CCP ROUNDTABLE DAY, May 13, 2022. Report

REPORT

The CCP Roundtable was held on May 12, 2022 and the RCMI. It was attended by 48 participants (8 administrative staff, 11 clinical instructors. 22 faculty and 7 undergraduate students). There were 2 lecture presentations by Drs Laura Tam and Jack Gerrow, followed by 3 rotations of round table discussions. Group Leaders presented their summaries at the end of the day. The summary findings from the group leaders include opinions, suggestions and impact statements from key stakeholders for each theme. The summary findings will be used to provide vision for clinical education planning and direction for action items.

This report contains:

Appendix 1. Proposal and Agenda

Appendix 2. Group Leader Report for Theme 1. Streamline patient intake (leader Dr Karen Burgess

Appendix 3. Group Leader Report for Theme 2. Change minimum core experiences (leader Dr Greg Anderson)

Appendix 4. Group Leader Report for Theme 3. Change CCP patient scheduling (leader Dr Jim Posluns)

Appendix 5. Group Leader Report for Theme 4. Generalist clinical instructors (leader Dr. Jim Lai)

Appendix 6a. Group Leader Report for Theme 5 (first of two). Group Practice Model (leader Dr. David Cornell)

Appendix 6b. Group Leader Report for Theme 5 (second of two). Group Practice Model (leader Dr. Jack Gerrow)

Appendix 1. Proposal and Agenda

INTRODUCTION

Currently in the Comprehensive Care Program (CCP), discipline-specific instructors, mostly part-time, supervise DDS3 and DDS4 students tasked to manage patient care after the patient intake appointment(s). Patients "belong" to an individual student and are primarily managed (scheduling and treatment) by their individual student. Students are expected to attain minimum core experiences (credits) in each clinical discipline within CCP and receive grades for each clinical discipline.

The purpose of the CCP roundtable discussion is to gather stakeholders together to consider how clinical dental education, in particular, the Comprehensive Care Program, should be delivered in the future.

"RE-ENVISIONING DENTAL EDUCATION AT THE UNIVERSITY OF TORONTO" May 7, 2021,
This report by an external Advisory Group to the Dean made several observations and recommendations related to Clinical Education and Comprehensive Care.

OBJECTIVES

The overall objectives of the CCP roundtable, adopted from the Advisory Group report, are:

- To improve student learning
- To enhance patient experience and a higher level of quality of care, timeliness of care

Five themes have been selected for Roundtable group discussion. Each theme presents (i) specific observations and recommendations from the report related to the theme and (ii) highlighted questions to be discussed by each group.

THEMES

1. Streamline patient intake (leader Dr Karen Burgess)

"The delivery of patient care in the undergraduate clinic is perceived by many as being fragmented and inefficient in many ways. This is especially true related to the admission of the patient at the first visit and the subsequent early visits to determine an overall diagnosis, problem list, preliminary treatment plan and an estimation of treatment costs."

Recommendations for improved efficiency, improved patient timelines?

Move Radiology into CCP (and/or into group practice)?

Move OD into CCP (and/or into group practice)?

Move Emerg into CCP (and/or into group practice)?

2. Change minimum core experiences (leader Dr Greg Anderson)

"Student requirement systems based on discipline-specific procedures rather than overall patient treatment did not provide the best approach to student learning, nor was it in the best interest of the patient."

Change distribution of minimum discipline-specific core experiences?

Eliminate minimum core experiences? Each CCP discipline creates its own grading system which does not depend on CCP patients, eg manikin or OSCE-type assessments? or

Eliminate minimum core experiences AND the individual discipline-based clinical grades (ie. No separate perio, resto, prostho grades; only a CCP grade)?

CCP tracks students based on patient encounter rates? On $production? On patient completion rates?

3. Change CCP patient scheduling (leader Dr Jim Posluns)

"… Responsibility appears to be on the student to arrange for patient visits. There was concern expressed that there is not a system in place to ensure that patients are navigated through the undergraduate clinic to complete their care in a comprehensive and timely basis."

