# UCSF School of Dentistry

## Work Group to Investigate Increasing Predoctoral Clinic Sessions
## Final Report

Prepared by Mark Kirkland, Chair, March 29, 2014

The Work group is comprised of the following members:
Mark Kirkland (Chair), Al Lipske (Project Manager), Maria Guerra, Drs. Sean Mong, Biana Roykh, Avelino Silva, Gaurav Setia, Brent Lin, Kurt Schroeder, Ray Scott, Jim Giblin, Rose Brao (student), Shahab Parsa (student), Heather Wong (student), Ramon Gutierrez (student), Venkat Kadiveti (student).

**Executive Summary**

On September 11, 2013, Dean Featherstone established this work group to investigate the desirability and feasibility of increasing the number of Predoctoral clinic sessions in a day. This was in response to recommendations by the Academy for Academic Leadership (AAL) in their 2012 report to the School of Dentistry entitled "Strategic Review of Operations and Opportunities." Over the years, the State has reduced its allocation to higher education a number of times. As a result, the School implemented a number of strategies to cope with the financial challenge, including reducing staffing levels and strategies designed to increase efficiencies. In response to the ongoing financial challenges, the School contracted with the AAL to seek additional solutions to the problem.

The Committee met a total of six times. Not all members were able to attend each of the meetings. Minutes were recorded and distributed by Al Lipske. The last meeting occurred on March 5, 2014. Nine Committee members attended that meeting. The vote of the members who attended the last meeting was 8:1 to not increase daytime clinic sessions from 2 to 3 per day. The Committee voted 9:0 in support of implementing pilot evening clinic sessions.

Regarding the proposed evening sessions, the financial analysis projects a net loss of approximately $87,000 per year, assuming we implement evening clinic sessions which consists of two sessions per week, using Clinic A, having adequate support staff, 6 general dentists, 1 prosthodontist, 1 periodontist and 1 endodontist (all at the HS Assoc Clinical Prof 2 level).

**Background:**

On September 11, 2013, Dean Featherstone established this work group to investigate the desirability and feasibility of increasing the number of Predoctoral clinic sessions in a day. This was in response to recommendations by the Academy for Academic Leadership (AAL) in their 2012 report to the School of Dentistry entitled "Strategic Review of Operations and Opportunities."

The consultants made a number of recommendations to enhance revenue generation. Two of these recommendations were (1) increase the number of clinic sessions within the same total hours and (2)

increase the total hours of clinic operation (by adding evening and weekend clinic sessions). The relevant portion of that report is below (from pages 7-9 of the AAL report):

**2C. —Increase the Number of Clinic Sessions (Within the Same Total Hours): page 7**

There are two widely held views in managing dental school clinic operations that the AAL consultants have found to be flawed. The first view is that dental students are slow in performing clinical procedures (certainly true compared to private practitioners) and that this factor, coupled with the need for instructor oversight, creates the need for clinical sessions of three hours or longer. The second flawed perception is that if very long clinic sessions are scheduled, the student will have the initiative to book two or more patients into that session depending on the procedure that is being performed.

Based on proprietary analysis and careful observations, the reality of dental school clinic operations is much different. Specifically, students–unlike private practitioners–work to the session, not to the hour. Whereas a private practitioner seeking to earn a higher income is driven to seat as many patients in a day as he/she can comfortably treat, the dental student is satisfied in seating one patient per session whether it is a two-hour session or a four-hour session. Moreover, the longer sessions breed two or three additional negative outcomes. First, dental students tend to come to the clinics unprepared because there are few time pressures to complete a procedure. It is not unusual for them also to come late. Second, the long sessions and the tardiness aggravate patients, who have busy days and jobs and children to care for. Moreover, some would say that sitting in a dental chair for three or more hours for a single restoration is cruel treatment, and it leads patients to drop out. Finally, as students progress through such overly generous time allocations, they are not incented to focus in getting procedures done in reasonable time frames, and their slow pace often can create problems for them on clinical board examinations that are timed.

One large dental school changed from three-hour sessions to two-hour sessions over the protests of some faculty who maintained that students simply could not complete their work in a two-hour session. Yet, the students did complete their work, dramatically improved performance on clinical board exams, and clinical revenue increased 24% in a single year without an increase in fees.

In interviews with principals at UCSF-SOD, the consultants were advised that the two 3.5-hour sessions each day are set so that each student could seat two or more patients in a session. In reality, when clinical managers were probed about this, it was routinely stated that two patients are rarely seated in a 3.5-hour session. Therefore, the SOD should move aggressively towards a restructured clinical “day” as described below.

Change the two 3.5-hour clinical session day (seven hours total) to a three-session day consisting of one 2.5-hour session (presumably for longer procedures and/or students new to the clinic) and a pair of two-hour sessions for a total of 6.5 hours/day. This must be accompanied by a mandatory clinic session attendance rule or the students will default to attending fewer sessions than their schedule allows. If students know that (1) they must

attend, and (2) if they do not have a patient their faculty leader will assign them to assist other students, they will be incented to seat their own patients so that they can gain the additional experience and make progress toward graduation.

**2D. —Increase the Total Hours of Operation: page 8**

Add an evening clinic session of two hours from 6:30-8:30 PM on Monday-Thursday plus two sessions on Saturday mornings. This can provide the basis of a new advertising program that focuses on service to the "working community" of San Francisco and convenience to parents who want to bring their kids in for care and cannot take off from work to do so.

The evening/weekend clinic is a perfect place to break down the silos in a department/specialty-based clinic that characterize the pre-doctoral clinic program. The judicious use of the general practice model in this clinic, with specialists providing necessary consultation and care, provides a collaborative atmosphere for patient-centered care.

**Dean Featherstone's Charge to the Work Group:**

1. Determine the desirability and feasibility of increasing the weekday predoctoral clinic sessions from two per day to three per day, within the same total hours.
2. Consider scheduling units of time along with more sessions per day, and finding efficiencies of procedures in the clinic.
3. To look at all the positive and negative ramifications of this move especially educationally, financially and the effects on patient care. Think broadly about how such a change might, or might not enhance the quality of patient care and enhance patient recruitment.
4. Determine a time scale and logistics of implementation if such a change is recommended.
5. The Committee Chair asked the workgroup to consider an additional charge: determine the desirability and feasibility of adding two evening sessions per week.

## Methods

The committee met six times. The dates were October 28, November 13, November 25, December 4, 2013, January 13, 2014 and March 3, 2014. The committee was assisted by Al Lipske and chaired by Mark Kirkland. Minutes were recorded and distributed to committee members. Several dental schools were contacted to find out how their clinic sessions are structured. Committee workgroup members were tasked with liaising with their respective constituent groups (faculty or students) who participate in the Predoctoral clinics. Specifically, committee members were to explain the Committee's charge and obtain feedback from faculty and students in the Predoctoral clinics on the possible restructuring of clinic sessions and addition of evening sessions.

**Response to Committee Charge**

1. Sean Mong and Biana Roykh contacted 15 different dental schools to determine if they have more than two clinic sessions in a day and if they have evening sessions. Three of the schools have more than two sessions in a day. One of those schools has more than three sessions in a day.

   Of the 15 dental schools that were contacted, nine responded. The nine schools are listed below. Those with asterisks have multiple clinic sessions between 8am-5pm.

