AMERICAN DENTAL EDUCATION ASSOCIATION

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

ADEA Minority Dental Faculty Development and Inclusion (MDFDI) Program

Project Support from the W.K. Kellogg Foundation

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February 2017

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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CONTENTS

ACKNOWLEDGEMENTS

The ADEA Minority Dental Faculty Development (MDFD) program was created through ADEA's collaborations with the W.K. Kellogg Foundation and 11 partnering dental education institutions. MDFD initially focused on the dental faculty development, 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), Federally Qualified Health Center (FQHC's) 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 the evidence base 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; 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; Framing the Dialogue on Race and Ethnicity to Advance Health Equity, National Academies of Sciences, Engineering and Medicine, 2016.

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. Susan Kimner, and Ms. Linda Mabrey; former WKKF staff members Dr. Henri Treadwell and Ms. Barbara Sabol; and guest editors.

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

CHAPTER 1: INTRODUCTION

Framing the Institutional Climate for Inclusion and Sustainable Academic and Community Partnerships.

Jeanne C. Sinkford, Richard W. Valachovic, Joseph F. West

Introduction

The ADEA Minority Dental Faculty Development (MDFD) Program was supported in part by a grant from W.K. Kellogg Foundation (2004–2010). MDFD was designed to promote health systems change through academic and community partnerships focusing on leadership development within the faculty of U.S. dental schools providing enhanced dental care to underserved communities. MDFD funds were initially utilized primarily for direct educational costs for underrepresented minority and low-income dentists who were being prepared for academic leadership and careers that would help promote health system changes. MDFD continued (2012–2015) with a focus on allied dental leadership training, community partnerships, pipeline recruitment and cultural competency. In 2015–2017, MDFD became the Minority Faculty Development and Inclusion (MDFDI) Program, incorporating interprofessional education (IPE) concepts, leadership training and best practices for collaborative care. ADEA has the responsibility of distributing grant funding to grantee schools, administration and reporting. The grantee institutions supplemented WKKF grant funds through other grants and resources for outreach and diversity-related programming.

Background

The 66 U.S. dental schools serve as safety nets and “homes” for dental care. They provide more than three million patient visits per year according to the American Dental Association.[1] Through their tripartite mission of education, research and service, dental schools promote health systems change through networks of academic/community partnerships that contribute to the competency of graduates and provide dental care to neighboring communities. It is within the context of increasing diversity in the dental faculty, work force and health systems changes benefitting children that the partnership between the American Dental Education Association (ADEA) and the W.K. Kellogg Foundation (WKKF) was conceived. Initially, the partnership was for Pipeline Recruitment of Underrepresented (URM) and Low Income (LI) students through ADEA/WKKF Access to Career grants.[2]

The Minority Dental Faculty Development (MDFD) Program has developed in four phases that link faculty development with: mentoring, academic/community partnerships, pipeline recruitment, cultural competency and leadership. The first phase was directed toward dental faculty and phases II, III and IV have targeted allied dental faculty.

The MDFD Program has benefitted from support of the U.S. dental school deans under a "Growing Our Own" philosophy and from seminal reports that have documented health disparities and the need for health systems change.[3–6]

Implementation

The MDFD grants were initially awarded to 10 U.S. dental schools and one advanced dental education institution over the six-year period 2004–2010. Six dental schools and one consortium of five dental schools in New York comprised the seven grantees. These were the University of Oklahoma College of Dentistry; University of Michigan School of Dentistry; University of Alabama at Birmingham School of Dentistry; Howard University College of Dentistry; Texas A&M University College of Dentistry; University of Illinois at Chicago College of Dentistry; and the New York State Academic Dental Centers, which includes New York University College of Dentistry, Columbia University College of Dental Medicine, Stony Brook University School of Dental Medicine, and the University of Rochester Medical Center Eastman Institute for Oral Health. The seven grantees were chosen for their unique capacities to implement the MDFD grant objectives, and to leverage resources that would support an infrastructure for sustainability. Program objectives included academic/ community partnerships, formal mentoring, community-based care, leveraging of resources, leadership and cultural competency training. A major challenge to the grantees was the vertical integration of the MDFD program into the mission, goals and objectives of the parent institution and dental school. A logic model was used for strategic implementation, evaluation, program progress reporting and outcomes. Institutional site visits, grantee meetings and surveys of deans and trainees contributed to evaluation of this pilot project for institutional capacity building. ADEA had responsibility for grant oversight, assessment and reporting.

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 Pilots 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. More than 1,500 students participate each year in their academic community/partnerships.

The ADEA/WKKF Minority Dental Faculty and Inclusion (MDFDI) Program 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. The ADEA MDFDI program expands its focus and develops more diverse generations of allied dental health professionals as a new frame in which to meet the significant unmet need for access to dental care across the United States. The leadership training models emphasize interprofessional education (IPE) and collaborative care, cultural and linguistic competency, academic mentorship and increased diversity in the academic pipeline.

ADEA MDFDI produced Toolkit Vol. 1 (2016), which builds on institutional models, the convenings, lessons learned and best practices which have helped change institutional climates.[8]

Outcomes

The interface of ADEA/MDFD grant trainees (234) with the ADEA/WKKF Access to Dental Careers (ADC) Pipeline grant pool (124) has produced a unique talent pool of 358 individuals for future dental faculty across clinical disciplines: prosthodontics, periodontics, orthodontics, pediatric dentistry, endodontics, restorative dentistry, oral and maxillofacial surgery and dental public health. The grantee schools are challenged for both sustainability of diversity initiatives as well as continued and future engagement of alumni who have benefitted from MDFD funding in pursuit of their academic goals. The MDFD schools now have the data for continued involvement of MDFD graduates in a variety of community outreach, recruitment and service programs throughout the United States. Other dental schools have also benefitted from experiences of the leaders that have completed the mentorship, strategic thinking and planning during their training. The 11 academic/ community partnerships that were formed are now positioned to become a part of statewide and regional alliances that are anticipated in the transformation of the dental health care system in the United States. The skills that were learned by MDFD program leaders will be useful in the systemic changes envisioned for increased access to care in a collaborative delivery system. The MDFD program has produced a group of minority leaders who possess skills and behaviors required for increased academic/community engagement and sustainable partnerships that improve the health of underserved communities.

