THE UNIVERSITY OF IOWA | College of Dentistry and Dental Clinics

# Curriculum Committee
## Minutes – November 7, 2018

**Members Present:** Drs. DC Holmes (Chair), David A. Jones, Natalia Restrepo-Kennedy, Brian J. Howe, Leonardo Marchini, Zeina Al-Salihi, Sandra Guzman-Armstrong, Michael Murrell, Lily T. Garcia, Nidhi Handoo, Sherry R. Timmons, Michelle Krupp, John Schaeffer (D1), Cody Glass (D2), Tanner Brolsma (D3), Kathleen Bohr (D4)

**Absent**: Drs. Maged M.E. Abdelaal, Tad Mabry, Paula Weistroffer

Meeting called to order 12:05 p.m.

I. **Approval of September 5, 2018 Minutes;** – Dr. DC Holmes
**MOTION: to approve the September 5, 2018 minutes as submitted. Motion seconded. MOTION APPROVED.**

II. **Introduction**
Introduction of Brenda Selck, new secretary for Office for Education.

III. **CODA Site Visit – Debrief** –Dr. Garcia
A. Key points:
- No recommendations were made by the Commission.
- Predoctoral program – acknowledged Dean Johnsen for creating a humanistic environment. Commended dental student scholarly activity, Biomedical Science faculty, the embedded counselor, and good resources and staff.
- Recognized great exposure for students with all advanced education programs.
- Excellent recognition of assessment and faculty calibration in D4/Family Dentistry; Dr. Garcia acknowledged Dr. Michael Murrell and his work on faculty calibration in FAMD.
- The strategic plan needs improvement.
- While the educational program is bold and aspiration, the language around competency needs to be more consistent. There are still faculty using competency terminology inconsistently, creating confusion among faculty and students. Calibration of external sites beyond directors should include all faculty supervising dental students.
- All international rotation programs are suspended and Dean Johnsen is sending letters to directors of international sites. Alternate plans are being explored based on "on your own time/on your own dime".

B. ***NOTE:*** The Commission on Dental Accreditation has recorded a 'notation' such that the next accreditation site visit will follow-up on compliance in regards to international rotation sites.

IV. **Faculty Retreat – Review Outcomes** – Ms. Krupp (see attachment)
A. Faculty retreat: faculty input was key in helping identify educational priorities. Overall feedback from faculty was that they really enjoyed & appreciated having a voice; it is important to have follow-up on their input.
B. Committee feedback on faculty retreat topics:
1. *Sequence of Clerkships:* "Challenges" arise as a result of our clerkship clinical education model. What is the driving underlying reason for our clerkship model?
- The clerkship model is successful. Graduates have shared that they feel like their training here has set them up to be ready to do more compared to graduates of other schools. Clerkships are credited to ensure clinical experiences for students.
- Consider conducting clerkships from 12 months to expand over 2-4 years and have family dentistry clinics function as groups over all 4 years.

- D1 to D4 learning is conducted in a linear progression; how is integration occurring?
- Need feedback from D4 students.

2. New curriculum subjects into a FULL/packed curriculum
   - In order to add content, something must be removed to accommodate.
   - All topics and content are interconnected, so if one change is made in one area, this impacts other areas. Have to get the big picture not necessarily one item at a time when we are trying to decide what to do.
   - Consider preservation of key concepts and avoid depth of content to an extent.

3. D3 Comprehensive Care
   - D3 and D4 comprehensive care – envision continuous comprehensive care of patients over 2+ years. Ensure all predoctoral dental students experience special patient care. The Geriatrics & Special Patient Care Program (GSN) is highly regarded across the country.
   - Consider extending time for comprehensive care as opposed to 30 weeks in D4 allowing for managing patients over a longer time period?
   - Referrals – predoctoral students should learn the screening process as well as perform aspects of comprehensive care. Sometimes students are assigned screenings. The process of learning is not equal across the board.

4. Treatment Planning
   - Biggest issue involves diagnoses of diseases – are faculty diagnosing similarly to what students are learning? Are guidelines for diagnosis being followed?
   - Diagnosis should be consistent and information should be entered correctly. Residents who teach should be apprised of collegiate guidelines since many were not educated at the CoD.

5. Patient Ingress
   - Patients in D3 clerkships – Questions remain regarding patient ingress and patient assignment throughout clinics.
   - Admissions clinic refers patients and depending on where the patient is sent, is where a patient will receive a comprehensive diagnosis.

