Improving the Quality Assurance Program: Vancouver Session

Feedback Report

1 June 2018

Presented by the Quality Assurance Working Group
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Improving the QA Program – Vancouver Session

Event Details

Location

Holiday Inn Vancouver-Centre
711 West Broadway (at Heather Street), Vancouver

Date & Time

30 May 2018
Registration – 5:15 pm
Light meal served – 5:30 pm
Session – 6:00 pm – 8:00 pm

Presenter

The session was presented by Dr. Ash Varma, Chair of the Quality Assurance (QA) Committee and QA Program Working Group.

Table Facilitators

There were also ten committee and staff volunteers who helped facilitate the discussion at each of the tables:

Dr. Sigrid Coil, CDSBC Complaint Investigator; Dr. Douglas Conn, Certified Specialist Board Member; Dr. Michael Flunkert, Board Member and Member of the QA Committee; Dr. Alex Hird, Member of the QA Committee and Working Group; Dr. Meredith Moores, CDSBC Acting Director of Professional Practice; Ms. Renée Mok, CDSBC Policy Coordinator; Ms. Róisín O’Neill, CDSBC Director of Registration and HR; Ms. Sabina Reitzik, CDA Board Member; Ms. Leslie Riva, CDSBC Senior Manager of CDA Certification and Quality Assurance; and Ms. Karen Walker, CDSBC Dentist Registration Officer.

Presenter: Dr. Ash Varma
Participants

The registration was full for this session. 80 people registered for the event online and 54 people attended.

Participants included a range of people and perspectives from within the profession. This included:

- 35 dentists
- 17 CDAs
- 3 other (2 BCDA representatives; 1 public member)

Gender:

There were more women than men present at the session:

- 30 females
- 24 males

Format

This was a 2 hour session. It started with a light meal where participants had the opportunity to meet and mingle with members of the working group.

At the beginning of the session, participants were asked to evenly distribute themselves among the tables. There were 10 tables with approximately six participants per table. Each table had program outlines, note-pads and post-its for participants to record their feedback. There was also a table facilitator at each table to help guide the discussion.

Dr. Varma welcomed participants and began the session with a brief introduction about why the College is hosting the session and what the agenda is for the night.

The session consisted of two presentations followed by table discussions. At the end of each presentation, there were a series of questions for participants to answer. The participants were asked to discuss the questions with their colleagues and write their responses on the post-its provided. The table facilitator collected the feedback on flipcharts. Following the discussion
period, one person from each table would volunteer to report back to the larger group. They were asked to report one topic from their table’s conversation that they would like to share with others in the room.

Presentation #1

The current program vs. the proposed program

Dr. Varma went through the program outline and highlighted the main changes being proposed. The presentation showed the differences between the current program and the proposal. Following the presentation, participants were given three questions to discuss at their tables:

1. What do you like about the program?
2. Do you see any challenges/obstacles with the proposed program?
3. Is there anything we missed? Do you have any suggestions?

Feedback

The tables discussed the questions and some of the main ideas are outlined below:

<table>
<thead>
<tr>
<th>What participants liked about the program:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Support for required competencies</strong></td>
</tr>
<tr>
<td>- Required competencies – access to sessions online through BCDA or dental societies</td>
</tr>
<tr>
<td>- Required competencies – especially recordkeeping and ethics → similar to Ontario where ethics exam is completed by all new registrants. Maybe consider making this even more streamlined.</td>
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<tr>
<td>- Situational exercises</td>
</tr>
<tr>
<td>- Good to increase ethics – to protect the professions. Decrease complaints and our licensing fees</td>
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<tr>
<td><strong>Support for participatory learning</strong></td>
</tr>
<tr>
<td>- 1.5 credits for hands-on learning</td>
</tr>
<tr>
<td>- Participatory learning – 1.5 credits per hour for study clubs that require more time and money commitment provides more incentive for participation</td>
</tr>
<tr>
<td>- I like that hands on gets me credits.</td>
</tr>
<tr>
<td>- Hands-on courses for CDAs</td>
</tr>
<tr>
<td><strong>The requirements are unchanged</strong></td>
</tr>
<tr>
<td>- The hour requirement stayed the same.</td>
</tr>
<tr>
<td>- Same requirements for hours</td>
</tr>
<tr>
<td><strong>Increased accountability</strong></td>
</tr>
<tr>
<td>- Motivation to consider what we might be lacking and pursue education that will help us grow.</td>
</tr>
<tr>
<td>- More accountability e.g. every member required to maintain updated CPR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Challenges/obstacles participants identified:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Auditing</strong></td>
</tr>
<tr>
<td>- Audit → waiting to end of cycle *want an immediate yay or nay</td>
</tr>
<tr>
<td>- Documenting study club activity</td>
</tr>
<tr>
<td>- Audit is a challenge</td>
</tr>
<tr>
<td>- Challenge – audit – how audit will be administrated</td>
</tr>
<tr>
<td>- Core vs. non-core – If people think its core then end up needing to make up for the mistake</td>
</tr>
</tbody>
</table>
### Cost
- Financial obstacles (fees = money)
- Potential costs for courses (e.g. CPR for CDAs)
  - Deductibles
  - Cost for mandatory courses
- Auditing costs
- Cost of program?

### CPH requirements
- Hours in the case of illness or medical exemption / young female practitioners with pregnancies – make very clear what specific requirements are in place.
- Educator license – small but important subset of retired educators who teach (but should not have a requirement of 100 practice hours and CE credits (volunteer license – can’t practice)
- Volunteers – CPD hours vs. CPH (teaching at UBC)

### Difficulty accessing courses
- Remote areas – how do they access these courses? If online, who offers these sessions? Has to have a checklist (universal) for all of these courses offered
- Do CDAs need to take situational judgment exerciser? Specific to CDAs (expired material, drug seeking behavior, difficult young children)
- Areas to go for hands on
- Some CE hard to access if not local, same for topics or categories

### Participant suggestions:

#### Definitions
- Definition of participatory learning? Does conversation at Starbucks count?
- More details about self-learning (research, journaling, etc.)
- Do overseas volunteer hours count towards the 100 hours / year needed?

#### Measurement of Quality
- Nothing clear on how online courses will be measured.
- Ensuring quality re: billing hours – could include in the Ethics course
- How to assess quality of CE courses? Objectivity

All of the feedback from Discussion #1 is available in Appendix A.

**Presentation #2**

**Objective assessments**

Dr. Varma gave a quick explanation of the proposed objective assessment requirement and the two options that the College would develop if this component moves forward. He briefly described the peer collaborative groups and peer-to-peer office visits, and answered a few questions from participants. Following the presentation, participants were given four questions to discuss at their tables:

1. How many people should be in a collaborative peer group and how could they be formed?
2. What do you think is important to review during a peer-to-peer office visit?
3. Do you see challenges/obstacles with these requirements?
4. Do you participate in peer groups already? If so, please share details about how your group works.

Feedback

The tables discussed the questions and some of the main ideas are outlined below:

<table>
<thead>
<tr>
<th>Participants’ thoughts re: collaborative peer groups</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group size</strong></td>
</tr>
<tr>
<td>- Different areas different availability. Should not define a number.</td>
</tr>
<tr>
<td>- # in a group – 2-3 min/max</td>
</tr>
<tr>
<td>- Minimum of 2 and maximum of 6?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Forming groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>- What if you are the only dental office in town?</td>
</tr>
<tr>
<td>- Concerns if associate + principle collaborate in a group</td>
</tr>
<tr>
<td>- Formed within a town/community – how can a dentist find out about peer groups in their area?</td>
</tr>
<tr>
<td>- They could be formed online or self-assigned or assigned because it’s a mandatory requirement there should be something to generate groups.</td>
</tr>
<tr>
<td>- If there are existing study clubs that meet the requirements, they could be a collaborative peer group.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What participants thought should be included in peer-to-peer office visits:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peer-to-peer office visits</strong></td>
</tr>
<tr>
<td>- Core skills</td>
</tr>
<tr>
<td>- Practice management</td>
</tr>
<tr>
<td>- Problem areas</td>
</tr>
<tr>
<td>- Online</td>
</tr>
<tr>
<td>- Community</td>
</tr>
<tr>
<td>- New technology (new techs in tech)</td>
</tr>
<tr>
<td>- Infection control</td>
</tr>
<tr>
<td>- Situation judgment exercise</td>
</tr>
<tr>
<td>- Problem solving</td>
</tr>
<tr>
<td>- Record keeping</td>
</tr>
<tr>
<td>- Tricks and techniques</td>
</tr>
<tr>
<td>- Piezo tips can be dunked in ultrasonic</td>
</tr>
<tr>
<td>- Wrapped cassettes MUST be vertical not horizontal in Lisa Sterilizer</td>
</tr>
<tr>
<td>- Statim will fail sooner (solenoid) if allowed to run overnight overtime</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Challenges/obstacles for these requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectivity/Quality</strong></td>
</tr>
<tr>
<td>- Objective assessments – this would be difficult to ensure the quality of meetings, as dentists are already collaborating/learning peer-to-peer</td>
</tr>
<tr>
<td>- Those dentists who would most benefit from objective assessment would find a way to bypass or “fudge” having done the assessment – no way to assess degree of difficulty</td>
</tr>
<tr>
<td>- Peer to peer office visit is actually a subjective assessment and we cannot control or ensure that review are reasonable (privacy issue, having someone drop in, friend)</td>
</tr>
</tbody>
</table>
- Knowledge base
- Acceptance of feedback – ethical issues / political
- Measuring improvement “what’s the outcome?” “How do we measure it?”
- Validity of info shared (what inspires person to share their knowledge?)

**CDAs**
- Don’t have peer review for CDAs
- There needs to be a template for CDAs: Who do CDAs learn from? What do CDAs discuss?

**Resistance to objective assessments**
- Peer review may result in lots of resistance
  - Fear of being judged
  - Feels like back in school
  - Don’t have the name include peer review – call it: “clinical rounds”
- Peer review sounds like judgment – can’t look like a test. Call it clinical rounds instead.
- Don’t want another dentist “policing” around my office
- Peer assessment – “rat out” a colleague or 2 buddies’ sign off each other without doing anything.
- Peer office visits - Too complicated – won’t work – emphasis tattletale / How to monitor it – study club better.
- Dentist feeling insecure with staff discussing outside office

All of the feedback from Discussion #2 is available in Appendix B.

**Situational Judgment Exercise**

At each table, there was a “parking-lot” sheet asking participants to think of any scenarios that might be good for the situational judgment exercise (SJE). This activity was meant to get participants thinking about the SJE and relating it to their own practice. During the first presentation, Dr. Varma explained what an SJE is and encouraged everyone to submit examples.

There were a few examples provided by participants:

- At what age would whitening or Invisalign be recommended (i.e. 60 years) or not.
- Patient had 12 implant fails. Prior to failure patient said an original placement it took almost a “year” to “heal.” Time passed. Area bone grafted, etc. healed. New implant later place UPD given during healing. Area not reacting normal. UPD uncomfortable. Mass noted on x-ray. Cancer found by oral surgeon. At what point could we have changed treatment, if at all?
- Specific to CDAs e.g. expired material, drug seeking behavior, difficult young children
- Patient needs a crown, but they won’t be on insurance until or insurance units don’t poll over until next year. Can you do the crown now and bill me in the future?
- 19 year old patient: full bony impaction; no pathology; radiographs are negative; no dental concerns; patient is unaware of impactions; refer to O.S.; some minor medical concerns presented to O.S. ??? Patient to be G.A.
Dr. Michael Flunkert and Ms. Leslie Riva, table facilitators, answering questions during the table discussions.

