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TOOLKIT VOLUME I:
A CASE FOR DENTAL ACADEMIC/COMMUNITY
PARTNERSHIPS FOR LEADERSHIP AND DIVERSITY

ADEA Minority Dental Faculty Development
and Inclusion (MDFDI) Program

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About ADEA

The American Dental Education Association (ADEA) is The Voice of Dental Education. Its members include all 76 U.S. and Canadian dental schools, over 800 allied and advanced dental education programs, 66 corporations and more than 20,000 individuals.

The mission of ADEA is to lead institutions and individuals in the dental education community to address contemporary issues influencing education, research and the delivery of oral health care for the overall health and safety of the public.

ADEA's activities encompass a wide range of research, advocacy, faculty development, meetings and communications, including the esteemed Journal of Dental Education, as well as the dental school admissions services ADEA AADSAS, ADEA PASS, ADEA DHCAS and ADEA CAAPID.

ADEA is incorporated as a District of Columbia nonprofit corporation and as such is subject to the District of Columbia Nonprofit Corporation Code. As established by its Articles of Incorporation, the purpose of the Association is to advance and support dental education, dental research and the dental health and education of the general public. ADEA is recognized by the Internal Revenue Service as a 501(c)(3) organization.

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CHAPTER I: INTRODUCTION

Toolkit Summary and Purpose

Over the last 20 years, the American Dental Education Association (ADEA) has given attention and priority to increasing the number of underrepresented minority (URM) dental school applicants, enrollees and faculty members and to meeting the challenges of achieving diversity in the oral health workforce of the future. These efforts are of national importance as racial and ethnic minorities continue to grow and are expected to comprise more than 50% of the U.S. population by the middle of the 21st century.

ADEA's diversity and inclusion policies and programs have evolved in concert with seminal reports from the Institute of Medicine (now the National Academy of Medicine [NAM]) and the U.S. Department of Health and Human Services.[1,2,3]

ADEA's major policy statement regarding diversity in dental education includes the following:

- I.A.1. Diverse System of Higher Education: All dental education institutions and programs should support and help enhance the diverse system of higher education (1996).
- I.A.4. Admissions Criteria: Nondiscriminatory policies should be followed in selecting students (2001).
- I.A.5. Recruitment, Retention and Access: The American Dental Education Association strongly endorses the continuous use of recruitment, admissions and retention practices to achieve excellence through diversity in American dental education (2001).

ADEA's Statement on the Roles and Responsibilities of Academic Dental Institutions in Improving the Oral Health Status of All Americans (2001) was revised by the House of Delegates in 2004.

ADEA has six core values. The ADEA/WKKF Minority Dental Faculty Development MDFD Programs support Core Value Number 5: Expanding Diversity in Dental Education:

> "The Association values diversity and believes that those who populate dental education- students, faculty, staff, administrators, and patients-should reflect the diversity of our society." These Bylaws, Policies and Position Statements have contributed significantly to ADEA's ability to partner with

WKKF in pilot programs that involve community partnership which improve the lives of vulnerable children and families.

ADEA Access to Dental Careers (ADC)

In 2001, the W.K. Kellogg Foundation (WKKF) provided the resources for ADEA to lend support to the Robert Wood Johnson Foundation (RWJF) Pipeline, Profession, and Practice: Community Based Dental Education Program.[4] Through the WKKF grant, 11 dental schools were added to the Pipeline effort. The awards were known as ADEA/WKKF Access to Dental Careers (ADEA/WKKF ADC) grants. ADEA/WKKF ADC grant funds (2001–2005) were used for direct educational costs only to support underrepresented minority (URM) and low-income students based on need as determined by each individual school.

The 11 schools that received ADEA/WKKF ADC awards were as follows: University of California, San Francisco, School of Dentistry; University of Connecticut School of Dental Medicine; Howard University College of Dentistry; University of Illinois at Chicago College of Dentistry; Boston University Henry M. Goldman School of Dental Medicine; University of North Carolina at Chapel Hill School of Dentistry; The Ohio State University College of Dentistry; Meharry Medical College School of Dentistry; University of Washington School of Dentistry; West Virginia University School of Dentistry; and The Maurice H. Kornberg School of Dentistry, Temple University .

In addition, The California Endowment (TCE) provided funding for four additional dental schools in California to be added to the Pipeline Program. ADEA administered the ADEA/TCE grants for direct educational costs only to the four California dental schools. A total of 234 URM/low-income students were recipients of ADC awards during the four-year grant period. The average grant award was $4,867.25.

ADEA/ WKKF Minority Dental Faculty Development (MDFD)

An ADEA Special Task Force (August, 1999), "Future of Dental Faculty," identified a crisis in dental education related to the shortage of dental faculty, the "graying" of the faculty workforce and the insufficient numbers of faculty that were being recruited from advanced dental education programs. At the same time, a shift in U.S. population demographics was increasing the numbers of dental shortage areas throughout the country. The IOM and Surgeon General's Reports elevated national attention to the serious lack of diversity in the dental workforce and the lack of access to care for millions of Americans. It is within this context that the ADEA/WKKF grants were awarded to identify better ways and best practices for recruiting and retaining URM

faculty, Academic/Community Partnerships for patient care and student pipeline recruitment. ADEA/MDFD grants promoted health systems change by building networks involving a variety of community-based outreach programs. The outreach efforts focused on primary care, prevention and pipeline recruitment to dental careers. Grant funds were used primarily to support direct education costs for URM/low-income faculty for careers that will help promote health systems changes.

ADEA MDFD grants were awarded to 10 U.S. dental schools and one advanced dental education institution over a six-year period from 2004–2010. Seven awards were made to six individual dental schools and one consortium of dental schools in New York State. These schools were University of Alabama at Birmingham School of Dentistry, Texas A&M University Baylor College of Dentistry, Howard University College of Dentistry, University of Illinois at Chicago College of Dentistry, University of Michigan School of Dentistry, University of Oklahoma College of Dentistry, and the New York State Academic Dental Centers (NYSADC), which includes New York University College of Dentistry, Columbia University College of Dental Medicine, University at Buffalo School of Dental Medicine, Stony Brook University School of Dental Medicine, and the University of Rochester Medical Center.

The NYSADC consortium served as a single grantee whose goal was to improve the oral health of all New York State residents through the enhancement of dental education, research and clinical care. It functioned under shared leadership and common policies and procedures.

The grantees were chosen for their unique capacities to implement the overall grant objectives and leverage resources that would support an infrastructure for sustainability of diversity-related outcomes and programs in the future. The unique features of the seven grantee models are being shared with others for their potential value to the leadership at non-grantee schools.

- Alabama and Illinois: These two models have clearly articulated university-wide diversity mandates with resources allocated to diversity initiatives and accountability. These models demonstrate the potential and value of an academic climate for sustaining resources that affect both university-wide and external collaborations.
- Oklahoma: This institution's location and demographics provide a model for collaborative faculty development initiatives that can serve to enhance the understanding of the many Native American cultures that contribute to both tribal and nontribal educational policies and resources.

- Michigan: This institution has successfully defended legal challenges to its diversity policies and practices in fulfillment of the Michigan Mandate "Excellence Through Diversity." Michigan has the opportunity to contribute to the framing of the rational discussion regarding the value of diversity to the quality of the educational experience through holistic admissions that benefit all.

- Howard and Illinois: These two institutions were Pipeline, Professions, and Practice: Community-Based Dental Education Program and ADEA/WKKF ADC grantees. In addition to academic partnerships, they have developed strong community-based partnerships. These models serve as valuable resources for the development of social policy that link dental schools with access and community health.

- Baylor: This school conducts an Exploring Dental Academia course for undergraduate students interested in academia and provides a model of STEM activities and information that nurtures interest in academia and guides decisions for career success.

- NYSADC: This consortium model of the five dental academic institutions in New York has the potential to expand collaborative research across health disciplines and institutions and for regional programming in URM student recruitment efforts, research and advanced dental education.

The 83 community-based ADEA MDFD partnerships that were formed provide enriching patient treatment experiences for dental students and Fellows and care needed by vulnerable children and families in surrounding and remote communities. The community partnerships involve a broad spectrum of clinical settings, including school clinics, Federally Qualified Health Centers, mobile units, nursing homes, Indian Health Service clinics, migrant workers and a health disparities center. Including advanced-level Fellows in the community partnerships allows treatment of complex patient needs in chronic and acute stages of diseases.

The models support experiential learning for predoctoral students by covering a full range of treatment options in a broad spectrum of treatment settings. The MDFD models have formal sustainable academic/community partnerships that serve as the foundation for concepts of community-based dental education (CBDE). A database of 358 individuals exists from MDFD (N=124) and ADEA/WKKF ADC (N=234) trainees. These individuals compose a unique talent pool for future dental faculty. The ADEA MDFD Fellows now contribute to teaching, service and outreach activities that support their communities and their schools' diversity programs and objectives.

Best practices and lessons learned have been derived from institutional site visits, surveys of deans and trainees, leadership training, community-outreach visits, postgraduate mentoring, student recruitment, academic policy reviews and external evaluation of program progress and outcomes.

Regardless of the variations seen in the ADEA MDFD models or the status of their prior or new activities for increasing their numbers of URM dental applicants, enrollees and faculty, the schools demonstrated three core factors essential for success in achieving objectives in diversity programming: 1) Bold and committed leadership is required to integrate URM programmatic activities with other academic objectives. 2) A clearly communicated philosophy of "grow your own" is required, with strong formal and informal mentor/mentee relationships that identify students early who indicate interest in exploring academia as a career and mentoring these individuals during their pre- through postdoctoral years of education. 3) Logic model thinking as an effective tool in program planning, implementation, outcomes assessment and sustainability. Successful lessons learned and outcomes from MDFD have been included in MDFD II, III and MDFDI programs.

Minority Dental Faculty Development (MDFD) II and MDFD III

ADEA/WKKF MDFD II and MDFD III are a continuation of program objectives from MDFD with a change in focus toward allied dental leadership. ADEA MDFD II and III (2012–2015) awards were made to institutions with allied dental education programs.

These grants provided leadership development opportunities to allied dental education faculty whose opportunities are expanding in the changing U.S. health care workforce. MDFD II and III continued the focus on leadership training, cultural competency, academic/community models for experiential learning, patient education, mentoring, preventive therapies and URM student recruitment. MDFD II and III awardees included the University of Detroit Mercy School of Dentistry, Howard University College of Dentistry, University of Minnesota School of Dentistry, Georgia Regents University Dental Hygiene Program, and University of Oklahoma College of Dentistry.

The MDFD II and III grants contributed to the value of community-based service learning in allied dental education. MDFD community partnerships have added an important dimension to student learning and experiences in the treatment of underserved patients in a variety of settings. In remote sites, students gained increased awareness of the need for dental care for the underserved public.

Clinical skills, self-confidence and experience in remote site patient management are important adjustments to the skills learned within an academic dental clinic facility. The MDFD II and III academic/community partnerships benefitted from MDFD findings in their partnerships that are academically sound and, at the same time, sustainable in underserved communities. They also benefitted from the Macy Study (1999) findings.[5]

The MDFD grants helped position dental schools for unprecedented opportunities for access to care through the Affordable Care Act (ACA), "health home concept" and research from Patient-Centered Outcomes Research Institute (PCORI).[9]

Minority Dental Faculty Development and Inclusion (MDFDI)

The ADEA/WKKF Minority Dental Faculty and Inclusion (MDFDI) grant (2015–2017) builds on lessons learned and best practices from dental and allied dental pilots in the former WKKF grants as the focus continues to be leadership, academic/community partnerships and increased diversity in the dental workforce. MDFDI extends efforts to reach geographic areas with new or no existing dental schools. Research indicates that patients from diverse racial, ethnic and socioeconomic backgrounds are more likely to seek health care from a minority provider.[6] In addition, trends show that health providers from underserved areas tend to practice in these areas.[7,8] The ADEA MDFDI program expands its reach and develops more diverse generations of allied dental health professionals as an avenue to meet the significant unmet need for access to dental care across the United States. The leadership training models emphasize: interprofessional education and team-based care, cultural and linguistic competency, academic mentorship and increased diversity in the academic pipeline.

The 24 MDFD partnering schools will share their strategies with newer dental schools and allied dental education programs to reduce barriers to dental care through academic/community partnerships that increase diversity in the dental workforce and support educational change and leadership training.

MDFDI focuses on allied dental leadership training and the development of a toolkit to help achieve the goals of improving the delivery of dental care to children in dentally underserved areas. The toolkit focuses on developing dental and allied dental teams and strengthening the pool of URM allied dental health professionals. The toolkit will be designed and prepared for both printed and web distribution.

The ADEA MDFDI toolkit builds on institutional models, the convenings, lessons learned and best practices that have helped change institutional climates. The MDFD grantee

schools serve as models for diversity transformation within dental and allied dental academic programs. The 24 schools that have received ADEA/WKKF ADC and MDFD grant funds take us to a new level of academic/community engagement for both experiential learning and patient care in disadvantaged communities. The sustainability efforts support the "Growing Our Own" philosophy, newer concepts of interprofessional education (IPE), community-based dental education (CBDE), new workforce models, and dental and allied leadership development.

References

1. Field MJ, ed. Dental education at the crossroads: challenges and change. An Institute of Medicine Report. Washington, DC: National Academy Press, 1995.
2. Oral health in America: a report of the surgeon general. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.
3. Missing persons: minorities in the health professions. A report of the Sullivan Commission on Diversity in the Healthcare Workforce, 2004. At: minority-health.pitt.edu/archive/00000040/01/Sullivan_Final_Report_000.pdf. Accessed: August 10, 2010.
4. Formicola A, Bailit H, D'Abreu K, Stavisky J, Bau I, Zamora G, Treadwell H. The dental pipeline program's impact on access disparities and student diversity. J Am Dent Assoc 2009; 140(3):364-55.
5. Community-based clinical education programs. (Special Issue). J Dent Educ 1999; 63(12):867-989.
6. Cooper-Patrick L, Gallo JJ, Gonzales JJ, Vu HT, Powe NR, Nelson C, Ford DE. Race, gender and partnership in the patient-physician relationship. JAMA 1999; 282:583-589.
7. Health Resources and Services Administration. The rationale for diversity in the health professions: A Review of the evidence. October, 2006. At: http://bhpr.hrsa.gov/healthworkforce/reports/diversityreviewevidence.pdf
8. Improving access to oral healthcare for vulnerable and underserved populations. Washington, DC: Institute of Medicine and the National Academy Press, 2011.
9. National Academies of Sciences, Engineering, and Medicine. Achieving health equity via the Affordable Care Act: Promises, provisions, and making reform a reality for diverse patients: Workshop summary. Washington, DC: The National Academies Press, 2015.

Resources

1. Sinkford JC, Valachovic, R. Growing our own. The ADEA Minority Dental Faculty Development Program. A manual for institutional leadership in diversity. Project

support from the W.K. Kellogg Foundation. Washington, DC: American Dental Education Association, 2011.

2. West JF, Sinkford JC, Valachovic RW. Taking mentoring and leadership to the next level. Minority dental faculty development. ADEA/W.K. Kellogg Foundation, December 2008.

3. Sinkford JC, West JF., Weaver, R.G., Valachovic RW. Modeling Mentoring: Early Lessons from the W.K. Kellogg/ADEA Minority Dental Faculty Development Program. J Dental Educ. 2009; 73(6): 753-63.

4. Sinkford JC, Valachovic RW, Weaver RG, Harrison SG. ADEA/WKKF access to dental careers program: Supporting a dental pipeline concept and program. J Dental Educ. 2010; 74(10):1166-69.

5. Brunson, WD, Jackson, DL, Sinkford JC, Valachovic, RW. Components of effective outreach and recruitment programs for underrepresented minority and low-income dental students. J Dental Educ. 2010; 74(10 Suppl):S74-86.

6. Sinkford JC, Valachovic RW, Weaver RG, West JF. Minority Dental Faculty Development: Responsibility and Challenge. J Dental Educ. 2010; 74(12):1388-93.

7. Sinkford JC, Valachovic RW, West JF. Retooling for change. Building leadership teams for sustainable academic and community partnerships. ADEA/MDFD training symposium report. June 13-14, 2013. At: http://www.adea.org/retooling.html

8. Sinkford JC, Valachovic RW, West JF. Building leadership teams for a diverse dental workforce. ADEA/MDFD training symposium report. June 12-13, 2014. At: http://www.adea.org/MDFD/Leadership-Training-Programs/Diverse-Dental-Workforce.aspxhttp://www.adea.org/MDFD/Leadership-Training-Programs/Diverse-Dental-Workforce.aspx

9. Haywood S, Berkman R, Sinkford J, Sullivan L, Sussman J, Gershen J. Diversity in the academic health center: Progress and opportunities. In: Wartman SA (Ed.). The Transformation of Academic Health Centers: The Institutional Challenge to Improve Health and Well Being in Healthcare's Changing Landscape. Elsevier, 2015. (ADEA/WKKF Case Study: The Minority Dental Faculty Development Initiative).

10. Sinkford JC, Valachovic RW, West JF. Building academic and community partnerships for innovation and change. ADEA/MDFD training symposium report. June 11-12, 2015. At: http://www.adea.org/MDFD/Leadership-Training-Programs.aspx#collapse0

MDFD Timeline

Phase I: Minority Faculty Development | 2004-2010

- **Purpose:** To enhance the lives of vulnerable children and communities.
- **Grantees:** Six dental schools and NYSADC Consortium Schools; Alabama, Baylor University, Howard University, University of Illinois Chicago, University of Michigan, University of Oklahoma and five schools in the New York University systems: Columbia, Buffalo, Stony Brook and Rochester
- **Objectives:** Academic partnership formation and sustainability, formal mentoring, outreach/ pipeline, leveraging resources, data collection, leadership training

Phase II: Minority Faculty Development II | 2012-2013

- **Purpose:** Allied dental leadership training
- **Grantees:** Howard University and University of Detroit Mercy
- **Objectives:** Leadership training, community partnerships, pipeline recruitment, cultural competency

Phase III: Minority Faculty Development III | 2013-2015

- **Purpose:** Allied dental leadership training
- **Grantees:** University of Detroit Mercy, University of Oklahoma, University of Minnesota, Augusta University
- **Objectives:** Leadership training, community partnership formation and sustainability, pipeline recruitment, cultural competency

Phase IV: Minority Faculty Development and Inclusion | 2015-2017

- **Purpose:** Produce allied dental leadership training and a two-volume toolkit for dissemination of best practices and key learned lessons
- **Objectives:** Leadership training and best practices for integrated oral health care

Supporting the Dental Pipeline

ADEA MDFD grants were awarded to 10 U.S. dental schools and one advanced dental education institution over a six-year period from 2004–2010. Seven awards of $255,000 each were made to six individual dental schools and one consortium of dental schools in New York State. These schools were University of Alabama at Birmingham School of Dentistry, Texas A&M University Baylor College of Dentistry, Howard University College of Dentistry, University of Illinois at Chicago College of Dentistry, University of Michigan School of Dentistry, University of Oklahoma College of Dentistry, and the New York State Academic Dental Centers (NYSADC), which includes New York University College of Dentistry, Columbia University College of Dental Medicine, University at Buffalo School of Dental Medicine, Stony Brook University School of Dental Medicine, and the University of Rochester Medical Center.

The ADEA MDFD grants were used primarily to support direct educational costs for URM and low-income dentists who were recruited to faculty positions that will help promote health systems change.

Grantee institutions created formal and informal mentoring programs, academic partnerships, and community-based practices and projects for both service and experiential learning. Leadership was an added objective as related to cultural competency, institutional climate and academic support for diversity objectives.

Implementation

Grantee meetings and annual leadership training sessions were held during the six-year grant period. The four grantee meetings provided a forum for exchanging information, sharing best practices, strategic planning, team-building across institutions, maximizing human potential through leadership training, and sharing personal stories that energize, build trust and motivate program directors toward sustained commitment to grant objectives.

Mentoring Program[1]

Mentor/mentee surveys, site visits and institutional reports document the value of the mentor/mentee experience throughout the grantee schools. Reports from the ADEA MDFD program include mentor programming milestones at the postdoctoral level. The outcomes include: 1) the value of the personal interaction of faculty mentors with fellows, 2) variety in mentor program structure, 3) the use and value of multiple mentors, and 4) the emergence of the importance of peer-to-peer mentoring among postdoctoral

fellows. Qualitative assessments were obtained from mentors and fellows regarding their perceptions of value and satisfaction. Portfolios were a useful tool for mentoring, career guidance, self-motivation, assessment, career tracking and decision-making. Peer-to-peer online mentoring proved to be a valuable component of postdoctoral mentoring.

The definition of "formal mentoring" at the postdoctoral level varied across the seven programs, and often ran in tandem with or supplemental to the mentoring received at the postdoctoral level. Formal mentoring required a written or verbal agreement between mentor and mentee describing the mentoring relationship and setting expectations. Mentees selected their mentors or participated in a group selection process. The formal mentoring process included academic policy review, assignment of mentors, development of goals/plan, mentor/mentee meetings and interaction, feedback from mentees, feedback from mentors, evaluation and changes, outcomes, and rewards. The process is linear and supports a concept of continuous quality improvement. It is important to note that in postdoctoral mentoring, one size does not fit all. In all cases, an individualized, personalized effort assisted the fellows in setting goals, assessing progress and perceived successful achievement.

Success in Mentoring

Throughout the six years of the MDFD grant, fellows not only received financial support, but mentoring toward excellence in research and leadership, and also training in educational foundations toward excellence in teaching. The schools placed particular importance on mentoring, which is identified as an integral part of academic faculty recruitment and retention, particularly in medicine and dentistry.[1,2,3,] MDFD program fellows have expressed the importance of their mentoring relationships and satisfaction with their mentors. For example, at a NYSADC Symposium in 2008, one MDFD fellow quoted his mentor, saying "Your success is my success." This particular fellow, with the guidance of his mentor, has attended nine research and professional development conferences, identified short-term and long-term goals, and was awarded a K Award from the National Institutes of Health for his research project.[4]

The mentoring component within the MDFD program, across all seven MDFD awards throughout the United States, has been particularly successful. In a 2007 survey distributed to MDFD program mentors and mentees, an overwhelmingly majority of mentees (91%) responded that they have felt as though their MDFD mentors made a

difference in their lives in general. The majority of mentees (71%) also felt that their MDFD mentors made a difference in their career choices.[5]

The characteristics of effective mentoring relationships that were found in the survey align well with those cited in the ADEA President's Commission on Mentoring (2004).[6]

The debate between the relative effectiveness of "formal" structured mentoring programs and "informal" organically developed mentoring relationships continues. Both have their merits and their drawbacks. Informal mentoring programs have been assumed to be better because of the "natural chemistry" that exists between the mentor and mentee and forms the basis of the relationship. These "organic" relationships are fairly rare, however, and often exclude underrepresented groups. Formal mentoring programs tend to be more structured and task oriented. These "assigned" relationships sometimes lack the interpersonal dimension, but provide equal access to mentoring relationships for all mentees. A third option is emerging: the structured match. Mentors and mentees complete detailed profiles of their personal and professional interests, areas of expertise, and demographics. Mentees then choose a mentor based on the similar interests or backgrounds listed in the profile, increasing the probability that the right "chemistry" will be developed.[8]

A key component of mentoring is professional development, a mentor characteristic identified as "most important" by MDFD fellows.[4,5,7] One element of professional development is attendance at professional, society and research meetings and conferences. A dentist who participates by giving lectures, seminars and presentations at the school, local, state or national dental societies is recognized positively in the community by fellow professionals and patients.[2] For MDFD fellows in particular, professional conferences, such as the annual conferences of ADEA, ADA, the National Dental Association, the Hispanic Dental Association, and the Society of American Indian Dentists, are an excellent opportunity to network with practitioners of the same race and ethnicity, as such networking possibilities may not exist at their parent institutions.

Cascading Effect of Mentoring

The "profiles" document the cascading effect of the mentoring received in the mentees' continued commitment to mentoring others and their humanistic lifestyles. The trainees are using mentoring skills they learned for the identification, recruitment and mentoring of minority students at various levels of the academic pipeline. There is a sentiment expressed as "giving back" to students some of the encouragement and guidance they received. In spite of their busy schedules as teachers, researchers and clinicians, they

serve as mentors, role models and examples of both personal and professional achievement.

Profiles of ADEA/WKKF MDFD grant recipients are now being updated through personal interviews with the fellows (http://www.adea.org/MDFD/Growing-Our-Own.aspx). The profiles document the long-term value of mentoring in professional development and in the cascading effect of mentoring across cultures and generations.

Summary

The mentoring outcomes of ADEA /WKKF MDFD continue to be realized from lessons learned, profiles of the grant recipients, and newer strategies that contribute to the evidence base for the value of diversity to educational quality and societal expectations.

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Jeanne C. Sinkford, D.D.S., Ph.D.

Joseph F. West M.Sc., Sc.D.

Richard W. Valachovic D.M.D., M.P.H.

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References

1. Sinkford JC, West JF, Weaver RG, Valachovic RW. Modeling mentoring: early lessons from the W.K. Kellogg/ ADEA Minority Dental Faculty Development Program. J Dental Educ 2009; 73(6):753-63.
2. Hempton TJ, Drakos D, Likhari V, Hanley JB, Johnson L, Levi P, et al. Strategies for developing a culture of mentoring in postdoctoral periodontology. J Dental Educ 2008; 72(5):557-88.
3. Throndyke LE, Gusic ME, George JH, Quillen DA, Milner RJ. Empower junior faculty: Penn State's faculty development and mentoring program. Acad Med. 2006; 81(7):668-73.
4. Carrion JA. The impact of the MDFD program: reflections of an MDFD senior awardee. Proceedings of the Minority Dental Faculty Development Program Symposium. April 10-11, 2008, Buffalo, NY.
5. West JF. 2007 mentorship survey results. Presentation at the ADEA Fall Meetings, October 22-25, 2008, Philadelphia, PA.
6. Friedman PK, Arena C, Atchison K, Beemsterboer PL, Farsai P, et al. Report of the ADEA President's Commission on Mentoring. J Dental Educ 2004; 68(3):390-96.
7. Woolfolk MW, May K, et al. Postgraduate and faculty mentoring: Portfolio development. In: Growing Our Own: The ADEA/ WKKF Minority Dental Faculty Development Program Manual. Washington, DC. 2011.
8. Sinkford JC, Valachovic RW. Growing Our Own: The ADEA Minority Dental Faculty Development Program—A Manual for Institutional Leadership in Diversity. Page 93. 2011.

Mentoring Resources

1. Allen TD, Eby LT, Poteet ML, Lentz E, Lima L. Career benefits associated with mentoring for protégés: a meta-analysis. J Applied Psych 2004; 89(1):27-136.
2. Feldman DC. Toxic mentors or toxic protégés? a critical re-examination of dysfunctional mentoring. Human Resource Management Review 1999; 9(3):247-78.
3. Higgins MC, Thomas DA. Constellations and careers: toward understanding the effects of multiple development relationships. Journal of Organizational Behavior 2001; 22:223-47.
4. Tevor K, Myers AS. Issues in mentoring. New York: Rutledge Publishing Company in association with The Open University, 1995.
5. Kram KE. Mentoring at work: developmental relationships in organizational life. Glenview, IL: Scott Foresman Publishing Company, 1988.
6. Menges RJ, et al. Faculty in new jobs. San Francisco: Josey Bass, Inc. Publishing Company, 1999.
7. Noe RA. An Investigation of the determinants of successful assigned mentoring relationships. Personal Psychology 1988a; 41:457-79.

8. O'Neill PN. Faculty Mentoring guide. Houston: The University of Texas Dental Branch, 2001.

9. Seneter M. The mentor's spirit. New York: St. Martin's Griffin Publishing Company, 1998.

10. Senge P. The fifth discipline: the art & practice of the learning organization. New York: Double Day Currency, 1990.

11. Shea GF. Mentoring: how to develop successful mentor behaviors. Menlo Park, CA: Third Crisp Publications, Inc., 2002.

12. Shepard KR, Nihill P, Botto RW, McCarthy MW. Factors influencing pursuit and satisfaction of academic dentistry careers: perceptions of new dental educators. J Dental Educ 2001; 65(9):841-48.

13. Walker WO. Mentoring for the new millennium. Medical Education Online 2002; 7(15). At: http:\\www.med-ed.online.org.

14. Friedman PK, Arena C, Atchison K, Beemsterboer PL, Farsai P, Giusti JB, Haden NK, Martin ME, Sanders Jr CF, Sudzina MR, Tedesco LA, Williams JN, Zinser N, Valachovic RW, Mintz JS, Sandmeyer MS. Report of the ADEA President's Commission on Mentoring. J Dental Educ 2004; 68(3):390-96.

Deans' Commentary From ADEA/WKKF MDFD Recipient Schools

Supportive leadership by the dental school deans contributed to enhanced use of ADEA MDFD funding that was comingled with other dental school resources in support of diversity programming.

University of Alabama at Birmingham School of Dentistry
The awarding of an ADEA MDFD grant to the University of Alabama at Birmingham (UAB) School of Dentistry afforded us an opportunity to support the training of many young women and men in their development as future academicians. Building on an exemplary institutional climate at UAB and leveraging experiences gained through various training grants, we have been able to foster an environment that encompasses a spectrum of activities including early identification of minority predental students, formal mentoring academic programs for dental students, and faculty development, mentoring, and recruitment programs.

