked for NERB feedback from the D4’s. Sara and Manny reported that the Endo teeth supplied by NERB were horrible.

Gary reminded students to complete the Infection Control on-line tutorial. The tutorial meets the dental school’s annual Infection Control compliance requirements.

The meeting adjourned at 7:50 a.m.
Clinical Science Foundation Team Meeting

February 18, 2010

Agenda:

1. What clinical science topics are best coordinated with the Clinical Foundation Curriculum and Oral Health Sciences Core?
   - Clinical Science Foundation Team will look at the Predoctoral Course Syllabii and identify courses that currently have appropriate content
   - Will coordinate with Core Topic Leaders (Foundation Curriculum Team, Foundation Sciences Core and Oral Health Sciences Core) regarding duplications, omissions and sequencing of topics

2. What is the best way to coordinate appropriate repetition and integration of topics such as risk assessment, treatment planning, occlusion, esthetics, treatment sequencing etc.?
   - Meet with other team directors
   - VIT create common place in CTools for info
   - OHSC course directors keep in contact with other teams
   - Clinical Sciences team identify core people responsible for content
     - Discipline Coordinators:
       - Perio – Phil Richards,
       - Endo – Trish Bauer,
       - Restorative – Mark Fitzgerald,
       - Prostho - Marianella Sierraalta,
       - Ortho ??? Scott Conley,
       - Pedo - Jimmy Boynton,
       - Oral Surgery Pilar Hita-Iglesias,
       - Oral Med – Preetha Kanjirath,
       - Occlusion- Geoff Gerstner
     - Other key people ???
       - Cariology – Carlos Gomez and Margareta Fontana
       - Dental Implants?
     - Diagnosis and treatment planning – others beyond Preetha Kanjirath?

3. How can we further move along the transition of the Clinical Foundation Curriculum being “patient driven” in the sense that all activities are centered around treating simulated patients. How can the clinical sciences help with the “treatment planning” of these patients and how can the sim lab activities reinforce the content in the clinical science courses?
   - Coordinate with Clinical Foundation Team and discipline coordinators
   - Coordinate with DI regarding MiDent and integration into Sim Lab
   - Coordinate with Grand Rounds group

4. What is the best way to communicate and coordinate these activities?
   - Communicate with
     - Team leaders
     - Discipline Coordinators
     - Core Topic Leaders (Foundation Curriculum Team, Foundation Sciences Core and Oral Health Sciences Core)
Clinical Science Foundation Team Meeting February 25, 2010

Members present: Fitzgerald, Lantz, Richards, Stefanac

Agenda:

1) Relate discussion with VIT team
   a) Updated VIT on team’s current progress
   b) Discussed what VIT could do to help the teams
      i) help in defining outcomes by semester
      ii) provide coordinated support for tracking potentially orphaned or dropped topics
      iii) establish and enforce time line for team progress
      iv) create an easy to monitor site that summarizes all team’s progress

2) Review course list for courses related to Clinical Sciences (please see attached file)
   a) Dr. Edwards suggested that Oral Path 624 should be clinical sciences and 711 should be in the Oral Health Sciences Core
   b) Dr. Saglik suggested that 612 should be Clinical Science
   c) Dr. Lantz suggested that 501 and the Behavioral Sciences courses be included in clinical sciences
   d) List has been updated and will be re-distributed to the team. We will use this list as an aid in keeping inventory on content as it is re-arranged in the new curriculum.

3) Discuss overall organizational structure we want to use for sequencing content.
   a) Do we want to parallel the structure adopted by the Oral Health Sciences Core or is there a better organizational structure to look at
   b) We should consider the advantages and disadvantages of different approaches
   c) Approaches include but are not limited to:
      i) Mirroring the Oral Health Sciences Core structure which consists of:
         (1) The oral facial complex in health
         (2) The patient with caries and pulpal disease
         (3) The patient with periodontal disease
         (4) The patient with orofacial pain, masticatory dysfunction, altered oral sensation
         (5) The patient with oral neoplasia, oral mucosal disease
         (6) The patient with infection, inflammatory, reactive disease of the oral cavity
         (7) The patient with special dental needs
         (8) Oral/systemic interactions
      ii) Mirroring the treatment planning sequence used in the clinic which includes
         (1) Information gathering and problem/diagnosis list generation
         (2) Systemic phase
         (3) Urgent care
         (4) Preventive
         (5) Disease control
         (6) Re-evaluation
         (7) Corrective
         (8) Maintenance
   d) Began discussion of broad outcomes descriptions for each semester. These could be used to help the teams better coordinate their curriculum designs. We will discuss these and appropriate approaches more at the next meeting. Attached is a draft of outcomes the team discussed at today’s meeting. Please contribute to this list by e-mailing your suggestions to Mark: markfitz@umich.edu
Performance Outcomes for the New Dental Curriculum
(Empty bullet points indicate incomplete entries)

By the end of each of the following Semesters the dental student will be able to:

D1 – Summer
• MiDent – Log on, search for patient records and review information in the EHR.
• Identify and name normal structures of the healthy oral cavity
• Demonstrate a deep understanding of the structures of the head and neck
• Setup a cubicle, Assist and check out instruments
• Demonstrate basic skills in interviewing techniques in a simulated environment
• Recognize basic ethical dilemmas and apply the ADA Codes and Honor System to resolve those dilemmas in the light of patient confidentiality
• Recognize some basic normal oral functions and the consequences of deficiencies in those functions
• Tracks – describe the track options available

D1 – Fall
• MiDent – Health questionnaire, treatment entry, test case entry,
• Demonstrate basic skills in interviewing techniques in a clinical setting
• Visually diagnose caries
• Apply to a patient non-invasive preventive treatment for disease control (caries management, including counseling, fluoride application, sealant application, OHI)
• Demonstrate the ability to resolve ethical dilemmas using a structured format
• Conduct a self and peer assessment
• Demonstrate a beginning ability to apply basic science knowledge to the solution of clinical problems
• Tracks

D1 – Winter
• MiDent – Perio module, recall module
• Conduct a preventive recall visit for a healthy patient
• Tracks

D1 – Spring
• MiDent
• Tracks

D2 – Summer
• MiDent
• Tracks
D2 – Fall
  • MiDent
  • Tracks

D2 – Winter
  • MiDent
  • Tracks

D3 – Summer
  • MiDent
  • Tracks

D3 – Fall
  • MiDent
  • Tracks

D3 – Winter
  • MiDent
  • Tracks

D4 – Summer
  • MiDent
  • Tracks

D4 – Fall
  • MiDent
  • Tracks

D4 – Winter
  • MiDent
  • Tracks
Clinical Science Foundation Team Meeting
March 04, 2010

Members present: Fitzgerald, Richards, Conley, Stefanac, Saglik

Agenda:

1. Appropriate approaches for organizing the presentation and sequencing of the Clinical Sciences (ie. Do we parallel the organizational structure of the Oral Health Sciences Core or is there another structure that makes more sense such as paralleling the sequencing we use for treatment planning?)
   a. Concern that following the Oral Health Sciences Core process may not fit well with a four year vertical implementation for the Clinical Sciences Curriculum.
   b. Feel that there are great opportunities for collaboration between the Oral Health Sciences Core and Clinical Sciences Team and need to increase cooperative efforts
   c. There was unanimous agreement to pursue the treatment planning organization for generating Clinical Sciences curriculum.
   d. Recommendation was to create a single-page “Map” of the clinical science curriculum based on the TOC of the Treatment Planning in Dentistry text book. ALL courses would start with a slide of this “Map” pointing to where the course fits into the process. Steve Stefanac will forward an example used at Iowa.

2. Continuing defining the semester-by-semester expected outcomes
   a. Will continue next week
   b. Mark will provide initial outline for team to add to

Next Week:
1. invite Carol-Anne for discussion on core activities
2. Start matching course content to “Map”
Clinical Science Foundation Team Meeting

March 11, 2010

Members present: Fitzgerald, Richards, Conley, Stefanac, Edwards,

Guests: Gillie, Quintero, Murdoch-Kinch

Agenda:

1. Best practices for coordinating with the Oral Health Sciences Core
   a. The two teams need to meet to help coordinate activities
   b. Discussion occurred around the sense that the different organizational approaches by
      the two groups are not disconnected but rather attempts to create optimized
      environments for learning
   c. Looked at possibility of using “Map” across the curriculum
2. Refining the Treatment Planning “Map” for matching curriculum content and sequencing.
   (See handout) –
   a. add &7. Correlations with basic science. To the Information Gathering box in the
      Treatment Planning Process Map.”
   b. Submit map to the VIT as a suggestion for all courses to use to “Unify” the curriculum
3. Continuing defining the semester-by-semester expected outcomes –
   a. Recognized contributions by Dr. Edwards
   b. Request additions to be sent to Mark Fitzgerald by Monday morning, March 15.
   c. Will send the performance outcomes list to the VIT on Monday.

Next meeting: Meet with Oral Health Sciences Core. Thursday, March 18, 7 am in G311.

Agenda:

1. Agreement on how two teams should coordinate activities
2. Map including oral health science components
Clinical Science Foundation Team Meeting March 18, 2010

Members present: Fitzgerald, Richards, Conley, Stefanac, Edwards,

Guests: Oral Health Science Core Team Members

Agenda:

1. Determine process that will best allow our teams to interact and coordinate content.
   a. Identify where resources will be on a weekly and term basis—where are lecture/small discussion/lab/clinic opportunities
   b. Need to be aware of content and innovative ways to organize and coordinate
   c. Should look at clinical science in both areas as being a continuum
   d. Need to look at ways to optimize success
   e. As connections are identified, leader of those areas will meet to coordinate activities.

2. Identify key content essential for the D1 year and establish best connections.
   a. Most D1 Clinical Science content already being managed by Foundation Sciences and Oral Health Science Cores
   b. Some content to be presented in Clinic Foundation Team courses
   c. Major emphasis for Clinical Science Foundation Team content will be D2 and D3 years

Next meeting: Thursday, March 25, 7 am in 1397.

Agenda:

1. Review Faculty Forum discussion
2. Refine vision of course design
   a. Could be organized around a patient type: e.g. ASA 1 with minimal dental needs, healthy with moderate dental needs, ASA 2 with moderate dental needs, ASA 2 with extensive dental needs
   b. Use of Oral Health Science core content to support clinical science courses
Members present: Fitzgerald, Richards, Stefanac, Edwards, Tarrazzi

Guests: Oral Health Science Core Team Members

Agenda:

1. Review Faculty Forum discussion
   a. Discussion generally positive
   b. Support for concept of integrated courses organized around patient type and needs
2. Refine vision of course design
   a. Could be organized around a patient type: e.g. ASA 1 with minimal dental needs, healthy with moderate dental needs, ASA 2 with moderate dental needs, ASA 2 with extensive dental needs
      i. ASA classification may be too limiting – probably want better descriptors
      ii. Courses could be one per semester starting D1 Winter and ending D3 Winter or D4 Summer
   b. Use of Oral Health Science core content to support clinical science courses

Next meeting: Thursday, April 1, 7 am in 1397.

Agenda:

1. Refine vision of course design for D1 Year to see how it might work out.
   a. Could be organized around a patient type: e.g. Patient with minimal health concerns and minimal dental needs or patient with moderate health needs and moderate dental needs,
   b. Use of Oral Health Science core content to support clinical science courses
Clinical Science Foundation Team Meeting  

April 1, 2010

Members present: Fitzgerald, Richards, Stefanac,

Guests: Carol-Anne Murcoch

Agenda:

1. Refine vision of course design for D1 Year to see how it might work out.
   a. A
2. Review draft outline of proposed D1 Fall course.
   a.

Next meeting: Thursday, April 8, 7 am in 1397.

Agenda:

1. Review D1 Fall (and Winter?) course design.
   a. Define patient type(s),
   b. Identify Oral Health Science core content to support course(s)
Clinical Science Foundation Team Meeting  
April 8, 2010

Members present: Fitzgerald, Richards, Conley, Edwards, Stefanac, Tarrazzi

Guests: None

Agenda:

1. Draft D1 proposed courses review
   a. Appropriate content?
      Generally agreed on D1 Fall and Winter outline. Feel we should look into what level of involvement Perio will have (Phil will talk to Carol-Anne)
   b. Who is responsible? Clinical Science Team or Clinical Core? Mark will talk with Carol-Anne and Carlos and Margareta about logical venues for integrating content.

2. Define patient type(s)
   a. Defining patient types
      i. Patient – Paul will work on this – Simple, Moderate and Complex
      ii. Oral health care needs: Each discipline representative will suggest descriptions for the Minimal, Moderate and Complex Treatment Needs
   b. Each member will share definitions with the group via e-mail. Will discuss finalized descriptions in two weeks (April 22, 7 am in 1397)

Next meeting: Thursday, April 22, 7 am in 1397.

Agenda:

1. Finalize Review D1 Fall and Winter course design.
   a. Define patient type(s),
   b. Define Perio involvement
   c. Identify Oral Health Science core content to support course(s)
Clinical Science Foundation Team Meeting  

April 22, 2010

Members present: Fitzgerald, Richards, Edwards, Stefanac

Guests: None

Agenda:

1. Draft D1 proposed courses review
   a. Appropriate content? In general yes. Suggestions:
      i. Look for opportunities for interdisciplinary integration – Perio, Oral Path, Pedo, Ortho
      ii. Possibly three “courses” would house the content:
         1. 519 (some lecture, laboratory preparation experiences)
         2. CompCare for D1’s course (clinical experiences with support seminars)
         3. Treatment Planning for D1’s (first of a series)
   b. Who is responsible?
      i. Directors vary based on year and content
      ii. D1 – focus on caries management in Fall, include more perio and oral path Winter
      iii. D2 would focus on more complex cases (see patient and case type descriptions below)

2. Define patient type(s) ( 
   a. Med Classification System
   b. Path Classification System
   c. Dental needs system could be the “A” and “B” patient division

3. Meeting times – now that the semester is over, is there a better time? General concensus is to keep Thursday at 7 am.

Next meeting: Thursday, April 29, 7 am in 1397.

Agenda:

1. Discuss detailed D1 course outlines
Clinical Science Foundation Team Meeting            April 29, 2010

Members present: Fitzgerald, Richards, Edwards, Stefanac

Guests: None

Agenda:

1. Draft D1 proposed courses review (continued)
   a. Appropriate content? In general yes. Suggestions:
      i. Look for opportunities for interdisciplinary integration – Perio, Oral Path, Pedo, Ortho
      ii. Possibly three “courses” would house the content:
          1. 519 (some lecture, laboratory preparation experiences) – do we “pull out” the lecture component as a separate course (same time, place, content) to get a better handle on student acquisition of conceptual vs clinical skills.
          2. CompCare for D1’s course (clinical experiences with support seminars)
          3. Treatment Planning for D1’s (first of a series)
   b. Who is responsible?
      i. Directors vary based on year and content
      ii. D1 – focus on caries management in Fall, include more perio and oral path Winter
      iii. D2 would focus on more complex cases (see patient and case type descriptions below)
2. Define patient type(s)
   a. Med Classification System
   b. Path Classification System
   c. Dental needs system could be the “A” and “B” patient division – “A” and “B” should be switched to follow complexity growth of other classification systems – i.e. Med and Path systems go from least complex to most complex. Dental system goes from most complex to least complex. Can we get them to match?
   d. Ortho classification
3. Other issues to be addressed
   a. Coordination with Oral Path in winter term for patient treatment plans
   b. Increased Ortho and Pedo presence and input in curriculum development
   d. Potential coordination with prophy experiences in winter

Next meeting: Thursday, May 6, 7 am in 1397.

Agenda:

1. Discuss detailed D1 course outlines Fall and Winter -
Members present: Fitzgerald, Richards, Edwards, Stefanac

Guests: None

Agenda:

1. Draft D1 proposed courses review (continued)
   a. Appropriate content? In general yes. Suggestions:
      i. Look for opportunities for interdisciplinary integration – Perio, Oral Path, Pedo, Ortho
      ii. Possibly three “courses” would house the content:
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   a. Coordination with Oral Path in winter term for patient treatment plans
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Next meeting: Thursday, May 6, 7 am in 1397.

Agenda:

1. Discuss detailed D1 course outlines Fall and Winter -
Members present: Fitzgerald, Richards, Edwards, Stefanac

Guests: None

Agenda:

1. Draft D1 proposed courses review (continued)
   a. Appropriate content? In general yes. Suggestions:
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   3. Other issues to be addressed
      a. Coordination with Oral Path in winter term for patient treatment plans
      b. Increased Ortho and Pedo presence and input in curriculum development
      d. Potential coordination with prophy experiences in winter

Next meeting: Thursday, May 6, 7 am in 1397.

Agenda:

1. Discuss detailed D1 course outlines Fall and Winter -
Clinical Science Foundation Team Meeting  

May 27, 2010

Members present: Fitzgerald, Richards, Edwards, Stefanac, Bashutski

Guests: None

Agenda:

1. Review Clinical Science Course spreadsheet for omissions, overlaps and content
   a. Reviewed “Clinical Science Sort” tab of the Clinical Sciences Tally.xlsx worksheet
      i. Identified for D1 year which of the existing courses had content already being
         addressed by either our group or other teams.
      ii. Those courses are highlighted in Green
   b. Agreed to complete the process on years D2 through D4 by Friday, June 4.
      i. Paul Edwards will look at Oral Med, Oral Path and radiography
      ii. Phil Richards and Jill Bash will look at perio
      iii. Mark Fitzgerald will look at Restorative and Prosthodontics in coordination with Daler Tarrazzi
      iv. Mark Fitzgerald will look at Endo in coordination with Dr. Bauer
      v. Scott Conley will look at Ortho and Pedo.
   c. Team members will submit edited lists to Fitzgerald by Friday, June 4. He who will compile a
      master list and re-distribute to the team prior to our next meeting on Thursday, June 10.

2. Discussion on how content is best integrated
   a. Committee members felt that the treatment planning course format is a good way to
      integrate content.
   b. Discussed whether it made sense to present treatment methods and the underlying
      supporting evidence in a discipline specific or integrated approach
   c. General consensus was to use discipline approach and use the treatment planning courses
      to create the inter-disciplinary connections
   d. Stefanac suggested we look at the organizational scheme in the new treatment planning
      MiDent as a possible way to approach organizing content in all of the Clinical Science
      courses. It was agreed that this may be a very effective approach.

Next meeting: Thursday, June 10, 7 am in 1397.

Agenda:

1. Identify areas of curriculum remaining to be addressed by team based on the results of the Clinical
   Sciences Tally sheet exercise
2. Agree upon approach to complete D1 and subsequent years
Clinical Science Foundation Team Meeting       June 10, 2010

Members present: Edwards, Fitzgerald, Richards, Stefanac, Tarrazzi

Guests: None

Agenda:

1. Reviewed Clinical Science Course spreadsheet for omissions, overlaps and content
   a. Want to identify which group is responsible for each line in spreadsheet (fill in column “A”)
   b. Need to finalize who is covering 531 course content
   c. Next week begin to finalize design for D1 winter Tx Plan course
2. Discussion on how content is best integrated
   a. Is there a better way? Consider timing, sequencing process.
      i. Ortho/Pedo content in 531, 642, 643, 747 may best be covered in a OHSC titled: Developing patient with and without malocclusion
      ii. Opportunities to re-sequence content within and between disciplines?
   b. Are there opportunities for connections to other parts of the curriculum? – for example the new Cariology Curriculum and Risk Assessment and Management focus
   c. Are there any gaps that should be filled or excesses that should be eliminated?

Next meeting: Thursday, June 17, 7 am in 1397.

Agenda:

1. Agree upon patient profile and approach to complete Winter D1 and subsequent years
2. Finalize column “A” on spreadsheet
Members present: Edwards, Fitzgerald, Richards, Stefanac, Tarrazzi

Guests: None

Agenda:

1. Update on Curriculum Committee review of Fall D1 Curriculum
   a. Courses approved for Fall
   b. Will combine treatment planning component with the CompCare/Seminar course
2. Identify which group is responsible for each line in spreadsheet (fill in column “A”)
   a. Need to finalize who is covering 531 course content
   b. Identified most of other course responsibilities
3. Review Discussion on how content is best integrated
   a. Is there a better way? Consider timing, sequencing process.
      i. Ortho/Pedo content in 531, 642, 643, 747 may best be covered in a OHSC titled: Developing patient with and without malocclusion – Will talk to Scott about best process to resolve
      ii. Opportunities to re-sequence content within and between disciplines?
         1. Meet with Prostho/Restorative to look for opportunities in D2 year
         2. Phil, Steve, Mark and Preetha will meet regarding tx planning, special needs patients clinical integration
   b. Are there opportunities for connections to other parts of the curriculum? – for example the new Cariology Curriculum and Risk Assessment and Management focus
   c. Are there any gaps that should be filled or excesses that should be eliminated?
4. Finalize design for D1 winter Tx Plan course

Next meeting: Thursday, July 1, 7 am in 1397.

Agenda:

1. Reports from sub committees
2. Finalize D1 Winter proposed courses
3. Propose spring and summer courses
Clinical Science Foundation Team Meeting        July 15, 2010

Members present: Bashutski, Conley, Edwards, Fitzgerald, Richards, Stefanac, Tarrazzi

Guests: Murdoch-Kinch

Agenda:

1. Reports from sub committees
   a. Treatment planning –
      i. meeting next week to finalize design
      ii. Plan on Summer course
         1. 7 weeks
         2. Focus on patient with perio and simple prosthodontics needs
         3. Focus on aspects related to actual treatment planning appointment in clinic
   b. Perio -
      i. Looking for ways to integrate intro perio experience into D1 Winter – may not be enough time and space in winter term
      ii. Don’t want course to go beyond end of Spring term – might span Winter and Spring
      iii. Concerned about other clinic skill development – BP, Tooth Vitality,

2. Finalize D1 Winter proposed courses
   a. Perio – see above
   b. CompCare – 3 half days a week, coordinated with Perio activity
   c. Restorative content integrated in 520
   d. Prosthodontics – may want to continue intro course that currently exists. Perhaps as an interdisciplinary treatment planning course of a patient with severely compromised and missing teeth.

3. Propose spring and summer courses
   a. Is there a better way? Consider timing, sequencing process.
      i. Ortho/Pedo content in 531, 642, 643, 747 may best be covered in a OHSC titled: Developing patient with and without malocclusion – Will talk to Scott about best process to resolve
      ii. Opportunities to re-sequence content within and between disciplines?
         1. Meet with Prosthodontists/Restorative to look for opportunities in D1 and D2 year
         2. Phil, Steve, Mark and Preetha will meet regarding tx planning, special needs patients clinical integration
   b. Are there opportunities for connections to other parts of the curriculum? – for example the new Cariology Curriculum and Risk Assessment and Management focus
   c. Are there any gaps that should be filled or excesses that should be eliminated?

Next meeting: Thursday, August 12, 7 am in 1397.

Agenda:

1. Reports from sub committees
2. Finalize D1 Winter proposed courses
3. Further define spring and summer courses
Clinical Science Foundation Team Meeting 

August 19, 2010

Members present:  Edwards, Fitzgerald, Richards, Stefanac, Tarrazzi

Absent: Bashutski, Conley

Guests: Murdoch-Kinch

Agenda:

1. Reports from sub committees – Finalizing Winter Courses
   a. Winter D1 CoursesTreatment planning – Summer D2 Course
      i. Perio – Winter D1  (Richards reporting for Bashutski)
         1. General design
            a. 1 hour lecture / week
            b. 1 ½ to 3 hour sessions per week for clinical experience
            c. Will span winter and spring terms – spring component will be
               patient care component
            d. Oral health sciences course will connect into the series in the spring
      2. Coordinating design with clinical foundation group and directors of 522
       CompCare Clinic/Seminar and oral health science group
      3. Still meeting to finalize design
   ii. Prosthо – (Tarrazzi reporting)
       1. Possible Title: Treatment planning a patient with prosthodontic needs
       2. Propose changing course from 28 sessions to 14
       3. Will integrate treatment planning process and concerns into course
       4. Looking to coordinate activities with 522 CompCare Clinic/Seminar
   iii. CompCare – 3 half days a week, coordinated with Perio activity (Fitzgerald
       reporting)
   iv. Restorative content integrated in 520
   v. Cariology course coordinated with OHSC

2. Informing those who follow what students currently know
   a. Propose each course should “Publish” at the end of their course a summary of:
      i. What students know and what others should expect of them
      ii. What they did not get to
      iii. What they should get next
   b. This should be coordinated by a central entity – Curriculum Committee?
   c. This should be accessible to all faculty

3. Proposed spring and summer courses
   a. Plan on Summer treatment planning course (Richards reporting)
      i. 7 weeks
      ii. Focus preparing for treatment planning on real patients and their associated
          modifiers.
          1. Money
          2. Behavior
          3. Culture
          4. Patient expectations
      iii. Emphasis on patient with perio and simple prosthо needs
   b. Still need to converse on:
i. Is there a better way to teach. Consider timing, sequencing process.

ii. Ortho/Pedo content in 531, 642, 643, 747 may best be covered in a OHSC titled: Developing patient with and without malocclusion – Will talk to Scott about best process to resolve

iii. Opportunities to re-sequence content within and between disciplines?
   1. Meet with Prosthodontic/Restorative to look for opportunities in D1 and D2 year
   2. Phil, Steve, Mark and Preetha will meet regarding tx planning, special needs patients clinical integration

iv. Are there opportunities for connections to other parts of the curriculum? – for example the new Cariology Curriculum and Risk Assessment and Management focus

v. Are there any gaps that should be filled or excesses that should be eliminated?

Next meeting: Thursday, September 2, 7 am in 1397.

Agenda:

1. Reports from sub committees to finalize D1 courses
2. Further define spring and summer courses
Clinical Science Foundation Team Meeting  

September 2, 2010

Members present: Bashutski, Fitzgerald, Richards, Stefanac, Tarrazzi

Absent: Conley, Edwards

Guests: Murdoch-Kinch

Agenda:

1. Reports from subcommittees – Finalizing Winter Courses
   a. Winter D1 Courses
      i. Perio – Winter D1 (Richards reporting for Bashutski)
         1. General design
            a. 1 hour lecture/week
            b. 1 1/2 to 3 hour sessions per week for clinical experience: 2 half days with 1/4 of the class each
            c. Will span winter and spring terms – spring component will be patient care component
            d. Oral health sciences course will connect into the series in the spring
         2. Coordinating design with clinical foundation group and directors of 522 CompCare Clinic/Seminar and oral health science group
         3. Still meeting to finalize design
      ii. Prostho – (Tarrazzi reporting)
         1. Possible Title: Introduction to Prosthodontics Treatment Options
         2. Course changed from 28 sessions to 14
         3. Will integrate treatment planning process and concerns into course
         4. Looking to coordinate activities (assigned assisting in prosthodontic chairs with guided reflective writing on experience) with 522 CompCare Clinic/Seminar
      iii. CompCare – 3 half days a week, coordinated with Perio activity (Fitzgerald reporting)
      iv. Restorative content integrated in 520
      v. Cariology course coordinated with OHSC

2. Standardized evaluation/teaching tools.
   a. Looking for ways to have integrated experiences across courses
   b. Example: Template for reflection on clinical experiences

3. Proposed spring and summer courses
   a. Plan on Summer treatment planning course (Richards reporting)
      i. 7 weeks
      ii. Focus preparing for treatment planning on real patients and their associated modifiers.
         1. Money
         2. Behavior
         3. Culture
         4. Patient expectations
      iii. Emphasis on patient with perio and simple prostho needs
   b. Still need to converse on:
      i. Is there a better way to teach. Consider timing, sequencing process.
ii. Ortho/Pedo content in 531, 642, 643, 747 may best be covered in a OHSC titled: Developing patient with and without malocclusion – Will talk to Scott about best process to resolve

iii. Opportunities to re-sequence content within and between disciplines?
   1. Meet with Prostho/Restorative to look for opportunities in D1 and D2 year
   2. Phil, Steve, Mark and Preetha will meet regarding tx planning, special needs patients clinical integration

iv. Are there opportunities for connections to other parts of the curriculum? – for example the new Cariology Curriculum and Risk Assessment and Management focus

v. Are there any gaps that should be filled or excesses that should be eliminated?

4. Informing those who follow what students currently know
   a. Propose each course should “Publish” at the end of their course a summary of:
      i. What students know and what others should expect of them
      ii. What they did not get to
      iii. What they should get next
   b. This should be coordinated by a central entity – Curriculum Committee?
   c. This should be accessible to all faculty

Next meeting: Thursday, October 7, 7 am in 1397.

Agenda:

1. Reports from sub committees to finalize D1 courses
2. Further define spring and summer courses
Clinical Science Foundation Team Meeting

October 7, 2010

Members present:  Bashutski, Fitzgerald, Richards, Stefanac, Conley, Edwards

Absent: Tarrazzi

Guests: None

Agenda:

1. Reports from sub committees – Finalizing Winter Courses
   a. Winter D1 Courses
      i. Perio – Winter D1 presented to Curriculum Committee
      ii. Prostho – Tarrazzi presented to Curriculum Committee
      iii. CompCare – 3 half days a week, coordinated with Perio activity (Fitzgerald reporting)
      iv. Restorative content integrated in 520
      v. Cariology course coordinated with OHSC

2. Creating a “Map” for the remaining curriculum
   a. Areas to include:
      i. Perio – use current “courses” as placeholders (Phil)
      ii. Prostho– use current “courses” as placeholders (Modified by Renee)
      iii. Restorative– use current “courses” as placeholders (Modified by Mark)
      iv. Ortho/Pedo – See document from SCOTT ******* Yea!
      v. Occlusion – talk with Geoff
      vi. Oral Surgery– use current “courses” as placeholders (Modified by Pilar)
      vii. Endo– use current “courses” as placeholders (Modified by Trish)
      ix. Practice Management see Fitz
   b. Parts of the Curriculum to cover:
      i. D2
         1. Spring
         2. Summer
         3. Fall
         4. Winter
      ii. D3
         1. Spring
         2. Summer
         3. Fall
         4. Winter
      iii. D4
         1. Spring
         2. Summer
         3. Fall
         4. Winter
Next meeting: Thursday, October 14, 7 am in 1397.

Agenda:

1. Reports from sub committees to finalize Clinical Science Map
Clinical Science Foundation Team Meeting

October 14, 2010

Members present: Fitzgerald, Richards, Stefanac, Conley, Edwards Tarrazzi

Absent: Bashutski

Guests: None

Agenda:

1. Update on D1 Winter courses
   a. All courses submitted to Curriculum Committee
   b. All courses approved. Next step is to finalize coordination of shared time between Cariology, CompCare Clinic, Radiography, Perio and Restorative pre-clinic.
2. Creating a “Map” for the remaining curriculum
   a. Began organizing map
      i. Perio – use current “courses” as placeholders (Phil)
      ii. Prosth– use current “courses” as placeholders (Modified by Renee)
      iii. Restorative– use current “courses” as placeholders (Modified by Mark)
      iv. Ortho/Pedo – See document from SCOTT ***** Yea!
      v. Occlusion – talk with Geoff
      vi. Oral Surgery– use current “courses” as placeholders (Modified by Pilar)
      vii. Endo– use current “courses” as placeholders (Modified by Trish)
      ix. Practice Management see Fitz
   b. Will distribute map for review prior to next meeting

Next meeting: Thursday, October 21, 7 am in 1397.

Agenda:

1. Reports from sub committees to finalize Clinical Science Map
Clinical Science Foundation Team Meeting                              October 21, 2010

Members present:  Bashutski, Fitzgerald, Richards, Stefanac, Tarrazzi

Absent: Conley, Edwards

Guests: None

Agenda:

1. Update on D1 Winter courses
   a. Proposed schedule for D1 Winter courses reviewed
   b. Concerns/recommendations arising from schedule:
      i. Switch 9 am time slots for the Pros course with Perio – request sent to Dr. Murdoch-Kinch, Tom Green
      ii. Expressed concern that proposed schedule has one less shared clinic/preclinic day than originally planned. Fitzgerald will look into re-mapping activities between CompCare Clinic, Cariology, Perio and Radiography to see if they can be fit in.

2. Editing the Clinical Science Foundation “Map”
   a. Began organizing map
      i. Concern raised in how to best sequence Restorative and Prosthodontics Science Foundation courses without knowing the true sequence of the Preclinic sequence
      ii. Want to support and push the goal of being able to assign patient pools to D2’s beginning of Winter Term
         1. Will require “moving up” all current 600 series Perio, Prosthodontics and Restorative courses
         2. Can be done if 614/621 and 622 start in the Spring, D2
         3. Ortho/Pediatric Dentistry may also have to start in Spring D2 but might be able to be delayed – need feedback from Dr. Conley
      iii. Need better clarification on time commitments – committee members will review map and make suggestions for corrections
   b. Will distribute updated map for review prior to next meeting

Next meeting: Thursday, October 29, 7 am in 1397.

Agenda:

1. Reports from sub committees to finalize Clinical Science Map
Clinical Science Foundation Team Meeting          October 28, 2010

Members present: Edwards, Fitzgerald, Richards, Stefanac,

Absent: Bashutski, Conley, Tarrazzi

Guests: None

Agenda:

1. Editing the Clinical Science Foundation “Map”
   a. Revised distributed map
      i. Concern raised regarding how to provide clinic experiences for D2’s starting Spring – there will need to be 4 sessions in the schedule provided to distribute the students appropriately. Not sure how that will interface with Pathways
      ii. Need feedback from Dr. Conley regarding Ortho/Pediatric Dentistry. Currently scheduled for start in Spring D2. May need to be delayed to Summer D2.
      iii. Need final clarification on time commitments – committee members will review map and make suggestions for corrections
      iv. Need Further clarification from oral surgery regarding didactic courses and anesthesia course
      v. Need further clarification from Dr. Murdoch-Kinch regarding Special Patient Care/ Management of Complex Medical Patient Course.
   b. Will distribute revised Map for final review by committee members. Target of Tuesday, November 2 for submitting Map to VIT Committee.

Next meeting: Thursday, November 11, 7 am in 1397.

Agenda:

1. Review courses to be submitted for D2 Spring and Summer
Clinical Science Foundation Team Meeting  
December 9, 2010

Members present: Edwards, Fitzgerald, Richards, Stefanac, Bashutski

Absent: Conley, Tarrazzi

Guests: None

Agenda:

1. Update on where we are in curriculum planning: Winter D1
   a. Oral Path/Radiology
      i. Limited time for radiology
      ii. Other areas OK
   b. Pros – OK
   c. Cariology
      i. Limited time for lab/clinic experience
      ii. Rest OK
   d. Perio
      i. Limited time for lab/clinic experience
      ii. Rest OK
2. Update on where we are in curriculum planning: Spring D2
   a. Real challenge – limited clinic space/times
   b. 7 / 7 split in semester creating artificial time grouping for content
3. Discussion of creating an ethics and professionalism theme throughout the Clinical Sciences courses.
   a. Want to have each Clinical Science Foundation course contain an ethics and professionalism element – challenge is to ensure and coordinate activities
   b. Create competency driven process – may require revision to Competency Document

Next meeting: Thursday, January 13, 2011, 7 am in 1397.

Agenda:

1. Review courses to be submitted for D2 Spring and Summer
Clinical Science Foundation Team Meeting  
January 13, 2011

Members present: Edwards, Fitzgerald, Richards, Stefanac, Bashutski

Absent: Conley, Tarrazzi

Guests: None

Agenda:

1. Discuss VIT White Paper report
2. Recap on Winter D1 courses
   a. Want to have each Clinical Science Foundation course contain an ethics and professionalism element – challenge is to ensure and coordinate activities
   b. Create competency driven process – may require revision to Competency Document
   c. Need to develop a means to ensure continuing improvement of the new curriculum
   d. D1 Winter Courses:
      i. Clinical Science Foundation Team based
         1. CompCare 522 – Extremely limited clinical time
         2. Diagnostic Sciences 526 – David Tindle running the course
         3. Fundamentals of Perio 530 – Limited clinic time
         4. Intro to Prostho Treatment Options 536 – Working well
      ii. Other Team Based
         1. Basic Radiology 506 – Limited clinic (Radiology Clinic) time
         2. Clinical Foundation 520
         3. Behavioral Science 534
         4. Cariology II 542 – Limited clinic/lab time
      e. Need to continue working on better connections with the Oral Health Science Team efforts.
3. Review Spring D2 courses
   a. Anesthesia as part of pharmacology course
   b. Clinical experience in anesthesia
   c. Patient with neoplasia
   d. Intro to Ortho
   e. CompCare 520
4. Review Summer D2 courses
   a. Treatment Planning the patient with multi disciplinary needs (many diseases) 6XX.
   b. Cranial Facial Growth – Ortho
   c. Medical emergencies / Dealing with Pharmacies
   d. CompCare 520
5. Look ahead into Fall and Winter

Next meeting: Thursday, January 27, 2011, 7 am in 1397.