6. IPCP – interprofessional collaborative practice.
   - Family dentistry conducts calibration of content. What are students being taught?
   - Curriculum drives learning, not about location or infrastructure. Are concepts and teaching consistent?
   - Goal is to have the patient get the best oral health care possible.
   - There is a need for more training, education, and understanding of change in order to respond and anticipate evolving evidence.

V. **Alignment with Curriculum Committee "Educational Priorities"** – Dr. Holmes (Attachment)
The Office for Education will develop a listing of educational initiatives for review and action by the Curriculum Committee.

VI. **….creating time in the curriculum?** – Dr. Garcia
There is a need for curriculum decompression and this fundamental issue will be discussed at the Administrative Staff Retreat in January 2019.

VII. **Round Table Comments** – Committee

- Many core concepts permeate throughout all courses – use as a core or thread through the 4 years. Educational concepts can help evolve the clerkship clinic education model.
- Concerns noted that the D3 "superblock" is too intense for students. Consider addressing this issues and propose possible solutions to improve learning; shuffle and blend concepts better. These ideas would require work and encounter difficulties.
- A core concern regarding the collegiate culture was highlighted as "inflexible" when addressing any change in the clinical education model – the clerkships.
- "Things are taught very well but taught very well in pieces".
- Dental students experience burnout in superblock. D2-D3 get entire hands-on patient experiences and also expected to know all information.
- Currently seeking the Biomedical Science representative to replace Dr. Hoffman on the committee.

**Next Meeting: Wednesday, December 5, 2018**
Minutes recorded: Ms. Brenda Selck

| **Extramural Experience:** What contributes to our competencies? Criteria for participation; International Exchange/Outreach in lieu of local/region; GSN. | |
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| **Barriers:** | **Vision/Possibilities:** |
| • Socio-economic level<br>• Gap in pat treatment -> maybe divide the time<br>• Hard to determine fairness<br>• How equal the experiences are?<br>• Follow-up<br>• FAMD<br>• Finances<br>• Time availability<br>• Education difficulty (student)<br>• Faculty development/calibrator<br>• Training of faculty – geography<br>• International experience – equal or comparable to local<br>• GSN – faculty, time, curriculum | • Good to get out of dental School<br>• More realistic experience -> close to private practice<br>• Enrichment experience<br>• Everybody leaves in the same time<br>• Go where you want to go<br>• Gap (especially for 2, 3 group) in pat tx -> divided into 1-2 weeks<br>• Not seeing pat in GSN -> up # chairs for faculty<br>• Follow-up and supervise student performance -> requirement sheets and signatures<br>• 15 weeks for extramurals<br>• Every student does GSN<br>• Every chance to expand time<br>• Endowment and support travel to extramurals – lodging<br>• Team up with nursing, medicine and pharm<br>• More IT staff to help with workload<br>• Dental emergency clinics<br>• D3/D4 comprehensive care to facilitate more extramural time<br>• Having 3-5 week extramurals over D3-D4 years. |

**Sequence of Clerkships**: For example, constraints of the 5-wks as opposed to 20-wks; precise timeframe versus flexibility in student-centered learning in patient-centered care.

| **Barriers:** | **Vision/Possibilities:** |
|---|---|
| • Is 5 weeks enough?<br>• How can comp care happen<br>• Lack of patients<br>• What patients are coming in – screening<br>• One rotation could take 5 weeks<br>• Timing of OD – problem if at the end of the D3 year<br>• Radiology, same issue<br>• If student doesn't pass, remediation when?<br>• Complexity of patients – many not suitable for D3's<br>• Timing related to other clerkships (sequence of clerkships) leave groups with different background knowledge<br>• Some sections don't have enough time to finish after the block<br>• Spread clerkships over the entire year<br>• Sometimes there is a long gap of time between clinical experiences of a given sort<br>• Reluctance to change<br>• Short duration may be affected by external circumstances – for example – severe winter weather<br>• Huge transition | • Pay "ideal" patients for removable prosth to expand student experiences<br>• Admissions/screening/OD tx plan for all incoming patients<br>• Lower class size<br>• Add faculty to four on slower students<br>• Recognize students with learning problems or poor hand skills earlier<br>• Different admissions process<br>• Offer summer-time remediation – have faculty to do this to keep students "on cycle"<br>• Have OD for everyone at the same time.<br>• Have enough clinical space to do this.<br>• Add a 5th year to the curriculum<br>• Stretch out or segment the clerkships into half-days<br>• Have 9 groups of students spread out over the week |