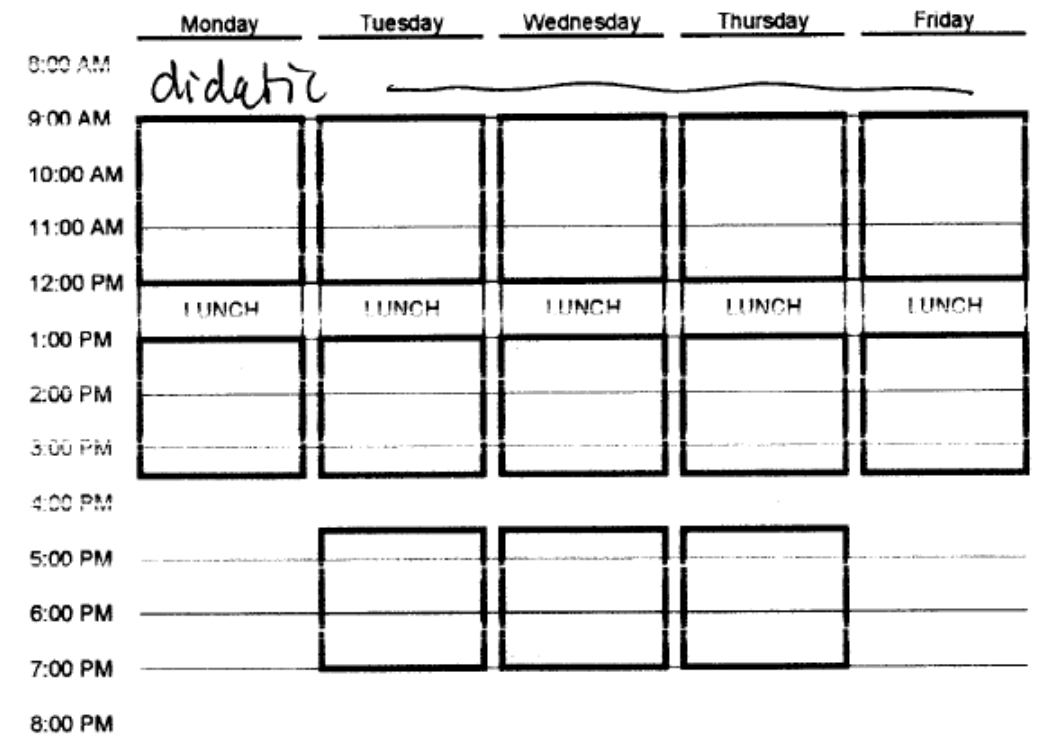
   1. Univ of Maryland
   2. Tufts
   3. Case Western*
   4. NYU*
   5. UOP
   6. ASDOH (Arizona)
   7. Univ of Nebraska
   8. Univ of Tx, Houston
   9. UCLA

   The following schools have evening clinic sessions

   1. NYU (Mon-Thur)
   2. UOP (Mon & Thur)
   3. Univ of Maryland (Tues & Thur)
   4. Tufts (Mon-Thur)
   5. UCLA (Tues)

   The University of Maryland had clinic hours similar to ours. They decided to add 3 evening clinic sessions (Tues –Thurs).

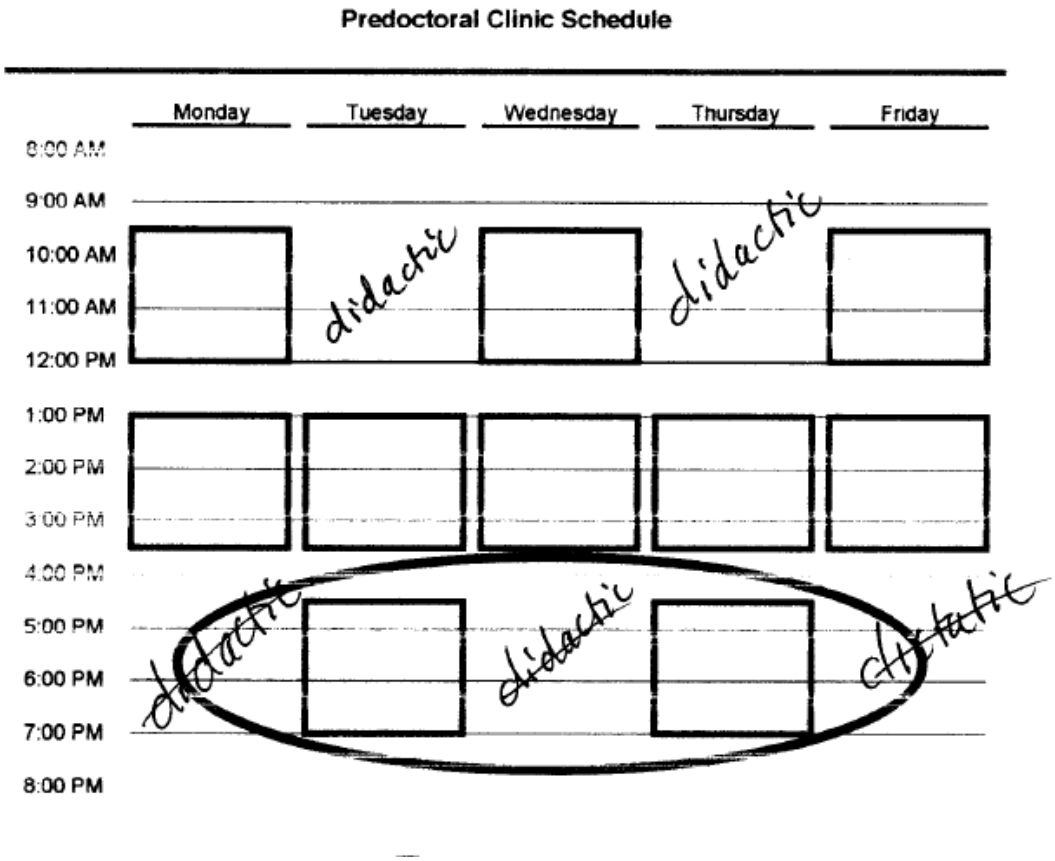
**Predoctoral Clinic Schedule**




Their clinic hours were 9am-12pm, 1-3:30pm and 4:30-7pm.
This 13 session arrangement resulted in:

1. increased production
2. increased student clinical experiences
3. expanded patient demographics (working poor) and service hours
4. increased participation of volunteer faculty members (during the evening sessions)
5. Full-time faculty unhappy with extended day
6. Students with families experienced hardship with the longer days
7. Lecture schedule became difficult
8. Specialty coverage was limited

The University of Maryland decided to implement a modified 10 session weekly schedule.




The new clinic hours are 9:30am-12pm, 1-3:30pm and 4:30-7pm.
This modified 10 session schedule resulted in:

1. Increased production
2. Increased clinic experiences
3. Expanded service hours and patient demographics (working poor)
4. Better faculty support/participation from both full and part time faculty
5. This was a better arrangement for students with families
6. Better lecture schedule because of block lecture spots

Compared to the 2 morning sessions, the 2 evening sessions resulted in a 38% increase in the number of patients seen.

2. Some faculty committee members recommended that the clinic sessions not be changed, but that efforts should be focused on improving clinic efficiencies. (See **Appendix A: List of Clinic Efficiencies for Consideration**).

3. A survey was circulated to D3/4 students. The survey indicated that students felt it would be difficult to increase the number of clinic sessions by shortening the length of the sessions because of fluctuating teaching ratios and faculty punctuality.
4. Concerns were expressed about increased expenses (personnel and materials) associated with possible evening sessions.
5. Some students want to maintain the 12-1:30pm lunch period so that they can participate in meetings involving various campus student groups. This would restrict the ability to easily add a third clinic session to the normal work day.
6. The Committee members were tasked with liaising with their constituent groups to solicit feedback on possible clinic hours if a third clinic session is added to the normal work day. Committee members were also tasked with discussing the possibility of adding evening clinic sessions. Faculty Committee members were to liaise with faculty who teach in the Predoctoral clinics. Student Committee members were tasked to liaise with D3/4 and ID3/4 students. (See **Appendix B: Results of Student Survey,** and **Appendix C: Results of Faculty Survey**).
7. The feedback from the faculty and student surveys showed/indicated there is more support for adding evening sessions rather than for increasing the number of sessions during the day.