Eighty-three academic/community partnerships were created during the first six-year grant period. Patients received their dental care from undergraduate, advanced and allied dental students and residents in remote sites such as school clinics, mobile units, nursing homes, Indian Health Service (IHS) clinics, migrant workers and a health disparities center. The inclusion of advanced-level treatment in the community settings was of value to both students and patients as complex patient needs were addressed in team delivery of care. Through this

grant, dental schools will continue their "safety net" role in caring for the underserved. The dental school outreach programs are now linked with a variety of social services and community-building opportunities in challenged neighborhoods. The Federally Qualified Health Centers, dental schools and their extramural clinics form a triad of resources for dental care for the underserved. There has not been a "quality of care" issue in the remote academic/community partnerships because direct supervision and standards of care are the same as those in the accredited dental school dental clinics.[9] An additional 56 academic/community partnerships were created in MDFD II and III.

Mentoring

Mentor/mentee surveys, site visits and institutional reports document the value of the formal and informal mentoring experiences throughout the grantee schools. Outcomes include 1) the importance of personal interaction of faculty mentors with mentees, 2) variety in mentor program structures, 3) use and value of multiple mentors, and 4) emergence and importance of peer-to-peer and online mentoring between and among fellows. Qualitative assessments were obtained from mentors and fellows regarding their perceptions of value and satisfaction. In a 2007 survey, an overwhelming majority of mentees (91%) responded that they felt their mentors made a difference in their lives in general. The majority of mentees (71%) also felt that their mentors made a difference in their career choices.[11] MDFD/MDFDI trainees found a cascading effect from the mentoring received in their continued commitment to mentoring others and in their humanistic lifestyles. The trainees are using mentoring skills they learned for the identification and recruitment 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. Profiles from interviews of grant recipients continue to be updated (http:/www.adea.org/MDFD/Growing-Our-Own.aspx). The profiles document the long-term value of mentoring in professional development and the cascading effect of mentoring across cultures and generations.

Deans' Leadership

The leadership of the dental school dean emerged as the consistent, critical driver in both implementation and perceptions of the value of diversity and inclusion. However, changes in leadership at the MDFD grantee institutions approached 99% during the term of the grant. These leadership changes present a major challenge for creative realignment and marketing of diversity and inclusion objectives among priorities. The sustainability efforts at schools such as Michigan, Howard, Oklahoma and Alabama are bound to both history and missions. There is much to be learned from these schools whose institutional missions bring historical perspective to diversity as a national challenge. Baylor and UIC, on the other hand, are models that are University-mission oriented. They sustain diversity activities through commingling of institutional resources and strategies.

The Challenge

The MDFD schools serve as academic laboratories from which continuous new insights and knowledge are applied to operations and sustainability efforts.[9] For example, the concept of "inclusion" became an important frame for linking diversity objectives with access and interprofessionalism in collaborative care initiatives. Lessons learned from the MDFD/MDFDI and Leadership Core Competencies have evolved from institutional site visits, document reviews, grantee meetings and surveys of deans and trainees at the partnering schools. Lessons Learned and Leadership Core Competencies are useful "Tools" as institutions prepare for changes that are now delineated in Accreditation Standards for Dental Education Programs (Commission on Dental Accreditation. Implemented July, 2013). The new Standards include specific language regarding: diversity and cultural competence. Accreditation Standards 1-3 and 1-4 speak specifically to diversity requirements and institutional expectations. New Accreditation Standards for Dental Therapy Programs were approved for implementation (February, 2016). New models in the dental workforce are anticipated for the future.

Summary

A "Growing Your Own" philosophy for the recruitment, retention, and the advancement of a diverse faculty prevailed throughout the grantee schools. Through innovation, commitment and enthusiasm, the MDFD grant program and its grantees, individually and collectively, have produced a whole that is greater than the sum of its parts. The MDFD/MDFDI grantee institutions serve as academic models for other health professional institutions as they accept the continuing challenge to increase diversity in health workforce, improve access to care in underserved communities, and meet accreditation standards that support quality and innovation in dental education. The original ADEA/WKKF MDFD grantees are academic/community laboratories that serve as in situ resources from which continuous new frames will emerge as new knowledge is applied to changing concepts, ideas and opportunities. 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.

REFERENCES

1. American Dental Association. 2015-16 Survey of Dental Education: Report 1 – Academic Programs, Enrollment, and Graduates. October 12, 2016.
2. Sinkford JC, Valachovic RW, Weaver RG, and Harrison SG ADEA/WKKF Access to Dental Careers Program: Supporting a Dental Pipeline Concept and Program. Journal of Dental Education. Vol.74, No. 10. October 2010.
3. Field JD, ed. Dental education at the crossroads: challenges and change. An Institute of Medicine Report. Washington, DC: National Academy Press, 1995.

4. 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.
5. 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.
6. 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.
7. 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.
8. Toolkit Volume I: A Case for Dental Academic/Community Partnerships for leadership and diversity. ADEA Minority Dental Faculty Development and Inclusion (MDFDI) Program. Project support from the W.K. Kellogg Foundation. American Dental Education Association, Washington, DC. April 2016.
9. Sinkford JC and Valachovic RW. 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. American Dental Education Association, Washington, DC. Copyright 2011.
10. Sinkford JC, West JF, Weaver RG, Valachovic RW. Modeling Mentoring: Early Lessons from the W.K. Kellogg/ADEA Minority Dental Faculty Development Program. Journal of Dental Education. Vol. 73, No. 6. June 2009.
11. The Transformation of Academic Health Centers: The Institutional Challenge to Improve Health and Well Being in Healthcare's Changing Landscape. Chapter: Diversity in the Academic Health Center: Progress and Opportunities. Haywood S, Berkman R, Sinkford J, Sullivan L, Sussman J, Gershen J. (ADEA/WKKF Case Study: The Minority Dental Faculty Development Initiative). Elsevier. May 2015.