Session Survey

At the end of the session, participants were asked to complete a survey about the session format. Overall, participants felt that the session format worked well and thought there was good dialogue during the group discussions. Many participants felt that the session was too short and they needed more time to express their ideas. They were also given the opportunity to provide any additional feedback about the proposed program.

The survey results are available in Appendix C.
Appendices

Participant Feedback

The tables had lively discussions about the proposed program and many of the tables had multiple items that they wanted to share with the group. The participants provided valuable feedback to the working group, including potential areas of concern, and asked challenging questions that will require more thought and planning to address.

You can find all of the feedback from the session in the appendices below:

- Appendix A – Feedback from Discussion #1
- Appendix B – Feedback from Discussion #2
- Appendix C – Survey Results
### Appendix A – Feedback from Discussion #1

#### Q.1 – What do you like about the proposed program?

- Required competencies – access to sessions online through BCDA or dental societies
- That the courses are put on by the College
- The 4 categories
- Hands-on courses for CDAs
- Sounds like CPD could offer a broader range of subjects with the situational judgment exercise.
- 1.5 credits for hands-on learning
- The hour requirement stayed the same.
- Motivation to consider what we might be lacking and pursue education that will help us grow.
- Good variety – more global learning
- Situational exercises
- Mentorships
- 2/3 core is good 1/3 none core
- Support required competencies
- 1.5 credits for participatory learning
- Simplified core and non/core categories
- Liked the addition of CPR requirement
- Required competencies – especially recordkeeping and ethics → similar to Ontario where ethics exam is completed by all new registrants. Maybe consider making this even more streamlined.
- Recognizing volunteer hours
- Participatory learning – 1.5 credits per hour for study clubs that require more time and money commitment provides more incentive for participation
- CDA teaching credits being limited to 2/3
- 1.5
- Participatory Learning if broadly defined
- Study club concept
- Audit
- CE hours – reasonable # → believe always should be learning
- I like that hands on gets me credits. How would it apply to Invisalign, a --- based course?
- Participatory learning
- I feel CDAs don’t do enough CE love the differential appreciate viewed effort
- Good that credit is given for volunteering
- Good that audit for CPD will be done
- Good to increase ethics – to protect the professions. Decrease complaints and our licensing fees
- Appreciate opportunity for feedback
- More accountability e.g. every member required to maintain updated CPR
- Same requirements for hours
- More credit for participatory hands on courses
- The proposed plan seems quite comprehensive and seems good

#### Q.2 – Do you see challenges/obstacles with the proposed program? If so, what would those challenges be?

- Don’t like the extra credits for the hands-on component – it sends a message that technical skills are more important than decision making.
- There are barriers for those in remote areas where it is difficult to access programs
- Remote areas – how do they access these courses? If online, who offers these sessions?
  - Has to have a checklist (universal) for all of these courses offered
- Do CDAs need to take situational judgment exerciser? Specific to CDAs (expired material, drug seeking behavior, difficult young children)

- How will those with non-practising licenses be able to meet the requirements for objective assessments and continuous practice hours?
- Financial obstacles (fees = money)
- Informed consent
- Education of aux.
- There are a whole lot of offices to reach. Will there be other sit downs like the one this evening?
- 900 continuous practice for young female practitioners who are having children at start of practice
- Hours in the case of illness or medical exemption / young female practitioners with pregnancies – make very clear what specific requirements are in place.
- Required competencies need to keep fresh otherwise will be tedious → do you have to rotate through the four?
- CDA hands on courses should be developed

- Expertise of mentors
- Honor system
- Auditing costs
- Like the system as is. Why change it?

- 3 year cycle is too short suggest 5 year e.g. too lax
- CDA assisting in one office → hands-on component
- Areas to go for hands on
- Observing in a hands on just as good as doing?

- Credits during maternity leave
- Required competencies – the 4 courses should be “free” online, similar to Vancouver Coastal Health (20 mins + quiz online)
- Educator license – small but important subset of retired educators who teach (but should not have a requirement of 100 practice hours and CE credits (volunteer license – can’t practice)
- CE submission – why not submit / scan

- Potential costs for courses (e.g. CPR for CDAs)
  - Deductibles
  - Cost for mandatory courses
- What qualifies as volunteering (for CE credit)?

