| Curriculum Committee Meeting Agenda | |
|---|---|
| February 1, 2017 | 12:00 – 12:50 pm; Deans Conference Room (N304 DSB) |
| Dr. DC Holmes, Chair | Recorder: Ms. Michelle Krupp |

**Lunch served.**

| Agenda Items | Responsible Individual |
|---|---|
| 1. Approval of January 4, 2017 Minutes | LTGarcia (*Dr. Holmes absence)* |
| 2. Office for Education – Update<br>• AEFIS-Curriculum Mapping<br>• WG on Practice Management Curriculum<br>• Patient Ingress & Treatment Planning<br>• 50:10 Lecture Protocol - Policy | Krupp/Garcia |
| 3. Curriculum Management – Family Dentistry Curriculum Review | Abdelaal |
| 4. Round Table Comments | Committee |
| 5. Next Meeting: **March 1, 2017** | |

| Action Items | | | |
|---|---|---|---|
| **Status** | **Action to be taken** | **Responsible** | **Due Date** |
| Pending | Department Curriculum Review: Family Dentistry | Abdelaal | February |
| Pending | ICCMS Implementation in the College | Kolker/Guzman-Armstrong | |
| Pending | Biochemistry & Pharmacology WG | Hellstein/Krupp/Hoffman | |
| Pending | Prerequisite Basic Science Question; INDBE | Garcia | |

**Curriculum Committee (2016-2017):**

DC Holmes, Chair
Maged M.E. Abdelaal
Marsha Cunningham-Ford
Darren Hoffman
Brian Howe
Terry J. Lindquist
Leonardo Marchini
Natalia Restrepo-Kennedy
Cheryl L. Straub-Morarend
Fabricio Teixeira
Paula L. Weistroffer
D2 – Amanda Phan
D3 – Stacey Howes
D4 – Briana Lage

**Ex Officio:**

Lily T. Garcia, Associate Dean for Education
Ms. Michelle Krupp, Director, Education Development
Tad Mabry, Chair, Clerkship Directors
Galen B. Schneider, Executive Associate Dean
Catherine M. Solow, Associate Dean for Students
Sherry R. Timmons, Chair, CAPP Committee
Guest: Tara Sears, D2, ADCFP Fellow

THE UNIVERSITY OF IOWA
COLLEGE OF DENTISTRY & DENTAL CLINICS

# Curriculum Committee
## Minutes – February 1, 2017

**Members Present:** Drs. Maged Abdelaal, Darren Hoffman, Brian Howe, Terry Lindquist, Leonardo Marchini, Natalia Restrepo-Kennedy, Cheryl L. Straub-Morarend, Fabricio Teixeira, Lily T. Garcia, Tad Mabry, Sherry Timmons, Dean Catherine Solow, Ms. Marsha Cunningham-Ford, Ms. Amanda Phan (D2), Ms. Stacey Howes (D3) and Ms. Michelle Krupp

**Absent**: Drs. DC Holmes (Chair), Paula Weistroffer, Galen Schneider and Briana Lage (D4)

**Guest:** Ms. Tara Sears, ADCFP Fellow

Meeting called to order 12:03 p.m.

I. **Approval of November 1, 2016 Minutes** – Dr. Garcia (Dr. Holmes Absent)
- Approved
- Dr. Garcia asked everyone to RSVP's to the committee meetings so we can order the appropriate amount of food and reduce cost.

II. **Office for Education Update** – Ms. Krupp & Dr. Garcia
- AEFIS- Curriculum Mapping
  - We have functioning reports. Dr. Garcia and Ms. Krupp have been presenting the curriculum courses mapped to the competencies at multiple meetings. The overall impression we are getting is that courses are over-mapped. DEO's were asked to check the accuracy of the mapping within their departmental courses.
  - A 2nd AEFIS Syllabus pilot is with a 3rd planned for late February. The process is revealing glitches that are being addressed. We appreciate the selected faculty's participation and patience.
- WG on Practice Management Curriculum
  - The workgroup has not met yet, but this is in the works.
  - Please try to keep your outlook calendar as complete so we can schedule meetings accurately and efficiently.
- Patient Ingress & Treatment Planning
  - No updates at this time.
- 50:10 Lecture Protocol- Policy (See Attachment)
  - The 50:10 Lecture Protocol- Policy states that for every hour of lecture the students should have a 10 min break. It is recommended that a mental break should happen every 15-18 minutes, though this is not being implemented. As a courtesy to the next class, please leave the room at 10 to the hour so the next group can set up.
    - There were a few comments including: a wording change, suggestion to start on time regardless of who's missing, this also applies to multi-hour sessions. People are asked to be respectful if there are attendees still in the room but those who "run over" should be respectful and mindful to those that follow.
    - To allow time for scheduling and reconfiguring other elements in courses, this policy will be in effect for Academic Year 2017-2018.
    - The 45-minute timeframe for lecture is preferred. All CCOM/basic sciences faculty course directors will be sent this information as well. The medical school has already implemented a similar policy.Faculty can conduct multi-hour sessions, but should break for 10 minutes every 50 minutes. Course liaisons can interact with course directors and offer feedback when not in compliance with the collegiate policy.