Agenda:

1. Tx plan course for the Summer
2. Other Summer courses
Clinical Science Foundation Team Meeting

January 27, 2011

Members present: Conley, Edwards, Fitzgerald, Richards, Stefanac,

Absent: Tarrazzi, Bashutski

Guests: None

Agenda:

1. Review Tx Plan course for Summer
   a. Reviewed “Tx Plan 2” course submission
   b. Discussed “connections” with previous courses and future courses
2. Reviewed other courses for Summer – OK, need to continue to look for connections
3. Began Planning for Fall Courses – Restorative, oral med, ortho/pedo will develop their courses as planned
4. Discussed combining Clinical Science Foundation Team and Oral Health Sciences Teams
   a. Want to have groups meet together regularly
   b. Can have one committee with separate teams within the combined group
   c. Look at other organizational model or members
   d. Mark will talk to Carol Anne about the possibility
5. Strategies for migrating new curriculum changes into VICs daily activities need to be developed soon

Next meeting: Thursday, February 10, 2011, 7 am in 1397.

Agenda:

1. D2 Fall and Winter courses
2. Review ethics and professionalism content in courses
3. Strategies for migrating new curriculum changes into VICs daily activities
Clinical Science Foundation Team Meeting February 17, 2011

Members present: Conley, Fitzgerald, Murdoch-Kinch, Richards, Tarrazzi, Tindle

Absent: Edwards, Bashutski, Stefanac

Guests: None

Agenda:

1. Welcomed new member – Dr. David Tindle
2. Reviewed existing courses for D1 and D2 Years. Will re-visit after end of Winter Term
3. D2 Fall and Winter courses
   a. Fall - Proposed

<table>
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<tr>
<th>Course</th>
<th># Wks</th>
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<th>Sessions/Wk Clinic</th>
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<td>Oral Surg</td>
<td>7</td>
<td>2</td>
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<td>Ortho</td>
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<td>3</td>
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<td>Perio</td>
<td>14</td>
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</tr>
<tr>
<td>Rest</td>
<td>7</td>
<td>1</td>
<td></td>
<td>Start second half</td>
</tr>
<tr>
<td>CompCare</td>
<td>14</td>
<td>1</td>
<td></td>
<td>2 sessions/week</td>
</tr>
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i. Ortho is set

ii. Concern about Oral Surgery course and it’s development. Not sure of new contact: (Brent Ward?)

iii. Perio Therapy 1: Course under discussion in Perio. Will re-visit at next meeting

iv. Restorative course: Originally projected to be in last half of Fall. May be better sequenced in first half of Winter.

v. CompCare (620): Schedule for Spring/Summer and Fall in place. Have had to make several compromises:

1. Perio and Restorative experiences in Foundation Clinic will need to be reduced:
   a. These experiences were reduced by approximately 2 for the 2010-2011 sessions
   b. Will need to be reduced by another 1 to 2 experiences due to limited clinic space.
   c. May be able to increase experiences if we re-open the VIC clinic treatment opportunities.

2. Pedo will not have a D2 experience. Instead, the three sessions will be added onto the first D3 Pedo rotation.

3. Radiology will reduce their sessions by one

4. Students in the Research Pathways Track will only have one CompCare session per week during the Spring session.

5. Looking into adding a PAES experience into the schedule

6. There will be a stress on the VIC’s regarding accommodating approximately 80 students assisting in the VIC’s on Tuesday and Thursday afternoons.
### b. Winter - Proposed

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<th>Course</th>
<th>Title</th>
<th>Credit Hours</th>
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<td>DiagSci</td>
<td>Diagnosis and Management of Head and Neck Lesions III</td>
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<tr>
<td>Oral Surg</td>
<td>Advanced Oral Surgery, roughly 14 hrs</td>
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<td>Pedo</td>
<td>Intro to Pedo</td>
<td>14</td>
<td>1</td>
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<tr>
<td>Perio</td>
<td>Perio Therapy 2, roughly 20 hours</td>
<td>14</td>
<td>1.5</td>
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<tr>
<td>Prostho</td>
<td>Dental Implants ideally D2 Winter</td>
<td>7</td>
<td>3</td>
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<tr>
<td>Multi</td>
<td>Managing Dental Emergencies</td>
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<td>Special Patient Care/Hospital Dentistry</td>
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<td>Special Patient Care/Geriatrics</td>
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<td>Rest</td>
<td>Digital/Ceramic Dentistry</td>
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<td>PracMan</td>
<td>Practice Management 1</td>
<td>14</td>
<td>1</td>
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<td>CompCare</td>
<td>CompCare (620)</td>
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<tr>
<td></td>
<td>Tx Plan 3 - Issues in tx planning</td>
<td>7</td>
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<td>(restorability, sequencing, multiple options, interdisciplinary approach)</td>
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</table>

i. Oral Med – Medically complex patient (to follow basic science course)

ii. Where do we put in special needs patients? Sam Z., Cornwall, Pedo?, Sweier?, Englehart

iii. Details of other courses not discussed – will continue discussion next meeting

4. Review ethics and professionalism content in courses – delayed to future meetings

5. Strategies for migrating new curriculum changes into VICs daily activities – delayed to future meetings

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Next meeting: Thursday, March 10, 2011, 7 am in 1397.

Agenda:

1. D2 Fall and Winter courses – continued discussion
2. Review ethics and professionalism content in courses
3. Strategies for migrating new curriculum changes into VICs daily activities
Clinical Science Foundation Team Meeting March 3, 2011

Members present: Bashutski, Fitzgerald, Richards, Stefanac, Tindle

Absent: Edwards, Conley, Tarrazzi

Guests: Murdoch-Kinch

Agenda:

1. D2 Fall and Winter courses – continued discussion
   a. Fall - Proposed

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<tr>
<td>Oral Surg</td>
<td>Introduction to Oral Surgery</td>
<td>7</td>
<td>2</td>
<td></td>
<td>Possible Winter?</td>
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<td>Ortho</td>
<td>Biology of tooth movement (642, 643, 745)</td>
<td>14</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Perio</td>
<td>Perio Therapy 1, roughly 14 hours</td>
<td>14</td>
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<td>Start second half</td>
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<tr>
<td>Rest</td>
<td>Clinical Applications for Direct Restorations</td>
<td>7</td>
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</tbody>
</table>

   i. Ortho: Rich Johnson and Mark Perkman have a draft of the D2 Fall Ortho Course proposal set for finalizing and Curriculum committee review
   ii. Concern about Oral Surgery course and it’s development. Not sure of new contact: (Brent Ward?) May move to Winter but not sure how it will then tie with current Winter plans
   iii. Perio Therapy 1: Will be meeting on Monday to further the details.
   iv. Restorative course: Originally projected to be in last half of Fall. Still looking at possibility of a winter time slot coordinated with Implant Experience.
   v. CompCare (620): Schedule for Spring/Summer and Fall in place. Need to assess impact of D2’s in VIC’s in the Winter Semester 2012. Fitzgerald will draft a potential solution.
b. Winter - Proposed

<table>
<thead>
<tr>
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<td>DiagSci</td>
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<td>2</td>
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<td>1</td>
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<td>1</td>
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<tr>
<td>Perio</td>
<td>Perio Therapy 2, roughly 20 hours</td>
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<td>1.5</td>
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<tr>
<td>Prostho</td>
<td>Dental Implants ideally D2 Winter</td>
<td>7</td>
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<td>Multi</td>
<td>Managing Dental Emergencies</td>
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<td>Medically Complex Patient I</td>
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<td>Special Patient Care/Hospital Dentistry</td>
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<td>Special Patient Care/Geriatrics</td>
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<td>Rest</td>
<td>Digital/Ceramic Dentistry</td>
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<td>PracMan</td>
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i. Oral Med – Medically complex patient (to follow basic science course)
ii. Where do we put in special needs patients? Sam Z., Cornwall, Pedo?, Sweier?, Englehart
iii. Details of other courses not discussed – will continue discussion next meeting

2. Review ethics and professionalism content in courses – deferred to later date
3. Strategies for migrating new curriculum changes into VICs daily activities – deferred to later date

Next meeting: Thursday, March 10, 2011, 7 am in 1397.

Agenda:

1. D2 Fall and Winter courses – continued discussion
2. Review D2 Winter Clinic Experience – design for new curriculum for D2’s
Clinical Science Foundation Team Meeting  
March 10, 2011

Members present:  Bashutski, Fitzgerald, Richards, Conley, Tindle

Absent: Stefanac, Tarrazzi

Guests: Murdoch-Kinch

Agenda:

1. D2 Fall and Winter courses – continued discussion
   a. Fall - Proposed – considered complete with exception of Oral Surg

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<tr>
<th>Area</th>
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<td>Oral Surg</td>
<td>Introduction to Oral Surgery</td>
<td>7</td>
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<td>Possible Winter?</td>
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<td>Ortho</td>
<td>Biology of tooth movement (642, 643, 745)</td>
<td>14</td>
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<td>3</td>
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<tr>
<td>Rest</td>
<td>Clinical Applications for Direct Restorations</td>
<td>7</td>
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<td>Start second half</td>
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<tr>
<td>CompCare</td>
<td>CompCare (620)</td>
<td>14</td>
<td>1</td>
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<td>2 sessions/week</td>
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<tr>
<td>i.</td>
<td>Ortho: Rich Johnson and Mark Berkman have submitted a proposal for Curriculum committee review</td>
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<tr>
<td>ii.</td>
<td>Concern about Oral Surgery course and its development. Message sent to Pilar regarding who might know.</td>
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<tr>
<td>iii.</td>
<td>Restorative course: Will be focused on treatment decisions related to treatment planning direct restorative restorations including complex restorations, cores and direct esthetic restorations. Possibly coinciding with D3 course in old curriculum.</td>
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<td>iv.</td>
<td>Perio: Full semester, 1 hour / week. Proposal in process for submission</td>
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<td>1</td>
<td>May need 2 hrs</td>
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Multi Special Patient Care/Hospital Dentistry 7 2
Multi Special Patient Care/Geriatrics 7 2
Rest Digital/Ceramic Dentistry 7 1 3
PracMan Practice Management 1 14 1
CompCare CompCare (620) 14 1 4 sessions/week
Tx Plan 3 - Issues in tx planning 7 1
(restorability, sequencing, multiple options, interdisciplinary approach)

i. Oral Med – Medically complex patient (to follow basic science course)
ii. Where do we put in special needs patients? Sam Z., Cornwall, Pedo?, Sweier?, Englehart
iii. Details of other courses not discussed – will continue discussion next meeting
   submitting proposal to Curriculum Committee

2. Combining the Oral Health Science Team with Clinical Science Foundation Team
   a. Combining would help encourage innovation in course design – collaboration between areas
   b. Carol Anne would propose a meeting for both teams.
      i. Only agenda item is discussion of merger
      ii. Will look for an evening soon for the meeting.

3. Strategies for migrating new curriculum changes into VICs daily activities – deferred to later date

4. Review ethics and professionalism content in courses – deferred to later date

Next meeting: Thursday, March XX, 2011, 7 am in 1397.

Agenda:

1. D2 Fall and Winter courses – continued discussion
2. Review D2 Winter Clinic Experience – design for new curriculum for D2’s
Clinic Implementation Team
Meeting Notes, 1-20-09, 9-10 a.m., room 1397

Members present: Dan Edwards, Mark Fitzgerald, Mary Garrelts, Wendy Kerschbaum, Phil Richards, Marianella Sierraalta, Nikki Sweier

Guest: Paul Krebsbach – Vision Implementation Steering Committee Chair

Dr. Krebsbach provided a general introduction regarding the nature and scope of some of the anticipated curricular changes designed to optimize both the efficiency and the effectiveness of the learning environment. The findings and recommendations of previous committees and some specific clinical models and overall goals for the clinical program were discussed. Specifically, general practice teams in the 4 main clinics with assigned students and patients were described. Further, discipline-based learning environments where competency can be established and in which patients can also be managed/referred were also discussed. The importance of formal treatment planning of patients as a process critical to the success of the educational model and for which specific skill and competency must also be demonstrated was emphasized. Committee members were asked to try to consider and prioritize specific objectives (listed below) for early versus more gradual implementation prior to the next meeting.

- Patient families managed by student teams directed by Team Leaders
- Discipline-specific competencies achieved in specialty teams
- Referrals back to specialty teams for advanced care based on discretion of generalist team leader following
- Guidelines set by disciplines
- Centrally managed scheduling and appointing of operatories
- Strengthen linkages with other health care providers
- Maintain basic science and medicine concepts throughout clinical care
The perceived benefits of providing highly focused, concentrated early clinical learning experiences (particularly for D1 and D2 level students) in discipline-based clinical environments were discussed. While the potential educational value of developing concentrated clinical “rotations” (with some of the attributes of the assigned blocks that currently exist in Oral Surgery and Pediatric Dentistry) were considered, the logistical challenges of providing the necessary numbers and types of patient experiences within disciplines for all students at appropriate times were also considered to be potential barriers to instituting such an approach. The importance of assigning specific and appropriate treatment/patients for students for clinical activities earlier than the current system (particularly at the D2 level) was particularly emphasized. With this in mind, the importance of comprehensive treatment planning for all patients, particular as they are entering the school clinic system, was again emphasized. The potential design features of “teams” were considered. The size, constitution and physical proximity characteristics of “a team” were discussed. The potential for both “physical” and “virtual” teams were discussed. The potential importance and value of developing informational documents for patients regarding “their” assigned team (possibly in the form of pamphlets with photos and contact info for team members, etc.) were discussed. There was strong advocacy for designing programmed, formal interactions between students and supervising clinical faculty (pre- and/or post-treatment “huddles”) on a daily basis for discussion of the clinical activities that took place during that session. The need for a dedicated group of full-time faculty working closely with small groups of students was considered to be important for the tracking of both student and patient status and progress. The need to constantly consider how to optimize faculty and staff efficiency and reduce costs was again reinforced. The level of staff and team member support necessary to coordinate and schedule patient care among members of a diverse team was also considered. The question of how many clinic bays/chairs should ultimately be dedicated to general dentistry/comp care and discipline-based clinical education were considered. The possibility of dedicating some flexible chair space in the 4 existing clinics to discipline-specific instruction (perio, prosth, operative?, treatment planning?) were considered. Potential opportunities for general and discipline-based clinics to be scheduled for different numbers of half days each week (or more/less during certain times of year) were considered.
Clinic Implementation Team
Meeting Notes, 2-3-09, 9-10 a.m., room 1397

Members present: Dan Edwards, Mark Fitzgerald, Mary Garrelts, Wendy Kerschbaum, Phil Richards, Marianella Sierraalta, Nikki Sweier

Dr. Richards had been informed of some unknown concerns that had been expressed by some member(s) of the Vision Implementation Steering Committee following his briefing to them about the discussions of this Team following last week’s meeting. With this in mind, today’s meeting began with a general review and analysis of the conversations from the two previous meetings. The composition of student treatment teams were specified to specifically include D1, D2, D3, D4 and DH students. The four disciplines that were proposed for the development of more specific clinical instructional environments were re-specified as Perio, Prosth, Endo and Oral Med/Treatment Planning. Concerns were expressed about the ability to implement any of the discipline-specific clinical instructional models that were being discussed within the current VIC clinic environments because the scheduling of students into chair space in the four clinics is already becoming well established for Fall, 2009. It was felt that the additional weeks of external student rotations that are being planned are unlikely to reduce the crunch for chair space significantly. With the consideration of the importance of clinical utilization and efficiency factors, it was felt that re-purposing chair space for disciplines may be considered by many to be an undesirable near-term option because it would be likely to reduce the availability of clinical opportunities for D3 and D4 students and reduce overall clinical productivity. The high rate of patient no-shows and cancellations was cited as an unacceptable reality for the school. The fact that clinical faculty are so commonly under- or over-utilized based on the unpredictable nature of clinical activity and the inability to reliably predict and govern appropriate and efficient staffing levels was cited as another unacceptable reality for the school. Some trends through the year (Perio heavy in Summer and Fall, Prosth heavy in Winter) are also undeniable but difficult to accommodate in the current clinic design. The need to find a new and different method to manage students’ clinic schedules was felt to be a pressing issue. Creating a method to effectively but dynamically schedule students (particularly in the early part of the learning curve), faculty members and suitable patients with particular needs into discipline-specific clinic areas will require an entirely new scheduling concept. The fact that Monday and Wednesday clinics have traditionally been overloaded, at least in part because of the locked-in nature of the D2 curriculum, will require consideration for change. The 3rd floor Orange clinic was discussed as a resource that may be used for some types of focused clinical experiences but may be insufficient for others.
Clinic Implementation Team
Meeting Notes, 2-10-09, 9-10 a.m., room 1397

Members present: Dan Edwards, Mark Fitzgerald, Mary Garrelts, Wendy Kerschbaum, Laurie McCauley, Phil Richards, Nikki Sweier

Guest: Steve Stefanac

Dr. Stefanac was invited to join our meetings whenever his schedule allows. The meeting began with a conceptual discussion of the goals of the Clinic Implementation Team in order to focus our efforts. Development and early implementation of some “do-able” clinical curricular changes in the short-term would certainly be valuable in order to pilot and demonstrate some design concepts. However, such early modifications probably cannot be the definitive ones because of the many other supporting curricular and systematic changes that will be required to achieve our future goals. There was general agreement that we should begin to focus primarily on what we feel that we can begin to implement in the near term that will ultimately also lead us down the desired path for the broader future vision. The importance of trying to make the future vision “attainable” and “concrete” to the entire school community on an ongoing basis was emphasized. The strategy for creating Teams, specifically the grouping of D1, D2, D3, D4 and DH students, and outlining their function within Teams was discussed. Members of Teams should develop systematic relationships that mimic a private practice environment. This would represent a significant contrast to the currently cumbersome nature of referrals and shared patient care in the school clinics. The importance of truly incorporating dental hygiene into this process was emphasized. The goal would be that patient assignments to established student groups would enhance continuity of care and the “drop down” process for patients following student graduation. The need to make referrals more proactive and systematic (eliminating the current norm of referrals occurring primarily “on the fly”) was emphasized to facilitate improved student accountability through allowing better access to patient information to enhance preparedness prior to appointments. The process of re-treatment planning all clinic patients whenever they are assigned to a new student provider was cited as a key example of the inefficiency of the current single-student assignment system. The coding and fee structure for patient exams conducted in the school clinics was also discussed. The potential value of visiting peer institutions to investigate successful and unsuccessful practices involving generalist and Team-based concepts was also discussed. Some discussion took place regarding the background information that D1 and D2 students need in order to participate meaningfully in the clinic, but no conclusions were reached.
Clinic Implementation Team  
Meeting Notes, 2-17-09, 9-10 a.m., room 1397

Members present: Dan Edwards, Mark Fitzgerald, Mary Garrelts, Wendy Kerschbaum, Phil Richards, Marianella Sierraalta, Nikki Sweier

Guest: Steve Stefanac

The goal of the meeting was to try to develop some clarity regarding the composition and functional aspects of clinic Teams. Mark Fitzgerald provided an overview of discussions and potential clinic design elements that had been developed through the efforts of a previous clinical design committee that he had chaired. He emphasized the significant restrictions that were placed on this previous committee (changing only clinical education elements without any non-clinical curricular changes). The main thrust of the previously suggested clinical design model was a generalist-focused clinical environment that would mirror a general dental practice. A key focus was the attainment of clinic efficiency and the needs and expectations to achieve it. One conclusion was that staffing needs for these clinics by specialty disciplines could potentially be reduced significantly – e.g. one specialist per floor, primarily for consultation purposes. Potential roles for graduate students assigned to Teams were also discussed. The potential value of a “Team huddle” during each clinic session was discussed. Significant discussion of potential functional designs for clinics and Teams within clinics followed. A number of potential questions and challenges were discussed; no clear conclusions were reached for many of these issues. Appropriate sizes for Teams were discussed, considering the fact that the smaller the Teams, the more Team leaders would be needed. Potential roles for full-time faculty, part-time faculty and D4 students to serve as Team leaders in some capacity were discussed. The potential challenge of implementing smooth transitions between multiple Team leaders through the week was discussed. The assignment of patient families to Teams and to individual students within Teams was discussed. For patient care continuity purposes, D4 students may be most ideally teamed with D2 students and D3 students may be most ideally teamed with D1 students for shared patient assignments. The role of support staff and students in patient scheduling and cubicle utilization was discussed. The challenges of creating flexibility in the use of existing clinic space for generalist clinical Teams as well as discipline-based teaching activities were discussed. One possible concept might be the use of different clinic areas for discipline-focused teaching on a rotating schedule through the week. The flexibility of the rest of the academic schedule, particularly for D2 students now (and for D1 students in the future) would need to facilitate such discipline-based teaching rotations. The challenge of creating an efficient clinical care environment that is both patient-friendly and educationally rich for students in all areas of dentistry persists.
Members present: Dan Edwards, Mary Garrelts, Wendy Kerschbaum, Laurie McCauley, Phil Richards

Guest: Steve Stefanac

This meeting began with a discussion of potential Comprehensive Care Seminar modifications that could assist in reinforcing biomedical science content using clinical contexts. (A separate discussion had taken place at a meeting convened by Dr. Bayne on 2-26-09.) Discussion included optimal group size, topical focus (biomedical vs clinical), the use of online cases as well as actual ones, grand rounds (with modeling by faculty) and potential implications for students participating in outreach activities. This effort will need to include input from other teams (specifically the Science Foundation team) before moving forward.

Learning needs and instructional specifications per discipline will need to be developed for initial learning experiences

- Perio
- Prosth
- Oral Med
- Endo

Specific focal needs for early learners (outside the traditional dental disciplines) were discussed:

- Orientation to clinic
- Assisting skills
- Oral diagnosis

Flexible performance goals (to facilitate performance based progression) will also need to be developed
Clinic Implementation Team
Meeting Notes, 3-10-09, 9-10 a.m., room 1397

Members present: Mark Fitzgerald, Phil Richards, Marianella Sierraalta, Nikki Sweier
Guest: Steve Stefanac

Update – effort to develop design characteristics for discipline-specific instruction (from the previous meeting) described to Marianella for her consideration in prosth

Design characteristics will need to be developed for disciplines and generalist areas

What would happen in a general practice that has specialists available (vs not available)?

Should staff hygienists be included in the mix?
   Hygienists should definitely be utilized as members of generalist teams
   Perhaps more hygienists as faculty? (in place of some generalist dental faculty?)

Can discipline-based competencies be assessed by generalists? If so, which ones?

Do current test cases need to be broken up into smaller pieces to enhance convenience of administration?

What level of in-service training (and/or other enticement) is needed for generalists to be willing to take on more specialty procedures?

Calibration and instruction need to be closely linked – especially initially

General discussion of teams and “microteams”

What/when for the next step?
Members present: Mark Fitzgerald, Wendy Kerschbaum, Phil Richards, Marianella Sierraalta, Nikki Sweier

Consultant: Steve Stefanac

Challenges that must be addressed to move forward:
- The need for a more flexible weekly schedule for D2 students (more than M/W)
- The need for dedicated physical spaces for discipline-specific instruction

Is the current “square grid” clinic design optimal for our clinic environments? Should modular spaces centered around access points (and supervising faculty members) be considered? What are the infrastructure implications – what is do-able? What were the conclusions of the Paulien group and how should these be used in our current planning?

The term “initial skills development clinic” (ISDC) was developed as a conceptual description

Discussion of potential models of where/how initial instructional areas in disciplines could be designed
- One central area (i.e. all in one clinic)
- Segments of the existing clinical areas (i.e. reserved regions of each clinic)

Extensive discussion of the history and rationale for the restorative dentistry instruction programs “opting out” of the need/desire for discipline-specific early instructional models – Mark Fitzgerald

Still need to develop:
- The design criteria for the initial learning experiences by discipline for the ISDC
- The demonstrated competency measures by discipline for the ISDC
- The specific entry criteria by discipline to enter the General Dentistry clinic
Members present: Dan Edwards, Mark Fitzgerald, Wendy Kerschbaum, Laurie McCauley, Phil Richards, Marianella Sierraalta, Nikki Sweier

Consultant: Steve Stefanac

The focus of today’s discussion was Teams:
  How large should they be?
  How should they function?

Cubicles assigned to students (current system) versus cubicles assigned to teams/groups

Microteams: one D1, D2, D3, and D4 student assigned to function somewhat together

  DH3 and DH4 hygiene students will definitely participate in the larger groupings

  Look at the strengths and challenges of existing referral and patient care interaction models for systematization in all clinics? (3Green referral protocols – Cheryl Quiney)

Visualization of patient flow within teams
  Patients are assigned to a student (primary)
  Patients may be referred within the team (secondary)
  Patients may be referred outside the team (tertiary)

“Teams” as components of “Groups” (group practices) – 3 or 4 teams per group

Concept (agreed upon today) is that 3 group practices (2 rows) will function in each clinic – potentially with 1 faculty member supervising at any given time

A “shepherding role” is visualized for the D4 students in teams
  Organizational skills
  Leadership skills
  Must account for time out due to external rotations

Practice management assignments for D4s can and should represent real life in THEIR own clinical practices (clinical activities) and team practices (patient management activities) – Mark Fitzgerald will work on mocking up some criteria for assessing this

Some activities should be launched THIS FALL in order to inform future efforts

Focus on enhancement of D1 and D2 activities and experiences for this Fall
Clinic Implementation Team  
Meeting Notes, 5-12-09, 9-10 a.m., room G536

Members present: Dan Edwards, Mark Fitzgerald, Wendy Kerschbaum, Phil Richards, Nikki Sweier

Dr. Richards reviewed some aspects of the plans that have been proposed by the Clinical Foundation Team as described by Dr. Snyder at the Vision Implementation Steering Committee meeting from the previous week. The main focus was on developing a new structure and timeline for the Clinical Foundation content. Rather than each course in each term focusing on a specific discipline or a specific category of skills (e.g. intracoronal direct restorations or extracoronal indirect restorations), the proposed model for the future would potentially involve “modules” that might include mixed content that may encompass skills that traditionally originated from both restorative dentistry and from prosthodontics. The intent is that once a student successfully completes a given module, (s)he would then immediately begin to provide some clinical patient care that includes procedures from that specific module – as early as perhaps midway through the D1 year. The hypothetical example that was given was that “module 1” may be given early in the D1 Fall Term and include skills for preparation and restoration of one-surface occlusal and cervical direct restorations and full gold crowns. Concurrently with or shortly after some of these early clinical experiences have been completed, students would then return to the Sim Lab for basic skill development from the next module (hypothetically this may include two-surface direct restorations and porcelain crowns). Some unresolved details that were discussed regarding how this system may function included: 1) how to best appropriate and assign patients and procedures to these early learners who are in the clinic only on a limited basis, and 2) what specific characteristics (e.g. clinic space and faculty skills/numbers) would be necessary for these early clinic learners to thrive in such experiences.

Dr. Fitzgerald provided a proposal for a clinical pilot for consideration by the group. Mark’s proposal is also posted on the CIT CTools site for review. Much of the content of the proposal originated from discussions from the Clinical Design Committee that had considered many of these same issues from 2006-2007. Some discussion took place regarding logistics and staffing consideration under such a model. Further discussion was anticipated at future meetings.
Members present: Mark Fitzgerald, Wendy Kerschbaum, Laurie McCauley, Phil Richards, Nikki Sweier

Consultant: Steve Stefanac

The group discussed Dr. Fitzgerald’s proposal for a clinical pilot that was introduced at the previous meeting. Several specific attributes of the proposal addressing goals that have been discussed previously by the group were cited for inclusion in future designs involving team structures – specifically: 1) regularly scheduled team meetings, 2) “morning huddles” for real-time coordination of treatment provided within the teams, and 3) enhanced biomedical science integration by utilizing team projects. However, as specified in the original charge to the CITeam, the development of discipline-based team structures is not effectively facilitated by the cubicle usage patterns depicted in the proposal.

Dr. Richards presented some graphic images in powerpoint to demonstrate a variety of cubicle utilization models for consideration to attempt to strategize and achieve goals for both generalist teams and discipline-specific teaching. Phil’s images, labeled “clinic design visuals” are posted on the CIT CTools site. The “standard assumptions” represent an arbitrary but standard pattern of color-coded, activity-labeled cubicle use (by discipline) that was applied to all of the graphical examples.

The “current configuration” represents a “typical day” with the 2 clinics on the left representing the current second floor (including endo) and the right side representing the third floor. The “modified mid 90s configuration” represents D3 discipline-based teaching for perio, prostho, restorative and endo on one floor (on the left side) and a “comprehensive care” distribution (on the right side). The “discipline-focused configuration” is a potential concept wherein each of the 4 current clinics would house “density zones” for discipline-specific teaching in endo, prostho, treatment planning and perio. One concern about such an approach is that these four discipline-rich clinics may evolve to become philosophically and/or functionally different from one another to an undesirable degree. The image labeled “Mark’s configuration (interpreted)” represents a possible extension of the cubicle usage pattern described in Dr. Fitzgerald’s proposal…one concern about this approach is that the efficiencies and faculty interactions that could ideally be created by discipline-focal areas are not fully realized.

The “three plus one configuration” represents a concept where endo teaching would stay the same as it is now, but one of the non-endo clinics would be re-assigned from being a comprehensive care treatment area to be an “initial skills development” and “advanced procedures” area with focal concentrations in periodontics, prosthodontics and diagnosis/risk assessment/treatment planning. Chair assignment flexibilities could occur in this model and ongoing internal adjustments of chair usage proportions would be likely based on the activities encountered during different days of the week or times of year. The group discussed some of the potential challenges and benefits of creating such an environment. Further discussion and involvement of other stakeholders in analyzing and critiquing this concept is anticipated in the coming days/weeks.
Members present: Dan Edwards, Mary Garrelts, Mark Fitzgerald, Laurie McCauley, Phil Richards, Marianella Sierraalta, Nikki Sweier

Consultant: Steve Stefanac

The main discussion centered around the “three plus one” clinical configuration that was introduced at the previous meeting. The conceptual basis for this idea was reviewed – specifically to get Marianella and Mary up to speed on recent discussions.

The need for creating and managing a dynamic scheduling process for the cubicles within proposed generalist-based and discipline-based teaching clinic environments in order to optimally utilize space and faculty resources was discussed. The staffing implications and potential challenges of central scheduling (as defined in the Clinic Implementation Team’s original charge) was also discussed at some length. The new and potentially different roles for the Patient Care Coordinator and other staff who may potentially be required for new clinic designs was also discussed. The implications of assigning all students to only 3 primary clinics (versus the current 4 clinics) were discussed in terms of the physical space limitations as well as the additional workload for support staff that such a change would create.

The plusses and minuses of creating a dedicated clinic teaching environment for initial clinical experiences in restorative procedures (as well as periodontics, prosthodontics and diagnosis/risk assessment/treatment planning) were considered with input from Mark. He concluded that initial clinical experiences in restorative dentistry can and should still take place within the generalist team clinics.

The need to create a suitable patient base for initial clinical experiences for early learners was discussed with significant input from Steve. He described how he and Lynn Johnson had successfully created a “check up clinic” previously at the University of Iowa, specifically marketed online to target University Students, who may potentially have more limited dental care needs, as patients.

The need to specify how the dental care team concept may facilitate internal patient care referrals, particularly for early learners was also discussed. The potential need to adjust both the patient care assignment structure that is currently in place as well as modifying the culture of the students was discussed. The need to engage early learners (at the level of current D2 students, for example) more intensively in the patient care process was emphasized. In many cases in the current system, D2 students who are not able to acquire a patient treatment opportunity that is to their liking prior to or early within a clinic session may tend to simply “disappear.” Requirements (i.e. taking attendance in clinic) or other reward systems for early learners as well as likely patient referrers (D3 and D4 students) will need to be created in order to maximally utilize clinic opportunities.
Clinic Implementation Team
Meeting Notes, 6-2-09, 9-10 a.m., room B312A

Members present: Dan Edwards, Mark Fitzgerald, Mary Garrelts, Wendy Kerschbaum, Laurie McCauley, Phil Richards, Marianella Sierraalta, Nikki Sweier

Consultant: Steve Stefanac

The following topics for discussion were initially proposed for the meeting:
1) scheduling chair space
2) future needs in the area of treatment planning, and
3) team activities that may potentially be implemented for Fall 2009

Some initial discussion took place regarding scheduling of chair space. Clinic staff members were envisioned as “gatekeepers” with patients appointed and chairs assigned by staff only following initial student requests. The potential need for adjusting the activities of some current staff members (e.g. appointment office and/or information desk) and/or potentially hiring additional staff for such tasks was discussed.

A discussion was initiated regarding an early clinical learner student scenario: (a D1 student who has successfully completed clinic foundation module 1 and is now eligible to do certain procedures in clinic is looking for suitable early clinical care opportunities). How would appropriate patients be acquired? Where would these initial experiences take place? How would the assignment/scheduling process be handled? The clinic foundation modules themselves will need to be designed to contain both skill development elements as well as all of the other underlying concepts that will allow for smooth transitions into the patient care environment.

Clearly the processes of orientation to and preparation for clinic will be very important in such situations. The D4 (D3 also in the future?) mentoring program may provide a structure that could be strengthened to offer even more value in shepherding and facilitating early learners and their activities in the clinic. The implementation of a practice management curriculum that is centered on the actual activities within patient care teams could also provide significant value for assisting the early clinical learners.

The team concept would also require much more faculty involvement in the organization and implementation of systematic patient care and functionality of the team concept for all clinical learners. Previous discussions regarding the need for and value of formal group meetings for the teams - e.g. the pre-treatment “huddle” - as well as boosting and coordinating the patient care seminars (initiated for D1s at week 1) were also reinforced.

For the near future, launching what could be termed a clinical “Pilot” (e.g. Fall, 2009) is not considered to be optimal terminology…the descriptions of “phase 1” and/or “transitional” clinic activities or plans were brought forth as potentially more appropriate descriptive terms.

The potential value of naming and charging a faculty member who might wield greater authority over the teaching and assessment of diagnosis/risk assessment/treatment planning then has been
the case in recent years (similar to the discipline coordinators for other clinical disciplines) in the predoctoral curriculum was discussed.

A list of key goals that will require specific focus for the future and for which participation of individuals outside the team will likely be needed was generated by the group:

- Define coordination needs for early learners clinic
- Define skills that maximize early learners contribution to patient care
- Find and define simple experiences for early learners in clinic
- Orientation to clinic needs to be more “flexible”

- Define functional aspects of teams within groups
  - Roles and responsibilities for faculty and staff
  - Roles and responsibilities for upper class students
- Identify activities for team development/communication
  - Pre-clinic “huddle”
- Enhance interactions between dental and dental hygiene clinical programs
- Define test case/advanced case scheduling protocols and coordination/management

- More robust and phased treatment plans
  - Where, when, how, by whom?
- Coordination/coordinator for risk assessment and management education
  - New or more empowered discipline coordinator?

It was expressed that planning longer weekly meetings (1.5 hours for now) might provide greater progress in meeting our near term goals.
Clinic Implementation Team
Meeting Notes, 6-9-09, 9-10:30 a.m., room 1397

Members present: Mark Fitzgerald, Laurie McCauley, Phil Richards, Marianella Sierraalta, Nikki Sweier

Consultant: Steve Stefanac

Topics initially proposed for the meeting included 1) developing/describing treatment planning processes, and 2) specifying/describing key team activities in the next clinical education structure. The questions that had been posed by Dr. Bayne in his e-mail to Phil were discussed, specifically the possibility of moving endo instruction into the discipline-based clinic in place of treatment planning activities. A visual mock up with endo in the 4th clinic was reviewed (see the top of the following page). There was some consensus that most future treatment planning activities can and should take place in the general dentistry clinics. However, initial treatment planning experiences for early learners (like the current D2 rotations) should still be planned as separate, clustered activities. The CONTINUING NEED for alternative and additional clinic spaces (outside the 4 main clinics) for treatment planning experiences for early learners as well as MANY other “special” clinic activities was discussed, specifically the 3rd floor Orange clinic (24 chairs) and the 6 predoctoral chairs in the AEGD clinic. The role of the PAES screening process for patient intake and assignment was discussed – patients appointed through the “check up clinic” would not require a PAES-type screening, but other patients probably still would. The recent pilot project for completing initial visits in the VIC clinics this past year has not generally been viewed as a strong success. The categorization of patients based on their level of complexity at their initial visit (data already being collected) may play a valuable role in determining patients’ paths to student assignment in the next clinical education structure.