Clinic staff become responsible for scheduling all CCP patients?

If there are insufficient number of CCP patients, student attend to emergencies or assist?

How to ensure continuity of care for a single patient, or for that matter, for a single multiple-appointment procedure?

How to manage distribution of core experiences?

4. Generalist clinical instructors (leader Dr. Jim Lai)

"Generalist concept (overseeing all basic treatments) represents private practice, improves patient continuity of care, moves patient care forward, can improve student experience and simplifies instructor staffing of clinics."

Maintain discipline-specific instructors or adopt generalist instructor for current CCP model? Or for group practice model?

Keep specialists on clinic floor for consultation?

If generalist instructor: supervise perio, rest and prostho? Treatment planning? Endo?

Or, separate instructor supervises treatment planning and separate instructor supervises endo?

How do you calibrate a generalist instructor to teach and grade all the different disciplines?

5 & 6. Group practice model (leaders Dr. David Cornell and Dr Jack Gerrow)

"Primary care for each patient is managed in the general dentistry care units, including some treatment of emergency patients."

"Groups are supported with general dentist faculty member, an office manager, a scheduler, and a dental assistant. Instructors within each group can be either discipline-specific or generalist."

"An experienced faculty member obtains a diagnosis, problem list and tentative treatment plan in relatively short order, and arranges the treatment for the patient to be done by the group. The sharing of patients allows for vertical integration. The sharing of patients allows for distribution of core experiences within the group."

Adopt group practice model?

What type of instructor(s)?

How to handle scheduling of students and patients in group practice model?

SCHEDULE

Fri May 13, 2022, RCMI, 426 University Avenue

8:30 am	Arrival and registration: Light refreshments
9:00	**Welcome: Opening Remarks. Dean Haas**
9:05	**Introduction, presentation of themes.** L. Tam.
9:50	**Sustainability of changes.** J. Gerrow.
10:10	**Presentation of schedule and assignment to Roundtable rotations.**
10:15	**Discussion Groups (round 1)**
10:45	break
11:00	**Discussion Groups (round 2)**
11:30	**Discussion Groups (round 3)**
12:00pm	Lunch
12:00	**Group Leaders debriefing**
1:15	**Presentations by each group discussion leader (15 minutes each)**
2:45	**Conclusions and Summary**
3:00pm	End

Appendix 2. Group Leader Report for Theme 1. Streamline patient intake (leader Dr Karen Burgess)

1st question

Recommendations for improved efficiency, improved patient timelines?

We discussed the major problems or roadblocks to efficient and timely patient care, at the same time as having time to teach. What are the roadblocks to this?

For the initial appts - diagnosis, problem list, treatment planning and estimate of treatment cost

1. The students discussed what they felt were the main roadblocks to efficient and timely care, and everyone discussed options for improving these.
2. There was an excellent comment - We ask - Are things inefficient? – don't assume that it is inefficient. These are students, and they need to become proficient – so need the time in these appointments to learn how to do this.
3. Comments that
    a. The initial process is everything up to the treatment planning
    b. OD and Radiology appts are not the problem according to students and other participants,
    c. Delays are after this.
    d. In 3rd year – doing the OD – takes the full session, as the students are learning the steps
    e. In 3rd year – radiology takes the whole session – if you want to do teaching, and not just take radiographs.
    f. In one session, Faculty were discussing the order of OD and Radiology appointments. There was no consensus on any change. Changing the order did not appear to decrease number of patient appointments or speed up the process. This could be different if there was a new clinic with x-ray heads at each unit in CCP.
    g. One student suggested that Radiology was not needed in 4th year. Other views were that there are less sessions in 4th year for OD and radiology, but that these are needed to maintain competency.
    h. There was consensus that more x-ray heads are needed in the CCP clinics 1 and 2.