**Charge 1: Determine the desirability and feasibility of increasing the weekday predoctoral clinic sessions from two per day to three per day, within the same total hours.**

**Feedback from Faculty & Students**

**Adding a 3rd session to our day: Pros**

a) Increased production
b) Increased clinical experience for students
c) Increased opportunity for students to complete requirements
d) Reduced time in chair for patients (shorter appointment times are easier for pts)
e) May help with anticipated influx of pts that are expected because of the Affordable Care Act and the reinstatement of adult DentiCal benefits

**Adding a 3rd session to our day: Cons**

a) Increased stress/workload for students and faculty
b) Requires increased equipment/cassettes/supplies
c) Requires School owned instruments/cassettes
d) School owned instruments requires renovation of the dispensary in order to meet the demand of dispensing/receiving cassettes and equipment
e) Will increase expenses (e.g., materials)
f) Concerns expressed about inconsistent faculty to student ratio
g) Concerns about faculty and student punctuality
h) Limited options for adding third clinic session because of need to maintain 12-1:30pm lunch period for student participation in RCOs (Registered Campus Organizations)
i) Reduced time for faculty to review EHR and provide electronic signatures
j) Compromised infection control
k) Requires quick turn-around between patient appts (e.g., 15 minutes)
l) Compromised quality of care?

m) During the Leadership Retreat on January 22, 2014, there was minimum support for increasing the number of day-time clinic sessions from two to three

**Recommendation**: There are many challenges to adding a 3rd session to the daytime hours. It is probably not feasible in the immediate future.

**Charge 2: Consider scheduling units of time along with more sessions per day, and finding efficiencies of procedures in the clinic.**

**Recommendation**: The units of time are already available. Either students are not familiar with them or are not using them. Course Directors and Clinic Administration need to remind students, especially 4th year dental students, where this information is located and the importance of scheduling patients as per the appointment guidelines.

**Charge 3: To look at all the positive and negative ramifications of this move (adding a third daytime clinic session) especially educationally, financially and the effects on patient care. Think broadly about how such a change might, or might not enhance the quality of patient care and enhance patient recruitment.**

**Action**: Since there was a lack of support for increasing daytime clinic sessions, the Committee did not pursue this charge any further.

**Charge 4: Determine a time scale and logistics of implementation if such a change is recommended (adding a third daytime clinic session).**

**Action**: Since there was a lack of support for increasing daytime clinic sessions, the Committee did not pursue this charge any further.

**Charge 5: The Committee Chair asked the workgroup to consider an additional charge: determine the desirability and feasibility of adding two evening sessions per week.**

**Adding evening sessions: Pros**

a) Increased production
b) Increased clinical experience for students
c) Increased opportunity for students to complete requirements
d) Expands patient pool
e) Expands service hours
f) Opportunity to provide care to working adults
g) Does not disturb structure of daytime clinic sessions
h) May be desirable for students who have low production or who need to make-up absences
i) May attract more volunteer faculty

j) Plenty of available parking
k) May help with anticipated influx of pts because of Affordable Care Act and the reinstatement of adult DentiCal benefits

**Adding evening sessions: Cons**

a) Increased stress/workload for students and faculty
b) Requires increased equipment/cassettes/supplies
c) Will increase expenses (e.g., materials)
d) Need specialty coverage (pros, endo, perio)
e) Need to adjust sterilization hours of operation
f) Security concerns?

**Details**

a) The WG Committee felt it will be easier and more feasible to add evening sessions rather than additional daytime sessions
b) Educationally, students would have more clinic time
c) Would provide opportunity to attract new patients by expanding service hours
d) Would increase opportunity for patients to receive care
e) Financially, the expenses of running an evening clinic session would exceed the revenue
f) Need to identify/recruit faculty to cover the evening sessions
g) Could be implemented as early as the 2014-15 academic year
h) It is possible to structure the clinic rotations so that students are not in clinics from morning through evening session
i) If implemented, the goal will be to start with Clinic A (48 chairs)
j) Evening clinics would need to be "full service", including specialty coverage
k) Financial projections are based on an assumption of two evening sessions per week, for 39 weeks, using all 48 chairs in Clinic A. We assumed a worst case scenario using no volunteer faculty and assuming faculty would be at the HS Associate Clinical Professor 2 level. Using these assumptions, the estimated ending balance after 1 year will be a net loss of approximately $87,000. See **Appendix D: Financial Analysis for Evening Clinic Sessions** (estimated revenue and expenses for staff and faculty, including benefits and supplies).
l) **Workgroup Committee Vote during the last meeting on 3-5-14**: the WG Committee (9 members in attendance) voted 8:1 to not increase daytime clinic sessions from 2 to 3 per day. The Committee voted 9:0 in support of implementing pilot evening clinic sessions.

**Next Steps**

The next steps that need to be taken include the following. These steps are not part of the charge of this Committee and will be for other groups to consider.

a) Transitioning to School owned cassettes/equipment (currently planned)
b) Ensuring faculty teaching ratios are constant (work in-progress)
c) Ensuring there is an adequate patient base to fill the additional appointment times (will require increased marketing effort and strategies)
d) Improving clinic efficiencies

# APPENDICES

**Appendix A: Recommendations for Improving Clinic Efficiency**

**Appendix B: Results of Student Survey**

**Appendix C: Results of Faculty Survey**

**Appendix D: Financial Analysis for Evening Clinic Sessions**

# Appendix A: Recommendations for Improving Clinic Efficiency

Improving Efficiency: Recommendations by Workgroup Committee

1. Provide appt scheduling guidelines for students (i.e., appropriate amount of time for each procedure). Monitor scheduling for compliance with guidelines.
2. Have clinic staff schedule appointments. Eliminate 3½ hour appts for cementation or prophy. This was mentioned several times.
3. Increase number of clinical faculty. Additional faculty need to be scheduled with D3 students early in the year due to large number of COE & POE appts and students being novice providers (particularly Summer and Fall quarters). Ideally, this should be a 1:4 ratio (faculty to student ratio).
4. Paperwork and informed consent forms take a lot of time to complete.
5. Improve patient check-in process at the beginning of the clinic sessions.
6. Facilitate getting ER patients to the 2nd floor earlier in the session.
7. Allow D3 and ID3 students to do S/RP procedures on the 2nd floor. Limiting this to the 3rd floor delays efficient treatment of patients. This comment was listed a number of times.
8. Have more periodontists on 2nd floor.
9. Consider training D1 and/or D2 students in 4 handed dentistry and rotate them through the Predoc clinic to assist D3, D4 and ID3 students.
10. Encourage attending faculty to be more proactive in helping students work more efficiently. Recognize early in clinic session when student needs assistance in order to complete procedure efficiently.

Committee members were asked to identify their top 6 ideas for improving clinic efficiencies. They were tasked with liaising with their colleagues for their input. A total of nine committee members responded. This was the result of that survey.

**5 Votes for each of the following:**

1. Need to modify or eliminate students scheduling their own patients.
2. If staff were able to schedule patients with the student and faculty member, it would allow adequate time for the procedure, clean up and setting up the chair for the next patient. This would reduce a lot of wasted chair time and "phantom" patients.
3. Additional faculty need to be assigned to third year students, particularly during the summer and fall quarters.

**4 Votes for each of the following:**

1. A smaller faculty to student ratio would be immensely helpful (e.g., a 1:4 faculty to student ratio)
2. Assignment of NPV patients should result in an equitable distribution of patients and procedures.

**3 Votes for each of the following:**

1. NPV and ER: Patients need to be triaged and routed much more quickly to allow students enough time to provide care.
2. Consideration should be given to reducing S/RP fees to allow patients the affordability of proceeding with their restorative work.
3. Perio treatment for 3rd year students "only in the perio clinic" needs to be reconsidered. There is a backlog of D3/ID3 patients waiting for their perio treatment. This delays restorative work because the students can't get a perio chair because they are not on their perio rotation.
4. Perio treatment (particularly D3/ID3 S/RP) should be provided on the second floor so that treatment can progress efficiently.
5. Students need more time in the clinic.

**2 Votes for each of the following:**

1. Will informed consents and paperwork be more efficient so as to not take 30 minutes to complete?
2. Keep the predoc clinics for teaching third year students only and once they are ready for more independence, allow them to move to the externship sites.
3. Clinic assistants should help turn the chairs around and be more readily available for more efficiency.
4. Current schedule allows for students to see 1 or 2 patients. It should be up to faculty and students to ensure students are busy.
5. Clinic assistants need to be involved with scheduling or implement block scheduling so students can't give themselves a whole period for a 60-minute procedure.
6. Students need more patients if they expect to fill their schedules.