Calibration and coordination of faculty working within and between the 9 planned clinic groups will certainly be an important consideration, particularly for future treatment planning activities. The level of coordination that will be required for group and team activities will require MUCH more faculty involvement than current clinic directors could possibly manage on a per clinic basis. The potential merit of creating an administrative structure with both central coordination and distributed management to facilitate these activities was discussed. The potential benefits of creating a “Director of Predoctoral Education,” someone who could effectively monitor and manage both 1) overall curricular issues (with the Associate Dean for Academic Affairs), and 2) clinical education issues (with the Associate Dean for Patient Services) was discussed at some length. A preliminary organizational structure was developed (see the bottom of the following page). Many peer institutions with large numbers of students already have a Director of Predoctoral Education in place. In addition to being responsible for coordinating all of the clinic groups/group leaders, the Director of Predoctoral Education would also be responsible for coordinating the foundation curriculum/course directors and the disciplines/discipline coordinators in the 4th “discipline skills” clinic. Some requisite characteristics for Group Leaders were discussed. The possibility of utilizing committed adjunct faculty in such roles was considered. The potential benefits of implementing a rotating Group Leader structure to facilitate the development and maintenance of faculty with the requisite skill set were discussed. The anticipated focus for the next meeting will be to develop details regarding Group and Team activities that may be implemented soon (Fall, 2009).
Three Plus One Revised

Dean

Associate Dean for Academic Affairs
Associate Dean for Patient Services

Director of Predoctoral Education

PCC

Clinical Foundation Sim Lab
Course Directors

PCC

Head Group Leader
Group Leader

PCC

Head Group Leader
Group Leader

PCC

Head Group Leader
Group Leader

PCC

Head Group Leader
Group Leader

Teams

Teams

Teams

(retire annually)
Clinic Implementation Team
Meeting Notes, 6-16-09, 9-10:30 a.m., room 1397

Members present: Dan Edwards, Mark Fitzgerald, Mary Garrelts, Laurie McCauley, Phil Richards, Marianella Sierraalta, Nikki Sweier

Consultant: Steve Stefanac

Discussion of endo being located in the discipline skills clinic – is enough clinic space available for this? We will need to determine “real world” numbers to model cubicle allocations in the discipline skills clinic…even with such careful prior estimation there may be shortages or surpluses and we will need to develop contingency plans.

*We need to define more specifically what actually occurs in the discipline skills clinic!

Discussion of organizational structure: Group leaders – who would they be? (what skills, department affiliations/disciplines, % effort would be necessary?) Should there be rotation of the group leaders or should there be a consistent director for each clinic? (without an assigned group to lead…)

Proposal of a revised structure:

Director of predoctoral education – who? (what skills, time commitment, etc.)
Consideration of 4 groups (versus 3 groups) per clinic – staffing implications (also discussed later with the VIC directors).

Discussion of potential connections and separations for the roles of:
- All faculty supervising day to day patient care, vs.
- Specific faculty responsible for leading groups

Patients will be assigned primarily to students but patient management opportunities/responsibilities will also be created/required within teams. When considering the team concept, there are currently LARGE numbers of patients assigned to each student...what type of system would be necessary for tracking/coordination to manage this population of patients most effectively utilizing/maximizing the abilities/capacities of teams/groups?

In the future, all dental school patients may not be provided with endless recall opportunities at the school...many schools do not provide ongoing preventive/maintenance care for all patients. Hygiene faculty participation in the teaching of dental students may be important for supervising recall needs in the general dentistry clinics.

Treatment Planning: specifically phased treatment planning will need to be more explicit and systematic to allow effective coordination of care within groups/teams. The current heavy reliance on perio and prosth consults during routine treatment planning will need to diminish, aiming for these disciplines to provide only consultations in the general dentistry clinics.

Importance of dealing with high no-show rates for both patients and students (specifically current D2s)...this leads to massive losses of both productivity and learning opportunities. Clinical activity of D2s was down quite a bit this past year...what changes can be made to reverse this trend?

Need to maximize early learner/D2 expectations to boost learning opportunities:
- Need to stimulate more effective referrals to D2s
- Need to create ambitious productivity goals as a component of D2 clinic grading
  Mark and Phil will meet later to discuss…

Later discussion of D2 program (Mark and Phil)
Implementation of qualitative assessments (Test Cases) for all D2 clinic disciplines?
- Perio using Test Cases now…
- Restorative:
  - Rubber dam?
  - Anesthesia?
  - Others?
- Radiology?
- Oral Med?

Need for more explicit quantitative assessments regarding clinic attendance/participation?
- Use MiDent to track?
  Data should be reliable, assuming:
vigilant entry habits
creation of appropriate reports to track

Practice management 835 series
Group/Team/Microteam exercises using monthly reports to track activities based on prescribed targets/goals
- for D4s (referrals and timely patient care)
- for D2s (performance of numbers/types of clinical procedures)
- for D1s (participation in numbers/types of clinical procedures)

More structured role for assigned D4 mentors
Guiding early learner students performing procedures in Fall Term
Also guiding treatment planning activities in Winter Term

How to assess? Should PCCs be involved? Should D4s be assessed by D2s?

Issues raised at VIC directors’ meeting on 6-17-09
Organizational scheme
- Too complex to function effectively?
- Will patient management effectiveness by assigned student be compromised?
- What are potential negatives from shuffling patients/procedures between students?

Need to determine “real world” numbers to model cubicle allocation for the discipline skills clinic (should endo stay or go?)

Need to promptly define specifically what types/levels of procedures/treatments will occur in the general dentistry clinics as well as the discipline skills clinic
- Need formal guidelines for “what occurs where”
  - Firm, clear and strict
    - Everyone must universally accept and apply
  - Importance of rigorous in-servicing to support and enforce

Scheduling of cubicles
- Specific to group locations? How to cluster groups effectively?
  - Computer technology should be able to help with this…
  - “Virtual” groupings in clinics rather than physical ones

*Forgot to mention the pre-treatment and post-treatment “huddles”…OOPS!

Faculty numbers for general dentistry clinics:
- 3 generalists + 1 floater generalist (clinic director or equivalent) + 1 RDH?
  - Is this enough? There are some concerns that it will be insufficient
  - Only on-call faculty for perio and prosth consults

Group leaders
- How involved in patient management?
How taxing on the faculty? Can part-time faculty do this job? Which ones? Role of D4 students?
Clinic Implementation Team  
Meeting Notes, 6-23-09, 9-10:30 a.m., room 1397

Members present: Mark Fitzgerald, Mary Garrelts, Wendy Kerschbaurn, Phil Richards, Marianella Sierraalta, Nikki Sweier

Consultant: Steve Stefanac

Review of 3 major topics that were discussed at the VIC directors’ meeting on 6-17-09:

1. Number/role of group leaders

   Contrasting patient care supervision versus group activity/coordination functions

   How would “group leader”/attending faculty role differ from current practices?

   Pre-treatment huddle = important future leadership activity for all faculty

   Professionalism and the team concept
   Success of the group/team is a key goal for the future

   What is the day-to-day role of the clinic director?
   Distribution of faculty within the clinic?
   Floater to augment patient supervision needs?

   Should an assistant clinic director also be named to serve this role?

2. DDS faculty for general dentistry clinics – how many will be needed?

   3 assigned + 1 floater = 4 DDS faculty should manage groups of chairs

   RDHs also needed to supervise prevention and recall in general dentistry clinics
   Not the same faculty who are also supervising dental hygiene students…
   Hired/employed by which department?

   Should students be able to self-select faculty with whom they work?
   In the future, they should not be allowed to do this…
   Except for rare patient care continuity circumstances

   Can/should we launch faculty assigned by rows and group/huddle protocols soon?
   Mary and Mark to consider implications/possibilities for this Fall

3. Guidelines for procedures to be performed in the various clinical environments

   Process for establishing guidelines…clinical disciplines should create the rules
   governing this but final guidelines must ultimately be:
• Accessible and clear to all
• Rigid enough to guide both routine practices and uncommon scenarios
• Flexible enough to achieve buy-in from all

Potential examples for discussion:

Perio:
• All Perio Records and Perio Re-Evals must be completed in discipline skills clinic
• All initial perio procedures (both preventive and therapeutic) must be completed in the discipline skills clinic
• Once the associated Test Cases are completed successfully, subsequent recall/maint and SC/RP procedures may be completed in the general dentistry clinic
• After completion of prerequisite assisting experiences, periodontal flap procedures may be performed in the discipline skills clinic with supervising faculty approval

Prostho:
• All initial planning and fabrication procedures for removable prosthetic devices must be completed in discipline skills clinic
• Once the associated Test Cases are completed successfully, subsequent uncomplicated CD procedures may be completed in the general dentistry clinic
• All initial planning and fabrication procedures for fixed partial dentures and multiple adjacent (3+) single fixed restorations to be fabricated simultaneously must be completed in the discipline skills clinic
• Once the associated Test Cases are completed successfully, subsequent fixed partial dentures and multiple adjacent (3+) single fixed restorations may be completed in the general dentistry clinic with supervising faculty approval
• All planning and fabrication procedures for metal framework RPDs must be completed in discipline skills clinic

Oral surgery:
• All initial tooth extraction experiences must be completed in the Oral Surgery Clinic
• Once the associated Test Cases are completed successfully, subsequent simple extraction of mobile teeth may be completed in the general dentistry clinic with supervising faculty approval

Goal for the next meeting is to discuss and begin to specify these guidelines for all common clinical procedures – all Team members should devise their own lists to share.

Regardless of the guidelines that are established:
  On any given day...how do we know that the student is qualified to perform the procedure that they plan to do?
    How to indicate this so part-time faculty will know?
    Use MiDent to track?!

Other issues:
Mark provided some preliminary data derived from MiDent regarding procedure totals by discipline completed this Summer…further discussion anticipated at future meetings

Comments from the Vision Implementation Steering Committee meeting on 6-24-09

Based on the discussions from 6/23/09, I introduced the updated concept depicted below to the steering committee:

The steering committee wonders: is the administrative layer of the “clinic director” still functional and necessary in the future?

The descriptive names of “clinic” and “clinic director” may be too traditional and potentially counterproductive for attainment of future group- and team-based functional goals.

Should the 3 general dentistry areas be called something else? (“pods”? “clusters”?)

The huge numbers of patient appointments that need to be managed each year were cited…who and how to manage?
Clinic Implementation Team
Meeting Notes, 7-7-09, 9-10:30 a.m., room 1397

Members present: Mary Garrelts, Laurie McCauley, Phil Richards, Marianella Sierraalta

Consultant: Steve Stefanac

Discussion of the dilemmas surrounding the recent organizational chart changes that have been made, attempting to satisfy the stated goals as well as the differing perspectives of various stakeholders (e.g.: VIC directors, Vision Steering Committee members).

Some important near-term action items:

1. Specific structures, functions and activities of clinic groups/teams need to be established and clarified

2. Specifics regarding the interrelationships between the general dentistry clinics and the disciplines (particularly the discipline skills clinic) need to be established and clarified

Increased and ongoing involvement of the current VIC directors (and others) in both 1 and 2 above definitely needs to be part of the plan forward in order to attempt to build consensus.

In order for the team concept to succeed, significant CULTURAL CHANGES will be required to guide both STUDENT BEHAVIORS (not to spontaneously leave the clinic when a patient cancels) and FACULTY BEHAVIORS (not to be merely passive clinical “checkers,” some of whom frequently arrive late and leave early).

New types of “carrots” and/or “sticks” needed for STUDENTS?

Refinement and increased stringency of the “patient management” expectations and assessment of students will be required – PCCs may find this challenging with increasing numbers of students in each general dentistry clinic.

New types of “carrots” and/or “sticks” needed for FACULTY?

Attending faculty will need to be much more engaged in the entire patient management and educational processes in the future (individually responsible for pre- and post-treatment team/group meetings, etc.).

Discussion of how to best achieve these goals…what organizational structure will best promote these behaviors?

Attending faculty SHOULD ANSWER TO A CLINICAL SUPERVISOR (not simply the discipline coordinator from the department for which they work).
Individual clinics also need an authority figure available consistently to deal with frequent patient care action items that arise.

Clinic utilization concerns: will the discipline skills clinic be appropriately sized, excessive (underutilized) or deficient (overflowing) at certain times? We will potentially need to make adjustments along the way to accommodate for unexpected realities.

Patient flow concerns: very limited availability of patients with certain needs (e.g. RPDs, Perio treatment patients) – how to optimize equitable distribution?

Should we consider expanding upon the patient assignment model used by Endo (utilizing a staff person to monitor and distribute specific patient assignments)?

Initial group discussion and editing of patient care guidelines for generalist and discipline skills clinics…will need input FROM ALL to critique and refine these.

Cultural changes may also be needed here, based on establishment of criteria that may differ from some ongoing clinical behaviors

Will need input from some non-specialty areas (e.g.: oral med, complex esthetics)

**Comments from the VIC directors’ meeting on 7-8-09**

Phil attended the VIC directors’ meeting on 7-8-09 to update them on recent discussions and sought their input on some pending CIT activities and decisions.

The most recent clinical organizational scheme (including designated “Assistant Clinic Directors”) was presented and discussed. Even considering the increased number of students that will be assigned to each general dentistry clinic in the future, the consensus opinion was that there will be no need for “Assistant Directors” to be identified or utilized.

The concept that attending faculty should answer to a “clinical supervisor” (not simply the discipline coordinator from the department for which they work) was raised…the VIC directors were not strongly in favor of this idea, at least at first blush.

A general review of groups, teams and student supervision/coordination roles for faculty in the general dentistry clinics was given. The proposed staffing concept for the general dentistry clinics was discussed:

- 3 generalists, each supervising a 12-chair group
- 1 additional generalist (clinic director or other highly experienced individual) to “float” between groups where the need arises
- 1 dental hygienist educator specifically assigned to supervise prevention/recall procedures performed by dental students
Concerns were raised regarding whether or not this level of generalist staffing would be sufficient or appropriate, considering the fact that the anticipated student to faculty ratio for the discipline skills clinic may estimated to be ~6:1 (3 perio faculty for ~18 chairs) or even less (5 prosthodontics faculty for ~18 chairs). The overarching goal of a “leaner” clinical staffing model for the future was raised as part of the underlying motivation for this staffing concept. The idea was also expressed that if we initially “over staff” the clinics, it will be subsequently impossible to become “leaner.” No conclusions were reached.

The most recent draft of the “preliminary patient care guidelines” (describing which clinical procedures can/should be performed in the various clinical environments) was also presented and discussed. The perio section generated very little discussion. However, **considerable concern arose regarding prosthodontic procedures and which of these should or should not be allowable in the general dentistry clinics.**

There were strong opinions expressed that many traditionally prosthodontic procedures (including fixed, removable and implant-based procedures) should be routinely performed and supervised in the general dentistry clinics. The goal of having all generalist faculty conform to an established, perhaps more limited list of procedures for which all may be routinely responsible in supervising versus the challenge of allowing each individual generalist faculty member to supervise “whatever they are comfortable with” was discussed. The varying levels of confidence and flexibility of some faculty members (particularly adjunct faculty who traditionally focus primarily on restorative procedures) and the confusion that could arise for students regarding “who is in the clinic on which half days?” and “which generalists are comfortable supervising what?” was discussed. No conclusions were reached.

The parallel complexities of determining “whether or not a student has successfully completed the required Test Cases” on the fly during patient care were also discussed…no conclusions were reached.

The idea of allowing limited oral surgery procedures (extractions of mobile teeth) in the general dentistry clinic was mentioned, but not significantly discussed.
Clinic Implementation Team  
Meeting Notes, 7-14-09, 9-10:30 a.m., room 1397

Members present: Mark Fitzgerald, Mary Garrelts, Wendy Kerschbaum, Phil Richards, Marianella Sierraalta

Consultant: Steve Stefanac

Discussion of the numbers of dental hygiene students anticipated to be in clinics during various days/terms took place…4-6 chairs per general dentistry clinic (with 1+ dental hygiene faculty member to supervise) will always typically be required specifically for hygiene students, based on a 3 clinic design. The possibilities for, and potential advantages of having dental hygiene students working in clinic during the Summer was discussed. Clearly there are patients whose treatment/maintenance needs could be managed in an enhanced way by this, but history suggests that some such patients may be reluctant to make or attend Summer appointments.

Concerns were expressed regarding the increased numbers of students assigned to and potentially working in each of the general dentistry clinics when compared to current conditions. The use of the discipline skills clinic for patient care that is designated for and/or chosen to occur there, supervised by the disciplines, will certainly relieve much or all of the crowding that is feared. The faculty assignments that have been proposed for the general dentistry clinics (3 + 1 general dentists, 1 dental hygienist specifically to supervise dental students) may or may not be sufficient for every set of circumstances.

A potential re-thinking of the proposed concept of 3 “groups” within each of the general dentistry clinics (3 double rows of cubicles) was suggested. In order to both ease the numerical burden of 12 cubicles for each “group”/faculty member as well as allowing for enhanced physical proximity of assigned faculty members, a suggestion for 4 clinic groups (each with an assigned general DDS faculty member), populating primarily the 4 corners of each general dentistry clinic was made. The area in the center of each clinic would be designated as the preferred location for dental hygiene students, dental students performing maintenance recalls and D1/D2 students who are treating patients. (A preliminary depiction of this concept for a single general dentistry clinic is on the top of the next page.)

Certainly, this structure would potentially REQUIRE 4 generalists in order to staff it properly at all times; providing predictable coverage for unexpected faculty absences would be crucial. The planning for and/or use of an additional, “floater” general DDS faculty member (in addition to the 4 assigned DDSs – “4 + 1” in this case) may require some consideration, at least if early experiences suggest such a need.

The “clinical supervisor” role for clinic directors was discussed. During the last VIC directors’ meeting, there was little excitement expressed about assuming this function. The administrative roles that may need to be included in this would include:

1. patient care issues (e.g. patient concerns, economic adjustments, etc.), as well as
2. faculty/performance issues (e.g. promptness, attendance, adherence to policies, etc.)
Clearly, some of these functions could and would ultimately fall within the purview and job description of a “Director of Predoctoral Education.”

The anticipated level of staffing that will be required for the discipline skills clinic (specifically for perio and prosth) were also discussed briefly. Preliminary estimates of need for perio faculty are 3 (or at most 4) faculty (for ~18 chairs plus or minus). Preliminary estimates of need for prosth faculty have ranged from 3 to 5 faculty (for ~18 chairs plus or minus). There may be significant fluxuation of need through weeks and between terms in the discipline skills clinic based on variable, “seasonal” patient care activity in the disciplines. There may also be significant variations on a per-half-day basis in the discipline skills clinic because of space that will be required planned D1 and/or D2 activities (based on the students’ weekly schedules in classroom and foundation lab activities, which are yet to be determined). Some concern has been raised about having sufficient numbers of available cubicles for test cases at certain times in various clinical environments because of the observed tendency for students to wait until the last minute to challenge some of their test case exercises.

The question of having formal perio examinations for perio maintenance patients being managed by dental hygiene students in the general dentistry clinics was raised…it is anticipated that the “on call” perio faculty member for the general dentistry clinic would fulfill this role. Because the majority of treatment plans – even complex ones – will take place in the general dentistry clinics, discipline input (particularly from perio and prosth) will be needed…again, it is anticipated that the “on call” faculty members for these disciplines in the general dentistry clinic will fulfill these functions. The future migration away from paper records and toward a fully Electronic Health Record was raised as a potential stimulus to look critically about which data
are collected (and how they are documented) during treatment planning as well as during specialized, discipline-specific processes (e.g. “perio records” and the “blue prostho forms”).

The patient care guidelines, specifically pertaining to prosthodontics, were reviewed and edited further (the latest version was circulated shortly after the meeting on 7/14/09). Specific criteria will need to be established regarding the meaning of “COMPLEX” in the context of such guidelines…this concept may also need to be applied to other disciplines (e.g. extractions for oral surgery). Guidelines to define the scope and activities in the general dentistry clinics will also be established…Mark Fitzgerald has some existing materials that may serve to begin this process.

Based on discussion of the Guidelines and how day-to-day activities, particularly in the general dentistry clinics, can be planned and undertaken to avoid as many of the potential faculty-student-procedure mis-matches as possible, the graphic below was introduced and discussed briefly.

Our next meeting (7/21/09) will be devoted to discussion of Team-based concepts and activities, particularly those anticipated for early implementation (i.e. Fall 2009).

Comments from the Vision Implementation Steering Committee meeting on 7-15-09

Phil attended and briefly described some of the recent CIT activities to the other members of the Steering Committee. The important and strategic role for the Director of Predoctoral Education was emphasized. The inclusion of and attentiveness to foundation skills development, clinical discipline activities, a general dentistry focus as well as biomedical sciences in the skill set of any individual who would serve this role was emphasized. The importance of defining a job description and beginning a recruitment process VERY SOON for this important role was voiced.

Comments from the VIC directors’ meeting on 7-15-09

Phil again attended the VIC directors’ meeting, introducing the colorful 4-group general dentistry clinic concept as well as the most recent version of the patient care guidelines. Discussion took place regarding some of the mechanical processes that are likely to be needed in order for students to request and acquire chair space that is appropriate for the treatments that
they plan for any given day. The potential for certain clinic spaces to be either over- or underpopulated at certain times is considered to be significant…adjustments will certainly be required “on the fly” in some situations. The potential for a significant segment of the chair requests in the discipline skills clinic to be needed for completion of test cases (e.g. in perio) was raised…potentially creating challenges if students in large numbers postpone these until late in the term. The most recent draft of the patient care guidelines were discussed but did not raise any significant concerns today. The importance of creating and instituting a formal program of in-service training and credentialing was discussed.
Discussion of the development of patient care guidelines – After polling the faculty for opinions, Marianella has concluded that the prosthodontic faculty as a group prefer a more restrictive policy for which procedures may be performed in the general dentistry clinics. Today’s discussion reinforced the concept that the goal of a general dentistry instructional environment (the main one in our model) is that it must include all major aspects of general dentistry. Some goals from the original vision of the VIC clinics (significant cross-teaching between disciplines by faculty from all departments and disciplines) were never achieved…the problem of “us versus them” attitudes and behaviors between all departments really needs to be solved. Marianella plans to work to try to achieve some level of compromise with the prosthodontics faculty, with the importance of the general dentistry concept in mind.

The “clinical supervisor” function – an authority figure to monitor and respond to clinical faculty behaviors – is certainly a difficult but important role. Despite the obvious challenges, the clinic directors are potentially the individuals who are best equipped to perform this function on a day to day basis. There may be a more global role in policy setting and responding to chronic problems for the future Director of Predoctoral Education. Despite some important efforts to engage and mobilize the clinical adjunct faculty regarding educational and protocol issues (CRSE during the past year is a prime example of such excellent initiatives), more of this probably needs to be done.

Mark Fitzgerald reported on his recent efforts toward analyzing and planning for space and personnel decisions as well as “Team” concepts and activities. He provided 3 prepared handouts for the group:

1. “Clinic requirements” (1 page)
   - Cubicle utilization estimates per term

2. “Discipline clinic chair needs vs availability” (3 pages)
   - Session estimates and procedure count linkages
     - Based on the patient care guidelines distributed most recently…
     - Fluctuation in demand not accounted for…
     - It appears that endo chairs would “fit” in the discipline skills clinic…but more restrictive prosthodontic treatment protocols and/or more clinical perio experiences prior to successful completion of test cases (likely needed…) could change this significantly

3. “4 group practice target clinic model analysis” (1 page)
   - Team/group size determination estimates and color visualization
In the future, students will not be specifically linked to any particular cubicle…how will appointments be translated into chair locations?

Cubicle acquisition for students assigned to groups:
- Appointment requests go to their group area of cubicles first
- Then outside their group area but within their clinic
- Then outside their clinic (?)

Faculty involvement in monitoring groups/teams
- There must be a CONSISTENT PROTOCOL for clinical supervision/management of groups
  - Faculty participants will change from day-to-day, but the process must be uniform

D4 mentoring program
- Historical origins uncertain…
- For the future, expanding the time devoted to this program and assigning “mentor” D4s to a strong organizational role for groups/teams could be EXTREMELY valuable
  - Could decompress some of the organizational demands that are anticipated for the attending faculty members
- Another useful suggestion would be to arrange for 1-week rotations for D4s as GROUP LEADERS, with reduced clinic activity planned for that week (e.g. simple recall or adjustment visits, etc.) to supplement the early (“huddle”) and late (“wrap-up”) activities of a group leader (student, faculty or some combination) during individual clinic sessions.

For the Fall of 2009, the plans that were discussed for tentative implementation were:
1. Divide each clinic into 4 groups (Mark Fitzgerald will work on this in 4 clinics for this Fall)
2. Restorative faculty to supervise general dentistry treatment based in groups:
   - 2 of the groups in a clinic would work with 1 restorative faculty member
   - the other 2 groups would work with the second restorative faculty member
   - Prosthodontics and periodontics student supervision will probably need to retain the status quo

In order to better inform “the system” regarding clinical activities, APPOINTMENT NOTATIONS entered into MiDent need to be PRECISE AND ACCURATE right away!
- This may potentially need to be stimulated by creating tangible student incentives (e.g. “shortcuts” in instrument acquisition, or some other equivalent “perks”) in order to move it forward

Discussion of assessment of individual and Team-based patient management performance
- Patient management – “individual student” activities – graded by PCC
- Team management – “group” clinical activities – graded by practice management
  - Reports to monitor the appropriate parameters will need to be created in order to implement this for the Fall
• There may also be significant and useful roles for DH4 students in helping to manage recall monitoring and schedules, as this is a common function for dental hygienists in general dental practices

Comments from the Vision Implementation Steering Committee meeting on 7-22-09

Phil Richards was urged to create a tentative job description and list of qualifications/attributes for the position of Director of Predoctoral Education for discussion and potential consensus building within the Clinical Implementation Team. Mark Snyder and the Clinical Foundation Team will undertake the same type of process. The Vision Implementation Steering Committee will then combine and refine to create a proposed description that may be used for recruitment/selection of this individual. It will potentially be very important for such an individual to be identified and on-board during the planning stages (and certainly during the initial implementation stages) of phasing-in the new curriculum.

First Draft – Director of Predoctoral Education

Job description:
This individual is responsible for management, oversight and coordination of the educational content, process and outcome for the dental curriculum (with the Associate Dean for Academic Affairs). Specific involvement with and monitoring of the activities in all clinical learning environments (with the Associate Dean for Patient Services) is a primary focus, including all clinical foundation learning experiences as well as the general dentistry, discipline skills, specialty rotation and outreach clinics.

Required attributes:
• DDS/DMD degree
• Significant teaching experience
• Significant clinical practice experience and active in clinical practice
• Strong organizational, communication, managerial and leadership skills

Desired attributes:
• A general dentist
• Experience in curriculum development and assessment
• Knowledgeable of leaders and trends in dental education
• A record of professional accomplishments in dentistry and/or dental education

Other special skills?

Time commitment?
Clinic Implementation Team  
Meeting Notes, 7-28-09, 9-10:30 a.m., room B312B

Members present: Mark Fitzgerald, Mary Garrelts, Wendy Kerschbaum, Laurie McCauley, Phil Richards, Marianella Sierralta, Nikki Sweier

Consultant: Steve Stefanac

Potential timelines for implementation of curricular changes…there is significant angst for all working teams – still some significant unknowns:

- Changes for the 2009-2010 academic year? What can/should/will they be?
- 2010 summer session (early enrollment) for the entering D1 class? What would it include?
  - Anatomy?
  - Prophy camp?

Discussion of the proposed Patient Care Criteria:

- Other disciplines have been approached – no feedback yet
  - Endo (Trish Bauer)
  - Oral medicine (Preetha Kanjirath)
  - Complex esthetics (Dennis Fasbinder and Peter Yaman)
- General dentistry criteria will need to be fleshed out
- Oral surgery criteria (in any form similar to the current draft) will require significant dialogue and lobbying
- Prosthodontics – following a recent faculty meeting, a new format for criteria may now be forthcoming
- Pedo – should general dentistry include this?
  - Dr. Jimmy Boynton will be approached to inquire about possibilities

Job description for the Director of Predoctoral Education

- Significant group editing completed during the meeting…
- Other concepts/examples also available for reference (will be provided separately)
- Is a single person sufficient to perform this job? The consensus is “yes,” as long as the biomedical science focus is directed specifically toward application in clinical education
- Suggested change of the title for this position to “Director of Predoctoral Clinical Education”

Most recent version of the edited job description following the meeting:

**Second Draft – Director of Predoctoral Clinical Education (July 28, 2009)**

**Job description:**
This full time faculty member is responsible for management, oversight and coordination of the content, process and outcome for the predoctoral clinical education program (with the Associate Dean for Academic Affairs). Specific involvement with and monitoring of the activities in clinical learning environments (with the Associate Dean for Patient Services) is a primary focus, including clinical foundation learning experiences as well as the general dentistry, discipline skills, specialty rotation and outreach clinics.
individual will also actively participate in the clinical teaching program and be responsible for facilitating biomedical science integration in the clinical curriculum.

**Required attributes:**
- DDS/DMD degree
- Significant teaching experience
- Significant clinical practice experience and active in clinical practice
- Strong organizational, communication, managerial and leadership skills

**Desired attributes:**
- Significant general dentistry experience
- Experience in curriculum development and assessment
- Knowledgeable of leaders and trends in dental education
- A record of professional accomplishments in dentistry and/or dental education

Other suggested editorial changes…
- Change title for “Clinic Directors” to “Clinic Leaders”?
- Vertically Integrated Clinics (VIC) – no longer a primary focus for anticipated changes…
  - The term “General Dentistry” probably supercedes “VIC” for in describing future goals

Suggested edits of the Organizational Chart reflecting these suggestions (and also simplifying it) are provided for consideration of the team below:

**Team activities**
- The current extent of outreach rotations is making patient management goals for many individual D4 students difficult to achieve now
- Team structure – can this potentially support patient care needs better?
Microteam co-assignments? Probably not that useful for early implementation…

The “team activity” of reviewing monitoring reports together – could have some utility…

Direct drop down of individual patient pools to microteam members (1 to 1) is likely too inequitable with the current variations in D4 student patient pools

There may be significant benefits from earlier identification of potential patient assignments for D2 students (well before rising to D3 status), potentially facilitated via case maintenance lists?
Clinic Implementation Team
Meeting Notes, 8-4-09, 9:10-10:15 a.m., room 1397

Members present: Dan Edwards, Mary Garrelts, Laurie McCauley, Phil Richards, Marianella Sierraalta, Nikki Sweier

Consultant: Steve Stefanac

Further editing was completed on the draft position description for the Director of Predoctoral Clinical Education. Following this, it was concluded that this document is now ready for wider distribution:

**Working Draft – Director of Predoctoral Clinical Education**

**Job description:**
This full time faculty member is responsible for management, oversight and coordination of the content, process and outcome for the predoctoral clinical education program (with the Associate Dean for Academic Affairs). Specific involvement with and monitoring of the activities in clinical learning environments (with the Associate Dean for Patient Services) is a primary focus, including clinical foundation learning experiences as well as the general dentistry, discipline skills, specialty rotation and outreach clinics. This individual will also actively participate in the clinical teaching program and be responsible for integration of biomedical science and preclinical activities into the clinical curriculum.

**Required attributes:**
- DDS/DMD degree
- Significant teaching experience
- Significant clinical practice experience and active in clinical practice
- Strong organizational, communication, managerial and leadership skills

**Desired attributes:**
- Significant general dentistry experience
- Experience in curriculum development and assessment
- Knowledgeable of leaders and trends in dental education
- A record of professional accomplishments in dentistry and/or dental education

Brief additional discussion and editing was also done on the organizational chart pertaining to this position (see the most recent version on the top of the following page).
Further discussion took place relating to patient care guidelines. No formal responses have yet been received from Endo, Oral Med or Complex Esthetics regarding those segments. A preliminary response was received from Pedo (discouraging any plan to potentially treat pediatric patients in the general dentistry clinics)…further clarification will be sought. No inquiries have been pursued regarding the preliminary Oral Surgery ideas yet. Additional conceptual guidelines (for the as-yet blank ones) may be drafted as preliminary stimuli for ideas and distributed to potential stakeholders for their reactions in the near future in order to attempt to move this process forward.

Based on the original charge for the Clinical Implementation Team, the disciplines can and should establish guidelines for teaching and patient care in their specific areas. However, the overarching goal of creating a general practice clinical concept must be maintained and supported by all. There is some concern that, if most or all of the prosthodontic procedures that are currently proposed for inclusion in the discipline skills clinic actually occur there, the amount of cubicle space available in this 4th clinic may be insufficient (even if this area is only used for periodontics and prosthodontics procedures, with endo continuing to be blended into the general dentistry areas). Dr. Sierraalta plans to continue to work on specifying prosthodontic procedures that must be limited to the 4th clinic, and particularly working to define - what are the COMPLEX procedures.

Some discussion took place regarding timelines and the scope of any clinical changes planned for early implementation (e.g. for the coming academic year). While it would be potentially desirable and informative to launch some procedural concepts as soon as possible, confidence regarding readiness for such efforts to be truly successful must also be considered. The need to develop and collect a full palate of specific metrics to gauge the levels of participation and success in team-based activities (well ahead of full implementation) was emphasized. The need to develop and deliver a robust faculty in-service training program for early introduction of team-building and group-teaching activities prior to definitive implementation of any new clinical
teaching model was also emphasized. Significant discussion took place regarding how to best deliver the necessary background information and concepts to all clinical faculty members, with emphasis on the challenge of reaching part-time faculty with limited time commitments here at the school. It was generally agreed that many of the intended, necessary messages for faculty must be delivered personally and interactively, not simply posted on-line for independent viewing.

The next meeting will focus on:

- Defining team-based activities and relationships
- Patient care guidelines
Clinic Implementation Team  
Meeting Notes, 8-11-09, 9-10:30 a.m., room 2397

Members present: Mark Fitzgerald, Mary Garrelts, Wendy Kerschbaum, Laurie McCauley, Phil Richards

Consultant: Steve Stefanac

Patient Care Guidelines  
Marianella Sierraalta had e-mailed her modified and expanded Patient Care Guidelines for prosthodontics prior to today’s meeting. Mark Fitzgerald also brought a significant number of suggested additions to today’s meeting. These additions and changes, as well as other recent additions and changes were incorporated into the Patient Care Guidelines document. Some team editing was also done during the meeting. Some inconsistencies still exist in the different segments of the Guidelines (see the most recent *DRAFT* compilation at the Patient Care Guidelines at the end of this document). Further discussion will definitely be forthcoming.

Some concerns were raised regarding looming conflicts pertaining to prosthodontic procedures that should also fall within the scope of general dentistry. The Guidelines themselves are intended to guide everyone in the planning and implementation of patient care leading to student competency, not to impose or accommodate limitations or undue freedoms for faculty groups or individual faculty members. Emphasis was again placed on the idea that general dentistry is a focal point of the next clinical curriculum and robust in-service training programs will be necessary for successful implementation.

Team Activities  
Mark Fitzgerald also introduced protocols for patient management grading and team based activities (2 separate handouts – a “patient management grading sheet” and “team based activities and relationships in generalist clinic”).

The “grading sheet” has been methodically constructed and thoroughly vetted and will be used by the Patient Care Coordinators for monitoring D3 and D4 students on a monthly basis.

The “team based activities…” handout outlines and defines the PCC activities and the practice management activities. The practice management activities include both individual and team-based assignments. Some prescribed goals will be provided to the teams…others will need to be established by the teams themselves. Goal setting activities by students will be a strong focus. Objective outcomes that are actually achieved will also be assessed.

Three issues yet to be defined:
1. Size of teams/groups  
   a. Microteams (1 D1, 1 D2, 1 D3, and 1 D4 student) ~26+ teams per clinic
      - very compact and personal for students but lots of reports for review by faculty
      - no straight forward way to incorporate DH students (DH3 and/or DH4) into groups of these sizes
   b. Microteams X 2 ~13 teams per clinic
• Probably more workable for faculty review of reports
• still compact enough to facilitate conveniently-sized meetings, if needed
• easier incorporation of DH3 or DH4 participants
• may foster rotating responsibilities term by term

(“b” seems the best approach for initial implementation)

2. Weighting of activities and performance

3. Number of areas and which specific areas of performance to be measured/emphasized
   • Requests for specific reports to be generated from MiDent anticipated once this is established

Methods and practices of communication for team activities will be defined and implemented by the teams themselves.

A process of measuring the success of this process will be undertaken, based on comparisons to metrics derived from previous years.

How to introduce the team-based activities?
• D4 students, D2 students and D1 students can all be introduced to team activities during existing course activities…efforts will be made to provide a quick introduction to D3 and DH students – following this, the D4 leaders of the teams will be responsible for coordinating and managing subsequent team activities.

Phil Richards briefly discussed the planning for the upcoming convocation event on August 28. Following a brief introduction by the Dean, the Steering Committee leader and the four individual Team leaders, separate breakout sessions are being planned for general discussion of various aspects of the implementation of the next curriculum. CIT members are encouraged to plan to attend either the Clinical Implementation breakout session or any other breakout session for which they may have a strong interest.