- If approved, Lori Kayser will reflect the new schedules with the understanding that 10-minute breaks will be incorporated.
  **Motion: to approve the policy as presented including edits.**
  **Motion passed.**

III. **Curriculum Management- Family Dentistry Curriculum Review** – Dr. Abdelaal (See Attachment)

- Dr. Abdelaal thanked Prof. Cunningham-Ford, Ms. Stacy Howes (D3) and Dr. Holmes for their help with this review. Please see attachments for the summary. Dr. Abdelaal, Ms. Stacy Howes (D3) and Prof. Cunningham-Ford presented. The following was discussed:
  - It was asked if it is easy for students to achieve there RVU's. Students can put what they need on their "Needs List" on AxiUm. Dr. Straub-Morarend meets monthly with her students to see what their needs are as well. The group leaders and patient managers help ensure students can meet clinical expectations.
  - Practice Management- we are looking at highlighting where students are learning Practice Management. Faculty staffing issues are noted as a concern for Family Dentistry.
  - D3-D4 Transition issues - Ms. Krupp is working on aligning the clerkships to create a smoother transition in the area of assessment documentation. The issues of patients in the transition is managed by staff to help ensure patients are followed to address their needs.
  - Discussion occurred contrasting the clerkship clinical education model as opposed to others, including comprehensive care clinical models. Some suggested a mixed model would be best for the patients. No changes will be made to the clerkship clinical education model.
  - Discussion occurred regarding MEE's and RVU's as the measures related to competency assessment. Points for clarification: DS go above and beyond the minimum expectations; just because the DS completes a MEE, does not mean they meet the standard; DS continue to provide patient care, regardless of RVU's and other metrics.
  - Dr. Garcia suggested to review the broad curriculum issues and she can provide feedback to Dr. Holmes on areas of confusion from the perspective of the Curriculum Committee.

IV. **Round Table Comments** – Committee

- Dr. Howe- FAMD lost between 10-15 adjunct faculty over the past years, with possibly 2 more leaving this year. 75-80% of current adjuncts are ≥65 years old; 17% are ≤40 years old. Compensation and health insurance are concerns for adjunct faculty so there needs to be discussion on a sustainable faculty model in order to recruit younger dentists. Their pay hasn't changed since the 1970's.
  **ACTION:** Dr. Howe will share data from his study Dr. Garcia.
- Dr. Straub-Morarend welcomes any advice for FAMD.
- Dr. Hoffman– has been working with Ms. Tara Sears (D2) to put together an optional course for D1 students – "Body Mechanics (all things wellness) – to adapt the course for dental students. It was suggested to offer the course to faculty as well to help DS along the way and to be able to reinforce information in clinic.
  Dr. Hong Cheng was mentioned as a reference in the area of TMD disorders. resource for this class.

V. **Next Meeting: March 1, 2017**

Minutes recorded: Ms. Lauren Moniot

# Policy on Lecture Time
# "50:10"

The College of Dentistry recognizes that our students are scheduled throughout the day with a variety of courses, with minimal to no designated time for transition between courses, whether in laboratory, simulation, or clinical settings. It is also evident that our classrooms, conference rooms, and other facilities are booked throughout the day to accommodate courses, meetings, and other collegiate educational, governance meetings, and social activities.

All faculty, staff and students are requested to follow the "50:10" policy. Collegiate educational activities involving lectures, including seminar style formats, be limited to *no longer than 50 minutes in length per hour*. This also applies when conducting a multi-hour session, so students should still be allowed a 10-minute break for each hour in attendance.

The 50-minute time period includes time for faculty-student discussion or interactions. In this manner, it allows for students and faculty to either take a break if remaining in the same classroom/auditorium, or move to another location. The same 10-minute transition period allows time for others to move into the location, set-up, and general readiness for the next class or activity.