Academic Leadership Core Competencies for Building Diversity Programs

There are five Academic Leadership Core Competencies for Building Diversity Programs: 1. Values and Beliefs; 2. Collaboration; 3. Strategic Thinking and Assessment; 4. Persistent Commitment and Change; 5. Effective Communication.

Thinking about Academic Leadership within the past 12 months, we'd like your feedback on the Academic Leadership Core Competencies for Building Diversity Programs within your University/Institution.

Values and Beliefs

	Not at All	Rarely	Some-times	Often	Very Often	Total	Weighted Average
Academic Leadership clearly identify values and beliefs upon which to base actions related to building faculty diversity programs.	0.00% 0	14.29% 1	28.57% 2	42.86% 3	14.29% 1	7	3.57
Academic Leadership clearly define direction or focus of change related to building faculty diversity programs.	14.29% 1	0.00% 0	57.14% 4	14.29% 1	14.29% 1	7	3.14
Academic Leadership clearly identify potential change agents or mechanisms of change related to building faculty diversity programs.	16.67% 1	16.67% 1	50.00% 3	16.67% 1	0.00% 0	6	2.67
Academic Leadership clearly establish a formal plan for engagement related to building faculty diversity programs.	14.29% 1	28.57% 2	57.14% 4	0.00% 0	0.00% 0	7	2.43
Academic Leadership clearly establish benchmarks for progress toward goals related to building faculty diversity programs.	42.86% 3	14.29% 1	42.86% 3	0.00% 0	0.00% 0	7	2.00

Collaboration

	Not at All	Rarely	Some-times	Often	Very Often	Total	Weighted Average
Academic Leadership facilitate shared responsibility and/or authority with partners or change agents.	0.00% 0	28.57% 2	42.86% 3	14.29% 1	14.29% 1	7	3.14
Academic Leadership Facilitate forums or knowledge and transparency.	0.00% 0	28.57% 2	28.57% 2	42.86% 3	0.00% 0	7	3.14
Academic Leadership build collaborations in which all partners have vested interests and common goals as part of action steps and objectives for reaching targets.	0.00% 0	28.57% 2	28.57% 2	42.86% 3	0.00% 0	7	3.14

	Not at All	Rarely	Some-times	Often	Very Often	Total	Weighted Average
Academic Leadership establish a high degree of trust between the delegated organizer and the rest of the group.	0.00% 0	16.67% 1	66.67% 4	16.67% 1	0.00% 0	6	3.00

Strategic Thinking and Assessment

	Not at All	Rarely	Some-times	Often	Very Often	Total	Weighted Average
Academic Leadership provide an opportunity for reflection and analysis of action steps, objectives, and outcomes (expected and unanticipated).	0.00% 0	28.57% 2	42.86% 3	28.57% 2	0.00% 0	7	3.00
Academic Leadership reformulate vision if necessary to move agenda forward.	0.00% 0	42.86% 3	42.86% 3	14.29% 1	0.00% 0	7	2.71
Academic Leadership examine communications and ensure that values and beliefs remain relevant.	0.00% 0	57.14% 4	28.57% 2	14.29% 1	0.00% 0	7	2.57
Academic Leadership are prepared to assimilate and accommodate new and relevant information.	0.00% 0	0.00% 0	71.43% 5	14.29% 1	14.29% 1	7	3.43
Academic Leadership encourage idea generation.	0.00% 0	14.29% 1	14.29% 1	42.86% 3	28.57% 2	7	3.86

Persistent Commitment and Change

	Not at All	Rarely	Some-times	Often	Very Often	Total	Weighted Average
Academic Leadership are persistent and committed to values driving change.	0.00% 0	0.00% 0	57.14% 4	28.57% 2	14.29% 1	7	3.57
Academic Leadership avoid ambiguity and overcome resistance; continue to identify and address barriers.	0.00% 0	42.86% 3	57.14% 4	0.00% 0	0.00% 0	7	2.57
Academic Leadership plan for sustainability.	14.29% 1	14.29% 1	57.14% 4	14.29% 1	0.00% 0	7	2.71

Effective Communication

	Not at All	Rarely	Some-times	Often	Very Often	Total	Weighted Average
Academic Leadership clearly communicate a plan to articulate values and beliefs, both written and spoken, to potential agents of change or partners.	0.00% 0	28.57% 2	28.57% 2	42.86% 3	0.00% 0	7	3.14
Academic Leadership provide a formal presentation of background/ empirical evidence to support the articulated vision.	0.00% 0	42.86% 3	28.57% 2	28.57% 2	0.00% 0	7	2.86
Academic Leadership consider multiple perspectives and provide opportunities to listen to resistance and possible opposition.	0.00% 0	28.57% 2	57.14% 4	14.29% 1	0.00% 0	7	2.86
Academic Leadership conceptualize a framework or model (e.g., logic model) to communicate all of the elements needed for change and anticipated outcomes.	14.29% 1	28.57% 2	57.14% 4	0.00% 0	0.00% 0	7	2.43
Academic Leadership allow some means for immediate feedback	14.29% 1	42.86% 3	14.29% 1	28.57% 2	0.00% 0	7	2.57

Recruiting Allied Dental Professionals, Junior Faculty, Senior Faculty (Including Building Social Support)

	Not at All	Rarely	Some-times	Often	Very Often	Total	Weighted Average
Leadership establishes guidelines for hiring Allied Dental Professionals (including readiness to hire, candidate selection, etc.)	0.00% 0	20.00% 1	40.00% 2	20.00% 1	20.00% 1	5	3.40
Leadership effectively assists and serves in hiring Allied Dental Professionals.	0.00% 0	20.00% 1	60.00% 3	0.00% 0	20.00% 1	5	3.20
Leadership acknowledges concerns and issues related to hiring Allied Dental Professionals.	0.00% 0	20.00% 1	20.00% 1	40.00% 2	20.00% 1	5	3.60
Leadership clarifies and communicates expectations for hiring Allied Dental Professionals.	0.00% 0	40.00% 2	20.00% 1	40.00% 2	0.00% 0	5	3.00
Provides feedback on the status and opportunities for hiring Allied Dental professionals.	0.00% 0	40.00% 2	40.00% 2	20.00% 1	0.00% 0	5	2.80
Takes appropriate steps to resolve problems and advance the hiring of Allied Dental professionals.	0.00% 0	60.00% 3	20.00% 1	20.00% 1	0.00% 0	5	2.60