*Draft 8-11-09*

Preliminary patient care guidelines for general dentistry clinics and disciplines:

**General Dentistry:**
• All Restorative Test Cases
• (All Oral Medicine Test Cases?????)
• General dentistry activities
  o Diagnosis
  o Treatment Planning
  o Patient Management and referral when appropriate
  o Risk assessment and management
    ▪ Systemic
    ▪ Periodontal
- Pulpal (endodontic emergencies)
- Caries
- Occlusal function
  - Restoration of single or multiple diseased, damaged or missing teeth
    - All single tooth restorations
    - Multiple teeth in an arch
    - Restoration of dental implants
  - Esthetic dentistry

**Periodontics:**
- All Perio Records and Perio Re-Evaluation procedures must be completed in discipline skills clinic
- All students’ initial clinical patient treatment procedures in periodontics (prophy recall, perio maintenance and SC/RP) must be performed in the discipline skills clinic
- Once the associated Test Cases are completed successfully, subsequent prophy recall, perio maintenance and SC/RP procedures may be performed in the general dentistry clinic
- Clinical application of locally delivered antimicrobials may occur in either the discipline skills clinic or in the general dentistry clinic with prior perio faculty approval
- After completion of prerequisite assisting experiences, certain periodontal surgical procedures (primarily uncomplicated access flap procedures and/or soft tissue excisional procedures) may be performed in the discipline skills clinic with prior supervising perio faculty approval

**Prosthodontics:**
All students’ initial diagnosis, planning and treatment procedures and Test Cases pertaining to:
- Definitive Complete Dentures
- Temporary Removable Partial Dentures and Complete Dentures
- Simple 3 unit Fixed Partial Dentures (non stress-breaker)

must be completed in discipline skills clinic

All diagnosis, planning and treatment procedures for:
- Complex definitive Complete Dentures
- Definitive Removable Partial Dentures
- Surveyed crowns
- Complex Fixed Partial Dentures (stress-breaker) and more that 3 units FPD
- Implant based restorations
- Multiple (2+) single fixed restorations to be fabricated simultaneously

must be completed in discipline skills clinic

Advanced complex cases MUST be referred to the Graduate Prosthodontics Clinic, unless approved by the Prosthodontic Discipline Coordinator for treatment in the discipline skills clinic. This includes:
1. Treatment that would require increasing the vertical dimension other than with a complete denture.
2. Treatment that would require a fixed partial denture of over four units (2 abutments / 2 pontics), except when restoring mandibular canine to canine.
3. Treatment that would require single crowns or a fixed partial denture with precision attachments or semi-rigid connectors.
4. Treatment that would require either a precision attachment removable partial denture or swing lock removable partial denture.
5. Treatment that would require an overdenture on natural teeth.
6. Treatment that would require a metal base complete denture.

**Oral surgery:**
- All students’ initial tooth extraction experiences must be completed in the Oral Surgery Clinic.
- Once the associated Test Cases are completed successfully, subsequent simple extractions of fully erupted, mobile teeth may be completed in the general dentistry clinic with prior supervising faculty approval.
- Other case selection requirements for extractions in the general dentistry clinics:
  - ASA 1, ASA 2
  - Systolic blood pressure <160 and diastolic blood pressure <100
  - Pregnant patients must have written clearance from OB/GYN
  - No suture placement anticipated

**Endodontics:**
- All students’ initial clinical patient treatment procedures in endodontics (single and multiple root teeth) must be performed in the designated endo treatment area.
- All complex endodontic procedures
- All endodontic test cases

**Oral Medicine:**
- All initial experiences supervised by Oral Medicine faculty in the 3rd floor orange clinic.
- All ASA I, ASA 2 treatment planning activities, including Test Cases performed in the general dentistry clinics supervised by general dentistry faculty.
- All ASA III, ASA IV treatment planning activities, including Test Cases performed in the general dentistry clinics supervised by Oral Medicine faculty on a requested basis.

**Complex Esthetics (to be completed either in the general dentistry clinic or the AEGD clinic as the case dictates):**
- Vital and de-vital tooth bleaching
- Multi-disciplinary cases that may include endo, ortho, oral surgery, perio
- Complex composite restorations on single or multiple teeth
- All-ceramic restorations on single or multiple (including adjacent) teeth
  - All ceramic crowns
  - All ceramic veneers
  - All ceramic inlays and onlays
- Chair side CAD/CAM ceramic restorations
  - All ceramic crowns
  - All ceramic veneers
  - All ceramic inlays and onlays
- Digital impressions for the fabrication of CAD/CAM restorations
**Pediatric Dentistry:**
All clinical care of pediatric patients (<14 years of age) by predoctoral dental students must take place in the pediatric dentistry clinic.
Clinic Implementation Team
Meeting Notes, 8-18-09, 9-10:10 a.m., room 1397

Members present: Mark Fitzgerald, Mary Garrelts, Wendy Kerschbaum, Phil Richards

Consultant: Steve Stefanac

Team activities for Fall, 2009
- DH linkages discussed…a DH3 or DH4 student will be included in each team beginning Fall, 2009 – DH2s will then be paired with DH4s and added to teams in the Winter term
- Teams will probably represent a pair of cubicles whenever possible
- Currently dual assigned patients (dental student and dental hygiene student) will NOT be re-assigned – any established linkages will be maintained
- Goal for development and demonstration of team leadership skills – definitely applies to DH4 students as well as D4 students
- D4 Practice management course – first 2 sessions this Fall will be devoted to introducing team activities

School Convocation, 8-28-09
- Discussed and reviewed brief CIT introductory powerpoint presentation that is planned for the convocation
  - Some suggestions were offered and some minor editing of the introductory slides was done by the group in attendance
- All CIT members are encouraged to attend and participate in the Clinical Implementation breakout session (location still TBA)
- Steve Stefanac volunteered to serve as the recorder for breakout discussion

Patient care guidelines
- Guidelines should represent the desires of the disciplines but must also be based on an achievable reality…history has taught us that unrealistic limitations are likely to be ignored – rendering such guidelines pointless
- Intensive in-service training needs in order to support goals in all areas will need to be planned for and managed
- Credentialing tracking systems (e.g. University Hospital) are being looked at for potential usefulness in managing dental school needs

Roll-out plans for “the next curriculum – curriculum innovations”
- Time-lines still uncertain, but a significantly transformed DDS program is still anticipated for the incoming DDS class of 2010
- Possible inclusion of a Summer term for new D1 students (July & Aug) is being discussed
- Challenges of implementing “new” curriculum for incoming D1s while also following established pathways for other student groups – very complex and realistic possibilities not yet established

Director of Predoctoral Clinical Education
• Some discussion regarding the importance of having a true “authority” figure in terms of managing the clinical curriculum…unclear if/how this individual could develop/assume this function – probably depends on “the person,” potentially as much or more than the job description. It might be useful to create a set of example scenarios (e.g. clinical faculty behavior issues) for discussion of how this individual might be expected to function and/or react.

Future meetings
• It is anticipated that our current scheduled weekly meeting time will be maintained for the foreseeable future.
  o Wendy Kerschbaum has a conflicting class during the Fall term…Anne Gwozdek has been asked to take her place on the Team starting on 9-8-09
  o Some members may have other conflicts arise – we’ll react accordingly
Members present: Dan Edwards, Mark Fitzgerald, Mary Garrelts, Wendy Kerschbaum, Laurie McCauley, Phil Richards

Consultant: Steve Stefanac

Convocation
There was discussion of the upcoming School Convocation (scheduled for Friday, 8-28-09 from noon until 2 p.m). The main Convocation meeting will begin at noon in room G390. This meeting will be followed by team breakout sessions (rooms still TBA). CIT members are encouraged to attend the main meeting as well as the CIT breakout session if they are able to do so. One minor edit to the existing CIT introductory slides was made.

Patient Care Guidelines
Recent edits of the Guidelines were briefly discussed… only one minor addition (dental hygiene) was made during the meeting. Discussed seeking more active involvement of Oral Medicine faculty in CIT activities soon in order to clarify goals and desired elements for this aspect of the clinical curriculum. Additional clarifications are potentially still forthcoming regarding esthetic dentistry issues. Any additional, meaningful movement toward resolution of the red text issues now appears unlikely until after Labor Day.

Frequently Asked Questions
The current edit of the preliminary FAQs were briefly discussed. These are now likely to be edited further and distributed soon after the Convocation (rather than before) in order to incorporate any major issues that may emerge directly from Convocation discussions. The most recent version will be circulated to team members soon (before the Convocation) for general reference and perspective concerning the overall Vision Implementation process as well as the goals and perspectives of other teams.

Some additional potential FAQ questions were proposed during the meeting:

- What will be the effects of curricular innovations be on current clinic patients?
- In some ways, CEUs “drive” patient care activities…will this also be true in the future?

These questions (challenging to answer, but most likely only answerable by the CIT itself…) will be considered for inclusion in future versions of the FAQs.

Key Goals
The CIT list of key goals, last reviewed back in June, was considered for updating based on recent activities and realizations. Some team editing was accomplished during the meeting in order to clarify and create some thematic linkages for certain action items. Some of these items, although potentially guided by CIT, will likely require recruitment and involvement of others (i.e. support staff) for management and implementation.
Members present: Dan Edwards, Mark Fitzgerald, Preetha Kanjirath, Wendy Kerschbaum, Laurie McCauley, Phil Richards

Preetha Kanjirath was welcomed to the meeting as a new member of the Clinic Implementation Team.

**Job Description for the “Director of Predoctoral Clinical Education”**
The most recent iteration of the job description created by the CIT was briefly reviewed. According to Mark Snyder, the Clinical Foundation Team has also now reviewed this document and supports it in its current form. Rather than adding an administrative layer, an important goal of this new position is to allow specific focus on the historically broad administrative duties of the Director of the Comprehensive Care Program while also including responsibility for nurturing and integrating the Clinical Science, Clinical Foundation and Science Foundation areas of the curriculum. While it is expected that this individual will participate in clinical teaching, he/she will not likely be responsible for a specific sub-group of students as are the current Clinic Directors.

**Patient Care Guidelines**
The apparent overlaps in the scope of General Dentistry and Prosthodontics and the need to work toward an acceptable and practical compromise were briefly discussed for historical perspective.

The potential creation of a designated clinical area for management of more complex Oral Medicine patients requiring specific monitoring and follow-up, as Preetha had proposed earlier, was discussed. This could likely include educational opportunities for both DDS students and Oral Pathology residents in the future. The Discipline Skills clinic would not likely be a desirable location for this, based on the anticipation of limited available space. The 3rd floor orange clinic was discussed as a more likely possibility. The complex logistics of planning for and capitalizing on clinical space refurbishment and utilization (i.e. the 3rd floor orange clinic, the old pedo clinic, etc.) were discussed.

Adding a Summer half term for incoming D1 students, now considered likely for implementation for the DDS class entering in 2010, was discussed. This may potentially provide an opportunity for scheduling and integration of anatomical sciences (specifically including head and neck) instruction. A natural accompaniment could be to also include initial clinical learning experiences pertaining to head/neck and oral clinical examination techniques, historically not emphasized until the very end of the D1 year.

The potential for routine extractions to selectively take place in the general dentistry clinics remains in the current draft of the Patient Care Guidelines. Some minor group editing was completed on this portion of the Guidelines again today. Case selection will be paramount in preventing untoward intraoperative events requiring “bailout” help from Oral Surgery faculty. Grad perio was discussed as another potential source of such expertise, should the need ever arise. Mechanisms for providing awareness and seeking feedback from Oral Surgery (both
predoctoral discipline and departmental leadership) were discussed. Phil Richards will plan to approach Pilar Hita-Iglesias and Laurie McCauley will plan to approach Joseph Helman to advise them of the proposed concept and seek their preliminary reactions and input in the near future.

**CIT Breakout Session from Convocation on 8-28-09**
The strongest themes represented in the reactions and questions from those in attendance during the breakout session were reviewed:

1. adequacy of staffing to minimize wait times for students
2. adequacy of clinic space to allow discipline-specific treatment to proceed unhindered

Additional issues from the breakout session were also discussed briefly. Appropriate staffing for student activities, particularly in the general dentistry clinics (and the potential “home” departments for the general dentistry faculty) were discussed. Boarded and declared specialist and generalist numbers and density in CRSE and BMS/Prosth were discussed.

The scheduling system (dedicated computer task) as well as the conceptual paradigm for this activity that has evolved historically (filling rotations first, then scheduling the remaining students in their “home” clinics) will need to be approached in a different way in the future. The potential elegance and simplicity of linking “a schedule” to “a cubicle (number)” was discussed as one strategy, but the flexibility that may be required for individual pathways/learning tracks for students later in the curriculum may not be easily accommodated using such a design.
Clinic Implementation Team
Meeting Notes, 9-8-09, 9-10:30 a.m., room B312B

Members present: Dan Edwards, Mark Fitzgerald, Anne Gwozdek, Laurie McCauley, Phil Richards, Marianella Sierraalta, Nikki Sweier

Consultant: Steve Stefanac

October faculty retreat
Phil Richards informed the group of some initial Vision Implementation Steering Committee strategizing for the faculty retreat on 10-10-09. Discussion of specific methods for connecting and integrating curricular content across subjects, disciplines and environments (classroom, patient care), specifically utilizing case studies and grand rounds, is currently being proposed as a primary focus for the retreat.

Monitoring systems
With the complexity that will potentially be introduced by having students on more individualized and asynchronous trajectories, particularly in terms of their clinical development and experiences, the need for centralized systems for monitoring and managing student progress was discussed. There may be related additional needs for monitoring and managing in-service training and calibration activities for faculty members as well. The need and value of potentially tying together information that can be gathered directly through MiDent with other data sources to track more global learning experiences and goals was discussed. The potential value of expanding the use of portfolio methods for collecting and reflecting on student experiences was discussed. Through discussion, some key individuals were identified (Lynn Johnson, potentially also utilizing the skills of Emily Springfield and/or Melissa Peet, as well as Roger Gillie for his expertise regarding MiDent). Lynn and Roger will potentially be invited to an upcoming CIT meeting for further discussion of needs and goals for this purpose.

Patient Care Guidelines
Discussion from the CIT convocation breakout session regarding potential clinic space flexibility concerns and the distribution of student activities in the general dentistry versus discipline skills areas was reviewed. On the other hand, the strong positivity regarding the response to and potential value of the pre-treatment clinic team “huddle” during the breakout session was also cited. The original objectives from the CIT committee charge were also briefly reviewed and discussed.

Recent conversations with Oral Surgery representatives suggest a potential willingness for them to participate in the creation of more specific guidelines for certain tooth extractions to be performed in future general dentistry clinic environments. However, concerns were also expressed regarding some disciplines “opting out” of the general dentistry concept. Pediatric dentistry (through Jimmy Boynton) has indicated that they wish to maintain a system wherein all dental care for children takes place in their clinic environment.

The limited amount of clinical activity that takes place within the in-house DDS curriculum for some disciplines (specifically endodontics and pediatric dentistry) was highlighted as a factor
potentially restricting opportunities for more general dentistry involvement. The needs for specific equipment and/or staffing for some activities (e.g. chairside assistants for pedo) was also discussed. Pediatric dentistry experiences in general practice environments outside the school (i.e. outreach sites) seem to be working well. There may be value in asking pediatric dentistry to assist in developing conceptual criteria for patients younger than 14 years of age that would render them suitable for treatment in the general dentistry clinics. Phil Richards will revisit this issue with Pedo.

Guidelines for other disciplines or clinical skill areas (e.g. esthetic dentistry) will also require some additional clarification. One perspective guiding the development of patient care guidelines is to attempt to create a set of goals or activities that will potentially ELEVATE the effective and comfortable participation of some more “reluctant” dentistry faculty members (in clinical skill areas outside their traditional/departmental comfort zones) while also potentially CONTROLLING the types of complex or discipline-specific patient care that is acceptable to be undertaken, even by eager and highly capable faculty members, in the general dentistry treatment environments. The historical emergence of faculty “reluctance” to teach outside of their department/discipline has been an unfortunate by-product of the departmental specificity of faculty appointments as well as the freedoms that have traditionally been exercised by students and faculty members during clinical patient care when faculty members representing all individual disciplines are routinely present and available. ELEVATING faculty participation outside of these patterns will certainly require a strong commitment to the importance of the generalist concept across the board as well as robust new in-service training and calibration processes for the future.

The potential barriers created by the current departmental/administrative structure that may interfere with the goals of interdisciplinary, truly generalist-driven patient care were discussed. The trends toward individual faculty members to act (or fail to act) based on potentially misplaced allegiances in patient care were cited as continuing concerns. Additionally, the appropriate departmental affiliation for the proposed dental hygiene educators who will teach dental students within the general dentistry clinics was briefly discussed. The potential value of creating a “department of general dentistry” (as exists at many other dental schools) was discussed.

Some limited discussion and editing of the prosthodontics patient care guidelines took place during the meeting in order to attempt to resolve some of the clear incompatibilities with the desired scope of general dentistry. The most recent draft of the patient care guidelines will be circulated to all CIT members for consideration and comments following the meeting.

Key Goals
The list of Key Goals for future activities of the CIT were again briefly reviewed and discussed. The concept of the pre-treatment “huddle” was cited as a potential high-value, low effort initiative to highlight in the near-term. The most recent draft of the Key Goals will also be circulated to all CIT members for consideration and comments following the meeting.
Clinic Implementation Team  
Meeting Notes, 9-15-09, 9-10:30 a.m., room B312B

Members present: Dan Edwards, Mark Fitzgerald, Mary Garrelts, Anne Gwozdek, Preetha Kanjirath, Phil Richards, Marianella Sierraalta, Nikki Sweier

October retreat
Some of the initial ideas and plans for the October 10 faculty retreat were discussed. A main focus of the retreat will likely be directed toward establishment and enhancement of stronger educational linkages between science and clinical patient care. Presentations to highlight and foster the development and utilization of case studies may be a primary element of the retreat. Case studies to be managed and addressed/presented by clinic teams/groups may represent an initiative that could boost problem solving and critical thinking.

Problem solving and critical thinking
Some initial discussion also took place regarding any realistic potential for developing a stronger emphasis on problem solving and critical thinking during patient care activities within the teaching clinics. Clearly, the established, ongoing need for efficiency and productivity in patient care may tend to discourage any significant enhancements in this direction. The potentially competing interests of efficiently supervising students who are providing patient care (focused on the faculty member as “checker” function) versus having clinical faculty members be actively engaged in guiding/teaching students will need to be reconciled. The prevailing culture and habits of both students and faculty may also counteract the desired outcomes and potentially be difficult to overcome.

Conditions must be created that will require students in clinic to be more independent and more prepared as a matter or routine. There will be a strong need for a unified attitude and approach by faculty…this will require strong efforts to establish and broadcast message, policy and process. Department chairs will need to require attendance at all in-service and team-building events. Greater numbers and intensities of such events will also be a primary need and goal for the future.

The question of whether students should be allowed greater freedoms later on in their clinical curriculum, (e.g. following successful completion of their outreach experiences) in order to allow them to function with a lesser level of faculty supervision (and potentially be more productive while allowing faculty to focus more attention on other students) was considered.

Other issues
Treatment planning…should there be a formal “course” in this in order to tighten up the processes, goals and expectations?

More on the October faculty retreat…discussion of and/or focus on the “huddle” concept was highlighted for potential inclusion in the retreat.
Clinic Implementation Team  
Meeting Notes, 9-29-09, 9-10:30 a.m., room 1397

Members present: Dan Edwards, Mark Fitzgerald, Mary Garrelts, Anne Gwozdek, Preetha Kanjirath, Laurie McCauley, Phil Richards, Marianella Sierraalta, Nikki Sweier

Consultant: Steve Stefanac

Director of Predoctoral Clinical Education  
The creation of the proposed position has now been discussed at the Vision Implementation Steering committee but is not yet ready to be moved forward. Any further action in this regard will likely now be delayed for at least a month or more. While the potential value of having someone to play this role is generally acknowledged by all, there is some apparent confusion of how much the respective Associate Deans can and should also be engaged in this regard. There are also some who feel that the biomedical sciences may benefit from equivalent representation. With this in mind, some concerns continue to be expressed regarding the wisdom of creating additional administrative layers. Also, the crossover with and/or the perceived need for “clinic director” authorities (under whatever name) in the future is still raised frequently as a point of contention.

October retreat  
The specific agenda for the upcoming retreat (Saturday morning, October 10) is still being worked out, but a primary focus will be to discuss the use of case study and grand rounds teaching strategies to attempt to draw more clinical scenarios into the teaching and application of biomedical concepts and also to highlight biomedical and problem solving skills during ongoing patient care activities. The effective application of the pre-treatment “huddle” concept has also been proposed for inclusion in this discussion.

Progress and integration of Vision Team activities  
Establishment, integration and implementation of the significant curricular changes that are being discussed by the various Teams is proving to be much more complex, difficult and lengthy than anyone had anticipated. The goal of having all proposed changes in place for the 2010 entering class may or may not be a reasonable expectation at this point. However, moving forward with some of the CLINICAL initiatives that we have discussed may or may not require completion of all other curricular elements.

Student and clinic scheduling and structure  
The continued linkage of individual students to individual cubicle assignments and schedules is likely a poor strategy beyond this year for a variety of reasons. Establishing rotation schedules first and then “back filling” the clinics may become much less effective and less appropriate for the future as students will be asked to work in a more coordinated way within smaller clinical groups. Making some significant process changes in the clinics (specifically for upper level students) sooner rather than later may be very useful to inform and enhance the broader curricular changes that will certainly be forthcoming in future years. The potential for and wisdom of moving from a “4-VIC-clinic” structure to a “3-general-dentistry + 1-discipline-skills clinic” structure soon – perhaps in the coming year – was discussed at length.
While there was general support for the possibilities, even for the coming year, some potential challenges and significant potential barriers were also discussed. The potential levels of change that were preliminarily entertained for the coming year included:

- Maintaining 4 homogenous clinic spaces, but dividing them into 4 more functional team groupings
- Moving to a preliminary but bona-fide 3 + 1 structure, specifically to facilitate greater early learner focus in disciplines
- Maintaining the existing 4 clinic structure, but formally utilizing the 3rd floor Orange clinic for expanded and enhanced early learner experiences

The need for and usefulness of the 3rd floor Orange clinic space was discussed at length. There was a general consensus that attempting to move forward with equipment upgrades for 3 Orange in the short-term to allow it to continue to be used for special teaching initiatives and possibly as “swing space” for emerging clinical needs was considered by all to be a very good idea and necessary. Steve Stefanac will pursue possibilities for this in the near future.

Despite the expertise present at the table, it became clear that actually planning for and making any significant changes to the existing clinic structure, utilization and scheduling processes will require the involvement and dedication of significant outside expertise and resources, particularly from the Dental Informatics and Patient Services groups. A preliminary meeting will be called to discuss this with some key stakeholders and IT personnel.
Clinic Implementation Team
Meeting Notes, 10-13-09, 9-10:30 a.m., room 1397

Members present: Dan Edwards, Mark Fitzgerald, Mary Garrelts, Anne Gwozdek, Preetha Kanjirath, Phil Richards, Marianella Sierraalta, Nikki Sweier

Student and clinic scheduling meeting
Mark Fitzgerald, Mary Garrelts and Phil Richards met with Roger Gillie and Georgia Kasko on October 6 to discuss prospects for revising the students’ clinic schedules and patient scheduling strategies for the coming year. Maintaining the 4 VIC clinic model, particularly for incoming D4 students was considered to be an important goal for the coming year...migrating to a 3 + 1 strategy would most likely be considered for implementation later. There will likely be insufficient mailbox and storage locker spaces located proximal to assigned clinics if students are assigned to only 3 general dentistry clinics. One approach to scheduling students would be to create a system wherein Comp Care half days are categorized as a “rotation” – much as other rotations are in the students’ schedules now...this may serve to simplify the entire student scheduling process and also allow for more flexibility and control than has been available in the past. A working goal is to try to specify “quadrants” of the clinic for student assignments rather than isolating specific chair locations. While this may ultimately require more management of specific cubicle locations for students on a day-by-day basis (i.e. the need to process appointment requests for all chairs), this could ultimately facilitate the anticipated group- and team-based goals for patient care more effectively. A number of questions arose regarding the capacities of the Axium software package to effectively manage these tasks...Roger Gillie will investigate with his Exan contacts and report back in the near future on what he learns.

Oral surgery reaction to the Patient Care Guidelines proposal
Pilar Hita-Iglesias has been contemplating the most recent draft of the Patient Care Guidelines for a while...she recently expressed a wish to meet with the Clinic Implementation Team to discuss this issue further. We will include her on the agenda of a future meeting pending her availability.

Team concept implementation
Mark Fitzgerald reports that students have generally reacted favorably (if sometimes reluctantly) to the initial implementation of team activities this term. Some students have expressed that they feel that some patient flow and patient availability concerns may be improved upon by capitalizing more fully on the opportunities that are provided by a team-based structure. Ken Stoffers has been implementing a “pre-treatment huddle” activity for D2 students and D4 mentors prior to each clinic session this term. There have already been some perceived improvements based on this...Ken may be able to provide useful insights to the CIT based on his initial experiences.

CIT key goals
Some group editing and categorization of the working “key goals” document was undertaken by the group during the meeting – the resulting document-in-progress will be sent to CIT members along with these notes. The group perspective is that re-focusing our efforts toward evolutionary moves that can be implemented prior to the creation of an entirely new curriculum (and prior to
the full implementation of a 3 + 1 clinic model) should be our first priority for the near-term. There is a general consensus that SIMPLE educational process changes may have the potential to create SIGNIFICANT benefits to the educational culture and likely educational outcomes.

Significant conversation took place regarding the focus areas of risk assessment/risk management and treatment planning. Margherita Fontana, a new CRSE faculty member known as a leading expert in this area may be asked to join our group and assist us in creating greater curricular and clinical impact in this area.

Significant discussion also took place regarding the potential value of developing a more robust treatment planning curriculum, potentially utilizing case-based methods for treatment planning and risk assessment/risk management exercises. The relative contribution of traditional Comp Care Seminar and potential future Grand Rounds educational environments were discussed. Creating a curricular emphasis for D1 and D2 students that may allow them to develop a greater sense of awareness and capability (perhaps to the extent that they may play a more active role in the clinics, even during observation and assisting sessions) was also discussed. It was felt strongly that case-based exercises focusing in this area SHOULD NOT be housed within a freestanding course – rather they should be woven into the general curriculum with specific dental care goals/objectives attached to them.
Clinic Implementation Team  
Meeting Notes, 1-20-09, 9-10:30 a.m., room 1397

Members present: Mark Fitzgerald, Margherita Fontana, Anne Gwozdek, Preetha Kanjirath, Phil Richards, Marianella Sierraalta, Nikki Sweier

Consultant: Steve Stefanac

Margherita Fontana was welcomed as a new member of the team. Much of the discussion during the meeting was directed toward orienting her to the past and ongoing efforts of the team and how her unique interest and expertise may apply to future goals.

**Third floor orange clinic**

Steve Stefanac informed us that bids have been solicited regarding the goal of outfitting the 3rd floor orange clinic with updated and fully functional clinical equipment (including uniform x-ray capability) that would allow this space to be used more effectively particularly for small group activities. The initial estimate of cost is somewhere in the neighborhood of $200,000.00. It is anticipated that wireless networking can be used to provide MiDent connectivity in this area. In order to move this project forward, it is likely that a detailed and comprehensive list of potential usage purposes and patterns for this clinical space will be necessary in order to promote it and justify the expense. The “check up clinic” is now using this clinic space…this patient population may also be a potential target for implementation of focused prevention activities in the future.

**Prevention, risk assessment and management**

The third floor orange clinic was mentioned as a potentially suitable environment to promote a family-based prevention focus (parents with children). Margherita Fontana shared her experiences at Indiana in terms of what has worked well versus what has not worked so well. The potential for creating a purpose-specific, best-practices demonstration clinic area to implement policies and practices that can then be implemented more broadly throughout the teaching clinics was discussed. Significant discussion took place regarding strategies for implementing a more inclusive process for assessing and managing risk in the teaching clinics. The in-service training initiatives and the shift of culture that would be required to promote greater involvement of current clinical faculty members in encouraging/requiring students to be more engaged in risk assessment/management would certainly be significant…and potentially variably successful. The potential value of identifying and assigning rotating “expert” faculty members to encourage and assist in these efforts was also discussed. Even with this type of focused mentoring, it is clear from previous experiences that the ownership of preventive strategies and approaches by the students themselves will ultimately be necessary for success. When expectations are made clear and assessed uniformly and objectively, students generally follow through. One of the early needs will be the establishment of a uniform risk assessment process and data form/data set around which preventive strategies can be built. Ideally, such a process can be designed to seamlessly access and utilize clinical information that already exists within the MiDent system.

For future consideration: pre-treatment huddles and case discussions – do we need to present this for review and approval by the curriculum committee?
Clinic Implementation Team
Meeting Notes, 10-27-09, 9-10:30 a.m., room 1397

Members present: Dan Edwards, Mark Fitzgerald, Margherita Fontana, Mary Garrelts, Anne Gwozdek, Laurie McCauley, Phil Richards, Marianella Sierraalta

Faculty development, In-service training for faculty
Particularly in view of the types of clinical education changes that are being contemplated for the future, in-service training for clinical faculty members will be increasingly necessary and important. The history of faculty in-service training at the school was briefly reviewed. Prior to the early to mid 1990s, no predoctoral clinics were scheduled on Wednesday afternoons and these times were used by departments for regular, structured meetings for clinical faculty members. The school made a conscious effort to protect the time for these activities as they were valued.

The issue of how much time needs to be (or should be) devoted to clinical faculty in-service training was discussed. The need to maximize the utilization of the clinical facilities is clearly different now than it was in the past. While one half-day per week of unscheduled predoctoral clinic time for faculty development may no longer be practical or possible, there was general agreement that as much as one half-day per month or as little as one half-day per term, specifically if PRE-PLANNED for in-service training activities, might be appropriate and necessary.

In recent years, CRSE has undertaken some creative strategies for ongoing dissemination of information intended specifically for clinical faculty. Powerpoint presentations with audio narratives (30 minutes or less) as well as some PDF documents have been created and posted on the CRSE web site. These online modules have been created by selected departmental faculty members with expertise in the specific topic areas and include online assessments to certify achievement of basic learning goals. These modules collectively have been considered to be a faculty development “course” to which CE credit is applicable.

Creating and packaging the educational content was a particularly onerous task for some department faculty members…those with the expertise have often been overburdened. Also, some challenges in accessing these materials were encountered for some faculty members in the past (approximately 2-3 years ago), due to limited school server capacity and network bandwidth as well as slow internet access outside the school. Access to online content for faculty members now may be more successful than it was in the past due to improved internal dental school network capability as well as more reliable faculty access to high-speed internet sources outside the building.

Margherita Fontana described the clinical faculty in-service training systems that were used at Indiana when she was there. She indicated that the Dean at Indiana considered these activities to be important enough that they were mandatory for all clinical teaching faculty. She described two to four half-day sessions per term, about half of which were “whole school” activities, with the other half focusing on department-specific topics. There had been some on-line initiatives at
Indiana as well, but these were generally perceived to be less effective because of information and schedule overload.

Topics chosen for the group meetings were those that were deemed particularly worthy of the faculty members’ time. Discipline-driven offerings focused largely on “nuts and bolts” of clinical education and patient care within that discipline. Priorities were established based on clinical issues requiring specific or ongoing attention to serve “big picture” educational needs. One discipline-specific initiative that was described for restorative dentistry involved the use of case-driven dilemmas to identify and address faculty variations in treatment planning. Audience response data (based on “clickers”) were used to prompt discussions. Some strategies similar to these have also been used on a limited basis here at Michigan.

The creation of whole-school faculty development programs that run across traditional department and discipline barriers were proposed to be focused on broader philosophical topics. Such school-wide faculty training programs could be designed and focused on universal clinical education faculty skills issues (e.g. “how to teach”). In addition, school-wide programs were felt to be important to broaden awareness of important issues outside of a faculty member’s main focus or expertise and reduce the perception of departmental clinical education “turf” – that any one area of clinical dentistry is entirely owned or controlled by any one segment of the faculty.

The educational concept that “assessment drives student performance and achievement” was repeatedly mentioned as a significant basis for creating the type of learner involvement that we seek in the future. Along with this, the ownership of the learning process by the student (and creating an assessment system to encourage this) was reinforced. The potential use of portfolios as an element of future student assessment strategies may make the creation and communication of uniform criteria to describe student participation/achievement and faculty calibration a much more important need for the future.

The recent experiences of providing widespread initial faculty training for MiDent were considered as a model to contemplate what may constitute successful and less than successful in-service training methods. The MiDent training meetings themselves, while brief and focused, did provide at least some chances for interaction to gauge the level of understanding. In addition, the creation of lingering online reference sources in MULTIPLE forms (bare-bones “CHEAT SHEETS” for quick access on-the-fly, PDF FILES to provide for more in-depth details, and VIDEOS to provide the greatest level of demonstration/information) was generally felt to be an excellent strategy.

A responsible person or people (with a mandate as well as sufficient authority) will need to be charged with coordinating and administrating such an expanded in-service training initiative. The wisdom of charging a group of people (e.g. the VIC directors group, and/or the discipline coordinators) vs an individual (i.e. someone such as the proposed Director of Predoctoral Clinical Education) was discussed. Recent trends suggest that there is presently no one strong proponent or leader to drive such a plan for the future.

Near the end of the meeting, some suggestions or policies were raised for general agreement in concept:
- Flexible meeting times will need to be created well ahead of time for group attendance at school-wide meetings
- Use of some on-line delivery systems/methods will also be necessary
- Certification based on participation should be required for all clinical faculty members
- Faculty generally seek more of this type of information than they currently get
Clinic Implementation Team
Meeting Notes, 11-3-09, 9-10:30 a.m., room 1397

Members present: Dan Edwards, Mark Fitzgerald, Margherita Fontana, Mary Garrelts, Anne Gwozdek, Laurie McCauley, Phil Richards, Marianella Sierraalta

Consultant: Steve Stefanac

Oral Surgery
Pilar Hita-Iglesias was originally scheduled to attend the meeting, but called in ill the morning of. Steve Stefanac described some current concerns that oral surgery has raised regarding instrument requests, instrument losses and potential security/access issues based on the nature of their clinic.

Third floor orange clinic
Steve Stefanac has received initial bids from ADEC for new dental equipment for the third floor orange clinic. The projected costs of the chairs/units themselves is about $175,000.00. Additional costs would be incurred with the addition of other equipment, specifically x-ray capability.

Check up clinic
Steve Stefanac described the fact that the initial activities for the “check up clinic” have been successful. There appears to be significant potential demand for this type of dental care service for the future.

In-service training
Phil Richards discussed his recent update to the steering committee regarding ongoing CIT activities, specifically the perceived need to develop our in-service program. Based on this, the steering committee suggested that this initiative should be a faculty-driven process and that the CIT be “charged” to “map out what we believe are key components of such a program.” Some discussion took place regarding the relative benefits of central versus distributed management of the in-service training process. There was general consensus that: 1) in-service training requirements and processes should be standardized and cut across departments/disciplines school-wide if we are truly serious about them, and 2) central management and tracking, potentially facilitated and maintained by informatics, would be desirable. Steve Stefanac has been investigating more highly developed systems to track faculty credentialing activities…this could be a useful/important activity to fast-track (probably working with Lynn Johnson from informatics) to meet our emerging needs.

There was general consensus that there should be both “required” and “elective” elements within the ideal in-service training program. The creation of a faculty teaching “portfolio,” analogous to portfolio concepts that have been described for students, was also discussed. It was felt that there should be real consequences if a faculty member fails to meet stated minimum in-service training requirements – even potentially the withholding of annual teaching appointment renewals.
It was recognized by all that such an in-service training initiative would represent a HUGE commitment of time and resources by individuals and by the school at large.

Significant discussion took place about specific in-service training goals and those aspects that may be best served by on-line or asynchronous modes of delivery versus those that may be more effectively delivered by interactive, group-based meetings:

Can be provided on-line:
- Patient services background information
- Infection control
- Medical emergencies
- Materials and instruments information
- Concise summaries of curriculum content
- MiDent training – updates and reinforcement
- Discipline-specific, technical content
- Quality assurance and institutional risk management information

Should be provided in-person, in group settings:
- Teaching the best practices in teaching, with trigger vignettes to support
- New initiatives – clinical triage of patient types – case-based
- Patient risk assessment, risk management
- MiDent training – initial exposure and basics
- New or revised test case guidelines
- Discipline-specific lunch and learn discussions – topical focus – guiding future initiatives
A rather specific current and ongoing need, relative to the orientation of new faculty members, was also raised. The best form of in-service training for new instructors and how to best deliver such content was discussed, but no conclusions were reached.