Huw F. Thomas, B.D.S., M.S., Ph.D.
Dean (2004–2011), University of Alabama at Birmingham School of Dentistry

Texas A&M University Baylor College of Dentistry
The College has had many diversity efforts over the past eight to 10 years that have helped us reach diversity numbers that more closely reflect the ethnic diversity of Texas. Our outreach programs continue through the 7th through 12th grade education levels and baccalaureate and postbaccalaureate programs if required. Our ADEA MDFD program was designed so that we would attract students in their D3 year and be able to support them in their D4 year and throughout the years of their specialty programs. In our case, with the successes we have had, we feel that this has been a viable program. By having significant diversity numbers going through our predoctoral program, it became an excellent recruiting area for students interested in becoming faculty members or going into dental education.

James S. Cole, D.D.S.
Dean (2000–2011), Texas A&M University Baylor College of Dentistry

University at Buffalo School of Dental Medicine
The ADEA MDFD program has contributed to the University at Buffalo School of Dental Medicine's diversity objectives in several meaningful ways. First, its presence has increased the school's awareness, role, and sense of purpose in a tangible manner related to diversity matters. It has led to continued conversations and discussion with ADEA, who visited Buffalo to discuss such matters with our Admissions Committee in a retreat in 2008. The committee has since broadened its definition of minorities to include not only minority populations or ethnicity, but also applicants who possess other unique noncognitive factors for consideration. For example, if admitted, they would be the first in their family to attend dental school. The ADEA MDFD program has left a lasting imprint within our SDM community.

Richard N. Buchanan, D.M.D.
Dean (2001–2008), University at Buffalo School of Dental Medicine

Columbia University College of Dental Medicine
Participating in the ADEA MDFD NYSADC consortium has allowed our institutions to collaboratively work statewide with a focus on increasing the number of URMs who pursue academic careers in dentistry. One of the core elements of the ADEA MDFD logic model is academic partnerships, which is best represented by the consortium's accomplishments to effectively place and educate minority faculty into advanced degree programs. We intend to continue working with our consortium partners to pursue additional funding opportunities that will allow us to maximize our strengths and increase the diversity within our faculty and student body.

Ira B. Lamster, D.D.S., M.M.S.
Dean Emeritus, Columbia University College of Dental Medicine

University of Detroit Mercy School of Dentistry
I am a strong supporter of the ADEA MDFD program. At UDM we have been successful in recruiting and developing faculty from under represented populations based on a

deliberate and sustained effort to offer support, mentoring and external learning opportunities as well as a supportive environment. I believe that the success of these programs is based on continuous and sustained leadership from the top as well as peer recognition from organizations such as ADEA/WKKF. While the emphasis is on faculty development, programs such as these also provide the framework for URM student success and for school environments that promote inclusivity and strong student satisfaction. It takes a special kind of person to make these programs succeed and a commitment to celebrating the successes of others. I thank you for the opportunity to be a part of the WKKF/ADEA MDFD program.

Mert N. Aksu, D.D.S.
Dean, University of Detroit Mercy School of Dentistry

Howard University College of Dentistry
The mission of the Howard University College of Dentistry has always been to train URM dentists and provide oral health services to the underserved and underinsured populations in this nation and around the world. For the past 12 years The ADEA MDFD has reinforced these efforts by 1) increasing the number of students seeking advanced education, 2) facilitating a process toward formalized mentoring programs, 3) creating a foundation for intra and inter professional education collaborations, and 4) expanding our academic/community partnerships with school-based oral health programs. The ADEA MDFD is essential and critical to all dental schools that want to represent diversity, inclusion and community outreach in academia. The value of these grants supported by ADEA/WKKF to diversity and inclusion at your school is an important step to embrace these concepts. I wholeheartedly support the efforts of ADEA and WKKF in providing MDFD grants.

Dexter A. Woods, D.D.S.
Dean, Howard University College of Dentistry

University of Illinois at Chicago College of Dentistry
Through the support of the grant, the college was able to develop the infrastructure necessary with an emphasis on mentoring and leadership in faculty development. The grant has allowed us to provide resources and services necessary to promote an institutional commitment and climate that supported not only faculty diversity, but has also positively impacted the diversity in our student body. With the commitment and leadership of our URM faculty, the college has increased the recruitment and retention of outstanding URM students into the pipeline and for that, we are very thankful.

Bruce S. Graham, D.D.S., M.S., M.Ed.
Dean (2000–2013), University of Illinois at Chicago College of Dentistry

Meharry Medical College School of Dentistry
In 2001, Meharry Medical College School of Dentistry received the American Dental Education Association/W. K. Kellogg Foundation Access to Dental Care grant (ADEA/WKKF). The grant allowed Meharry to recruit additional minority students from

disadvantaged backgrounds who would be trained to carry out our mission of "serving the underserved." Currently, 81% of Meharry alumni are practicing in underserved communities. Grant recipients such as Dr. Brandon Hagler is serving the underserved communities in New Orleans, LA, while also mentoring at-risk youth. Dr. Venice Siffrard is touching lives one smile at a time in a practice in Memphis, Tennessee. It is grant opportunities such as the ADEA/WKKF which helped to defray the cost of dental education for these and other minority students from disadvantaged backgrounds, helping to make their dreams a reality. In 2004, four of our students went on to receive scholarships due to this grant: Crystal Ferguson, Brandon Hagler, Darian Hampton, and Venis Siffrard. These four students indeed went on to make very powerful impacts within their communities.

Cherae Farmer-Dixon, D.D.S., M.S.P.H., FACD
Dean, Meharry Medical College School of Dentistry

University of Michigan School of Dentistry
The University of Michigan School of Dentistry has continued its emphasis on achieving excellence through diversity of its student body and faculty. The ADEA MDFD has served as a catalyst for achieving our ambitious objectives for increasing the number of faculty members from URM/low-income backgrounds. As predicted by the ADEA MDFD program logic model, the grant activities had a clear impact not only on increasing the number of faculty members from diverse backgrounds, but also on changing the academic environment and the institutional culture. There is a sense that the program has changed feelings of isolation held by some students. They would most likely not have seized the opportunity to connect with faculty beyond the normal classroom or clinic interactions if the grant had not provided them with these opportunities. Through the project activities, the mentees got a sense of empowerment, realizing that they can contribute to dental education and can assume leadership roles in dental education in the future.

Peter J. Polverini, D.D.S., D.M.Sc.
Dean Emeritus, University of Michigan School of Dentistry

University of Minnesota School of Dentistry
The Minority Dental Faculty Development program at the University of Minnesota has an inestimable value in advancing the land grant mission of our school, to create a better society with health care providers and scientists who reflect the richness of our humanity, so as to better serve it. On a practical level, our minority students and faculty are working together to generate a new cadre of minority students into the health professions. Thanks to this partnership with ADEA, we are broadening our faculty development and professional development program for minority faculty. This is a customized development program led by faculty leaders. With our four major student dental associations for minority students we are partnering to create interest and pathways toward careers in academic dentistry, and promoting cultural and language skills. We are doing these efforts intra-professionally across the oral health professions of dentistry, dental hygiene and dental therapy. This has particular benefit in developing

a broad interest in oral health careers. Due to these foundational efforts we will this year embark on an inter-professional (medical, nursing and dental) clinic in North Minneapolis to serve as an incubator to advance health science careers in this most under-served part of our city.

Leon A. Assael, D.M.D.
Dean, University of Minnesota School of Dentistry

New York University College of Dentistry
Implementation of the ADEA MDFD program represents a key strategic initiative to improve the recruitment, retention, and development of URMs in the dental profession at New York University (NYU). As the program evolved, key insights were evoked that can contribute to the successful expansion of URMs in dental education, articulated in a logic model to guide development of institutional effectiveness in faculty diversity. The NYU College of Dentistry (NYUCD) is deeply committed to diversity and cultural competence, reflected in one of five major themes in our own Strategic Plan for the 21st Century. NYUCD is committed to, and continually seeks opportunity to realize, the recruitment and mentorship of URM faculty. The strategic directions in URM faculty development at NYUCD align perfectly with the logic model outputs as well as long and short term outcomes of the ADEA MDFD logic model.

Charles N. Bertolami, D.D.S., D.Med.Sc.
Dean, New York University College of Dentistry

University of Oklahoma College of Dentistry
The ADEA MDFD Grant has been instrumental in the development of several diversity programs and processes at the college. Most critical, has been the establishment of collaboration with other colleagues and entities to better address minority faculty recruitment and development. Working with our campus, we now participate in a regular minority faculty development program that not only includes our faculty, but their supervising faculty as well. Further, through this improved development of underrepresented minority faculty has emanated the creation of a standing committee: "Committee on Diversity." This committee is charged with the emphasis of student recruitment and using our recruited diverse faculty, to create a much better "student life" for our minority students. These programs, just passing their infancy, are becoming more of a continual mainstream at our college and continue to provide more avenues of collaboration.

Raymond A. Cohlmia, D.D.S.
Dean, University of Oklahoma College of Dentistry

Stony Brook University School of Dental Medicine
The ADEA MDFD program has been particularly influential in shaping the culture, policies, and practices at Stony Brook University School of Dental Medicine. Most notably, it has changed our view of the importance of mentorship and diversity in growing our next generation of academicians. Specifically, we were able to attract and

sponsor a Hispanic/Latino dentist. This led to the development of the new combined periodontics certificate/Ph.D. program at Stony Brook University School of Dental Medicine. The ADEA MDFD program led to many firsts at Stony Brook. We expect that as we continue to follow the logic model set forth in the program, our outcomes will continue to improve, leading to more URM and women on our faculty.

Ray C. Williams, D.M.D.
Dean (2008–2014), Stony Brook University School of Dental Medicine

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In addition to the personal commentary of the dental school deans, the following observations were made during site visits related to deans' leadership styles and diversity programming[1]:

1. *The dean's communication skills.* It was important for the dean to be able to communicate the value of diversity with a sense of compassion and commitment. This skill produces a synergy that is pervasive within the leadership teams and flourishes throughout the school's programs.

2. *The dean's physical presence at diversity-related events.* The dean's presence at seminars, meetings and other formal and informal events was seen as evidence of the level of importance and priority given to diversity-related events.

3. *The dean's interactions with the ADEA MDFD fellows* was indicative of the dean's interest and inclusive leadership style.

4. *Shared leadership.* The ability of the dean to delegate both power and resources to the administrative team members was of value to program officers. This skill imparted a sense of self-value and shared commitment to diversity initiatives.

5. *The dean's value as perceived by university administrators.* Comments about the dean's leadership were received from both higher and peer administrators and colleagues. They were perceived as leaders among the other schools and colleges within the health centers and universities. This value contributed to the dean's ability to leverage university resources that were designated to support diversity initiatives and programming.

6. *Resource allocation to support diversity programs.* The ability of the dean to "find a way to make it happen" was a leadership style and tangible sign of commitment valued by the ADEA MDFD program directors.

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[1] From Growing Our Own: The ADEA Minority Dental Faculty Development Program

ADEA MDFD Awardees

Dental schools, deans, principal investigators, and program directors:

University of Alabama at Birmingham School of Dentistry
Dr. Steven J. Filler

Texas A&M University Baylor College of Dentistry
Dr. Ernestine S. Lacy

University of Detroit Mercy School of Dentistry
Dr. Deirdre Young
Dr. Divesh Byrappagari

The Dental College of Georgia at Augusta University
Dr. Anna Luz Thompson

Howard University College of Dentistry
Dr. Earl M. Kudlick
Dr. Donna Grant-Mills

University of Illinois at Chicago College of Dentistry
Dr. Darryl D. Pendleton

University of Michigan School of Dentistry
Dr. Marilyn W. Woolfolk (Ret.)
Dr. Todd Ester
Dr. Kenneth May

University of Minnesota School of Dentistry
Dr. Karl D. Self

University of Oklahoma College of Dentistry
Dr. Kenneth S. Coy
Dr. Dunn Cumby
Dr. Marsha Beatty

New York State Academic Dental Centers (NYSADC)

Stony Brook University School of Dental Medicine
Dr. Christopher W. Cutler

Columbia University College of Dental Medicine
Dr. Dennis A. Mitchell

New York University College of Dentistry
Dr. David A. Sirois

University of Rochester
Dr. Stanley I. Handelman (Ret.)

University at Buffalo School of Dental Medicine
Dr. Richard Buchanan
Dr. Joseph J. Zambon

Associated Medical Schools of New York
Ms. Jo Wiederhorn

Association of American Medical Colleges
Dr. Marc Nivet

Acknowledgments

The ADEA MDFD program was made possible through ADEA's collaborations with 11 partnering dental education institutions. The program initially focused on the dental faculty, community outreach, mentoring, pipeline recruitment and leadership. ADEA/MDFD II and III were pilots that extended the focus to include allied dental professionals. Inclusion, diversity and cultural competency were objectives in MDFD II and III, with outcomes ultimately improving the lives of vulnerable children and communities. We value the support received from the W.K. Kellogg Foundation, the RWJF Pipeline (Summer Medical and Dental Education Program [SMDEP]) grants, federal agencies such as Health Careers Opportunity Programs (HCOP), Dental Centers of Excellence (COEs), NIH Minority Access to Research Careers (MARC)/Minority Biomedical Research Support (MBRS), and the national effort for diversity in the science, technology, engineering and mathematics (STEM) fields that contribute to the diversity pipeline.

Community-based partnerships included a broad spectrum of clinical care settings: school clinics, AHECs, FQHCs, mobile units, nursing homes, Indian Health Service clinics, migrant workers and a health disparities center. Partnerships also included advanced level dental fellows in general practice, and in advanced education in general dentistry and pediatric dentistry programs; deans of grantee schools; supporting departments; and dental school alumni.

The impact of major reports from the Institute of Medicine (2004, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*), Sullivan Commission (2004, *Missing Persons: Minorities in the Health Professions: A Report of the Sullivan Commission on Diversity in the Healthcare Workforce*), the U.S. Surgeon General Report (2000, *Oral Health in America: A Report of the Surgeon General*), and the 2003 Supreme Court ruling on the value of diversity in higher education are herein acknowledged. These resources provided support for the ADEA MDFD "grow your own" philosophy deemed essential to prepare students for an increasingly diverse U.S. population, to work in the global community, civic engagement and future leadership.

Several more recent reports have influenced program objectives and direction: Racial and Ethnic Disparities in Health Care: Updated 2010 by the American College of Physicians; Improving Access to Oral Healthcare for Vulnerable and Underserved Populations, Institute of Medicine, 2011; and Achieving Health Equity via the Affordable Care Act: Promises, Provisions, and Making Reform a Reality for Diverse Patients:

Workshop Summary, National Academies of Sciences, Engineering and Medicine. 2015.

Appreciation is noted herein for the wise counsel of Dr. Caswell A. Evans, who served as Chair of the MDFD Selection Committee, and Dr. Sidney Silverman, whose vision provided the seminal spirit for the NYSADC participation in ADEA MDFD.

Lastly, we must recognize the sustained commitment of the deans, program officers and staff who have sustained ADEA MDFD, MDFD II, MDFD III programming beyond grant funding. Drs. Kevin T. Avery and Billy R. Ballard, and members of the ADEA Minority Affairs Advisory Committee (ADEA MAAC), Drs. Richard Buchanan and Marc Nivet, are recognized for their support of the MDFD pilot concept. The models have demonstrated the effects of community-based service learning, inter-professional education and reflective learning on enduring learning behaviors and sustainable academic/community partnerships.

A special note of appreciation goes to Consultant Dr. Joseph F. West; Dr. Alice Warner, Project Officer at WKKF; ADEA staff members Dr. Diane Hoelscher, Ms. Cherelle Wright and Ms. Susan Kimner; and former WKKF staff members Dr. Henri Treadwell and Ms. Barbara Sabol.

Dr. Richard Valachovic D.M.D., M.P.H.   Dr. Jeanne C. Sinkford, D.D.S., Ph.D.

CHAPTER 2: ACADEMIC MODELS/REPORTS FROM INSTITUTIONS

Augusta University

PROJECT SUMMARY

The Department of Dental Hygiene, in collaboration with the Dental College of Georgia at Augusta University, received funding from the American Dental Education Association and the W.K. Kellogg Foundation to support the development of new partnerships with community organizations to provide dental hygiene care to minority populations of the Augusta area. Another important goal of this project was to achieve an increase in training and support for minority dental and allied dental faculty to aid them in further development.

This initiative was originally planned to take effect from July 1, 2013, to June 30, 2014. A no-cost extension was requested to allow for additional time to accomplish the objectives. These objectives were as specified in the grant proposal—to engage minority dental hygiene students, and communities within the area, in collaboration with minority faculty while reaching underserved minority populations. In this case, the target was minority children from elementary schools.

The experiences gained during the planning and implementation of the outreach activities of this project served two different missions. One of those missions was the increased awareness about the importance of involving faculty and students in outreach to underserved communities. For students, the realization that their knowledge can be transferred to children and the possibility of making a difference in their oral well-being was rewarding. Their enthusiasm while providing instructions to children was admirable.

Many dental hygiene students felt motivated to continue participating in outreach activities after graduation. For minority faculty, the leadership experience gained was valuable. It opened additional opportunities for collaboration with the community.

The other area in which this project served a relevant mission was an undoubtedly increase in learned cultural competency. A great number of hygiene students were exposed to populations different from their own. This outreach opportunity taught dental hygiene students to understand and accept cultural practices, attitudes, and educational and language barriers of children of underserved communities. Students from different

backgrounds also worked together while preparing their presentations for children at the elementary schools. In general, a greater understanding of the oral health needs of underserved children was obtained while exposing health care students to self-awareness.

As of December 1, 2015, additional opportunities for outreach have been explored. Faculty and students participated at a Hispanic Health Fair in October. A second outreach session was scheduled at Lamar-Milledge Elementary School during the fall semester. Faculty and students collaborated with the local chapter of the Hispanic Dental Association, which has funds from the W. K. Kellogg Foundation to provide "Lessons in a Lunch Box" to 215 children in grades 1–3. In addition, while continuing collaboration with the Richmond County Health Department, oral hygiene instructions were given to 206 additional children, and a total of 110 children received dental hygiene care, sealants and fluoride treatments.

Program Goals

- Minority dental and dental hygiene faculty furthered their preparation for leadership positions and continuous advancement in their careers
- A large number of children were affected by the outreach program
- Dental screenings and preventive dental treatment delivered to 172 children
- Oral health education presentations delivered to 872 children
- Dental kits and educational coloring books given to 872 children
- Increased number of underrepresented minority students accepted to the program
- Increased interaction of dental hygiene students with children—providing oral health education and preventive care
- Participation as members of the Dental Hygiene Diversity Student Organization, contributing ideas about additional outreach opportunities and community involvement
- Mentored, motivated and supported minority dental hygiene students in the pursuit of career advancement
- Dental hygiene program collaborating with the Dental College of Georgia
- Stronger relationship with the Richmond County Health Department
- Relationships built with the administration of two local elementary schools
- Collaboration with Boys and Girls Club officials
- Plans for fundraising events to continue outreach
- Revenue from coloring book sales

- Plans for applications to other grants for outreach support
- Outreach program—embedded in course content (dental hygiene program)

Faculty Development

The experience gained by participating minority faculty working on this project has been significant. Dealing with all aspects of planning and implementation of an outreach project involved several matters that needed to be addressed. The role of the minority dental hygiene faculty in planning the initiative and program progress involved constant collaboration with dental faculty and other members of the community. Lessons learned during the process are valuable and will serve as the basis for future undertakings.

Regardless of the number of underrepresented minority faculty in the department not increasing during the grant period, there was an increase in time effort for one part-time faculty, in addition to consideration for a full-time position when it became available. Prior to the grant there was only one full-time minority faculty out of three. Currently, there are two full-time minority faculty out of three. The rest of the faculty in the department are employed on a part-time basis. In that matter, having two full-time faculty from underrepresented groups is a remarkable sign of success. To increase the recruitment of underrepresented minority faculty, additional positions need to open, and programs should grow. During 2014, two dental hygiene part-time positions became available; unfortunately, no minority faculty applied to those positions.

The Minority Faculty Development Grant enabled minority faculty to develop professionally by supplying funds for travel to conferences, providing opportunities to improve leadership skills, and presenting opportunities for interprofessional and community collaboration. Program participation affected the dental and dental hygiene faculty in a positive way. As it was strategically planned, minority faculty attended numerous dental conferences and had opportunities for traveling and participation in professional development activities that, without the grant, would have been impossible to attain. These opportunities enhanced the reputation and recognition of participating faculty among other health professionals. Additional invitations to participate in other grant applications, research and outreach activities have developed. Increase in trust and appreciation of skills by other faculty has been noted, in which minority faculty have been invited to be members of new teams that will further support them to increase their recognition in the university, and at the national level.

Specifically, during the grant period, Ms. Ana Thompson had several opportunities for faculty development, which would have not been possible without the grant support. Ms.

Thompson, the princpal investigator of the project, was acting as interim chair of the department of dental hygiene at the time the grant was awarded. She attended the ADEA Annual Session in San Antonio Texas in March 2014, the Allied Program Directors' Conference, and the ADEA Building Leadership Teams for a Diverse Dental Workforce Training Session in June 2014. During those conferences, Ms. Thompson interacted with numerous distinguished dental professionals and learned from them about best practices, leadership and program management. Regarding career advancement, being the recipient of the grant greatly contributed to highlight Ms. Thompson as a prospect for consideration when it was time to select a permanent chair for the department of dental hygiene. She was appointed as a chair of the department in April 2014. During the same year, she qualified to apply for promotion to the next rank, which was the professor level. Her application for promotion was supported by the dean of the College of Allied Health Sciences, by the promotion and tenure review committee members and the Provost. She became a Professor in July 2015.

For dental hygiene faculty Ms. Kandyce (Mack) A'see, the grant provided funds to attend the 2014 ADEA Annual Session & Exhibition in San Antonio, TX. It also provided funds to take 20 hours of continuing education during a 3-week online class through the Institute for Allied Health Educators, titled "Teaching Foundations in Allied Health Education." This project introduced Ms. A'see to a new field as faculty. She learned about outreach project planning and management, and about student organization planning and developing. She has been active involving minority dental hygiene students in community events while being an outstanding role model for them. Her professional development benefited through the Minority Dental Faculty Development grant and increased her recognition in the university. This led to her promotion from Instructor to Assistant Professor, her progression from part-time faculty to full-time faculty, an invitation to recruit high school students at the Communities in Schools Conference at Augusta University, and an invitation to be keynote speaker at Communities in Schools Conference at University of West Georgia. She has also been invited to speak at the President's Breakfast at the National Dental Hygienists' Association in Atlanta.

Dr. Amara Abreu, dental faculty at the Dental College of Georgia, also participated in professional development activities funded by the grant. Dr. Abreu served as dental director during the treatment delivery clinics organized during the project. She supervised dental hygiene students and contributed referring children to other specialty clinics for additional needed dental care. This opportunity permitted her to get in contact

with the community, specifically the pediatric population. It also allowed her to collaborate with other faculty from the dental hygiene department, stretching the communication and enhancing the relationship between different departments in the institution. Furthermore, her involvement in this project greatly enhanced her application for consideration to promotion in the following year.

She attended the 2014 ADEA Annual Session & Exhibition in San Antonio, TX. This was her first time attending an ADEA event. Participating in such a big and important educational meeting allowed Dr. Abreu to interact with the dental community and at the same time allowed her to see what other schools were doing in terms of educational techniques and faculty development. This experience helped her grow as a dental professional, and opened doors at the local, state and national levels. Travel funds are frequently limited for faculty working in state institutions, for which this opportunity for travel and professional development was significant. In her opinion, this grant provided a great benefit to the community in the Augusta area, and contributed tremendously to the development of the faculty involved. She recently joined the local chapter of the Hispanic Dental Association and wishes to continue collaborating with the dental hygiene department in future outreach activities.

URM Recruitment and Mentoring

A new cohort of URM dental hygiene students was accepted in the program during the fall of 2014. One Hispanic and four African-American females, and two African-American male students, were admitted to the dental hygiene program. This is an increase from 6% the previous year to 20% of this year's entering class. Most of these students have been successful in the program so far. Two of them have struggled with some courses, but have been closely monitored and mentored by faculty to help them succeed. To motivate these students into considering higher education and possibly a transition into academics, minority faculty continues to mentor them by sharing ideas and stories. It is important to let them know that possibilities for further advancing are available for those who seek them. Strong relations with these students become even stronger after they graduate, as it has been observed by the continuous contact with minority students who graduated in May 2014. Meetings were scheduled with minority students to invite them to collaborate in community activities and to encourage them to consider career advancement. The expectation is that this group will continue functioning year after year in a systematic way to ensure continuous increase and involvement of underrepresented minorities in academia.

Outreach Activities

Expectations to reach as many children as possible were met. The following list provides the specific count of children accessed in one of two ways. Some were screened and treated, and others were reached by providing them with dental kits and oral health education.

- Children reached receiving treatment at Lamar-Milledge Elementary—106
- Children reached receiving treatment at Jenkins-White Elementary—66
- Children treated—172
- Children reached at other community events (school presentations/health fairs)—202
- Children reached at other community events (school presentations/health fairs)—495
- Children reached, not treated—697
- Grand Total—869

In addition, as planned in the grant proposal, the creation and production of the Coloring and Activity Book "Keeping up With Your Smile" was successful in delivering oral health instruction to a large number of elementary school-aged children. One hundred and six children at Lamar-Milledge Elementary received the book as part of the Children's Clinic Days when they attended the clinics at Augusta University in the spring of 2014.

Later, during the fall of 2014, all children attending Jenkins-White Elementary Charter School received the book during dental hygiene students' presentations in every classroom. A total of 417 coloring books were distributed. The goal of this initiative was to enhance the opportunity for children and their caregivers to learn about oral health. Children also received instructions on brushing and flossing, and a kit with a toothbrush, floss, and toothpaste.

During Phase 2 of our implementation, a strong relationship was formed with Mr. Earl Kelton, Principal of Jenkins-White Elementary Charter School. Mr. Kelton showed great enthusiasm for the project and expressed that the need for dental health education and care is excessive at this school, which is located at 800 15th Avenue, Augusta, GA, in a very low-income area. During several meetings with Mr. Kelton, the Augusta University team learned that 100% of the children attending this school qualify for free or reduced lunch, which provides information about their poverty level.

Most children were of minority groups, with 96% African American and 3% Hispanic or multiracial. Again, as in the initial segment of the outreach project, the Richmond County Health Department (RCHD) contributed significantly to the success of the project plan to reach a large number of children by supporting with facilities and supervision of Augusta University Dental Hygiene program students while providing dental sealants and fluoride treatment to 66 children of ages five to 12. As in the previous phase, the RCHD dental mobile unit was set up in front of the front entrance of the school to increase its visibility and serve as a reminder for parents and children to return their signed consent forms. The dental mobile unit is equipped with two operatories and a sterilization and sink area. Dental hygiene students delivered treatment to children in those operatories, while additional groups of dental hygiene students gave 30-minute presentations in the classrooms. The decision to provide treatment in the dental mobile unit was made because during the first phase of the program, the team had a low return of consent forms for transportation to the university clinics for treatment, even after children had already been screened.

During Phase 2 of the outreach project, one of the greatest barriers in treatment delivery was the limited number of signed consent forms returned by children in grades 4 and 5, which were going to be the main target population. After a few weeks attempting to reach this group, it was necessary to print more consent forms to deliver to 2nd and 3rd grade students. Later, when no more children were returning signed consent forms, a third attempt was made to reach children from grades K and 1st. A total of 66 children were screened and treated. Ms. Cheryl Fry, Assistant Principal of Jenkins-White Elementary Charter School, was a key player in making sure teachers were reminding children to return their consent forms. She was also helpful coordinating children's schedules for attendance to the dental mobile unit and to the classroom presentations.

Dental hygiene faculty were the main coordinators of the Jenkins-White activities. They attended every four-hour session and met with the principal and assistant principal to arrange clinical events. Dr. Blake Collins from RCHD was the dental supervisor of all activities and ensured that cards were completed to send to parents regarding the dental state of their children. Other participants in the project were dental assistants from the health department and a dental hygienist who collected the information from screenings to report to the Department of Public Health state office. Dental hygiene students shared their opinions about this project during course evaluations and expressed that one of their favorite things to do was to interact with children and provide needed services to underserved populations.

Community Relations and Partnerships

This project also served as a way to collaborate with the Dental College of Georgia at Augusta University and the Dental Hygiene Department. Exceptional support was received from the Dental College of Georgia's Department of Sterilization and Dispensary, which facilitated the team's access to instruments for treatment delivery.

Relationships were formed with senior administration, faculty and staff, which have facilitated forthcoming collaboration in outreach activities like the ones done with this grant, in addition to Give Kids a Smile events.

A stronger relationship was also developed with RCHD. Dr. Blake Collings and his staff were instrumental in the delivery of services. They collaborated with faculty and students throughout the project, and shared their experiences with project planning and delivery of services. Further plans include yearly dental hygiene students' participation with RCHD in similar outreach activities. Strategies are underway for upcoming continuous delivery of services and classroom oral health education for children of the targeted elementary schools.

Relations were also formed with the principals and administrators of both elementary schools as well as with staff of the Boys and Girls Club for uninterrupted involvement. Dental hygiene faculty have been invited to participate in other events organized at these schools, as in the Body Walk organized by the Supplemental Nutrition Assistance Program, where minority dental hygiene faculty provided oral care and explained the dangers of tobacco use to participating children. Faculty and dental hygiene students are becoming recognized figures in both schools. This will instill in children a comfortable familiarity with dental and dental hygiene education.