- Audit → waiting to end of cycle *want an immediate yay or nay
- Documenting study club activity

- The devil is in the details. What is in the courses in ethics and situational judgment?
- Situational judgment exercise
- Audit is a challenge
- Challenge – audit – how audit will be administrated
- Core vs. non-core – if people think its core then end up needing to make up for the mistake

- Auditing
- Cost of program?
- Core and non-core activities – what type of varieties of courses? Can it all be in oral surgery or ortho? Recordkeeping
- Some CE hard to access if not local, same for topics or categories
- CDAs don’t do enough CE
- Hesitant to feel confident on whether any one topic could be enhanced i.e. recordkeeping online course – how many versions are there? If I took this last 3 year period, how is it different now?
- What if I submit something in the wrong category by mistake?
- Obstacles: same learning is less applicable to an individual
- Can we carry over from last cycle to next cycle – maybe, especially if ill / a course is coming still in current cycle and have exceeded credits
- Push back from new grads and young dentists who like to get their CE from online
- Foreign dentistry count for practice hours: Teaching outside of BC should also qualify. We have become an international community or are we regressing?
- Enhanced CPD appropriate – 1.5 > 1.75 > 2 credits
- Volunteer hours – NFP – 3rd world country – committee
- Volunteers – CPD hours vs. CPH (teaching at UBC)

Q.3 – Is there anything we missed? What suggestions do you have?

- For the required – Why not do all 4 competencies in 3 year cycle?
  - Required competencies should have situations specific to dentists and CDAs
  - Would the requirements be the same for those practising internationally?
  - Cost issues: if 4 categories are specific/mandatory courses, could we include the fees in our college fees or offer them for free?
- Definition of participatory learning? Does conversation at Starbucks count?
- Availability of courses to meet requirement
- Nothing clear on how online courses will be measured.
  - If certificates not given after a course, how do you claim the credits?
- Do you repeat 2/4 required competency courses every cycle? How often does this go on? i.e. do recordkeeping every 3rd cycle?
- Hands-on study clubs deserve two credits/hour
- For SJE – way to see reasons for decisions (poll)
- Ethics course – cultural
- Ensuring quality re: billing hours – could include in the Ethics course
- More details about self-learning (research, journaling, etc.)
- Look at using BCDA CE portal to act as dashboard and/or populate it
- Pregnant, multiple pregnancies – how do we keep these people in profession?
  - College to have a course: those educated in certain era – things change – new technologies, products things that are important (new research) endo, keep current
  - Certification – course needs to be legit (not done by supplier)
  - Can you force an audit on yourself?
- Do overseas volunteer hours count towards the 100 hours / year needed?
  - Missed lots of this but not sure yet
  - Manpower required to do audits (financially feasible)
  - How to assess quality of CE courses?
  - Objectivity
- A SJE is done within a clinic as a routine review and training yearly, but how can a participant of that clinic claim those training hours for CE?
Appendix B – Feedback from Discussion #2

Q.1 – How many people should be in a collaborative peer group and how could they be formed

| Different areas different availability. Should not define a number. |
| 4 people? |
| 3-6 |
| # in a group – 2-3 min/max |
| What if you are the only dental office in town? |
| Concerns if associate + principle collaborate in a group |
| Formed within a town/community – how can a dentist find out about peer groups in their area? |
| Peer groups – do we need to define the number? |
| Minimum of 2 and maximum of 6? |
| They could be formed online or self-assigned or assigned because it’s a mandatory requirement there should be something to generate groups. |
| If there are existing study clubs that meet the requirements, they could be a collaborative peer group. |
| Do peer groups need to be people from different practices? It isn’t necessary since associate dentists work on different patients/cases. |
| 4-6, 3-5 (maybe odd #) |
| Peer groups 3-6 / group |
| Depends on location |

Q.2 – What do you think could be important to review during a peer-to-peer office visit?