| **New curriculum subjects into a FULL/packed curriculum**: For example, pain/TMD, practice management, domestic violence. | |
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| **Barriers:** | **Vision/Possibilities:** |
| • Which department does it fall under<br>• Making space/moving other curriculum out to make room for this<br>• Who will enforce this (altering other curriculum)<br>• Testing methods<br>• Extra work for faculty<br>• Keeping faculty up to date with new concepts (educate faculty on new subjects)<br>• Time<br>• Person with experience and training<br>• Are pre-curricular precursors in place???<br>• Personal interest<br>• Priority<br>• Student attitude | • Develop committee/curriculum committee decide adding curriculum<br>• Offer online courses<br>• Curriculum mapping – take out redundancy)<br>• Get student input<br>• Department that takes it on will have to monitor and assess<br>• Practice management – sim exercises – in other areas as well<br>• Multiple "tracks" for self directed learning – i.e. tailor for each student's post graduate plans, like academics, private practice, specialize, etc.<br>• Case/problem-based learning – clinical/case-based learning similar to what will be seen in private practice<br>• Faculty education on new technology – for example digital dentistry<br>• Small group continuing ed for changes to axium/eRx, etc.<br>• Requirement or not? – elective or special interest – have it on ICNO as elective – decompressed, now have holes in curriculum<br>• youtube |

| **D3 Comprehensive Care**: Explore if occurring in support of patient-centered care. | |
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| **Barriers:** | **Vision/Possibilities:** |
| • re-appointing may be lost in the system<br>• student perspective is different than patients<br>• monitoring/follow-up care is not possible<br>• coordination of care b/w practitioners may be inconsistent<br>• new disease or progression<br>• loss of patients<br>• may be better fir for limited care patients<br>• constant switch in providers even within the same clinic<br>• emergency limited care patients endo end up in pros with no tx plan<br>• back log/waiting for appointments in many departments<br>• non-functional recall system<br>• best treatment plans formed by disease control only in Phase I and only Phase I planned, incorporating more restorative specialists in OD, managing pt dental expectations with disease control plan (esthetic)<br>• balancing requirements/patient care<br>• patient scheduling – i.e. 20 weeks for pros -> schedule a clinic within the clerkship model. | • Not possible with in our clerkship system – student oriented? Patient oriented?<br>• NOT POSSIBLE!<br>• No incentive to look at the patient as comp care<br>• Attach pt to student not clerkship (or a student group)<br>• Interprofessional integration<br>• Outreach to interprofessional clinics<br>• 3rd year comp care (FamD)<br>• 4th year clerkship to hone skills<br>• Add 5th year!<br>• Support other group - explore pt appts/clinic within clerkship model.<br>• Consider 12 month clinic – better patient care, flexibility for faculty vacation, stagger student schedule (start-up/shut-down)<br>• Details provided by others – make ingress more patient friendly, efficient, effective, and profitable<br>• Over-haul recall system<br>• Over-haul advocacy system (more than 10%)<br>• Improved training (dental) of clinic clerks<br>• Create clinic care coordinators -> more people integration of patient training D2+D3+D4 |

| **Treatment Planning**: Meet operational/business office needs while learning how to treatment plan for patient centered care. | |
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| **Barriers:** | **Vision/Possibilities:** |
| • Various insurance companies for different patients<br>• Lack of mechanism or protocol for insuring a comprehensive exam/treatment plan has been completed/updated.<br>• Segment of care in clerkship (patients referred to department for other care)<br>• Timing of diagnosis and treatment planning is early D3 or late D3<br>• Teaching ideal treatment planning versus what we have in reality<br>• Giving ideal treatment plans versus a treatment plan that the patient can undergo<br>• Different levels of providers, and multiple treatment plans and clearing up the whole picture to the patient<br>• Limited care patient versus comprehensive | • Students in OD at least 1 day/week in D3 year and perhaps could have their OD patient assigned to them as a D3 patient – this would being continuity of care and comprehensive care before D4 year. This could be accomplished by modification of student's schedules. When students have a failure/no patient. They could report to OD or admissions.<br>• OD should have one faculty from each specialty (discipline) present to enrich student learning and more optimal treatment planning.<br>• In a perfect dental school environment, where ideal treatments can be provided to all patients with no cost restrictions, then a patient would come in for treatment planning and would get a comprehensive treatment plan that would be approved with all the departments and followed by all students taking care of the patient<br>• Increase the faculty per student ratio<br>• Having a more robust patient screening system to allow for a finalized refined treatment plan<br>• More dental assistants for the students<br>• Better recall systems for patients<br>• Free money for patient care of free treatment at CoD no restrictions for patient care to provide for the ideal treatment<br>• All appointments pre-screened by phone or in-person<br>• Better screening process – more time and more chairs<br>• More faculty per students – reduce faculty to student ratio<br>• Dental assistants for dental students |