Creation of an in-service training system with consistent “look and feel” and perceived strength of functionality for all will be crucial for success. The long list of requirements that need to be met may appear daunting, but best practices must be devised and adopted to deliver them. The specific question of how to “champion” this process was raised – good intentions will be necessary but will not be sufficient to move this process forward.

1. **Departments/disciplines** will need to be proactive in creating “specialty store” content…this will need to be championed by **discipline coordinators and department chairs**.

2. Similarly, the faculty at large will need to feel part of a clinical teaching “team” on *school-wide* basis – at more of a full-service, “department store” level. It was felt that such discipline-specific content should be made available to faculty in all disciplines, but certainly required for those teaching in the particular discipline in question.

This will need to be championed by:

- **Academic affairs**
- **Educational resources**
- **General dentistry “clinic director”**
  - Director of predoctoral clinical education?
  - Director of comprehensive care?
Clinic Implementation Team
Meeting Notes, 11-10-09, 9-10:30 a.m., room 1397

Members present: Dan Edwards, Mark Fitzgerald, Laurie McCauley, Phil Richards, Nikki Sweier

Consultant: Steve Stefanac

Phil Richards provided some background information regarding some of the preliminary planning for the D1 Summer curriculum. The challenge of creating a new course sequence, designed to meet the goals of developing academic independence, critical thinking and problem solving skills to span the entire curriculum were discussed.

Clearly the educational leaders who will participate most intensively in the planning for and administration of the “new” courses in this new term will need TIME to meet and coordinate their efforts. At the most recent Steering Committee meeting, the need to create dedicated time for faculty to hold such meetings was discussed. The prospect of “closing the clinics” on a planned basis, even possibly as much as ½ day each week, was discussed. Such time could also be used for other new initiatives, such as Grand Rounds and other types of faculty meetings.

However, even with these needs and goals in mind, the economic ramifications of such a move would also need to be considered. Some discussion regarding challenge of determining what types of school activities actually generate the most revenue, relative to overhead costs, took place. While x-rays and exams generate lots of clinic revenue, clearly we can’t base an economic model primarily on these activities. In many cases, the information to make educated decisions concerning revenue and cost ramifications of potential changes is not readily available.

While there is significant overlap between the “when can we find time to meet?” questions and the needs for intensifying the faculty development and in-service training programs, it was suggested that these issues will require some time for consolidation and interpretation by the team before any meaningful proposal can be developed. With this in mind, the majority of the remainder of the meeting was dedicated to discussion of “PRE-TREATMENT HUDDLES.”

In order to facilitate group activities and huddle conversations, it was expressed that students should not be allowed to self-select the instructors with whom they will work in the clinic on any given day. It was felt that this policy should be established and enforced as soon as possible. Clinic faculty should always be utilized as efficiently as possible, based on balancing the anticipated work load among the faculty and minimizing the geographic distance between students who are working with a particular faculty member.

The student appointment/procedures report (posted in the clinic each day) could/should be used more routinely to predict and distribute faculty assignments and activities more equitably. If this goal is to be achieved, ACCURACY AND COMPLETENESS OF THE INFORMATION PROVIDED BY THE STUDENT WHEN THE APPOINTMENT IS ENTERED INTO THE MiDent SYSTEM IS KEY! Students should be encouraged to plan and report as much specific
information as possible concerning the planned appointment (i.e. more than they do now) in order to facilitate:

- Faculty information/planning for the clinic session
- Efficient instrument requests/acquisition

What about the huddles themselves? Should faculty members huddle with other faculty members (e.g. to plan who will work with which students?) or should faculty huddle only with their students? Obviously, BOTH types of huddles will be needed. It was also anticipated that, in many cases, the PCCs should also be included in many such huddle conversations.

There will be a need to develop a standard, concise format to describe how patient care needs/plans are to be shared within a huddle. The issues that will likely be of greatest interest and importance to discuss/address during a pre-treatment huddle include:

- Emergent patient care needs
- Test cases – THESE SHOULD ALWAYS BE PRE-PLANNED AND ENTERED INTO MiDent!

Clearly, the VIC directors’ will need to be informed and consulted before any such initiative is launched. As faculty leaders, they will need to embrace and promote this concept if it is ever to have a chance of succeeding. Steve Stefanac also anticipates that he will introduce this idea at the clinic issues (student) meeting soon…perhaps even this week.

In order for any huddle activity to succeed, FACULTY MEMBERS (AND STUDENTS) MUST ARRIVE TO THE CLINIC ON TIME!

It was suggested that the huddle concept should start with basic, critical function discussions, hopefully demonstrate some success, then potentially grow the scope of this activity for the future from a successful starting point.

The issue of involving D1 and D2 students more effectively into the patient care process was raised…how can these students be included and participate most effectively? Whenever possible, D1 and D2 students (as well as D3s or D4s who are without patients of their own) should be recruited to assist and participate in the pre-treatment huddles and subsequently the patient care process in order to maximize both treatment efficiency and learning opportunities.

How should patient appointments be made in the future? Should students be directly involved or should all appointments be managed centrally? The original charge to our team suggested a mandate for central scheduling. YES, perhaps SOME appointments should be made centrally, but this would likely be most effective only for subsets of clinical procedures such as:

- Initial visits
- Recall/maintenance appointments

It was felt that central appointment management is likely NOT the most appropriate approach for managing patients in the middle of an active treatment plan with their assigned student. These appointments will probably still best be managed by the assigned student in order to enable efficient handling of cancellations, etc. (with quick substitutions being possible only if student
remains involved and aware). The down side of enabling students to maintain this type of control is the prospect that a small subset of students may continue to “game the system” by entering fictitious appointment requests in order to claim and hold onto clinic “real estate” that may or may not actually be utilized for patient care.

The meeting concluded with the creation of a basic proposal regarding a huddle system that could potentially be adopted and implemented soon – perhaps even by January, 2010:

**Pre-treatment huddle proposal**

Prior to and to facilitate the huddle:

- Faculty and students must arrive to clinic on-time
- Students must identify the primary discipline with whom they plan to work and enter it into MiDent

During the huddle, a discussion, led by the faculty member, will take place regarding:

- test cases
- any urgent, time sensitive or other special patient care concerns
- assigning students without patients to assist
  - D1 and/or D2 students
  - D3/D4s with broken appointments

The huddle will take place from 9:00 a.m. to 9:10 a.m. and from 2:00 p.m. to 2:10 p.m.

Patients cannot be brought into the clinic until after the huddle has concluded
Clinic Implementation Team
Meeting Notes, 11-17-09, 9-10:30 a.m., room 1397

Members present: Dan Edwards, Mark Fitzgerald, Margherita Fontana, Mary Garrelts, Anne Gwozdek, Phil Richards

Consultant: Steve Stefanac

Guest: Tilly Peters

Phil Richards informed that group that Pilar Hita-Iglesias has rescheduled and will now plan to attend our meeting on December 8.

The current meeting agenda was to focus on ways that we may be able to enhance our students’ clinical examination, risk assessment and treatment planning skills and, at the same time, hopefully boost the accuracy and usefulness of the MiDent data that results from this.

Tilly Peters requested to join today’s meeting in order to share some preliminary ideas that had emerged from a faculty group (including Tilly Peters, Margherita Fontana, Carlos Gonzalez, Mark Fitzgerald, Woosung Sohn, Nikki Sweier and Preetha Kanjirath) regarding caries management to be implemented within the curricular changes that are being discussed. A handout was provided (TPedits-CariesMgmtProgram-11_16_2009.docx) and discussed, outlining some of the guiding concepts that have been established by the group to date (this document will also be distributed and posted on CTools). The goal was to present some of these ideas for consideration by the Clinic Implementation Team and discuss potential next steps. Tilly Peters and Margherita Fontana reviewed and discussed the content of the handout point by point. The importance of creating a process that would be continuous and sustainable over the entire 4 year span of the DDS curriculum and beyond was emphasized.

Phil Richards also briefly described the “health behavior change” exercise that had been developed and applied during the past 2-3 years in perio (which may include a “motivational interviewing” approach to addressing cariogenic behaviors for affected patients, or alternatively to address plaque control behaviors or smoking cessation goals). He also emphasized the fact that, universally for dental students, “assessment drives performance.”

With this in mind, it was also expressed that “students should drive the system” (rather than faculty) when it comes to implementing a caries risk assessment and management protocol for the clinics. The concept of using either a requirement or a reward to motivate students was discussed…perhaps including the idea of withholding credit for any caries management intervention until a recall visit following the intervention itself.

The creation of a form for caries risk assessment, either on paper and/or among the data collected within Axium/MiDent was discussed as the basis for developing a management strategy. Obviously, the more integrated (the less “separate” and redundant) that the caries-risk-related data that are collected can be with other aspects of the patient record, the better. Along these same lines, the prospects of and potential for creating a single risk assessment/management
protocol that would be usable and shared by both dental hygiene students and dental students was also discussed. The potential benefits of blending all elements of an oral disease risk assessment process together (not diluting the importance of caries management nor considering it to be isolated and separate, but rather including all oral disease risk elements into an integrated whole) was discussed. The current disease risk assessment protocol that is used by dental hygiene is quite broad in scope, including both caries risk elements as well as risk assessments for other oral diseases. Unfortunately, Axium does not easily facilitate adding custom elements into existing electronic forms. Also, the Axium “treatment planning module” does not lend itself to effectively linking disease risk to planned interventions.

The goal would be to introduce the concepts of disease risk assessment and management to D1 students during the Fall term. This time slot could capitalize on the enthusiasm that these students bring with them and also possibly enable them to participate more meaningfully in patient care interactions during this time period. Following such an early introduction, maintaining consistent student involvement in risk assessment/management activities throughout the entire span of the DDS curriculum will also be an important goal.

The issue of students’ learning to use the knowledge base and enhancing their capacities to assess the strength and value of scientific evidence in making clinical decisions was raised. Determining where, when and by whom these skills are currently taught, assessed and reinforced is fraught with difficulty. These skills are among those that may be difficult to highlight and reinforce in the clinical environment; during active patient care the rapid pace of the activity does not routinely allow for deep and meaningful discussion of the literature. Similarly, having a free-standing, separate course on “assessing scientific literature” is also felt to be an ineffective option, as continuous application of such skills would not be fostered by such an approach. Effectively applying scientific knowledge to clinical decision making may be a skill set that could effectively be applied and reinforced via the use of case-based discussions and grand rounds activities, if the culture of such teaching activities is designed to emphasize it.

Patient information relating to disease risk that is currently collected (on the pink medical/dental history and the blue clinical exam form) were briefly reviewed. These forms do not serve to make such information readily accessible or actionable toward meeting the goals of achieving optimal patient education or guiding therapeutic behavioral enhancements. The next step in the process of collecting risk information is anticipated to be the development of a paper form that would not be strongly redundant with other information that is gathered, but rather serve to isolate and record more specific features/factors that would facilitate formulation of evidence based treatment plans. It was felt that such a form should be maintained in the patient’s dental record (in contrast to the current approach that is used in dental hygiene where the form is kept separately).

A working goal to move the process forward would be to create such a form and a system of assessment that could 1) apply to all major oral diseases (not just caries or periodontal risk behaviors/concerns) and 2) be usable by the students/curricula of both dental hygiene and dentistry. This will require the thoughtful consideration and active participation of many stakeholders (DH, DDS programs, multiple departments, including oral path, pedo) in order to establish and agree upon what can/should be included and in what format.
Clinic Implementation Team
Meeting Notes, 11-24-09, 9-10:30 a.m., room 1397

Members present: Mark Fitzgerald, Mary Garrelts, Laurie McCauley, Phil Richards

Consultant: Steve Stefanac

Phil Richards described some of the preparations that are underway for the faculty retreat that is scheduled for December 18. The overall concept for the retreat will be to provide the faculty with some significant background information concerning the broad philosophical underpinnings of the developing curricular initiatives such that they may be considered for approval by faculty vote in January of 2010. If approved IN CONCEPT by the faculty, it is anticipated that work by course directors and others on the SPECIFICS of curricular change can then proceed IN EARNEST. Planning for the retreat includes the creation of written Team summaries for all of the working groups detailing their goals, activities, recommendations and anticipated challenges. These summaries will be provided to all faculty prior to the retreat to supplement the presentations and discussions during the event. The regularly scheduled CIT meeting for December 1 will not take place in order for Phil Richards to use this time to work on the CIT summary document.

Pre-treatment huddles
The remaining discussion during the meeting dealt with the potential implementation of pre-treatment huddles during the Winter, 2010 term. Steve Stefanac described the initial responses that he received from student leaders when he described this concept to them during a recent clinic issues meeting. The students were enthused by the idea that faculty could/would routinely arrive to clinic on-time, as this has not always represented the prevailing norm. The curious fact that faculty seldom arrive late for lectures but more commonly arrive late for clinic was discussed – clearly creating a “new reality” concerning the importance of punctuality would require a change in behavior for some clinical faculty. The need for some students to alter their prevailing behaviors was also discussed. Pre-thinking and pre-planning patient care activities, enhancing clinic schedule entry notes and specifically registering some types of clinic activities (e.g. test cases) into the system ahead of time will potentially be more demanding for some students. However, everyone in attendance felt that this was a valid goal to strive for.

Even though the initial incarnation of a clinical huddle may not include all of the potentially valuable elements that may be desired for the future (e.g. once patient care teams are fully implemented), it was felt that starting “small and basic,” and sooner rather than later, in order to learn and adapt from such experiences would be desirable to inform future enhancements. In the big picture, if students are even A LITTLE better prepared for clinic and faculty are even A LITTLE better informed, this could provide significant benefit to the ongoing daily operations of the clinics. There was some preliminary discussion of the potential value of creating a “sign-in” process for the huddles as well as some type of daily “report” from the huddles, but no conclusions were reached regarding these elements.

The initial concept that was agreed upon during the meeting for initial implementation was that there should be 3 huddles for each clinic session in each clinic:
- one for students planning to work primarily with restorative faculty (with both/all assigned CRSE instructors involved)
- one for students planning to work primarily with prosthodontic faculty (with both/all assigned Proth instructors involved)
- one for students planning to work primarily with perio faculty (with the assigned Perio instructor for each respective clinic, in order that a floater faculty member may also brought up to speed for both)

There was some discussion of how “multi-disciplinary” clinical procedures might fit in to the huddle concept. If a student is anticipating doing both a treatment plan and a prophy during a given clinic session, what discipline should supervise them and what huddle should they go to? It was generally felt that most INITIAL treatment plans would be supervised by restorative faculty members (as they most frequently are now) but many UPDATE treatment plans may be most effectively and comfortably handled primarily by perio (in combination with a recall prophy or periodontal maintenance procedure). Specifying, and in some cases broadening the scope of expected activities for faculty within certain disciplines may ultimately help to both enhance the “general dentistry” ideals we strive for while also helping to identify those faculty members whose skill sets or comfort zones may benefit from enhancement.

It was strongly felt that this pre-treatment huddle initiative must be embraced and promoted by the VIC directors in order for it to effectively move forward. A preliminary time line would be to discuss this with the discipline coordinators and VIC directors at the regularly scheduled Clinic Program Group meeting on Wednesday, December 2. Following this, the DICSIPLE COORDINATORS could then be responsible to provide the clinical FACULTY with the necessary background information and the CLINIC DIRECTORS could be responsible to provide the STUDENTS with the necessary background information (during the 2 remaining Comp Care Seminars this term) in order that this activity could be launched in January, 2010.

The dissemination of information about this initiative will be very important to success and probably will need to include multiple methods (meetings/discussions, e-mail reminders, etc.). The primary “public relations” concept that must be continuously emphasized is that this activity is intended to BETTER MEET THE NEEDS of students, faculty and patients. It was felt that the specifics regarding the mechanics of the huddles could be kept to a minimum initially; the goals and processes of the huddles themselves should be kept brief, crisp, direct and specific.

The resulting proposal that was agreed upon during the meeting for distribution to and consideration of the VIC directors prior to the planned meeting on December 2 was as follows:

**Pre-treatment huddle**

In an effort to better serve the needs of students, faculty and patients and improve efficiency, organization and quality patient care there will be a pre-treatment huddle at the beginning of each clinic session starting in January of 2010.

The huddle will take place from 9:00 a.m. to 9:10 a.m. and from 2:00 p.m. to 2:10 p.m.
Prior to and to facilitate the huddle:
- Faculty and students must arrive to clinic on-time
- Students must identify the primary discipline with whom they plan to work and enter it into MiDent

Each of the major dental disciplines (restorative, perio and prosth) will have a separate huddle meeting in each clinic and these meetings will take place consistently in the following locations:
- Perio – in the corner of the clinic near the perio sign-up list
- Restorative – in the window corner nearest to the PCC’s office
- Prosth – in the corner of the clinic that is furthest from the dispensing desk

During the huddle, a discussion, led by the faculty member, will take place regarding:
- planned test cases
- any urgent, time sensitive or other special patient care concerns
- anticipated patient care that is planned for the clinic session
- assigning students without patients to assist
  - D1 and/or D2 students
  - D3/D4s with broken appointments

Patients cannot be brought into the clinic until after faculty staffing has commenced and the huddle has concluded. If a student misses the huddle for any reason, they must report in to the faculty member(s) for their chosen discipline immediately when they arrive.
Clinic Implementation Team
Meeting Notes, 12-8-09, 9-10:30 a.m., room 1397

Members present: Mark Fitzgerald, Margherita Fontana, Mary Garrelts, Anne Gwozdek, Preetha Kanjirath, Laurie McCauley, Phil Richards

Guest: Pilar Hita-Iglesias

Oral Surgery in general dentistry clinics
Pilar Hita-Iglesias joined the committee to discuss the patient care guidelines, specifically as they pertain to the idea of providing simple tooth extraction services in the future general dentistry clinics. Phil Richards briefly reviewed the origins and goals of the guidelines document itself. Pilar Hita-Iglesias initially expressed to the group that, upon thoughtful consideration, Oral Surgery had decided that they as a department were not comfortable with the idea of any significant number of extractions performed by predoctoral students occurring outside their clinic. She specifically cited: 1) the difficulties that may be encountered with regard to the management of emergencies that may be related to surgical procedures, 2) the current lack of the surgical instrumentation and equipment for surgical procedures, 3) the potential for intraoperative and postoperative complications to occur with such surgical procedures in significant numbers and 4) the limited expertise in and awareness of established educational policies and procedures for oral surgery procedures among the general dentistry faculty.

Open discussion followed. The fact that dental students routinely provide surgical treatment to patients during their outreach rotations, supervised primarily by general dentists, was raised. The need for both students and faculty to develop and routinely apply appropriate decision making skills to determine which patient care procedures are appropriate to be managed within a general dentistry environment versus those that should be managed by specialists (rather than simply “referring everything”) was discussed. The overriding, simultaneous goals of providing dental students with quality educational and patient care experiences while also providing patients with timely, quality treatment were emphasized. Developing and applying valid metrics to judge successful achievement of such goals (particularly to assess the benefits of any new clinical education initiative) is certainly challenging. The fact that patient treatment plans are sometimes delayed due to limited availability of appointment slots in the Oral Surgery clinic was discussed. Dr. Hita-Iglesias stated that a key limitation to undertaking a greater volume of surgical activity in the Oral Surgery clinic is the lack of consistent availability of sufficient numbers of faculty members. The need and plan to implement a vastly expanded faculty in-service training program was described to Dr. Hita-Iglesias…specifically as it may relate to the general dentistry clinics and faculty members.

Following the discussion, Dr. Hita-Iglesias was asked to assist in creating even more specific patient care guidelines that would potentially allow her department to become more comfortable with the idea that simple extractions may be successfully undertaken outside the Oral Surgery clinic. Leaving the meeting at about 9:45 a.m., she expressed that she would consider this issue and would be willing to meet with the CIT again in the future to further explore this aspect of the future clinic design.
Planning for the December retreat
Phil Richards advised the group about the activities planned for the upcoming faculty retreat regarding the Vision Implementation process. The goal will be to encourage open discussion among all faculty members in preparation for a planned faculty vote to approve the broad concepts of the new curriculum model in January.

Pre-treatment huddle proposal
Phil Richards advised the group that he proposed the pre-treatment huddle concept to the VIC directors at the December combined meeting with the discipline coordinators. The proposal was NOT endorsed by the VIC directors for implementation in January 2010. The reasons that were cited included: 1) the delayed start of patient care that this process would create, 2) the fact that existing student and faculty behavior patterns would not be supportive of early success, and 3) the huddle was not perceived to offer any distinct advantages to VIC directors or faculty members.
Clinic Implementation Team
Meeting Notes, 1-19-10, 9-10:30 a.m., room 2397

Members present: Mark Fitzgerald, Margherita Fontana, Mary Garrelts, Anne Gwozdek, Preetha Kanjirath, Phil Richards, Marianella Sierraalta

Consultant: Steve Stefanac

Student schedules for clinic
It appears that the goal of scheduling students into the existing VIC clinics using group/team priorities and designations may not be attainable for the coming year. Phil Richards will try to approach Roger Gillie and Georgia Kasko to explore any remaining possibilities. The Exan users meeting will take place in late January and Roger Gillie will be gone for much of the month of February.

Third floor orange clinic renovation and D1, D2 clinic activities
The goal of re-equipping the third floor orange clinic to enhance the functionality of this space appears to be inching closer to reality. An optimal timeline would include installation of new dental units and chairs by this coming June with the addition of chairside computer access by the end of August. The potential advantages of planning for the majority of all D1 and D2 patient care activity to take place in this clinic was discussed. However, because such a large proportion of the D2 patient care opportunities in the VIC clinics currently result from D2s taking over D3 and D4 patients “on the fly,” patient referrals or assignments to students who will be working in 3 Orange will demand a much greater degree of pre-planned functionality.

The potential advantages of “pooling” patient referrals rather than focusing on facilitating referrals specifically to “team members” was discussed. If chair locations and treatment times in 3 Orange can be designated ahead of time for specific D2 activities, the potential for directly scheduling patient appointments there (as the referral is being made) would be enhanced.

Related to scheduling, the potential advantages of changing D2 clinic days from Mondays/Wednesdays to Mondays/Fridays were cited once again. Also related to the topic of clinic space and chair utilization, the “check up clinic” activities are now anticipated to be moved into the VIC clinics, beginning this Summer.

Attainable goals for clinic curriculum enhancement
Phil Richards reviewed the specific elements of the original charge to the CIT:
  - Patient families managed by student teams directed by Team Leaders
    - Suggested edit during the meeting: “Patient families managed by students in teams directed by Team Leaders”
  - Discipline-specific competencies achieved in specialty teams
  - Referrals back to specialty teams for advanced care based on discretion of generalist team leader following guidelines set by disciplines
  - Centrally managed scheduling and appointing of operatories
  - Strengthen linkages with other health care providers
  - Maintain basic science and medicine concepts throughout clinical care
He also expressed his concerns regarding the challenges/barriers that he perceives regarding the potential for eventual success in implementing many of the new initiatives that have been discussed and generally advocated by the CIT during the past year. Can the 3 +1 concept truly be implemented? Are there other alternatives, such as optimally capitalizing on the 3 Orange clinic space, that could fulfill many of the clinical education goals that are being sought but would not require the huge upheaval that 3 + 1 would bring?

Phil Richards also confessed some strategic errors along the way that have perhaps detracted from the potential for future success – most notably, failure to sufficiently involve current clinical leaders and other stakeholders in the process. As a result, many of these individuals may now be defensive and resistant based on the fact that they were not involved or consulted to the degree that they may have wished. The VIC directors’ reaction to the “huddle” proposal in December may represent a key example. If such a limited, low-stakes initiative is not at least considered for a trial run, what chances of success are more sweeping changes likely to face?

Despite the emphasis on educational innovation in the models that have been described to date, the overriding importance of realizing greater levels of financial efficiency in any future clinic design may also require greater attention. Focusing more on economic realities as potential driving forces for change may now represent a lost opportunity. Marianella Sierraalta expressed that she would anticipate much greater clinical instruction efficiencies with the 3 +1 concept. However, the patient/chair scheduling limitations that could emerge with such a system may limit student opportunities.

Phil Richards reflected on the consistently competing goals of:

- Maintaining student/patient/procedure scheduling flexibility, while
- Achieving and maintaining the appropriate level/type of faculty support

In preparation for the next CIT meeting, all members were urged to consider the 6 elements of the original charge to the CIT and contemplate new or revised wording that could preserve as much of the original intent as possible while also focusing on what is most likely to be attainable. He will then plan to share the perspectives and suggestions that bubble up with the Vision Implementation Team in the near future.
Clinic Implementation Team
Meeting Notes, 1-26-10, 9-10:30 a.m., room 2397

Members present: Mark Fitzgerald, Margherita Fontana, Mary Garrelts, Anne Gwozdek, Laurie McCauley, Phil Richards, Nikki Sweier

Consultant: Steve Stefanac

Discussion of the over arching questions:

“what can we accomplish now”
versus
“what can we accomplish EVER?”

The challenge of physically and functionally incorporating 1/3 more student home base assignments into each of the planned future general dentistry clinics (required by the “3 + 1” design) would be very difficult to achieve. With the progress toward making the 3 Orange clinic an accessible and usable space in the near future, some of the anticipated benefits of the 3 + 1 clinic design may be achievable by maintaining 4 fully functional interdisciplinary dentistry clinics and using the 3 Orange clinic for special clinical teaching (“4 + 1” so to speak).

A primary purpose of the 3 Orange environment in such a design would be for initial clinical experiences and achievement of some initial competencies for students at the D1 and D2 levels. Potentially, restorative dentistry, prosthodontics and periodontics could all utilize this clinic space for such early clinical teaching. It is then likely that the more advanced treatment opportunities in the disciplines, perhaps limited to “selective” or “pre-specialization” students, would then take place in the various graduate clinics.

Considering this, it is still important that overall faculty/staffing demands not be greater than current levels; more ideally, clinical faculty numbers should be reduced. This could potentially be achieved by applying stricter controls over the types and numbers of clinical activities that can take place in the various clinics at any given time. This would require students to plan and schedule their clinical activities much more specifically than they currently do. An other potential benefit from more specific student planning of clinical activities would be to facilitate direct pre-ordering of the instruments and materials automatically through MiDent.

It is NOW NECESSARY to control the huge daily variations in clinical busyness for particular disciplines and faculty. Related to this, efforts should be undertaken right away to try to alleviate the oppressively high levels of clinical activities that are consistently seen on Wednesdays. Mark Fitzgerald and Phil Richards agreed that the curriculum committee should be approached to investigate the potential for switching the D1 and D2 curricula for Wednesdays with those of Fridays starting this Fall.

A large segment of the meeting was then devoted to consideration and discussion of the 6 elements of the original charge for the Clinic Implementation Team:
1. **Patient families managed by students in teams directed by Team Leaders**
   - There must be a primary, responsible student assigned to each patient
   - Would/could dental students assume a team leadership role? Can this be rolled into the current “management” assessment? What is the role of faculty?
   - This year’s pilot for team activities is a good first step
   - Team-based activities for incoming D1s will need to be developed on a limited basis from the beginning and then grown and refined incrementally
   - Develop a “social network” type of structure
   - Must be designed to work across and between courses

2. **Discipline-specific competencies achieved in specialty teams**
   - Is the 3 + 1 model the best way to structure discipline-specific instruction?
   - 4 + 3O (specifically for early learners) may provide much of the benefit with much less of the potential challenge

3. **Referrals back to specialty teams for advanced care based on discretion of generalist team leader following guidelines set by disciplines**
   - Could more advanced care opportunities be made available within selective course offerings?
   - The graduate clinics themselves are very restricted in terms of available space as well as economically

4. **Centrally managed scheduling and appointing of operatories**
   - Staff intensive, costly to adapt current mechanisms to accomplish this
   - Focus on accomplishing this for D1 and D2 programs in particular?
   - Must be approached incrementally

5. **Strengthen linkages with other health care providers**
   - Will this be initiated outside of our team?
   - Is the outreach environment the best way to initially promote and implement this?
   - Lower priority for our team at this time
   - Potential for pilots that would be supplemental add-ons to our existing programs

6. **Maintain basic science and medicine concepts throughout clinical care**
   - Promote opportunities for this via in-service training and behavioral faculty guidance
   - The scope of this WITHIN THE CLINICS THEMSELVES will likely be limited despite our best efforts in this regard…
   - Promote linkages with other elements of the curriculum in order to introduce formal activities elsewhere to accomplish this
   - Create a TREATMENT PLANNING structure that promotes or demands more of this
   - Electronic portfolios as a tool to encourage this
Clinic Implementation Team
Meeting Notes, 2-2-10, 9-10:30 a.m., room 2397

Members present: Mark Fitzgerald, Margherita Fontana, Mary Garrelts, Anne Gwozdek, Preetha Kanjirath, Laurie McCauley, Phil Richards, Marianella Sierraalta, Nikki Sweier

Consultant: Steve Stefanac

This meeting consisted of discussion concerning the potential benefits and challenges of various clinical instruction models.

1. The significant logistical difficulties involved with creating a functional “3 + 1” clinic model anytime in the near future were reviewed. Issues as basic as the locations and numbers of available clinic mailboxes in students’ “home clinics” may appear trivial to some, but certainly cannot be ignored. Also, the challenge of creating a robust in-service training program that will truly allow all faculty members to become comfortable and competent in managing the scope of instruction that the “Patient Care Guidelines” document would likely allow could be very challenging to implement quickly.

2. Another strategy would be to maintain 4 generalist clinics (much like the current model) supplemented by use of the 3 Orange clinic as a more focused, controlled instructional environment designated for early clinical learners. Unfortunately, such a plan would not satisfy many of the initial goals for discipline-based instruction that were part of the original charge for the CIT. As a feature of any plan worth pursuing, the creation and enforcement of guidelines/restrictions regarding the number of clinic chairs that can be scheduled/taught per discipline within the 4 main clinics would certainly need to be implemented in order to try to control the huge variations in demand for certain faculty that currently exist.

3. A third strategy that was mentioned could be to maintain current instructional models in the 4 main clinics and utilize the 3 Orange clinic primarily to create an environment for discipline-focused instruction for ONE particular discipline (e.g. prosthodontics OR periodontics) as a transitional test bed process to allow us to gain experience and insight concerning potential plusses and minuses. Such an initiative could inform and potentially guide efforts to create more inclusive discipline-focused models for the future. The limited number of chairs in the 3 Orange clinic and the potential need for other existing programs to continue to use this clinic space concurrently with this new function were cited as potential limitations for this strategy. Also, the 3 Orange clinic has also been identified as potentially the only appropriate space for development of a clinical oral diagnosis/pathology environment for both predoctoral and postdoctoral students as well as potential specialty consultations.

Despite the enormous day-to-day variations in busyness that exist in the clinics, there are also some clear historical trends that span the clinic year that were reviewed, specifically as they relate to the disciplines of periodontics and prosthodontics:
While such patient-population-needs-driven trends through the year are unlikely to change or to ever be controllable, we need to try to develop a clinical education structure that may allow departments to plan for, control and ultimately manage faculty resources more effectively than they currently can.

There was also discussion about the number of half days per week that are traditionally assigned to D4 students versus D3 students. Is 3 full days in clinic per week on average for D4s and 2 full days in clinic per week on average for D3s still the most appropriate distribution? How might the potential for increases in the amount of time dedicated to outreach activities in the future influence this?

The challenge that we have as an institution to provide timely and appropriate patient assignments to individual students in order to meet their learning needs must also be considered. The implications of limited patient availability as it relates to our current “test case driven” student assessment systems may need to be considered. Would heavier reliance on portfolio assessment strategies perhaps enhance our capacity to appropriately guide and track student progress? Could more team-based initiatives potentially reduce some of the undesirable patient squandering and/or patient hoarding trends that we perceive?

A hybrid model based on option #2 described earlier was discussed. The early learners would be taught primarily in the 3 Orange clinic during D1 and potentially much of D2 year. Once students have established and demonstrated a set of essential skills there, they could then be assigned their own patient family and begin to treat patients in the main clinics on their assigned floor.

Rather than students having a specific chair assigned to them for their scheduled clinic sessions, they would need to submit appointment requests for ALL patient appointments containing sufficient information to allow them to be placed into a “virtual chair” area in a clinic on their
floor (a “reserved parking” space, subsequently to be given a more specific location based on the specific type of treatment that is planned for that session).

Each floor would have specific areas designated for instruction in prosthodontics and in periodontics (and possibly in endodontics?). The treatment area designated for prosthodontic instruction for all students on a floor would be located in one of the main clinics on that floor (e.g. 2 blue). The periodontics treatment area for the floor would be located in the other main clinic on that floor (e.g. 2 green). Equivalent discipline designated treatment areas would be located on both the 2nd and 3rd floors.

The graphic below could represent 1 floor…the blue shaded area on the left could hypothetically be designated for prosthodontic instruction, the red shaded area on the right could hypothetically be designated for periodontal instruction and the green shaded areas could be where most diagnosis, treatment planning, restorative and other general dental care would be done. The prosthodontic and periodontal faculty members assigned to the discipline designated areas would also provide consultations anywhere else on the particular floor where they are teaching.

Endodontics is not specifically represented in this particular example...designated chairs for endo could be established: 1) all on one floor as they currently are (better for staffing efficiency), 2) on both floors (better for student/patient proximity/access) or 3) somewhere else (e.g. in 3 Orange?).

Each discipline-specific area could include a limited number of chairs designated for advanced procedures or for demonstration activities by experienced clinicians (accommodated in the schedule using “valet parking” space holders). The discipline-specific areas could be expanded or contracted, based on available staffing as well as demonstrated demand for chair space.

Support staff would be required to manage all final chair assignments. Based on the designated discipline chair areas having the potential to expand and contract to serve the instructional needs of all students on the entire floor, on any given day, a student may need to be assigned to a cubicle in the “other” clinic on their floor (not in their “home” clinic).
Potential challenges regarding cubicle scheduling were discussed…apparently the ability to schedule chairs and make appointments must currently be linked to providers who can bill for procedures. Some new type of appointment scheduling system may be required in order to facilitate expansion and contraction of designated clinical spaces. Georgia Kasko will be invited to a future meeting in order that we may utilize her significant expertise and perspective to guide and inform our further discussion and consideration of this concept.
Clinic Implementation Team
Meeting Notes, 2-9-10, 9-10:30 a.m., room 2397

Members present: Mark Fitzgerald, Margherita Fontana, Mary Garrelts, Anne Gwozdek, Laurie McCauley, Phil Richards, Nikki Sweier

Consultant: Steve Stefanac

Guest: Georgia Kasko

The team welcomed Georgia Kasko to share her perspectives on how student schedules and cubicle assignments may interact if the clinical teaching strategy discussed last week were to be implemented. The support staff requirements to backfill the different clinic areas effectively (and often in real time or at least at the very last minute) were not perceived as being insurmountable. The issue of cubicle maintenance and materials stocking, traditionally the responsibility of the “assigned” students, would need to be addressed, but also could likely be dealt with in some creative way; rather than students “owning” a cubicle, perhaps they could have rights and responsibilities more akin to those of a “time share” participant.

The traditional practice of allowing D4 students to have clinic access an equivalent of 6 half days per week and allowing D3 students to have clinic access an equivalent of 4 half days per week when they are not otherwise assigned elsewhere was raised. Is this the appropriate mix? Considering the common reality that interested students currently seek clinic over-rides relatively freely and at will – based on patient availability and needs as well as students’ own personal ambitions, should we even limit students’ official clinic schedules this way at all? What if all D3 and D4 students (at least for now) who are not assigned to an official rotation were simply listed as “open” on their official schedules with regard to clinic? Would this create chaos?

The preliminary feeling was that this could potentially work, and may actually allow for a more balanced distribution of activity in the clinics overall. In essence, “open clinic” could be considered as the default on students’ schedules in the absence of any other scheduled rotation or activity. While “open” availability the clinic would allow students a hypothetically greater level of access to limited clinic space than they have ever had before, they would still need to submit an appointment request (including enough specific information to allow their clinic access needs to be properly handled by support staff) in order to be considered for placement into an actual clinic chair. Mary Garrelts was asked to seek input from the entire PCCs group regarding any concerns that they may perceive or insights that they may be able to offer regarding this “open” scheduling strategy and report back as feedback becomes available.

Using “assigned half days” as a measure of students’ ability to access the clinic in order to determine their CEU productivity per available clinic session as a basis for determining the quantity portion of their overall clinic grade would certainly need to be looked at differently if access to the clinic became more “open.” It is likely that the number of rotation weeks per term would still need to be factored in as a modifier for doing such calculations, but it was felt that traditional numerical norms could be used as a basis for judging patient care productivity by
individual students and that grading algorithms would probably not need to be changed all that much.

