ADEA AMERICAN DENTAL EDUCATION ASSOCIATION

Charting Progress

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A Monthly Newsletter from ADEA Executive Director Richard W. Valachovic, D.M.D., M.P.H.

In this month's letter, Dr. Rick Valachovic, Executive Director of the American Dental Education Association, visits with the leaders of dental education programs that are implementing patient-centered care in the clinic and the classroom.

Holding Ourselves to the Highest Standard: Doing What's Best for Patients

A sense of responsibility regarding the gamut of oral health needs is the foundation of patient-centered care.

When the Medical College of Georgia (MCG) broke ground for a new children's medical center in 1995, the event marked a major step forward in the development of patient-centered care and a significant rupture with MCG's past. According to an episode of *Remaking American Medicine,* which aired on PBS, MCG hospitals and clinics ranked among the poorest performing academic medical centers in the country at the time. Patients were seen as little more than a vehicle for teaching, and in the pediatric wards, children's parents were sometimes viewed as obstacles or nuisances.

It was an administrator at MCG's Children's Medical Center, Ms. Pat Sodomka, who seized the opportunity presented by the construction of the new facility to turn things around. She engaged parents in what she termed a "very unique and unprecedented" planning process. They weighed in on everything from room design to how parents could be involved in their children's care. Among other innovations, patient rooms now have trundle beds that sleep two, there are parent beds in the ICU, parents participate in discussions during rounds and have the option of escorting their children into the operating room, and families can visit patients 24 hours a day, a policy unusual in hospitals. After implementing so many patient- and family-friendly policies, MCG's Children's Medical Center has now ranked in the 90th percentile in patient satisfaction (as scored by Press Ganey Associates) every month for the past three years.

Pat Sodomka passed away in February, but her legacy as a pioneer of what MCG calls "patient- and family-centered care" lives on. Successive areas of the medical center have renovated their facilities and revamped their approaches to care in recent years, and the dental school is following suit.

Dr. Carol Lefebvre, who serves as the Chair of the Patient and Family Centered Care Committee for the MCG School of Dentistry, can cite numerous examples of how MCG's dental patients helped shape the design of the new dental school facility currently under construction. The school's patient advisory board asked for check-in areas on every floor, diaper changing stations, and family restrooms, and provided input into the selection of dental operatory units. MCG is soliciting the group's views on procedural matters such as billing and how to notify current patients about the move to the new facility.

In addition to responding to patient concerns about the clinical care environment, MCG is looking at how to incorporate patient- and family-centered care into the curriculum. The dental school plans to borrow a page from the medical school and establish what they call a "family faculty," members of the patient advisory board who are willing to share their care experiences with students.

"Our plan is for students to begin their training with these patients," Carol told me. "They will be asked to listen to their stories and consider the whole person and their cultural background, as well as their symptoms, to become more compassionate caregivers." While MCG's patient- and family-centered care initiatives are sweeping in their scope, many of our institutions have also found ways to incorporate patient-centered care in their clinics and teach its principles in their classrooms. Some see it as integral to the work they do.

Dr. Robert Berkowitz, Chair of the Division of Pediatric Dentistry at the University of Rochester School of Medicine and Dentistry, will tell you, "Every pediatric residency program is patient-centered." He defines patient-centered care as providing comprehensive oral health care for the whole child. By that he means taking into consideration compromising conditions—be they medical, psychiatric, or

developmental—and looking beyond the mouth to the social and economic factors shaping the child's health.

"A parking fee in a garage is not going to stop a middle-class mom from taking her child to a dentist," Bob reminds residents. "But is a 21-year-old mom going to wait in the snow for a bus for half an hour to get to an appointment? That's not likely to happen, and when it does, if they are late, we have to treat them. We tell our residents, you need to sensitize yourself to these issues."

Rochester goes the extra mile to meet the needs of its pediatric patients by employing a social worker who interacts with patients and residents on a daily basis. According to Dr. Jeffrey Karp, Residency Program and Pediatric Dentistry Clinic Director, the social worker helps residents see things from the perspective of patients and their families. "Our social worker is hugely important. She brings a lot of resources to the table. Our residents are learning to work with insurance companies, social service agencies, health care organizations, and community support systems. This exposure gives the residents a full understanding of the barriers facing families seeking oral health care."

Bob Berkowitz would like to see the concept of a dental home that provides comprehensive care become as pervasive in dentistry as it is in medicine. He worries that at the undergraduate level and in some specialty programs, patients are often treated as procedural units.

"Regardless of specialty, all residency programs should inculcate their residents with a sense of responsibility, a sense of diligence regarding the gamut of their patients' oral health needs," he explains. "That is the foundation of patient-centered care."

