CLERKSHIP DIRECTORS COMMITTEE

January 17, 2014

MINUTES

Present: Justman (Chair), Allareddy, Anderson, Clancy, Clark, Cunningham-Ford, Duffe, Eckert, Elvers, Gratton, Guzman-Armstrong, Handoo, Kanellis, Kayser, Lindquist, McKnight, Naberhaus, Schneider, Solow, Spector, Synan, Timmons, Welsh-Grabin, Yoder

Absent: Mabry

Guest: Straub-Morarend

1.0 Approval of November 8, 2013 Meeting Minutes

The minutes from the November 8, 2013 meeting were approved as written.

2.0 Treatment Planning Work Group Feedback

The treatment planning initiative is an effort to streamline patient care and patient flow and increase retention. Treatment planning is a collegiate program common to all programs and departments.

Dean Johnsen commissioned a Treatment Planning Group in May 2013

- Purpose: to evaluate and improve the coordination of treatment planning in the College of Dentistry from educational and patient-centered perspectives. (See attachment).

PROPOSALS:

• PROPOSAL I

Assignment of specialists to the Oral Diagnosis Clinic for specialty consultation during the D 3 treatment planning process.

Comments/Questions

- Which specialties would be assigned to the OD Clinic? Prosthodontics and Operative; possibly Periodontics and Endodontics.
- It would be beneficial to have a prosthodontist OD.
- Title 19 requires preauthorization for periodontics with probing depths which are not done in OD, delaying the preauthorization process.
- Acquire all diagnostic information up front in OD. .
- Assigning a Periodontist to OD would be helpful.
- Endodontics gets questionable cases and needs to know if teeth are restorable before conducting procedures. Having a Pros specialist in OD would help to expedite and streamline patient treatment.
- Some complex cases have to mount casts before the treatment plan can be finalized. Compiling a final treatment plan on the day of entry is not always an option.
- Family Dentistry does not always develop a complete treatment plan on the initial visit.
- How much additional faculty would be needed? Patient lines and faculty hiring must be considered.
- A goal of this project at this point is to consider possibilities conceptually without considering details.
- What problems would Proposal I solve?
  - It would provide consistency of calibration
  - It would reduce or eliminate redundancy of changing treatment plans
  - It would increase patient retention
  - It would be helpful if more students could complete treatment for patients for whom they developed the treatment plan.

PROPOSAL II

Routine comprehensive care patients are directed from Admissions to the Oral Diagnosis Clinic. ***Complex*** *patients are routed from Admissions to the D 3 Prosthodontics Clinic or the Family Dentistry Clinic.*

Comments/Questions:

- If patients are to be diverted to Family Dentistry, why not immediately? Family Dentistry patients now go to Family Dentistry from the D3 Admissions clinic.
- There are 3 options: Pros, Family Dentistry or OD. Having OD experiences in Pros. MAY reduce the number of appointments.
- Patient flow: the College reaches certain times of year when one option is OD not available.
- It may be possible to open flow of pats from D3 to D4 and the patients could follow student as they enter the 4th year. But in October is there enough student coverage to have that line of options?
- Complex needs to be defined. Everyone would have to be trained and calibrated on the new Pros scale.
- The overall requirements for Pros must be considered. Students who do the treatment plan may not be ready to treat a Pros patient.
- This could be solved with readjusting patient flow, but it would not work for the first block. Right now patients with moderately complete plans go to Family Dentistry. Dr. Morarend often hears that there are not a lot of simple cases. Would it be possible for OD to expand into more of a recourse for D4 students, as well?
- Complex patients would be presented with a treatment plan until disease control is completed. The suggestion was made to combine Operative treatment with Pros, Perio and Endo consults. Many patients do not continue treatment after disease control is complete.
- Omitting the Admissions appointment and moving patients to OD or Family Dentistry or the third year would3rd year would reduce the number of visits.
- Radiology is the issue. At an Admissions clinic appointment, radiographs must be ordered before a patient can move on.
- A more accurate reflection of number would be to get radiographs that day. Skip the Admissions appointment and admin orders them and more likely to have patient return. (Timmons)
- In Family Dentistry student make radiographs that day. D3 students in OD can do radiographs, but students are waiting for patients.