**1 Vote for each of the following:**

1. Suggestions: Use Isolite instead of rubber dam.
2. Need an assistant-too much time running around to find instructor, obtain dispensary items, obtain approval swipes, break down and set up again, etc.
3. Will the backlog of patients checking in be eliminated to allow patients to be seated on time?
4. Perio faculty need to be increased to allow COEs to be completed in a timely manner.
5. Lack of faculty, and poor faculty attitude. Faculty often are on their computers or phones and sometimes even seemed annoyed when you ask for their help or feedback.

# Appendix B: Results of Student Survey

**My Report** Last Modified: 12/05/2013

**1. What is your current year in dental school?**

| # | Answer | Bar | Response | % |
|---|---|---|---|---|
| 1 | D3 | | 26 | 47% |
| 2 | ID3 | | 0 | 0% |
| 3 | D4 | | 29 | 53% |
| 4 | ID4 | | 0 | 0% |
| | Total | | 55 | |

| Statistic | Value |
|---|---|
| Min Value | 1 |
| Max Value | 3 |
| Mean | 2.05 |
| Variance | 1.02 |
| Standard Deviation | 1.01 |
| Total Responses | 55 |

**2. I maximize the time allotted during each clinic sessions. (i.e. perform more than one procedure when possible, see more than one patient when possible, etc.)**

| # | Answer | Bar | Response | % |
|---|---|---|---|---|
| 1 | Strongly Agree | | 4 | 7% |
| 2 | Agree | | 36 | 65% |
| 3 | Neither Agree nor Disagree | | 8 | 15% |
| 4 | Disagree | | 6 | 11% |
| 5 | Strongly Disagree | | 1 | 2% |
| | Total | | 55 | |

| Statistic | Value |
|---|---|
| Min Value | 1 |
| Max Value | 5 |
| Mean | 2.35 |
| Variance | 0.71 |
| Standard Deviation | 0.84 |
| Total Responses | 55 |

**3. If you feel you are not able to maximize your current clinic sessions, please rank why you are unable to maximize your sessions with 1 being the most relevant reason and 6 being the least.**

| # | Answer | 1 | 2 | 3 | 4 | 5 | 6 | Total Responses |
|---|---|---|---|---|---|---|---|---|
| 1 | Lack of skill/experience (i.e. I'm slow at clinic procedures) | 4 | 10 | 7 | 10 | 11 | 3 | 45 |
| 2 | Not enough patients/unreliable patientsItem 2 | 13 | 14 | 8 | 9 | 1 | 2 | 47 |
| 3 | Not enough instruments to bring in multiple patients to one session | 0 | 2 | 11 | 10 | 17 | 3 | 43 |
| 4 | Not enough time in the clinic session | 4 | 7 | 6 | 10 | 9 | 7 | 43 |
| 5 | Current faculty:student ratio | 31 | 9 | 7 | 1 | 1 | 1 | 50 |
| 6 | Other (please specify) | 5 | 4 | 2 | 1 | 0 | 8 | 20 |

| # | Answer | 1 | 2 | 3 | 4 | 5 | 6 | Total Responses |
|---|---|---|---|---|---|---|---|---|
| | Total | 57 | 46 | 41 | 41 | 39 | 24 | - |

**Other (please specify)**

Depends on faculty

Need an assistant-too much time running around to find instructor, obtain dispensary items, obtain approval swipes, break down and set up again, etc.

Faculty are lazy

Bureaucracy of clinic slows procedures down, needing this signature or that form, etc.

Faculty too slow in checking off students

Some faculty like to talk to other faculty/students/patients about unrelated things and waste alot of time

lack of assistant

Lack of staff to help ie dispensary/clinic assistants

Slow faculty

Elaborating on 1, this is the biggest problem of all, a smaller faculty to student ratio would be immensely helpful

Slow Faculty

Paperwork

Administrative/scheduling issues

| Statistic | Lack of skill/experience (i.e. I'm slow at clinic procedures) | Not enough patients/unreliable patientsItem 2 | Not enough instruments to bring in multiple patients to one session | Not enough time in the clinic session | Current faculty:student ratio | Other (please specify) |
|---|---|---|---|---|---|---|
| Min Value | 1 | 1 | 2 | 1 | 1 | 1 |
| Max Value | 6 | 6 | 6 | 6 | 6 | 6 |
| Mean | 3.51 | 2.51 | 4.19 | 3.79 | 1.70 | 3.55 |
| Variance | 2.16 | 1.86 | 1.11 | 2.50 | 1.28 | 4.79 |
| Standard Deviation | 1.47 | 1.37 | 1.05 | 1.58 | 1.13 | 2.19 |
| Total Responses | 45 | 47 | 43 | 43 | 50 | 20 |

**4. My current clinic schedule adequately prepares me to practice general dentistry when I graduate.**

| # | Answer | Bar | Response | % |
|---|---|---|---|---|
| 1 | Strongly Agree | | 0 | 0% |
| 2 | Agree | | 14 | 25% |
| 3 | Neither Agree nor Disagree | | 16 | 29% |
| 4 | Disagree | | 20 | 36% |
| 5 | Strongly Disagree | | 5 | 9% |
| | Total | | 55 | |

| Statistic | Value |
|---|---|
| Min Value | 2 |
| Max Value | 5 |
| Mean | 3.29 |
| Variance | 0.91 |
| Standard Deviation | 0.96 |
| Total Responses | 55 |

**5. Please rank your preference with 1 being the most preferred and 4 being the least preferred.**

| # | Answer | 1 | 2 | 3 | 4 | Total Responses |
|---|---|---|---|---|---|---|
| 1 | Clinic assistants are in charge of my patient scheduling/ management. They make sure my schedule is full, manage my procedure experiences, make sure I am fulfilling production requirements, handle my emergency patients, deal with my cancellations, discontinue unreliable patients, etc. | 27 | 15 | 3 | 6 | 52 |
| 2 | I am in charge of my patient management; I make sure my schedule is full, manage my procedure experiences, make sure I am fulfilling production requirements, handle my emergency patients, deal with my cancellations, discontinue unreliable patients, etc. | 24 | 18 | 3 | 7 | 52 |
| 3 | I am indifferent | 1 | 2 | 17 | 22 | 42 |
| 4 | It does not matter as long as my patient shows up | 2 | 12 | 20 | 9 | 43 |
| | Total | 54 | 47 | 43 | 44 | - |

| Statistic | Clinic assistants are in charge of my patient scheduling/ management. They make sure my schedule is full, manage my procedure experiences, make sure I am fulfilling production requirements, handle my emergency patients, deal with my cancellations, discontinue unreliable patients, etc. | I am in charge of my patient management; I make sure my schedule is full, manage my procedure experiences, make sure I am fulfilling production requirements, handle my emergency patients, deal with my cancellations, discontinue unreliable patients, etc. | I am indifferent | It does not matter as long as my patient shows up |
|---|---|---|---|---|
| Min Value | 1 | 1 | 1 | 1 |
| Max Value | 5 | 4 | 4 | 4 |
| Mean | 1.83 | 1.87 | 3.43 | 2.84 |
| Variance | 1.20 | 1.06 | 0.49 | 0.66 |
| Standard Deviation | 1.10 | 1.03 | 0.70 | 0.81 |
| Total Responses | 52 | 52 | 42 | 43 |

## 6. How do you think increasing the number of clinic sessions and decreasing the time of each session (e.g. 3 sessions that are 2 hours each) will affect your preparedness for practice? Select all that apply.

| # | Answer | Bar | Response | % |
|---|---|---|---|---|
| 1 | Better prepare me for practice | | 38 | 69% |
| 2 | Increase clinical experience | | 32 | 58% |
| 3 | Increase stress | | 35 | 64% |
| 4 | Decrease stress | | 3 | 5% |
| 5 | Increase speed and efficiency | | 42 | 76% |
| 6 | Increase quantity of procedures, but decrease quality of them | | 20 | 36% |
| 7 | Improve patient management skills | | 23 | 42% |
| 8 | Increase patient management load | | 22 | 40% |
| 9 | Decrease work-life balance | | 6 | 11% |
| 10 | Other (please elaborate) | | 9 | 16% |

**Other (please elaborate)**

It'll force us to work faster. When given 3 hours, people usually take the whole time.