Additionally, the Dental Hygiene Department recently partnered with Augustus R. Johnson Health Science and Engineering Magnet High School (A.R. Johnson) and their dental sciences program. High school students who are aspiring dentists and dental hygienists shadow senior dental hygiene students weekly to learn more about the profession. Since A.R. Johnson is comprised of 69% African Americans, this will serve as an excellent mentoring and recruitment pathway. This is expected to be an annual collaboration, and positively will serve as a direct pipeline from high school to dental professions at the Dental College of Georgia at Augusta University.

Lessons Learned

The project team learned about project planning, budgeting, creation of relationships with community organizations and team work. Lessons learned during this activity were many. One of the most important lessons was that planning and managing arrangements to provide service to children during outreach events takes more time than what was originally expected. An example of this is the time separated in the faculty schedule to dedicate to planning and visiting entities, and the time demanded to arrange schedules for faculty and students to participate in screenings and delivery of treatment, as well as coordinating schedules with the elementary school to prevent children from missing important class sessions or lunch hours. Scheduling coordination took several meetings with elementary school administrators, nurses and personnel from the RCHD. It was also a challenge to coordinate schedules for the dentist who was working for the Dental College of Georgia for the dates when we were planning clinical activities. Another lesson learned was that the main coordinator of the project must dedicate a considerable amount of time to such activities, and in this case, serving as a program director and chair of the department limited the time that could be spent in grant activities. It was also learned that additional office support is necessary to arrange clinical space, instrument request, sterilization, ordering supplies and budget control with the university department of grants and contracts, which manages grant funds.

Numerous meetings and planning sessions were scheduled with officials from the Augusta University Office of Innovation and Commercialization to obtain permission to sell the Coloring and Activity Book created by faculty. The purpose of selling the coloring book is to aid in funding for additional outreach activities, and to increase delivery of oral care education to the public. After several considerations, it was decided that the best route to market the coloring book was through the university's book store.

Sales of the coloring book have not been as productive as was expected. Additional marketing strategies and exposure are needed to inform possible buyers about the book. Messages have been sent to dental professionals who showed interest in the book. Plans are underway to involve students in the delivery of information to dentists not only in surrounding communities, but also beyond state borders.

There were some difficulties preparing and having approved contracts with the RCHD. Old equipment in the dental mobile units also caused a few unexpected delays, but the team worked full of enthusiasm, accomplishing as much as was possible to do at the time.

During scheduled outreach activities, there were instances in which there were electrical problems in the dental mobile unit. A mechanic had to be called twice while students were working. This wait delayed the delivery of sealant applications. However, to use time wisely, children were screened by dental hygiene students and faculty using portable flashlights. Those children received oral hygiene instructions and fluoride varnish applications. From the screened children, a list was created to flag the children who had a need for sealants. Those children were treated at a later date.

New educational opportunities arose when the team encountered noncooperative children. There were instances where, even though there were signed consent forms, children did not cooperate or cried when approached for screenings. Faculty used these moments to teach dental hygiene students behavioral modifications to approach situations like these. At least fluoride varnish treatment and oral hygiene instructions were given to children who did not cooperate for placement of dental sealants.

Another challenge encountered was the insufficient time during fall semester to complete a thorough documentation of all activities. Additional time is required to design a successful plan of action to deliver service to larger groups. More faculty and staff working on the project are needed for more efficient delivery of services. Heavy faculty teaching loads, as well as other administrative and service responsibilities to the university, influenced the amount of time reserved for conducting this project. During the time in which this project took place, there were also some changes in personnel that affected faculty workloads. With shortness of faculty, no other faculty were available to volunteer, or to dedicate time to community projects. It would have been beneficial for all to involve the entire group of faculty of the department of dental hygiene, but their schedules did not allow it.

University of Detroit Mercy

PROJECT SUMMARY

The Dental Hygiene Exploration Program (DHEP) is designed to expose underrepresented minority students, nontraditional students, dental assistants, veterans and other interested community members to the dental hygiene profession. Dental Hygiene Exploration Workshop (DHEW) participants gain hands-on laboratory experience dealing with the oral, head and neck anatomy; the use of dental materials; dental hygiene instrumentation; and patient communication techniques. Admissions counseling will also be available to facilitate entry into the dental hygiene profession.

Through personal contact hours with students, teachers and counselors in the targeted school districts, 10 schools in the Detroit area participated in a Dental Career Day. Over 300 students in the school district were exposed to careers in dental hygiene and dentistry through descriptive posters displayed throughout the targeted schools. The targeted schools were all located in health profession shortage areas. Two hundred students in grades 7–12 participated in a tour of the University of Detroit Mercy and University of Detroit Mercy School of Dentistry. The tour informed students about dental hygiene and dentistry. The tour program increased students' knowledge of careers in allied dental health professions, community outreach activities, and oral hygiene health and research. We performed pre- and posttesting to determine the degree to which students increased their knowledge.

We created a database to track the students by Michigan Area Health Education Center (AHEC). AHEC tracked the students through their professional placements. We collected data on school selection, career selection and placement. We strongly encouraged the participants to consider serving in underserved areas.

Program Goals

Dental Hygiene Exploration Program

- Enlist the support of the WDS and the WDHS and other active societies in Metropolitan Detroit.
- Develop a brochure and place it in reception areas of dental programs, and send it to community college counselors to be distributed to interested students.
- Personally contact particular high school counselors for student referrals.
- Contact ministers of churches in metropolitan Detroit and provide information about the program.

- Contact and inform Kaplan, Dorsey, Everest, University of Phoenix and vocational technical high schools.
- Identify programs in Macomb, Oakland and Washtenaw counties, Muskegon and Flint.
- Contacting the Director of Veterans Administration Building in Detroit to identify unemployed veterans of the Iraq and Afghanistan war.
- Identify underrepresented minority dental hygiene applicants of the UDM admissions department that were not accepted into the program.

Dental Imprint Program

- Exposes underrepresented minority high school students to careers in allied dental health and dentistry.

Tour for Diversity

- Brings premedical enrichment activities to underrepresented minority undergraduate students at campuses across the United States.

URM Recruitment Program

- Through active partnerships with the Michigan AHEC and the Detroit-area school district will actively recruit, train and retain underrepresented minority students to become allied dental health and dental professionals.

Dental Hygiene Emphasis Workshop

- Exposes underrepresented minority students in Michigan to the dental hygiene profession.

URM Professional Development Program

This program has not been implemented due to lack of interest from the Wolverine Dental Hygienists' Society. After approval from the grant officer, the funding was reallocated to conducting an evaluation of the sealant program. A set of focus groups were conducted to collect data to enhance the services provided through the School Based Sealant Program.

School Based Sealant Program

The UDM School of Dentistry's (UDM Dental) School Based Dental Sealant Program is a well-established program operating successfully since 2008 in partnership with Henry Ford Health Systems (HFHS). Since October 2013, UDM Dental's Office of Community

Programs has taken over the administration of the program in partnership with the Dental Hygiene Program. This student-based model not only delivers the preventive care needed in the Detroit-area schools but also trains the next generation of dental hygiene providers who are culturally competent and have the clinical skills and technical knowledge to plan and implement school based dental sealant programs as well as other community-based oral health programs.

The UDM Dental's School Based Dental Sealant Program is implemented by two staff persons: Ms. Christiana Morton (dental hygiene faculty) and Ms. Laura Wright (Sealant Program Coordinator). The dental hygiene faculty supervises dental hygiene students who provide preventive dental services three days a week and also present oral health education in classrooms. A total of 24 dental hygiene students have participated in the community-based program in the current academic year. The faculty also provide didactic instruction related to community programs. The following services are provided through the Sealant Program at the school location:

- Oral Health Screenings
- Oral Prophylaxis
- Fluoride Varnish Applications
- Dental Sealant Applications
- Oral Health Education

Key partners and collaborators include:
- Detroit-area schools (Detroit Public Schools, charter and private schools)
- Michigan Department of Community Health
- Children's Tooth Fairy Foundation
- Old Newsboys' Goodfellow Fund of Detroit
- Delta Dental of Michigan, Ohio and Indiana

Outreach Activities

The DHEW classes are facilitated by the UDM School of Dentistry Explorations in Dentistry/ADEA student organization, a group of dental and dental hygiene students interested in pursuing academic dentistry careers. The Exploration in Dentistry/ADEA is led by Dr. Michelle Wheater, Director of Research and Student Leadership, and Ms. Kathi Shepherd, Director of Educational Development and Outcomes and Director of Dental Hygiene.

- Three-day intensive program
- Exposure to the dental hygiene field and hands-on activities
- Receive financial aid information and admission counseling
- Participate with social and cultural competence modules
- Engage with local dental hygiene professionals
- Receive dental hygiene admissions counseling
- Dental Imprint

Career Day Presentation at the School

Dr. Deirdre Young gave a presentation at 10 schools during the 2013 fall term. Students were at the middle and high school levels, and the school counselors identified students interested in the medical/dental field. Selected students were given a presentation in their career resource lab or during elective periods. Emphasis was placed on public health dentistry to encourage the students to pursue various career options in dentistry in an effort to address the needs of health shortage areas. The Dental Imprint Student was mentored with regard to proper curricula/majors to choose while an undergraduate.

Tour of University of Detroit School of Dentistry

The targeted 6th-12th grade students within the Detroit-area school districts were able to participate in a tour of the dental school. Counselors and teachers identified 25 students to participate in the dental school tour. Ten tours were conducted in the 2013 winter term. The tours focused on primary care exposure through the various dental clinics within the school, including orthodontic, oral surgery, endodontic, periodontic, pediatric, radiology, 3rd-year clinic, and 4th-year clinic. Students observed dental procedures and patient/faculty/student interactions. The tour served as a recruitment initiative, designed to attract more Detroit-area students to dental careers. The pre- and posttest given assessed participants' increased knowledge on careers in dentistry (dental assisting, dental hygiene and dentistry), oral hygiene maintenance, and the importance of a strong academic background. Table 1 presents the data from this assessment. The pretest mean $\pm$ SEM: 5.2 $\pm$ 0.4, while the posttest mean $\pm$ SEM: 7.2 $\pm$ 0.4 (Paired t-test: $p < 0.0001$). Nineteen students improved their pretest scores, five were unchanged. No students decreased their scores.

Dr. Young and other dental school faculty conducted a dental materials lab session as a part of the preclinical experience. Students participated in hands-on activities in the simulation lab, providing preliminary education on dental materials and procedures. They took impressions of teeth and learned about dental anatomy. The main intention

was to aid in facilitating entry into professional school by providing the participant with advice and knowledge before college matriculation. With increased knowledge in the dental hygiene and dental school application process, the applicant ultimately becomes a more competitive applicant. A diverse proportion of dental students, faculty and staff participated at different phases of the tour. The dental school community offered insight into their experiences in the dental profession at various times during the tour. Between 2013 and 2014 academic years, 10 area middle and high schools participated in the dental imprint program: Western, King, Cass Tech, Ben Carson, U of D Jesuit, Detroit Collegiate, DSA, Spain, Chandler Park, and Renaissance.

Table 1: Pre- and Postcourse Survey Analysis Dental Hygiene Explorations Program Results (N=24)

Question	Pre Score from 1-5	Post Score from 1-5	Paired t-test
What is your current level of interest in becoming a dental hygienist?	3.6 $\pm$ 0.3	4.0 $\pm$ 0.2	P = 0.0179
Do you think this course will help you (did this course help you) decide if you want to become a dental hygienist?	4.3 $\pm$ 0.2	4.2 $\pm$ 0.2	P = 0.8246
How familiar are you with dental terminology?	3.3 $\pm$ 0.5	3.8 $\pm$ 0.2	P = 0.3944
How familiar are you with dental anatomy?	2.6 $\pm$ 0.2	3.8 $\pm$ 0.2	P < 0.0001
How familiar are you with taking impressions?	3.0 $\pm$ 0.3	4.3 $\pm$ 0.2	P = 0.0002
How familiar are you with dental hygiene instruments?	2.5 $\pm$ 0.3	3.9 $\pm$ 0.2	P = 0.0002
How familiar are you with career options available in dental hygiene?	2.7 $\pm$ 0.2	4.2 $\pm$ 0.2	P < 0.0001

Community Relations and Partnerships

School Based Dental Services Program: UDM Dental, in partnership with Delta Dental Foundation, has established a School Based Dental Services Program in the southeast Michigan schools as an adjunct to the current School Based Dental Sealant Program. Senior year dental students, along with Department of Pediatric Dentistry faculty, will provide comprehensive dental services in schools. The program started in the fall of 2015 and has so far provided comprehensive services in two elementary schools and at several community participating schools.

2013-14	2014-15
1. **Amelia Earhart** 2. **Holy Redeemer** 3. **Thirkell Elementary** 4. **Stewart Academy** 5. **New Paradigm Loving Academy** 6. **Ross Hill Academy** 7. **CMA High School *** 8. **Cristo Rey *** **~3000 Students** **90% or more on FRL**	1. Detroit Service Learning Academy-Detroit 2. Detroit Service Learning Academy-Redford 3. Holy Redeemer 4. New Paradigm Loving Academy 5. Ross Hill Academy 6. Cristo Rey* 7. Loyola High School* ~2400 Students 90% or more on FRL

Other participating partners included:

- Michigan Area Health Education Center

- Detroit Public Schools

- Detroit-area school districts and colleges

- Michigan universities and Historically Black Colleges and Universities (HBCUs) and Hispanic-serving institutions

- American Indian Dental Society

- American Indian Youth Programming

- SNDA and SNDHA

School Based Sealant Programs

a) URM Professional Development Program: Proposed in partnership with Wolverine Dental Hygienists' Society.

b) School Based Sealant Program: Ms. Christiana Morton (RDH faculty) and Ms. Laura Wright (Sealant Program Coordinator) manage the School Based Dental Sealant Program.

c) School Based Sealant Programs: Strategies implemented by UDM Dental to promote "Seal A Smile" Sealant program

Lessons Learned

The URM recruitment and outreach programs allowed for students to become exposed to dental health careers. The Dental Imprint Program and Dental Hygiene Explorations Program allowed for outreach with Detroit-area students and provided an opportunity for participants to interact with health care professionals from their communities. Students learned about dental career paths from dental professionals who graduated from their school districts. This key component offered the opportunity for students to converse with professionals that were relatable and could serve as role models. Having role models that matriculated from participants' school districts could serve as a successful strategy for recruitment. Participants' commentary provided through reflection essays and direct verbal feedback highlighted the benefits of having facilitators who served as local role models in the dental profession. Additionally, participants discussed the benefits of having culturally competent providers in their communities and pointed out the increased likelihood of follow-up care for patients with a practitioner who could understand the needs of their communities.

The Tour 4 Diversity served as a key component for recruitment nationally, affording high school and college age students the opportunity to gain insight on dental career pathways. Dr. Deirdre Young, Program Director of URM Recruitment and Retention Programs, continues to serves as a dental mentor with Tour 4 Diversity. With Kellogg/ADEA support, Dr. Young has reached students in over 20 states to aid toward increased awareness of dental careers.

Strategies for building new models of community-based partnerships, and school-based care models where dental caries prevention, sealants, and treatment can be provided:

a) Invite school administrators to an annual meeting where they are presented with information about the school programs and their benefits. This includes specific data related to the schools and the impact on the children accessing these services.
b) Provide a report to the school with information of the services provided to children.
c) Involve parent volunteers at school in planning and scheduling the program.
d) Promote the program in local communities and make the UDM brand more visible to encourage participation.
e) Include information in school newsletters.
f) Create incentives for children to turn in consent forms.

g) Place banners inside and outside schools announcing the program and an online link to assess information.

h) Mail or email take-home instructions and referrals to parents instead of handing it to the children.

i) Provide a list of low-cost providers apart from the UDM dental school referral.

j) Create a website to access information about the program and the services provided.

k) Provide information about dental careers along with services.

Howard University

PROJECT SUMMARY

The Howard University College of Dentistry (HUCD) has educated and trained qualified general dentists since 1881 and dental hygienists since 1934. Increasing the diversity of the oral health workforce is an integral solution to improving access to care for underserved populations, in addition to advanced cultural competence, strengthened research agendas, and increased management of the health system efficiency.

The MDFD grant has allowed HUCD to further develop community-based and academic partnerships to improve the oral health care of the underserved populations, and requires a center to integrate, develop, conduct, and coordinate programs, workshops and forums.

The Howard University College of Dentistry Integrative Center (HUCD-IC) expands on this history by coordinating with the DC Dental Hygienists' Association, the Maryland Dental Hygienists' Association, the Virginia Dental Hygienists' Association, the DC Dental Society, the Robert T. Freeman Dental Society, and the Hispanic Dental Society. HUCD-IC organizes and develops new collaborations to include area health clinics, dental clinics, mobile health vans, private practices, public schools, allied dental education programs, the Interprofessional Education Collaborative (IPEC) practice environments, the DC Department of Health, Oral Health America, The National Children's Oral Health Foundation, and various dental companies.

The aim of these collaborations is to ensure the integration of knowledge and approaches to enhance the lives and guarantee vulnerable children access to dental care and education for them and their families.

The HUCD-IC is focused on the following:

a. <u>School Based Oral Health Program</u>
   - The HUCD-IC continued activities at two school-based wellness centers at Coolidge and Dunbar high schools. A dental unit was installed at Coolidge and a part-time dentist was hired at Dunbar through the DC Department of Health.
   - The Department of Dental Hygiene continued oral health education and exposure to careers in dentistry for students at H.U. Middle School for Math and Science (STEM).

- The school-based program expanded in January 2015 to include eight charter schools in the District of Columbia. Two hundred pre-K and K-12 children have been treated.

b. Academic Community Collaborations
- Use of the Colgate Bright Futures Van expanded outreach efforts providing oral health education and screening for children in DC and the Baltimore metropolitan area.
- HUCD-IC is currently working with the Department of Health, DC Public Schools and Gordon Dental Associates to expand the scope of services for the school-based program during the 2015–16 school year.

c. Interprofessional Education Collaboration (IPEC)
- The HUCD-IC (now a part of IPEC) expanded its collaborative team of dental and dental hygiene students, orthodontic and pediatric residents, nutritionists, speech language pathology students, and family nurse practitioner students.
- Collaboration with the Speech Language Pathology Program in the College of Nursing and Allied Health. Two community partnerships support this new collaboration: the National Congress of Black Women, Maryland Chapter and the Colgate Bright Futures Van.
- HUCD-IC collaborative includes eight health assessments that link oral health to systemic health with follow-up recommendations on a status report to parents. The work of the HUCD-IC is being integrated into the IPEC for sustainability and long-term value to health outcomes of children screened.

d. Recruitment Programs
- H.O.P.E. Yes! Continues as a one-day interactive program for 35 elementary, middle and high school students. This program is supported by three departments: orthodontic, dental hygiene and pediatrics.
- Oral health education, career advisement, test taking skills, dental hygiene and laboratory exercises are included.
- The program links public school students with dental and dental hygiene students and Summer Medical and Dental Education Program (SMDEP) scholars.

   e. <u>Faculty Development</u>
- The HUCD-IC is hosting one-day interdepartmental faculty development workshop as a final MDFD III activity. The workshop will include lessons learned from MDFD leadership training. Participants will be provided with tools to increase interprofessional collaboration across health science disciplines to improve health outcomes.

Program Goals

- Establish Each One Reach One with URM dental and dental hygiene students to expose and encourage them to pursue careers in academics.
- Establish a pipeline for dental assisting students into dental hygiene careers.
- Encourage the participation of junior faculty in university-wide faculty development opportunities.
- Encourage and sponsor at least one dental hygiene junior faculty to attend the 2013 Allied Dental Health Leadership Institute.
- Advance academic support for career laddering (transition from allied dental to dental careers).
- Coordinate a one- to two-day faculty development program for the College of Dentistry.
- Development of dental hygiene career days.
- Development of a summer externship to expose URM elementary, middle, and high school students to careers in health sciences and leadership with a specific focus on the allied dental profession.
- Coordinate interventions during the academic year for URM elementary, middle, and high school students to have continued interaction with dental and allied dental professionals.
- Development of a degree completion program for graduate dental hygienists with the School of Allied Health, specifically with the Health Care Management Program.
- Establish IPEC relationships with DCPS School Nurse Program; HU College of Nursing, Family Nurse Practitioner Program; and the District of Columbia Child and Family Services-Nurse Care Management Program—to be trained by AEGD residents to enhance prevention and dental education in schools, community clinics, and the District of Columbia Child and Family Services Program.

Faculty Development

"Career laddering" partnerships and relationships are in place involving dental technology, dental assisting, dental hygiene and predoctoral and advanced dental education programs. There are opportunities to expand career choices for allied health personnel. Allied health personnel are mentored and directed toward these expanded opportunities by the faculty. HUCD has several individuals who have moved through the dental curriculum from dental hygiene to dentistry and on to advanced residency training. HUCD staff have also moved from dental laboratory technology and dental assisting to dental hygiene, dentistry and on to advanced residency training. These individuals are testimony to the commitment and success of HUCD in furthering career development. They also now live and work in the community and several come back to the school to mentor and teach.

More than 70% of the predoctoral dental class is made up of underrepresented minorities. Moreover, the alumni of the College interact with the program directors of residency training programs and the chairs of dental departments and dental hygiene programs during the year and at continuing education programs regarding recruitment efforts. Several of the alumni members serve as faculty in other institutions.

Quality, practice-based learning environments are integral to the experience at HUCD. The following represent community-based and academic partnerships currently in place that further faculty development:

1. The Advanced Education in General Dentistry Residency (AEGD) training program provides a clinical situation that mirrors private practice with the inclusion of dental hygienists, dental assistants and specialty input.
2. The Evening Clinic provides dental services to an underserved population in the Washington, DC area. Dental students, dental hygiene students and AEGD residents work together to provide these services. Practice at the Spanish Catholic Center is an opportunity to treat patients from the local underserved community with the support of dental assistants, dental hygiene students, AEGD residents and HUCD faculty. Furthermore, the Center provides/promotes oral health screenings for dental caries and oral cancer through a variety of venues, such as health fairs and school screenings.
3. The Pediatric Dental Rotation for dental hygiene students at the HUCD and Prince Georges Primary Care Clinic provides training by residents, which increases the hygiene students' capacities to treat and serve the pediatric population and patients

with special health care needs for the overall purpose of reaching a minimum of 250 children in medically underserved communities.

4. The Howard University Healthcare at Coolidge High School in Washington, DC, (HUHC): The Colts Center is a school based health center. Working through a strong, visible, collaborative and effective effort, the goal is to improve access to health care and the overall health of Coolidge students and their children by using an IPEC focus on academics, youth development, family support, health and social services.

5. The Colgate Bright Smiles Bright Futures Van/Children's National Medical Center Van/Georgetown University Medical Van provides education, screenings and preventive services in an IPEC setting, using family nurse practitioners, dentists, dental hygienists and social workers.

Currently, the Advanced Education in General Dentistry (AEGD) residency training program at HUCD is initiating a IPEC with primary care medicine residents at Howard University Hospital to crosstrain dental and medical residents and allied health professionals in early detection of caries and preventive measures to implement to decrease its incidence and prevalence. Additionally, the Pediatric Dentistry residency training program at HUCD is implementing an IPEC with The Family Nurse Practitioner (FNP) program in the College of Nursing to provide joint training of FNP students and pediatric residents. The FNP will be trained to screen for oral diseases and the manifestation of major diseases during the assessment phase of treatment in a primary care setting.

URM Recruitment and Mentoring

HUCD-IC's existing recruitment program involves alumni in their private practices, public schools and undergraduate campus programs to recruit young students into the profession of dentistry and develop cultural sensitivity to the oral health needs of the underserved populations. Alumni are encouraged to contribute financial support to the college and to give back time as part-time faculty. Alumni volunteer to speak with and interact with current students to encourage academic careers. There is a plan to host an alumni event in concert with the HUCD annual Hancock Alumni meeting, a week-long dental hygiene externship program for high school students, and a one-day allied dental advisor's workshop for area high school counselors, community college and university advisors. Interchange of professional experiences can enhance recruitment of possible new faculty and highlight the academic career tract. Guest speakers will include leadership in organized dentistry and dental hygiene, former residents, dental and

dental hygiene alumni and students who are now involved in teaching in community dental settings to the underserved and vulnerable populations.

HUCD-IC has the ability to create academic partnerships with surrounding dental schools in Maryland (an academic partnership with the University of Maryland Master's in Public Health program offers a transition of faculty into advanced programs) and Virginia, located in the inner city to develop programs that promote the recruitment of URM students who live in these inner cities. These partnerships are designed to expose individuals to health careers with an emphasis on choosing a career as a dentist, dental hygienist or other allied dental health professional, such as dental assistant and dental laboratory technician.

HUCD-IC is well positioned to develop partnerships with the new allied dental models to include dental therapists and advanced dental and dental hygiene practice models.

HUCD-IC has the ability to provide leadership skills training for executive-level URM faculty, academic leadership and entrepreneurships through ADEA and collaborative efforts with other schools and colleges within the university, including the Leadership Academy Programs; the Center for Excellence in Teaching, Learning and Assessment Programs; the Business School Programs in entrepreneurial training; and the School of Communication, Radio and TV programs that service the Washington, DC metropolitan area.

Outreach Activities

HUCD leads organized focus groups that include educators, sociologists, psychologists and community leaders (e.g., religious and civic leaders, teachers) to discuss ideas and concerns that address the oral health needs of the underserved, underinsured and uninsured communities. The focus groups have allowed us to provide venues for access to care, uncover new and old methodologies that provide evidence to what worked and didn't work, and to help design approaches that modify social behavior patterns.

HUCD conducts activities with Howard's School of Social Work, School of Communication, the College of Medicine, the Howard University Hospital, and the College of Nursing, Pharmacy, and Allied Health to engender and create a collaborative team of experts that will provide assistance and support to secure the success of the program.

This work has led to:

- Organizing screening opportunities with the Colgate Van, District of Columbia Dental Society (Give Kids A Smile) and treatment referrals with the HUCD Pediatric Dental Clinic, Evening Clinic, private dental practitioners, and community health clinics.
- Increased participation in health fairs.
- Collaboration with the District of Columbia Dental Society and DC Public School System to develop a "Post Give Kids A Smile" treatment protocol for children in need of continued care following the annual Give Kids A Smile Day.
- Established relationship with Colts Wellness Center of Coolidge High School.
- Implement oral health program at newly established School-Based Health Center at Dunbar High School.
- Collaborate with the DC government to develop school-based dental clinics in elementary schools in those wards that need the most help.

Community Relations and Partnerships

The H.O.P.E. *Yes!* Program is in its third year, taking place in the orthodontic suite and focusing on mentoring youth toward careers in the health sciences. The Orthodontic Department hosts elementary, middle and high school students for the program. The orthodontic residents and faculty speak to the participants about mouth guards and sports safety, about study skills and taking tests, brushing with braces on and time management. The residents work closely with the dental, dental hygiene, pediatric dentistry, nursing, nutrition and SMDEP guest speakers, counseling the students, and going into the clinic working on different science modules together.

- Develop a model for access to care for the underserved.
- Utilizing the Interprofessional Educational Collaborative and partnership with the Colgate Mobile Dental Van.
- Students have planned and conducted outreach in Haiti and Jamaica.

Lessons Learned

The operation of the integrative center at Howard University is a unique model creating a synergy among the various factors necessary in reducing health disparities. The goal is to strengthen dental and allied dental's capacity to improve the health of families and communities by developing and implementing innovative academic/community practice models that use providers from different professional backgrounds in an IPEC setting.

The Department of Orthodontics is working to strengthen research efforts. These efforts include collaborations with the Montague Cobb Lab, the National Human Genome Center, and the Speech/Language Pathology Clinic, all housed on Howard University's Campus. Each orthodontic resident must write and defend a thesis, therefore, the department will have standing projects to be completed with the aforementioned entities.

HUCD-IC is forging relationships with the HU Hospital orthopedics and otolaryngology departments, and continued relations with pediatrics. An IPE course is being constructed to use the HU Health Science Simulation Center to bring together a cadre of health care professionals to accomplish collaborative, patient-centered care. These programs may include pediatric dentistry, oral and maxillofacial surgery and orthodontics, as well as, pharmacy, nursing, medicine, and other allied health professions.

Minnesota University

PROJECT SUMMARY

The University of Minnesota School of Dentistry (UMSD) established a program to address oral health disparities in vulnerable children and communities by bringing together academic dental health professionals with partners in their communities. UMSD sought to develop new, more diverse generations of allied dental health professionals prepared to meet the systemic, unmet need for dental care in the United States. One way UMSD aimed to improve oral health care was to increase the cadre of allied dental health professionals by:

a. Hiring a dental therapy faculty member on a permanent basis;
b. Creating and formalizing a mentoring program in the Department of Primary Dental Care; and
c. Identifying potential mentors as volunteers for the community-based organization Ready, Set, Smile that will serve as a project subcontractor and expand its services to Sojourner Truth Academy, a pre K-8th grade public elementary charter school in North Minneapolis serving 423 students.

We successfully hired a permanent minority dental therapy faculty member, Danae Seyffer, M.D.T., a Clinical Assistant Professor in the Division of Dental Therapy - Department of Primary Dental Care. To guide her into her new position, Karl Self, D.D.S., Associate Professor, Director, Division of Dental Therapy in the Department of Primary Dental Care, developed a professional development program. As part of the program, a mentor was assigned and an academic career planning guide was developed. Danae completed the guide and reviewed it with her mentor, Lisa Ahmann, dental hygiene faculty.