Suggestions for improving efficiency and timeliness of appts

In order of importance by students

1. Number one – was the length of time it takes to book a treatment planning session due to availability of treatment planning appts. It can be weeks.
    a. Suggested solutions – have more treatment planning coordinators to decrease this delay.
2. Number 2 – length of time to get a Dental Anaesthesia consult – at certain times of the year it was up to 4 weeks to get an appointment.
    a. Suggested solutions
        i. Arrange more Anaesthesia Faculty to do the consults. Students felt that ideally, they should be able to book a consult within ½ week of the request.
        ii. Reassess if all of the Anaesth consults are needed
        iii. Could the Anaesth consults be triaged, and some done in person/virtual, and some done by email request.
        iv. Do they all have to be done with a Dental Anesth Faculty, could they be done be general dentists?

v. Could Anaesth residents do some. Other people said that they thought some are done by Anaesth residents.
vi. Could there be a simplified process when a consult has been done by a previous student, and it has been updated by new student – does it need to be done in real time with an Anaesth Faculty .

3. Students said that for a few patients, the medical letter takes a long time to come back from the MD. One student asked how we can speed up process of getting medical letters back from physicians. Some come back quickly, some do not.
    b. Currently Oral Diagnosis contacts the patient after 4 weeks to get them to return letter
    c. Suggestion for improvement – students to contact MD's office or patient after 2 weeks to remind them to return the letter as well.

These were the main roadblocks identified by students. The students did not identify OD and Radiology appts as roadblocks to timely patient care.

2nd question

Move Radiology into CCP (and/or into group practice)?

1. Strong consensus (unanimous) against moving radiology into CCP/group practice.
   Comments
   Radiology works well because they are organized.
    a. Patients are booked by Rad staff, and confirmed. This is better than if patients were booked by students.
    b. Instructors are booked by Rad, and are calibrated.

3rd question

Move OD into CCP (and/or into group practice)?

1. Strong Consensus against moving OD into CCP/ group practice
   Comments that OD works well because it is organized.
    c. Patients are booked by OD staff, and confirmed. This is better than if patients were booked by students
    d. Instructors are booked by OD, and are calibrated.

   with the caveat, that if a change to Group practice with all the elements listed were in place – e.g super group leaders were in place with small groups of students, and practice manager in place, and front desk booking in place and working, then this could be revisited, but OD should NOT be moved into CCP before that is in place and confirmed to be working.

4th question

Move Emerg into CCP (and/or into group practice)?

1. No consensus on moving Emerg to CCP - advantages, and disadvantages.
2. From a student prospective – the students said
    a. Emergency Clinic – Current system working well
    b. difficult to tell if it could be better as COVID has changed procedures.

3. No consensus on moving Emerg to CCP - advantages, and disadvantages.

   Advantages –

   a. Possibly better utilization of empty chairs in Clinic 1 or clinic 7 for current Faculty patients
   b. possible use of Clinic 7 for same day AGP if indicated.
   c. Other patients need 124 Edward street facilities – oral surgery same day, Grad clinics.

   Disadvantages –

   a. Difficult to know if AGP is needed or not without seeing patient first.
   b. New patients to the Faculty may or may not be suitable medically. In current arrangement, these patients can be reviewed by Dr. Burgess or Black at the time of the appointment. This speeds up the process.
   c. Screening of patients not suitable for undergrads, and other processes may get missed in other clinics. This puts Faculty at risk.

Appendix 3. Group Leader Report for Theme 2. Change minimum core experiences (leader Dr Greg Anderson)

At the CCP Roundtable held on May 13, 2022, our table was provided the topic of **core experiences vs a comprehensive core model.**

The first question to be discussed was whether or not it is feasible to eliminate core experiences altogether, and the unanimous decision was that at least some minimum number of core experiences must still be required.