Only if we have assistants

I feel like a good deal of time is spent seating your patient and updating medical history and getting a start check and rubber damn etc and then at the end getting checks and axium note and swipes would be too little time to get anything done esp with waiting for faculty

I don't think that this would do anything. At this time we are able to see more patients if we would like to.

This would only work with more faculty or no one could finish anything.

Decrease production. More time cleaning up. I want to see 1 patient for 4 hrs and do quadrant dentistry.

impossible unless we are given more freedom/less check-ins with faculty

If you want us to be faster you need to allow is a certain level of autonomy. That's why externship is faster because we are given more trust to make decisions.

| Statistic | Value |
|---|---|
| Min Value | 1 |

| Statistic | Value |
|---|---|
| Max Value | 10 |
| Total Responses | 55 |

### 7. How do you think increasing the number of clinic sessions and decreasing the time of each session (e.g. 3 sessions that are 2 hours each) will affect your interactions with patients? Select all that apply.

| # | Answer | Bar | Response | % |
|---|---|---|---|---|
| 1 | Improve patient relationships | | 9 | 16% |
| 2 | Strain patient relationships | | 15 | 27% |
| 3 | Neither improve nor strain patient relationships | | 25 | 45% |
| 4 | Improve patient satisfaction | | 17 | 31% |
| 5 | Broaden (or change) patient population | | 16 | 29% |
| 6 | Other (please elaborate) | | 5 | 9% |

**Other (please elaborate)**

They will appreciate 2 hr appts!

Worried patient will be late and will not have enough time

It would make finishing some procedures in one appointment difficult.

I see this as not enough time to get anything done, especially for third years (as I cannot speak for the 4th years). Many time pts are late or you need to get consents or financial things done and after all the paperwork is done a two hr session would leave almost no time to do things, especially anything more complex

Multiple appointments frustrate patients. If the time is cut but the procedure isn't then a crown for instance will take 4 appointments instead of 2.

| Statistic | Value |
|---|---|
| Min Value | 1 |
| Max Value | 6 |
| Total Responses | 55 |

### 8. What do you think is a major obstacle to increasing clinic sessions? Select all that apply.

| # | Answer | Bar | Response | % |
|---|---|---|---|---|
| 1 | Limited faculty | | 48 | 87% |
| 2 | Limited patient population | | 29 | 53% |
| 3 | Limited instruments | | 19 | 35% |
| 4 | Limited staff | | 29 | 53% |
| 5 | Culture of our program | | 18 | 33% |
| 6 | Attitudes of faculty | | 28 | 51% |
| 7 | Attitudes of patients | | 8 | 15% |
| 8 | Attitudes of classmates | | 10 | 18% |
| 9 | Other (please elaborate) | | 6 | 11% |

**Other (please elaborate)**

harder to manage our own schedules

types of procedures that can be done in shorter appointments

My main time limiting factor is waiting for faculty to check my work, increasing clinic sessions without increasing faculty will make operative procedures (or COE/POE) significantly more stressful

cleaning and setting up cubicles will take up too much time.

too many students, not enough chair time. i have many weeks with only THREE half days in clinic. Doesn't matter if sessions are shorter and more numerous if I still only have three half days!

**Other (please elaborate)**

UCSF is a slow moving dinosaur held back by never ending rules and regulations, AxiUm approvals, an endless number of administration, and a frustrating lack of communication. In addition to this students cannot be expected to efficiently schedule their own patients when their clinic time is constantly being interrupted by rotations and externship all while not being able to remotely access AxiUm.

| Statistic | Value |
|---|---|
| Min Value | 1 |
| Max Value | 9 |
| Total Responses | 55 |

## 9. Please Rank your preference:

| # | Answer | 1 | 2 | 3 | Total Responses |
|---|---|---|---|---|---|
| 1 | [redacted] | 21 | 6 | 24 | 51 |
| 2 | [redacted] | 23 | 11 | 14 | 48 |
| 3 | [redacted] | 10 | 28 | 4 | 43 |
| | Total | 54 | 45 | 42 | - |

| Statistic | | | |
|---|---|---|---|
| Min Value | 1 | 1 | 1 |
| Max Value | 3 | 3 | 6 |
| Mean | 2.06 | 1.81 | 1.95 |
| Variance | 0.90 | 0.75 | 0.71 |
| Standard Deviation | 0.95 | 0.87 | 0.84 |
| Total Responses | 51 | 48 | 43 |

## 10. In your opinion, what is the weakest point in our current clinic session schedule?

**Text Response**

The faculty, [redacted], that wander off during clinical sessions to take "breaks" and generally don't seem to care about things being done in a timely manner.

Students not being efficient with their time. Patients also do not take our time seriously and fail to show up. If patients cancel last minute, we can't do anything.

Limited faculty to student ratio

Indifference of some faculty/students

N/A

Faculty are late

It is unrealistic to get such long sessions in private practice. However, we are much faster on externship when we have assistants helping us. Our clinic is not set up for speed, we don't have assistants, there is a plethora of paperwork, wait time for faculty, and can be difficult to get a chair with the faculty you need. But, I recognize this is a hard clinic to run, with SO many students, and this may just be the nature of a huge clinic.

Everything. It is a lazy solution that does not fix the problem

most session time is limited to 1 procedure because faculty does not want to start check multiple procedures at once

Inefficient faculty, not enough faculty

having to wait for faculty. Having to do so much paperwork. waiting for consults. All these things have varying amounts of time and make it difficult to know how long an appointment will take

**Text Response**

Too few specialists. Especially perio

lack of faculty (perio, row faculty)

wait times for check-offs

Lack of faculty. lack of access to materials - we should have several more stations that carry materials throughout the clinic, it wastes so much time running around gathering things because there is one station for PPE equipment per A/B side of clinic, one dispensary per side, and one cart per row. lack of equipment- it is not often i run out of equipment, but it does happen, the dispensary should have some equipment available to us in case we need a backup. Access to patients- scheduling patients ourselves is a big job and even though i think it is an important one, we should be getting help too.

3.5 hour blocks are allotted for all procedures, large or small. that makes no sense.

faculty spent too much time on one student sometimes, or are chit chatting on the side ignoring students waiting. makes clinic painful at times

Not enough chair time, too many ISOs

N/a

Lack of faculty. Long wait time for checks. Too many admin steps prior to actual procedures

POEs and COEs and getting certain consults take way too long! We are given way too much time to do fillings.

The faculty is the weakest point. We need more faculty because a great amount of clinic time is wasted waiting for precious faculty time. I think longer blocks would be the best adjustment to clinic schedule because then if you want to see two pts you can on your own scheduling or you can do multiple procedures on one. If an adjustment has to be made, maybe 8:30-12:30 (because pts hate having such an early appointment) and 2-6pm. However I think faculty to student ratio should be changed first and will probably alleviate many of the current issues and bring up production etc

Availability of staff and faculty such as those for perio consults, financial support etc.

Patient late or no-show

We don't lay flaps, we do limited endo, we are made to refer our patients when things become only slightly complex. Why don't we get to do the same things that most other schools do (like crown lengthening)?

The horrible student to faculty ratios. We NEED more faculty!!! There needs to be more than 1 faculty per 8 students , at least in d3 year

I don't think that our scheduling is weak. I think that the part that is weak is the procedures that we are allowed to do. I also think that our prices are high and by offering payment plans or CareCredit more patients would be able to receive care here and would.

Lack of efficiency enforcement

Many patients are unable to conform to the current schedule (lack of flexibility).

Lack of faculty, and poor faculty attitude. Facutly often are on their computers or phones and sometimes even seemed annoyed when you ask for their help or feedback.

Inefficiencies! Efficiency is not encouraged, an often it's not the fault of the student!

Not enough patients, spending too much time waiting for faculty, no night clinic, too much administrative stuff

na

that we don't see patients after 5pm. the patients who can afford treatment often work til 5 so opening clinic up after working hours would be beneficial to everyone

Lack of faculty and waiting in lines.