Meetings occurred to ensure that Danae was staying on task with her career goals and to discuss any issues and/or successes she encountered. Lisa sought out new opportunities for Danae that have not only helped her grow professionally, but also allowed her to become recognized as faculty within the school. The mentorship between Danae and Lisa is being used as a demonstration to show how our professional development program has been successful. We have passed on our professional development program to other divisions within the department to be implemented. Also, the school of dentistry is undergoing a strategic planning process, in which one area of focus is school-wide faculty and staff development.

Danae has assumed many new roles and responsibilities with guidance from Lisa since her mentorship began. She is now involved with the Clinical Affairs Committee, comprehensive care division meetings, and most recently became the course director of the pediatric dentistry course for dental hygiene students.

We've created academic partnership with community-based nonprofit organization Ready, Set, Smile and established a protocol for students to receive preventive school-based care. In the protocol, students with visible oral health care needs receive comprehensive care. Through this collaboration we promote charter school participation in a school-based dental program, we've partnered with the director of the Saturday Academy and the Summer Dental School Experience programs, and participate in college fairs and workshops to inform URM students, parents and families about our program.

The relationship with both the Saturday Academy and the Summer Dental School Experience program has been positive and will continue to grow. Karl and Danae are actively engaged as requested for various presentations and activities with the students, and we help recruit school of dentistry students to be mentors for the Saturday Academy. This past year, the mentors received a scholarship to help compensate for their time. To continue to provide this scholarship, we will need to seek more funding sources. Naty Lopez, Ph.D., Assistant Dean for Admissions and Diversity and Associate Professor Division of Dental Public Health-Department of Primary Dental Care, continues to actively search and apply for additional grants to help fund these programs. Current grant opportunities she has applied for include the Minnesota Department of Health Rural Dentistry, HRSA Rural Dentistry, and HRSA HCOP.

The partnership between Ready. Set. Smile. and the University of Minnesota will continue to grow. We will continue to be a resource for them while they are at Sojourner Truth Academy (STA). We will continue with our current activities; coordinating student volunteers and treatment of children from STA in our pediatric clinic. In the future we are going to expand our volunteer pool by involving the dental students. This will also help strengthen our goal of promoting team-based care. Also, more defined roles for each party will be obtained, as it will be necessary for smooth operation as our collaboration expands.

Program Goals

- Reduction of oral health disparities among children grades pre-K to 8th through targeted patient care, school-based preventative care and classroom oral health education.
- Engaged faculty members who are developing the skills to become respected educators and leaders within the institution.
- Established academic partnerships to recruit URM students and faculty to bolster the cadre of allied dental health professionals and increase faculty diversity.
- Evidence-based dental education program implemented.
- Parents informed of participation requirements of school-based oral health program and universal protocols for students to receive comprehensive care.
- Dissemination process of knowledge of school-based oral health care programs is established.
- Use of professional development program for URM is evident in the Department of Primary Dental Care.
- Educate URM students regarding allied dental professions opportunities.
- Development of leadership skills in URM student mentors.
- Parents and families are knowledgeable about allied dental professions opportunities

Allied Dental Professional Development

Continual professional development is a priority for us. The school of dentistry has given its full support for the Division of Dental Therapy to use their grant writer, Judy Fox. One challenge has been identifying grant money and although we do have more resources available to us now, it has taken longer than anticipated. We have and will continue to discuss options with Judy about grant funding opportunities that will help Danae grow professionally. We are hopeful that we will identify a grant opportunity soon. When looking for sustainable funding for continued professional development, we are proposing to address the following:

    a) Increasing oral health literacy through classroom education;
    b) Reducing decay rate in students who receive preventive services;
    c) Disseminating knowledge of school-based oral health care programs in the community;
    d) Increasing accessibility of low-income children to the University of Minnesota Pediatric Dental Clinic;

e) Enhancing leadership development of faculty;

f) Strengthening faculty development, mentoring and advancement;

g) Increasing minority students and faculty members in the dental professions;

h) Increasing cultural competency;

i) Engaging URM families, parents and communities.

Outreach Activities

We are currently partnering with a nonprofit organization, Ready. Set. Smile. They served as a subcontractor to the school of dentistry during this grant. This partnership was essential for establishing a continuum of comprehensive care for underserved children in the targeted schools through community-based and academic partnerships to reduce oral health disparities.

We are currently collecting and organizing the raw data from our activities. Information collected from Ready, Set, Smile during screenings was sent directly to the New England Surveillance System, who then reported back to them with the raw data. Initial screening data has shown an increase of children with no visible suspect caries between the fall 2014 and spring 2015 screenings. The number rose from 34% to 48%. Children with urgent visible needs decreased from 50% to 41% and children with nonurgent visible suspect caries decreased from 16% to 11%. After receiving feedback, seven out of the original 20 participants for the Saturday Academy are interested in pursuing dental careers. One of those seven is interested in becoming a dental therapist. This is a great achievement as we aim to increase the number of minority students and faculty.

Community Relations and Partnerships

To create a more diverse group of allied dental care providers in the future, we partnered with Dr. Lopez, who oversees two pipeline programs, the Saturday Academy and Summer Dental School Experience. These programs are designed for minority and disadvantaged high school and college students who express interest in dental professions. Karl offered his expertise to the students by talking to them about oral health disparities and the different dental professions. Danae interacted with the students several times and also helped supervise them while they performed dental screenings at the Hmong Market for their health disparities research project. As part of the Saturday Academy, we also established and implemented a mentor scholarship program consisting of dental, dental therapy and dental hygiene students. This program

has been very successful and the students really enjoy their time in the program. Here is a reflection from one of our previous students:

"HCOP was such a vital experience for me. The program instilled a deep passion in me and gave me the focus and direction that I needed. The program exposed me further to the field of dentistry that needed most care and the amount of people who face unfortunate barriers that are in need of someone who cares for them and understands. It showed me the shoes that I wanted to fill in the future as a dentist and gave me purpose."

Danae worked closely with Ready, Set, Smile to coordinate student volunteers while they conducted screenings, taught lesson plans and completed dental services for the children at Sojourner Truth Academy (STA). Since Ready, Set, Smile only provides preventive and educational services at this time, a clinic referral list was created to give to the parents/legal guardians. Ready, Set, Smile and we wanted to take this one step further and find a way to bring the children directly to the UMN pediatric clinic to eliminate a couple barriers to care: transportation and time. STA supported us by allowing the children to go to their appointments during school hours, with the consent of their parent/legal guardian. A relationship was established with Naty Lopez, the Assistant Dean for Admissions and Diversity and Director of Saturday Academy for high school students and Summer Dental School Experience program for college students. Student mentors have been identified and include one dental student, two dental therapy students and two dental hygiene students. These mentors will engage with the participants of these programs.

<u>Saturday Academy:</u> 20 students have been recruited and some are part of the leadership program at the Brian Coyle Center within the Somali community.

<u>Summer Dental Program</u>:

    a) Each summer, students from rural communities and underrepresented populations are selected to participate.

    b) In 2015, Karl Self met with the students on multiple occasions and presented on the topics of access to care/health disparities and midlevel dental health providers.

    c) In 2015, Danae supervised the students while they provided oral health screenings at the Hmong Market in St. Paul. Other screenings were completed at the Hispanic Market and Somali Market, both located in Minneapolis.

Lessons Learned

A few challenges we encountered were how to obtain consent for treatment without a parent/legal guardian present, getting documents translated into Spanish, and how to transport the children. Danae worked with our Associate Dean for Clinical Affairs, Pediatric Predoctoral Director, attorney, STA and Ready, Set, Smile to develop a protocol for treatment without a parent/legal guardian and the forms that would be used. Bringing the children to the UMN to receive care was not part of our original plan and funding was not allocated for translation of documents and transportation. With the financial support from clinical affairs we were able to get the necessary documents translated into Spanish. We received support from Medica to help transport the children to the UMN pediatric clinic. Although it had been challenging arranging everything for this to happen, it has been very rewarding as we have been able to see 10 children in our pediatric clinic so far.

Institutional Culture and Leadership

Dean Assael met with the executive leadership team and faculty consultative committee to change the "diversity committee" from ad hoc to a standing committee. We also recently sent six people to a workshop, Searching for Excellence and Diversity, a workshop for current and future search committee members.

The UMN Pediatric Dental Clinic played a vital role in ensuring that the children from STA receive the care they need. To date, 10 children have come to our clinic. Three have completed treatment and are now caries/pain free, two are still receiving care, one was seen only for emergency treatment and has a regular dentist elsewhere, and four children needed to be referred to the Resident Pediatric Clinic due to complex medical needs, behavior, or extent of treatment needs.

Ready, Set, Smile is analyzing the 3rd and 6th grade pre- and posttests that were given to determine the change in oral health literacy among these students. A spring post-exposure survey on attitudes toward health care was recently administered to the students and the results need to be examined and compared with the pre-exposure results. Also, student reflection papers are being examined to look for common themes among the students.

Environmental/Challenges/Opportunities:

The school of dentistry has been very supportive of this grant, helping its success. One example of their support occurred in Karl's absence earlier this year. Sheila Riggs, the

Chair of the Department of Primary Dental Care, stepped up and offered to be our lead while he was away. Sheila would often check in with Danae to see if there was anything she needed and offered guidance when needed.

Our partnership with Ready, Set, Smile was successful due to the great relationship that was created. Our organizations worked very well together and shared a common goal: to reduce oral health disparities among children. We supported each other's ideas, creating a stronger program than we ever anticipated. We learned quickly that we needed to be flexible as unforeseen schedule changes occurred occasionally.

Despite some challenges that we encountered during the past year, we did not let them get in our way. With each challenge, we took it as an opportunity to take a step back and to look at things from a different angle. This helped us keep our creative mindset as we problem solved. With additional grant funding we are going to pursue additional opportunities to help Danae with her professional development. The direction in which we move forward depends on the type of grant funding obtained. Some areas of interest are research, further studies in education and additional scholarly activities.

Lisa, along with other faculty members, will frequently evaluate Danae's current roles and provide feedback to ensure she is on the correct track. As new opportunities become available, we will continue to allow Danae to expand her function within the school. Mentorship between Danae and Lisa will be maintained as she continues her growth and responsibilities as a faculty member. In the future to help coordinate better, mentoring times will be decided well in advanced since both schedules are often busy.

Additional activities going forward will include:

a) Calibration training for allied dental health students and faculty by Ready, Set, Smile staff.
b) Weekly communication between project coordinators for each organization.
c) Establish consistent participation of university students.
d) Connect with school of dentistry recruitment and career events to ensure allied dental programs are promoted to minority students.
e) Connect with newly created pipeline programs such as the Saturday Academy and Summer Dental Schoo Experience.
f) Identify existing school of dentistry URM students as mentors.
g) Recruit URM students into the ADEA student group to promote career as an educator.

h) Connect the Women Faculty in Dentistry group as mentors for the student group Women in Dentistry Association and encourage participation by minorities in both groups.

i) Using best practices, identify important components of a professional development program.

j) Incorporate into school-wide faculty development program.

The University of Oklahoma

PROJECT SUMMARY

The considerable impact of faculty development activities on the ability of URM and allied dental faculty to grow not only as programmatic leaders but as effective academicians cannot be overemphasized. Dental faculty who participated in the Faculty Leadership Program in particular are actively working with the Vice Provost to facilitate the more systematic availability of mentoring and appropriate training opportunities for all faculty within the College of Dentistry. University of Oklahoma College of Dentistry (OU COD) faculty will also be strongly and routinely encouraged to participate in the development and training programming available to all faculty on campus.

The OU COD emphasized three major activity areas during Phase III of the MDFD grant cycle: a) URM and Allied dental faculty development, b) cultural competency training for students and c) outreach to underserved areas. A brief description of activities undertaken in each of these areas is provided below, along with information on challenges faced and lessons learned.

URM and Allied Dental Faculty Development

The development of URM and allied dental faculty as innovators and leaders in higher education is critical to positioning them as change agents. These faculty must be uniquely prepared and qualified to have a positive impact on the educational process for ALL students, not just URM and allied dental students, if they're to be taken seriously as change agents, particularly for issues related to diversity and inclusion. Therefore, we strongly encouraged and supported URM and allied dental faculty participation in a wide range of outstanding faculty development and training opportunities routinely available to all faculty in every college on our campus. These included the following:

Ed Tech Tuesdays—a pilot program of the Department of Academic Technology, held the second Tuesday of each month, which introduces OUHSC faculty and staff to tools for effective teaching and learning using educational technology resources.

Education Grand Rounds—a monthly series of interactive sessions that present faculty, staff, fellows and graduate students with a variety of evidence-based strategies to enhance student mastery.

Educators for Excellence—a special project within the Office of Academic Affairs and Faculty Development that engages faculty in continuing professional development activities focused on sustaining and enhancing educational excellence.

Read & Lead Book Club—an opportunity for faculty to interact with students and staff from across our campus while discussing books focused on leadership or personal insight.

Our URM faculty were consistently in attendance for those training opportunities and benefitted greatly from their experiences. A major bonus was the additional exposure they received among faculty and administrators from other colleges across campus, and the new professional relationships developed with faculty from other disciplines. As a result, several opportunities now exist to collaborate with faculty from other colleges on academic research projects, especially ones that relate to interprofessional educational opportunities for students. The visibility and leadership development aspects of this training has also resulted in URM faculty being consistently viewed and tapped by various community partners from across the Oklahoma City area and the State of Oklahoma as the "go-to" person for dental community outreach, access to care and policy development activities.

Of particular importance to our grant activities was the involvement of two URM faculty and one dental hygiene faculty member in the 2014–2015 OUHSC Faculty Leadership Program. This program provided 11 months of integrated, day-long seminars for 14 faculty fellows from across our campus that focused on knowledge, skill building and leadership information for the teaching, scholarship and service roles of an academic health center. The FLP provided our OU COD fellows and their comrades with a structured approach to acquiring and applying new skills while refining existing ones, all of which better prepared them to engage as strong academic team members and flourish in a variety of leadership roles. Topics addressed during the FLP included:

- Time Management
- Development of Teaching Philosophies, Goals and Objectives
- Preparation of the Individual Faculty Career Development Portfolio
- Alignment of Personal Goals with the Teaching, Research and Service Missions of an Academic Health Center
- Development and Implementation of Scholarly Research Projects
- Instructional Design and Teaching Fluency
- Presentation Skills
- Working With the Media

Our dental faculty fellows and their coworkers graduated from the FLP during its 25th Anniversary Celebration held on June 11, 2015.

URM faculty memberships in a variety of professional organizations were supported with MDFD grant funding, including from ADEA, ODHA, OPHA, OPA and NNOHA.

Travel to the ADEA Annual Session & Exhibition for three faculty members was also supported by our MDFD grant. For two of them, this was their first opportunity to attend an ADEA annual session, and they found the informational and training sessions to be highly beneficial. Two of the three attendees also participated in a "post-ADEA debriefing" at OU COD in which all 10 faculty and administrators who attended the annual session met with the new dean to identify best practices to be adopted and/or adapted at OU COD. The planning and implementation process for this effort is ongoing, and it provides an outstanding opportunity for URM and allied dental faculty to impact strategic direction as well as day to day operations at the college.

Cultural Competency Training:

URM faculty at OU COD reviewed a wide range of cultural competency training resources for use with our dental and dental hygiene students. This is particularly important due to the college's increased emphasis on placing students in community-based settings for externship rotations, a practice that ultimately requires students to interact effectively with patients and other health care providers from a variety of ethnic, cultural and socioeconomic backgrounds.

We ultimately decided to make the HRSA-sponsored "Effective Communications Tools for Health Care Professionals" modules available to our students in the self-paced, online format. This training will begin in the fall 2015 semester, and will be required of all 60 students in our senior class. Initial implementation targeted for spring and/or summer 2015 with only a subset of senior students was postponed to allow for a smoother overall transition into the CBDE program.

Outreach Activities

OU COD has encouraged, maintained and supported a strong commitment among faculty, students and staff to engage in community outreach and professional service to Oklahoma's most vulnerable and underserved populations. Resources made available through the MDFD Phase III grant allowed us to add more structure to that effort among our students in particular, while positioning URM faculty in our department as the students' faculty resource person of choice. All total, more than 500 children were served through various student-led community outreach projects during the grant year, including the Oklahoma Mission of Mercy (February 2015 in Tulsa, OK; ~ 30 children

served); Give Kids a Smile Day (March 2015 in OKC; ~120 children served) and a series of School-Based Oral Health Fairs (November 2014–May 2015; ~350 children served). With each of these events, our students developed and implemented several interactive Oral Hygiene Stations for school-aged children that taught tooth brushing, flossing and healthy diet choices in a fun and engaging manner. At the Kids Day and school-based events in particular, more than a dozen predental students from several different area colleges also served alongside our dental students and faculty as volunteers, giving them a better picture of life as a dental student, and better positioning them for the application and interview processes.

The new pilot program in community-based dental education was launched in January 2015 with 21 students being deployed for two-week externship rotations that spanned almost the entire semester at two pilot sites. More than 850 individual patient procedures were recorded, and the estimated value of the care provided was ~$55,443 for those two sites alone. The remaining 39 students in the senior class were deployed at various times for two-week rotations at another 15 externship sites, and recorded more than 1,500 procedures. All patient visits, demographic data, treatment data, including diagnosis codes and treatment codes were captured using the eCLAS cloud-based clinical reporting system. Resources made available through the MDFD Phase III grant made full implementation of this data collection effort possible.

The CBDE project has undergone full implementation as of June 1, 2015 with 12 students participating in summer externship rotations and the remaining 48 students scheduled for deployment beginning with the fall semester. The overall goal is to have each student complete a series of externship rotations in community sites, ultimately doubling the time they have spent in previous years of the program serving patients in underserved communities. Program evaluation efforts will measure 1) the impact on students' development of clinical skills, and 2) the impact on access to care from both short-term and long-term perspectives. It is hypothesized that students who have extended, high-quality externship experiences in community settings will choose to practice and/or volunteer in similar settings in greater numbers upon graduation. This is of particular importance due to the oral health workforce shortages that exist in many communities across Oklahoma.

As noted above, outcomes for our student-led community-outreach efforts resulted in more than 500 children being served throughout the year. With respect to our Community Based Dental Education program, more than 2,300 patient procedures were completed by dental students on externship rotations during the spring 2015 semester.

Community Relations and Partnerships

The development of new collaborative partnerships and the strengthening and expansion of existing ones were critical elements in the successful completion of grant activities. For example, OU COD has enjoyed strong, long-standing partnerships with the Oklahoma Dental Foundation and the Delta Dental Oral Health Foundation. Over the last year, those partnerships have been strengthened significantly, at least in part as URM faculty in our department have worked on a number of access-to-care initiatives such as the Oklahoma Oral Health Coalition and the Tulsa Oral Health Safety Net Commission alongside staff from those two entities. These strengthened relationships have led to more frequent opportunities for our dental students to provide care to the underserved. Our CBDE program now sends dental students on rotations routinely with the Mobile Smiles Unit. And thanks to incredible leadership provided by our new Dean, Dr. Cohlmia, the Delta Dental Foundation just recently approved $80,000 in funding to support our CBDE program.

Our ever-growing partnership with the OUHSC Office of Community Partnerships and Health Policy resulted in a new, week-long Summer Dental Enrichment Program for rising high school seniors, held the week of June 1–5. This inaugural program offered a combination of lectures, clinical observations, hands-on activities and student research projects and presentations, all designed to enhance the students' knowledge regarding dental education and the profession of dentistry. Ten high school seniors, all of whom had expressed at least a moderate interest in dentistry, joined us for the program. Two college-aged mentors were embedded with the participants all week, and four of our 4th-year dental students assisted with hands-on clinical activities as well. By the end of the week, at least three of the high school students plus one of their mentors seemed especially interested in pursuing a dental career. The students were encouraged to remember what they learned about oral health and access to care issues, no matter what career they ultimately choose to pursue.

One of our newest partnerships is with the Oklahoma Caring Foundation, a nonprofit arm of Blue Cross-Blue Shield. They have historically provided preventive medical services such as immunizations and BMI testing for school children by sending Caring Vans into underserved areas across the state. They are working with us now to develop a Dental Caring Van, which they will provide to OU COD at no cost. It will be used primarily for outreach by dental hygiene students to provide preventive clinical services such as screenings, fluoride varnish and sealants. The cargo van has already been purchased, is in the conversion process, and will ultimately have a fully functional pedo

dental operatory on board! Contracts are being finalized, policies and procedures are being developed, and the van's first actual deployment is anticipated during the fall 2015 semester. The availability of this resource is especially exciting since OU COD has distance sites associated with our dental hygiene program at technology centers in several different parts of the state. These resources may also facilitate the development of a statewide sealant program, which has been a goal for some time.

Lessons Learned

A major challenge has been carving out the time for departmental faculty to visit different colleges of dentistry across the country to gather first-hand information about innovative CBDE and outreach programming. This resulted from the need to absorb/reassign coordination of our standard Senior Externship Program following the March 2015 resignation of our Externship Director, at a time with the CBDE Pilot was also being launched. We are particularly interested in visiting programs with noteworthy community-based extramural rotation programs, as well as those with strong interprofessional educational experiences. We anticipate completing visits to sites in North Carolina, Arizona and Missouri over the next several months.

A significant lack of diversity still exists within the dental and allied dental student populations at OU COD. While the new administration has consistently voiced a commitment to increase student diversity, any real growth in this area will require the acquisition of new resources (e.g., funding for URM pipeline programs, scholarships and specialized student support services) that are not currently available for these purposes. The political climate in Oklahoma is generally not conducive or supportive for reallocating any existing resources for diversity-related purposes, so great creativity and persistence will be required to effect meaningful change.

On another positive note, as of June 1, the OUHSC campus has a new provost who has also voiced a significant commitment to addressing diversity issues in a meaningful way. Any progress to be made in this area will require strong leadership from the provost's office as well as our dean, that makes a clear case for the benefits that accrue to all interested parties when diversity is embraced and encouraged (e.g., enhanced, well-rounded educational experiences for students, increased access to care and more effective treatment for the underserved, etc.). Cultural competency training for all of our students will remain a high priority activity for OU COD as we seek to increase diversity among the next generation of dental professionals. Program evaluation efforts will focus

on the impact of these training efforts on the ability of all students to interact effectively with patients and health professions colleagues from different walks of life.

The future for professional development among allied dental faculty at OU COD is relatively bright due to the breadth and depth of resources that are widely available on our campus. The OUHSC Office of Academic Affairs and Faculty Development is to be highly commended for the excellent campus-wide programming they facilitate on an ongoing basis. However, major limiting factors are 1) faculty shortages at OU COD tend to overburden existing faculty with day-to-day and special project responsibilities that limit their availability for participation in campus-wide professional development activities, and 2) the lack of faculty development programming made available specifically within OU COD, particularly for junior faculty who may be outstanding clinicians, but who are new to the academic environment. New leadership at OU COD seems to be attuned to these issues and has articulated a commitment to making progress in these areas.

At the same time, the number of URM dental and allied dental faculty at OU COD remains very small, despite several new hires over the last two years. The dental hygiene faculty has only one part-time URM clinical instructor, and despite an articulated desire and grant-funded efforts to increase her FTEs and involve her in classroom instruction, no commitments are in place to actualize those goals following the expiration of grant funding.

The Summer Dental Enrichment Program will certainly continue going forward, with a goal of securing stable, follow-on funding directly from OU COD, the OUHSC Office of Community Partnerships or directly from the OUHSC provost's office. The Office of Community Partnerships is actively pursuing major grant funding for a health sciences pipeline initiative that incorporates a dental component. The dissemination of narrative reports, videos, program evaluation data and other descriptions of the summer program's initial success will be critical to solicitation of subsequent funding.

Addendum: The Value of the Institutional Site Visits in the ADEA Minority Dental Faculty Development Program

The American Dental Education Association (ADEA) Minority Dental Faculty Development (ADEA MDFD) program, supported in part by a grant from the W. K. Kellogg Foundation, was developed to promote health systems change that is focused on primary care, prevention and public health by building networks of educational institutions and other organizations focused on developing health leadership within the faculty of U.S. dental schools. The ADEA MDFD grant funds were used primarily to support direct educational costs for underrepresented minority and low-income dentists who are being recruited to faculty positions that will help promote health systems change. ADEA had the responsibility for distribution of the ADEA MDFD funding to the grantee schools, oversight, assessment, and reporting progress and outcomes of the grant. The grantees supplemented the grant funds through their own program allocations to support faculty and related operating expenses.

ADEA MDFD grants were awarded to 10 U.S. dental schools and one advanced dental education program over a six-year period, 2004–2010. Seven awards of $255,000 each were made to six individual dental schools and one consortium of dental schools in New York. These were the University of Oklahoma College of Dentistry; University of Michigan School of Dentistry; University of Alabama School of Dentistry; Howard University College of Dentistry; Texas A&M University System Baylor College of Dentistry; University of Illinois at Chicago College of Dentistry; and the New York State Academic Dental Centers that includes New York University, Columbia University, State University of New York at Buffalo, State University of New York at Stony Brook, and the University of Rochester Eastman Dental Center. The seven grantees were chosen for their unique capacities to implement the ADEA MDFD grant objectives, and to leverage resources that would support an infrastructure for sustainability of diversity-related outcomes and programs in the future.

The seven grantee institutions now serve as models for other health professions institutions as they accept the continuing challenge to increase diversity in the health workforce and improving care to underserved communities. A "grow your own" philosophy for the recruitment and advancement of a diverse faculty prevailed throughout the grantee schools. Through innovation, commitment and enthusiasm, the ADEA MDFD grant program and its grantees, individually and collectively, have produced a whole that is greater than the sum of its parts.

Now, what has institutional site visits got to do with it?

The site visits were designed to get an overview of the status of what was being done to meet grant criteria and objectives and, more importantly, to obtain information as to what's working, why is it working, what still needs to be done to achieve or improve intended results, and what needs to be shared with others. There are three areas where the site visits, in and of themselves, contributed to the whole of these grants.

Program integration: Efforts to increase minority student and faculty representation cannot be successful in relative isolation from the overall operation of the parent institution and dental school. These programs must be vertically integrated into the mission, goals and activities of the parent institution and well integrated horizontally into the mission, goals and activities of the dental school: everything from K through 12 health careers awareness, preparedness and development programs to working with college career counselors; from minority student recruitment programs to dental school admission policies; from mentoring in attaining clinical knowledge and skills for clinical practice; to providing mentoring and opportunities in teaching and research that can promote early awareness and interest in careers in academia.

The way the site visits were structured, these vertical and horizontal integrations had to be addressed during the site visits. As grantees prepared for the site visits and in the conduct of the site visits, all of the related parts had to be brought together and reviewed. Together, this process gave emphasis to the importance of these integrations to the success of the ADEA MDFD grant program. In preparing for the site visits, these integrated parts were reinforced and individuals could see that they were essential parts of the whole. Again, successful minority development programs must be well integrated into the operations of the school. The site visits helped emphasize this. In implementing and maintaining ADEA MDFD efforts, schools will need to hold their own periodic internal site visits and evaluations to continually underscore how these integrated parts contribute to the success of the whole.

Sharing information: Reviewing the original grant application evaluation criteria, it becomes obvious that the intent is more than just developing and producing a few more minority faculty with these grant funds. The evaluation criteria were process oriented, related to faculty mentoring, academic partnerships, training opportunities, community projects and practice, and institutional culture and leadership. The structure of the site visits also focused on these evaluation criteria; and so did the self-assessment logic model evaluation framework that was employed throughout the grant project period. Again, the site visits were structured to obtain information not just on the number of individuals who might be receiving grant support and how funds were being expended, but on processes

essential to growing one's own minority faculty. Again, an overall objective of the site visits was to obtain information on what's working in meeting the grant criteria and objectives, why is it working, and what still needs to be done to achieve or improve intended results.

Preparing for the site visits and completing the logic models around the criteria areas has produced intended results. The amount of useful descriptive information that has come in through the site visits and logic models has been overwhelming; information such as institutional strategic plans regarding minority enrollments and faculty development, program visibility efforts to promote minority programs, innovative partnerships, curriculum changes, mentoring, student recruitment activities and admission policies, teaching and research opportunities, funding arrangements, leadership development, institutional commitment, and best practices.

The information resulting from the ADEA MDFD grants has produced a whole greater than the sum of its parts. The challenge is how to organize all of the information and usefully prepare it for sharing with others.

It's not enough to share within the ADEA MDFD grantees and grant program administrators. Efforts must include dissemination and share findings, processes and best practices with other schools. That is an original intent of the grant program: that the grantees would serve as academic models useful in improving minority representation in dental school faculties and useful also in addressing vacancies in faculty positions.

ADEA already has been disseminating ADEA MDFD information through symposiums at its annual sessions and fall meetings. There was an article by Jeanne Sinkford and Joseph West in the June 2009 issue of the *Journal of Dental Education*: Modeling Mentoring: Early Lessons from the MDFD Program. A Best Practices Manual is being developed. An ADEA MDFD capstone meeting was held just prior to the 2010 ADEA Annual Session & Exhibition as part of ongoing efforts to disseminate the experiences and findings of the ADEA MDFD grantees. As the ADEA MDFD grant program ends, grantees will be preparing to disseminate their own results and best practices.

Enthusiasm: Site visits usually produce at least a little anxiety. A little anxiety in most situations is usually good. It can be a positive stimulus. For these site visits, if there was a little anxiety, it was well hidden. What was most evident were enthusiasm, pride, and commitment. These were evident by site visit participants at all levels; particularly by principle investigators, faculty mentors, both pre- and postdoctoral students and individuals being supported by the ADEA MDFD grant.

Did the site visits create the enthusiasm, pride, and commitment? Not really. These came from within the grantees. But the site visits did create opportunities for individuals to express their enthusiasm, pride and commitment in what they were doing, with the result that the ADEA MDFD whole, again, became greater than the sum of its parts. The job now is to sustain the enthusiasm, pride and commitment that have been created by the ADEA MDFD grant program.