PROPOSAL III

Limiting the breadth of the Oral Diagnosis Clinic to oral diagnosis and findings. Potential for streamlined appointing for D 3 patients from Admissions to Oral Diagnosis (one visit).

Comments/Questions:

- OD becomes the clerkship and then the treatment plan is separate entity.
- If a patient comes to Operative for the treatment plan, then consultants would come to Operative. Would this mean less consistency in treatment planning? No, the proposal would improve consistency
- Where is the treatment plan going to happen? That's the issue.
- The proposal would miss Perio, other clinics would have to refer to Perio which may have more demand. Consultants would be spreads thin.
- If researching the advantages and disadvantages of the proposal it may be helpful to determine how many patients do not come back when additional diagnostic appointments are needed.
- In Family Dentistry, the patient has a home--it their clinic—which is an advantage.
- Dr. Kanellis noted that at some schools 50% of patients do not complete treatment plans.

PROPOSAL IV

Limiting the breadth of the Oral Diagnosis to oral diagnosis and findings. Creation of a distinct and separate Treatment Planning Clinic.

Comments/Questions:

- The proposal does not address the cycles of student rotations
- Clinics would be running almost all year around: D3 until July 1 and D4s start up 2 weeks later.
- Would this be another clerkship?
- Every department has to have their skin in the game.
- There has to be some kind of screening: electronic and face-to-face. Some with resources. Screening 20-25 patients per day does not negate that.
- Proposal 1 would not be viable. The greatest impact would be on clerkships.
- Streamline the process and lower the number of appointments before treatment starts.
- The Proposal models private practice behavior
- Avoid redundancy
- How can we get consistency in treatment planning across disciplines?
- When presenting a treatment plan to a patient it should be emphasized that it may change over the course of treatment. Treatment plans will evolve—that will never change.
- Limited care patients are more likely to fail to complete treatment.
- Dr. Straub-Morarend would like additional feedback from the clerkship directors.
- Communication among disciplines is vital to the success of this project.

3.0 AxiUm Consult Form

During an audit of AxiUm records Ms. Yoder noted that documenting consultations is not consistent. Usually, the student and or consult completes it. Sometimes it is not completed.

Comments:

- Often the consultants does not have time to fill in the information.
- The internal, rather than the external recording, appears to be inconsistent.
- Keep the consultation notes in the body of the appointment note so it is easy to access and it would also be easier to review the record in the same place.
- Insert space between the consult and the pat notes.
- Have a check box for "*Was consult needed?"* If no, then that section disappears.
- Have a different color for consult notes. Answer: AxiUm currently does not allow for different colors at this time, and the company is working on it.
- There is a code for consult that can be entered in the record.

4.0 Additional Comments and Discussion

No comments were offered.

5.0 Next Meeting

February 14, 2013 at noon in the Deans Conference Room.

Minutes respectfully submitted by Mary Lynn Eckert.

Coordination of Patient-Centered Care

Cheryl Straub-Morarend DDS

Background

- Dean Johnsen commissioned a Treatment Planning Group in May 2013
- Purpose:
  - Evaluate and improve the coordination of treatment planning in the College of Dentistry from educational and patient-centered perspectives

Background

- Members of the committee:
  - Dean Garcia
  - Dean Schneider
  - Dr. Ron Elvers
  - Dr. Nidhi Handoo
  - Dr. Carrie McKnight
  - Dr. Cheryl Straub-Morarend