Faculty don't show up on time. Support staff often late. Creates a culture of lax scheduling.

Lack of faculty

Too many students, not enough chair time. I have many weeks with only THREE half days in clinic. Doesn't matter if sessions are shorter and more numerous if I still only have three half days!

It's not the scheduling. it's the fact that there are not enough faculty to oversee treatments. I'm stuck waiting for faculty sign off's most of the time, which decreases my clinical efficiencies.

I think as a third year, it is tough to be fast enough to be more efficient with your time because you are still gauging which patients are dependent. As a fourth year, you may be overwhelmed with patients but cannot do as much as you want because you seem to be waiting for faculty a lot and the clean up/set up is the biggest obstacle of it all.

Time inefficiency.

Wait time between faculty checks since some work slower than others, and wait time to get sepcialty consults

Clinic schedule is fine,

Student/faculty ration-

Not enough sessions. If students are forced to work in shorter session they will be better prepared before each session and this increases their efficiency. Student's right now sometimes do no come to clinic prepared because they feel like they have so much time in clinic that they will finish regardless.

We don't get enough patients with enough procedures

The number of faculty is definitely the limiting factor in clinic. Quality of patient care could be much improved (less time in the chair, a provider who can stay on task without having to leave the patient track down faculty, improved ability to show up appointments because patients do not have to sacrifice an entire half day) with a better faculty-to-student ratio.

Number of sessions per week (usually 4-6 when there are 10 half day sessions, 9 if you include class)

Not enough faculty

No night clinic to accommodate patients who work during the week.

Exam steps, busy professors including periodontists

Not enough one on one time with faculty

| Text Response |
|---|
| Not enough clinic. And not enough available space. |
| Not enough faculty: even though students doing POEs/COEs finish within 2 hrs, they are the last students seen by the faculty. |
| The lack of assigned chairs. I expect to have 3 chairs per week my final two months while in school. That seems extremely low for refining my skills just before graduating |

| Statistic | Value |
|---|---|
| Total Responses | 55 |

## 11. In your opinion, what is the strongest point in our current clinic session schedule?

| Text Response |
|---|
| Stress reduction, not necessarily a good thing but our clinic schedule is not very stressful. |
| We control our own schedule... but it could be a bad thing if one student is not proactive or is "unlucky" |
| Good patient flow |
| Motivated students and faculty |
| N/A |
| Open at 830 most of the time |
| Having longer appointment times allows us to learn at a good pace, gives us time to do difficult procedures (ie RCT), and eventually gets us to the point where we can schedule two patients per session. |
| Nothing |
| 3 hrs time slot which allows for multiple patient scheduling |
| N/A |
| being able to see the whole years schedule and who you will be working with |
| Existing faculty work hard |
| familiarity |
| nothing |
| having that much time allows us to complete many procedures for each patient that comes in making the most of their visit. |
| staff and faculty work pretty hard and are very helpful. |
| many specialty consults available, except for perio consult. we need more perio circling around |
| Sufficient amount of time to finish procedures with the current student/faculty ratio |
| N/a |
| Faculty able to have time and teach student one on one |
| The long appointments allow for adequate crown and bridge and pros time. |
| An additional weak point is the inability to open chairs on Monday or Tuesday morning. This new rule is making it hard for is to have more clinic time if we don't have normal clinic time on those days. At the end of the day, it's hard to meet all the requirments not because we aren't trying but because of faculty to student ratio, chair time, and an in-even distribution of good patients due to the very random and unpredictable NPV protocol |
| Not sure |
| Clinic assistants help schedule patient in openings. |
| I get time off because I'm given ISO during times I'm. Not even allowed to schedule a patient |
| Patients enrolled |
| The long clinic sessions allow us to ease into clinic and to take time to get to know our patients. |
| Time to build a relationship with our patients and ensuring quality due to increased time spent on procedures |
| Adequate time to complete a variety of procedures |
| n/a |
| With 3.5 hour appointment blocks, we can devote a lot of time and attention to our patients. |
| Faculty that are there and the clinic assistants |
| na |
| i dont know |
| . |
| Long time blocks. |
| Critical Thinking and Diagnosing |
| Enough time for in depth learning |

| Text Response |
|---|
| I like that we have two large blocks of time. |
| that we have ample time to complete most procedures. As a third year, when you are still slower it is nice to not be rushed but do things right. Perhaps we can stick with our schedule as is for 3rd year but then 4th year it can change to 3 sessions so we can build up our speed/see more patients? I dont feel like i have enough clinic sessions any more. And i still have so many more requirements to complete. I think there should be a rule against someone doing more than 5 arches of prosth or more than 12 crowns while other classmates may be struggling for that requirement. Our biggest concern in clinic right now is how procedures are not distributed equally. Someone may have 15 crowns while a classmate has 3. Or someone may have 8 arches of prosth while one might only have 1. |
| Appropriate for entering third years/struggling students. |
| N/A |
| N/A |
| N/A |
| None. We need more sessions and more faculty to overlook the students |
| Good faculty |
| The long appointment windows allow enough time for a thorough comprehensive exam plus multiple specialty consults and a prophy. However, with Option 2, this is still a possibility. |
| Length of each session |
| That our appointments can last as late as 5pm |
| Lots of time to build repoir with patients. Important to establish good relationship with patient before beginning work. |
| Through exam |
| Time for each patient |
| The sessions are not the problem. It's the efficiency of those sessions. |
| There is usually enough time to finish a procedure and form a relationship with patients. |
| The willingness of young faculty members to aid in advanced procedures as well as offer advice on applying for jobs |

| Statistic | Value |
|---|---|
| Total Responses | 55 |

## 12. Other suggestions:

| Text Response |
|---|
| I like the idea of having 3 sessions. We'll be forced to be more efficient which I think is definitely possible. |
| I think if you increase the number of clinic sessions and shorten the hours, you need to have assistants for the providers. I think you could do this by having clinic partners be the assistant. This would increase efficiency, and teach us how to be prepared to work with an assistant when we enter private practice. |
| Get rid of grumpy, old, and unwilling faculty and staff |
| My chair schedule seems to change all the time, making it difficult to bring patients back to work with the same faculty. If I am not completely paying attention, things get switched and it makes it very difficult to continue a patient's treatment. Just makes life a little bit harder. |
| I believe increasing clinic sessions is a terrible idea that does not address the real issue which is lack of quality faculty. |
| increase faculty student ration, and standarize ways in which students are getting check so more procedures can be done |
| Faculty need to be on board with making things go faster instead of chatting on the phone, browsing the internet, talking to other faculty about vacations they take, and talking to patients about everything but dentistry |
| idp take half the clinic, get a faculty per 4 students, and dont allow us to open chairs on certain days. all the students should have the same opportunities. |
| Adding clinic sessions will have everything to do with the faculty in our clinic. It is hard to imagine completing a session in two hours with the lack of faculty and/or staff in our clinics. In the beginning of the year I was attempting to schedule 2 patients per session, however, these appointments are always more stress than they are worth since it is our responsibility to setup/clean up/get all our swipes from faculty that don't have time for you/rely on dispensary staff that are not enough and are usually slow/waiting on the one clinic assistant assigned to 1/4 of the students in the clinic/ and gather all the things necessary for the procedure. It is more efficient to complete more than one procedure on the same patient for the full 3 hours than try to fit two patients in. As the students we have too many duties and absolutely no help at all. The amount of approvals for every single thing we do is impossible with the small number of faculty/staff in the clinic, this makes the clinic extremely slow and actually slows our work down since all we ever do is rush only to wait. I always gain speed during my externship rotations, then my work slows way down once I am in clinic. |
| If decrease time for each session we need to have more faculty per student because that is one of the main reasons why each procedure takes so long. I would love to have more clinic time in the form of evening clinic. I have patients who need work to be done but I don't have enough chairs to open. Also I don't like the idea of not being able to open up chairs on Mondays and Tuesdays (morning). It's not fair to the students who have ISOs on those days. |
| We need for faculty |
| The first clinic schedule has students working too many hours in one day. So some students should serve the morning session and other the evening session. Evening clinic would be great if we can find faculty and staff to work those hours, but I don't think there is a need for us to go past 8pm. 5 to 7 would be an adequate evening clinic. |

**Text Response**

If faculty can start thier shift at 8:15 and 1:15 that would be extremely helpful. We would be able to get swipes from them and review the case for the day or possibly have time for a row huddle to learn from what everyone else is doing. This way, we would be able to utilize the clinic time when our pt gets there much more efficiently

More faculty so we can be more efficient!!!! It's ridiculous to wait more than 30 minutes to get anything checked by faculty, while the patient sits in the chair. When people do POEs I tend to wait an hour plus to get checked- THIS iS NOT OKAY!!!!!