Mentoring (for Mentee and Mentor, Including Career Planning)

	Not at All	Rarely	Some-times	Often	Very Often	Total	Weighted Average
Leadership establishes guidelines for mentoring for both mentors and mentees (including readiness to mentor, mentor/mentee selection, etc.)	28.57% 2	28.57% 2	42.86% 3	0.00% 0	0.00% 0	7	2.14
Leadership effectively assists and serves in faculty mentoring including career planning.	0.00% 0	42.86% 3	28.57% 2	14.29% 1	14.29% 1	7	3.00
Leadership acknowledges concerns and issues related to faculty mentoring including career planning.	0.00% 0	28.57% 2	57.14% 4	14.29% 1	0.00% 0	7	2.86
Leadership clarifies expectations related to faculty mentoring including career planning.	0.00% 0	57.14% 4	28.57% 2	0.00% 0	14.29% 1	7	2.71
Leadership provides feedback on the status and opportunities associated with related to faculty mentoring including career planning.	14.29% 1	42.86% 3	42.86% 3	0.00% 0	0.00% 0	7	2.29
Leadership takes appropriate steps to resolve problems and advance faculty mentoring.	0.00% 0	42.86% 3	57.14% 4	0.00% 0	0.00% 0	7	2.57

The MDFD Program and Leadership's Role in Influencing the Institutional Environment

	Not at All	Rarely	Some-times	Often	Very Often	Total	Weighted Average
Leadership actively collaborates with other faculty and/or departments to produce desired results in a supportive environment.	0.00% 0	14.29% 1	57.14% 4	28.57% 2	0.00% 0	7	3.14
Leadership shares knowledge, expertise and encourages MDFD Leadership in the Institutional environment.	14.29% 1	14.29% 1	42.86% 3	14.29% 1	14.29% 1	7	3.00
Leadership supports collaboration and team building for MDFD program and leadership.	0.00% 0	14.29% 1	57.14% 4	28.57% 2	0.00% 0	7	3.14
Leadership shares accountability for MDFD program and leadership results as it relates to influencing institutional environment.	14.29% 1	14.29% 1	57.14% 4	14.29% 1	0.00% 0	7	2.71
Leadership supports constructive resolution of conflict for MDFD program and leadership results as it relates to influencing institutional environment.	0.00% 0	28.57% 2	28.57% 2	42.86% 3	0.00% 0	7	3.14

	Not at All	Rarely	Some-times	Often	Very Often	Total	Weighted Average
Leadership appreciates the different strengths of MDFD program and leadership as it relates to influencing institutional environment.	0.00% 0	14.29% 1	57.14% 4	28.57% 2	0.00% 0	7	3.14
Leadership recognizes accomplishments of MDFD program and leadership and stands behind decisions as results as it relates to influencing institutional environment.	14.29% 1	14.29% 1	28.57% 2	42.86% 3	0.00% 0	7	3.00

Building Partnerships (Between and Within Institutions, in the Surrounding Community, etc.)

	Not at All	Rarely	Some-times	Often	Very Often	Total	Weighted Average
Leadership builds and maintains equitable relationships to promote diversity.	0.00% 0	14.29% 1	28.57% 2	42.86% 3	14.29% 1	7	3.57
Leadership builds and maintains equitable relationships to promote training and development of Allied Dental professionals.	16.67% 1	16.67% 1	50.00% 3	0.00% 0	16.67% 1	6	2.83
Leadership welcomes different perspectives to expand partnerships (including between and within institutions/school, community).	0.00% 0	14.29% 1	28.57% 2	42.86% 3	14.29% 1	7	3.57
Leadership follows through on commitments to promote partnerships and facilitate collaboration (including between and within institutions/school, community).	0.00% 0	14.29% 1	28.57% 2	42.86% 3	14.29% 1	7	3.57
Leadership seeks areas of common interest to strengthen community relationships and active engagement.	0.00% 0	14.29% 1	14.29% 1	42.86% 3	28.57% 2	7	3.86

What would you say is at least one (1) important next step forward for Academic Leadership development at your school?

#	Responses	Date
1	An organizational chart.	12/8/2016 12:20 PM
2	Development and dissemination of strategic diversity plan with clearly articulated goals and outcomes for staff, faculty and students.	10/21/2016 11:01 AM
3	Leadership mentoring	10/14/2016 12:32 PM
4	Expand and increase opportunities for mentorship of minority faculty.	8/31/2016 4:02 PM

What would you say is at least one (1) important next step towards advancing Community Outreach and Engagement at your school?

#	Responses	Date
1	Commitment to a sustainability plan for existing programs.	12/8/2016 12:20 PM
2	Improve patient-centeredness is all areas, especially community clinics.	10/21/2016 11:01 AM
3	Increase exposure by reaching to different elementary schools every year and involve the media to inform other communities about our outreach.	8/31/2016 4:02 PM

In what ways could the School/Institution better support you in your own Academic Leadership development?

#	Responses	Date
1	Demonstrated commitment to advancing existing programs and sustaining	12/8/2016 12:20 PM
2	Continued support and mentorship by Deans and University's highest administrators to provide resources for personal development and programming.	10/21/2016 11:01 AM
3	The institution provides numerous opportunities for academic leadership development, but busy schedules hinder faculty participation. Additional time to	8/31/2016 4:02 PM

MDFD Academic Leadership Core Competencies for Building Diversity Programs

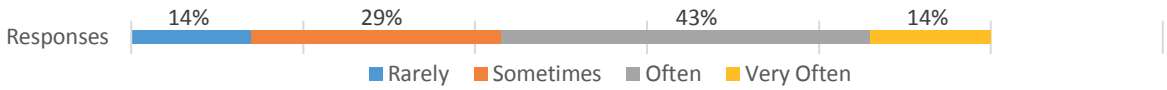
We conducted an online survey of MDFD Grantees, asking them to think about academic leadership at their respective universities/institutions. We sought their insight and feedback on the five core competencies for MDFD Academic Leadership Core Competencies for Building Diversity Programs: 1. Values and Beliefs, 2. Collaboration, 3. Strategic Thinking and Assessment, 4. Persistent Commitment and Change, and 5. Effective Communication. Additional questions sought information regarding institutional leadership—recruiting, mentoring, institutional environment, partnerships that promote training and development of Allied Dental professionals. There was an 80% response rate.