Would the reorganization of the clinic into defined regions as was discussed last week actually lead to more efficiency and/or reduce the number of faculty required to staff the clinics? Hypothetically, if 12 chairs per floor (maximum) were to be designated specifically to periodontal instruction, it is estimated that 2 perio faculty per floor (maximum) would be needed to staff these areas. This could represent a savings of 2 perio faculty overall (both floors)…although additional instructors would certainly be needed to instruct early learners in the 3 Orange clinic during certain half days (when D1 and D2 students are scheduled to be there). Similar to the perio example, if 12 chairs per floor (maximum) were to be designated specifically to prosthodontic instruction, it was proposed that only 2 prosth faculty per floor may be needed to staff these areas. This could represent a savings of up to 4 prosth faculty overall (both floors). The faculty needs for general dentistry instruction could be 2, but may require 3 per clinic each half day – depending on likely variations in clinic demand. This would not represent any significant savings from current staffing levels…in fact it may require more instructors. Could/would some of the faculty employed by the BMS/prosth department who have traditionally focused on prosthodontic instruction be re-tasked as members of the general dentistry faculty? Such discussions may need to occur at the department chair level.

Further discussion involved the impact of these potential changes on the dental hygiene program and on endodontic instruction. In essence, the dental hygiene students are already functioning successfully in an appointment request or “parking lot” cubicle assignment system, so these changes would not be expected to impact their program significantly. With regard to endo chairs, it would clearly be more effective for the endo group in terms of staffing to keep predoctoral endo activity all on one floor – and all in one clinic if possible. The 3 orange environment could represent a possibility for this, but it is doubtful that the available space there would be sufficient for ongoing endo activities along with the other educational programs that are likely to be planned for this area.

As future D1 and D2 students may be allowed to progress at an accelerated pace in the future, the appropriate timing of “patient family” assignment for students was discussed. Would it be possible/beneficial for D2 students to have patient families assigned to them earlier? The huge crunch of treatment planning activity that has traditionally been seen during the Summer as patient families are assigned to all D3s en-mass has clearly created a lack of capacity for assigned faculty to effectively attend to this demand (along with other clinical patient treatment activities) during these times. This discussion raised another question: what is the relative distribution of actual activities and procedures within the different disciplines month-by-month and class-by-class? Georgia Kasko offered to try to crunch some numbers for us to look at for next week’s meeting…she offered to join us once again.

Considering the closer linkage to upper class students through their team activities that future D2 students may have, could much of the potentially re-treatment planning of patients that we currently undertake during the Summer be reduced or eliminated completely? Related to this, a suggestion was made that students can and should develop significant awareness and likely discern and at least tentatively plan a large proportion of patient care needs for patients –
particularly previously treated patients – by conducting a thorough and structured RECORD REVIEW before even examining the patient. In fact, it was strongly felt that such a process should actually be required before even requesting a first clinic appointment – not just for the occasional patient (as an exemplary learning exercise) but for every initial patient assignment! Such an activity may also have relevance and widespread benefits for supporting other potential curricular initiatives that could be contemplated to guide students in developing greater confidence in the areas of preventive dentistry and general treatment planning approaches.

The potential for moving D2 clinic activities from the current Mondays and Wednesdays arrangement to Mondays and Fridays was brought up near the end of the meeting. How might this impact the curriculum beyond the clinical foundation program and the Comp Care clinics? Does this impact the pedo rotation? What about the D2 oral path didactic course? Could prostho still run their existing Friday morning preclinic courses on a Wednesday? Phil Richards will try to get as many eyes on this idea as possible in order to try to make sure that it can actually work before any formal proposal is brought to the Curriculum committee.
Clinic Implementation Team
Meeting Notes, 2-16-10, 9-10:00 a.m., room 2397

Members present: Mary Garrelts, Preetha Kanjirath, Phil Richards

Guest: Georgia Kasko

The meeting began with further discussion of and reflection on the revised clinic design that was discussed at the last meeting. Georgia Kasko reported that Minna Katsabassi from dental computing (who has perhaps the most significant role in creating the students’ clinic schedules) had been consulted regarding the scheduling implications of the changes that have been proposed for implementation in Summer, 2010 and feels that such plans are definitely “doable.” Mary Garrelts also reported that the VIC directors are likely to react positively to the proposed changes, based on some initial, preliminary discussions.

Despite the lack of any planned physical proximity for students who are members of the same group/team during routine patient care activities, there will still need to be a focus/emphasis on coordinated team activities, particularly to support patient care opportunities for the early learners. Because D1 and D2 patient care activities are anticipated to take place primarily in the 3 Orange clinic, sufficient numbers of patients with suitable needs will need to be identified and appropriately referred to this area. These referrals and any additional treatment that these patients may require will need to be coordinated and managed in a systematic and patient friendly manner.

The significant value of D4 students serving as mentors to D2 students was discussed…particularly in regard to specific activities such as treatment planning which already take place in the 3 Orange clinic. Currently, students are scheduled to serve as clinical mentors for 3 to 5 half days during their D4 year. Would it be useful to have students do this more? Should D3 students also be exposed to this activity? Any decisions to make changes in this regard would need to be made soon, as the D4 schedules will need to be finalized by early April.

Some discussion took place regarding the high frequency of inappropriate patient referrals to hygiene and D2 students that have recently been encountered. It was proposed that whenever students seek a faculty approval swipe for a patient referral, the patient record should be available for faculty inspection. While this may seem like a minor issue, the prevailing culture may make such a change difficult to implement. Students will need to be told about such a policy in a formal and systematic way (likely during orientation). If such a policy change is to have the desired effect, faculty will also need to require that it be adhered to 100% of the time; this will require a formal faculty education process as well as regular reinforcement.

It is anticipated that D2 students may have the potential to be more active in patient care than has previously been the case, so appropriate coordination of early patient assignments/drop downs may need to be handled differently in the future. The topic of always updating treatment plans for patients when they are assigned to new student providers was briefly discussed. Mary Garrelts felt that the value of requiring the assigned student to be responsible for an entire treatment plan (based on completion of their own blue form), particularly when case completions
are sought, may still be significant. While record reviews in addition to or in lieu of entirely new treatment plans may hold some value, a new requirement for pre-treatment record reviews may be difficult to define (who would be responsible for reviewing them?) and could also be very time consuming for clinical faculty.

The student group that will be impacted the most by the revised clinic design that is being contemplated will be the current D3s who will become D4s this year. It will be important to introduce these students to the proposed changes strategically and systematically, with an emphasis on the new approach/philosophy that it represents. Georgia Kasko has observed that the student clinic representatives have been a very active, responsible and thoughtful group, particularly this year. She has been particularly impressed by the current D2 members. The clinic issues meetings are held on the second Wednesday of each month at 7:15 a.m. – this may be a good environment to seek reactions and feedback from students regarding the proposed changes. Also, MiDent training for students will be planned in conjunction with their return to clinic in June. This may represent an excellent opportunity to launch new procedures such as linking appointment requests with specific procedure codes to facilitate automatic dispensing of the instruments that are appropriate for the work that is planned.

A brief discussion of when/how students will first be participating in active patient care was initiated. One of the initial goals of the Vision Implementation was to accelerate and expand D1 patient care experiences. While the initial D1 perio instruction and clinical experiences may be able to take place sometime during the D1 year (in the form of “rotations”) rather than as an entire class as they currently are during the month of May, the logistics of implementing such a rotation (during the Fall term? the Winter term? both terms?) have yet to be explored.

Preetha Kanjirath reported that she will be involved with coordinating the D1 Summer initial clinical experiences. She will be meeting with Drs. Lantz and Stefanac on Thursday, 2/18 to coordinate the activities and schedules that will surround this course.
Clinic Implementation Team  
Meeting Notes, 3-9-10, 9-10:30 a.m., room 2397

Members present: Mark Fitzgerald, Margherita Fontana, Anne Gwozdek, Preetha Kanjirath, Phil Richards, Marianella Sierraalta, Nikki Sweier

Consultant: Steve Stefanac

Recent and planned activities
The VIC directors were recently informed of the clinic revisions proposed for this Summer. While there were some discussions concerning the proposed staffing ratios and potential issues regarding the composition of the general dentistry faculty, no significant immediate concerns were raised. There are also plans to introduce the proposed clinic revisions to the student clinic representatives and the school of dentistry faculty at meetings scheduled for this Wednesday…hopefully additional feedback will be forthcoming following these meetings.

In-service training
A brief discussion was initiated regarding the goals and plans for clinical faculty in-service training (specifically short-term). The discussion focused primarily on those elements that will be directed toward the general dentistry faculty, as this is likely the group that may be asked to adapt the most in the early process of implementing the proposed clinic revisions.

Three primary focus areas were proposed for the initial in-service training efforts:
1. Perio – prophylaxis and perio maintenance
2. Prosthodontics – removable partial denture design
3. Treatment planning – in general and specifically related to the MiDent module

Some brief reference to previous CIT discussions of in-service training was made…it was generally agreed that face-to-face, interactive training strategies (probably in group sessions) should be the initial focus of these new efforts. While reference materials should also be created for online access and use by clinical faculty, such strategies alone will clearly not be effective or sufficient to satisfy our current and emerging in-service training needs.

It was felt that the Patient Care Guidelines could potentially play a significant role in shaping the content and direction of the in-service training plans and that the expectations and intended clinical processes and outcomes should be very clear for all faculty members.

Treatment planning
A substantial segment of the meeting pertained to the implementation of the MiDent treatment planning module this Summer. While significant efforts are already underway to plan in-service training for faculty regarding the data collection process, the chairside protocols and the MiDent computer interface that will be used, a strong focus on the intended clinical education goals and philosophy will also be needed. Clearly, risk assessment and risk management must become a more integral part of the treatment planning process.
There was some discussion regarding the sequence and timing of clinical data GATHERING and RECORDING, data ENTRY into the system and ultimately, faculty APPROVAL of treatment plans. Because of the need to assure that the electronic record, specifically the treatment plan itself, is complete and correct when digitally signed, the plan is that students will also present data to faculty members on printed forms, at least initially. Whether or not the data collection, entry and digital signing will require more clinic time than we are accustomed to when using the new electronic protocol is uncertain. The implications of this new process on patient flow for common types of clinical scenarios were discussed. The common practice of students completing a “simple” treatment plan and subsequently completing a prophylaxis during the same visit was discussed. Will this still be possible with the new electronic protocol?

Based on the need for perhaps an even greater degree of accuracy and completeness than we are used to regarding the clinical findings that are entered into the electronic health record, it was felt that it may be desirable for students to complete at least a basic dental cleaning (even just a rubber cup polish in many cases) BEFORE the hard tissue examination is completed and recorded. While this has never been the sequence used in the teaching clinics in the past, performing some type of cleaning first, followed by the dental exam, is certainly most common in the majority of private dental practices.

While this altered sequence may still allow for completion of both procedures (prophy and treatment plan) during a single visit for the most straightforward cases, patients with significant periodontal needs (as well as many of the patients with more complex dental care needs) may commonly require a 2nd appointment for finalization and digital signing of their treatment plans. Students and faculty may both need to recalibrate regarding their productivity expectations and “CEU gratification” in such situations. It is also likely that many complex treatment plans initially supervised by one faculty member during the data collection phase of the process (during the first clinical visit) may ultimately need to be approved by an entirely different faculty member during a subsequent clinical visit. Through discussion, this was not viewed by the group to be a significant concern.

Cubicles and appointments
There was some discussion regarding the protocols that will need to be established for appropriate placement of student appointment requests into specific cubicles. For the short term, it is anticipated that the clinic areas to be used for dental student endodontic procedures will not change. The expectation that students will sometimes request more peri or prosth chairs than there are designated for these disciplines was raised…how will this be handled? Strict guidelines and policies will need to be established that will be adopted and uniformly interpreted, followed and enforced in all clinics. Again, interpretation of the patient care guidelines should allow students, faculty as well as staff members to transition and function efficiently and effectively within the revised clinic environment.

Because students will not be specifically assigned to any particular cubicle in the proposed clinic model, the tasks of stocking and maintaining the cubicles will need to be managed differently in the future. The clinic services staff will be approached soon to discuss implications of and options for managing this issue.
Other issues
The Clinical Sciences Team has begun working on a list of student performance/ability expectations describing the intended trajectory for dental student activities – Term by term – through the 4 years of the DDS curriculum. The goal will be to seek and incorporate input from as many stakeholders as possible as this document is developed. Mark Fitzgerald will distribute the working version of the document so that it may be discussed at next week’s meeting.

Dean Polverini had recently expressed interest in joining a CIT meeting…based on his availability, he will attend our meeting on April 6th.
Clinic Implementation Team  
Meeting Notes, 3-16-10, 9-10:30 a.m., room 2397

Members present: Mark Fitzgerald, Anne Gwozdek, Preetha Kanjirath, Laurie McCauley, Phil Richards  
Consultant: Steve Stefanac  

Before the beginning of the main meeting, a concern was raised regarding what may be considered to be insufficient or inappropriate radiographic surveys that are sometimes being ordered for some of the patients coming out of PAES. Steve Stefanac suggested that specific representative example scenarios/patients should be identified and brought forward directly to him in order to help to identify any policy or process changes that may be needed in this regard.  

Recent discussions  
The proposed clinic revisions were recently presented to the student clinic representatives and the dental faculty. While some specific questions arose, no major philosophical concerns arose at either of these meetings.  

Pre-cleaning the teeth during treatment planning  
As the meeting began, there was a brief review of recent discussions. The idea of routinely performing a tooth debridement/prophylaxis procedure BEFORE completing the hard tissue examination during treatment planning has recently been casually discussed with some ad-hoc clinical faculty and opinion leaders. No significant disagreements or concerns have been raised regarding this suggestion.  

It is likely that some periodontally unstable patients with extensive calculus deposits on their teeth may require some modification of protocol in this regard, potentially with the more frequent use of the D4355 code (debridement for diagnostic purposes). It is also likely that some prophylaxis procedures may be deemed “incomplete” following the first clinical visit under such an initiative…this was not viewed to be a huge problem.  

Clearly, there will be a need to develop, define, describe and broadcast any such protocol changes to faculty and students in order for such a new initiative to be successful. Steve Stefanac also pointed out the potential value of the A/B (predictable/unpredictable) patient categorization system to assist in guiding decision-making and clinical process in this regard.  

Cubicle maintenance and stocking  
There was some further discussion regarding cubicle maintenance and stocking. Phil Richards had spoken briefly with Jane McDougall regarding this issue last week. Her suggestions were that either 1) students should still remain responsible for this task in some way, or 2) all consumables should be moved to central dispensing.  

There was strong sentiment during the meeting that materials and supplies should be kept available in cubicles as they are now. The additional storage spaces (the “cubbies”) in cubicles that are used by students for some patient-related items (models, lab equipment, etc) will still
need to be accessible to students as well. It was proposed that students should still be held responsible for cleaning and stocking the specific cubicles where their personal “cubbies” are located. Any cubicles that are currently unassigned (hygiene or D2 cubicles) should also be assigned to responsible students in a similar way. Clinic services staff will be consulted to create some equitable plan in this regard.

Cubicle placement criteria
The group undertook some editing of the working document to guide students and faculty regarding clinical procedures for which specific cubicle requests would apply starting in June. The goal of this editing was primarily to make the decision criteria as simple and straightforward as possible, as it was felt that a more specific and lengthy document would be unlikely to be utilized or followed day to day. Because prosthodontic input was unavailable during the editing process, input from them will be sought before moving any further in this regard.

Other issues
The strategies for creation of dedicated times for enhanced in-service training are still being explored. One concept is the creation of a regularly unscheduled block of time (potentially an entire half day) for all dental students and clinical faculty that may allow for flexible student activities as well as regular meetings with and among faculty members. Unfortunately, it is anticipated that graduate clinics and their faculty would not be included in such an initiative. Such a dedicated time could be viewed as a “tunnel” through the entire curriculum. As scheduling plans come into focus, this issue will be re-visited sometime soon. With implementation of the MiDent treatment planning module and the revised clinical design pending for June, there will be a need for more intensive in-service training protocols soon.

There was some casual discussion regarding the potential value of trying to plan a prosth preclinic course to take place during the Summer months. This could mesh favorably with clinical faculty demands in prosthodontics, as there tends to be a lower level of prosthodontic patient care activity during the Summer months when compared with other times of the year.

The issue of when and how much to re-treatment plan patients upon reassignment to a new student was briefly discussed, specifically as it relates to the expanded implementation of the electronic record. Despite the efficiencies that may come from decreasing the re-treatment planning requirements, the need to hold students personally responsible for any treatment plan that they are following remains a key philosophical priority.
Clinic Implementation Team  
Meeting Notes, 3-23-10, 9-10:30 a.m., room 2397

Members present: Mark Fitzgerald, Anne Gwozdek, Preetha Kanjirath, Laurie McCauley, Phil Richards, Marianella Sierraalta, Nikki Sweier

Consultant: Steve Stefanac

Prior to the main discussion, Marianella Sierraalta asked about any plans to outfit any of the cubicles in 3rd floor Orange clinic with special technology (e.g. intraoral cameras for capturing clinical scenarios for demos, etc.). Apparently, Renee Duff had specifically expressed interest in this. Steve Stefanac stated that the current plans for 3rd Orange provide only for dental chairs, dental units, radiographic capability and MiDent/computer access. He suggested that creation and submission of a formal proposal for acquisition and use of additional technology features in 3rd Orange could be undertaken, but he was not aware that any such request or plan was currently in the works.

Feedback from prosthodontics
Marianella Sierraalta reported back to the team regarding feedback from the prosthodontics faculty regarding the proposed clinic revisions (a prosthodontics division faculty meeting had been held the previous day). Comments were made that the proposed clinic structure did not represent a new design at all, but rather it was really only a minor modification of existing practices and may actually be less desirable than the system that is currently in place. Some of the prosthodontics faculty members expressed that the plan as it was described to them was unacceptable. They felt that the highest level of quality needs to be instilled in all clinical teaching, from the very beginning. They feel that the current focus is not on teaching.

Marianella reported that prosthodontics faculty members had expressed fear that general dentistry faculty would ultimately teach everything. However, they also anticipated that the general dentistry faculty would potentially ask prosthodontics faculty to assist with many of the prosthodontics cases that are handled in the general dentistry chairs. Marianella expressed some specific concerns, stating that “general dentists never survey RPDs” and that “general dentists never border mold.” The critical need to implement a more robust clinical faculty in-service training program to instill and reinforce the clinical policies and practices that are determined by the disciplines was again discussed.

Marianella reported that the prosthodontics faculty felt strongly that more clinic space than what has been designated for the prosthodontics teaching areas will ultimately be necessary and that more prosthodontics faculty members than designated will also be needed. (The proposal that was presented to them the previous day suggested that only 2 prosthodontic faculty would be needed per floor…more recent strategies, incorporating feedback from Mark Snyder, had suggested that 3 prosthodontic faculty per floor would most likely be required.) Marianella expressed that the number of prosthodontics Test Cases is currently large and may actually grow in the future. She also emphasized that initial experiences – e.g. a student’s first denture – require lots of visits (e.g. 6 appointments for fabrication of complete dentures).
Additional discussion ensued. Phil Richards specifically asked Marianella if she knew what type of clinic design would please or satisfy the prosthodontics faculty? She suggested that it might be a good idea for Phil to meet with the prosthodontics faculty sometime soon in order to try to air this out.

During the meeting, Mark Fitzgerald assisted in accessing and utilizing a data set that had been created previously to inform the discussion of potential procedure/chair needs for the disciplines. Based on the data reviewed during the meeting (and also following the meeting), it appeared that an AVERAGE of 12 chairs per floor through the year would be sufficient for the anticipated prosthodontics teaching requirements. While some strict limitations on the allowable maximum size of the discipline teaching areas FOR ANY GIVEN DAY still need to be established, it is clear that the prosthodontics and perio areas will need to be able to routinely grow and shrink on a controlled basis in order to satisfy patient care needs day to day and from Term to Term. Based on the likely variability, 12 chairs per half day per floor will sometimes be unnecessary while at other times a hard 12 chair limit will likely be insufficient to satisfy patient care needs.
Clinic Implementation Team  
Meeting Notes, 3-30-10, 9-10:30 a.m., room 2397

Members present: Mark Fitzgerald, Margherita Fontana, Mary Garrelts, Anne Gwozdek, Preetha Kanjirath, Phil Richards, Marianella Sierraalta, Nikki Sweier

Consultant: Steve Stefanac

Prior to the main discussion, Phil Richards briefed the group regarding recent VIT activities to attempt to rough out tentative weekly schedules for the future curriculum. At this point in the draft schedules, unscheduled, “flexible” time is being reserved for students consistently for one full half day per week (4 contiguous hours) every week. As the students matriculate and the new curriculum is implemented for all dental classes, all dental students as well as all DDS teaching faculty would eventually also be included because no classroom or clinic teaching would be planned for these times. The underlying concept is that such preserved time could be used for students to meet with students, for students to meet with faculty and for faculty to meet with faculty – specifically for expanded activities such as in-service training and clinical calibration.

During the CIT discussion, the need for a contiguous 4 hour block of time was strongly questioned. A strong priority for such a move is that any designated clinic down time should/must be used effectively and efficiently. Could 2 hour blocks ultimately end up being more manageable/useful? Would having the predoctoral clinics consistently unavailable for patient care on any given half day create other unanticipated problems? (e.g. would PAES, Pedo, Oral Surgery be adversely affected?). No resolution of these questions was achieved, but clearly these issues are worthy of further discussion.

Following last week’s meeting, Phil Richards reported that he had an extended conversation with Paul Krebsbach regarding the less than favorable reception that the prosthodontics faculty had rendered during the previous week regarding the proposed clinic revisions. Paul expressed that he did not feel that it would be necessary or desirable for Phil himself to meet with the prosthodontics clinical faculty representing the CIT in further discussions anytime soon. Rather, Paul expressed that, based on his understanding of the directions and plans of the Clinic Implementation Team as well as his working knowledge of the perspectives and concerns of the Prosthodontics faculty, he could serve as an intermediary in order to move the concept forward.

Clinic design and cubicle placement – logistics and implementation
Steve Stefanac expressed a need to determine – right away – if the proposed clinic revisions are indeed moving forward for this Summer. Not knowing specifically who has the authority to “flip the switch” regarding the suggested changes, the group sentiment was that the plan for implementation SHOULD move forward now. Phil Richards will consult with the entire VIT to make sure that this is their desire. Following this, it was agreed that a schoolwide message regarding the proposed changes will need to be formulated and sent out very soon. Additional information for students and faculty can then potentially be included in the MiDent training sessions that are already being planned.
Mary Garrents indicated that the new strategy for clinic operations may ultimately simplify appointment requests for students once it is implemented. In terms of other strategic issues, the CEU calculations that have traditionally been used to assess student productivity per clinic session will definitely need to be adjusted. The sections of Patient Care Manual that describe clinical documentation and treatment planning will definitely need to be changed. Because the Patient Care Manual is an electronic resource (thus easily edited “on the fly”), some of the major sections that need to altered for this year may actually need to be left “blank” for the short term and definitively modified/edited later.

Discussion of the periodontics and prosthodontics teaching areas on each floor followed, specifically concerning the mechanics of handling student appoint requests. The goal of “clustering” students treating patients as specified by the specific disciplines is a key feature. However, some flexibility will also need to be built into the system. While 12 chairs per floor for each discipline has been frequently cited as a reference in most recent discussions, there will certainly need to be some ebb and flow. No “fence” will be build around any 12 specific dental chairs…however, there may be some wisdom to populating these areas strategically in order to make the best use of the attending faculty resources. Theoretical maximums for these teaching areas were discussed, e.g. for Perio, 16 students per floor may represent the outside limit, while for Prostho, 18 students per floor was discussed as a theoretical maximum. There was general agreement that active patient care that is specified to occur only in these specific areas will not be able to be supervised by these attending faculty members elsewhere…only consults can be anticipated from faculty assigned to these specific areas in other regions of the clinic.

Mary Garrelts described her perceptions of the new mechanisms as they would apply to students: 1) all chairs will be populated by submission of appointment requests, 2) a specific reason for the appointment must be written on the request – in the form of either clear text or a specific procedure code…the request will be summarily rejected if this is not done. Then, 4) a clinical staff member will place the appointment requests into a “parking lot” to subsequently be placed into specific chair locations strategically based on, 5) the full scope of what has been requested by all students for that clinic session, as well as 6) specifically when each request was made relative to all other requests. The need for both floors and all support staff working on these tasks to function uniformly and consistently was emphasized.

Pre-cleaning teeth during treatment planning - Implementation
The concept of performing definitive dental hard tissue examinations as a part of the treatment planning process only after the teeth have been rendered free of most extrinsic deposits has been discussed informally among many of the clinical faculty as well as by the clinic directors. The general consensus is that this is also an new initiative that we should implement this Summer. There will be a need to create simple, useful criteria to guide students when faced with certain borderline or complex clinical circumstances (e.g. periodontally unstable patients) in this regard. There will also be a need to get the message out to all students and faculty as soon as possible. It is likely that many patients may favor this approach, even if the treatment plan and/or the prophylaxis procedure is not deemed totally “complete” during the initial visit (as patients are likely to feel that “something is getting done”). Students and faculty will need to get used to the idea that some of these procedures will end up “incomplete” and then completed at a later visit.
Cubicle maintenance and stocking
The issue of maintaining and stocking cubicles continues to pop up as a concern among many. The idea of a “communal” approach to managing this makes sense theoretically, but is unlikely to work effectively in actual practice. The most likely approach to be successful will probably be to leave the students’ responsibilities much the same as they are now for the cubicles where their storage “cubbies” are located. The patient services staff will be consulted again soon in order to nail down this issue.

In-service training – planning and implementation
This topic will be an important early priority for coming meetings.

Dean Polverini is scheduled to join our meeting next week (4-6-10).
Clinic Implementation Team
Meeting Notes, 4-6-10, 9-10:00 a.m., room 2397

Members present: Mark Fitzgerald, Margherita Fontana, Mary Garrelts, Anne Gwozdek, Preetha Kanjirath, Laurie McCauley, Phil Richards

Consultant: Steve Stefanac

Guest: Peter Polverini

Peter Polverini joined the meeting based on the interest he had expressed regarding team activities several weeks earlier. Based on the notes from the previous meeting, Steve Stefanac expressed some concern and urgency in regard to “pulling the trigger” for the planned clinic changes, as he had already given computing the go ahead. Phil Richards had discussed the proposed changes with the VIT group earlier that very morning and it had been endorsed. As the VIT members had realized, despite the plan to move the clinic changes forward, the year-by-year implementation of the new curriculum will definitely limit some important aspects (e.g. “Flex time” for meaningful in-service training and calibration) and incremental “tweaks” will likely be ongoing for quite a while. In addition to the CIT and the VIT, many other school leaders and stakeholders (including Don Heys, Georgia Kasko and the Curriculum Committee) will need to be actively involved in continuously examining and modifying the new protocols.

Mary Garrelts described some of the preliminary discussions among the PCCs regarding the creation of “1 big parking lot” per floor to plan and map out cubicle assignments. Mary also stated that she has already been working with Don Heys to strategize regarding new ways to assess clinical productivity (because the number of half days “assigned” to individual students for clinic cannot be counted anymore). The idea of required clinic attendance for students was mentioned for consideration in the future.

Other goals for future changes were briefly discussed…an ongoing working list will need to be created. Peter Polverini suggested creating benchmarks to describe present conditions, new initiatives, measuring resulting outcomes and proposing additional changes that can be provided to the University Provost to demonstrate effective innovation/performance as well as to support the need for future support and resources.

Much of this shorter than normal meeting was spent strategizing and group editing the initial draft of a schoolwide e-mail message regarding the planned clinic changes for the Summer. In addition to the planned e-mail, there will clearly be a need to provide some formal orientation sessions for both students and faculty members regarding the planned changes for the clinics. Steve Stefanac will be involved in delivering faculty training on the treatment planning module. An additional in-service training session designed primarily for CRSE faculty regarding perio assessments and prophy/maintenance protocols will also need to be planned.
Clinic Implementation Team  
Meeting Notes, 4-20-10, 9-10:30 a.m., room 2397  

Members present: Mark Fitzgerald, Margherita Fontana, Anne Gwozdek, Preetha Kanjirath, Phil Richards  

Consultant: Steve Stefanac  

Planned agenda topics:  
- Teams in clinics – culture and function  
- Patient referrals  
- Clinic attendance policies  

As the meeting began, Mark Fitzgerald shared his observations from participating in a recent site visit at UNC. He described how the students work on separate floors based on their class year. On one floor, the 4th year students work in a General Dentistry clinic that is based on a truly generalist model...e.g. extractions, periodontal flap procedures, etc. are performed in this area, supervised by general dentists. The UNC faculty with whom he spoke reported very few interdisciplinary “turf” difficulties based on this approach. The 3rd year students work in discipline-based clinics on a completely separate floor of the facility. UNC also has an active, separate “special needs” clinic where patients with complex background needs or conditions are managed.  

Phil Richards will present and seek faculty feedback at the faculty forum on Wednesday, 4-21-10 regarding the plans that were described in the recent schoolwide e-mail message on the impending clinic changes. Through discussion with the team, he wanted to become as prepared as possible for any and all questions and concerns that might be raised. The issue of the anticipated staffing profile and needs was anticipated to be one such item of interest.  

Paul Krebsbach will present the other major agenda item that is planned for the 4-21 faculty forum…the proposal for creating protected, “Flex time” for both students and faculty in the future curriculum. At this point, the tentative plan is to close the predoctoral clinics and teach no dental classes one half day per week to preserve 4 contiguous hours for Flex time. Mark Fitzgerald raised the question of whether or not this full half day approach is the best strategy. He as well as others felt that planning Flex time in two 2 hour blocks per week might actually be both less disruptive and more effective.  

Clinic attendance policies  
The idea of proposing required clinic attendance for students was raised. Clearly this is an approach that is used routinely and successfully at many other dental schools. The specific motivations for considering such an idea at Michigan at this time are based on:  
- The emerging need for additional chairsides participants to accurately and efficiently gather clinical data (e.g. perio charting, treatment planning module) and enter it into MiDent  
- The benefits to patients of improving both the quality and efficiency of patient care based on having chairsides assistance available more frequently
• The benefits to the educational process for students based on becoming more familiar with 4-handed dentistry as both operator and assistant
• The benefits to the educational process for students based on the opportunities to expand their patient-based learning experiences by being actively imbedded in greater numbers of dental care procedures beyond their own personal patient treatment
• The potential benefits to the overall clinical program from fostering a greater emphasis on a team-centric culture – perhaps decreasing the current emphasis on individual student needs/rewards

Having students participate in the “team practice” in this way is a natural way to link this proposal to the initial CIT charge. However, we probably can’t depend on students to embrace and participate in such a system without either a defined reward or some type of requirement. Using the “supplemental CEU” carrot is NOT an approach that can even be considered.

The question of tracking clinic attendance was briefly discussed. It was anticipated that “assistant” activities could potentially be tracked directly at chairside through MiDent. Could students’ level of clinic attendance/participation contribute to the practice management component of the Comp Care clinic grade? The group agreed that we will need to seek perspective and input from Mary Garrelts regarding this concept and potentially how to approach it and move it forward most effectively.

Patient referrals
There was some discussion of how to optimize timely and appropriate referrals of preventive recall/periodontal maintenance procedures (as well as other dental procedures appropriate for early clinical learners) to the future 3rd floor Orange clinic environment. The demonstrated lack of timeliness and effectiveness of individual student-to-student referrals was raised as a major concern. It was felt that students may be more likely to effectively and efficiently refer patients to a general treatment area/environment rather than to a more limited or specific student or group of students. On the other hand, referral to a recall “pool” for subsequent assignment and scheduling would potentially require a greater (prohibitive?) level of staff involvement. Mark Fitzgerald felt that patient appointments could potentially be made directly by referring students to pre-planned treatment cubicles. Steve Stefanac suggested the need to create a “3rd floor Orange group” to meet and strategize regarding many emerging issues pertaining to the implementation of this teaching clinic.

Cleaning teeth prior to treatment planning
The idea of deplaquing the teeth prior to definitive treatment planning was again briefly discussed. Much of the initial, informal feedback from students regarding this concept has been positive. What would be the best way to launch/reinforce this practice and when? The criteria for when/how the pre-cleaning process can/should be implemented for patients with more significant periodontal needs must still be established. In many cases, initiating a coded “prophy” might not even be necessary, as simple toothbrushing through an earlier and more comprehensive approach to oral hygiene instructions may deliver many of the intended goals.
Clinic Implementation Team  
Meeting Notes, 4-27-10, 9:10:30 a.m., room 2397

Members present: Anne Gwozdek, Preetha Kanjirath, Laurie McCauley, Phil Richards, Marianella Sierraalta

Consultant: Steve Stefanac

Agenda Items:
- Perio stability
- Pre-cleaning teeth

The meeting began with further consideration and discussion of implementing an attendance policy for dental students in the clinics. The notes from the previous CIT meeting included summary statements regarding the potential value of this for the students, their clinical learning, for fostering patient care teamwork and for delivering better patient care. It was noted that dental hygiene students not actively engaged in treating their own patients are frequently seen helping out in the clinics…Anne Gwozdek suggested that these most likely are students functioning as peer teachers.

Strategies were discussed for assessing students on their level of “clinic participation” and factoring in their activities as part of a “teamwork grade.” Steve Stefanac described a likely move in the near future to equip students with smart phones in lieu of the current messaging system. He described the potential for smart phone applications to allow “I need help now” messages to be sent out that could then be responded to by other students in real time (like a “flash mob” phenomenon). The team participation “credit” for assisting in this way could theoretically be tracked digitally with limited administrative involvement.

Because of the complexity of the many new initiatives in the clinics that are being launched this Summer, the idea of instituting an attendance policy immediately was not considered by the group to be prudent. However, it was agreed that input would be sought from the clinic directors to explore their perspectives on instituting such a policy in the future. Once the work flow for the new MiDent data collection and entry activities becomes clearer, a more receptive climate may emerge for such an initiative to be considered more seriously – wouldn’t it be great if students came up with such a recommendation themselves?

Pre-cleaning teeth
Phil Richards confessed that the development of criteria/guidelines for when/how teeth should be rendered “clean” prior to definitive treatment planning continues to fall off of the top of his to-do list. Margherita Fontana had sent him an e-mail regarding this subject, as she could not attend this meeting. She suggested that the patterns/presence of biofilm on individual tooth surfaces represents a key feature of disease activity and risk assessment that really needs to be recognized and documented before the plaque is mechanically removed as a ritualistic prelude to the examination and treatment planning process. There was some discussion regarding the various forms that initial biofilm assessment and recording could take (e.g. visual/tactile vs disclosed plaque identification, % plaque-positive sites vs site specific recordings) and how they
can/should be tracked. There was some discussion of a gradual implementation process whereby a visual plaque assessment could be instituted now with a more formal process (using disclosants) possibly could be implemented later. However, no decisions regarding any particular “system” for recording were made. It will be important to have Margherita present to be involved in the discussions of this issue.

There was some concern that requiring any “new” additional documentation/procedure as a part of an initial visit and further changing established work flow patterns may be very unpopular; the receptiveness of students and faculty to what is likely to be perceived as adding additional steps may create a problem. However, recognizing the presence of dental plaque as an issue that needs to be dealt with and actively involving the student and the patient at the first visit in addressing/managing it could set a very good precedent about what is truly important and given priority in patient management and patient care. Emphasis on interactive risk identification and management was viewed as particularly pertinent to those patients with more limited access to routine dental care and more limited, specific needs – e.g. “check up clinic” patients. It was also suggested that instituting a strongly preventive examination protocol may lend itself most strongly to students’ earliest (e.g. D2) treatment planning rotations.

Toward the end of the discussion, the overall initial goal of pre-cleaning the teeth prior to definitive treatment planning was reviewed: achieving a more precise and informative clinical examination. One perspective of the next step for this issue is to merely suggest the precleaning protocol as a viable option, as opposed to generally requiring it. Another approach would be for faculty to initially make recommendations for this procedure only in selected cases, almost as an experiment, in order to see how it goes. Once some experience is acquired in this way, a more fully developed protocol could potentially be created for later implementation, based on establishment of some level of faculty consensus.