| Have to get the dentist to buy in |
| Peer visits should include a CDA always |
| Infection control records, procedures (2-way street) |
| Core skills |
| Practice management |
| Problem areas |
| Online |
| Community |
| New technology (new techs in tech) |
| Infection control |
| Situation judgment exercise |
| Problem solving |
| Record keeping |
| Difficult patients |
| Are peer/peer concerns initiated? |
| Management |
| Infection control |
| Not clinical treatment |
| P2P visits must be very specific and objective in order to work. |
| NOT clinical procedures / chart review |
| o No standards of care |
| o Expertise of assessor |
- Self-selection may perpetrate/reinforce problems

- Checklist:
  - Infection control (so much to cover)
  - Recordkeeping

- Infection control
  - Wrapping methods
  - Storage of instruments
  - Layout of office with mapping

- Tricks and techniques
  - Piezo tips can be dunked in ultrasonic
  - Wrapped cassettes MUST be vertical not horizontal in Lisa Sterilizer
  - Statim will fail sooner (solenoid) if allowed to run overnight overtime

- Any topic or subject goes – treatment planning, office procedures, problem solving, employment issues
- All aspects

Q.3 – Do you see any challenges/obstacles to either of these requirements?

- Peer review may result in lots of resistance
  - Fear of being judged
  - Feels like back in school
  - Don’t have the name include peer review – call it: “clinical rounds”

- How do we set this up so that it is non-discernable?
- Don’t have peer review for CDAs
- Peer review sounds like judgment – can’t look like a test. Call it clinical rounds instead.

- Manpower would be helpful. Process if objective.
- Maybe the College can facilitate 5 (?) peer-to-peer group session per cycle and registrants can sign up knowing that it’s a random group. Registrants could also organize their own peer groups.

- Technology
- Time restrains
- Knowledge base
- Acceptance of feedback – ethical issues / political
- Measuring improvement “what’s the outcome?” “How do we measure it?”

- Won’t fly
- Don’t want another dentist “policing” around my office
- What criteria/information should be given prior to a peer-to-peer?
- Concerns about “competition” with other dentists in the area

- Objective assessment may be a problem – office visits / study club and peer-to-peer is more helpful
- Objective assessments – this would be difficult to ensure the quality of meetings, as dentists are already collaborating/learning peer-to-peer
- Those dentists who would most benefit from objective assessment would find a way to bypass or “fudge” having done the assessment – no way to assess degree of difficulty
- Peer to peer office visit is actually a subjective assessment and we cannot control or ensure that review are reasonable (privacy issue, having someone drop in, friend)

- What is the rationale? – Not sure if this is the way to encourage participants’ learning/not sure this should be a mandatory requirement.
- There needs to be a template for CDAs: Who do CDAs learn from? What do CDAs discuss?
- There may not be incentive for registrants to attend peer groups after they've met their objective assessment requirement. There needs to be a minimum required # of meetings.
- Peer groups being required to meet a bunch of times – CDAs may not have enough to talk about – if they could arrange for one peer group meeting to each discuss a case instead of meeting multiple times.
- If goal is to mitigate “lone wolves” mandate “collaborative group” vs. P2P office visits
- Isn’t this just a study club?
- Peer-to-peer office visit
- Peer-to-peer office visits – challenge – too objective
- Objective assessments may be subject to individual bias
- How to form collaborative peer groups? persons interested (dentist/CDA/hygienist) can post willingness and availability to hangout and discuss
- “Popular” groupings only group with popular groups
- Dentist feeling insecure with staff discussing outside office
- Validity of info shared (what inspires person to share their knowledge?)
- Peer-to-peer:
  - o will cause a lot of problems – dentists have big egos / dentists against each other
  - o If with a buddy, then what’s the purpose?
  - o Abuse of process – slack off – give each other a “pass”
- Collaborative peer groups likely more useful than peer-to-peer groups > Good documentable discussion vs. get a friend in to say everything okay – too subjective
- Peer-to-peer with no other specialist like me (radiology) in BC private practice at this time
- How do you have a non-practising dentist critique or peer review a clinical dentist?
- Outlying areas
- Peer assessment – “rat out” a colleague or 2 buddies sign off each other without doing anything.
- Peer office visits - Too complicated – won’t work – emphasis tattletale / How to monitor it – study club better.