Values and Beliefs

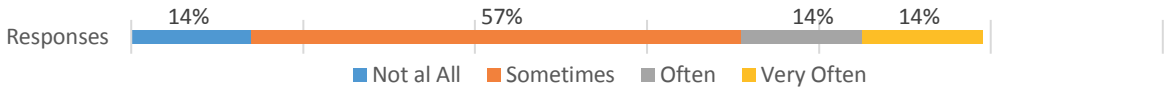
Grantees indicated that Academic Leadership (e.g., Department Chairs, Deans, Provosts, University Presidents at their respective universities/institutions) would sometimes clearly define values and beliefs of the university, department or institution upon which to build faculty diversity programs. Sometimes (57%) to Often (14%) to Very Often (14%), clearly defined values and beliefs related to diversity focused the direction of faculty development programs. Potential change agents or mechanisms of change were sometimes important to faculty development as was establishing a formal plan for engagement related to building faculty diversity programs.

Results

Academic Leadership clearly identify values and beliefs upon which to base actions related to building faculty diversity programs.

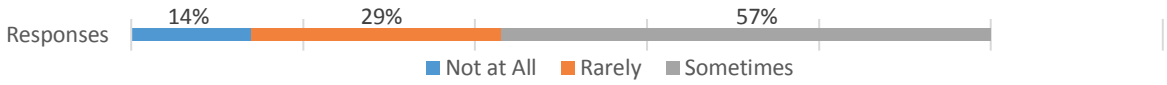


Academic Leadership clearly define direction or focus of change related to building faculty diversity programs.

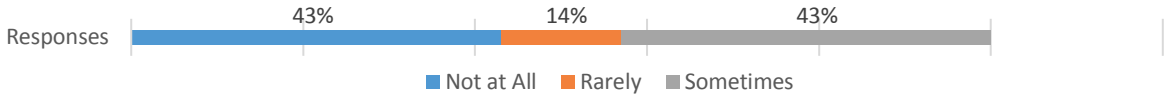


Academic Leadership clearly identify potential change agents or mechanisms of change related to building faculty diversity programs.

Academic Leadership clearly establish a formal plan for engagement related to building faculty diversity programs.



Academic Leadership clearly establish benchmarks for progress toward goals related to building faculty diversity programs.

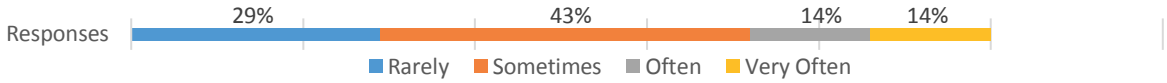


Collaboration

Grantees indicated that Academic Leadership (e.g. Department Chairs, Deans, Provosts, University Presidents at their respective universities/institutions) would sometimes clearly define shared responsibilities of the university, department or institution upon which to build faculty diversity programs. Often (43%) to Sometimes (28%), collaboration was facilitated through forums or mediums for shared knowledge and transparency. Building collaborations in which all partners have vested interests and common goals as part of action steps and objectives for reaching targets was often facilitated by Academic Leadership. Sometimes a high degree of trust between the delegated organizer and the rest of the group was established.

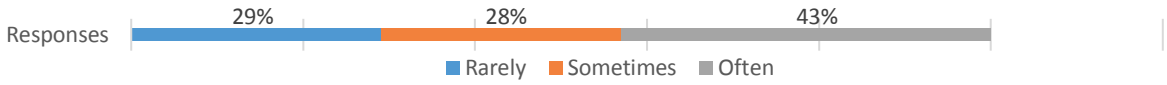
Results

Academic Leadership facilitate shared responsibility and/or authority with partners or change agents.

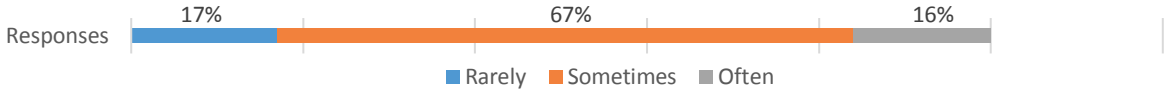


Academic Leadership facilitate forums or mediums for shared knowledge and transparency.

Academic Leadership build collaborations in which all partners have vested interests and common goals as part of action steps and objectives for reaching targets.



Academic Leadership establish a high degree of trust between the delegated organizer and the rest of the group.

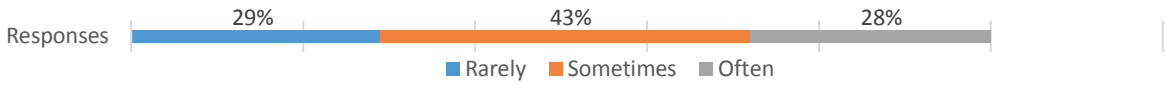


Strategic Thinking and Assessment

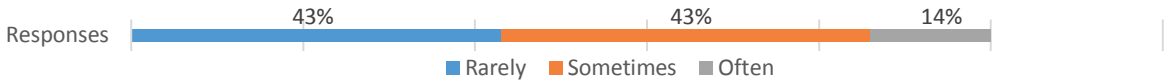
Grantees indicated that Academic Leadership (e.g., Department Chairs, Deans, Provosts, University Presidents at their respective universities/institutions) would sometimes clearly use strategic thinking to build faculty diversity programs. Assessments Sometimes (43%) were used to reformulate vision moving agenda forward, but Rarely (43% and 57%) was strategic thinking a part of communications used to ensure that values and beliefs remain relevant. Sometimes Academic Leadership used strategic thinking to prepare new and relevant information, but often Academic Leadership encourage idea generation.

Results

Academic Leadership provide an opportunity for reflection and analysis of action steps, objectives and outcomes (expected and unanticipated).