Perio Stability
In order to guide students and general dentistry faculty through some of the decision-making that will be required for determining periodontal stability during the treatment planning process and provide guidance regarding the types of cases where a perio faculty member should be consulted, Phil Richards had created an initial draft document describing some defining characteristics of periodontally unstable patients. At the end of the meeting, the remaining members present reviewed the document and undertook some group editing. This document will later be reviewed by the POM Clinical Advisory group for additional refinement.
Clinic Implementation Team  
Meeting Notes, 5-4-10, 9-10 a.m., room 2397  

Members present: Mark Fitzgerald, Margherita Fontana, Mary Garrelts, Anne Gwozdek, Laurie McCauley, Phil Richards, Nikki Sweier  

Planned meeting topic: In-service training  

Near the end of the previous meeting, a group editing effort to attempt to concisely define the characteristics of periodontal instability for use as a guide during treatment planning and to specify potential needs for specialty consultation and periodontal treatment took place. Later that week, the POM Clinical Advisory group attempted to refine the resulting document even further…this led to a much more lengthy and detailed product than what had originally been intended. Further edits will be suggested to attempt to shorten the document into a more practical and potentially useful scope once again.  

There was some additional discussion of the concept of required clinic attendance. Mary Garrelts reported that the PCCs have now preliminarily discussed this idea. Their general consensus was that it could be very useful to have additional students available in the clinic based on the potential for the enhanced efficiency, collaboration and educational opportunities that could result. However, they also expressed significant concerns regarding the difficulties that would be likely to arise with managing and tracking such a program. There is certainly potential for abuse of any reward or requirement system for clinic attendance. Checks and balances will be necessary…the PCCs and their staffs definitely cannot be responsible for “taking attendance” in the clinics under any circumstances. Tracking attendance directly in MiDent (as has been done for D2 students in recent years) has also been shown to be fraught with difficulty. The identifiers that are used to specify individual students in the “assistant” column in MiDent were created arbitrarily and do not match up at all with those used in the “provider” column. This means that there is no convenient way to sort and report based on this. There is however a field for a “secondary” provider that may potentially be of some use.  

Another idea that was briefly discussed was the possibility of tracking attendance through some type of a daily MiDent entry that could be created for both the student clinicians and those who have meaningfully assisted them. Such a daily assignment could/should also potentially be linked to some form of daily self-assessment by students regarding their own activities and learning experiences. The proposed future CODA guidelines include some new goals and requirements for peer- and self-assessment processes. Theoretically, a required field could be created in MiDent for students (both operators and assistants) to document “what they did” and “what they learned” during any particular clinic session. The output from this could potentially be stored and ultimately exported in a form that students could save and use as part of their educational portfolio. This type of entry should be created in the clinic in real time and would require a faculty approval swipe as well. However, at some later time, there could be some form of faculty review/assessment of these entries to provide feedback and potentially make them more meaningful. There was some concern about “who” could be responsible for reviewing such entries and “how” such a task can/should be done.  

In-service training
Phil Richards had compiled a summary of earlier CIT discussions regarding clinical in-service training, generated from previous meeting notes. The group briefly reviewed this summary, but discussion of general goals and the need for timely action immediately ensued. Despite the logistical challenges, there was some support for planning some traditional lecture/seminar events for initial dissemination of information to faculty regarding new and timely clinical concepts and practices, at least as a first go round. The potential topics for early sessions that were proposed include: 1) “clinical documentation” used in the various clinical disciplines/activities, and 2) the “CHIPS” format used during preventive recall visits to examine and document clinical periodontal conditions. Another timely topic that should be considered for early faculty awareness is a more in-depth discussion of desirable treatment planning and sequencing concepts and practices. The mechanics of the MiDent treatment planning module is certainly the more urgent priority at this time, but a more conceptual, philosophical discussion among the faculty should also be planned to follow as soon as possible.

There was some concern that such sessions may end up being somewhat detached or confusing to some faculty members and potentially of limited usefulness without a concerted effort toward planning and delivering strategic follow-ups. The ongoing concern is always the significant disconnect between what is discussed as “best practices” during in-service training sessions and what actually ends up happening in a busy teaching clinic.

There was some discussion of some other potentially innovative methods of “spreading the good word.” Despite the apparent lack of support for this concept previously, the “pre-treatment huddle” could provide a vehicle for regular sharing of clinical protocol information. Developing and sharing a “teaching tip of the day” regularly at pre-treatment meetings, or even more widely (e.g. via a daily e-mail or web posting) could also be useful if it were supported and became part of the culture. Along these same lines, developing a “question of the day” for which students would be responsible (e.g. everyone gets asked…) could also create a culture of enhanced interest and responsibility. Such “teaching tips” or “questions” of the day could be designed to be very applicable to all clinical areas or some could be intended for more discipline-specific goals. Also, the creation of a central electronic storehouse of clinical teaching resources, arranged by discipline, topic, procedure, etc. could be created. This could serve as a repository of general clinical information and procedures as well as a place from which new processes and procedures could be disseminated.

Such initiatives would certainly constitute a significant undertaking, but with advocacy and support, they could provide significant dividends. The ongoing educational efforts in this regard could be distributed across the faculty leadership on a rotating basis (e.g. one week at a time or one month at a time); some potential leaders to contribute to such an effort would certainly include discipline coordinators and clinic directors, but other local experts or opinion leaders would also be urged to contribute. Coordinating and maintaining such a process consistently could be a very important and difficult job…at the end of the meeting, those present revisited the fact that we really need a “Director of Predoctoral Clinical Education!”
Clinic Implementation Team  
Meeting Notes, 5-25-10, 9-10:00 a.m., room 2397

Members present: Dan Edwards, Mark Fitzgerald, Margherita Fontana, Mary Garrelts, Anne Gwozdek, Preetha Kanjirath, Laurie McCauley, Phil Richards

Consultant: Steve Stefanac

Planned meeting topic: general discussion about impending clinic changes and related concerns

Phil Richards described the noon meeting that he had with the new D3 students on May 11 (at their request) regarding the new clinic arrangements. Phil made a short powerpoint presentation and then tried to answer all student questions. About 30-40 students attended…they had a few questions about patient scheduling and cubicle placement scenarios but actually had many more questions about the electronic health record. The concept of potentially requiring/tracking clinic attendance at some point in the future was also introduced…no strong negative emotions were expressed.

Some discussion regarding the MiDent electronic health record implementation arose. The process of gathering and entering clinical data will likely be more complex and time consuming than we are used to. Having additional people available in the clinic to assist and participate in the data gathering and data entry processes will certainly be necessary/helpful. There was some discussion regarding past concepts to attempt to link our clinical program with the dental assisting program at WCC in order to share some resources in this regard. Unfortunately, the timing of their established curriculum and the “crunch time” for our clinics in regard to clinical examination and treatment planning (as well as other activities) has never been a good fit.

Mary Garrelts was asked to comment about any discussions/concerns among the PCCs regarding the new process of placing students into cubicles. Only limited numbers of appointment requests have been processed so far. Clearly, certain basic info will be needed in order to properly place students…planning some multi-function clinic sessions (e.g. perio re-eval followed by a denture adjustment during the same visit) will require some creativity and flexibility. It will be crucial that Test Cases are pre-identified as much as possible. D3s will need to be provided with some specific scheduling info/guidelines during training sessions.

Steve Stefanac reported that the Orange clinic renovation is moving forward nicely. Some of the early D1 activities may potentially be able to be held there in August. It is becoming clear that there will be a need to establish a weekly schedule for access to and utilization of this clinic space. There was also some discussion of the potential need for staff support to create a central referral repository for D1/D2 patient care procedures – potentially fostering a process of D3 and D4 students referring patients/procedures to the Orange CLINIC rather than referring to individual STUDENTS.

(Post meeting note, dental hygiene students’ referral needs will also need to be accommodated within any such referral network).
Steve also reported that the MiDent training modules are being finalized and that additional info and supporting documentation is also available online.

Near the end of the meeting, it was mentioned that some individual faculty members from prosthodontics have expressed some discomfort/misgivings regarding the planned clinic changes. The “Patient Care Guidelines” document (that was last reviewed by the CIT in draft form several months ago) still includes potential lack of clarity and a number of potential points of conflict between the General Dentistry and Prosthodontics treatment environments. Sooner or later, this will need to be definitively dealt with, potentially by the CIT. With Marianella’s imminent departure, we will need to recruit prosthodontic representation for the CIT. Renee Duff has been named as the new prosthodontic discipline coordinator…Phil Richards will ask Paul Krebsbach if she can/should join the CIT to participate in these as well as many other future discussions.

(Post meeting note, a group attempt was made to simplify and moderate the Prosthodontics section and clarify all likely conceptual disagreements in RED in the last draft version of the “Guidelines” that was reviewed during a CIT meeting – file name: “Guidelines 12-8-09.doc” Unfortunately, no prosthodontic input or review/editing took place after this point. Marianella provided an up-to-date version representing the BMS/Prostho perspective and goals on March 23, 2010 – file name: “Prosthodontics Guidelines.doc”
Clinic Implementation Team  
Meeting Notes, 6-8-10, 9-10:30 a.m., room 2397

Members present: Renee Duff, Mark Fitzgerald, Margherita Fontana, Mary Garrelts, Anne Gwozdek, Laurie McCauley, Phil Richards

Planned meeting topics:
1. debrief on the initial experiences in our new clinic arrangement
2. begin some definitive discussion toward resolving remaining conflicts regarding the relative scope of prosthodontic and general dental care in our DDS teaching clinics

Renee Duff was welcomed to the team, representing prosthodontics.

Initial discussion of Clinics
So far, the overall level of clinical activity has not been high. D3 patient assignment information and initial appointments were handled differently this year (with less early, active staff involvement)...this may be contributing to the slow start. The pre-treatment perio meetings with students have not yet been highly productive, primarily because of the small number of students working in the perio areas so far. Although students are a bit overwhelmed with all of the changes, the overall response to the clinic arrangement and the MiDent initiatives have generally been favorable.

Entering perio charting data into MiDent is a big job, but will certainly be manageable in the long run. Some faculty seem a bit intolerant of the need for multiple swipe approvals, but this will most certainly become our new reality. Unfortunately, the current placement of the clinic flat screens does not allow visibility for digital perio chart clinical data verification from chairside patient care positions...this issue may prompt consideration of logistical adjustments if/when hardware upgrades occur. Tablet-type screens may provide many advantages if such options may ever be considered.

SPIs will begin observing D3 students during treatment planning visits next week – they will also provide assistance with chart data entry as needed and specifically attempt to characterize how the computer influences the dynamics of the patient/student interactions during treatment planning.

Mark Fitzgerald brought forward the idea that there should be an option for a treatment plan to be considered complete prior to the completion of all specialty consults. The members present agreed that there should be a way to make this happen.

Patient care guidelines
Phil Richards provided a brief history to describe the formulation and intended purposes of the previous versions of the Patient Care Guidelines, focusing on the discussions and actions (and the recent lack of actions) that have led us to where we are now. Phil emphasized what he perceives to be the strong need to create guidelines that are as concise, simple and straightforward as possible so that students will be able to use them routinely to anticipate faculty support and plan their care effectively.
Many assumptions have been made regarding the interests and abilities of different faculty members/groups to teach and supervise certain procedures, but do we REALLY know who is actually comfortable and/or competent to supervise what? Should we construct a survey for faculty to assess their perceptions in this regard? The resulting data could be useful to guide further discussions of how the guidelines may be best be constructed and applied…faculty perceptions as expressed in such a survey may also serve to shape in-service training priorities.

Renee Duff pointed out that the overall number of prosthodontic patient care experiences that students actually have during the DDS curriculum is typically quite limited. With this in mind, the prosthodontic perspective in regard to the guidelines intends to make the very best possible use of each prosthodontic clinical experience in order to maximize/optimize “teachable moments” for students. With regard to the restoration of implants, there are established restrictions currently in place with regard to who is eligible to supervise these activities (prosthodontic faculty and Ron and Don Heys only). Any Guidelines that the CIT may advocate would also need to synchronize correctly with the Patient Services/Implant Directors’ established policies.

The prosthodontics guidelines for graduate level care (as well as some similar suggestions to guide periodontal patient assignments) are rather stringent…are patients in these categories actually referred and treated at the graduate level as suggested, or do we routinely “bend the rules” based on financial restrictions and other special circumstances? Do we need to consider constructing another survey (or some other evaluation of actual practices) to assess what is actually happening in this realm?

Significant time during the meeting was spent on group edits of the prosthodontics guidelines (attempting to simplify, shorten and consolidate wherever possible) with members sharing their perspectives. Multiple full-coverage restorations appears to remain a key point of potential conflict between prosthodontics and general dentistry. Further consideration will be encouraged in the near future…Renee Duff was encouraged to share CIT concerns and seek additional input from the prosthodontics faculty.

For next week’s meeting, the plan will be to work on a faculty survey pertaining to faculty perceptions of their own capacities and comfort zones to supervise students performing dental care of various types and in the various disciplines. Phil will attempt to construct a framework for a survey and distribute this prior to the meeting…CIT members will then be asked to contribute pertinent questions for group editing during the next meeting.
Clinic Implementation Team  
Meeting Notes, 6-15-10, 9-10:00 a.m., room 2397

Members present: Renee Duff, Mark Fitzgerald, Preetha Kanjirath, Laurie McCauley, Phil Richards, Nikki Sweier

Consultant: Steve Stefanac

Planned meeting topic: formulate a survey for clinical faculty members regarding their perspectives on supervision of various dental procedures

VIT update
Phil Richards informed the CIT that he will be providing an update to the VIT at tomorrow morning’s meeting. The original charge given to the Clinic Implementation Team was briefly reviewed by the group.

The heavy focus on clinical teams that was suggested in the original charge has not been reflected or implemented in many of the CIT initiatives. The VIT perspectives on the curriculum and educational processes (viewed from a “visionary” point of view) may be different from broad faculty perspectives…ultimately, the faculty “owns” the curriculum.

Centrally managed patient appointments is another area where the initial charge to the CIT has not been followed closely by any new initiatives. While this is not something that can be implemented in the near term, Steve Stefanac expressed that there may be future possibilities for incremental moves in this direction.

Similarly, there may be ways that progress toward more team-based educational activities could be made in the future, but this has not ended up to be a strong short-term priority for the CIT. Changes such as these may be more effective if they were to be advocated for or driven by a central coordinator with sufficient focus and authority (a Director of Predoctoral Clinical Education).

Questionnaire
Prior to intensive review of the questionnaire, there was some discussion regarding the wisdom/need to submit the survey for IRB approval. The desire to acquire information from the questionnaire promptly would potentially not be well served if IRB review ended up creating any significant delays. It is possible that exempt status could ultimately be granted retroactively by the IRB (based on some past experiences with similar initiatives from members of the group). However, this would not likely be a “sure thing” for such a survey.

Based on the initial draft questionnaire that had been circulated to the team as well as suggested edits that had been incorporated incrementally, the members present worked on additional group edits of the clinical procedures questionnaire for faculty. Near the end of the meeting, the suggestion was made that each of the questionnaire items should be formatted to reflect the
performance of a specific clinical task. Phil Richards will undertake some additional editing based on this concept and circulate for further review and approval.
Clinic Implementation Team
Meeting Notes, 6-22-10, 9-10:10 a.m., room 2397

Members present: Renee Duff, Mark Fitzgerald, Mary Garrelts, Anne Gwozdek, Phil Richards, Nikki Sweier

Consultant: Steve Stefanac

Planned meeting topics:
1. discussion of how the new clinic model is running and potential strategies for assessing this
2. “easy” patient referrals and the mechanics of initiating patient care in the new foundation (“orange”) clinic

VIT update
Phil Richards described his discussion of CIT activities at last Wednesday’s VIT meeting. Each of the original charges to the CIT was reviewed…the concept of developing a multidisciplinary clinic is one for which little action has taken place nor is currently planned. The VIT definitely supports the efforts of the CIT and understands the limits/challenges that have been encountered. While many elements of the overall vision are progressing nicely, some have yet to be moved forward in any meaningful way. Managing limited resources, maximizing efficiency and assuring sustainability are overarching issues with which all of the working teams must still grapple. The long term function/role for the VIT in the school is currently being discussed/considered in many ways and at many levels.

New clinic model: working? How to assess?
Because of her proximity to the day to day activities in the clinics, Mary Garrelts was asked to comment on how she feels things are going. While there have been few significant issues with the MiDent implementation…placing students effectively into clinic chairs in order for them to accomplish what they have in mind has been more challenging. Steve Stefanac met with students and acquired some early feedback 2 weeks ago. There will be a schoolwide town meeting this Wednesday specifically designed to allow comments regarding the MiDent electronic health record implementation.

Establishing consistency across the faculty and between the different floors/clinics will be a key priority. Right now, it appears that faculty patterns are deviating quite a bit…the concept of general dentistry faculty working within rows with specific students has reportedly been applied in a rather rigid way in the 3G clinic – this has created some unfortunate limitations for students attempting to continue with ongoing patient care in collaboration with a specific instructor who is already familiar with their case. One comment was “all the e-mails in the world won’t change them.” A nice goal would be to “create a buzz” regarding best practices for faculty, but how to actually accomplish this? The new system may actually facilitate the identification of “rogue” faculty and allow such individuals to be targeted for more specific and direct guidance.

Mark Fitzgerald suggested constructing and distributing a formal survey about the new clinic system – perhaps at the end of the Summer term? Such an effort would ideally be designed to
seek feedback from students, staff and faculty and be directed to all of these groups. Steve Stefanac mentioned some emerging concerns with regard to cubicle stocking and maintenance since the new clinic system came on-line...there will be some decisions made in this regard soon, as impending “cube checks” will potentially identify the scope of the current problems.

Are there any urgent issues regarding the new clinic format that need to be directly targeted for intervention/management right now? Not really. The treatment planning frenzy that we struggle through in the Summer every year is always problematic...patients do complain about the time required – perhaps even more now because of the more intensive computer demands that are in play. Could some of the treatment plans be done in a more virtual way? Once reliable data is available within MiDent, developing a better preliminary sense of patient needs should be more easily accomplished – perhaps even before the patient arrives to the clinic. Building on a set of treatment needs that is already firmly established (particularly with diagnoses, phasing and sequencing in place) may allow a simpler approach for re-treatment planning efforts in the future. However, the process of undertaking the treatment planning task itself is also a good educational experience for students – particularly D3s…it reveals a lot of important information about patient characteristics and needs that would be difficult to discern any other way.

Faculty questionnaire
Some minor group editing of the faculty questionnaire regarding comfortable supervision of different dental procedures was undertaken. Mark Fitzgerald has kindly developed a preliminary mock up of the questionnaire to be distributed electronically in Qualtrics…he will massage the most recent version and send it out to the CIT group so that “look and feel” issues as well as individual requirements/limitations for faculty can be investigated.

Foundation (orange) clinic issues
The issue of creating patient flow for beginning students in clinic, particularly D2 students starting this Fall, will require lots of planning. Scheduling of D2 students may need to be undertaken much differently this year than it has been in the past. Networking with a number of stakeholders outside the CIT, particularly from patient services (e.g. Georgia Kasko) will be necessary in order for meaningful decisions to be made and proper actions to be planned. It was decided that this discussion should be postponed until more preliminary groundwork can be completed.
Clinic Implementation Team
Meeting Notes, 6-29-10, 9-10:05 a.m., room 2397

Members present: Mark Fitzgerald, Anne Gwozdek, Preetha Kanjirath, Laurie McCauley, Phil Richards, Nikki Sweier

Planned meeting topics:
1. the clinic design town hall meeting being planned for Wednesday at noon
2. a strategy for establishing and disseminating more structured clinic policies

General Dentistry adjunct faculty meeting
CRSE had convened a meeting of adjunct faculty just the previous evening. It is estimated that about 60-70% of the target faculty audience was in attendance. The goal of transparency and uniformity of practices for all clinics was disseminated. While the 3Green clinic had established some unique student supervision protocols, the plan for the short term is that this group will attempt to conform to the more flexible patterns that are currently being used in the other clinics. It appears that making faculty group assignments “on the fly” may be the more equitable plan for now.

Mark Fitzgerald specifically reviewed some of the pertinent elements of the discussion from the adjunct meeting:
- Some faculty had only been granting final treatment plan approvals when all data had been entered into MiDent. A Flow sheet has now been created to guide approvals based on a more formal structure:
  1. OK to approve treatment plans when the clinical summary form – first page (medical history and clinical findings) with “no red” remaining – PLUS – the white treatment plan summary form (paper), signed by faculty are BOTH completed…the student may then enter all elements into MiDent subsequently
  2. What about subsequent faculty approval of the MiDent treatment plan without the patient physically present? Once the paper form has been approved, swiping after the fact should not be a big deal, particularly if completed by the same faculty member…in essence, this is the way we’ve always done things.
  3. What about approval of a MiDent treatment plan by a different, previously uninvolved faculty member during a second visit? Should a faculty member new on the scene feel comfortable doing this? Maybe…this will need to be an individual, situation-based determination for each case.

A survey regarding in-service training topics of interest was completed. In lieu of formal in-service training programs, it was felt that distribution of brief protocol and policy statements may be the preferable option at this point. Compiling all available protocols and policies and creating an informational booklet, perhaps to be kept on each floor – available in the PCCs area, would seem to be a good near-term goal.

Clinic Design Town Hall meeting
Last week’s MiDent town hall meeting served as a stimulus for this week’s clinic design town hall meeting. Mark Fitzgerald has graciously offered to moderate this meeting…he will attempt
to set the tone and offer some preliminary suggestions of potential topics in order to stimulate discussion. While there will potentially be more problems than solutions forthcoming, the hope is that both positives and negatives can be discussed. Good information will certainly arise from this…the priority should be that we simply listen and acknowledge issues rather than becoming defensive, debating issues or attempting to create solutions on the fly.

Establishing and disseminating clinic policies
Phil Richards expressed his concerns that there does not seem to be any coherent management structure for dealing with overall clinical education or clinic protocol issues, particularly relating to the recent changes. Neither the VIC directors nor Patient Services/Clinical Affairs nor the CIT group or team leader is really “in charge” of what has been evolving during the past few weeks. Phil has expressed his concerns regularly to the VIT group as a way of encouraging movement toward establishment of a Director of Predoctoral Clinical Education. It was even suggested that one way to get this appointment to move forward would be to specifically suggest someone for the job who may potentially be particularly ill suited for it in order to elicit some type of emergency reaction from the school leadership.

In the near term, the potential value of creating a “syndicate” of discipline coordinators and planning regular (weekly?) meetings analogous to the VIC directors’ meetings was raised. Mark Fitzgerald offered to try to convene such a group in the near future.

The importance of encouraging a more science-based approach to patient care activities is still a priority in terms of the overall Vision for the new curriculum. Maintaining patient care efficiency while instilling richer (even if very brief) discussions in the clinic may still be considered to be impossible by some…however, we really need to focus on how concepts introduced in the classroom can be nurtured in the clinic rather than being ignored or actually torpedoed. Establishing and introducing “best practices” in regard to this should be included among the priorities for future in-service training efforts for all clinical faculty members.
Members present: Renee Duff, Mark Fitzgerald, Mary Garrelts, Preetha Kanjirath, Phil Richards

Consultant: Steve Stefanac

Planned meeting topic: Town Hall meeting…interpretation and reaction

Town Hall meeting
Special thanks to Mark Fitzgerald for arranging, moderating and summarizing the clinic design town hall meeting that was held on 6-30-10 (the summary notes had been distributed to CIT members earlier). While there was no detailed analysis of the many individual issues that were raised at the town hall meeting during the CIT meeting, there was some discussion regarding the potential that cross-over concerns (the time of year, other ongoing circumstances) may have contributed significantly to what was being expressed, particularly by students.

Although Nikki Sweier could not attend today’s CIT meeting, she had provided her own interpretations ahead of time. She pointed out that indeed many of the items that were raised could be viewed as ongoing clinical education challenges that may be largely unrelated to the new clinic structure. There was a general sense that many of the students’ hot button issues may actually relate more to the policies and behaviors of individual faculty than to the new protocols.

It was acknowledged that the level of prosthodontic patient care activity in the clinic to date this Summer had exceeded expectations, particularly for D4s. There will be a need to monitor students’ abilities to access prosthodontic patient care opportunities…Mary Garrelts stated that such clinic trends for cubicles should be relatively easy to track. Renee Duff reinforced the fact that maintaining students’ abilities to schedule and complete prosthodontic Test Cases is a very important priority. Having said this, she feels that the requirements and opportunities that currently exist should not pose a problem for any students at this point.

The “Fix MiDent” submissions have declined significantly, so one could assume that folks are getting used to and becoming more efficient and effective with the electronic record. Targeting and solving IT challenges may be more easily accomplished, as the informatics group has an entire staff of people dedicated at least in large part to such activities. Isolating, troubleshooting and addressing clinic structure and individual faculty concerns may prove to be much more challenging.

Student concerns can be monitored from a variety of sources. The monthly Clinic Issues meeting was certainly lively source of input last month. This month’s CI meeting is scheduled for tomorrow morning…it could allow more isolation and targeting of potential action items. Phil Richards will plan to attend this month, just to get a sense of what is on everyone’s minds.

Some significant unanticipated problems with cubicle maintenance and stocking of equipment and consumables have been experienced based the new clinic design. Steve Stefanac has created
A survey for students to gauge their impressions and preferences regarding this issue...the survey will be distributed this week.

A significant segment of the meeting was devoted to discussing some emerging challenges concerning scope, content and sequencing for the ITDP program. Just as an example, these students are already working in the clinics but have yet to receive any MiDent training. A more formal treatment planning curriculum for these students may also be needed. The Summer ITDP schedule is very dense...it might be difficult or impossible to “fit in” anything more. Perhaps the ITDP program needs to begin earlier in the future?

The perceived need for a formal curriculum review of ITDP program was expressed. Dennis Fasbinder, Mark Snyder, Pattie Katcher, Academic Affairs (and others?) will all need to be engaged in the discussions that surround these issues...potentially sooner rather than later.

A new discipline coordinators group (also convened by Mark Fitzgerald) will meet for the first time this week. Hopefully this group can consolidate, collaborate and move many important issues forward, both in terms of the current clinical patient care enterprise as well as the creation of a more integrated clinical sciences curriculum for the future.
**Clinic Implementation Team**  
**Meeting Notes, 7-20-10, 9-10 a.m., room 2397**

Members present: Renee Duff, Mark Fitzgerald, Mary Garrelts, Anne Gwozdek, Laurie McCauley, Phil Richards

Consultant: Steve Stefanac

Pre-cleaning of teeth at treatment planning visit – do we want to try to move this forward?
The history and original motivation for this suggestion was briefly reviewed. Obviously, it is logical that clinicians can only diagnose what they can actually see. When the Summer Term was starting, this was not considered to be an “easy win” as a new policy (particularly in view of the other significant changes that were being undertaken at that time) so it never gained any real traction. Although having the prophylaxis performed initially is a common scenario in private dental offices, our predoctoral patient population may not tend to have the same types of clinical dental conditions and treatment needs as many private practice patients might exhibit. There was some discussion regarding the potential value of implementing a “prophy first pilot project” in order to assess how such a system might work. On the other hand, it was also felt that perhaps we should continue to handle treatment planning visits much as we always have. It was concluded that a formal recommendation should be made to all students and faculty that it may be prudent under certain circumstances (and is optional) to selectively debride the teeth to facilitate treatment planning. However, we are clearly not ready to implement any type of policy or rule at this time…patient management decisions should continue to be made on a case-by-case basis, in order to facilitate gathering the most accurate clinical findings possible in order to create the most accurate treatment plans possible. The opportunity to capitalize on “preventive education moments” with new patients (during which biofilm deposits may be identified and discussed and a toothbrush may be dispensed and used) and promoting the feeling that “something is getting done” during those initial visit may bring added value if everyone remains attentive to this issue.

Clinic attendance policy – is this something we want to try to implement next year? How?  
Clearly, we need a system that will ENCOURAGE students to be present and participate in clinical activities as much as possible. Overall CEU requirements have historically fulfilled these goals to a certain degree, however, it is clear that many students are able to disengage from clinical activities on a regular basis and still complete their requirements. There was discussion regarding the ways that students may be able to participate meaningfully in patient care even if they are not the clinicians of record. All students at all levels can and should be involved with chairside assisting activities much more than they ever have in the past. In addition, it is anticipated that even D1 students will be able to be significantly involved in the treatment planning process, particularly in terms of performing data entry and facilitating completeness of the entire process. These learning experiences may also serve as a good basis upon which an educational portfolio could ultimately be based. Many D2 student activities will now take place in the Foundation Clinic and as such, their participation may now be much more “visible,” making it less likely that they will be able to “disappear” without being noticed (as so many have in the past). Having some additional, unscheduled D3 and D4 students available to cover unexpected patient care needs (e.g. emergencies, student absences, etc.) is certainly an important
goal for the future, as circumstances such as these arise on a regular basis. In the discussion, there was no support for actually tracking student attendance (“counting heads”) on a daily basis. It was felt that it would be better to create a “reward” system for clinic involvement rather than a “penalty” for not attending. Rather than tracking individual days of “attendance,” there was some support for the idea that D3 and D4 students could acquire specific “credit” for their contribution to TEAM-BASED goals. For example, sitting beside students’ INDIVIDUAL CEU goals, there could also be a parallel assessment of TEAM PARTICIPATION. There was general agreement that the functional size of teams would need to be somewhat large in order for such an initiative to work properly.

Foundation Clinic – strategy for scheduling and use for this Fall?
D1s will be working in the Foundation Clinic this Summer. Steve Stefanac confirms that routine patient care should not be planned there until November 1. The DH2 preclinical program has an established schedule for use of the Foundation Clinic (including Monday afternoons) for preclinical and partner-based clinical activities. Unfortunately, this conflicts with the historical D2 Fall clinic schedule. Perhaps D2 students could also be working in the foundation clinic (in limited numbers, in any remaining available chairs) along with the DH2s on Mondays? We’ll need to learn more specifics concerning the DH2 clinical curriculum for the Fall – particularly for Monday afternoons – before we can plan anything concrete. Mary Garrelts feels strongly that integrating D2 PATIENT CARE appointments into the VICs is no longer a viable option. Even though D2 patient care has traditional begun during the month of September, there is no reason that it could not be planned to begin in November, particularly considering the many other partner-based projects (anesthesia, rubber dam, occlusal analysis, etc.) that these students have on their agenda. Mark Fitzgerald has spoken to Roger Gillie…apparently there is the potential for at least 4 hard-wired computer access points in the foundation clinic (not at chairside, but located in the “office” area). Perhaps D2 PATIENT CARE activities for this Fall could be weighted more to the end of the Term and more to Wednesdays than Mondays (with more ASSISTING activities on Mondays) in order to maintain a consistent D2 treatment venue and process for that entire term (and leading into a more traditional D2 schedule for the Winter term)? Georgia Kasko potentially is or will soon be working on D2 schedules for the Fall…we will invite her to a CIT meeting soon in order to make sure that everyone is on the same page.

Prophy referrals – can we do differently? better? How?
Previous discussions regarding the potential benefits of directing referrals toward GROUPS of clinicians rather than to INDIVIDUAL D2 or DH students were recounted. Maureen from patient services will be participating in the management of some preventive and maintenance referral appointments in the future. Steve Stefanac is likely more aware of what is specifically being planned (he had to leave the meeting prior to the emergence of this discussion).

Other issues
The faculty survey regarding supervision of specific procedures is pretty much ready to go, but it was felt that it may be more likely to receive the desired level of attention if we wait to distribute it until sometime in August, potentially just as the Fall Term is starting (e.g. August 20-23).
Clinic Implementation Team  
Meeting Notes, 7-27-10, 9-10 a.m., room 2397

Members present: Renee Duff, Mark Fitzgerald, Mary Garrelts, Anne Gwozdek, Laurie McCauley, Phil Richards, Nikki Sweier

Consultant: Steve Stefanac

Guest: Georgia Kasko

Meeting Topic: Foundation Clinic and D2 clinic curriculum/schedule, particularly for Fall Term

Georgia Kasko was invited to join this particular meeting because of her historical expertise in and involvement with clinic rotation schedules and “orange clinic” activities. These discussions are timely, as the parameters that need to be applied this Fall in order to create D2 schedules during the coming weeks must be solidified promptly. D2 students continuing in the “old curriculum” will still be assigned to clinic activities all day on Mondays and Wednesdays (still using the A-B split). The clinic activities for D2s will still consist of assisting/observing in the VIC clinics, completing assigned clinical exercises with partners, and treating referred patients who require simple restorations and prophylaxis/maintenance procedures. Traditionally, these activities were scheduled in a rather consistent manner on all Mondays and Wednesdays, during both mornings and afternoons and spanning the entire D2 year. For this year, it appears that there will be a need to develop a more asynchronous pattern of assignments, weighting the Mondays and Wednesdays differently as well as utilizing the available time and space in the Foundation Clinic differently through the year.

DH2 teaching activities will occupy 16 chairs in the Foundation clinic on Monday afternoons as they always have. For the first time, the interdigitation of this program with the D2 schedule and the Foundation Clinic space and resources creates a space utilization problem. Will there be potential flexibility regarding the scheduling of DH2 Monday p.m. activities in future years? This will need to be investigated. (Later discussion with Wendy Kerschbaum suggests that, with sufficient lead time, the timing of scheduled DH2 preclinical activities may be adjustable in the future). There has also been some recent discussion regarding the potential development of an all new Endo preclinical course (for the new curriculum) to be taught during the D2 Fall term. Clearly, there are lots of moving parts!

What is the potential to mix preclinic and clinical activities in the same clinic at the same time? Does this breach any OSHA regulations? Apparently not…however, it appears that the historical reticence to do this will likely result in continuing efforts to keep such mixing to a minimum.

In terms of planning for D2 patient care (simple restorative, perio patients), there are many challenges attached to the Foundation Clinic at this time (limited available chairs on Mondays, the lack of chairside computer infrastructure until November and the potential need to add or re-assign faculty to staff this area). Furthermore, there is no workable mechanism to assign D2 patient care activities into the VIC clinics under the new clinic design. Considering all of this, would it make the most sense to simply “give up” on direct patient care for D2s during the Fall Term of this year and focus our resources more heavily on the Winter? Mark Fitzgerald strongly
expressed that we should still try to “work the system” to our best possible advantage for patient care activities in the Fall, despite these issues.

The idea that 4 hard-wired computer workstations for MiDent access can be made available in the Foundation Clinic for this Fall, even before November (not at chairside, but rather in the “office” area within this clinic) has been suggested. Would this be sufficient to support patient care? Perhaps…however, we would need to place strict limits on the types of patients that are to be treated under such circumstances. No patient who needs treatment planning or perio charting could be treated there under such conditions…the only appropriate patient care would be individual referred procedures for patients with previously established/completed treatment plans.

We will need to verify that the computer access for the Foundation Clinic that has been described for the early Fall can actually be provided. Steve Stefanac suggested that we should check in with Minna and Justin to confirm that this can actually be implemented. Is it likely that physical access to the clinic for teaching and patient care will be constrained by the need for workers involved with computer installation activities to have access to the clinic? Steve stated that this should not present a problem – the testing phase of the computer and network installation process will likely represent the most significant time and access challenge.

Because of the cumbersome and historically less-than-effective nature of direct student-to-student referrals directed toward D2s, there was once again further discussion of the concept of routing referrals intended for D2 students to the Foundation Clinic itself rather than to any particular student. Under such a new paradigm, the chairs of the clinic could be populated with referred patient appointments by support staff and then the assigned students could then be placed into these appointed chairs to provide patient care accordingly. This process should be workable from a staff support standpoint, the only major unknown element appears to be the acquisition of sufficient numbers of appropriately referred patients.

Along these same lines, there was some discussion of the challenge of securing timely and appropriate patient availability for the D2 treatment planning exercises in the Winter Term. The current concept is that D2 students may be paired with the D3 or D4 student providers participating in the Check-Up clinic and that these D2s may acquire more learner-appropriate treatment planning experiences in this way. Mark Fitzgerald also reminded the group that a significant number of D4 mentors will also be assigned to the Foundation Clinic during the times that D2 students will be working there.

During the meeting, there was significant discussion of potential D2 patient care scheduling strategies. The tentative Fall Term D2 Foundation Clinic scheduling plan that was ultimately endorsed at the end of the meeting, at least in concept, was as follows:

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<tr>
<td>AM</td>
<td>4 restorative chairs</td>
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<tr>
<td>PM</td>
<td>4 restorative chairs</td>
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Clinic Implementation Team  
Meeting Notes, 8-10-10, 9-10 a.m., room 2397

Members present: Renee Duff, Mark Fitzgerald, Mary Garrelts, Preetha Kanjirath, Laurie McCauley, Phil Richards

Consultant: Steve Stefanac

Guest: Georgia Kasko

D2 Schedules and planning for Foundation Clinic  
Georgia Kasko and Mark Fitzgerald briefly reviewed the scheduling strategy that is underway for the Foundation Clinic and other D2 clinical rotations/activities. Because the DH2 program does not begin on Monday afternoons until after Labor Day, all available chairs in the Foundation Clinic are being maximally scheduled during this time in order for students to complete as many of their partner-based clinical exercises as possible very early in the Fall Term. Because of the reduced amount of overall Monday time that will be utilized for patient care during the Fall Term, there will be slightly fewer overall clinic sessions available for patient care for D2s this year. However, there is optimism that the new referral and scheduling process will be able to provide actual patient care experiences for students during their assigned patient treatment sessions more predictably than in the past.