Primary Objectives

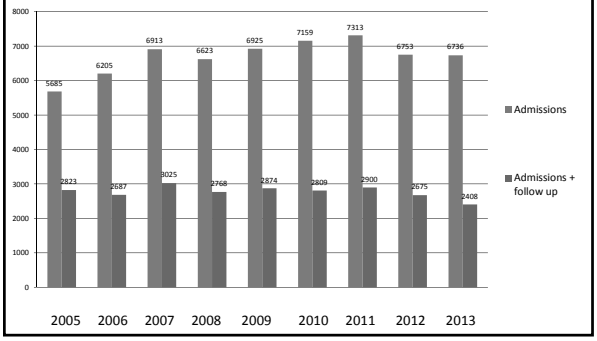
- Identify areas which can enhance the ingress of patients
- Improve coordination of treatment planning for the benefit of the patient and the educational mission
- Streamline the oral health care needs presented as a personalized treatment plan with a focus on patient-centered care across departments
- Address treatment planning as a collegiate program

Cibus Pro Sententia

- Is our current system of patient flow in the College of Dentistry patient-centered?

Patients' flow in Admissions/Patients follow up at COD

A Gasparoni



Cibus Pro Sententia

- Is our current system of patient flow in the College of Dentistry patient-centered?
- Is "Pooling of Patients" modeling appropriate patient-centered care?

Presentation Objectives

- Discuss proposals to improve patient-centered care at the College of Dentistry
- Gain insight from clerkship directors regarding issues with the current model
- Request feedback regarding proposals to improve patient-centered care
- Request additional proposals to improve patient-centered care

Patient-Centered Care

- Acknowledgements:
  - The clerkship system will remain intact
  - Proposals are in infancy stages
  - More information is required

Patient-Centered Care

- Proposal I

  Assignment of specialists to the Oral Diagnosis Clinic for specialty consultation during the D 3 treatment planning process.

  - Advantages:
    - Affords additional screening of patients
    - Improves consistency/calibration in treatment planning
  - Disadvantages:
    - Faculty coverage
    - Coordination of schedule
    - Fails to address concerns regarding the number of visits for a patient to achieve treatment

Patient-Centered Care

- Proposal II

  Routine comprehensive care patients are directed from Admissions to the Oral Diagnosis Clinic. *Complex* patients are routed from Admissions to the D 3 Prosthodontics Clinic or the Family Dentistry Clinic.

  - Advantages:
    - All complex patients bypass an OD appointment
    - Improves consistency/calibration in treatment planning for complex patients
    - Improves chair utilization from Aug-Sept in the Prosthodontics clinic
  - Disadvantages:
    - Oral Diagnosis exposure will change
    - Fails to address concerns regarding the number of visits for a patient to achieve treatment

Patient-Centered Care

- Proposal III

  Limiting the breadth of the Oral Diagnosis Clinic to oral diagnosis and findings. *Potential* for streamlined appointing for D 3 patients from Admissions to Oral Diagnosis (one visit).

  - Advantages:
    - OD becomes a distinct clerkship addressing diagnosis, radiographic, oral medicine and interpretation of findings
    - Potential opportunity to combine the OD and Admissions appointments to one visit allowing initial entry into the College of Dentistry to be maximized
    - Opportunity to expand the Admissions Clinic to Screening/Urgent Care
  - Disadvantages:
    - Treatment planning would require diversion to a D 3 clinic for comprehensive management
    - Admissions & OD would change interaction/operations

Patient-Centered Care

- Proposal IV

  Limiting the breadth of the Oral Diagnosis to oral diagnosis and findings. Creation of a distinct and separate Treatment Planning Clinic.

  - Advantages:
    - OD becomes a distinct clerkship addressing diagnosis, radiographic, oral medicine and interpretation of findings
    - Expands the Admissions Clinic to Screening/Urgent Care
    - Patient flow continues throughout the calendar year
    - Resource for D 3 & D 4 students
  - Disadvantages:
    - Fails to address concerns with patient flow and the number of visits for a patient to achieve treatment
    - Admissions & OD would change interaction/operations

Brainstorming Session