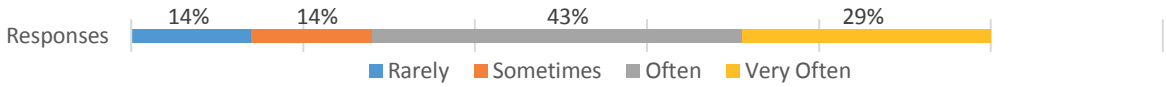
Academic Leadership reformulate vision if necessary to move agenda forward.



Academic Leadership examine communications and ensure that values and beliefs remain relevant.

Academic Leadership are prepared to assimilate and accommodate new and relevant information.

Academic Leadership encourage idea generation.

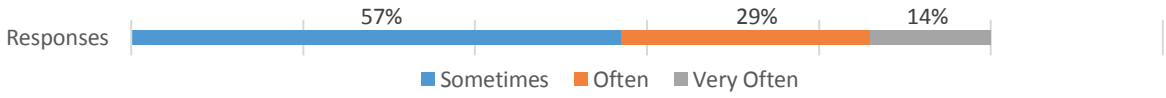


Persistent Commitment and Change

Grantees indicated that Academic Leadership (e.g., Department Chairs, Deans, Provosts, University Presidents at their respective universities/institutions) would sometimes demonstrate persistent and committed change for building faculty diversity programs. Leadership also only sometimes demonstrated commitment to addressing barriers and planning for sustainability.

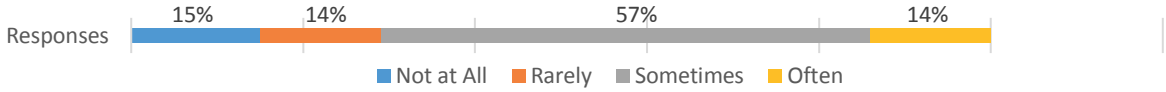
Results

Academic Leadership are persistent and committed to values driving change.



Academic Leadership avoid ambiguity and overcome resistance; continue to identify and address barriers.

Academic Leadership plan for sustainability.



Effective Communication

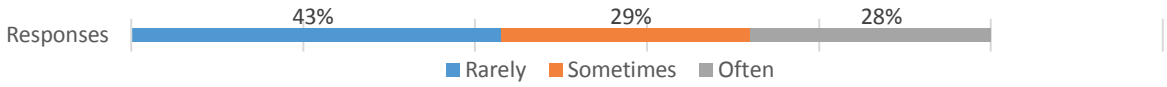
Grantees indicated that Academic Leadership would often communicate a plan to articulate values and beliefs, both written and spoken, to potential agents of change or partners. Academic Leadership rarely or sometimes provides a formal presentation of background/ empirical evidence to support the articulated vision. Sometimes multiple faculty perspectives are effectively communicated during conceptualizing frameworks or models for faculty development.

Sometimes communicating elements needed for change and anticipated outcomes, and Academic Leadership allow some means for immediate feedback for faculty development.

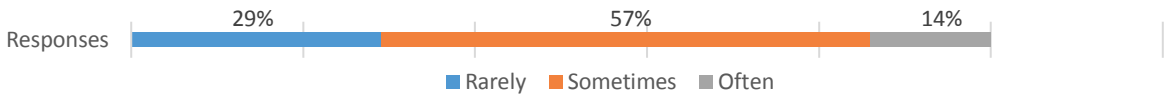
Results

Academic Leadership clearly communicate a plan to articulate values and beliefs, both written and spoken, to potential agents of change or partners.

Academic Leadership provide a formal presentation of background/ empirical evidence to support the articulated vision.



Academic Leadership consider multiple perspectives and provide opportunities to listen to resistance and possible opposition.



Academic Leadership conceptualize a framework or model (e.g., logic model) to communicate all of the elements needed for change and anticipated outcomes.

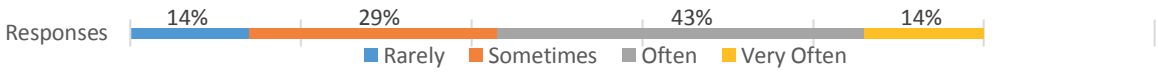
Academic Leadership allow some means for immediate feedback.

Recruiting Allied Dental Professionals, Junior Faculty, Senior Faculty (Including Building Social Support)

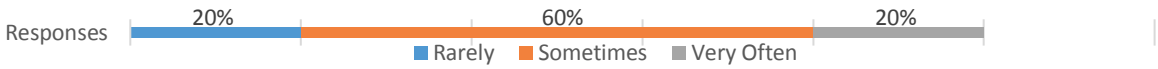
Often Academic Leadership establishes guidelines for hiring Allied Dental Professionals (including readiness to hire, candidate selection, etc.). Often Academic Leadership acknowledges concerns and issues related to hiring Allied Dental Professionals. Sometimes Academic Leadership effectively assists and serves in hiring Allied Dental Professionals. However, rarely are appropriate steps taken to resolve problems and advance the hiring of Allied Dental Professionals.

Results

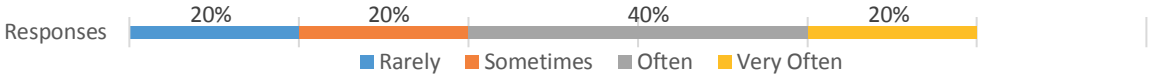
Leadership establishes guidelines for hiring Allied Dental Professionals (including readiness to hire, candidate selection, etc.)



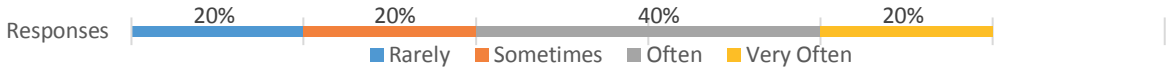
Leadership effectively assists and serves in hiring Allied Dental Professionals.



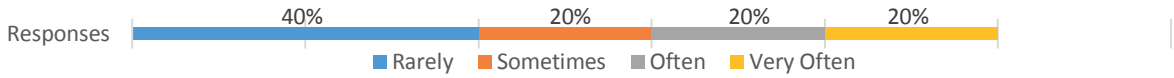
Leadership acknowledges concerns and issues related to hiring Allied Dental Professionals.