THE UNIVERSITY OF IOWA

# FAMILY DENTISTRY CURRICULUM REVIEW

Dr. Maged Abdelaal, Dr.Marsha Cuninngham, Ms. Stacy Howes

# The Process

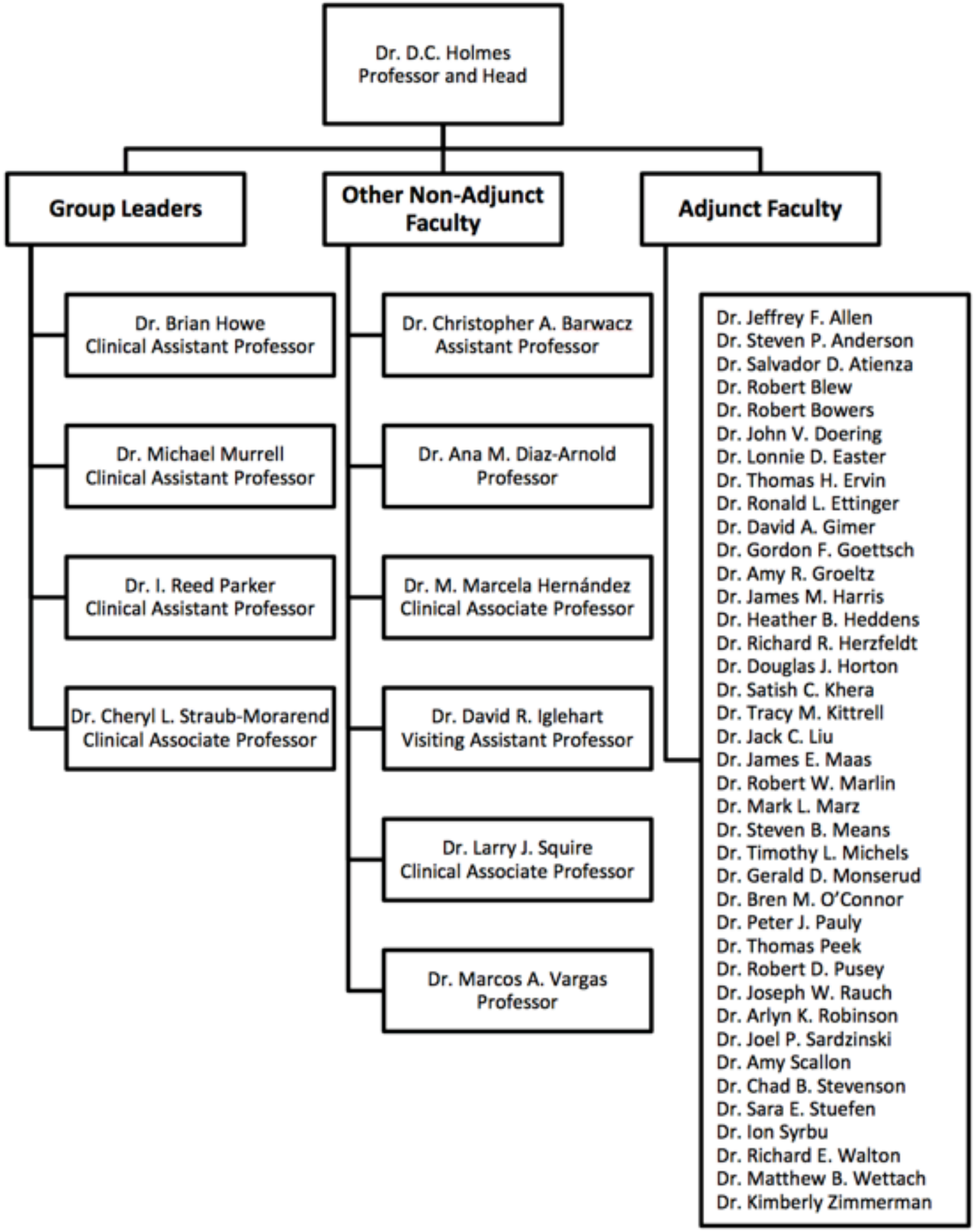
- The work group met on Nov 29 & Dec 6, after reviewing the documents submitted by the DEO Dr. David Holmes.

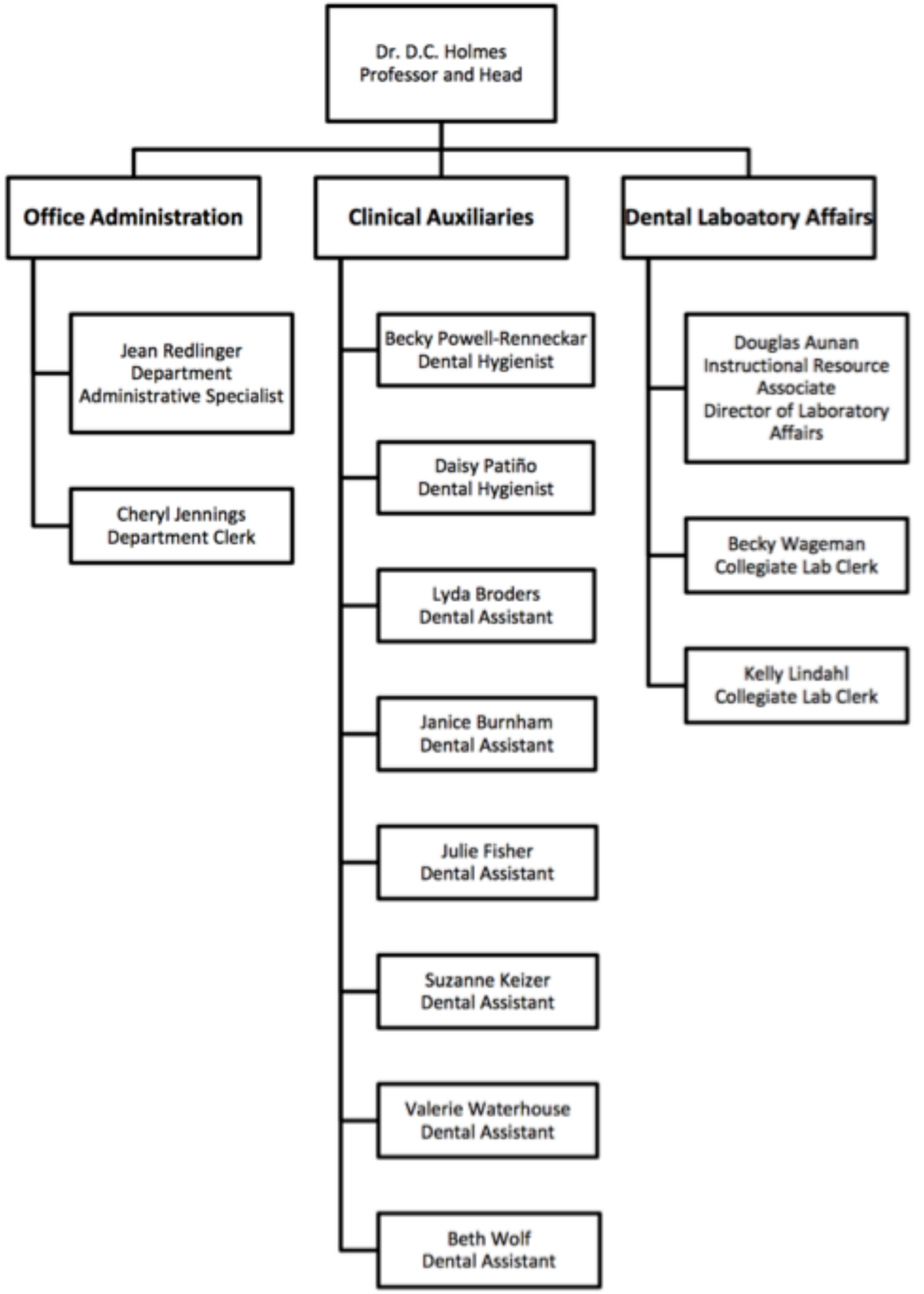
- The work group sent questions to Dr. Holmes to clarify on & he responded on Jan 23.