**Q.4 – Do you participate in peer groups already? If so, please share details about how your group works.**

- In a group of 6: 4 participate in study / peer groups
- Yes, I participate in a study group
Appendix C – Survey Results

48 total responses

Q1: Please rate the extent that you agree with the following statements about tonight's session:

Answered: 47    Skipped: 1

<table>
<thead>
<tr>
<th>Statement</th>
<th>DISAGREE</th>
<th>SOMEWHAT DISAGREE</th>
<th>NEUTRAL</th>
<th>AGREE</th>
<th>STRONGLY AGREE</th>
<th>TOTAL</th>
<th>WEIGHTED AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The session format worked well.</td>
<td>0.00%</td>
<td>6.38%</td>
<td>19.15%</td>
<td>45.94%</td>
<td>25.33%</td>
<td>47</td>
<td>3.04</td>
</tr>
<tr>
<td>The materials were clear and the proposed program was well communicated</td>
<td>0.00%</td>
<td>6.38%</td>
<td>27.66%</td>
<td>42.55%</td>
<td>23.40%</td>
<td>47</td>
<td>3.83</td>
</tr>
<tr>
<td>I had adequate opportunity to express my views</td>
<td>0.00%</td>
<td>6.38%</td>
<td>17.02%</td>
<td>51.06%</td>
<td>25.83%</td>
<td>47</td>
<td>3.96</td>
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<td>There was adequate opportunity for participants to exchange views and learn from each other.</td>
<td>0.00%</td>
<td>10.67%</td>
<td>23.91%</td>
<td>41.30%</td>
<td>23.91%</td>
<td>46</td>
<td>3.78</td>
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</tbody>
</table>
Q2: What worked well at the session?

1. Good idea.
2. Group discussion - assigned facilitators
3. Open participation and the College willingness to listen to the professional
4. table discussions
5. Chair presented the programs well and was optimistic about the eventual outcome.
6. Small group discussion
7. structured sharing group discussions
8. Exchanging ideas in our groups
9. Group discussions
10. There’s room for mixed reviews / input is valuable.
11. Group discussion was valuable - learned different POVs.
12. Good visual presentation and lead speaker.
13. Good dialogue
14. Good opportunity for feedback
15. It was a good introduction to a promising change.
16. We had a good facilitator.
17. Organizing the audience in groups and encouraging discussion worked quite well.
18. Table talk - was very informative.
19. The session was too short, good discussion started but were cut short due to time available.
20. Group discussion was beneficial in small groups.
21. Everyone has chance to participate.
22. Good start.
23. Table groups worked well
24. Round table discussions
25. collaborative brainstorming/discussion Activity was effective
26. The groups had great variety at the tables. Lots of discussion; input from various points of view.
27. Facilitated conversation No one in the small group dominated the conversation. Equal participation
28. organized
29. Team discussion, free opinions, food was good.
31. Freedom to speak freely (both dentists and CDAs)
32. Table discussion was good, hearing others opinions
33. I feel some people just want to argue - not liking changing but with table monitor it aided in keeping on task.
34. Your participatory format was excellent and allowed for as much interaction that an attendee wished to become involved. As Dr. Ash Varma indicated this will be an ongoing process that possibly not all registrants will initially embrace. I felt this forum was well worth the time expenditure. Well done to you and your team.

Q3: What could have been improved?