Preetha Kanjirath was brought up to date regarding the idea that D2 students will participate in treatment planning activities for Check-Up Clinic patients during the Winter Term (in lieu of the traditional Treatment Planning rotation). This strategy may be the most workable way to formally expose these students to the treatment planning thought process for patients with dental treatment needs that are potentially at an appropriate level for D2s. However, there was also some discussion that the traditional “immersion” experience (D2 students being fully responsible for treatment planning a somewhat more complex patient) may also still hold educational value. There will likely be some Check-Up Clinic patients whose treatment needs are found to extend beyond the Check-Up Clinic guidelines...could this potentially create a pipeline of patients for alternative treatment planning opportunities? Mark Fitzgerald pointed out that there will be more D4 students scheduled to be clinical mentors with the D2s this year...this may help to reduce the anticipated gaps in faculty assignable to this activity. It was also pointed out that 2 unassigned chairs are likely to be available in the Foundation Clinic...these could be set aside for treatment planning activities (possibly 4 students working in pairs with a single faculty member) as well.

Phil Richards raised the need to describe and disseminate the new policies and practices for referring patients to D2 providers in the Foundation Clinic. The team agreed that granting CEU credit for all referred procedures is an ongoing reward policy that will remain important to success. Mark Fitzgerald described some of his thoughts regarding the Team concept and how it could mesh well with this process as well. Devising an optimal Team size for effective interactions remains under consideration. Mark’s current thoughts are that creating larger sized Teams (either half-clinic or full-clinic sized groups) seems to make the most sense. Roger Gillie
will likely be involved with creating the reports that will aid the referral tracking and Team management process and Jean Thompson will also likely be asked to participate from the referral and patient assignment management/staffing side.

Phil Richards raised the issue of how to best broadcast the information regarding the new referral protocol to students? It was felt that a short (5 minute) intro during one of the early Comp Care Seminars, potentially involving both Roger (representing the MiDent interactive side) and the PCCs (regarding D3/D4 responsibilities and the patient management side) as a “tag team” intro might work the best. Georgia and Mary mentioned that the PCCs are scheduled to meet early next week…we can/should revisit the strategy and specifics for a potential PR blitz following this meeting.

**Issues from the June Town Hall meeting**

Is the perceived lack of multidisciplinary flexibility and/or patient-centeredness that was expressed by some students at the Town Hall meeting based on the new clinic design itself or more on the misbehaviors of some individual “rogue” faculty members? The more specific and detailed information that can be gathered regarding the “unfortunate episodes” that seem to prompt such negative perceptions, the more effectively we may be able to understand and correct them. It was suggested that documenting the specifics of disruptive events (particularly faculty misbehaviors), while potentially awkward and unpopular for the clinic services staff, may prove to be the best way to identify the problems and strategize the solutions.

One of the prevailing concerns is the unexpected busyness in Prostho this Summer along with a perceived lack of predictable availability of Prostho chairs. Mark Fitzgerald has crunched some chair utilization numbers from the entire Summer Term that may shed some light and help us sort out the realities versus the perceptions. Mark indicated that he could provide these data to the group prior to the next CIT meeting. Clearly, there are patterns based on which floor, which day, etc. that may be useful to identify. History suggests that Wednesday will potentially always be a problem unless something epic is done to change it.

The ongoing worry is that limited Prostho chair availability may be something that could create even more problems as the Fall Term gets underway. Clearly, we will need to have a contingency plan to manage this if such problems are encountered. One likely workaround for this could be to seize chairs in the Perio areas of the Green clinics if needed. Renee Duff pointed out that when discipline faculty have to leave their primary clinic for any reason (e.g. to consult or manage something on the other side), they become “invisible” in their assigned area and this creates lots of angst for students who may be looking for them. Phil Richards mentioned that the sign-up system that Perio has traditionally used can be helpful in this regard, as the last request that was “crossed off” generally indicates where a “missing” faculty member can be found.

He also informed the group of the ideas that Eileen Quintero has been promoting to eliminate the “conga line” of students often seen intrusively stomping their way through the clinic, following after a faculty member who happens to be in high demand at any given time. Efforts are underway to potentially create a digital faculty request system, likely linked to MiDent or MiTools, allowing students to request a faculty member electronically from chairside. The sequence of such requests could be managed centrally by floor or by clinic…faculty could then
reference the number and nature of the student requests on the fly, potentially either by way of a flatscreen display in the clinic or a mobile handheld device. Such a system could provide real-time information and perspective for faculty who are in the trenches while also enabling students to stay with their patient and focus on chairside tasks without losing their place in line. There was brief discussion of the fact that airlines and even fast food restaurants use electronic systems to maintain order and provide information so why can’t/shouldn’t we?
Clinic Implementation Team
Meeting Notes, 8-17-10, 9-10 a.m., room 2397

Members present: Mark Fitzgerald, Mary Garrelts, Anne Gwozdek, Phil Richards

Guest: Georgia Kasko

D2 Foundation Clinic, Patient Referrals and Scheduling
Phil Richards expressed his lingering uneasiness regarding some of the impending changes in the Foundation Clinic – particularly related to patient acquisition and scheduling for D2s. Because there will be fewer overall patient care opportunities this year, it will be important to make the most of them. Based on the recent experiences from the D1 “prophy camp” and ITDP patient scheduling process (handled centrally), it seems that appropriate prophy/maintenance patients in sufficient numbers should generally be easy to come by. Georgia Kasko predicts a higher proportion of filled appointments for D2 providers through such a centralized appointing process.

Georgia Kasko and Mary Garrelts described how potential prophy/maintenance procedures can be (and have been…) successfully generated directly from the MiDent recall system. Based on this, D3/D4 student involvement in the patient referral/appointing process for D2 perio providers is probably not so crucial. However, generating appropriate RESTORATIVE patient resources for the Foundation Clinic may prove to be more difficult. Student involvement in the restorative referral process will be very important – we will definitely need to get the word out. As discussed earlier, the plan will be to have Roger Gillie and/or the PCCs discuss this with the students during Comp Care Seminars the first or second week back. Georgia and Mary will follow up with the other PCCs on the specifics once a meeting time can be established. Mark Fitzgerald may also set some threshold expectations for restorative referrals that can be tracked and motivated through his practice management course to inspire student involvement.

The group felt that confirmation of patient appointments for the students in the Foundation Clinic will also be important to success…who will do this? There was general consensus that staff members should perform this task in order to assure consistency and avoid confusion and potential unintended redundancy. Who specifically is best equipped to serve this function? Appointment confirmation may potentially be something that the info desk staff could undertake during down times.

Phil Richards was curious about how prophy/maintenance referrals are distributed to DH students vs D2 students. It seems that the majority of DH patients are those who are already automatically dual assigned with a dental student (based on previous treatment by that DH student). Although DH students are generally always looking for the more challenging patients, it seems that most DH students are not strongly reliant upon new patient referrals to populate their clinic schedules. Mary Garrelts described the disparities that she has observed among hygiene students in terms of how effectively they manage the recalls for their assigned patients…it seems that most DH students have plenty of assigned patients to keep them busy. The operational plan for now is for DH patient referrals and appointments to be handled just as they have in the past for the coming year.
Mark Fitzgerald and Marilyn Guenther have created two D2 SPI experiences that are planned for the early Fall. An SPI (serving as the patient) will be interviewed by the student (including health history, chief concern, etc.)...the student will then summarize their findings to attending faculty. This will be done twice by each student during the early part of the Term. Following this, SPIs will also be observing in the Foundation Clinic on Wednesdays, primarily working on the students’ interactive skills during their prophy/maintenance appointments. The D4 mentors will also be in the Foundation Clinic to help guide the D2s...the mentor assignment schedule will be available shortly.

Other discussion
The idea of having an additional D2 treatment planning experience (outside of the Check-Up Clinic experience) was revisited. It now appears that dedicated chair space in the Foundation Clinic is unlikely to be available during the Winter Term. Another possible location that was mentioned for this type of activity was predoc chairs in the AEGD clinic.

It seems that overall predoc clinic appointments conducted and procedures completed were both down significantly this Summer. Not sure if this was related to the MiDent roll-out, lack of student initiative (without “assigned” clinic days), general manifestations of the down economy or other issues. It appears that D4 students (in particular) were not as active in the clinic this Summer...many were out of the clinic on rotations A LOT (more than normal?).

Mark Fitzgerald reminded everyone that on the morning of September 7, MiDent training for all D2s will take place in the Sim lab.

Faculty Supervision of Procedures Survey
The survey is ready to go as soon as we are ready to send it. Mark Fitzgerald will check in with Margherita Fontana with regard to accessing the faculty mailing list that she used for her recent survey. The plan is to launch the survey late this week or early next week.

Due to the many other things that will be going on next week, no CIT meeting is planned for Aug. 24.
Clinic Implementation Team
Meeting Notes, 8-31-10, 9-10 a.m., room 2397

Members present: Renee Duff, Mary Garrelts, Laurie McCauley, Phil Richards

Consultant: Steve Stefanac

Guests: Georgia Kasko, Jean Thompson

Foundation Clinic, Patient Referrals and Scheduling

Phil Richards initially provided some background information, specifically for the benefit of Jean Thompson, regarding many of the past challenges that ultimately led to the development of the Foundation Clinic concept. These issues included: 1) a general lack of focused faculty attention directed toward early learners in the VIC clinics, and 2) referral processes that were generally losing effectiveness, resulting in 3) more and more “drive by” transfers of often inappropriate procedures to D2s, often with insufficient time remaining for appropriate management, and 4) unpleasant and undesirable learning experiences and outcomes.

The goals of centralizing the referral, scheduling and patient-to-student matchup processes were reviewed, but a primary motivation for the discussion was to assure that everyone was comfortable with the scope of these initiatives and the likelihood of success. Open discussion and “troubleshooting” of many of the “what-ifs” took place around the table during the meeting.

It was generally agreed that appointment confirmation calls should definitely be made for the patients of the Foundation Clinic and that this task should be handled by staff. Some individuals who may be particular well suited to provide guidelines to optimize communication effectiveness and telephone best-practices advice for those staff members who may ultimately be making these calls were identified.

The idea that students will be able to bring friends and family members into their own clinic schedule was confirmed in concept, but some guidelines and processes will need to be developed and disseminated. Clearly, all clinical appointment “substitutions” for patients brought in by D2 students will need to be managed by the appointment office directly. Students (D2s as well as others) will need to be provided with information regarding how these systems will function. No formal plans were established in this regard, except for the plan to introduce the new Foundation Clinic referral process to the D3 and D4 students, most likely during the Comp Care Seminar sessions on Friday, September 10.

There was also some discussion regarding the types of consumable items that will be needed for the Foundation Clinic (patient care items for the cubicle drawers as well as paper forms…and even the receptacles to hold paper forms). There may be a need to develop a small planning group to determine what items will be needed, specifically for cubicle drawers, and how they should be distributed/arranged/managed/restocked. Steve Stefanac suggested that Jane McDougall, Mark Fitzgerald and Phil Richards should definitely be included in this group initially.
Will there be a need for a staff person to be physically present in the Foundation Clinic to follow through on patient/cubicle/student matchups in real time? (Someone to act as a maître d' of sorts…) The idea may merit…we’ll need to discuss further and evaluate what the level of need might be and recruit/plan accordingly.

**Chair Utilization and Scheduling**

While there have been no catastrophic breaches of the new clinic design system so far, there is still significant anxiety regarding the potential constraints of the system, particularly for prosthodontics. The question lingers regarding what to do if demand/need exceeds capacity, particularly as the Fall term activities get fully underway. Faculty numbers are limited…even if more chairs can be made available, the amount of clinical work that can be undertaken remains constrained based on this. Renee Duff is concerned that Test Case opportunities and quality learning opportunities must be safeguarded no matter what and that patient care must remain the primary focus. The plan is to review Mark Fitzgerald’s clinic utilization data from the Summer and discuss more at next week’s meeting (ideally during the second half so Renee can assure that she will be present).

**Faculty Survey / in-service training planning**

Phil Richards will check in with Mark Fitzgerald regarding distributing the Qualtrics faculty procedures survey to the clinical faculty soon. Renee Duff suggests that, once the responses are in, we should attempt to focus on those areas where respondents report a “potential willingness to help” as we brainstorm about in-service training foci for the near future.
Members present: Renee Duff, Mary Garrelts, Anne Gwozdek, Phil Richards

Consultant: Steve Stefanac

Guests: Georgia Kasko, Jean Thompson, Maureen O’Rielly

Planned Topics:
1. Foundation Clinic
2. VIC discipline spaces, student placements, faculty issues

Steve Stefanac reported to the group that the initial experiences with the Check Up Clinic during the Summer were successful. In an effort to generate greater numbers of University students to become Check Up Clinic patients, there is a plan to distribute brochures describing the program to a greater number of sites around campus in the near future.

A good share of the meeting was devoted to a discussion regarding a recent student e-mail expressing genuine concern regarding the proposed process (already underway) for contacting and appointing patients for the Foundation Clinic directly from the recall list. The student in question had received an e-mail message to indicate that a patient from the student’s patient family had been contacted for this purpose, however this particular patient was not actually appointed in the Foundation Clinic. From the discussion during the meeting, the consensus opinion was that the high level of concern raised by this particular student most likely represents a minority opinion among all students. There was additional discussion regarding whether or not there is a need to ask for recalls to be referred before patients are scheduled into the Foundation Clinic. The concern is that the likely rate of referrals forthcoming would most likely be insufficient to supply the patients needed for the D2 program (without also using the recall lists to attempt to find prophylactic recalls appropriate for the Foundation Clinic). While both restorative and prophylaxis patients MAY be referred specifically to this clinic, it is likely that referrals may constitute the vast majority of the potential restorative opportunities, as staff can not reliably identify likely D2 restorative procedures using any other mechanism. It was proposed that students should be instructed to specifically enter MiDent contact notes for any patients that they feel would be inappropriate for D2s – i.e.: “not a good D2 case.” Through discussion, it was decided that the most desirable target patient population for Foundation Clinic prophylactic recall identification would be those patients who are currently 3-6 months overdue. The plan is that the PCCs will briefly introduce the referral and scheduling process to the D3 and D4 students during the Comp Care Seminars this Friday.

Steve Stefanac described results of a MiDent EHR compliance audit. Very good follow through was found for most metrics (including health history entered, signed by patient, perio chart completed, diagnoses for all treatments, phasing/sequencing). The lowest rate of compliance was seen in regard to patient records actually containing a printed copy of the clinical summary.
There was a brief discussion of general clinic issues near the end of the meeting. The primary issue that comes up repeatedly is the perceived shortage of clinical faculty (and those who are present being overworked), particularly in prosthodontics and general dentistry. Faculty tardiness has also been reported as a significant concern in some instances. There was some discussion regarding whether or not the chairs designated for the disciplines are being used to actually limit available appointments. Mary Garrelts indicated that creative efforts on a daily basis are focused toward finding a spot for all appointed patients no matter what it takes in order to avoid “compromising patient care.”
Clinic Implementation Team
Meeting Notes, 9-21-10, 9-10 a.m., room 1033

Members present: Renee Duff, Mark Fitzgerald, Mary Garrelts, Anne Gwozdek, Laurie McCauley, Phil Richards, Nikki Sweier

The meeting began with a discussion concerning the perceived loss of patient centeredness in the new clinic design…one of the original guidelines was that the change should be seamless/invisible to patients – this is clearly not what has happened. It is difficult to say how much of the trouble we are currently seeing is due to the new clinic design itself and how much can be attributed directly to the behaviors of inflexible or dogmatic “rogue” faculty members. Regardless of this lack of clarity, we now need to reinvest in the process of developing a culture of flexibility in the management of patient care – the question is: how do we do that?

One obvious possibility would be to migrate back to a system that would look something like the previous clinic design…while this might be the easiest reaction at the present time, it would be unpopular and undesirable in terms of efforts to move the Vision Implementation for the new curriculum forward. Also the “old” system clearly masked significant problems in our clinical teaching and patient care processes…what we have experienced since June has simply made some “gaps” or systematic overruns in our system much more evident – this may be most clearly represented by the challenges that are currently being experienced in prosthodontics. Finally, the level of staffing that is currently assigned to the clinics for each discipline may not be sufficient/appropriate to “switch back” to the old design.

Clearly, some of the problems we are experiencing have to do with poor compliance concerning the types of activities that should be taking place within the discipline areas…the original design included a limited intended scope of procedures for the discipline areas (initial experiences, test cases and advanced procedures). There was some discussion of the student/faculty ratios that are currently in play…Mark Fitzgerald has concerns about the nominal general dentistry ratios (up to 8 students for every 1 faculty member) when compared to the much smaller ratios (by design) for prosth. Students (particularly D4s?) clearly have followed habitual patterns in that they generally seek out only prosthodontic faculty members whenever they are performing any prosthodontic procedures.

While there are some general dentistry faculty members who are willing/able to cross teach, the effectiveness of this is diminished when students are frequently working outside of their home clinic and may not know or understand the interests/skills/willingness of individual faculty members in regard to cross teaching. We may be hindered right now based on the lingering need to provide more targeted in-service training, particularly for general dentistry faculty members…perhaps in the future when faculty development efforts can be ramped up (using Flex time?), we will be able to arrive at something approaching the original vision?

Based on the meeting of Renee Duff, Mark Fitzgerald and Phil Richards that took place last week, one possible modification that may preserve some positive aspects of the discipline-based areas while also providing more access/flexibility for students in both clinics would be to create discipline spaces in all clinics that would include both Perio and Prosth chairs. There was some
discussion regarding the mechanics/logistics that might surround such a system. Those in attendance seemed receptive to the potential benefits of such a design.

There was some discussion of the pre-treatment perio huddles as a focus of student concern. While there have been some positive experiences from some of these interactions, unfortunately it appears that the majority of the students have not gained an appreciation for the value…in fact it appears that they have spent significant time and effort developing creative strategies to purposefully avoid the huddles…as a result, these student behaviors appear to be interfering significantly with the potential for smooth, efficient application of this and other new clinical education initiatives. There was general agreement with the concept that a long term goal for the entire clinical program should include some type of formal, separate student-faculty interaction in the clinics to support the patient care process for ALL DISCIPLINES. It is likely that different disciplines would design and use these opportunities in slightly different ways, however it was felt that this should eventually become part of the culture of the entire clinic. Based on this, it is anticipated that appointment times would need to be formally adjusted to accommodate these huddles in the future.

The end of the meeting included a brief discussion of lingering concerns that Phil Richards has regarding who should represent and lead/manage the current and future predoctoral clinical education enterprise and thus be responsible for responding to emerging challenges like the ones that we are currently experiencing. Between the CIT group, the Discipline Coordinators, the VIC directors and Patient Services, there are many (actually too many?) leaders and stakeholders who are potentially “responsible” and should be able to manage tweaks of the system as well as the associated public relations issues. However, it appears that there is currently no particular individual or group who can/should/will take the reins and manage/maintain the daily operation of the predoctoral teaching clinics. Phil Richards reminded the group that he will be meeting with Drs. Stefanac, Murdoch-Kinch and Don Heys on Wednesday to discuss the current state of affairs in the clinics, specifically the ongoing student concerns.
Clinic Implementation Team  
Meeting Notes, 10-5-10, 9-10 a.m., room 1033

Members present: Renee Duff, Mark Fitzgerald, Mary Garrelts, Anne Gwozdek, Laurie McCauley, Phil Richards, Nikki Sweier

Consultant: Steve Stefanac

The main discussion of the meeting surrounded Phil Richards’ suggestion (in an e-mail preceding the meeting) to implement a change to include all disciplines in all clinics once again – as soon as possible. The primary challenge for near term implementation of such a plan (e.g. during the present academic term) would be the fact that staffing profiles for disciplines/departments are basically set for the present term and cannot really be changed now. Also, strategic planning with the patient services group would also be necessary in order to place existing appointment requests properly into a new clinic/cubicle profile. Steve Stefanac reports that prosthodontic appointment requests are already in the system for patient visits as far ahead as March, 2011.

The current “new” clinic model has created some significant and tangible benefits for perio instruction, but has clearly hindered effective management of student and patient needs in prosthodontics. Clearly some of this functional mismatch comes from students seeking out prosthodontic chairs and faculty by choice or by habit rather than by necessity. The scope and number of prosthodontic test cases also raises some concern…couldn’t some of this teaching burden be shared by some non-prosthodontic faculty? The examples that were cited included alginate impression test cases and those test cases associated with single crowns…Steve Stefanac mentioned that he himself would certainly feel comfortable assessing performance in these areas – do these test cases really require a prosthodontist (or a prosthodontic “chair” in the clinic)? Renee Duff expressed that “checking” such procedures COULD likely be done by any DDS faculty member…however, she feels strongly that test cases and the structure and feedback that they include should be much more than simply “a hoop” that must be jumped by students.

There was some anxiety expressed about “giving up” on a clinical program modification that was undertaken following the extensive discussions and negotiations that took place during nearly 2 years of meetings. In many ways, even with the preservation of “discipline specific areas” within each clinic, the resulting benefit (compared to the previous clinic design) that would result from simply including all disciplines in all clinics once again as Phil Richards has proposed would likely be minimal. Have we really done anything meaningful or good here?

Based on Phil Richards’ e-mail prior to the meeting, he also raised discussion regarding the potential value of creating separate D3 and D4 clinical environments (for basic skill development and more independent clinical care of patients by experienced students across disciplines, respectively) for the future. Mark Fitzgerald expressed that he is definitely not in favor of this concept…he feels that students would respond unfavorably to such a loss of patient care flexibility during the D3 year. Laurie McCauley expressed that incoming D3s in future years would most likely not have any such strong negative reactions, as they would not have ever experienced anything other than a highly structured clinical experience (in the Foundation
Clinic) before. There was general agreement that students should have been (and should in the future be) involved in the planning of such significant clinical program design changes.

One concept that must be acknowledged, based on the fact that appointment requests are basically never “turned down” once submitted is the fact that “discipline chairs” (mixed prosthodontics and periodontics) within each clinic should not be limited to any specific number…the goal is simply to regionalize them as much as possible. With this in mind, in order for the major daily swings in patient care activities to be effectively managed by faculty in the future, a more significant effort toward meaningful cross teaching will be a very important need/goal. Once again, this is something that hopefully can be encouraged by the development of a meaningful faculty in-service training program.

Mark Fitzgerald reports that about 48 faculty members have responded to the procedure supervision on-line survey so far…there was some discussion about sending out a reminder e-mail to prompt non-responders to participate as soon as possible. Hopefully the CIT can then begin to review the trends from the survey and begin to outline in-service training priorities in the near future.

No one expressed any direct opposition to Phil Richards’ proposal to change the current clinic design to include all disciplines in all clinics once again. Based on this, Phil Richards plans to propose this to the VIC directors at this week’s monthly meeting of Discipline Coordinators with VIC directors. The plan will then be for the CIT to meet again next week, to invite Georgia Kasko to join the meeting, and to discuss the logistics and specific plans/changes that will be needed in order to make the transition happen as quickly and painlessly as possible.
Clinic Implementation Team
Meeting Notes, 10-12-10, 9-10 a.m., room 1033

Members present: Renee Duff, Mark Fitzgerald, Margherita Fontana, Anne Gwozdek, Phil Richards, Nikki Sweier

Consultant: Steve Stefanac

Guest: Georgia Kasko

The initial discussion focused on the plans to restructure the clinics to include all disciplines (except for endo) in all four clinical areas once again. The question of precisely when this change should be implemented was posed. There was general agreement that the change should be made as soon as possible, but there are some professional conferences occurring during the first week of November that may render changes during that time less successful. The target date that was ultimately agreed upon: November 8, 2010.

Based on some of the preliminary discussions preceding the meeting, clustering of cubicles in each clinic for periodontal and prosthodontic activities was suggested near the student lockers. There was some perceived advantage to making both floors look somewhat the same (despite the presence of endo chairs on the 2nd floor)…with this in mind, it was decided that the “middle” bank of cubicles (running from North to South) would be the target areas for periodontal treatment activities and the East rows of cubicles (again, starting at the end of the clinic nearest the student lockers) would be target areas for prosthodontic procedures in all four clinics. Georgia Kasko stated that she would incorporate these changes in the schematic clinic maps that had been distributed previously and re-distribute them.

It was emphasized that chair numbers and areas of focus within the clinics are not intended to be limited or fixed in any way – e.g. all chairs in the clinic are ultimately treated “the same.” Chair numbers and activities will certainly need to be very fluid from day to day based on patient needs. However, at least some attempt to “cluster” clinical procedures will still be made, with the intention of allowing at least some concentration of faculty resources. Despite this goal, faculty will clearly need to move around the clinics significantly in order to serve the needs of patients and students wherever they happen to be located.

It was agreed that, in the future, all appointment requests submitted by students should include the specific procedure codes that are planned for that clinic session. While the web-based appointment request tool may not allow full functionality in this regard, it is possible that modifications could still be made to facilitate and enhance this in the future as well.

It was also agreed that there may be functional advantages from attempting to cluster dental hygiene students to be somewhat nearer to the perio activities – specifically attempting to avoid the far corners of the clinics as much as possible for placement of hygiene students. The imbalance between the two floors that results from the placement of the endo cubicles is a concern, particularly as it relates to having sufficient numbers of available chairs for dental hygiene activities on the 2nd floor. The idea was raised that perhaps the number of dental
hygiene students assigned to or treating patients within the 3rd floor clinics should be increased in the future in order to partially manage this issue? The plusses and minuses of such a policy were briefly discussed, particularly as they relate to the staff and patient management inequities across clinics that could potentially result from such a change. Despite these concerns, this concept was considered to be worthy of at least some additional thoughtful consideration. Anne Gwozdek volunteered to investigate and discuss with the Dental Hygiene faculty leadership and report back at a later time.

One of the key initial charges to the Clinical Implementation Team was related to the development of a team focus and patient care team activities – where should we go next in planning for and discussing this? Phil Richards once again verbalized some of the frustrations that have been faced regarding the development of a shared vision for the clinical education environment. One could argue that, with the impending reversal of some of the more significant new initiatives that have been proposed by the CIT based on our many months of work, our path into the future is certainly less than clear. Between the VIC directors, the discipline coordinators, patient services and the CIT group, it has proven to be very difficult to achieve buy-in, create excitement, sustain momentum and get new policies and strategies to “stick.” At some point, the CIT will be the group from the above list that will cease to exist…development of a CIT “exit strategy” will be necessary, possibly sooner rather than later. There was once again general agreement that having a singular director for the predoctoral clinical education program makes good sense.

There was a brief discussion regarding the Foundation Clinic and its use. At some point, there will be a need to map out specifically who will be using this facility and when. While dental hygiene, perio and restorative activities are currently in place within the Foundation Clinic, there will need to be a coordinated effort to manage this area. It was agreed that there could also potentially be advantages to developing some early learning activities in prosthodontics for the Foundation Clinic. With the emergence of regular D1 activities within the Foundation Clinic during the upcoming Winter term, schedules will need to be mapped out and planned very soon in order to prevent head-on collisions.

There was also a brief discussion of pre-treatment clinical huddles. While the “huddles” of dental offices may have a certain function, the underlying concept of these interactions within an educational environment suggest that they are really best described as “rounds.” While the ongoing initial experiences with such activities in perio have been largely faculty-driven, it is hoped that these interactions could become primarily student driven in the future. The latest CODA standards suggest that student leadership in activities such as these will need to be emphasized. This could also have a positive effect on fostering the “team” concept within all clinics and between all disciplines. Finally, the dental office intentions for the “huddle” may also be translatable into the teaching clinics as an application of practice management principles.
Clinic Implementation Team
Meeting Notes, 10-26-10, 9-10 a.m., room 1033

Members present: Renee Duff, Mark Fitzgerald, Margherita Fontana, Mary Garrelts, Anne Gwozdek, Laurie McCauley, Phil Richards, Nikki Sweier

Consultant: Steve Stefanac

Phil Richards summarized some of the discussion from this morning’s VIT meeting. The primary focus of the meeting was the D2 Spring term. There had been a push to create significant pathways time for the students during this particular term – primarily to allow students in the research pathway to meaningfully incorporate themselves into labs. Considering other curricular elements that must also be presented during this time, there has more recently been some discussion of the potential need to constrict the pathways time during this term somewhat. In particular, the use of the sim lab during this period must be as efficient as possible (exemplified by the pending elimination of the A/B split)…this change will require more faculty resources during fewer half days. Mark Snyder reported that, while the “fixed” courses can be moved forward into the Spring/Summer and Fall terms, it appears that the removable prosth courses cannot be moved. This will mean that the goal of patient families being assigned to students midway through the D2 year may still be possible, but that the students will not have completed their coursework and training in RPDs by that time.

Phil Richards asked the question of whether or not patient families for D2s in the Winter term be effectively assigned without the students having RPD treatment capability? In the discussion among the group, no major concerns were expressed. This situation may require modification of the patient screening and assigning processes to accommodate, but this was generally felt to be do-able. Steve Stefanac emphasized that having the ability to shift patient assignments from D4 to D2 students during the Winter term remains an important patient care goal.

The issue of the November 8 clinic transition was raised. Phil Richards reported that perio is planning to try one sign-up list per floor, centrally located somewhere in the hallway between the main clinics in order to try to accommodate the ebb and flow of clinical activity as effectively as possible. The faculty request mobile electronic application that informatics is developing was also mentioned. Steve Stefanac reported that Ron Heys will be involved with assessing this tool and indicated that Ron has historically expressed some concern about the impersonal nature of such queues. In terms of when something like this might be ready for actual use in the clinic, Steve Stefanac indicated that it most likely would NOT be ready for early Winter term implementation – not sure exactly when or how, but at least it is moving along.

Renee Duff indicated that prosthodontics will be moving back toward 2 assigned faculty per clinic as soon as possible and that they are currently not planning for any signup lists. Mark Fitzgerald expressed concern that the faculty coverage shortfall that students will experience in the near term is likely to be in general dentistry due to rededication of some individuals back to prosth. Further, Mark lamented that no faculty reductions have been realized in any of the changes that have been made…he feels strongly that we need to work on creating flexibility and changing/correcting processes that are inflexible and inefficient. Mark feels that the most
notable inefficiency that we currently have is in treatment planning – particularly in the RE-
treatment planning of patients whenever they are reassigned to a new student.

Phil Richards asked how we would/should go about creating meaningful changes in complex
processes such as these? The difficulties that the CIT has experienced in terms of achieving buy-
in and moving change forward have been very frustrating and have rendered many of our
initiatives ineffective. While treatment planning is complex and “owned” by multiple
disciplines/departments within the school (making it a complicated task to manage), it was
agreed that current conditions (particularly following the successful MiDent implementation)
may represent a golden opportunity to modify the treatment planning protocols and processes.
Steve expressed that he feels that the VIC directors would likely be the best group to manage
such a change. Mark Fitzgerald also raised the point that he feels that we really need to take a
close look at how we measure clinical competency. It was mentioned once again that portfolio
strategies may have some merit in this regard, particularly in light of some recent moves to
facilitate licensure opportunities (in California) based on clinical portfolios, rather than by way
of a traditional clinical board exam.

The faculty survey was discussed briefly. Mark Fitzgerald indicated that a reminder e-mail had
been sent to non-responders and that ~80 responses have now been received…this represents a
very good sample, based on the number of faculty members who were initially targeted. The
respondents were most numerous among the general dentistry faculty group. Mark was able to
pull up some of the results data in real time during the meeting and there was some brief,
preliminary discussion. Mark will send out a report on the data for review by the group.

The final agenda item for this meeting was consideration of CIT plans for the future. Phil
Richards shared the fact that he is troubled by the amount of effort that has gone into the work of
the CIT with so little apparent change/benefit having been achieved, based on this work. The
future role of the CIT (as with other “vision team” groups as well…) is not clear – even in the
near term. Phil Richards mentioned that there is a faculty retreat planned for
December…following that time, there will likely be some efforts for some groups to switch from
implementation mode into a more sustainable administrative arrangement. Phil also expressed
the uncertain status of director of predoctoral clinical education position and how this may
influence future needs and activities.

While there will be no CIT meeting on November 2, we will tentatively plan to meet on
November 9 and the most likely focus for that meeting will be on interpreting and responding to
the faculty survey results.
Clinic Implementation Team
Meeting Notes, 11-9-10, 9-10 a.m., room 1033

Members present: Renee Duff, Mark Fitzgerald, Mary Garrelts, Laurie McCauley, Phil Richards, Nikki Sweier

Consultant: Steve Stefanac

Phil Richards opened the meeting by raising the issue of the future goals/directions for the CIT. He expressed the likelihood that, following the upcoming December faculty retreat, many “vision” activities may be scaled back with the specific goal of placing ongoing management/responsibility for the curriculum and clinical programs into the existing school leadership structure or some modified future organizational scheme. While many aspects of the original charge to the group have not been realized, Phil feels strongly that further progress should be pursued by working through “normal” administrative pathways within the school rather than through the decisions and actions of this team – particularly in view of the challenges that the CIT has faced and the unanticipated recent reversals of new clinical initiatives. The group reflected on the original and current composition of the team, particularly the absence of any regular representation from the clinic directors group or from students, as well as the limited involvement of many discipline coordinators. There was some support for invigorating and empowering the discipline coordinators group for the future in order to inspire greater representation and involvement of all disciplines, particularly those that have not been significantly engaged in the vision implementation so far.

There was also significant discussion regarding the potential value/function of having a director of predoctoral clinical education. Phil Richards described his observations that, in the early years of the VICs, it appeared that lots of energy was devoted to analyzing, managing and enhancing the clinical program on an ongoing basis. He spoke about the need for someone to be specifically responsible for monitoring and maintaining forward momentum for the clinical education program. However, both Mark Fitzgerald and Mary Garrelts spoke out against adding a new position, emphasizing both the potential inefficiency and public relations challenges of hiring someone new (another administrative “layer”). Mary reflected on the poor staff morale at the current time and how a new hire at this time would be viewed very negatively. Indeed, one of the primary motivations for recent clinical curricular change was the goal of increased efficiency…this clearly has NOT been realized in any way, shape or form. Mark and Mary also expressed their concern regarding the potential for a new “director” to be perceived as either lacking sufficient authority or imposing too much of a “top down” influence on the existing organizational structure. Any future actions in terms of administrative reorganization and/or recruitment of a director of predoctoral clinical education will clearly occur outside of the CIT group, so further CIT debate in this regard would serve no meaningful purpose.

Two ongoing activities of the CIT that still need to be moved forward were discussed briefly.

1. Clinical faculty development is clearly a priority for the future. The faculty response data derived from the recent survey regarding supervision of clinical procedures should
serve as a valuable resource to help guide future clinical in-service training efforts. Based on initial inspection of these data, there do not seem to be any specific “hot button” areas of more immediate need at the present time. Mark Fitzgerald reinforced the idea that adjunct faculty as a group are very willing to teach within the realm of general dentistry (but outside their traditional departmental designations)…they simply wish to support the “party line,” and need to be told what the clinical care policies and practices within the school actually are in order to be equipped to follow them. Clearly some of the current limitations in terms of effective “cross teaching” also originate from the fact that students have generally continued to seek out the discipline specific faculty routinely (whether they actually need them or not). **It is felt that future clinical in-service training programs should most likely be planned and/or managed through the discipline coordinators’ group, the VIC directors group, by Academic Affairs or by some future director of predoctoral clinical education.**

2. **Development of ongoing and meaningful Team Activities** is also an important goal for the future. It was proposed that Team activities must not just be “a clinic thing” that is managed by clinical leaders, but rather the team focus should follow an organized and integrated theme or thread throughout the entire curriculum. There was brief discussion regarding the potential evolution of teams through the curriculum – e.g., membership in (a) given team(s) for a particular student should potentially shift and adapt (possibly based on common or complementary pathway interests, etc.) during different stages of dental school. With this in mind, it was suggested that creation, integration and management of team activities should most appropriately fall within the realm of Academic Affairs and be overseen by the curriculum committee in the future.

On a positive note, the successful refurbishment and early success of the Foundation Clinic certainly represents a significant positive outcome from the work of the CIT!

As the meeting concluded, Phil Richards indicated that no additional meetings will be planned for the CIT group. He will work during the next few weeks to formulate a CIT report as well as a representative CIT summary to be included in an upcoming VIT white paper report. Phil will distribute this work to the CIT group for comments and approval upon completion.