| **Patient Ingress**: For example, need for learning how to triage care for patients; Oral Dx Clinic = patient bottleneck, only through Admissions/Emergency. | |
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| **Barriers:** | **Vision/Possibilities:** |
| • Patient self-reporting may be inaccurate – can end up in the wrong clinic – patient abuse the system to be seen quickly.<br>• No walk-in clinic<br>• Urgent care booked out 1+ week<br>• Staff protocol how to schedule emergencies<br>• Difficult to get into OS and Endo already<br>• Low number of clinical examiners<br>• Access to medical records -> lower planning time<br>• Faculty expertise can be utilized in other ways effectively – who cover?<br>• Waiting for faculty checks – waste of time<br>• Lack of 8 clinical spots -> to go through proper treatment phasing<br>• FamD not assigning initial exam past February<br>• Lack of availability of clinic spaces for comprehensive exams<br>• Are there other options for comprehensive exams? – pros? – oper?<br>• Options for fast-track limited care? i.e., limited caries port-ortho)<br>• Limitations of facility space/faculty availability | • Trained hygienist to triage phone calls<br>• Walk-in clinic (triage clinic) – D2s: no hand skills, D3: another extramural rotation especially with additional students due to advanced standing program, faculty can screen for comprehensive care<br>• Have two clinics – emergency clinic and combine admissions clinic and oral diagnosis clinic. Resources, faculty or resident's coverage (preferably from all disciplines), students. This will reduce the number of exams, makes the triage effective, and more comprehensive exam, including perio exam.<br>• Staggered student schedules (winter/summer)<br>• Connect unscheduled students (D3/D4) with an initial comp exam<br>• 6am/6pm patients (now). Floater student/faculty with overscheduling<br>• Specialty floater for direct screenings. Chief residents of grad program. |

**IPCP**: Interprofessional Collaborative Practice – intent versus reality; taught and practiced?

| **Barriers:** | **Vision/Possibilities:** |
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| • Patient bottleneck – oral radiology<br>• Student's consistency in oral radiology.<br>• Implement more digital dentistry between pre-clinic and clinic settings<br>• Family dentistry -> more specialty coverage (endo, perio, oral pathology)<br>• (Calibration) -> Different approaches from other departments not knowing what the other department is doing.<br>• Quality of patients, complexity.<br>• Being updated<br>• Different departments working together<br>• Communication barrier<br>• Lack of patients<br>• Who deals with complication<br>• Stay out of my turf/territorial<br>• Timely consults<br>• Lack of experience<br>• Scheduling limitation<br>  o Book months in advance<br>  o Can pts be seen by more than 1 provider on same day?<br>• Dolphin, Epic – no access to notes/clinic info<br>• Different Tx philosophies and Tx plans<br>• Lack of clear referral system<br>• Vary on who will take pts – chronic pts should be ??<br>• Not enough pts in for students in some clinics & too many pts in others<br>• Where do recall pts go?<br>• Outside CoD referrals, medical records, how to communicate with different providers | • Interaction between different groups – what is taught in each area.<br>• Sleep apnea dentistry into the curriculum. Didactic and clinical. Money for lab.<br>• D4 more pediatric clinic<br>• Clinics open<br>• Technology requirements (cases and digital center)<br>• Improving access to care -> cases into D4-D3 students.<br>• Identify students that will be good in procedures that are more complex.<br>• Staff that will be dedicated for recall for the student's patient pool.<br>• Dean's office move to the clinics to have more contact with faculty<br>• Give more time and resources to make innovations such as lectures (online…)<br>• Student programs – the opportunity to work in cases so they can elect what specialty is better for them<br>• After demonstrating competency, D4 can have clinical experience in specialty areas.<br>• CoD<br>• Communication barriers – use social media<br>• Common database – pt records, imaging, so anyone has access to all notes in Epic & Dolphin<br>• Access to panopto – hear other lectures, access content – learn from others, hear inconsistencies<br>• Training across depts. – internal CE course<br>• Grand rounds to present pts – all discuss pt<br>• Schedule pt at same time in multiple depts.<br>External - physician, nursing<br>• IPE class – 2 dental students, pharmacy, medical student – discuss problem, hx |