- The work group met again on Jan 24 to discuss Dr. Holmes responses/ clarification and to prepare the final report.

# The Mission

The primary mission of the Department of Family Dentistry is to reinforce and refine the comprehensive approach for managing the oral health care needs of patients.


Dr. D.C. Holmes
Professor and Head
Group Leaders
Other Non-Adjunct Faculty
Adjunct Faculty
Dr. Brian Howe
Clinical Assistant Professor
Dr. Michael Murrell
Clinical Assistant Professor
Dr. I. Reed Parker
Clinical Assistant Professor
Dr. Cheryl L. Straub-Morarend
Clinical Associate Professor
Dr. Christopher A. Barwacz
Assistant Professor
Dr. Ana M. Diaz-Arnold
Professor
Dr. M. Marcela Hernández
Clinical Associate Professor
Dr. David R. Iglehart
Visiting Assistant Professor
Dr. Larry J. Squire
Clinical Associate Professor
Dr. Marcos A. Vargas
Professor
Dr. Jeffrey F. Allen
Dr. Steven P. Anderson
Dr. Salvador D. Atienza
Dr. Robert Blew
Dr. Robert Bowers
Dr. John V. Doering
Dr. Lonnie D. Easter
Dr. Thomas H. Ervin
Dr. Ronald L. Ettinger
Dr. David A. Gimer
Dr. Gordon F. Goettsch
Dr. Amy R. Groeltz
Dr. James M. Harris
Dr. Heather B. Heddens
Dr. Richard R. Herzfeldt
Dr. Douglas J. Horton
Dr. Satish C. Khera
Dr. Tracy M. Kittrell
Dr. Jack C. Liu
Dr. James E. Maas
Dr. Robert W. Marlin
Dr. Mark L. Marz
Dr. Steven B. Means
Dr. Timothy L. Michels
Dr. Gerald D. Monserud
Dr. Bren M. O'Connor
Dr. Peter J. Pauly
Dr. Thomas Peek
Dr. Robert D. Pusey
Dr. Joseph W. Rauch
Dr. Arlyn K. Robinson
Dr. Joel P. Sardzinski
Dr. Amy Scallon
Dr. Chad B. Stevenson
Dr. Sara E. Stuefen
Dr. Ion Syrbu
Dr. Richard E. Walton
Dr. Matthew B. Wettach
Dr. Kimberly Zimmerman


Dr. D.C. Holmes
Professor and Head
Office Administration
Clinical Auxiliaries
Dental Laboatory Affairs
Jean Redlinger
Department
Administrative Specialist
Cheryl Jennings
Department Clerk
Becky Powell-Renneckar
Dental Hygienist
Daisy Patiño
Dental Hygienist
Lyda Broders
Dental Assistant
Janice Burnham
Dental Assistant
Julie Fisher
Dental Assistant
Suzanne Keizer
Dental Assistant
Valerie Waterhouse
Dental Assistant
Beth Wolf
Dental Assistant
Douglas Aunan
Instructional Resource
Associate
Director of Laboratory
Affairs
Becky Wageman
Collegiate Lab Clerk
Kelly Lindahl
Collegiate Lab Clerk

- The D4 class is divided into 4 groups (20 students each). Each group is supervised in the clinic by a Group Leader and approximately six clinical adjunct faculty members.

- The Family Dentistry curriculum comprises 75% of the D4 year for students at The University of Iowa College of Dentistry. The other 25% of the D4 curriculum is composed of extramural experiences.

- The D4 Family Dentistry curriculum consist of five courses, each spanning the entire academic year from late July through early June:

1. FAMD:8484 Dental Practice Management
2. FAMD:8494 Topics in Family Dentistry
3. FAMD:8495 Treatment Planning and Sequencing
4. Two clinical courses:
   * FAMD:8487 - Clinical Experiences in Comprehensive Care
   * FAMD:8488 - Clinical Competencies in Comprehensive Care

* These two courses carry the most semester credit hours of any courses in the entire dental curriculum at The University of Iowa College of Dentistry.