1. Talk among members - concerns
2. Longer session period.
3. More time
4. Small groups were difficult to allow expression of personal views but it kept group under control.
5. More time
6. Good 2hrs to keep everyone engaged.
7. Conversations should be generated by the questions posed by groups vs. 'answers' or defensive positions given. To 'hear' the question is to hear the subtext instead of having an answer. Sometimes the best answer is we will have to dig deeper into it.
8. Longer discussion time.
9. The information delivery worked but not enough time for expressing opinions / thoughts
10. More time!
11. Timing, late start.
12. Let's see if feedback gets implemented
13. Perhaps a longer session would be helpful (maybe from 2 hrs. to 3 hrs.) My guess is that this series of sessions will increasingly improve every time it is presented. I look forward to a long-term process that will continue to improve the final outcome.
14. Confusion with the meaning of terms.
15. Possibly allowing a bit more time.
16. Not enough time to express our ideas - only one. Maybe set it for making 3 points per table - not one.
17. More time.
18. I think the larger group discussion should be longer as it was nice to hear other points of view from a large group instead of just the 6 people
19. I feel it would be beneficial to make this a 3 hour session.
20. Difficult subject but necessary.
21. People reading the info prior to the meeting so that less time can be spent on reading (yes, I know it is unrealistic.)
22. We had members at our table that did not participate.
23. As noted, more explanation re: the peer-to-peer review, collaborative peer groups.
24. food
25. Timing
27. More time for discussion
28. Length - too short. Don't feel enough was covered. - Directed implementation or identification of dentist vs. staff issues. - Was hard to get table on task and understand how to participate in requested questions, etc.
29. The format was excellent, possibly could have been three hours. Looking forward to a follow up next year? Many thanks.

Q4: Do you have any other feedback you would like to share about the Proposed Program?

1. CE - get dentists / CDAs to submit documentation when entered online at same time! So easy with scanning and photos.
2. The objective assessments seem to be geared to keep the small percentage of dentist who are struggling or isolated. The majority of dentists are engaged and involved in peer discussion and study clubs. The practicality of the formats are questionable (but preferable to a written test and mandatory office visit!) There should be a minimum 2 group to accommodate out of town dentists.
3. Consider rationale behind proposed mandatory requirements. Does it make sense? Is there a better solution? Do we need to reinvent the wheel - or maybe pick up what works in other colleges?
5. CDAs would have fewer opportunity to deal with the peer evaluation. This would need to have some facilitation from the College. Does not include enough about how quality assurance is addressed with the new guard of corporate dentistry.
6. I do not take notes. I would prefer examinations. A lot of online courses have self-examinations at the end. Examinations are verifiable and ensure that information was understood and retained.
7. VERIFICATION CODES A MUST.
8. Collaborative peer group / peer to peer visits concept seemed the most vague and requires a great amount of thinking through the ramifications and the implementation.
9. The objective assessment material was not clear.

10. Mandatory courses should be subsidized / no charge to dentist and CDAs - perhaps free webinar, etc. (esp. for ethics, recordkeeping, infection control courses, etc. - Peer-to-peer review or office visits is hard to be conducted fairly among different dentists. - some have more dentist friends that can form group early. Others may be solo dentist all the way, and may be a challenge for them to find trusted person to visit their office. Basically this will force dentist to pay study group as a result

11. Seems obvious that there is much more discussion to be had. Looking forward to future updates.

12. I prefer it to an exam. I agree with having required competencies the objective assessments will be difficult to arrange and keep objective while still keeping it rigorous (objective enough) Note: I was surprised at how adverse some dentists view their relationships with other dentists.

13. Lots more clarification on some areas are still needed.

14. I would like to see another consultation as the proposed program gets to the next stage.

15. Question re: Objective assessment: Which is the outcome the College is looking for? Is it the process being followed (meaning the office visit / peer group happened) OR the improvement made by the opportunities identified? What is the College going to do with the templates completed during the office visit?

16. I would love to offer my knowledge in peer-to-peer - hand piece motor --> to cable maintenance - saliva ejector + HUE = value maintenance with O-rings and silicon lube. - Sterilization tips - specifically no cavitron tips in ultrasonic BUT yes piezo tips can go in ultrasonic that LISA sterilization MUST have wrapped cassettes placed vertically - not horizontal like manual demonstration confirmed by LISA sterilizer maker, etc. But how does a CDA get the word out?