The new CODA accreditation standards will soon make patient-centered care the rule for predoctoral programs. They state that dental schools "must have a published policy addressing the meaning of and commitment to patient-centered care" and that "Graduates must be competent in the application of the fundamental principles of behavioral sciences as they pertain to patient-centered approaches for promoting, improving and maintaining oral health."

They further mandate that schools implement quality improvement programs to demonstrate that their standards of care are "patient-centered" and "focused on comprehensive care."

Dr. Ellen Grimes told me she was thrilled to learn about the new CODA standards related to patient-centered care. "I worry that in those dental offices that are more production oriented," she said, "the patient-centered aspect of care sometimes may not be treated with the respect it deserves."

Ellen is Program Director of Dental Hygiene at Vermont Technical College. At Vermont Tech, they raise the issues surrounding patient-centered care in classroom discussions on ethics and on caring for special patient populations, and they involve students in efforts to provide comprehensive care to their patients, many of whom lack the means to pay for it themselves. Last year students, faculty, staff, and local dentists took part in an event that provided $30,000 worth of dental services at no charge to many of Vermont Tech's clinic patients.

Since the 1990s, CODA's standards for dental hygiene programs have required that programs have a quality assurance plan in place that includes "standards of care that are patient-centered [and] focused on comprehensive care." Now it is time for predoctoral dental programs to find their way over similar terrain.

The University of Illinois at Chicago (UIC) College of Dentistry started down the patient-centered path in earnest in 2001, in part because of a recognition that dental practice had become more "business-like" than ever. It adopted new professional competencies and a group-practice clinical education model that replaced the traditional, specialty-based clinics previously in use at UIC.

In the group practice clinics, students work collaboratively with hygienists to provide comprehensive care under the supervision of general dentists and specialists. The students' fourth year is spent in a robust extramural program that places them in the community for 50 days on average. UIC's highly innovative program has brought many benefits to the institution and its students (for one perspective, see the April 2009 issue of the *ADEA CCI Liaison Ledger*), but when it comes to patient-centered care, what stands out is the elimination of all numerical requirements. With this single change, the temptation to see patients as vehicles for meeting numerical targets was eradicated at UIC.

Dr. Bill Knight, Associate Dean for Academic Affairs, and Dr. David Clark, Associate Dean for Clinical Affairs, call this innovation "the single largest factor in our success," and they point out to skeptics that their students are doing more procedures than before. According to Bill and David, who use clinic revenue as a surrogate measure, UIC's third-year students have increased their patient care activities threefold since 2004, and they are benefitting from a rich and varied clinical experience. Every category of ADA procedure code is up, despite the fact that increased extramural time means students now spend fewer days in the college's clinic.

Several elements of UIC's approach are in place on other campuses as well. Tufts University School of Dental Medicine was among the earliest adopters of the group

practice model. In 1997, it implemented eight group practices providing comprehensive care in its predoctoral program.

Despite the school's reputation for serving its patients and students well, Tufts recently embarked on a curriculum revision process, which will take a hard look at how the school evaluates the patient care that students provide. According to Dr. James Hanley, Associate Dean for Clinical Affairs, the faculty is considering portfolios and other alternatives to the current, procedurally based system of evaluation.

"We've dreamed of providing truly patient-centered care for a long time, and we're not alone. How do you do it?" Jim asks. He is pondering that question, but the biggest obstacles he sees are cultural.

"Dentists aren't rewarded for patient care," he observes. "They're rewarded for procedural care." He suggests that if we can do better in modeling comprehensive care in dental education, it can have a significant positive impact on oral health care delivery in the United States.

Last month when I spoke about the new CODA standards with Dr. Michael Reed, Dean Emeritus and Professor of Oral Biology at the University of Missouri-Kansas City and one of ADEA's representatives on CODA, he echoed Jim's sentiments.

"I think everyone has a positive picture in their own mind of what patient-centered care means," he told me. "Will there be one paradigm for patient-centered care? I doubt that. But the standards allow flexibility for how you define it and measure what's being done. The bottom line is: are we doing the best for the patients?"

Even at MCG, it may take some time before patient-centered care is fully integrated into the curricula of health professions schools, with measurable positive outcomes for students and patients alike. It has been several years since MCG formed an interdisciplinary committee to consider how best to achieve this goal, and its work is ongoing. The challenge will be even greater for campuses that are just coming around to this way of thinking.

As we struggle to fully incorporate the principles of patient-centered care into our clinics and classrooms, let me leave you with some reassuring words that Dr. Daniel Rahn, former President of MCG, delivered in the PBS program I mentioned above. "If we teach [our students] through the eyes of their patients and their families, they get it," he says. I agree. We may not know precisely which means to employ, but the dream of educating our students to provide patient-centered care lies within reach.

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