The site visits also created opportunities to extend recognition to individuals conducting and participating in the ADEA MDFD program, by having them involved in the site visit. Too often, "rewards for a job well done" is little more than a personal self-satisfaction. But to receive some external recognition contributes to one's own enthusiasm, pride and commitment to the job. As part of program initiation, conduct and sustainability, specific and continuing attention must be given to recognizing the efforts and accomplishments of individuals who conduct and participate in programs designed to increase minority representation in dental school applicants, enrollments and faculties.

ADEA has given priority to improving minority representation in dental education for the last 20 years; it remains a priority and requires continuous commitment. A review of the last five years of data ADEA has on faculty diversity (2004–2008), collected from its annual survey of dental school faculties, provides a trends picture of the race/ethnicity of dental school faculties. The picture is not too good. Native American faculty representation has remained unchanged at 0.3% of dental school faculties.

Asian faculty representation has slightly increased from 10.5% to 11.4%. Black/African American faculty representation has declined from 4.0% to 3.5%. Hispanic/Latino faculty representation has slightly increased from 5.1% to 5.5%.

Minority Dental Faculty Development programs must continue with enthusiasm, pride and commitment. A best-selling book a couple of years ago was Malcolm Gladwell's book *The Tipping Point*. A major chapter of the book was entitled the "Law of the Few." To paraphrase that chapter in a sentence, "Social epidemics are driven by the efforts of a handful of exceptional people."

The faculty data show much to be done, but with these ADEA MDFD grantees, we have had a handful of exceptional people with enthusiasm and commitment to creating a potential tipping point in improving the diversity of our dental school faculties. Efforts now must focus on disseminating their results, expanding participation and commitment, and turning a potential tipping point into a reality point for improving the diversity of our dental school faculties.

CHAPTER 3: COMMUNITY OUTREACH

Community Outreach

University of Illinois at Chicago College of Dentistry

Darryl D. Pendleton, D.M.D., Associate Dean for Student and Diversity Affairs and Director of the Urban Health Program

Caswell A. Evans, D.D.S, M.P.H., Associate Dean for Prevention and Public Health Sciences

The University of Illinois at Chicago College of Dentistry (UIC COD) Minority Dental Faculty Development (MDFD) has been very successful in assisting the college in attracting and developing underrepresentative minority (URM) faculty, residents and students. The success of the initial ADEA grant has enabled the college to leverage additional state and college support for URM faculty development through the COD Urban Health Program (UHP). With the support of the College and University, the MDFD is now a funded program of the COD UHP.

The goal of the MDFD program is to increase and retain minority faculty through networking, mentoring, research opportunities and skills-building with a long-term goal of directly improving oral health care at both the institutional and state levels. This is accomplished by developing faculty candidates from predoctoral and postdoctoral URM students enrolled in the UIC COD and Chicago area training programs, and by developing and retaining URM junior and adjunct faculty members at UIC and other universities. To accomplish our MDFD strategic goals, listed below are specific objectives to be accomplished:

Objective 1: To establish an advisory committee to oversee the administration of the program and develop policies and procedures.

The UIC COD Office of Student and Diversity Affairs (OSDA) oversees the development and implementation of the MDFD program. The OSDA coordinates the program in collaboration with other URM initiatives that include student recruitment and retention programming, such as the UHP, cultural competency training, the COD Diversity Advisory Committee and the UIC minority faculty recruitment and retention activities. Collaborating with these initiatives enables the COD to maximize our URM resources and integrate our initiatives and goals into the long-term fiscal and programmatic plans of the OSDA.

Dr. Darryl Pendleton, Associate Dean for Student and Diversity Affairs, serves as the Program Director of the MDFD and is responsible for the overall administration and oversight of the program. An ad hoc MDFD Advisory Committee was established to assist with the development and implementation of the program. The committee consists of the MDFD Program Director (who is the Associate Dean for Academic Affairs), the Director of Faculty Affairs and the Associate Dean for Research.

Objective 2: To develop a formal faculty mentoring program.

The MDFD program coordinates mentoring for our faculty, residents and dental student participants. To assist with faculty mentoring, the MDFD program collaborates with the UIC Office of Faculty Affairs. The UIC Office of Faculty Affairs is responsible for a university-wide minority faculty development program that includes mentoring and professional development resources. Collaborating with the Office of Faculty Affairs allows the MDFD program to develop a more comprehensive mentoring approach with a wider range of services and opportunities available for COD faculty.

To ensure mentoring for residents and dental students, each URM student, is eligible and encouraged to participate in the MDFD program. A student is assigned a senior faculty mentor and/or a nonfaculty mentor. Together, students and their mentors engage in a variety of mentoring and professional development activities. These activities include research, course design and implementation, and professional dental association activities. In addition, the students are also encouraged to seek and participate in mentoring opportunities outside of program. To facilitate this, the MDFD program supports the students' participation in professional dental organizations and attendance at local and national meetings.

Objective 3: Developing academic partnerships to facilitate the training of program participants.

The MDFD program established successful collaborative partnerships with the COD Office of Academic Affairs and Graduate Dental Education, which oversees the graduate programs and faculty development initiatives, respectively, and the COD Advanced Dental Education Training Specialty Programs. The collaborative effort of these partnerships is one of the reasons for the increase in URM faculty. Many residents who participated in the MDFD program are now UIC COD faculty. In addition, there has been an increase in URM graduate student enrollment and junior faculty hires since the inception of the program in the UIC COD clinical departments. Furthermore, collaboration with other dental schools enabled a URM pediatric dentistry junior faculty

member from Indiana University School of Dentistry to participate in the ADEA MDFD program.

Objective 4: Identifying and facilitating research opportunities for program participants.

All MDFD program participants are encouraged to develop and focus on an area of research concentration. To facilitate this, the MDFD program collaborates with the UIC COD Office of Research to support MDFD participants with their research. The support varied based on the participants' research interests and career goals. Many MDFD program participants have had the opportunity to present their research at local and national meetings.

Objective 5: Identify, develop and coordinate community-based training opportunities.

Through the initial assistance of the Robert Wood Johnson Dental Pipeline Program and subsequent assistance of the Illinois Children's Healthcare Foundation, the UIC COD identified and developed community-based service-learning sites through which senior (or D4) students rotate. The D.M.D. curriculum has undergone major revision, enabling D4 students to spend more time in these community-based sites. As result, there are also more opportunities for College faculty to participate in community-based experiences. In addition, community-based practitioners are being credentialed as adjunct faculty to provide oversight and mentoring for D4 students when they are on rotation.

Objective 6: Develop a process to identify and recruit participants for the program.

Candidates for the MDFD program are identified and selected from four groups: current dental students, graduate students, current junior faculty and members of the practicing community. All current URM faculty at the UIC COD regardless of rank, as well as a URM pediatric dentistry junior faculty from Indiana University School of Dentistry, were eligible to participate in ADEA MDFD program activities.

All UIC COD URM dental students were informed about the program through one-on-one contact and group presentations. The OSDA has regular contact with all predoctoral URM students and attends monthly meetings of the Student National Dental Association (SNDA) and Hispanic Student Dental Association (HSDA). The faculty advisors for SNDA and HSDA are also participants in the MDFD program. Information regarding academic and research career opportunities is provided to students and integrated into all recruitment activities.

All URM students enrolled in the college postgraduate programs are informed of the program and are eligible to participate. Through the MDFD program, the graduate students have access to resources and services designed to assist with their professional development. These services include career planning, research support, participation in organized dental activities and mentoring support.

All URM faculty members are informed of their eligibility to participate in the MDFD program via emails. Since the inception of the MDFD, the number of URM faculty at the COD has doubled. Our initial plan was to implement the program for faculty through an individualized one-on-one approach. The steady increase in the number of COD URM faculty requires that the MDFD revise this strategy to address the developmental needs of an increasing number of participants.

With assistance from the RWJF Dental Pipeline Program and the COD Extramural Education Program, the UIC COD is currently using community-based training sites and preceptors. Many of the sites identified employ URM dentists. If the sites are selected as training sites, the dentists at these sites will have the opportunity to be members of the UIC COD adjunct faculty. In addition, the MDFD partnership with the UIC COD Office of Dental Education has resulted in URM faculty recruitment becoming a priority of the college.

Objective 7: Design and implement individualized career development plans for each participant in the program.

Due to the increase of participants in the MDFD program, it was necessary to make some modification to the program component. Initially, the MDFD program made an effort to design specific programming for each candidate selected to participate. The proposal was to use "career development plans" to accomplish this. The proposal worked well during the first two years of the MDFD program, when there were few faculty and residents at the college. However, during the next four years, we experienced historical increases in URM students, residents and faculty with similar development needs and interests who were attracted to the college because of our initiative in targeting URM via the MDFD program.

We were able to institute a partnership with the UIC Faculty Mentoring Program and the COD's Office of Faculty Affairs whereby we collaborated in a "brown bag" workshop approach that emphasizes and supports mentoring. The partnerships have enabled the program to connect the UIC COD URM faculty with university and college faculty development resources and services. In response to all of this, we are now usng both

"group" and "individualized" approaches to assist our participants with developing the skills and knowledge necessary for careers in academia or research. Our approach concentrates on four core training areas: mentoring, professional development, training and research.

The MDFD program hosts a series of regular meetings for the entire URM UIC COD faculty. The purpose of these meetings is to serve as a forum for the presentation and discussion of information regarding faculty development. Guest speakers have been invited to present at the meetings as well such as University's Vice Provost of Faculty Affairs, the Director of the University's Office of Women's Affairs, the author of the COD Promotion and Tenure Guidelines, a mentoring expert and others. The officers of the minority student organizations have also attended the meetings to provide an update on student activities.

In addition, all dental student participants are required to participate in a similar series of regular meetings, which serves as a forum for presentation and discussion of information regarding academic and research careers. Guest speakers have included the UIC COD Assistant Dean of Dental Education, faculty and various experts in mentoring. In addition, the MDFD program dental student participants were required to complete regular assignments, such as interviewing faculty, attending professional dental association meetings and participating in activities that support the day-to-day operation of the college. Acquiring a faculty appointment in dental education requires having the appropriate essential credentials and experiences. Therefore, both students and faculty are still encouraged to have individual career plans.

Objective 8: Establish protocols to evaluate the effectiveness of the program and track the development and careers of the participants.

The MDFD program is tracking all of the participants through interviews and data collection. Participants are asked to complete self-evaluations. Faculty mentors and other key MDFD program staff are also required to provide evaluations of each Fellow.

The UIC COD is one of three dental schools in the state of Illinois, and the only school serving Chicago. In fall 2015, 404 students were registered in the professional and post-professional degree programs. Almost 85% of these students were from Illinois, and one in four dentists practicing in the state is a graduate of the College. Approximately 75% of the College's graduates stayed in Illinois to practice dentistry.

Through its Urban Health Program, the college seeks to assist minority and disadvantaged individuals aspiring to become dentists and to increase the number of minority enrollees. The goal is to admit and graduate individuals from minority backgrounds. In fall 2015, minorities (Native Americans, Black/African Americans and Hispanic/Latinos) represented 18% of the school's student body.

The stated mission of the College is to promote optimum oral and general health to the people of Illinois through excellence in education, patient care, research and service. In line with that mission, it operates the largest oral health care center in the state, in a building of approximately 186,000 net assignable square feet. Its clinics are staffed by the school's faculty, students and residents, and include 350 chairs from the periodontics, endodontics, pediatric dentistry, orthodontics, oral and maxillofacial surgery, oral medicine and prosthodontics departments.

Through these clinics, the College serves many needy individuals. In FY15, the clinics logged 122,000 visits. Of these, 42,000 visits were made by patients covered under dental Medicaid or the Illinois children's medical/dental insurance program ("Kid Care"). The college also provided $5 million in uncompensated dental care for patients who were indigent, disabled, elderly or infected with HIV. The college's pediatric dentistry clinic is the largest provider of dental services to children receiving Medicaid assistance in Illinois.

Inspired by the U.S. Surgeon General's report on the state of the nation's oral health, which estimated that 25 million Americans are living in areas lacking adequate dental services, the college launched a major effort to reach out beyond its own clinics to vulnerable populations in the community: the poor, ethnic and racial minorities, and medically compromised patients. Faculty and students provide staff support for the dental clinic at Goldie's Place in North Chicago, where homeless adults can receive preventive care and therapeutic services. The College's CAN-DO (Chicago AIDS Network for Dental Outreach) program places dental students into community clinics that serve AIDS patients, such as Cook County's The CORE Center and The Heartland Alliance.

On a larger scale, the College developed a novel community-based service-learning curriculum that places students in clinics serving minority, low-income, and medically compromised people in 20 dental/medical clinics throughout Chicago and the state. The curriculum serves as a model for dental schools across the country, and helps address the shortage of dental professionals in communities throughout Illinois. The curriculum

brings dental care and oral disease prevention services to underserved urban and rural populations and increases the diversity of the dental workforce in the state by recruiting more minority and low-income students into the profession.

The MDFD program is now a funded program of the College's UHP. Because of the UHP support and the coordinate support and resources of both the UIC COD and University's Offices of Faculty Affairs, the UIC COD continues the effort started by the ADEA's support a decade ago.

CHAPTER 4: PORTFOLIO DEVELOPMENT: LEADERSHIP AND MENTORING

Portfolio Development

University of Michigan School of Dentistry Gateway Future Faculty Development Program 2004–12

Portfolio Development as a Tool for Mentoring and Faculty Development

Todd V. Ester, D.D.S., Kenneth B. May, D.D.S., M.S., and Marilyn Woolfolk, D.D.S., M.P.H.

The University of Michigan School of Dentistry (U-M SOD) has been a "leader and best" in diversity programs, recruitment matriculation and professional development for decades. Through these efforts, it is suspected that the U-M SOD has graduated more African-American dentists (400+) than any other U.S. dental school after the Historically Black College Dental Schools Howard and Meharry. The school has also graduated 140 Latino dentists and 25 Native American dentists. These efforts were made possible through a dedicated office for recruitment of diverse students, staff and faculty established in 1973, the Office of Minority Affairs. This office evolved into the Office of Multicultural Affairs in 1999 and is now known as the Office of Diversity and Inclusion.

Consistent throughout the past 41 years has been the support of and dedication to diversifying the dental profession within our school, state and nation. Diversity is a compelling interest of the University of Michigan and higher education as a whole, as stated by the Supreme Court in June 2003. The University of Michigan has a long history of using affirmative action to achieve diversity on its campus. In 2007, the laws in Michigan were changed to ban admission by public institutions of higher education by giving preference to race, gender or national origin. Nonetheless, the University of Michigan is committed to diversity as a necessary way of achieving excellence in education, and continues to pursue diversity as a goal within full compliance the laws of the State of Michigan. Inherent in U-M SOD's mission statement is a dedication to stimulating the development of the faculty and staff and to inspire students to develop attitudes and skills necessary for continued professional growth. "To pursue its mission, the School of Dentistry will foster and exemplify equity, diversity, and multicultural value." To achieve this mission, U-M SOD must have a critical mass of minority members at all levels of academic attainment, including faculty, postdoctoral graduate

students, predoctoral graduate students and staff. The U-M SOD has a long history of recruiting, preparing competitive applicants, retaining and graduating underrepresented minority (URM) dentists and students from disadvantaged backgrounds. Our diverse alumni are leaders throughout our dental profession.

An early sponsor of a conference entitled "Black Dentistry in the 21st Century," the University of Michigan continues to highlight the need for strategic approaches to identifying, encouraging, preparing, enrolling and graduating successful practitioners who are heavily underrepresented in the profession and come from disadvantaged backgrounds.

One such approach was our Michigan Gateway to Minority Dental Faculty Development Program (MDFDP), established in 2004–10 through collaborative support of the American Dental Education Association and the W.K. Kellogg Foundation. The MDFDP allowed us to increase our efforts to recruit, retain and develop URM dental faculty members through formalized mentorship, professional development and training. To achieve this goal, our program took a multi-faceted approach that allowed participants to enter the program at many different levels of their professional development. The program included an overarching mentorship effort, a predoctoral linkage, a postdoctoral linkage, a faculty linkage and an evaluation effort.

Two of the Gateway Program's key objectives were:

1. Establish a formalized mentor program for URM faculty development, recruitment and retention.
2. Establish a future faculty training program for predoctoral dental students and advanced training candidates entitled the Gateway Future Faculty Organization (GFFO).

1) To provide a formalized mentor program for URM faculty development, recruitment and retention.

Mentor families were created to include a URM predoctoral, postdoctoral and faculty member. This mentor family allowed for formal and informal interactions among the groups. These opportunities allowed a greater sense of community and understanding of a faculty role. The mentor family included a faculty member who served as the coordinator. The faculty member interviewed the junior minority faculty (assistant professor equivalent and below), ascertained their career plans, and assisted them with identifying key advisors from our roster of interested faculty. A seasoned tenured faculty

member was available as a consultant for submitting grant applications for external funding. The mentoring effort also included using the university's Science and Technology Recruiting to Improve Diversity and Excellence (STRIDE) program as a resource. The STRIDE program provides information and advice about practices that will maximize the likelihood that well-qualified female and minority candidates for faculty positions will be identified and, if selected for offers, recruited, retained and promoted at the University of Michigan. STRIDE works with departments by meeting with chairs, faculty search committees, and other departmental leaders involved with recruitment and retention.

Mentor List 2007–08

Mentors	GFFO Dental Students
1. Mathilde Peters 2. George Taylor	1. Ogbanna Bowden
3. Kenneth May 4. Brian Clarkson 5. Hana Hasson 6. Darnell Kaigler 7. Marita Inglehart	2. Eileen Buckle 3. Allen Robinson 4. Justin Echols
8. Paul Krebsbach 9. Yvonne Kapila	5. Erin Ealba 6. Evelyn Lucus-Perry
10. Dennis Lopatin 11. Karen Jones-Stewart	7. Paul Lopez 8. Steve Fletcher
12. Marilyn Woolfolk 13. Airton Arruda	9. April Patterson 10. Phillipe Rouchon 11. Duane Bennett
14. Stephen Stefanac 15. Tae-Ju Oh 16. Peter Polverini	12. Jessica Lee 13. Natolya Thomas 14. Carlos Smith 15. April Patterson
17. Elliott Hill 18. James Boynton 19. Jan Hu	16. Nejay Ananaba 17. Ebone Jordan

2) Established a future faculty training program for predoctoral dental students and advanced training candidates called the Gateway Future Faculty Organization (GFFO).

The GFFO brought together a pool of qualified URM dental professionals by establishing a path for predoctoral and advanced training candidates to give them basic teaching competencies and skills. To encourage teaching skill development, our dental student participants were involved in many teaching opportunities, such as serving as tutors for basic science and clinical foundation courses,; peer teaching and group

facilitation, and research opportunities. Students were also encouraged to participate in existing dental school organizations, such as the student research program and other professional student groups, including the Student National Dental Association, Hispanic Dental Association, and Society of American Indian Dentists. Our GFFO was comprised of first-, second-, third- and fourth-year dental students, as well as advanced training candidates. The GFFO will allow us to underscore the importance of dental education to a group of interested students and get them involved in academic research and teaching during their matriculation through dental school or their advanced training programs. This group ranged from 15–20 students annually over the course of the grant.

A third-year dental student within the GFFO competed and was selected each year for the Gateway Scholar award. The award was applied to fourth-year tuition costs for a URM dental student. Each scholar had a demonstrated commitment to becoming a faculty member upon graduation from dental school. A mentor was assigned to serve as a master teacher as well as help the scholar plan out an appropriate educational pathway.

Selection Criteria for Gateway Scholar:

a. Underrepresented minority or disadvantaged student;
b. Competitive GPA and National Board Scores;
c. Commitment to becoming a dental educator as evidenced through personal essay/interview;
d. Experience (teaching ability, research interest and leadership ability) as evidenced in curriculum vitae;
e. Commitment to community service as evidenced in curriculum vitae;

The Journal

We incorporated journal writing into the GFFO requirements to give the students a place to capture their exposure and experiences during their participation in the program. Each student was given the same GFFO journal template to document an accounting of their activities as a future dental faculty. The journal served as an instrument that participants could use to communicate with their mentors and GFFO facilitators to chart a course to an academic career. Participants were encouraged to share and update their journals throughout the year. This tool was useful in helping our future faculty student pool visualize academic career paths. The contents of this journal serve as a working document on which the participants captured their scholarly interactions,

exposures, presentations, honors, publications, teaching, tutoring and awards. Two key messages regarding preparation of the journal were:

1. The GFFO journal is a work in progress throughout your career.
2. When the template is used as designed, it generates knowledge on the user.

GATEWAY FUTURE FACULTY ORGANIZATION JOURNAL TOOL

GFFO Journal

NAME:

The Gateway Future Faculty Organization (GFFO) is a University of Michigan effort driven by student participation and faculty/staff commitment to address identified barriers associated with the nationwide shortage of minority faculty. Opportunities to learn, grow and develop will be emphasized to provide participants a well-rounded overview of the many options available in academic dentistry. Shadowing, teaching, research, community outreach, recruitment and workshops are a few of the many methods we will use to create an effective program that is aligned with the goal of ADEA and the W.K. Kellogg Foundation to increase the number of underrepresented minority faculty in dental schools across the country.

Contents:

1. Original GFFO Statement of Purpose
2. Updated GFFO Statement of Purpose
3. Goal Setting and Planning
4. Current CV/Resume
5. Mentorship Program
6. Teaching Portfolio Development

Original GFFO Statement of Purpose

Include the statement of purpose you submitted with your application in 2004. In this statement you answered the following questions regarding the current issues in the shortage of dental educators:

1. Given what you know about the shortage of dental faculty, and especially minority dental faculty, what are your thoughts on the barriers that hinder this group's pursuit of careers in academic dentistry?

2. Describe your interests in academic dentistry and what you hope to accomplish as a participant in the Minority Dental Faculty Development program. (Please discuss your prior teaching or mentoring experiences.)
3. Describe the characteristics of an excellent faculty member.

Updated GFFO Statement of Purpose

1. Using the original statement submitted with your application in 2004, please expound upon your reasons for remaining actively involved in the GFFO.
2. What experiences from the previous year have impacted (positively and negatively) your decision to pursue a career in dental education?
3. What issues have you identified as being most crucial to dental education?
4. Consider the curriculum both clinical and didactic. Are there changes you would make to the curriculum?
5. How would your changes impact dental education?

Goal Setting & Planning: Personal/Professional: 5 and 10 year

Ready, Set, Goal:

Goal setting is a very powerful technique that can improve all areas of your life. The process of setting goals and targets allows you to choose where you want to go in life. By knowing precisely what you want to achieve, you know what you have to concentrate on and improve, and what is merely a distraction. Goal setting gives you long-term vision and short-term motivation. It helps to focus your acquisition of knowledge and helps you to organize your resources.

By setting sharp, clearly defined goals, you can measure and take pride in the achievement of those goals. You can see forward progress in what might previously have seemed a long, pointless grind.

By setting goals you can:

- Achieve more
- Improve performance
- Increase your motivation to achieve
- Increase your pride and satisfaction in your achievements
- Improve your self-confidence
- Plan to eliminate attitudes that hold you back and cause unhappiness

Goal Setting Helps Self-Confidence

By setting goals, and measuring their achievement, you are able to see what you have done and what you are capable of. The process of achieving goals and seeing their achievement gives you the confidence and self-belief that you need that you will be able to achieve higher and more difficult goals.

Setting Goals Effectively

The way in which you set goals strongly affects their effectiveness. The following broad guidelines apply to setting effective goals:

1. Positive Statement: express your goals positively.
2. Be Precise: If you set a precise goal, putting in dates, times and amounts so that achievement can be measured, then you know the exact goal to be achieved, and can take complete satisfaction from having completely achieved it.
3. Set Priorities: Where you have several goals, give each a priority. This helps you to avoid feeling overwhelmed by too many goals, and helps to direct your attention to the most important ones.
4. Write goals down to avoid confusion and give them more force.
5. Keep Operational Goals Small: Keep the goals you are working toward immediately small and achievable. If a goal is too large, then it can seem that you are not making progress toward it.

Current CV/Resume

Instructions: In Fall 2004, Steve Williams, a counselor from The Career Center, came to campus and presented to the GFFO the creation of a curriculum vitae (CV) for professional students. Using the handout he provided that day, please complete as much of your CV as possible. As you engage in activities continue to update your CV. Below are the most common sections found on the CV. At this time, omit any sections that do not apply.

a. Name/Contact Information
b. Education: Use reverse chronological order
c. Postgraduate Training
d. Employment History
e. Certification and Licensure
f. Military Service
g. Honors and Awards

h. Memberships/Professional Societies
i. Professional Committees and Administrative Service
j. Community Service
k. Educational Activities
l. Teaching/Facilitation/Development
m. Advising/Mentoring/Tutoring
n. Clinical Activities
o. Financial Support (e.g., grants, scholarships, etc.)
p. Bibliography
q. Published papers, submitted works, contributing author, etc.
r. Book Reviews/Abstracts
s. Presentations

Mentorship Program

1. Mentor Biosketch: insert your mentor's biosketch.
2. Are there areas of interest that you share with your mentor?
3. What research/scholarly activity has your mentor taken on, and what about these activities inspires you?
4. Think back to the mentors you have had. What positive experiences, advice, support, etc., did they provide? What do you hope to accomplish with your faculty mentor?

Teaching Portfolio Development

Teaching Portfolios/Teaching Dossiers are considered to be summaries of an instructor's teaching accomplishments and strengths. Document activities that you have participated in from 2004–2006 using the following areas as a guide.

1. Outreach/Recruitment
2. Teaching/Facilitating
3. Shadowing
4. Leadership
5. Research

Leadership and Mentoring

Resources

1

To accomplish leadership and mentoring activities for eliminating oral health disparities, increase faculty diversity and cultural competency resources are needed:

- Grantees have institutional leadership (i.e., office of president, provost, dean) committed to leadership development and mentoring.
- At least one non-MDFD U.S. dental school with dental hygiene program engaged in partnership for mentoring or research.
- URM leadership development forums, workshops and professional networks focused on mentoring programs.

Activities

2

Activities need to be accomplished to address eliminating oral health disparities, increase faculty diversity and cultural competency through leadership and mentoring:

- Have mentoring programs that develop dental and allied dental URM faculty and professionals.
- Include community-based partnerships that involve students in experiential learning and patient care.
- Establish forums and workshops, as well as professional networks to connect URM students and faculty for leadership development.

Outputs

3

Once accomplished, planned activities will produce measurable evidence of leadership and mentoring:

- URM faculty development, mentoring and advancement are evident in grantee schools.
- The academic and service pipeline is strengthened.
- A core series of URM leadership forums routinely held and a network for connecting URM student and faculty leaders established.

Short-Term Outcomes

4

Once accomplished, planned activities will produce measurable outcomes of leadership and mentoring in first year:

- Strengthened faculty development, mentoring and advancement.
- Strengthened the academic and service pipeline.
- URM leaders emerging for research and teaching.
- Established best practices for community-based and academic partnerships.
- Strengthening school-based oral health care.
- Supporting best practice guidelines that result in preventative oral care.

Long-Term Outcomes

5

Once accomplished, planned activities will produce measurable outcomes of leadership and mentoring in first three years:

- Established process for dissemination of knowledge to other dental schools.
- Disseminating of knowledge to other dental schools.
- URM leadership development forums, workshops and professional networks.
- Mentoring programs, school-based oral health initiatives, programs.

Impact

6

Once accomplished, planned activities will lead to lasting impact in leadership and mentoring:

- Established academic partnerships to recruit URM students and faculty to bolster the cadre of allied dental health professionals, increase faculty diversity and change institutional culture.
- URM students and faculty on pathways and in line for University and Institutional leadership positions.
- Established community-based and academic partnerships to foster leadership opportunities.

CHAPTER 5: CULTURAL COMPETENCY FOR HUMANISTIC HEALTH CARE

Introduction

Higher education in America has been conceived as a social investment for the common good. As a part of higher education, health professional schools accept the responsibility to serve the common good.[1,2] Also, as a part of the dental profession, health professional schools are part of a "moral community," a community whose members are bound to each other by a set of commonly held ethical commitments and whose purpose is something other than mere self-interest.[3] The moral commitment of health professionals continues to be honored in various codes of ethics evolving from the basic tenants of the Hippocratic Oath (Ca 460-375 B.C.),[4] which endures as the foundation for the scientific basis of medical practice. These tenants apply equally to all health professions and continue to serve as the basis for the public trust enjoyed collectively by the health professions and health professionals who serve.

Dental schools have a tripartite mission of education, research and service. It is within the service mission that U.S. dental schools have become a "safety net" for the care of the underserved, pioneers of tertiary care, and contributors to community health through accessible oral health care services. The "safety net" activities of U.S. dental schools address health disparities through outreach collaborations and community-based care. The experiential learning that occurs in community-based settings contributes to the knowledge base of cultural competency learning. Academic community partnerships improve access to dental care while enhancing student learning through exposure to diverse patients in varied clinical treatment settings.

Cultural competency adds value to quality in the workforce. It is expected to improve health outcomes, efficiency and satisfaction. Cultural competency, therefore, serves as a nexus that links access to care with quality through the delivery of care by culturally competent professionals and multidisciplinary teams.

Cultural Competency—Definition and Understanding of the Concept

Betancourt and colleagues[5] provide an early definition of cultural competence in health care: "cultural competence in health care entails: understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these

factors interact at multiple levels of the health care delivery system…finally, devising interventions that take these issues into account to assure quality health care delivery to diverse populations."