This led to further discussion of whether such numerical requirements are reasonable for all disciplines and/or procedures. We examined the concepts of competence, experience and exposure. And determined that in those areas in which competence is expected, a minimum number of core experiences should be established. This will necessitate an examination of those areas of practice where competence is an absolute requirement (diagnosis, treatment planning, restoration of carious lesions etc.).

Given the agreement that some "credits" would still be required, we then looked at two possible models in which this would be applied. The first was based on a continuation of the current system, and various advantages and disadvantages were reviewed. In this system, which is more student-centred, the completion of credits is a significant focus.

The second model was one of group practice, which itself has two iterations. One is the true group practice model in which there are multidisciplinary instructors supervising a group of students. This would simulate general practice in which a GP would typically perform many (if not all) procedures, at least involving disease control (diagnosis, treatment planning, restorative, periodontics, pain control). There are a number of **significant** concerns with this model, but this was not the focus of our table. The second use of the term group practice is based on the students ongoing care of patients as they have been for the last several years (with teams of instructors) but there would be a faculty member assigned to a group of students and that person would help manage their patients to ensure that a sufficient number of core experiences are represented in that cohort of patients. There were also a number of advantages and disadvantages examined. In this system, which is more patient-centred, patient management and completion become more of a focus.

We concluded that the group model, if operated efficiently, would be optimal but that implementation is unlikely at least in the foreseeable future. This is primarily due to the significant investments that would be needed in staffing and possibly physical space.

If the current system is maintained, which is most likely, some changes could be implemented which would hopefully eliminate or mitigate some of its weaknesses. Several of these suggestions are indicated below.

- As noted, consider development of a competence, experience and exposure framework into which core experiences can be incorporated
- A greater value can be placed on patient completion, perhaps by allocating a greater percentage of their clinical grade to this. In addition, a partial grade could be applied if patients are transferred to a student for a single procedure (for example if the patient only requires a final reline to be “completed”)
- Develop a consensus of which procedures can be satisfied through a preclinical approach (endodontics, crown etc.) which serve to support those areas where competency/experience is anticipated
- For procedures in which experience (or perhaps even competence) is expected, it was suggested that perhaps rather than a firm number of required procedures a range could be developed, taking into account the degree of difficulty of the procedures performed along with an element of student self-reflection.
- The faculty could consider development of more electives, which could serve to increase the number of areas in which competence or experience (and even exposure) could be attained
- As a form of a pilot project, perhaps the faculty could look at a variation of the old “clerkship” program in which 2 or 3 patients for each student would require completion. This should not result in a significant burden to faculty who might be selected to facilitate

Appendix 4. Group Leader Report for Theme 3. Change CCP patient scheduling (leader Dr Jim Posluns)

Synopsis

Three groups of stakeholders met for 30 minutes each to discuss the feasibility of Faculty staff assuming the responsibility of scheduling patient appointments for students enrolled in the CCP program. Stakeholders included students, staff, faculty and clinical instructors.

Each session commenced with an overview of the current mechanism of patient scheduling. At present, students are solely responsible for scheduling patient appointments as part of their management of the assigned patient docket. A brief review of the strengths and the weaknesses of the current system was provided.

An alternate system was then proposed, where Faculty staff would assume responsibility for patient bookings. A discussion then ensued, using the SWOT Analysis (Strengths, Weaknesses, Opportunities and Threats) as the framework of the discussion. All attendees were encourage to participate. Group engagement was excellent.

Results Summary

A copy of the presentation slides is included for review.

Scheduling of patients by Faculty staff:

Strengths

1. Has the potential to reduce student stress, by permitting greater focus on the fundamentals of clinical dentistry.
2. Has the potential to improve patient flow and efficient delivery of care.
3. Has the potential to increase clinic production.
4. Has the potential to reduce failed or cancelled appointments.
5. Has the potential to improve the overall student and patient experience.

Weaknesses

1. Requires ongoing sustainable resources to be successful.
2. Would be most effective as part of the Group Practice Model.
3. Has the potential to isolate students from their patients.
4. May eliminate a valued educational experience.
5. Needs to be intimately integrated with other Faculty clinics.