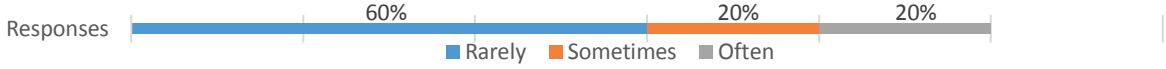
Leadership clarifies and communicates expectations for hiring Allied Dental Professionals.



Provides feedback on the status and opportunities for hiring Allied Dental professionals.



Takes appropriate steps to resolve problems and advance the hiring of Allied Dental professionals.



What Makes the MDFD/MDFDI Toolkit Unique?

Institutional Capacity	It is an instrument for change based on dental institutional capacity and optimization of the use of resources for diversity programs.
Change	It prepares institutions for change through Logic Model thinking, planning and evaluation.
Leadership	The Toolkit presents unique academic leadership mentoring strategies for dental and allied dental faculty.
Interprofessional Education	The models enhance the bench strength of dental schools for interprofessional education and collaborative care.
Partnerships	The Toolkit includes academic/community partnerships as models for experiential learning and the use of new models of care in nontraditional settings (e.g. FQHCs, nursing homes, dental trailers, school-based clinics and neighborhood centers).
Philosophy	The “Growing Our Own” philosophy is used in the pilot schools for commitment and strategic implementation.
Pipeline Recruitment	The models sustain pipeline recruitment for diversity in the dental and allied dental workforce. The creative models link dental careers with the health literacy.
Faculty Development	The models create academic partnerships for faculty recruitment, career development and research.

CHAPTER 2: TAKING MENTORING AND LEADERSHIP TO THE NEXT LEVEL

Forming Career Strategy Groups for Greater Success

By Adele Scheele, Ph.D.

To spur our careers, to realize our individual and organizational goals, to form cooperative work teams, creating career strategy groups is a vital and simple process. All it requires is the commitment of a small group of people to support each other by meeting monthly to think through each other's goals and dilemmas with suggestions and encouragement and without competition or betrayal.

Career crises happen to us all; no matter how consequential, they require action. An intellectually and emotionally supportive group can be motivational in its immediate and appropriate remedies.

To start a career strategy group, select a small group limited to six compatible people—no matter whether they are in the same organization, profession or community. You might choose a group from among one profession or else invite a mix of several—a lawyer, banker, engineer, manager, accountant, salesperson. Look for intelligent, experience, curious, open-minded and generous-spirited people who are all willing to meet to focus on better solutions to work issues. Ask each one to commit for at least six monthly meetings. Don't allow new members until that sixth session, if then.

The group's purpose is to provide a safe, supportive harbor for a group of smart people to get smarter by coaching each other's career success. Establish a two-hour monthly meeting and stick to a convenient time and place (say, the first Tuesday of every month at 7:00 a.m. or 6:00 p.m. in your conference room, separate room at a local restaurant or clubroom). Don't get distracted with food or phones. Ensure confidentiality; ask members to pledge aloud that they will not betray any confidences.

The Strategy Structure

Make the following process standard: Each member is allotted equal time, 15 minutes works every time. Keep time. Do not allow free-flowing conversation or allow a needy person to take a more resistant person's turn. Make sure that each person gets a full turn. Divide each person's time into a three-part turn: (1) the first five minutes for accomplishments or progress report, (2) the second five minutes for explaining a current career goal and/or dilemma in detail, and (3) the third five minutes for having the group brainstorm possible solutions, ideas to try, people to contact or plans to follow. This brain trust provides the homework assignment for each person to work on

and report back at the next meeting. In this highly structured and timed process, each person becomes both an expert giving advice and a client getting advice, a true supportive interaction.

At the end of each meeting, group members thank each other, citing valuable insights. The combination of personal and group validation fosters an esprit de corps that grows significantly over the succeeding months and bonds each one to the group.

Group Growing Pains

Some cautions: Most of us fear what we most want. We will find that we procrastinate or sabotage our chances to do what we long to do. Instead of admitting our fears—yes, we all have them—we are encased in fear that we don't know enough. That we are not smart and will be found out to be a fraud. That we don't and won't ever belong. That we are not enough and never will be. To counter our fears of inadequacy, we take refuge in excuses. We're experienced in the "My dog ate my homework" or "My boss gives me too much work" or "My in-laws came to stay for a month" or even "My rent has increased and I need to find another apartment." Fill in your own excuse. But know that any excuse is just that—an excuse. Don't fall for it. Don't let you or any of your group off the hook. Encourage action. Offer a daily buddy system for a week or two or as long as necessary. If you have trouble making a particular call or writing an important report, agree to call each other for a brief pep talk every day until you see results. While this sounds elementary, it works.

Remember your goal: to make positive goals happen positively. That takes breaking through old established defenses. But it will work for you and everyone else in your group.

Keep Going

We all advance at different times—our own readiness and drive, as well as the opportunities in the marketplace, spur or impede us. But don't let anyone in the group drop out because they feel left behind or perceive themselves as falling behind. It's not a competition. It's far from that.

In fact, each one of us needs to be cheered on. It's no accident that teams win more home games than away; fans actually inspire them to be their best. In the very same way, we crave encouragement and can provide it to each other in order to succeed at our own goals despite our obstacles, sense of hopelessness, or fears. Learning to think for and about each other, urging each other on, to share dreams and fears, makes us all stronger and more courageous. It will transform your careers and your lives.

To begin, you begin.

Start today.

Let me know what happens

www.DrAdele.com Adele@DrAdele.com

Applying a Logic Model to Mentoring and Leadership Programs

(Reprinted from *Proceedings of the ADEA Leadership Development Workshop for Diversity Officers at U.S. Dental Schools*, 2008)

Joseph F. West, M.Sc., Sc.D., President, Westwell Group Consulting and Research, Inc.