The Department of Health and Human Services (DHHS) Office of Minority Health took the lead in developing National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. The DHHS definition was broad in the context and intended application: "Cultural and linguistic competence is the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care encounter. As health providers begin to treat a more diverse clientele as a result of demographic shifts and changes in insurance program participation, interest is increasing in culturally and linguistically appropriate services that lead to improved outcomes, efficiency and satisfaction. The provision of culturally and linguistically appropriate services is in the interest of providers, policymakers, accreditation and credentialing agencies, purchasers, patients, advocates, educators and the general health care community."

The DHHS process for developing CLAS standards was derived from an analysis of current practice and policy on cultural competence and shaped by experiences and expertise of healthcare organizations, policy makers and consumers as reported by Cross and colleagues (1989): "Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities"

The CLAS Standards report was released in January 2000 (www.thinkculturalhealth.hhs.gov/content/clas.asp). As a result of this pioneering effort, HRSA now offers web-based training in cultural competency for health care professionals. The training tool is a free, accredited online cultural competency curriculum. (www.train.org/DesktopModules/Documents/viewDocument.aspx?LcmsltemID=76)

Cultural Competency Policies in Dental Education

For academic dental institutions, the following definitions currently apply to competencies and dental accreditation:

<u>Competency:</u> a complex behavior or ability essential for the general dentist to begin independent, unsupervised dental practice; it assumes that all behaviors and skills are performed with a degree of quality consistent with patient well-being and that the general dentist can self-evaluate treatment effectiveness.

Excerpted from: ADEA Competencies for the New General Dentist (As Approved by the ADEA House of Delegates, 2008).

<u>Competency Domains</u> have been identified, also for emerging workforce models that include culture and diversity: Competency domains for dental professionals in emerging workforce models should include: communication, culture and diversity, evidence-based patient care, health policy and advocacy, health promotion and disease prevention, professionalism and ethics, and systems thinking and financial management.

Excerpted from: ADEA Guiding Principles in the Education of Oral Health Professionals in Emerging Workforce Models (As approved by the 2011 ADEA House of Delegates) J Dental Educ. 2011; 75(7):78-9.

<u>Dimensions of Diversity:</u> The dimensions of diversity include: structural, curriculum and institutional climate.

Structural: Structural diversity, also referred to as compositional diversity, focuses on the numerical distribution of students, faculty and staff from diverse backgrounds in a program or institution.

Curriculum: Curriculum diversity, also referred to as classroom diversity, covers both the diversity-related curricular content that promote shared learning and the integration of skills, insights, and experiences of diverse groups in all academic settings, including distance learning.

Institutional Climate: Institutional climate, also referred to as interactional diversity, focuses on the general environment created in programs and institutions that support diversity as a core value and provide opportunities for informal learning among diverse peers.

Excerpted from: Accreditation Standards for Dental Educational Programs. Commission on Dental Accreditation. American Dental Association, 2010.

Cultural competency concepts have become closely linked with diversity objectives and institutional climate. The dimensions of diversity include institutional climate, which is now considered interactional diversity.

Cultural Intelligence and Cultural Competency

Cultural intelligence, cultural quotient or CQ, is a term used in business, education, government and academic research. The original research by Ang and Van Dyne[6] was a way of measuring and predicting intercultural performance that supported earlier theory related to cross cultural behaviors.[7] The Cultural intelligence concept has been found to be a measureable attribute and CQ scale is available through the Cultural Intelligence Center in East Lansing, MI. Cultural intelligence is defined as "a person's capability to adapt as she/he interacts with others from different culture regions," and has behavioral, motivational and metacognitive aspects. CQ can be measured on a scale similar to that used to measure intelligence or IQ.

We are beginning to understand the relationship of cultural intelligence to cultural competency and how this relationship will affect cultural competence training, evaluation, patient satisfaction and health outcomes in the future. Increased understanding of the four capabilities identified in cultural intelligence research will influence curriculum change and experiential learning as we consider: motivation, knowledge, strategy and action as the measurable capabilities. Additional research on cultural intelligence is being conducted by academics around the world. CQ, or "cultural quotient," is a theory within management and organizational psychology that is being used to measure an individual's ability to engage successfully in different environments and social settings.

In dental education, we are making efforts to address cultural competency through observable, nonverbal behaviors; for example, gestures, facial expression, eye contact, body language and verbal behaviors such as accent, tone and language. Culture competency training includes the development of skills for more effective provider-patient interactions that reduce racial and ethnic health disparities and improve health outcomes for all Americans.

The MDFDI schools have been encouraged to use the HRSA web-based training modules as educational tools and resources for cultural competency training and evaluation. The University of Oklahoma, for example has made the HRSA modules available to every student in the senior class in a self-paced online format. "Effective Communication Tools for Healthcare Professionals" (HRSA) was used during the fall 2015 semester. Using this tool, the faculty created an online evaluation tool based on key content from the HRSA training modules. As a result of this instruction and test results, their students "have already demonstrated an even greater appreciation for the

impact that culture, health literacy skills, limited English proficiency, and translation services can have on provider/patient interactions."[8] The MDFDI schools are in various stages of cultural competency development and integration into their schools' curriculums. They have been encouraged to benefit from use of the National Standards for Culturally and Linguistically Appropriate Services in Healthcare (DHHS/OMH),[9] AAMC's Tool for Assessing Cultural Competence Training[10] and other pioneering efforts for cultural competency training and evaluation in dental and medical education.[11,12,13]

Summary

Dental education has developed academic policies related to cultural competency that recognize knowledge, skills and behaviors that will improve communication, patient care and ultimately health outcomes. We will continue to learn from cultural intelligence research information that will improve both the understanding of the relationship of cultural intelligence to cultural competency and how we change faculty, students and the academic environment for intercultural performance.

Across the health professions, dentistry, as a member of the health team, will support inclusive statements led by the American College of Physicians 2010[14] (excerpts):

- As our society increasingly becomes racially and ethnically diverse, physicians and other health care professionals need to acknowledge the cultural, informational and linguistic needs of their patients.
- Physicians and other health care professionals must be sensitive to cultural diversity among patients and recognize that preconceived perceptions of minority patients may play a role in their treatment and contribute to disparities in health care among racial and ethnic minorities.
- A diverse health care workforce that is more representative of the patients it serves is crucial to promote understanding among physicians and other health care professionals and patients, facilitate quality care and promote equity in the health care system.
- Cultural competency training unites us in humanistic behaviors that improve health outcomes for all Americans.

References

1. Rudolph A. The American College and University: a history. Athens: University of Georgia Press, 1990.
2. Valachovic RW, Machen B, Haden NK. The value of the dental school to the university. In: Haden NK, Tedesco LT, eds. Leadership for the future: the dental

school in the university. Washington, DC: American Association of Dental Schools, 1999:6-13.

3. Bulger RJ, McGovern JP (eds.). Physician philosopher. the philosophical foundation of medicine-essays by Dr. Edmund Pellegrino. Charlottesville, VA: Carden Jennings, 2001.

4. ADEA Position Paper: Statement on roles and responsibilities of academic dental institutions in improving the oral health status of all Americans (As approved by the 2004 ADEA House of Delegates). J Dental Educ 2011; 75(7):988-95.

5. Betancourt JR, Green AR, Carrillo JE, Anaheh-Firempong II O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public Health Rep 2003; 118(July/August):293-302.

6. Ang S, Van Dyne L (eds.). The Handbook of Cultural Intelligence. New York:. ME Sharpe, 2008.

7. Earley PC, Ang S. Cultural intelligence: individual interactions across cultures. Redwood City, CA: Stanford Business Books, 2003.

8. Beatty, M. Direct Communication. 12/07/15

9. National Standards for Culturally and Linguistically Appropriate Services in Healthcare. Final Report. Washington, DC: U.S. Department of Health and Human Services, Office of Minority Health, March 2001.

10. Association of American Medical Colleges. Cultural Competence Education. 2005. Accessed: https://www.aamc.org/download/54338/data/culturalcomped.pdf

11. Rowland ML, Bean CY, Casamassimo PS. A snapshot of cultural competency education in U.S. dental schools. J Dent Educ. 2006; 70(9):982-90.

12. Evans L, Hanes P. Cultural competency education for millennial dental students. J Dental Educ. 2014; 78(6):867-75.

13. Like RC. Clinical cultural competency questionnaire (CCCQ). Center for Healthy Families and Cultural Diversity, Department of Family Medicine, UMDNJ- Robert Wood Johnson Medical School. 2001. At: http://rwjms.umdnj.edu/departments_institutes/family_medicine/chfcd/grants_projects/aetna.htmlMarch 22, 2016.

14. Racial and Ethnic Disparities in Health Care, Updated 2010. American College of Physicians; 2010 Policy Paper. Philadelphia, PA. https://www.acponline.org/acp_policy/policies/racial_ethnic_disparities_2010.pdf

Accreditation Standards for Dental Education Programs

Commission on Dental Accreditation
American Dental Association*
(Excerpts related to Cultural Competency Training)

Educational Environment

Humanistic Environment

A humanistic pedagogy inculcates respect, tolerance, understanding and concern for others and is fostered by mentoring, advising and small group interaction. (Page 12)

Diversity

Diversity in education is essential to academic excellence. Cultural competence cannot be effectively acquired in a relatively homogenous environment. Programs must create an environment that ensures an in-depth exchange of ideas and beliefs across gender, racial, ethnic, cultural and socioeconomic lines. (Page 15)

Cultural Competence

Having the ability to provide care to patients with diverse backgrounds, values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. Cultural competence training includes the development of a skill set for more effective provider-patient communication and stresses the importance of providers' understanding the relationship between diversity of culture, values, beliefs, behavior and language and the needs of patients. (Page 16)

Standard 1—Institutional Effectiveness

1-3 The dental education program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.

1-4c. systemically evaluate comprehensive strategies to improve the institutional climate for diversity.

<u>Intent:</u> The dental school should develop strategies to address dimensions of diversity including structure, curriculum and institutional climate. (Page 20)

Standard 2—Behavioral Science

2-16 Graduates must be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment. (Page 26)

2-19 Graduates must be competent in communicating and collaborating with other members of the healthcare team to facilitate the provision of healthcare. (Page 27)

2-25 Service Learning and/or community based learning experience.

Intent: Service learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral health care workforce. (Page 30)

Standard 3—Faculty and Staff

3-2 The dental school must show evidence of an ongoing faculty development process. Examples of evidence to demonstrate compliance may include:

Cultural Competency (Page 31)

Standard 5—Patient Care Services

5-1 The dental school must have published policy addressing the meaning of and commitment to patient centered care and distribute the written policy to student, faculty, staff and patient.

Intent: Considerate, respectful and confidential treatment (Page 35)

CHAPTER 6: TOOLS FOR EFFECTIVE LEADERSHIP: LEARNING FROM THE MILITARY MODEL

Leo E. Rouse, D.D.S., L.H.D. (Hon), FACD
Dean Emeritus, Howard University College of Dentistry
Dr. Rouse was Vice Chair of the ADEA Council of Deans and Immediate Past Chair of the ADEA Minority Affairs Advisory Committee.

Dr. Leo Rouse developed his leadership style during his 28 years in the U.S. military. He graduated from Howard University College of Dentistry, joined the Army, and was ultimately put in charge of the United States Army Dental Command (USADENCOM) with authority over 4,000 people worldwide and a budget of $210 million. (Racial diversity in units of the armed services was ordered by President Harry Truman in 1948. Twelve years later, there were no more all-Black units.)

Dr. Rouse's story illustrates effective leadership:

"When I was put in charge of the USADENCOM, it had a few African-American commanders, one Latino commander, and no American Indians or women in top positions. In other words, it had a diversity problem, which I was assigned to address. The military is autocratic. When you are tasked with a job, you get it done. I quickly brought in a female chief of staff to run day-to-day operations, an Asian-American as comptroller, and an American Indian consultant for minority affairs.

"In 1981, my boss General Norman Schwarzkopf, then a one-star general assigned as Director of Military Personnel Management in the Office of the Deputy Chief of Staff for Personnel in the Pentagon, would talk to me every day about leadership, responsibility, accountability, and taking care of your soldiers. My job was to keep America's forces dentally ready to deploy whenever Uncle Sam needed them.

"I taught leadership in the military for many years and learned to be a teacher at the United States Medical Field Service School at Fort Sam Houston, Texas, where physicians, dentists, pharmacists, dental hygienists, dental laboratory technicians, and other health care personnel from many different backgrounds are trained.

"In July 1997, I made the difficult decision to leave the Army to join the faculty of Howard University, at the request of a former colleague. The Army had been treating me well, and I was enjoying myself and a distinguished career.

"During the six years between leaving the army and becoming Dean of Howard University College of Dentistry, I saw that the school had problems with diversity. We had a grant from the Robert Wood Johnson Foundation requiring that we examine our record of accomplishments in cultural sensitivity.

"We saw, for one, no increase in our number of Hispanic dentists and American Indian dentists and (because I believe that leaders need to be on the front lines and not relegate or delegate or abdicate their responsibility) I took personal charge of the problem. I applied Military Rule #14: 'When in charge, take charge.' So, the faculty on the admissions committee who were reticent about diversity were replaced-and we met the objectives of the grant.

"The lesson here is that if you are an Associate Dean, a department Chair, or a Program Director, you are in charge. You cannot say that something is not your job. In 1982, General Schwarzkopf introduced me to Rule #14. 'Rouse, you are a commander,' he said. 'You are in charge. My troops have poor dental health. Fix it.' When the General brings you a whole battalion of soldiers on a Friday afternoon saying they need help, you had better be able to apply Rule #14 quickly. Teaching is our job; leading is our responsibility.

"Young men and women need to develop not only an understanding of the issues of today, but also a broader macro vision of the years ahead. At the Army War College in Carlisle, Pennsylvania, I learned about this by applying the lesson of 'Be, Know, and Do.' Be a professional. Know yourself and human nature. Do provide direction and motivation. The Army has a unique way of teaching leadership: Get out there and do it.

"Knowing yourself is very important. It helps build trust and cooperation. People want to trust that you understand their needs. If you do not have the trust of a community, find someone who does and who can be an advocate for your cause. A good tool for self-awareness is the psychological test called the Myers-Briggs Type Indicator. Everybody should take it and share results with everyone with whom they interact. It helps people deal with each other.

"Have frank dialogue with people. We need to motivate and direct people who are naysayers about the importance of diversity. When I became the first African-American

leader of USADENCOM some people were unhappy and said I was promoted because of affirmative action. I said yes, that I was an affirmative action baby, but I earned the promotion based on my credentials. Colin Powell did not wear a fourth star because he was Black. He earned the four stars because of his credentials. Leaders are not born, they are developed. They are developed because they understand truth and because they are trustworthy.

"Mahatma Gandhi said that 'we must become the change we want to see.' In other words, leaders must lead by example. When you leave here, take the message back to those who say you have to have a certain grade point average to be in dental school. These are what we call 'weird credentials'. You cannot let numbers be your only guide. That is not leadership. Challenge the status quo. Use data showing the success of diversity programs. If you do not believe your institution is doing what its claims, make it live up to the vision and the stated mission. There are three leadership styles: authoritarian (autocratic), participative (democratic), and delegative (free rein}. Whatever your leadership style is, believe in it. Oftentimes you have to apply all three. The military uses autocratic leadership.

"As a leader, you have to prove your leadership bottom up, not top down. I want to see folks take responsibility without having to push them. I like people to challenge my decisions, to be participative. The truth of the matter is that not everyone is a good fit for your vision. I call it the 'choice theory.' You can choose to be in my band, or I can choose to have you get out. At Howard University, the Robert Wood Johnson Foundation grant taught me a valuable lesson. I thought we had all the answers, but we did not. I had faculty members who had issues with the admission of Latinos and American Indians. It was not easy, but I removed people from the admissions committee who were not believers in the bigger picture called diversity.

"The Howard University College of Dentistry is now very diverse, although some people still think it is, or should be, a black-only university. I have gone to various universities to talk about the history of Howard University and to emphasize our values of family, community, diversity, trust, care, and passionate concern about dental health care. The perception is that Howard University treats only Black patients. When potential students come to campus, they are amazed at how much we do and our on diversity and inclusivity. That experience is very important".

In a nutshell, you must be trustworthy and able to communicate a vision of where the organization needs to go. In the military, I was tasked about to give a 45-minute

presentation requesting a new dental hygiene education program. The commander came in, *gave* me four minutes, and asked for the key points about money and people. I had to retool the presentation and determine the priorities and selling points on the spot. Fortunately, we got the program. The lesson here is that we need to communicate to our target audience. Then we need action to make it happen.

"ADEA has taken a strong positive position on diversity. We have traveled to Capitol Hill to tell Members of Congress that the slow growth of diversity in dentistry is a serious problem for the health of Americans. At ADEA, we are strategizing with the goal of reducing America's health concerns. There is no time like the present to make tough decisions and take tough actions. We know what to do. We are doing it.

"Being a dental administrator requires leadership skills. It requires the courage to take risks on a regular basis, to challenge the status quo, and to think outside the box. It requires interpersonal skills to communicate with the faculty, community, and people in power. It requires ethical behavior and the ability to be a model for those who are aspiring to become leaders. Students and faculty understand that our behavior is meaningful, and they can add or subtract value to any of our positions.

"Helping faculty develop into future leaders requires intensive mentoring from an established and diverse faculty. It also requires opportunities from the parent institution and its leaders. At Howard University we believe we are on our way to providing an excellent environment for leadership and diversity to flourish."

Leadership and Sustainability

Resources

1

To accomplish leadership and sustainability activities for eliminating oral health disparities, increase faculty diversity and cultural competency resources are needed:

- Grantees have institutional leadership (i.e., office of president, provost, dean) committed to eliminating oral health disparities, increase faculty diversity and cultural competency.
- Grantees have access to program and development office support.

Activities

2

Activities need to be accomplished to address eliminating oral health disparities, increase faculty diversity and cultural competency through leadership and sustainability:

- Grantees have developed strong programmatic vision and support to eliminating oral health disparities, increase faculty diversity and cultural competency.
- Grantees have developed a results-oriented framework to eliminate oral health disparities, increase faculty diversity and cultural competency.

Outputs

3

Once accomplished, planned activities will produce measurable evidence of leadership and sustainability:

- Grantees are tracking URM faculty and allied dental professional progress post program completion.
- Institutional leadership and grantees have defined measureable goals to eliminate oral health disparities, increase faculty diversity and cultural competency.
- Institutional leadership and grantees have defined attainable benchmarks for faculty development, mentoring and allied dental professional training.

Short-Term Outcomes

4

Once accomplished, planned activities will produce measurable outcomes of leadership and sustainability in first year:

- Institutional leadership has identified at least one faculty and/or student for faculty development, mentoring and advancement.
- Institutional leadership and grantees have identified realistic academic and service pipeline sources.
- Grantees have community-based partnerships involving students and faculty in integrated oral health care initiatives.

Long-Term Outcomes

5

Once accomplished, planned activities will produce measurable outcomes of leadership and sustainability in first three years:
- Grantees have defined long-term funding strategies for eliminating oral health disparities, increase faculty diversity and cultural competency.
- Grantees have strong research and outcomes-based orientation driven towards sustainability.

Impact

6

Once accomplished, planned activities will lead to lasting impact in leadership and sustainability:
- Leadership has defined commitments in Strategic Plan and Vision for faculty and student diversity and eliminating oral health disparities.
- Visible institutional commitment to developing dental and allied dental URM faculty and professionals.

CHAPTER 7: RESOURCES

Academic Leadership for Diversity—Suggested Reading List

MDFD—Leaders for the Future: "Learning as We Lead" and Building Communities of Commitment. Books and Resources that inform, inspire, and impact thinking, behavior and policy.

Books

1. Koehone NO. *Higher Ground: Ethics and Leadership in the Modern University*. Durham, NC: Duke University Press, 2006.
2. Friedman TL. *The World is Flat: A Brief History of the Twenty-first Century*. New York: Farrar, Straws and Giroux, 2005.
3. *Seven Measures of Success*. Washington, DC: ASAE and the Center for Association Leadership, 2006. (foreword by Jim Collins, author of *Good to Great and Built to Last*)
4. Jaworski J. *Synchronicity: The Inner Path of Leadership*. San Francisco, CA: Berrett-Koehler Publishers, Inc., 1996.
5. Senge PM. *The Fifth Discipline: The Art and Practice of the Learning Organization*. New York: Currency Doubleday, 1990.
6. Kouzes, James, Posner, Barry. The Leadership Challenge, 4th edition. San Francisco: John Wiley & Sons, 2007.
7. Wolverton M, Gmelch W. *College Deans Leading from Within*. Westport, CT: The Oryx Press and The American Council on Education, 2002.
8. Kaplan RS, Norton DP. *The Balanced Scorecard, Translating Strategy Into Action*. Boston: Harvard Business School Press, 1996.
9. Thomas Jr. RR. *Beyond Race and Gender, Unleashing the Power of Your Total Workforce by Managing Diversity*. Washington, DC: American Management Association, 1991.
10. Bowen WG, Bok D. *The Shape of the River, Long-Term Consequences of Considering Race in College and University Admissions*. Princeton, NJ: Princeton University Press, 1999.
11. Karmen M, Knoff A. *American Culture, American Tastes, Social Change the 20th Century*. New York: Basic Books, 1999.
12. Page SE. *The Difference: How the Power of Diversity Creates Better Groups, Firms, Schools, and Societies*. Princeton, NJ: Princeton University, Press, 2007.
13. Rock D. *Quiet Leadership: Six Steps to Transforming Performance at Work*. New York: Harper Collins Publishers, 2006.
14. Li C, Bernoff J. *Groundswell, Winning in a World Transformed by Social Technologies*. Boston: Harvard Business Press, 2008.
15. DuBois WEB. *The Souls of Black Folk*. New York: Barnes & Noble Classics, 2003. (First Published 1903).

16. Friedman L. *The World is Flat. A Brief History of the Twenty-First Century.* New York: Farrar, Straus and Giroux, 2005.
17. Franklin J. Farrar, *Mirror to America. The Twentieth Century Fight for Civil Rights by a Preeminent American Historian.* New York: Farrar, Straus and Giroux, 2005.
18. Gawan de A. *Better. A Surgeon's Notes on Performance.* New York: Henry Holt and Company, 2007.
19. Kidder M. *How Good People Make Tough Choices. Resolving the Dilemmas of Ethical Living.* New York: Harper, 1995.
20. Gladwell M. *The Tipping Point. How Little Things Can Make a Big Difference.* Boston: Little, Brown and Company, 2000.
21. Satcher D, Paimes R. *Multicultural Medicine.* New York: McGraw-Hill, Medical Publishing Division, 2006.
22. de Tocqueville A. *Democracy in America.* Vintage Books Edition. New York: Alfred A. Knopf, Inc., 1945.

ADEA Policy and Position Statements Regarding Equity and Diversity

Excerpts from the *Journal of Dental Education*, July 2014

ADEA Statement on Health Care Programs

The Association believes that the number of minority graduates of dental education institutions should better reflect their representation in the population and supports programs that will achieve that goal. Faculty role models are critical to the professional development of minority students and the ADEA advocates grants for programs that enhance the development of minority faculty. Additionally, the Association endorses efforts that result in improving the health of minority and under-served persons. The retention and graduation of practitioners from disadvantaged groups is a goal that is important for the public's health. Since the indebtedness of disadvantaged students, including minority students, is commonly higher than the average of all students, the Association supports grant and loan forgiveness programs for disadvantaged persons and minorities, with preference given to those who elect to pursue careers in dental education and research to provide care for underserved populations.

ADEA Competencies for the New General Dentist

Competence includes knowledge, experience, critical thinking and problem-solving skills, professionalism, ethical values, and technical and procedural skills.

3. Communication and Interpersonal Skills

Graduates must be competent to:

3.3

Communicate effectively with individuals from diverse populations

4. Health Promotion

Graduates must be competent to:

4.2

Participate with dental team members and other health care professionals in the management and health promotion for all patients.

4.3

Recognize and appreciate the need to contribute to the improvement of oral health beyond those served in traditional practice settings.

6. Patient Care

Graduates must be competent to:

6.1

Manage the oral health care of the infant, child, adolescent, and adult, as well as the unique needs of women, geriatric, and special needs patients.

ADEA Competencies for Entry into the Allied Dental Professions

Enhance opportunities for intra-and interprofessional collaboration in understanding professional roles of oral health team members and other health care providers.

Support developing new education models for accredited allied dental education programs.

Competencies for Entry into the Profession of Dental Assisting

Core Competencies (C)

C.10 Communicate effectively with diverse individuals and groups, serving all persons without discrimination by acknowledging and appreciating diversity.

Community Involvement (CM)

CM.7 Advocate for effective oral health care for underserved populations.

Competencies for Entry into the Profession of Dental Hygiene

Core Competencies (C)

C.10 Communicate effectively with diverse individuals and groups, serving all persons without discrimination by acknowledging and appreciating diversity.

C.12 Initiate a collaborative approach with all patients when developing individualized care plans that are specialized, comprehensive, culturally sensitive, and acceptable to all parties involved in care planning.

Health Promotion and Disease Prevention (HP)

HP.2 Respect the goals, values, beliefs, and preferences of all patients.

Community Involvement (CM)

CM.7 Advocate for effective oral health care for underserved populations.

Competencies for Entry into the Profession of Dental Laboratory Technology

Core Competencies (C)

C.9 Communicate effectively with diverse individuals and groups, serving all persons without discrimination by acknowledging and appreciating diversity.

Health Promotion and Disease Prevention (HP)

HP.1 Respect the goals, values, beliefs, and preferences of patients and oral health professionals

Community Involvement (CM)

CM.3 Advocate for effective oral health care for underserved populations.

ADEA Policy Statement on Health Care Reform

Oral Health Care: Essential to Health Care Reform (As approved by the 2009 ADEA House of Delegates)

Excerpts from Policy Statement, *Journal of Dental Education,* July 2014 (www.jdentaled.org/content/78/7/1068.full.pdf+html)

Principles for Health Care Reform

Academic dental institutions are vital public trusts and national resources. They educate the future dental workforce, conduct dental research, inform communities of the importance and value of good oral health, and provide oral health care services and serve as dental homes to thousands of patients. It is within the broad range of oral health expertise and the interests represented by our membership that the American Dental Education Association offers the following principles for providing access to and coverage of affordable oral health care services in health care reform:

1. The availability of health care, including oral health care, fulfills a fundamental human need and is necessary for the attainment of general health. Every American should have access to affordable diagnostic, preventive, restorative, and primary oral health care services so as to eliminate pain, suffering, and infection. Coverage must ensure that individuals are able to obtain needed oral health care and must provide them with protection during a catastrophic health crisis. Oral health care services are proven to be effective in preventing and controlling tooth decay,[11] gum infections, and pain, and can ameliorate the outcomes of trauma. Oral health services should have parity with other medical services within a reformed U.S. health care system. The equitable provision of oral health care services demands a commitment to the promotion of dental public health, prevention, public advocacy, and the exploration and implementation of new models of oral health care that provide care within an integrated health care system.

2. The needs of vulnerable populations have a unique priority. Health professionals, including those providing oral health care services, must individually and collectively work to improve access to care by reducing barriers that low-income families, minorities, remote rural populations, medically compromised individuals, and persons with special health care needs experience when trying to obtain needed services. New integrated models of care that expand roles for allied dental professionals as well as other health professionals (including family physicians, pediatricians,

geriatricians, and other primary care providers) as team members[12] may be needed to address the complex needs of some patients. Statutory language may be needed to clarify and expand coverage of "medically necessary" dental care provided under Medicare to beneficiaries with serious medical conditions in order to prevent complications and death associated with their health condition and treatment.

3. Prevention is the foundation for ensuring general and oral health. Prevention and wellness hold the promise of stemming escalating costs and treating diseases at early stages before expensive emergencies occur. Most dental diseases are preventable, and early dental treatment is cost-effective. Preventing and controlling dental diseases include adequate financing of organized activities to promote and ensure dental public health through education, applied dental research, and the administration of programs such as water fluoridation and dental sealants. Improving oral health by multiple preventive approaches (including periodontal disease management) has saved more than $4 billion per year in treatment costs.[13] Prevention of dental diseases ranks above HIV screening and influenza immunization in cost savings.[14] Children who receive preventive dental care early in life have lifetime dental costs that are 40 percent lower than children who do not receive care.[15] Oral cancer treatment costs in the earliest stages of the disease are estimated to be 60 percent lower than those at an advanced stage of disease.[16] Every dollar invested in community water fluoridation yields approximately $38 in savings on dental treatment costs.[17]

4. The financial burden of ensuring coverage for health care, including oral health care coverage, should be equitably shared by all stakeholders. Access to affordable health care services requires a strong financial commitment that is a responsibility shared by all major stakeholders, including individuals and families, as well as providers, employers, private insurers, and federal, state, and local governments. To ensure health, oral health care services must be an integral component of financing and delivery systems regardless of whether the care is provided by a public or private insurance program or in a community or an individual setting. The burden of uncompensated care and the cost shifting that occurs adversely impact U.S. businesses, limit governments' capacity to address other pressing economic and social concerns, and strain the health care safety net to the breaking point.