Opportunities

1. May present a unique educational environment where students learn from experts in patient management.
2. Can integrate with the Second Year Communications course where standardized patients provide feedback on the services provided.
3. Presents a unique marketing opportunity for the Faculty.
4. Provides a competitive edge for the Faculty in light of the incoming Federal Dental Program.

Threats

1. Costly to maintain.
2. Requires staff manpower that may be difficult to find.
3. Requires space and infrastructure.

Summary

Overall, there was support for the concept of having staff schedule appointments in CCP, but it was clear from the critical student input that patient interaction was something that was valued. A hybrid model of patient bookings was suggested and supported. There was support that if changes were to be made, that this system be part of the implementation of the Group Practice Model that would start as a pilot project. There was concern over the financial commitment that this system would require, and the long term sustainability of this service.

Action

Continue to develop this system in concert with the Group Practice Model is to be implemented in CCP.

Current System – Student Scheduling

- Students provided their own docket of patients (25-35 pts by DDS4)
- Over the course of the 3rd and 4th year, they treat a combination of new patients (OD), transfers and recall patients
- Students have a set number of clinical sessions and hours on specific days to deliver care
- Challenging to match up the schedules of students, patients and instructors

Current System – Student Scheduling

- Strengths
  - Educational value – "sink or swim"
  - Students have autonomy and control over their own destiny
  - Wide range of patient experiences
  - Saves staff resources

Current System – Student Scheduling

Weaknesses

- Can be stressful for students
  - Spend a lot of time on admin and management instead of learning dentistry
- Ethical issues and conflict of interest – "cherry picking"
- Student attendance – patients bookings not audited or assessed.
- No barrier between students and patients – privacy and security
- Patient treatment lags – not efficient
- Easy to patients to not attend - "vacation"
  - Students have one appointment to either engage a patient
- Wasted resources
  - Clinic, staff, instructors all there – empty chairs are costly

New System – Faculty Scheduling

Vision

- Integral part of the Group Practice Model – not done on its own
- Would need a call centre for initial patient contact
  - Pain – refer to dental student on 'emerg' in the group
  - Not – schedule "OD appointment" for intake
- Students work with GPL to determine the plan, then work with faculty receptionists to ensure the treatment is implemented in an efficient, consistent manner
- Once treatment has started, receptionist is responsible for all patient contact and collection of fees

New System – Faculty Scheduling

Strengths

- Alleviates student stress for patient admin and management
  - Improves student educational experience
- Ensures timely delivery of treatment
  - Improves patient experience and enhances PCC
- Lessens tendency for patient to dictate the schedule
  - More like private practice
- Strengthens student attendance
  - Reduces M/F-itis when its characteristically difficult to book a patient

New System – Faculty Scheduling

Strengths

- Potential to improve productivity
  - Real time scheduling
  - Students able to gauge their own speed and start thinking in units like the fee guide
  - Less down time and empty chair time in the clinic
- Better experiences overall
  - Receptionists are skilled at handing patient's concerns
  - Improve positivity in clinic overall

New System – Faculty Scheduling

Strengths

- Improve the efficiency of the intake and treatment planning process
- Less tendency for patients to fall through the cracks
- Consistent communication with patients about policies, hours etc.
- Improvements in patient oversight

New System – Faculty Scheduling

Weaknesses

- Need staff and resources for support
- Need to ensure coordination with ancillary and specialty clinics
- May reduce potential for learning by isolating students from direct patient contact
- Must have systems to prevent students from "booking out"
  - Attendance is key
- Expense
- Just one piece of puzzle
  - Faculty scheduling is integral to group practice.