* The distinction between these two course grades is intended to discriminate between two elements of professional performance:

1) Procedural efficiency/technical production (FAMD:8487).
2) A comprehensive assessment of overall clinical performance (FAMD:8488).

# QUESTIONS FROM THE WORK GROUP

## Questions from the work group

1. **How are patients assigned to students?**

**Dr. Holmes Responds:**

- Each student is assigned a pool of patients by the Patient Managers and Clinic Clerks.

- As the D4 year progresses, students work with their Group Leaders and the Patient Managers to arrange assignment of additional patients, with consideration given to the learning needs identified mutually by the student and Group Leader and the student's Needs List of MEEs posted on the Intradent.

## Questions from the work group

**2. How are MEEs different from RVUs?**

**Dr. Holmes Responds:**

-The The Minimum Essential Experiences (MEEs) for the 2016-2017 school year are:

- 3 single crowns (one of which must be a canine or incisor)
- 3 endodontic experiences including Molar root canal treatment
- 1 cast framework removable partial denture
- 2 periodontal surgery assists (or 1 surgery and 1 assist)
- 2 "board-quality" scales
- Complete prosthetic treatment for one implant patient (Posterior single tooth implant OR Mandibular Overdenture)
- 5 Major Care Patients
- 5 Disease Control (Minor Care) Patients

## Questions from the work group

**2. How are MEEs different from RVUs?**

**Dr. Holmes Responds:**

-Every procedure code posted on a patient's axiUm record has a standard number of Relative Value Units (RVUs) assigned to it (as listed in the Family Dentistry Predoc Fee Schedule).

-Faculty members and students are advised that, as a rule of thumb, a reasonably organized and efficient dental student should earn roughly six RVUs per hour of patient treatment.

# Questions from the work group

**3. Are individual RVUs "weighted" for amount of time to complete each procedure?**

**Dr. Holmes Responds:**

- The amount of time to complete the procedure is one of the factors considered in the weighting of RVUs.
- RVUs are a construct similar to production that roughly measures the volume of clinical accomplishment.
- Students can check their current cumulative RVU total in real time on a report in the "Personal Planner" tab in axiUm.

## Questions from the work group

**4. How are “major cases” & “minor cases” defined?**

**Dr. Holmes Responds:**

Major and Minor cases are defined **by RVU totals** enumerated in the course syllabus and recorded on the axiUm “RVU by Patient” tab.

Major Care Patients will be patients with major restorative needs. To be included as a major care patient, **a total of 150 RVUs is required.**

Five additional patients (“Disease Control” or “Minor Care” Patients) will be required to be treated to completion of the disease control phase of their treatment plan. **A minimum of 75 RVUs are required for a patient to be included.**

# Questions from the work group

**5. What are the challenges that the department facing?**

**Dr. Holmes Responds:**

"We still need to do better, as a college, in bringing together the missions of patient care and education by coordinating the pre-doc clinical curriculum with the care of patients in the pre-doc clinics." This is extremely challenging at our dental school, for the following reasons:

- students don't progress through the clerkships in the same sequence;
- clerkship content is constrained by 5-week blocks;
- two separate, discreet patient pools – one for D-3 clerkships, one for D-4 Family Dentistry;
- students manage an individual patient case for a maximum period of 30 weeks, typically less;
- appropriate treatment sequencing is sometimes unclear in the clerkships.

We can't think of a simple solution to these challenges. Recognizing that a major reorganization of our collegiate clinical curriculum structure is extremely unlikely, the best we can do is to acknowledge these challenges and continue to work together to find ways, given the constraints of our clinical curriculum structure, to coordinate the pre-doc clinical curriculum with the care of patients in the pre-doc clinics.

# FAMILY DENTISTRY STRENGTHS

# Summary of Family Dentistry Strengths:

-**Communication**: Communication between faculty and student is open and honest. Faculty allow the difference in opinion between themselves and the student providing an environment that fosters individual growth and clinical independence.

-**Evaluation**: Students receive regular written and verbal evaluations that guide them throughout the year towards becoming a self-sufficient practitioner. These evaluations examine both the technical component and patient management ability.

-

# Summary of Family Dentistry Strengths:

-**Faculty Calibration**: The calibration between the family dentistry adjunct and full-time faculty has allowed a consistent evaluation system while still allowing individual differences within providers. This has given students a strong background in the principles that the dental practice is founded upon while enhancing the different tools and methods to achieve these.

-**Student Environment**: Students are practicing in an environment that is conducive to their individual implementations of evidence-based practices. The environment is very positive and supportive of student independence and autonomy. Disagreements between students and faculty are encouraged when they result in discussion of differing treatment plans and patient management.

# RECOMMENDATIONS

1. Dr. Holmes noted that “we still need to do a better, as a College, in bringing together the missions of patient care & education by coordinating the predoc clinical curriculum with the care of patients in the predoc clinics.”

   This is extremely challenging due to reasons cited the Fam Dent document: -
   - 2 separate, discreet patient pools;
   - students do not progress through the clerkships in the same sequence;
   - some clerkship content is constrained by 5 week blocks;
   - students manage an individual patient case for a maximum of 30 weeks, but not until 4th year &
   - “appropriate treatment sequencing is sometimes unclear in the clerkships”, according to Dr. Holmes.