5. A diverse and culturally competent workforce is necessary to meet the general and oral health needs of our demographically changing nation. Racial and ethnic diversity of health professionals contributes to improved access to care, greater patient choice and satisfaction, and enriched educational experiences for students.[18] Proposals

to reform the U.S. health care system should include adequate funding for programs that are designed to increase the number of underrepresented minorities in the health professions. This would ensure a workforce that is prepared to meet the needs of a diverse population that continues to expand. Academic dental institutions, which educate and train oral health care professionals, have a distinct responsibility to educate dental and allied dental health professionals who are competent to care for the changing needs of society. This responsibility includes preparing oral health care providers to care for a racially and ethnically diverse population, an aging population, and individuals with special needs.

6. Reducing administrative costs and realigning spending can increase quality, improve health, and create savings for additional reforms. Approximately $700 billion (about a third) of U.S. health care spending is used for administrative and operating costs or to benefit third-party payers and does not directly impact health outcomes.19 Reducing these administrative burdens in the delivery of health care and creating new payment incentives that reward providers for delivering quality care will improve health care. It also has the potential to enhance provider participation and lower health care costs over time. More dollars would then be available for reforms such as strengthening primary care and chronic care management, increasing the supply and availability of primary care practitioners, and reinvesting in the training of a twenty-first-century health care workforce. Targeted tax changes might also be used to improve efficiencies, ensure the even distribution of health care, and promote efficient use of consumers' health care dollars.

ADEA Statement on Professionalism in Dental Education

(As Approved by the 2009 ADEA House of Delegates)

Excerpted from Statement, *Journal of Dental Education,* July 2015 (www.jdentaled.org/content/79/7/854.full.pdf+html)

Respect

Honoring the worth of others.

Expanded definition: Encompasses acknowledgment of the autonomy and worth of the individual human being and his or her belief and value system1; sensitivity and responsiveness to diversity in patients' culture, age, gender, race, religion, disabilities, and sexual orientation[5]; personal commitment to honor the rights and choices of patients regarding themselves and their oral health care. Maintaining vigilance about

protecting persons from inappropriate over-or undertreatment, abandonment or both and tolerance.

ADEA Guiding Principles for the Education of Oral Health Professionals in Emerging Workforce Models

(As Approved by the 2011 ADEA House of Delegates)

Excerpted from Principles, *Journal of Dental Education,* July 2015 (www.jdentaled.org/content/79/7/860.full.pdf+html)

Principle 1

Competency domains should be consistent across educational programs and should align with the ADEA Competencies for Entry into the Allied Dental Professions. Where the scope of practice for emerging workforce models extends beyond the allied dental competencies, competency domains should align with the ADEA Competencies for the New General Dentist. Competency domains for oral health professionals in emerging workforce models should include communication, culture and diversity, evidence-based patient care, health policy and advocacy, health promotion and disease prevention, professionalism and ethics, and systems thinking and financial management.

Principle 3

Educational programs for oral health professionals in emerging workforce models should ensure that students attain the skills necessary to engage individuals from diverse populations in decisions about their oral health.

Educational programs should emphasize the principles of population-based public health science as a means of engaging diverse populations and communities in the prevention and control of oral diseases and in reducing oral health disparities.

• Educational programs should ensure that graduates attain the values, attitudes, knowledge, and skills needed to provide care that is respectful of a patient's culture, class, race, ethnicity, and socioeconomic background.

• Educational programs should implement strategies to recruit, retain, and promote individuals from diverse backgrounds.

ADEA Position Paper: Statement on the Roles and Responsibilities of Academic Dental Institutions in Improving the Oral Health Status of All Americans

(As Approved by the 2004 ADEA House of Delegates)

Excerpted from Statement, *Journal of Dental Education,* July 2015 (www.jdentaled.org/content/79/7/870.full.pdf+html)

Background

As providers of care, academic dental institutions are a safety net for the underserved, centers of pioneering tertiary care, and contributors to the well-being of their communities through accessible oral health care services.

Access to basic oral health care is a human right.

The dental profession, including academic dental institutions, as the moral community entrusted by society with knowledge and skill about oral health, has the duty to lead the effort to ensure access for all Americans.

The oral health needs of vulnerable populations have a unique priority.

Every person has intrinsic human dignity. Oral health professionals must individually and collectively work to improve access to care by reducing barriers. The equitable provision of oral health care services demands a commitment to the promotion of public health, prevention, public advocacy, and the exploration and implementation of new models that involve each oral health professional in the provision of care.

A diverse and culturally competent workforce is necessary to meet the oral health needs of the nation.

The workforce of the future must be prepared to meet the needs of a diverse population. Academic dental institutions have a distinct responsibility to educate dental and allied dental professionals who are competent to care for the changing needs of our society. This responsibility includes preparing providers to care for an aging population, a racially and ethnically diverse population, and individuals with special needs. In so doing, academic dental institutions can anticipate and address unmet oral health needs in underserved populations.

ADEA Policy Statements: Recommendations and Guidelines for Academic Dental Institutions

(With Changes Approved by the 2015 ADEA House of Delegates)

Excerpted from Policy Statement, *Journal of Dental Education,* July 2015 (www.jdentaled.org/content/79/7/838.full.pdf+html)

Policy Statement I. Education, A. Admissions

1. Diverse System of Higher Education. All dental education institutions and programs should support and help enhance the diverse system of higher education. Continued autonomy and growth in the private and public sectors depend on the preservation of this diversity. The nation's private and public systems of higher education are complementary and interdependent. Their preservation depends on the continued attention of all institutional members and the ADEA itself. Students must have the freedom to choose, from the broad spectrum of dental education institutions and programs, the institution or program best designed to meet the students' specific needs.

2. Number and Types of Practitioners Educated. All dental education institutions and programs should use the public's need and demand for dental services as the criteria for determining the number and types of practitioners educated; and constantly assess those needs and demands, and the ability of the number and distribution existing practitioners to meet them.

4. Admissions Criteria. Nondiscriminatory policies should be followed in selecting students.

5. Recruitment, Retention, Access: Best Practices. The American Dental Education Association strongly endorses the continuous use of recruitment, admission, and retention practices that achieve excellence through diversity in American dental education. Dental education institutions and programs should identify, recruit, and retain underrepresented minority students and identify, recruit, and retain women students where inequities exist. Dental education institutions and programs should accept students from diverse backgrounds, who, on the basis of past and predicted performance, appear qualified to become competent dental professionals. Such efforts to achieve a diverse student body are predicated upon a highly qualified applicant pool and the support of private and public funding, which benefit qualified disadvantaged individuals regardless of race, religion, ethnic background, gender, or sexual orientation.

Collaborate with other organizations focused on increasing the numbers of underrepresented minorities in the health professions.

1B. Ethics and Professionalism

3. The Profession's Societal Obligation. The oral health professional enters an implicit contract to serve the public good.

4. Serving in Areas of Need. Offer programs that encourage students to serve in areas of oral health care need. These programs should be equally available to all students at a given educational institution and, when possible, implement an interdisciplinary care model.

7. Sexual Harassment Policy. Work with their parent institutions to have up-to-date policies and well-defined procedures for preventing and responding to incidents involving sexual harassment. Dental education institutions and programs should strive to go beyond legal compliance and risk management considerations to create and sustain a positive learning and working environment. While there are numerous definitions of sexual harassment institutions and programs are encouraged to develop their own definitions that could be applied in a broad context, including *quid pro quo* and hostile environments.[1]

Dental education institutions and programs should, in concert with their parent institution, demonstrate their commitment to preventing and dealing with sexual harassment by:

a. educating faculty, staff, students, and residents about the issue;

b. employing prompt and equitable grievance procedures;

c. setting forth formal and informal procedures and sanctions for dealing with instances of sexual harassment;

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[1] Examples of sexual harassment include the following: "Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when submission to such is made either explicitly or implicitly a term or condition of an individual's employment or academic advancement or when submission to or rejection of such conduct by an individual is used as the basis for employment or academic decisions affecting such individual" (ADEA Sexual Harassment Policy Statement, 1998). It also includes verbal or physical conduct that interferes with an individual's work, professional or academic or career opportunities, or services/benefits. Nonsexual conduct, such as intimidation, hostility, rudeness, and name-calling, and unwelcome behaviors influenced by gender, ethnicity, religion, disability, sexual orientation, or age are also included.

d. creating an environment that encourages persons to come forward with problems;

e. ensuring that policies address sexual harassment by any individuals in an interactive or supervisory role, whether they be peers, patients, students, or a third party;

f. including safeguards protecting confidentiality and prohibiting retaliation or reprisals;

8. Nondiscrimination. ADEA's Councils, Sections, Boards, the House of Delegates, committees, task forces, and similar entities do not discriminate on the basis of race, color, national or ethnic origin, ancestry, age, religion or religious creed, disability or handicap, sex or gender, gender identity and/or expression, sexual orientation, military or veteran status, genetic information, or any other characteristic as prohibited under applicable federal, state, or local law.

10. Confidentiality. Educate staff, students, and faculty to respect and protect patient confidentiality as part of professional interactions.

1C. Curriculum

Curriculum Content

All dental education institutions and programs should:

4. Working within an Integrated Health System. Develop and support new models of oral health care that involve other health professionals as team members in assessing the oral health status of patients and teach dental students to assume leadership roles in the detection, early recognition, and management of a broad range of complex oral and general diseases and conditions. When possible, interdisciplinary educational opportunities should be pursued.

10. Cultural and Linguistic Competence. Include cultural and linguistic concepts as an integral component of their curricula to facilitate the provision of oral health care services. Cultural and linguistic concepts should be included in the measurable dental curriculum objectives.

Dental hygiene education programs should:

2. Prepare Graduates for New and Emerging Responsibilities. Monitor and anticipate changes in supervision requirements within the state and modify the curriculum and extramural experiences of students so as to prepare them to provide more extended services in a variety of practice settings.

1D. Faculty Recruitment and Retention

All dental education institutions and programs should:

4. Gender and Minority Representation. Identify, recruit, and retain underrepresented minorities to faculty positions and promote, when qualified, underrepresented minorities to senior faculty and administrative positions, proportional to their distribution in the general population. Appropriate gender equity should be a goal of any faculty recruitment, retention, and promotion plan.

8. Mentoring Programs. Develop and support formal mentoring programs as a means of recruiting, preparing, and retaining new dental and allied dental faculty, as well as a vehicle for developing and retaining existing faculty.

II. Research

A. **Fundamental and Applied Research.** Dental education institutions and programs have the right and responsibility to conduct fundamental and applied research in the natural and social sciences and in the area of health services, in particular as it relates to oral health disparities.

IV. Access and Delivery of Care

A. **Health Care Delivery and Quality Review.** Dental education institutions and programs and ADEA should be leaders in developing effective health care delivery systems.

C. Dental Health Personnel.

2. Dental education institutions and programs have a vital role in providing access to oral health care to all, with special consideration for the underserved.

5. Dental education institutions and programs collaborate and create linkages with community-based agencies to increase access to care.

6. Dental education institutions and programs prepare their graduates to provide services in a variety of settings to reduce barriers to care and provide more accessible care to various population groups.

D. Dental Insurance, Federal, and State Programs. ADEA should be a strong advocate on both the federal and state levels for:

4. Educating federal and state policymakers about the lack of dental insurance and its relationship to access to oral health care for underserved and unserved populations.

V. Health Promotion and Disease Prevention

E. Alcohol, Tobacco, and Other Drug Hazards

1E. Provide training on general, culturally competent, and gender-specific tobacco prevention and cessation techniques for application in clinical practice.

Definition of Terms Used in Accreditation Standards for Dental Education Programs

Excerpted from Accreditation Standards for Dental Education Programs. Commission on Dental Accreditation (www.ada.org/en/coda/current-accreditation-standards/)

Diversity

Diversity in education is essential to academic excellence. A significant amount of learning occurs through informal interactions among individuals who are of different races, ethnicities, religions, and backgrounds; come from cities, rural areas, and from various geographic regions; and have a wide variety of interests, talents, and perspectives. These interactions allow students to directly and indirectly learn from their differences, and to stimulate one another to reexamine even their most deeply held assumptions about themselves and their world. Cultural competence cannot be effectively acquired in a relatively homogeneous environment. Programs must create an environment that ensures an in-depth exchange of ideas and beliefs across gender, racial, ethnic, cultural, and socioeconomic lines.

Cultural competence: Having the ability to provide care to patients with diverse backgrounds, values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. Cultural competence training includes the development of a skill set for more effective provider-patient communication and stresses the importance of providers' understanding the relationship between diversity of culture, values, beliefs, behavior, and language and the needs of patients.

Dimensions of Diversity: The dimensions of diversity include: structural, curriculum, and institutional climate.

Structural: Structural diversity, also referred to as compositional diversity, focuses on the numerical distribution of students, faculty and staff from diverse backgrounds in a program or institution.

Curriculum: Curriculum diversity, also referred to as classroom diversity, covers both the diversity-related curricular content that promote shared learning and the integration of skills, insights, and experiences of diverse groups in all academic settings, including distance learning.

Institutional Climate: Institutional climate, also referred to as interactional diversity, focuses on the general environment created in programs and institutions that support diversity as a core value and provide opportunities for informal learning among diverse peers.

Accreditation Standards for Dental Education Programs (most pertinent to diversity)

STANDARD 1—INSTITUTIONAL EFFECTIVENESS

1-4 The dental school must have policies and practices to:

a. achieve appropriate levels of diversity among its students, faculty, and staff;

b. engage in ongoing systematic and focused efforts to attract and retain students, faculty, and staff from diverse backgrounds; and

c. systematically evaluate comprehensive strategies to improve the institutional climate for diversity.

Intent:

The dental school should develop strategies to address the dimensions of diversity including, structure, curriculum and institutional climate. The dental school should articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. Schools could incorporate elements of diversity in their planning that include, but are not limited to, gender, racial, ethnic, cultural, and socioeconomic. Schools should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty, and staff.

STANDARD 2—EDUCATIONAL PROGRAM: Behavioral Sciences

2-16 Graduates must be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment.

Intent:

Students should learn about factors and practices associated with disparities in health status among subpopulations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental education in:

- Basic principles of culturally competent health care;
- Recognition of health care disparities and the development of solutions;

- The importance of meeting the health care needs of dentally underserved populations, and;
- The development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multi-dimensionally diverse society.

2-25 Dental education programs must make available opportunities and encourage students to engage in service learning experiences and/or community-based learning experiences.

Intent:

Service learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.

STANDARD 4—EDUCATIONAL SUPPORT SERVICES: Admissions

4-4 Admission policies and procedures must be designed to include recruitment and admission of a diverse student population.

Intent 4-1 to 4-4:

The dental education curriculum is a scientifically oriented program which is rigorous and intensive. Admissions criteria and procedures should ensure the selection of a diverse student body with the potential for successfully completing the program. The administration and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures that are non-discriminatory and ensure the quality of the program.

Academic Leadership Core Competencies for Building Diversity Programs

1. Establish Values and Beliefs
   - Clearly identify values and beliefs upon which to base actions related to building faculty diversity (substantive/empirical evidence can be used to support argument and beliefs).
   - Clearly define direction or focus of change.
   - Identify potential change agents or mechanisms of change and establish a formal plan for engagement.
   - Establish benchmarks for progress toward goals.

2. Collaboration
   - Facilitate shared responsibility and/or authority with partners or change agents.
   - Facilitate forums or mediums for shared knowledge and transparency.
   - Build collaborations in which all partners have vested interests and common goals as part of action steps and objectives for reaching targets.
   - Establish a high degree of trust between the delegated organizer and the rest of the group.

3. Strategic Thinking and Assessment
   - Provide an opportunity for reflection and analysis of action steps, objectives, and outcomes (expected and unanticipated).
   - Reformulate vision if necessary to move agenda forward.
   - Examine communications and ensure that values and beliefs remain relevant.
   - Be prepared to assimilate and accommodate new and relevant information.
   - Encourage idea generation.

4. Persistent and Committed Change
   - Be persistent and committed to values driving change.
   - Avoid ambiguity and overcome resistance; continue to identify and address barriers.
   - Plan for sustainability.

5. Effective Communication

- Clearly communicate a plan to articulate values and beliefs, both written and spoken, to potential agents of change or partners.
- Provide a formal presentation of background/ empirical evidence to support the articulated vision.
- Consider multiple perspectives and provide opportunities to listen to resistance and possible opposition.
- Conceptualize a framework or model (e.g., logic model) to communicate all of the elements needed for change and anticipated outcomes.
- Allow some means for immediate feedback

From: *Growing Our Own.* The ADEA Minority Faculty Development Program. A Manual for Institutional Leadership in Diversity. Support from the W.K. Kellogg Foundation. Copyright © 2011.

ADEA/WKKF Minority Dental Faculty Development (MDFD) Program: "Growing Our Own"

Background

The seven original ADEA/WKKF MDFD grantees are not just "models" for replication of lessons learned and best practices. They are academic/community laboratories that serve as in situ resources from which continuous new insights will be gained as new knowledge is applied to changing concepts, ideas and operations. These seven laboratories will experience continuous quality improvement from their collaborative partnerships and complex packaging of resources for sustainability of diversity and inclusion as a core value.

Lessons Learned (Summary)

1. The **Dean's Leadership** is critical to success.
2. Clearly articulated diversity **policy statement(s)** are major drivers for resource support.
3. **Diversity** is seen as numbers (compositional). Understanding and use of curricular and institutional components of diversity and inclusion are evolving concepts that change thinking and behaviors.
4. **Mentoring** programs are needed for predoctoral and advanced dental education trainees and for faculty.
5. **Academic climate** changes require supportive resources and opportunities for social and inclusive interactions.
6. A diversity executive **leadership pipeline** is missing (e.g., second tier and dean's "team") in dental education.
7. **Cultural competency** concepts require the inclusion of social determinants that affect behavior and policies.
8. **Logic modeling** and GAP analysis—strategic planning to provide understanding on where you are, where you want to be and how you're going to get there—are effective tools for strategic planning, messaging, and outcomes assessment.
9. **Be innovative** in considering interprofessional education collaboration, resource sharing and leadership development opportunities.
10. The value of short-term strategies to achieve long-term goals is being realized at MDFD grantee institutions. **Constant Vigilance** is required as the work in progress continues toward the long-term goal of diversity and inclusion in the dental workforce.

Sustainability Plans (Summary)

1. Logic Model use (bench strength change)
2. Deans' teams Leadership—skills, delegation
3. Collaborations (capacity building)
4. Pipeline focus—K-12 through faculty/research
5. Targeted institutional change—CQI

   - Admissions
   - Retention mentoring
   - Outreach community
   - Research development
   - Alumni—tracking and use
   - Allied dental inclusion
   - Interprofessional education and practice

References

1. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.
2. Bird WM, Clayton LA. *An American Health Dilemma: Race, Medicine and Health Care in the United States.* New York: Rutledge, 2000.
3. Institute of Medicine. *Unequal Treatment.* Washington, DC: National Academy Press, 2002.
4. Sullivan Commission on Diversity in the Health Workforce. *Missing Persons: Minorities in the Health Professions.* Washington, DC. September 2004.
5. Institute of Medicine. *In the Nation's Compelling Interest: Ensuring Diversity in the Healthcare Workforce.* Washington, DC: National Academy Press, 2004.
6. Malcolm SM, Chubin DE, Jesse JK. *Standing Our Ground: A Guidebook for STEM Educators in the Post Michigan Era.* Washington, DC: American Association for the Advancement of Science, 2004.
7. Sinkford JC, Valachovic RW, Harrison S. Continued vigilance—enhancing diversity in dental education. *J Dental Educ.* 2006; 70(2):199-203.
8. Satcher D, Paimes RJ. *Multicultural Medicine and Health Disparities.* New York: McGraw-Hill Companies, Inc., 2006.
9. Leadership Conference on Civil Rights. Policy brief: Creating an Agenda to Provide for Equal Opportunity in the States. Washington, DC. 2007
10. Perez T, Hallis P, Barnet, K. Health Professions Accreditation and Diversity: A Review of Current Standards and Processes. Study Commissioned by the W.K. Kellogg Foundation, May 2007.
11. Taking Mentoring and Leadership to the Next Level. Minority Dental Faculty Development. ADEA/W.K. Kellogg Foundation. December, 2008

12. Nivet MA, Taylor VS, Butts GC, et al. Diversity in Academic Medicine No. 1 Case for Minority Faculty Development Today. *Mt. Sinai J Med* 2008; 75:491-98.

13. Grumbach K, Mendoza R. Disparities in Human Resources: Addressing the Lack of Diversity in the Health Professions. *Health Aff* (Millwood) 2008; 27:413-22.

14. Landefeld T. *Mentoring and Diversity. Mentoring in Academia and Industry 4.* New York: Springer Science+Business Media, 2009.

15. Wade-Golden K, Matlock J. From: Accountability and Organizational Leadership/A Collection of Papers on Self-Study and Institutional Improvement. University of Michigan, 2009.

16. Policy Paper: A 21st Century Imperative: Promoting Access and Diversity in Higher Education. The College Board Advocacy, American Council on Education and Education Counsel. October, 2009.

17. Sullivan LW, Mittman IS. The state of diversity in the health professions: a century after Flexner. *Academic Medicine* 2010; 85(2):246-53.

18. Web "portal" for information resources on disparities in oral health. Division of Oral Health, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. http://www .cdc.gov/oral_health/oralhealthdisparities/

19. Rudolph A. *The American College and University: A History.* Athens, GA: University of Georgia Press, 1990.

20. Valachovic RW, Machen B, Haden NK. The value of the dental school to the university. In: Haden NK, Tedesco LT, eds. L*eadership for the future: the dental school in the university.* Washington, DC: American Association of Dental Schools, 1999:6-13.

21. Bulger, RJ, McGovern JP. eds. Physician Philosopher. The Philosophical Foundation of Medicine—Essays by Dr. Edmund Pellegrino. Charlottesville, VA: Carden Jennings, 2001.

22. ADEA Position Paper: Statement on Roles and Responsibilities of Academic Dental Institutions in Improving the Oral Health Status of All Americans (As approved by the 2004 ADEA House of Delegates). *J Dental Educ* 2011; 75(7):988-95.

23. Betancourt JR, Green AR, Carrillo JE, Anaheh-Firempong II O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Rep* 2003; 118(July/August):293-302.

24. Ang S, Van Dyne L (eds). *The Handbook of Cultural Intelligence.* New York. ME Sharpe, 2008.

25. Earley PC, Ang S. *Cultural Intelligence: Individual Interactions Across Cultures.* Redwood, CA: Stanford Business Books, 2003.

26. Beatty M. Direct Communication. 12/07/15

27. Association of American Medical Colleges. Cultural Competence Education. 2005. Accessed: https://www.aamc.org/download/54338/data/culturalcomped.pdff

28. Racial and Ethnic Disparities in Health Care, Updated 2010. American College of Physicians; 2010 Policy Paper. Philadelphia, PA. https://www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/racial_disparities.pdf

ADEA/WKKF "Family" of Access to Dental Careers (ADC Pipeline); Dental Student Outreach (DSOP) and Minority Dental Faculty Development (MDFD) Schools

Schools	Location
ADEA/WKKF Access to Dental Careers (ADC Pipeline) (11 Schools)	
University of California, San Francisco, School of Dentistry	California*
University of Connecticut School of Dental Medicine	Connecticut
Howard University College of Dentistry	Washington, DC
University of Illinois at Chicago College of Dentistry	Illinois
Boston University Henry M. Goldman School of Dental Medicine	Massachusetts
University of North Carolina at Chapel Hill School of Dentistry	North Carolina
The Ohio State University College of Dentistry	Ohio
Meharry Medical College School of Dentistry	Tennessee
University of Washington School of Dentistry	Washington
West Virginia University School of Dentistry	West Virginia
The Maurice H. Kornberg School of Dentistry, Temple University	Pennsylvania
ADEA/WKKF Dental Student Outreach (DSOP) Program (3 Schools)	
University of Michigan School of Dentistry	Michigan
University of Illinois at Chicago College of Dentistry	Chicago
Howard University College of Dentistry	Washington, DC
ADEA/WKKF Minority Dental Faculty Development (MDFD) (11 Schools)	
University of Alabama at Birmingham School of Dentistry	Alabama
Texas A&M University Baylor College of Dentistry	Texas
Howard University College of Dentistry	Washington, DC
University of Illinois at Chicago College of Dentistry	Chicago
University of Michigan School of Dentistry	Michigan
University of Oklahoma College of Dentistry	Oklahoma
New York State Academic Dental Centers (NYSADC): New York University College of Dentistry	New York
Columbia University College of Dental Medicine	New York
University at Buffalo School of Dental Medicine	New York
Stony Brook University School of Dental Medicine	New York
University of Rochester School of Medicine and Dentistry	New York
ADEA/WKKF Minority Faculty Development Phase II (2 Schools)	
University of Detroit Mercy School of Dentistry	Michigan
Howard University College of Dentistry	Washington, DC

Schools	Location
ADEA/WKKF Minority Faculty Development Phase III (5 Schools)	
University of Detroit Mercy School of Dentistry	Michigan
Dental College of Georgia at Augusta University	Georgia
Howard University College of Dentistry	Washington, DC
University of Oklahoma College of Dentistry	Oklahoma
University of Minnesota School of Dentistry	Minnesota
Total: N=24 ADC Pipeline (2001-2005); 4 years MDFD (2004-2010); 6 years DSOP (2009-2010); 1 year MDFD II (2012-2013); 1 year MDFD III (2013-2015); 2 years MDFDI (2015-2017); 2 years	

*Note: Four additional schools in the state of California received funds for ADC from The California Endowment.

ADEA/WKKF Programs: States Impacted by Community Outreach

AMERICAN DENTAL EDUCATION ASSOCIATION

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ADEA/WKKF MDFD II and III Academic/Community Partnerships

Oklahoma (12)
External
Oklahoma Caring Foundation BCBS (Van)
Blue Cross Blue Shield of Oklahoma (Cargo Van)
Oklahoma Oral Health Coalition
Oklahoma Mission of Mercy (Tulsa)
Tulsa Oral Health Safety Net Commission
Give Kids A Smile Day
Britton Elementary School Health Fair
Delta Dental of Oklahoma Oral Health Foundation
Mobile Smiles Unit
Morton Comprehensive Health Center (Tulsa)
Chickasaw National Medical Center (ADA)
Oklahoma Dental Foundation

Minnesota (8)
External
Brian Coyle Center
Ready, Set, Smile (RSS)
Sojourner Truth Academy (STA)
Community University Health Care Center
Delta Dental of MN
Hmong Market
Hispanic Market
Somali Market

Howard (15)
External
Colgate Mobile Dental Van (Bright Smiles Bright Futures)
Give Kids A Smile Day
D.C. Dental Society
Colts Wellness Center
Coolidge High School
College of Allied Health
H.U. College of Nursing
Nurse Practitioner Program
National Congress of Black Women
D.C. Child and Family Services Nurse Care Program
D.C. Public Schools
Community Health Clinics
DC Department of Health
Private Dental Practitioners
Gordon Dental Associates

University of Detroit Mercy (14)
External
Henry Ford Health Systems (HFHS)
U.S. Army
AETNA
AAMC
Area Health Education Center (AHEC)
Detroit Area School Districts
American Indian Youth Programming
Michigan Department of Community Health
SNDA and SNDHA
American Indian Dental Society
S Historically Black Colleges (HBSU)
Michigan Universities
Wayne County Schools
Mobile Dental Clinic

Augusta University (formerly Georgia Regents University) (Allied Dental) (7)
External
Richmond County Health Department
A.R. Johnson Health Science and Magnet School
Mobile Dental Clinic (Trailer)
Lamar-Milledege School
College of Allied Health Sciences
Give Kids A Smile Program
Dental School Pediatric Clinic

N=56*

*Note: The 56 Academic/Community Partnerships created in MDFD II and MDFD III are in addition to the 83 nascent Academic/Community Partnerships. The original partnerships include a broad spectrum of clinical settings for experiential learning and dental care in: dental school clinics, mobile units, nursing homes, Indian Health Service Clinics (IHC), migrant workers, and a health disparities center. These partnerships add value to both service learning and community-based dental education (CBDE).

Constellation of Core* Diversity Collaborations and Partnerships

WKKF Minority Dental Faculty Development (MDFD)

Ventures Scholars Program (VSP)

Academic Careers Fellowship Program (ADCFP)

ExploreHealthCareers.org

WKKF Dental School Outreach Program (DSOP)

Sullivan Alliances Statewide

Health Professionals for Diversity Coalition (HPD)/AAMC

ADA Career Diversity (Committee D)

Professional Student Organizations

RWJF Summer Medical and Dental
Education Program (SMDEP)/AAMC

Executive Leadership in Academic Medicine (ELAM)

Bridging the Gap (Macy Foundation)

Professional Organizations (ADA, NDA, SAID, HDA)

National Association of Advisors for
the Health Professions (NAAHP)

ADEA
C - Collaboration
A - Advocacy
P - Policy

Professional Diversity Roundtable

ADEA GoDental

College Board Collaborative (AAMC/ACE)

ADEA Leadership Institute

Corporate

P&G   J&J   COLGATE

*ADEA will expand its "core" collaborations in the future:
- Historically Black Colleges and Universities
- Hispanic Serving Institutions
- Tribal Colleges
- Non-Pipeline program dental schools
- Corporate/Education relationships
- STEM Pipeline

*ADEA will expand its "core" collaborations in the future:
- Allied dental programs
- Advanced dental programs
- Sullivan Statewide Alliances
- Advocacy
- Academic/Community partnerships

DENTAL SCHOOL ENROLLEES BY RACE AND ETHNICITY, 2010 AND 2015

2010

- Unknown Race and Ethnicity, 3.3%
- Two or More Races, 2.4%
- American Indian or Alaska Native, 0.2%
- Asian, 23.0%
- Black or African American, 5.4%
- Hispanic or Latino, 7.2%
- Native Hawaiian or Pacific Islander, 0.1%
- White, 58.4%

2015

- Unknown Race and Ethnicity, 4.7%
- Non-resident Alien, 4.8%
- Two or More Races, 2.6%
- American Indian or Alaska Native, 0.3%
- Asian, 22.2%
- Black or African American, 4.0%
- Hispanic or Latino, 7.0%
- Native Hawaiian or Pacific Islander, 0.4%
- White, 54.1%

Racial and Ethnic Trends in Enrollment

The chart shows the alone and in combination total for each racial and ethnic group.