New System – Faculty Scheduling

Opportunities

- Potential to learn time management skills
- Integration with the Second Year Communication Skills Course
  - Std pts can provide feedback to help enhance education
- Students less stressed
  - Opportunity for improved motivation and engagement
  - Credits are no longer a focus – attendance and patient completion are key
- Marketing opportunities – first contact with patients
- Improved competition in light of the Federal proposal

New System – Faculty Scheduling

Opportunities

- Improved integration of residents to provide teaching and services
- Increased patient flow
- Excellent opportunity to explore greater levels of automation
- Could consider a 'hybrid system" where students and faculty share the patient booking process

New System – Faculty Scheduling

Threats

- Costs
- Manpower
- Staffing
- Physical space
- Long term sustainability

Patient Scheduling - Summary

- All three groups saw real value in having staff oversee patient bookings
- Real potential to improve student and patient experience
- Would work best integrated with Group Practice Model
- Concerns include integration with the ancillary and specialty services, costs and infrastructure

Appendix 5. Group Leader Report for Theme 4. Generalist clinical instructors (leader Dr. Jim Lai)

Strength	Weakness
• Ease of access/efficient • Better patient care • Continuity of treatment/consistency – able to treatment plan and then implement tx • Recruitment – easier to find GP vs specialist • Easier for scheduling if have more GP who can teach more "discipline" • Represent real life of GP	• Unable to treat some pts • Limit scope • Learning experience "cap" at level of GP, no exposure of specialist input. • No interdisciplinary experience
Opportunities	**Challenges**
• Develop formal education model for GP • Recruit/develop faculty position • Take advantage of existing community based clinics • Develop referral culture – learn how to work with specialists. • Eliminate silo (tx plan/restor/perio/endo)	• Need more faculty • Variability in terms of skill set • Recruitment (finding instructors that commit to 2-3 days) • Liability issues • Calibration – educating GP on discipline specific standards and protocol • GP may be comfortable with doing endo but teaching endo may be a different aspect.

- In favour of keeping specialist on clinic floor
- Support idea of general dentist supervising all phase I therapy (exam, dx, tx plan, tx for caries/pain/perio)
- Concern about phase II – depending on level of complexity, comfort level of GP in teaching endo/prostho – may need more experienced GP or specialists
- Calibration is a recurring theme

Appendix 6a. Group Leader Report for Theme 5 (first of two). Group Practice Model (leader Dr. David Cornell)

Three groups circulated through this discussion to consider the Benefits and Drawbacks of implementing a group practice model at the Faculty.

There was some variation understanding what this model looked like, as some participants thought that only 1 "super-generalist" would look after the entire group. In general, we discussed this model as being made up of 1 "super-generalist" overseeing other generalist instructors with specialist consultations are needed. A support staff of a receptionist, and a CDA was the general vision we discussed.

Benefits

-closer, quicker ongoing monitoring and mentoring of students skills and core-experiences enables earlier identification of students that need more support or that are already "rock stars".

-this enables better pairing of students (weak + strong) which enhances both student learning and patient care

-better ability to assign easier procedures to weak students to build skills and confidence as well as to assign more challenging situations (both patient and procedural challenges) to stronger students

-students felt this would help decrease their stress both chairside and in trying to attain scarce core-experiences

-sharing a patient pool could expose students to more patients than the current 1-provider model

-would help decrease the current ability to cherry pick which instructor to work with, or which patients to bring in if the receptionist is tasked with scheduling patients. This would potentially increase busyness as there would be no phantom patient bookings

-potential to streamline/customize patient intake so a more patient-centered approach to care

-smoother transfer of patients upon graduation, as students have been involved in individual patient's care from year 1-4 (vertical integration).

-the team approach mimics private practice in a group setting

-could incorporate paedo patient management as well

-more consistent clinical direction and experience when working with the same team of instructors. Also easier to calibrate them.

-could set up cross group PBL sessions to expose everyone to how other teams are managing patient care.

Drawbacks

-Cost of hiring more staff to schedule patients for each group

-need to have instructors present for all 2.5 days each group is in clinic. Do we have the human resources and can we afford to pay them as Faculty?