**“Recognizing that a major reorganization of our collegiate clinic curriculum is extremely unlikely, the best we can do is to acknowledge these challenges & continue to work together to find ways… to coordinate the predoc clinical curriculum with the care of patients in all 4 years of the predoc clinics”.**

2. In the FAMD:8487 course assessment methods (for the Collegiate Competencies), the work group identified 8 Collegiate competencies which are listed in the “assessment methods column” of the document as being “assessed” by RVUs and MEEs:

a. 2.1 - Apply ethical & legal standards in the provision of dental care.
b. 3.1 – Apply appropriate interpersonal and communication skills.
c. 3.3 – Communicate effectively with individuals from diverse populations.
d. 4.2 – Participate with dental team members and other healthcare professionals in the management and health promotion for all patients.
e. 5.6 – Comply with local, state and federal regulations including OSHA and HIPAA.
f. 6.5 – Recognize the manifestations of systemic disease and how the disease and its management may affect the delivery of dental care.
g. 6.18 – Recognize and manage patient abuse and/or neglect.
h. 6.19 - Recognize and manage substance abuse.

**It was unclear to the work group how the above competencies could be assessed by RVUs and MEEs. Dr. Holmes agreed & he plans to modify the curriculum mapping document (i.e., delete those competencies?) & the course syllabus for FAMD:8487 or identify other assessment methods for those competencies.**

3. The work group identified that the FAMD:8484 syllabus is missing specific % weights for each component of the evaluations as required by University policies & CODA standards.

**Dr. Holmes agreed to correct that omission.**

4. The work group identified that in FAMD:8488 (Section III) document “no major changes/updates are planned in this course at this time”. However, the document expresses “concerns” about 2 areas:

a. Protocol for implants – “per mandate from our collegiate administration… 1:10 ratio is insufficient…problematic at times…additional faculty resources should be allocated” for faculty to cover predoc implant educational program.
b. Digital impressions & CAD/CAM milled restorations - …” 1:10 ratio is insufficient…additional faculty resources should be allocated…” for faculty to cover digital impression & CAD/CAM milled restorations.

**Both of these concerns will limit the expansion of our current predoctoral clinical education program, but both are constrained by significant budget cuts in the current academic year & in the foreseeable future.**

*THANK YOU*

**Curriculum committee Work Group for Family Dent review – 2016-17**

Chair: Dr. Maged Abdelaal & members: Dr. Marsha Cunningham & Ms. Stacey Howes (D3 student)

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Process: The work group met on Nov 29 & Dec 6, after reviewing the documents submitted by the DEO Dr. David Holmes. The work group sent the following questions to Dr. Holmes to clarify on & he responded on Jan 23. The work group met on Jan 24 to discuss Dr Holmes responses/clarification, prepare the final report & to plan for presentation to Curriculum committee on Feb 1, 2017.

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## Questions from the work group:

1. How are patients assigned to students?

**Dr. Holmes Responds:**

As D4 students enter the Family Dentistry program, each is assigned a pool of patients by the Patient Managers and Clinic Clerks. Using available individual patient characteristics (known treatment needs, age, time since last dental visit, etc.) the Patient Managers and Clinic Clerks attempt to balance the patient pool assignments among D4 students. D4 students are told that they are expected to provide (or arrange for provision of) timely, appropriate comprehensive care for each of their assigned patients. As the D4 year progresses, students work with their Group Leaders and the Patient Managers to arrange assignment of additional patients, with consideration given to procedural experiences that the student has already had, potential procedural experiences in the student's assigned patient pool, and learning needs identified mutually by the student and Group Leader. The Patient Coordinator selects patients for a particular student based upon that student's Needs List of MEEs posted on the Intradent.

2. Are individual RVUs "weighted" for amount of time to complete each procedure? (The work group did not receive a list of RVUs in our materials & that would be helpful to clarify)

**Dr. Holmes Responds:**

The amount of time to complete the procedure is one of the factors considered in the weighting of RVUs. RVUs are a construct similar to production that roughly measures the volume of clinical accomplishment.

The current version of the Family Dentistry Predoc Fee Schedule is attached as an appendix to this document. The Fee Schedule lists the standard RVU award for each procedure code. Students can check their current cumulative RVU total in real time on a report in the "Personal Planner" tab in axiUm.

3. How are MEEs different from RVUs?

**Dr. Holmes Responds:**

Every procedure code posted on a patient's axiUm record has a standard number of Relative Value Units (RVUs) assigned to it (as listed in the Family Dentistry Predoc Fee Schedule). Faculty members and students are advised that, as a rule of thumb, a reasonably organized and efficient dental student should earn roughly six RVUs per hour of patient treatment.

The Minimum Essential Experiences (MEEs) are listed in the FAMD:8487 Course Syllabus. In summary, for the 2016-2017 schoolyear, the MEEs are these:

- 3 single crowns (one of which must be a canine or incisor)
- 3 endodontic experiences including ne Molar root canal treatment
- 1 cast framework removable partial denture
- 2 periodontal surgery assists (or 1 surgery and 1 assist)
- 2 "board-quality" scales
- Complete prosthetic treatment for one implant patient (Posterior single tooth implant OR Mandibular Overdenture)
- 5 Major Care Patients
- 5 Disease Control (Minor Care) Patients

4. How are "major cases" & "minor cases" defined?

**Dr. Holmes Responds:**

Major and Minor cases are defined by RVU totals enumerated in the course syllabus and recorded on the axiUm "RVU by Patient" tab.