I think that 3 hour sessions would be very good. I also think that having a night clinic or Saturday clinic would be good for our patients.

I have extreme difficulty managing to fill my schedule with the limitations of the quarter (I have no chairs on mondays and no chair on tuesday morning, which are the times we were told we cannot open chairs due to IDP needs)

n/a

This survey was leading. I believe you will get unreliable data from it.

Give us more freedom, can't put 7 POE/COE in the same area nothing ever gets done. Too time consuming

thank you to all who thought of this survey. theres definitely room for improvement with scheduling in clinic =)

Shortening clinic times to increase the session numbers will not benefit us, especially since many of us start out really slow and could use all the time we need to effectively learn and get feedback and guidance from our faculty. Also, many of us already struggle with the wait time to get checks throughout our procedures with the 1:8 faculty-student ratio. Shortened time will only stress us out more and decrease the quality of the students UCSF releases into the real world. A night clinic would be great as long as it is scheduled carefully

Patient allocation is terrible. Some students have 10 RCTs done, some 0. No one wants to share. Faculty don't care, but we students have to graduate somehow. The same applies to Prost procedures and restorative!

I don't want to necessarily decrease the time of each session, but increase the number of sessions. As mentioned above, instead of having 4-6 half days in clinic, have 6-8 half days (still keeping appointments 8:30-12 and 1:30-5). Or add an additional night clinic option (5:30-8 pm).

Increase the sessions from 2 to 3 per day. This way we can see more patients each week. Having approx 4-5 guaranteed chairs per week is not enough.

Faculty calibrations. There are some procedures that can take 2-3x as long with some faculty than with others. These things add to patient and student frustrations. In addition to this students should not be in charge of their patient list. Too many patients are hoarded or traded around in order to get honors or reach production requirements. A production requirement causes students to not share patients. It's not just because they are holding out for things they need. In the end a student is very busy and inevitably phone calls and scheduling can fall through the cracks.

Distribute patient experiences/procedures better: some students are doing many procedures such as operative, crowns, and pros, while others are doing way less and have completely open schedules with no way to fill them.

| Statistic | Value |
|---|---|
| Total Responses | 26 |

# Appendix C: Results of Faculty Survey

**1. Assess the Pros and Cons of increasing the number of Predoctoral clinic sessions**

| | Pros (Positive Aspects) | Cons (Negative Aspects) | Infrastructure or resources needed for implementation |
|---|---|---|---|
| a. Add a third clinic session to each day | Increased production (x4) | Increased stress/workload (students, faculty , staff) (x5) | More faculty supervision, staff for patient appointments and dental assistants for setup/breakdown of cubicles, equipment (x5) |
| | More experience for students | Rushing to complete procedures (x2) | Faculty to student Ratio (x2) |
| | Address efficiencies (x2) | Compromise infection control (x3) | Sterilization turnaround time |
| | | Supplies/equipment to handle increase demand (x2) | |
| b. Add 2 evening sessions, Tue & Thu evenings | Increase production and student experience | Longer hours for faculty and students (x5) | More morning/evening staff/faculty needed (x3) |
| | Expands patient population pool (x5) | Difficulty for student/faculty/staff with family or young children (x2) | Adequate instument/sterilization (x2) |
| | Minimize disturbance to current day clinic structure (x3) | Increased overhead to run evening clinic (faculty/staff) (x2) | Coverage of specialty clinics (x2) |
| | Attract more volunteer faculty (x4) | Evening campus security issues (x2) | Student rotation for evening clinic |
| | | No Oral Surgery/Ortho consults | |
| | | More part time faculty will opt for evening vs day clinics (x2) | |
| c. Add additional sessions during both day and evening | None. It is impractical to have both daytime and evening clinics | Unpredictable care quality (x2) | Adequate instument/sterilization turn around (x3) |
| | There are no positive aspects to this proposed clinic practice model (x2) | Need additional faculty and supplies | Possible faculty shortages during daytime sessions for faculty who opt to do an evening so they don't have to travel to SF 3x a week |
| | Increased production (x2) | Longer hours for faculty/students/staff (x4) | Must create complex student/faculty/staff rotation schedule for coverage & pt. care |
| | Drastic increase in student clinical experience (x2) | Need additional faculty and supplies | |
| | Parking is available for evenings | | |
| | Staggering of shifts | | |

**Additional comments.**
See attached page

**2. Look at all the positive and negative ramifications of this move especially educationally, financially and the effects on patient care. Think broadly about how such a change might, or might not, enhance the quality of patient care and enhance patient recruitment.**

| | Pros (Positive Aspects) | Cons (Negative Aspects) | Infrastructure or resources needed for implementation |
|---|---|---|---|
| a. Costs | Possibilty of maintaining current student tuition | Increase expenditures on the clinic personnel, supplies, equipment and facilities (x5) | Financial cost analysis is essential in determing the breakeven point |
| | May increase clinic revenue and production (x2) | May take a couple of years before an increase in revenue is really "felt", once patient pool is expanded enough to compensate for the start-up costs. (x4) | Will need capital for equipment, staff and faculty |
| | Offset by production (x2) | | |

| | | | |
|---|---|---|---|
| **b. Educational advantages** | Increased clinical experiences (x4) | Extended schedule or multiple sessions can decrease student focus with too intense learning environment or too extended time frame (x2) | Will need resources to support good learning (staff, faculty equipment, enhanced didactic curriculum which includes more focus on patient mgmt, etc.) (x3) |
| | Shorter pt visits easier to tolerate as patient (x2) | Increase student stress in performing tasks (x4) | |
| | Opportunity to increase requirements given better efficiency and use of chair time (x2) | Compromise quality if we strive for quantity. | |
| **c. Patient access / Community Service** | Reaching to a broader patient pool (x4) | Very challenging for ER triage | Creative advertising regarding short appts to the community (x2) |
| | | Patient may not want to come in evening | More staff needs to be hired |
| | Evening clinics provide more access to patients that work all day and cannot take time off | Increased daytime clinics would not be beneficial to our patients without a different practice model | D1/D2 or potential dental school candidate as volunteer to act as DA to set up/break down cubicle for multiple sessions so ID3/ID4 can spend more time with the to establish proper professional relationships |
| | | Multilpe sessions translate into a short time between pt thus reduce person contact & care to pt | |
| | | | |
| **d. Logistics** | Opportunity to expand and increase production (x2) | Greater strain on current resources. Are we prepared for possible failure and back-tracking if the new practice model does not work out? (x2) | Need proper planning before implementation |
| | Ability to offer flex schedule to certain staff/faculty in both multiple sessions & evening sessions | Complicated to plan | Must have support personnel and funding in tracking/scheduling increased student, faculty and staff hours |
| | The current practice model would need logistical change | Implementing any of these changes, there will be lots of effort going in | Perhaps consider x-raying all patients who come into ER or POE so that its one less thing we do upstairs and wait for |
| **e. Sustainability (ability to continue activity into future)** | Commitment would be needed to sustain the new clinic practice model. There might need to be mid-course corrections/changes (x2) | Lack of commitment to the new practice model leads to failure and waste of resources (x2) | Increase faculty satisfaction and happiness so they are will to accept the change (x2) |
| | Reestablish relationship with patients that only have eveing availability | Increase cost in supporting staff (x2) | In both multiple and evening sessions, staff must reduce patient no show frequency |
| | Student with low production or requirement will be attracted to the evening sessions & multiple sessions | Full time faculty may not be attracted to the evening session (x2) | Student should be scheduled into evening session as rotational experiences instead of regular protected PCC time |
| | Evening sessions are usually supported/welcomed with part time faculty | Student with family may not be in favor of evening session | |
| **f. Faculty (do we need additional faculty)** | Yes (x5) | Can the school find enough qualified faculty to cover increased clinic sessions (volunteers and paid) (x2) | Need to hire more GP and specialists (x3) |
| | More flexible schedule | Increased cost to school/departments | Create a stronger alumni connection to improved volunteering efforts |
| | CP will make the call for specialty consult/referral similar to the private practice setting | Insufficient specialty faculty for consult or supervising procedures | |