-time to train and calibrate everyone to a new system

-students have a decrease in the number of instructors they work with, so also have a decrease in various approaches to patient care

-loss of student/patient communications/relationships when staff do the scheduling

-who is accountable for patients showing up and attainment of core-experiences? Current model has the students responsible. Group practice puts the "blame" on the staff scheduler

Summary remarks

All three groups supported the group practice model and felt it would be beneficial. Suggestions to do a literature search on various models and 5-10year outcomes was supported. The suggestion to do site visits to other Faculties was supported, as well as the use of a pilot project to test drive and de-bug this change if this was going to be implemented.

Respectfully submitted by the group facilitator:

Dr. David Cornell

Appendix 6b. Group Leader Report for Theme 5 (second of two). Group Practice Model (leader Dr. Jack Gerrow)

Comprehensive Patient Care: Responsibilities and Sustainability

Jack D. Gerrow CM, DDS, MSc, MEd, LLD (Hon)
Adjunct Professor

May 13, 2022

Outcomes

At the end of the workshop, participants will be able to:

- Discuss the models of Comprehensive Care documented in the dental education literature
- Determine strengths and weaknesses of different approaches considering local (U of T) and emerging external factors
- Identify a sustainable Comprehensive Care system for the Faculty of Dentistry

Main Messages

- Comprehensive Care / Patient Centred Care/ Group Practice approaches can work and are better than clinical requirement driven systems
- There is no one magical approach. The approach must be designed considering internal and external factors. It must be patient centred and sustainable.
- ALL graduates must have the experiences/competencies defined in the Faculty's Graduation Outcomes (FGO)
- Faculty monitors/group leaders (GL) and student must agree on which patients have to be completed to pass. These patients must provide the experience/competency defined in the FGO
- GL and clinic staff must monitor student experience and adjust agreed on patients when changes occur

Comprehensive Care in Dental Education

- University of North Carolina
  - Conferences in 1969, 1975 and 1984
  - Multiple publications on productivity and outcomes
- Journal of Dental Education
  - 1649 articles since 1970
  - descriptions of models, comparing productivity, surveys

Definition and Rational

<u>Comprehensive Care</u>
Provides seamless, patient centred, and integrated dental treatment that addresses all patients' dental needs.

<u>Rational</u>
Replace clinical requirements with patient centred care requirements
Increase productivity – more student experience and clinic income
Improve patient and student experience

Assumptions

1. Comprehensive Care is an improvement old system of Clinical Requirements
2. Faculty is responsible to ensure that graduates are experienced/competent in designated areas
3. Treatment plan changes happen
4. Critical opportunity for taking advantage of changes

Assumption 1: Comprehensive Care is an Improvement

Old system of Clinical Requirements
- Placed responsibility on students -pressurized novice learners
- Students knew it was not fair - frustrating
- Unethical
  - caused poor patient care
  - students who treated the patient correctly could fail
- Did not ensure competence

Comprehensive Care is an Accreditation Requirement

Assumption 2: Faculty Responsibility for Outcomes

- Must graduate experienced/competent dentists
  - determine graduation outcomes
  - implement a process to allow students to attain the outcomes
  - monitor/adjust/evaluate to ensure that all graduates have met the outcomes
- Accreditation Requirement
- Students and Patients must feel that they are valued

Assumption 3 : Treatment Plan Changes Happen

- Results of Phase 1 (Disease Control) treatment should be used to review and revise treatment plans
- Patients' priorities change causing treatment plan changes/dropping out/missed appointments
- Instructors change therefore treatment plans change
- Students are not experienced enough to discuss complex treatment plans and treatment plan changes with patients

Therefore, the system must accommodate changes

Assumption 4: Opportunity for change

- Lessons learned from the Pandemic
  - increased learning and production from pairing 3rd and 4th year students
  - improved clinic utilization through scheduling
- Recent announcement -publicly funded dental care for the Faculty's largest current patient groups
  - patient pool could disappear instantly
  - bureaucrats do not have a plan
  - Faculties of Dentistry need a plan and to be involved