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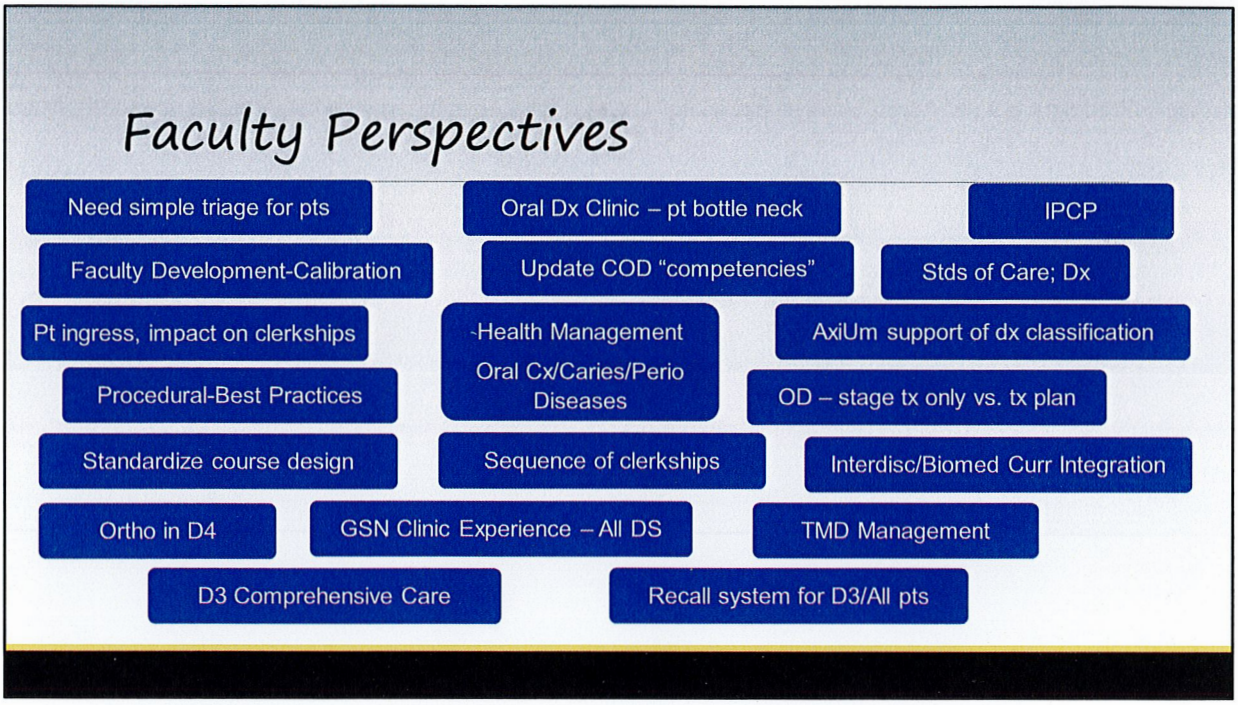
| | o Common work together – not just a meeting/class but outside of group in other times<br>• Integrated medical/dental records |


Faculty Perspectives
Need simple triage for pts
Oral Dx Clinic – pt bottle neck
IPCP
Faculty Development-Calibration
Update COD "competencies"
Stds of Care; Dx
Pt ingress, impact on clerkships
Health Management
Oral Cx/Caries/Perio Diseases
AxiUm support of dx classification
Procedural-Best Practices
OD – stage tx only vs. tx plan
Standardize course design
Sequence of clerkships
Interdisc/Biomed Curr Integration
Ortho in D4
GSN Clinic Experience – All DS
TMD Management
D3 Comprehensive Care
Recall system for D3/All pts