| | | | |
|---|---|---|---|
| c. Long-term | Additional daytime clinic sessions are possible if we train D1/D2 students as assistants to support student providers. | Hire additional staff and faculty | Long-term means 2 to 3 years |
| | Allow time to phase in various suporting stuctures: facility, instruments, supporting staff, faculty and student | Too long in implanting may send the wrong message on the needs of increased sessions | Provide a definitive timeline of implementation. The timeline should not exceed 2 to 3 years |
| | Enable to cultivate organic or cultural changes in supporting 3 sessions or evening sessions | Too long may also resulting in reducing support of stakeholders | Retainment of faculty/staff |
| | If it is successful and well operated, will generate revenues and enhance education experience | It may cost more to operate and students may not benefit from shorter sessions | |
| | Better for continuity of care, patients can get comprehensive care done quicker | Financial ramifications if this investment does not go as planned | |
| Additional Comments: | | | |

**4. Assess a time scal's Pros and Cons of implementating two (2) evening clinic sessions, Tuesday and Thrusday evenings.**

| | Pros (Positive Aspects) | Cons (Negative Aspects) | Infrastructure or resources needed for implementation |
|---|---|---|---|
| a. Short-term | Evening clinic session could be implemented in one year; we do need time to hire more staff and faculty | Poor for family life/personal life of students/faculty/staff | More doable on a shorter time period that daytime clinic development |
| | Increasing the patient pool and diversifying times patients can be seen | Cost for personnel and operation | Recruitment of faculty/staff; need more than just volunteer faculty |
| | Educate students on scheduling appts by units of time | Taking away day time faculty coverage which is already stretched tight (migrating to the evening session) | Creating evening student rotation schedule |
| | Consider adding some more staff to help with sterilization | | Support staff |
| | Evaluate the feasibility of the extended session | | Clinic assistants schedule/confirm/reappoint patient for the students |
| | Minimum disruption to the existing day time sessions | | |
| b. Medium-term | Same recommendations as for short term planning for evening clinics | Unless there is sufficient coverage from other essential service areas and specialist coverage, evening clinic will not be a full service clinic | Schedule/confirm/reappoint patient for the students should be done by CAA |
| | Allowing better equilibrium shifts between full-time & part-time faculty in covering both day and evening clinic | | Clinic Administration should have the control on faculty evening clinic schedule to ensure proper student/faculty rotation and extra floater as backup and substitute faculty |
| | Better creation of evening rotation schedule on the XO grid | | |
| | | | |

| | | | |
|---|---|---|---|
| c. Long-term | Additional daytime clinic sessions are possible if we train D1/D2 students as assistants to support student providers. | Hire additional staff and faculty | Long-term means 2 to 3 years |
| | Allow time to phase in various suporting stuctures: facility, instruments, supporting staff, faculty and student | Too long in implanting may send the wrong message on the needs of increased sessions | Provide a definitive timeline of implementation. The timeline should not exceed 2 to 3 years |
| | Enable to cultivate organic or cultural changes in supporting 3 sessions or evening sessions | Too long may also resulting in reducing support of stakeholders | Retainment of faculty/staff |
| | If it is successful and well operated, will generate revenues and enhance education experience | It may cost more to operate and students may not benefit from shorter sessions | |
| | Better for continuity of care, patients can get comprehensive care done quicker | Financial ramifications if this investment does not go as planned | |
| Additional Comments: | | | |

**4. Assess a time scal's Pros and Cons of implementating two (2) evening clinic sessions, Tuesday and Thrusday evenings.**

| | Pros (Positive Aspects) | Cons (Negative Aspects) | Infrastructure or resources needed for implementation |
|---|---|---|---|
| a. Short-term | Evening clinic session could be implemented in one year; we do need time to hire more staff and faculty | Poor for family life/personal life of students/faculty/staff | More doable on a shorter time period that daytime clinic development |
| | Increasing the patient pool and diversifying times patients can be seen | Cost for personnel and operation | Recruitment of faculty/staff; need more than just volunteer faculty |
| | Educate students on scheduling appts by units of time | Taking away day time faculty coverage which is already stretched tight (migrating to the evening session) | Creating evening student rotation schedule |
| | Consider adding some more staff to help with sterilization | | Support staff |
| | Evaluate the feasibility of the extended session | | Clinic assistants schedule/confirm/reappoint patient for the students |
| | Minimum disruption to the existing day time sessions | | |
| b. Medium-term | Same recommendations as for short term planning for evening clinics | Unless there is sufficient coverage from other essential service areas and specialist coverage, evening clinic will not be a full service clinic | Schedule/confirm/reappoint patient for the students should be done by CAA |
| | Allowing better equilibrium shifts between full-time & part-time faculty in covering both day and evening clinic | | Clinic Administration should have the control on faculty evening clinic schedule to ensure proper student/faculty rotation and extra floater as backup and substitute faculty |
| | Better creation of evening rotation schedule on the XO grid | | |
| | | | |

| | | | |
|---|---|---|---|
| c. Long-term | Makes us more competitive with UoP sessions and night session offerings | Poor for family life/personal life of students/faculty/staff | Retainment of faculty/staff |
| | With revamped didactic curriculum on board, adequate faculty coverage, success in night clinics, school owned kits, consider adding 3rd and or 4th "linkable" day sessions (3-5 years) | Faculty may perceive SOD leadership has minimum interest in creating evening session | Provide constant update and periodic participation to the committee/workgroup in the progress of starting evening clinic |
| | Two evening sessions may be sustainable (x2) | Request for more evening sessions | |
| | | | |
| | | | |

**Additional Comments:**

# Appendix D: Financial Analysis for Evening Clinic Sessions

a) Financials are based on first six months of 2013-14 (actuals from July-Dec, 2013)
b) Revenue based on current conditions – (including faculty shortages and NO DentiCal in the payor mix)
c) Personnel costs not included in O/H expenses (overhead). Personnel costs are listed as a separate line item
d) Visits taken from NIS report for first six months
e) Conservative analysis on revenue assumes no more than 1 patient per chair per session and a cancellation rate was not factored in.
f) Faculty salaries based on HS Assoc. Clinical Prof 2, Scale 2 (with 30% benefit estimate)

**Business Plan**
Financial Analysis

**Assumptions:**

**Clinic A (48 Operatories)**

**2 evenings sessions /39 wks**

**Additional visits per year 3,744**

**Projections based on Actuals**

**CY 6 months expenses and revenue per visit**

**Payor Mix for FY 12/13**

**85% cash Demographic**

**Evening Clinc Projections ( Annual)**

| | |
|---|---|
| **Revenue** | **$336,835** |
| **O/H (non salary)** | **$88,134** |
| **Sal & Benefits** | **$335,554** |
| **Projected Prof (loss)** | **$(86,863)** |

**Additional Personnel Costs**

| | |
|---|---|
| 2 front desk AAII | $22,801 |
| 1 AA II & Sup (back) | $28,295 |
| 2 Dispensary staff | $22,486 |
| 2 Sterilization | $22,486 |
| **Total Staff Sal & ben** | **$96,068** |
| 6 Generalist | $158,184 |
| 1 Prothodontist | $26,364 |
| 1 Endodontist | $26,364 |
| 1 Periodontist | $28,574 |
| **Total Faculty** | **$239,486** |
| (inc. Sal & benefits) | |

**Total Added Sal & Ben $335,554**