Major Care Patients will be patients with major restorative needs. To be included as a major care patient, a total of 150 RVUs is required. An Exit Examination (procedure code I9800) must be appropriately performed and recorded for a patient to be included. Patients should have no calculus deposits at the Exit Examination visit, and should have an exit prophy, if indicated, when treatment is complete. The patient should have no further needs (other than treatment that the patient has declined) and patient must be placed on appropriate recall.

Five additional patients ("Disease Control" or "Minor Care" Patients) will be required to be treated to completion of the disease control phase of their treatment plan. A minimum of 75 RVUs are required for a patient to be included. An Exit Examination (procedure code I9800) must be appropriately performed and recorded for a patient to be included. Patients should have no calculus deposits at the Exit Examination visit, and should have an exit prophy, if indicated, when treatment is complete. The patient should have no further needs (other than treatment that the patient has declined) and patient must be placed on appropriate recall.

5. Is there any vertical integration (or reinforcement of concepts, e.g. caries risk assessment) with the D1 & D2 clinical courses?

**Dr. Holmes Responds:**

Certainly, just as there is vertical integration of D1, D2, and D3 courses with prior and subsequent courses in the curriculum, there is vertical integration of the Family Dentistry Department courses with prior and subsequent courses (not just with the D3 courses). As noted in our original response to Question VI in the summary document, we view the specialty departments in our college as the experts in their respective disciplines, and the Family Dentistry Clinic as the venue where those skills and knowledge are reinforced, refined, and integrated.

In answer to your specific question concerning caries risk assessment, caries risk assessment is a required component of all initial and recall examinations in our clinics, and will also be performed at other appointments, as appropriate.

Patient visits in the Family Dentistry Clinic begin with starting checks which include health history review, caries assessment, blood pressure measurement and chief complaint identification which are skills first encountered in the D1 and D2 year. The performance of these skills is assessed as the starting check.

6. Do you think that the D1 & D2 clinical experiences contribute in any way to the student's preparation to be a D3/D4?

**Dr. Holmes Responds:**

Certainly; this is a fundamental tenet of the vertical integration of our collegiate predoctoral curriculum.

7. Page 9 – VIII. "We still need to do better, as a college…" Any suggestions on how that could be accomplished?

**Dr. Holmes Responds:**

The complete quote from our Departmental Curriculum Review is "We still need to do better, as a college, in bringing together the missions of patient care and education by coordinating the pre-doc clinical curriculum with the care of patients in the pre-doc clinics." This is extremely challenging at our dental school, for the reasons noted

8. students don't progress through the clerkships in the same sequence;
9. clerkship content is constrained by 5-week blocks;
10. two separate, discreet patient pools – one for D-3 clerkships, one for D-4 Family Dentistry;
11. students manage an individual patient case for a maximum period of 30 weeks, typically less;
12. accountability for comprehensive case management and timely,
13. appropriate treatment sequencing is sometimes unclear in the clerkships.

We can't think of a simple solution to these challenges. Recognizing that a major reorganization of our collegiate clinical curriculum structure is extremely unlikely, the best we can do is to acknowledge these challenges and continue to work together to find ways, given the constraints of our clinical curriculum structure, to coordinate the pre-doc clinical curriculum with the care of patients in the pre-doc clinics.

8. Appendix I - page 13 – FAMD:8487, in the "assessment methods column" RVUs & MEEs are cut & pasted for all competencies, but would you please clarify how the following competencies are "assessed" by RVUs & MEEs?
    a. 2.1 - Apply ethical & legal standards in the provision of dental care.
    b. 3.1 – Apply appropriate interpersonal and communication skills.
    c. 3.3 – Communicate effectively with individuals from diverse populations.
    d. 4.2 – Participate with dental team members and other healthcare professionals in the management and health promotion for all patients.
    e. 5.6 – Comply with local, state and federal regulations including OSHA and HIPAA.
    f. 6.5 – Recognize the manifestations of systemic disease and how the disease and its management may affect the delivery of dental care.
    g. 6.18 – Recognize and manage patient abuse and/or neglect.
    h. 6.19 - Recognize and manage substance abuse.

**Dr. Holmes Responds:**

This is a point well taken by the work group. In reflecting on this observation by the work group, we are inclined to agree that it's hard to make a compelling argument that these competencies are "assessed" by RVUs and MEEs. In this first round of designating assessment methods for entry into the AEFIS database, we were guilty of "over mapping" when we listed RVUs and MEEs as assessment methods addressing these competencies. In the future, we will not list RVUs and MEEs as assessment methods for these competencies in FAMD:8487.

9. FAMD: 8484 doc –
   - #I- there are no data presented on student/course evaluations (e.g., % response rate, % strongly agree, or whatever scale is used). It is just stated that the "students evaluate the course at end of 2 week rotation". What are the summarized results of those course evaluations for the past 2-3 years?

**Dr. Holmes Responds:**

We have access to compiled reports of quarterly evaluations of faculty by students, but the annual review of courses by students has always been administered and stored in the past by someone from Dental Administration. I am told that these course evaluations might not have been accomplished in the past few years. This is certainly a point of concern. If these evaluations are no longer being administered and stored by our Dental Administration, then we should start accomplishing them by other means.