ADEA Deans' Briefing Book 2014-2015

Note: The numbers add to more than the total first-year enrollment because students who selected multiple racial groups are counted in each group.

Source: American Dental Education Association, U.S. Dental School Applicants and Enrollees, 2004-2013

Graduates of Accredited Dental and Allied Dental Education Programs

2003-04 to 2012-13 academic years

ADEA Snapshot of Dental Education 2015-2016
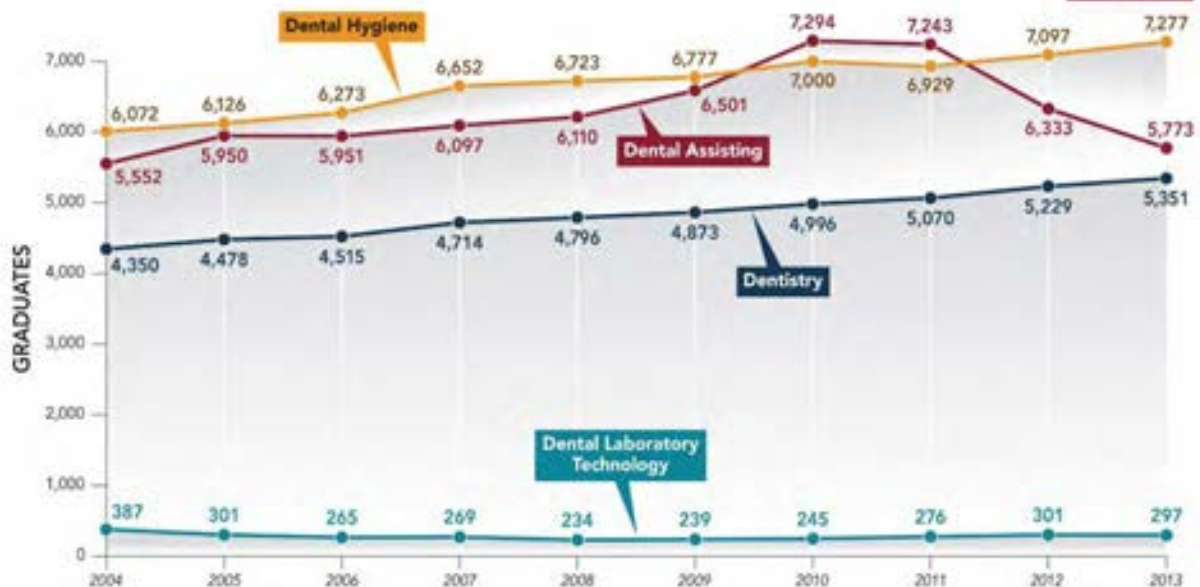
Source: American Dental Association, Health Policy Institute, Surveys of Dental Hygiene Education Programs, Surveys of Dental Assisting Education Programs, Surveys of Dental Laboratory Technology Education Programs, and Surveys of Dental Education

Available at adea.org/snapshot

First-Year Enrollment in Accredited Allied Dental Education Programs

1990-2014

ADEA Snapshot of Dental Education 2015-2016

Legend:
- Dental Assisting
- Dental Hygiene
- Dental Laboratory Technology

1990-91: Dental Assisting 6,162; Dental Hygiene 5,487; Dental Laboratory Technology 932

2000-01: Dental Assisting 6,433; Dental Hygiene 6,537; Dental Laboratory Technology 495

2010-11: Dental Assisting 10,390; Dental Hygiene 8,007; Dental Laboratory Technology 431

2013-14: Dental Assisting 7,397; Dental Hygiene 8,287; Dental Laboratory Technology 402

Source: American Dental Association, Health Policy Institute, Surveys of Dental Hygiene Education, Surveys of Dental Assisting Education Programs, and Surveys of Dental Laboratory Technology Education Programs.

Available at adea.org/snapshot

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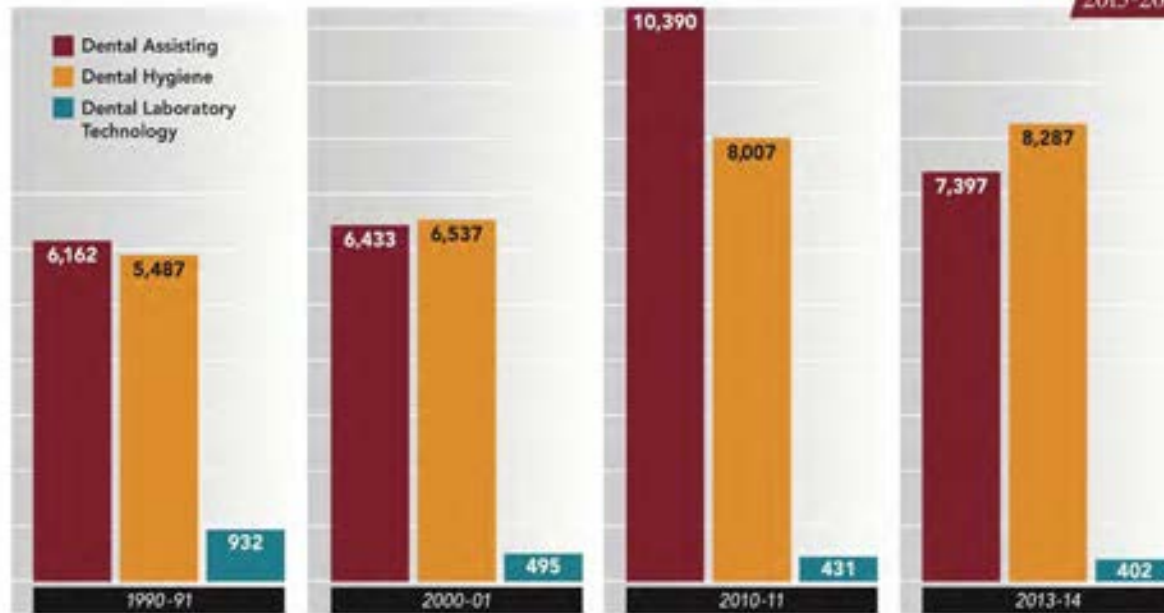
The Affordable Care Act (ACA) and the Health of Minorities and Women

Reforming the National health care system was President Obama's top domestic priority when he was sworn into his Office in January 2009. After major reconciliations of differences and compromise, the Patient Protection and Affordable Care Act (ACA) was signed into law by President Obama on March 23, 2010 (Pub. L. No. 111-148). The ACA was amended by the Health Care and Education Reconciliation Act of 2010 (H.R.4872). ACA, as reconciled by H.R.4872, increases care to the uninsured by 32 million over the next decade.

Some of the provisions in the ACA address innovative health education and preventive programs that will especially benefit ethnic minorities and women:

- Health professions training for diversity.
- Increased diversity among dentists.
- Investment in HBCU's and minority-serving institutions.
- Community-based training for AHEC's targeting underserved populations.
- Grants for Community Health Workers and Culturally and Linguistically Appropriate Services (CLAS).
- Cultural competence education and training.
- Health Disparities Research – new PCORI (Patient-Centered Outcomes Research Institute) to carry out comparative effectiveness research (CER).
- Elevate NCMHHD to Institute Status (National Center for Minority Health and Health Disparities)
- National Oral Health Campaign with emphasis on disparities.
- Support for preventive programs for AI/ANs.
- Maternal and child home visiting programs for at-risk communities.
- Standardized drug labeling on risks and benefits.
- Social determinants of health-prevention education.
- Home visitation programs for maternal and child care providing families with client-centered education.
- Establishes the Indian Health Care Improvement Reauthorization and Extension Act of 2009 (S.1790) as law.
- Mandate for nondiscrimination in federal health programs and claims appeal process.
- Insurance coverage-remove cost-sharing for AI/ANs at or below 300% FPL.
- Enrollment outreach targeting low income populations.
- Summary language of coverage that is culturally and linguistically appropriate.
- Expanded insurance coverage for women.
- Preventive health services for women, including screening and counseling.
- Lactation support in the workplace.
- Expanded coverage for children with pre-existing conditions.
- Monitor health disparities trends in federally-funded programs.
- Advancing health equity for racially and ethnically diverse populations.

Dr. Richard W. Valachovic
ADEA President and CEO

Dr. Jeanne Craig Sinkford
ADEA Scholar in Residence
Office of the President and CEO

Resources: Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diversity Populations. Joint Center for Political and Economic Studies, July, 2010.
The Affordable Care Act and Women. Nancy C. Lee, M.D. Presentation to NIH Advisory Committee ORWH, October 16, 2012, Bethesda, MD.
http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm
http://minorityhealth.hhs.gov/

Additional Affordable Care Act Provisions

Prevention:

- The Affordable Care Act helps make prevention affordable and accessible for all Americans by requiring health plans to cover preventive services and by eliminating cost sharing. According to regulations released by the U.S. Departments of Health and Human Services (HHS), Labor, and the Treasury, if an individual or family enrolls in a new health plan on or after September 23, 2010, then that plan will be required to cover recommended preventive services without charging a deductible, copayment or co-insurance.

Women's Health Issues:

- African American women are about one-third more likely to die from breast cancer compared to others. In 2006, 12,000 women in the U.S. were told that they had cervical cancer, and nearly 4,000 women died from the disease. More than 16% of women in the U.S. smoke, significantly increasing their risk of lung cancer and other tobacco related illness.
- Only about 67% of women aged 40 or older have had a mammogram in the last two years. The rate of women getting mammography screening has not improved since 2002. If 90% of women 40 and older received breast cancer screening, 3,700 lives would be saved annually. More than 17% of women in the U.S. have never had a Pap smear.

The new regulations ensure that new health plans offer coverage without cost-sharing for a variety of important cancer prevention tools, such as:

- Preventing breast cancer: Annual mammograms for women over 40. Other services to prevent breast cancer will also be covered, including a referral to genetic counseling and a discussion of chemoprevention for certain women at increased risk.
- Preventing cervical cancer: Regular Pap smears to screen for cervical cancer and coverage for the HPV vaccine that can prevent cases of cervical cancer.
- Tobacco cessation interventions -like counseling or medication to help individuals quit.
- Preventing colon cancer: Screening tests for colon cancer for adults over 50.

Minority Health Issues:

- Codifies into the law the *Office* of *Minority Health* within the *Department* of *Health and Human Services* (HHS) and a network of minority health offices within HHS, to monitor health, health care trends, and quality of care among minority patients and evaluate the success of minority health programs and initiatives.

- Moves toward elimination of disparities that African Americans currently face both in their health and in their health care by investing in data collection and research about health disparities.

- Ensures that families have guaranteed choices of quality, affordable health insurance if they lose their jobs, switch jobs, move, or become sick and provides premium tax credits to those who can't afford insurance, which will significantly reduce disparities in accessing high-quality health care. African Americans are roughly twice as likely to be uninsured as the rest of the population.

- Provides access to affordable insurance or uninsured Americans with pre-existing conditions through a temporary subsidized high-risk pool, which will help protect them from medical bankruptcy. This high-risk pool is a stop-gap measure that will serve as a bridge to a reformed health insurance marketplace.

Yvonne Knight, J.D.
Chief Advocacy Officer
American Dental Education Association

Appendix: MDFD III Site Visit Protocol

We are very interested in capturing information and best practices related to the grant program areas:

1. *Provide funding for training support allied dental health professionals.*

2. *Develop culturally competent allied dental professional program.*

3. *Recruit allied health professionals to reach children in medically underserved communities.*

4. *Allied health professionals and the MDFD grantee school building relationships and preventive dental services with school-based programs and remote care sites in underserved communities (where dental carries prevention and sealants can be provided).*

Below are some tools included below to elaborate upon your existing logic model for the purposes of sustainability planning. We are asking that you take a look at your previous logic model and planning information and build upon it to complete the **Gap S.M.A.R.T.** Logic Model and the **Sustainability Matrix** below. These are meant to help guide our day and a half discussion.

For the site visits we are also very much interested in updates related to community sites and community-based work.

The information for the site visits should be prepared and shared with Joseph West and with Dr. Jeanne Sinkford 1-2 weeks prior to your scheduled site visit. If you have any questions please feel free to contact Joseph West at jfwest.wg@gmail.com or 312-420-1336.

Purpose:

The purpose of the MDFD site visits to grantee institutions is three-fold:

- To evaluate the progress to date of the institution according to the grant proposal and objectives and as depicted in the progress report from the institution
- To provide supportive recommendations and assistance that will strengthen the program
- To review the evaluation model and help grantees with technical assistance for effective use of the model to chart progress and outcomes

Responsibilities of the Host Sites:

- Work in concert with ADEA to produce a draft agenda at least two weeks prior to the site visit
- Ensure that key university and institutional personnel faculty, staff and Allied Dental Professionals are available at scheduled times
- Provide supplemental information that may be necessary for adequate program evaluation
- Provide any updates relevant to the last progress report that was submitted by the grantee

Responsibilities of the External Evaluation Team (EET):

- Create an atmosphere that is conducive to open and candid discussions that relate to program progress and challenges
- Provide program leadership with objective commentary and feedback based on observations, submissions and discussions
- Offer advice specific to program changes that will assist in the achievement of favorable outcomes to goals and objectives

Sample Visit Timeline

Preceding Evening:

- Dinner (If necessary or desired)

Day One (8:30 a.m. – 3:00 p.m.)

- Breakfast/Preparatory Meeting
- Focus Area I
- Focus Area II
- Break/Lunch
- Focus Area III

Day Two (8:30 a.m. – noon)

- Clinic or Community Partner Visit
- Meeting with other Administrators/Academic Collaborators
- Meeting with Dean
- Wrap-Up / Next Steps Discussion

The Three Focus Areas for the Site Visit

Focus Area I: Program Update

Concise program updates outlined by the six criteria areas:

1. ***Formal Faculty Mentoring & Funding Program:*** Grantees have a formal mentoring plan or program either in place or in the late stages of development—meaning mentor/mentee connections have been defined, arranged and monitored.

2. ***Academic Partnerships*** *(established or planned):* Grantee has established reciprocal academic partnerships with other programs on campus, Pipeline programs or other dental programs in order to advance academic and service agendas related to diversity of each participating institution.

3. ***Allied Dental Professional Development:*** Grantee has either received or applied for supplemental funding to support mentoring activities and training opportunities.

4. ***Community-Based Practice and Projects:*** Grantee has established at least one community-based project or program.

5. ***Allied Dental Professionals Data Collection and Reporting:*** Grantee has a system for collecting data and also collects data for academic work including journal publications; academic presentations, etc.

6. ***Institutional Culture and Leadership:*** Leadership (Dean, Provost, etc.) at Grantee institution has made a visible commitment to the program including allied dental professional activity taken in the field regarding eliminating oral health disparities.

Focus Area II: Best Practices

We are asking that Grantees make a descriptive list of "Best Practices." Best Practices include techniques, methods, processes, activities or rewards that have been most effective for your program. Best Practices can also describe the most innovative, efficient (least amount of effort … yielding significant result), effective (best result) and replicable means of accomplishing the following areas of the program:

1. Recruiting Allied Dental Professionals, junior faculty, senior faculty (including building social support)

2. Mentoring (for mentee and mentor, including career planning)

3. The MDFD Program and Leadership's role in Influencing the Institutional Environment

4. Building Partnerships (between and within institutions, in the surrounding community, etc.)

5. Communications to Allied Dental Professionals, potential faculty, etc, regarding opportunity (internal and external)

6. Establishing guidelines for hiring Allied Dental Professionals (including readiness to hire, candidate selection, etc.)

Focus Area III: Sustainability Planning

Building upon your existing Logic Models and program planning information we will work on sustainability plans for your program. For this portion of the site visit we will use a "GAP /S.M.A.R.T." technique for building sustainability plans. We are asking grantee to try to complete the GAP Analysis Logic Model Tool and the Sustainability Matrix included in the protocol. There is a sample GAP Analysis Logic Model Tool to be used as a guide.

Consider two ways to achieve sustainability:

1. ***Internal support:*** obtaining support from the sponsoring institution to continue some or all of the former grant activities with possible changes in format.

2. ***External support:*** obtaining support from outside the institution to continue some or all of the former grant activities with possible changes in format.

A Logic Model for GAP Analysis[3]

A "GAP" Analysis is a step-by-step method for identifying gaps between the current state of the program and the desired state for the program with specific goals and dates for achievement. In others words, this process helps name areas of the program where you would like to improve, the resources needed to get there and clear markers of improvement in the plan. Some keys to the process:

- The method does not highlight weakness or fault as much as it does identify opportunity.

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[3] https://www.wkkf.org/resource-directory/resource/2006/02/wk-kellogg-foundation-logic-model-development-guide

- The method focuses on a system of improving, and not just on the need to improve the system.
- The method reinforces and replicates factors for achievement

S.M.A.R.T. inputs and action steps for sustainability planning are simple reminders of the five features to consider as you identify inputs, needs and resources for improvement. Inputs and actions should be:

- **Specific:** measurable with clear assumptions that can be easily interpreted and applied.
- **Measurable:** indicators for improvement established.
- **Attainable:** achievable and credible under anticipated circumstances.
- **Realistic:** cost-effective and efficient; work within fiscal and other constraints.
- **Timely:** results are expected within the timetables established

Sustainability Matrix

The matrix is organized to describe sustainability plans for each of the program areas.

1. Source of Assessment should be the one, two or three ways that you assessed where you need to improve. For example, survey, focus groups, informal discussion, feedback, records, etc.

2. Areas Needing Improvement ("what you're going to do") should be a list of the aspects or features of the program that have been identified as needing improvement.

3. Action Steps ("how you're going to do it") should show that you have thought through what is necessary to make the areas needing improvement attainable.

4. Resources Needed for Improvement is a list of financial and other resources need to make the areas needing improvement attainable.

5. Goals for Improvement ("how we know we improved")

6. Completion Timeline ("when you're going to do it") is an estimate of when you believe the goal(s) will be accomplished. If a component or activity will not have a specific conclusion, you can substitute "ongoing" for a future completion date.

Appendix: Sustainability Matrix

Topic Area:					
Areas Needing Improvement	**Action Steps for Improvement**	**Resources Needed for Improvement**	**Goals for Improvement**	**Completion Timeline**	**Source of Assessment**

Topic Areas:

1. Formal Faculty Mentoring & Funding
2. Academic Partnerships (established or planned)
3. Allied Dental Professional Development
4. Community-Based Practice and Projects
5. Data Collection and Reporting
6. Institutional Culture and Leadership

A Logic Model for Gap Analysis and Sustainability Planning: Example

S.M.A.R.T. Inputs
(list the Strategic, Measurable, Attainable, Realistic and Timely inputs to be dedicated to sustainability)

- Faculty training plan
- Monitoring/observational reports
- Written commitments describing the financial and intellectual contributions of and timelines for your collaborations
- Program promotion and marketing plan
- Pipeline program
- Mentors
- Incentives for retention
- Visible leadership commitment
- Faculty/allied dental professional input
- Research/teaching opportunities

Areas Needing Improvement

(related to the listed inputs)

- Program management
- Partnerships
- Communication
- Quality/commitment

Action Steps for Improvement

(related to the listed areas for improvement and resources)

- Training
- Re-tool vision and goals
- Networking conference
- Engage allied dental professional groups
- Examine faculty agreements
- Grant writing/fiscal requests

Resources Needed for Improvement

(related to the listed inputs)

Short-term Goals
1. Increase number of faculty mentors
2. Junior faculty exchange

Long-term Goals
1. Strengthened faculty placement
2. Enhanced quality of program /department /school

Feedback Loop

(describe your feedback loop)

A Logic Model for Gap Analysis and Sustainability Planning

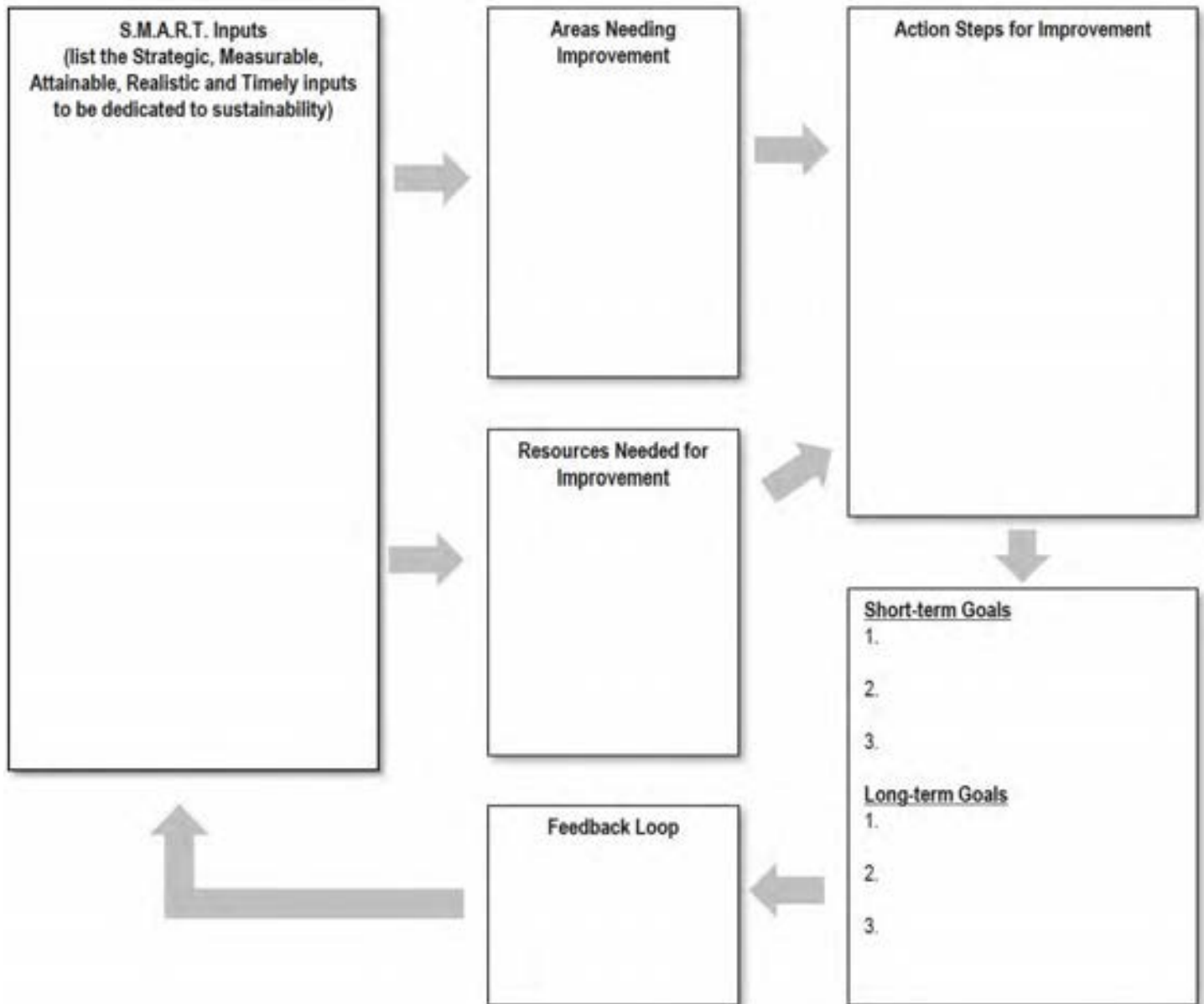| S.M.A.R.T. Inputs (list the Strategic, Measurable, Attainable, Realistic and Timely inputs to be dedicated to sustainability)	Areas Needing Improvement	Action Steps for Improvement

Resources Needed for Improvement

Action Steps for Improvement

Short-term Goals
1.
2.
3.

Long-term Goals
1.
2.
3.

Feedback Loop

ADEA Strategic Directions and Key Priorities

ADEA | THE VOICE OF DENTAL EDUCATION

2015–18

MISSION

The mission of ADEA is to lead institutions and individuals in the dental education community to address contemporary issues influencing education, research and the delivery of oral health care for the overall health and safety of the public.

Mission: The ultimate purpose of the organization's work. It is the primary lens through which major decisions are made.

LEADERSHIP
Provide leadership for the future of dental education and serve as the authority on the education of the dental and allied dental workforce.

TEACHING AND LEARNING
Provide dental, allied dental and advanced dental educators with the information, knowledge, resources and tools they need to prepare the future dental workforce for an undiscovered future.

LEADERSHIP
TEACHING AND LEARNING
SERVICE
RESEARCH
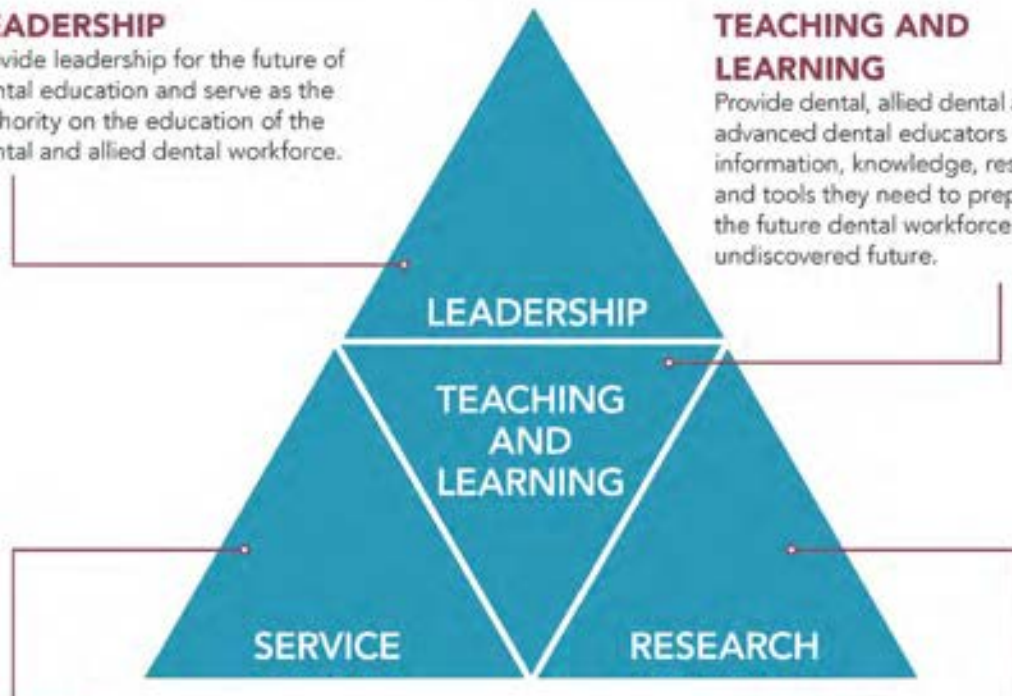
SERVICE
Support the academic dental community in its mission to meet the evolving oral health needs of a diverse society.

RESEARCH
Promote the importance of research as the foundation of dental education, and of the science and practice of dentistry.

AMERICAN DENTAL EDUCATION ASSOCIATION

www.adea.org/StrategicDirections

ADEA Strategic Directions and Key Priorities

2015–18

STRATEGIC DIRECTIONS AND KEY PRIORITIES

STRATEGIC DIRECTION 1:

LEADERSHIP

Priority 1: Demonstrate the value of dental education to students, graduates, academic institutions, corporate members, funders, policymakers and society at large.

Priority 2: Position dental education as a leader in interprofessional education, and dentistry as a core part of the collaborative health care team.

Priority 3: Prepare and engage ADEA members in providing leadership for the association and for the future of dental education.

STRATEGIC DIRECTION 3:

RESEARCH

Priority 1: Enhance the ability of all academic dental institutions to demonstrably advance their research missions.

Priority 2: Advocate for increased funding for dental and craniofacial research and research training, and enhance the competitiveness of academic dental institutions to receive support from NIH and other public and private funders.

Priority 3: Produce and promote evidence-based research and reports to inform decision-making by the dental education community and policymakers.

STRATEGIC DIRECTION 2:

TEACHING AND LEARNING

Priority 1: Provide tools and resources to support ADEA members in preparing graduates for the future of dental practice and their roles as practitioners in a collaborative health care environment.

Priority 2: Prepare dental educators to effectively use new and innovative approaches to teaching and learning that lead to academic success.

Priority 3: Promote the scholarship of teaching and learning as an integral part of the culture of academic dental institutions.

STRATEGIC DIRECTION 4:

SERVICE

Priority 1: Provide expertise and programming that helps develop a diverse and culturally competent workforce prepared to provide care for all segments of the population.

Priority 2: Promote academic dental institutions as key contributors to increasing access to dental care and improving the oral and overall health of their communities.

Priority 3: Serve as a collaborative partner in the global effort to improve oral and overall health.

Strategic Directions: The central areas that the organization will focus on to achieve its mission. The Strategic Directions are typically aspirational, and usually last throughout the full term of the strategic plan without change.

Key Priorities: The desired end-results to be achieved in the plan. By focusing on the Key Priorities, ADEA will advance its Strategic Directions.

American Dental Education Association
655 K Street, NW, Suite 800
Washington, DC 20001
202-289-7201
adea.org

AMERICAN DENTAL EDUCATION ASSOCIATION