Variables/Models of CCP

- Group Practice or GL not in a Group Practice
- CCP in 3rd and 4th year OR CCP in 4th year only
- Disciplines excluded from CCP
  - e.g., Oral Diagnosis, Pathology, Radiology, Orthodontics, Surgery, Complete Dentures, Paediatrics

Group Practice

Students and patients are assigned to a supergeneralist GL with roaming/on call specialists.
- GL is responsible for everything including referrals and needs to be onsite 3 days per week
- Usually need a practice manager and a hygienist in the group
- Reportedly works better if GL involved financially

Group Practice

- Strengths - treatment planning should be more efficient with fewer changes, student experiences monitored and adjusted
- Weaknesses - there are not many supergeneralists and they burn out and leave the program, increasing number of disciplines excluded from CCP, both cause SUSTAINABILITY issues

CCP in 4th year only

- 3rd year students rotate through discipline "blocks"
  - appointments made by clinic staff/patient advocate
  - students must complete designated treatment on assigned patients
- 4th year students and patients assigned to a GL (could be supergeneralist or specialist) for CCP who monitors experiences and adjusts patient families

CCP in 4th year only

- Weaknesses
  - 3rd year gets overloaded
    - disciplines try to cover everything but students are inexperienced
  - 4th year Group Leaders need time for monitoring
    - or get burnt out and leave which means too few GLs to do monitoring
    - need referral dental hygiene care

CCP in 3rd and 4th year

- 3rd year students initially primarily share 4th year student's patients
- Work as a team

Weaknesses
- requires more GLs and clinic staff with time for monitoring
- burnout and leave - no monitoring
- need referral dental hygiene care

Disciplines excluded from CCP

Oral Diagnosis, Radiology
- can be a bottleneck if excluded
- everyone must be trained to follow the process if included

Pathology
- usually a rotation so excluded

Orthodontics and Paediatrics
- usually excluded

Surgery - usually excluded or partially excluded

Complete Dentures, Endodontics
- problem in if Generalists are not comfortable

Main Messages

- Comprehensive Care / Patient Centred Care/ Group Practice approaches can work and are better than clinical requirement driven systems
- There is no one magical approach. The approach must be designed considering internal and external factors. It must be PATIENT CENTRED and SUSTAINABLE
- ALL graduates must have the experiences/competencies defined in the Faculty's Graduation Outcomes (FGO)
- Faculty monitors/group leaders (GL) and student must agree on which patients have to be completed to pass. These patients must provide the experience/competence defined in the FGO
- GL and clinic staff must monitor student experience and adjust agreed on patients when changes occur

A conclusion of May 2021 "Re-envisioning Report"

(current CCP)…a traditional …that prioritizes education and research while providing patient care to support its mission. … alternative …is the patient-centered model for clinical dental education, in which patient care becomes the primary focus of the institution, and clinical teaching and research occur in support …

This new model would require a significant rethinking and retooling of the current system at the Faculty of Dentistry

Outcomes

At the end of the workshop, participants will be able to:

- Discuss the models of Comprehensive Care documented in the dental education literature
- Determine strengths and weaknesses of different approaches considering local (U of T) and emerging external factors
- Identify a sustainable Comprehensive Care system for the Faculty of Dentistry

Group Practice

Good idea
-Advantage of less Tx Plan change especially RRP designs
-Consistent efficient patient care
-Better monitoring of student and patient progress

But
-Do not have enough supergeneralists 3?
-No culture of Group practice
-Who is accountable ?
-Physical structure of clinic

Group Practice

Alternatives

- Do not need a supergeneralist just generalist with ability to refer student and patient to go to a "specialty" clinic
- Possibly use generalists with referral clinics
- Hybrid using larger groups with management done within the group
- Could 2 3rd and 2 4th do CC in private practices for 3?
- Use a pilot