- Page 3 of 11 - #3 – Evaluation methods – need to add % weight for each component (that is University requirement in syllabi)

**Dr. Holmes Responds:**

While this information is alluded to in the course syllabus for FAMD:8484, it is not specifically presented in that syllabus. The final grade scale weighting is presented in the introductory Practice Management lecture in July, and again to each group of D4 students at their DAU Orientation. The formula for grade computation for the FAMD:8488 course is this:

| | |
|---|---|
| Assistant evaluation | 10% |
| Course director evaluation | 20% |
| Schedule/ production | 50% |
| Job description | 10% |
| Exam | 10% |

We are in agreement that this information should be included in the course syllabus. The formula for final grade computation will be included in the FAMD:8488 course syllabus beginning next year.

10. FAMD: 8488 doc –
    -Page 3 – Section III – "No major changes/updates in this course are planned at this time". But in this same section there seems to be 2 "concerns" expressed:
    a. Protocol for implants – "per mandate from our collegiate administration…1:10 ratio is insufficient…problematic at times…additional faculty resources should be allocated…". Is this a request for a change, even though "no changes are planned"?
    b. Digital impressions & CAD/CAM milled restorations - "…1:10 ratio is insufficient……" additional faculty resources should be allocated…"
    Is this a request for a change, even though "no changes are planned"?

**Dr. Holmes Responds:**

These concerns have been brought to the attention of our College of Dentistry Administration, and additional faculty resources have been requested. Given the current budgetary exigencies at the College of Dentistry, we recognize that it may be difficult for our College of Dentistry Administration to allocate the additional faculty resources to our department. So, as intimated by the Review Work Group, these are suggestions for change, even though no changes are planned.

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**Summary of Family Dentistry Strengths:**

- **Communication**: Communication between faculty and student is open and honest. Faculty allow the difference in opinion between themselves and the student providing an environment that fosters individual growth and clinical independence.

- **Evaluation**: Students receive regular written and verbal evaluations that guide them throughout the year towards becoming a self-sufficient practitioner. These evaluations examine the both the technical component and patient management ability.

- **Faculty Calibration**: The calibration between the family dentistry adjunct and full-time faculty has allowed a consistent evaluation system while still allowing individual differences within providers. This has given students a strong background in the principles that the dental practice is founded upon while enhancing the different tools and methods to achieve these.

- **Student Environment**: Students are practicing in an environment that is conducive to their individual implementations of evidence-based practices. The environment is very positive and supportive of student independence and autonomy. Disagreements between students and faculty are encouraged when they result in discussion of differing treatment plans and patient management.

**RECOMMENDATIONS:**

1. Dr. Holmes noted that "we still need to do a better, as a College, in bringing together the missions of patient care & education by coordinating the predoc clinical curriculum with the care of patients in the predoc clinics."
   This is extremely challenging due to reasons cited the Fam Dent document: 2 separate, discreet patient pools; students do not progress through the clerkships in the same sequence; some clerkship content is constrained by 5 week blocks; students manage an individual patient case for a maximum of 30 weeks, but not until 4th year & "appropriate treatment sequencing is sometimes unclear in the clerkships", according to Dr. Holmes. "Recognizing that a major reorganization of our collegiate clinic curriculum is extremely unlikely, the best we can do is to acknowledge these challenges & continue to work together to find ways… to coordinate the predoc clinical curriculum with the care of patients in all 4 years of the predoc clinics".

2. In the FAMD:8487 course assessment methods (for the Collegiate Competencies), the work group identified 8 Collegiate competencies which are listed in the "assessment methods column" of the document as being "assessed" by RVUs and MEEs:

   a. 2.1 - Apply ethical & legal standards in the provision of dental care.
   b. 3.1 – Apply appropriate interpersonal and communication skills.
   c. 3.3 – Communicate effectively with individuals from diverse populations.
   d. 4.2 – Participate with dental team members and other healthcare professionals in the management and health promotion for all patients.
   e. 5.6 – Comply with local, state and federal regulations including OSHA and HIPAA.
   f. 6.5 – Recognize the manifestations of systemic disease and how the disease and its management may affect the delivery of dental care.
   g. 6.18 – Recognize and manage patient abuse and/or neglect.
   h. 6.19 - Recognize and manage substance abuse.

   It was unclear to the work group how the above competencies could be assessed by RVUs and MEEs. Dr. Holmes agreed & he plans to modify the curriculum mapping document (i.e., delete those competencies?) & the course syllabus for FAMD:8487 or identify other assessment methods for those competencies.

3. The work group identified that the FAMD: 8484 syllabus is missing specific % weights for each component of the evaluations. Dr. Holmes agreed to correct that omission.

4. The work group identified that in FAMD:8488 (Section III) document "no major changes/updates are planned in this course at this time". However, the document expresses "concerns" about 2 areas:
   a. Protocol for implants – "per mandate from our collegiate administration…1:10 ratio is insufficient…problematic at times…additional faculty resources should be allocated" for faculty to cover predoc implant educational program.

b. Digital impressions & CAD/CAM milled restorations - …" 1:10 ratio is insufficient…additional faculty resources should be allocated…" for faculty to cover digital impression & CAD/CAM milled restorations.

Both of these concerns will limit the expansion of our current predoctoral clinical education program, but both are constrained by significant budget cuts in the current academic year & in the foreseeable future.