Dr. Joseph West described tools and led exercises to develop skills that dental institutions can use in preparing and sustaining mentor and leadership programs, based on the W.K. Kellogg Foundation Logic Model. According to the W.K. Kellogg Foundation at https://www.wkkf.org/~/media/pdfs/logicmodel.pdf

> *The program logic model is defined as a picture of how your organization does its work—the theory and assumptions underlying the program. A program logic model links outcomes (both short- and long-term) with program activities/ processes and the theoretical assumptions/principles of the program.*

The logic model is being used to evaluate the programs that were awarded W.K. Kellogg Foundation/ADEA Minority Dental Faculty Development (MDFD) grants. Seven awards of $250,000 over six years were made to six individual dental schools and one consortium of dental schools in New York state. The grants are being used primarily for direct educational costs to recruit into academic dentistry senior predoctoral dental students, postgraduate dental residents, or junior faculty who are from underrepresented minority or low-income groups. The grants are also being used to establish academic partnerships for career advancement and for community-based activities that enhance the oral health of minority groups.

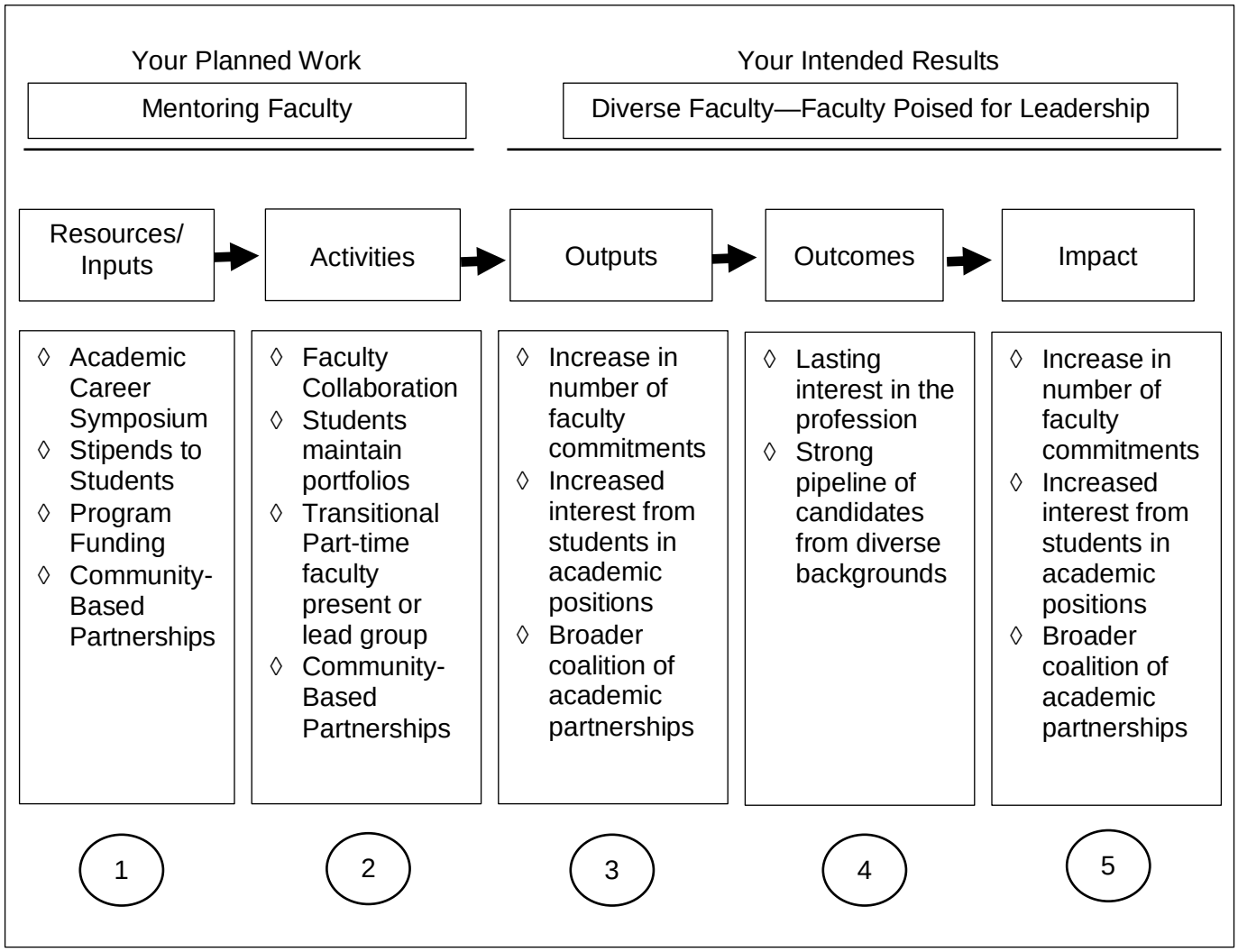
The logic model visually lays out a formula containing five basic units. The institution develops, tracks and manages the units. The role of *leadership* is to create the vision and build a strategy. The role of *management* is to make and track the plans and administer the budget.

The five units of the basic logic model:

1. **Resources**—sometimes referred to as inputs—refer to the human, financial, organizational, and community assets that are available to a program.
2. **Program activities** are the processes, tools, events, technology and actions that are supported by the resources and can be used to bring about the program.
3. **Outputs** are the direct products of the program activities.
4. **Outcomes** are changes in behavior, knowledge, skills, status, and level of functioning among the program participants. Short-term outcomes are attained in one to three years. Longer-term outcomes take four to six years.
5. **Impact** refers to the intended or unintended change that occurs because of the program. This is sometimes referred to as the legacy and occurs within the first five to 10 years.

Because of limited information, the most difficult part can be defining the specifics of the program activities and outputs. As a program grows and its strengths and weaknesses emerge, it is often useful to adapt the expectations for short- and long-term outcomes. External factors may also affect the plan. These should be accounted for in the visual representation of the logic model by adding a box with arrows to and from the appropriate unit.

The chart below illustrates how the logic model can be applied to a mentoring and leadership program in which mentoring faculty cultivate a diverse faculty poised for academic leadership. Resources/inputs and activities are the domain of the mentoring faculty. Outputs, outcomes and impact are the results elicited by the program.



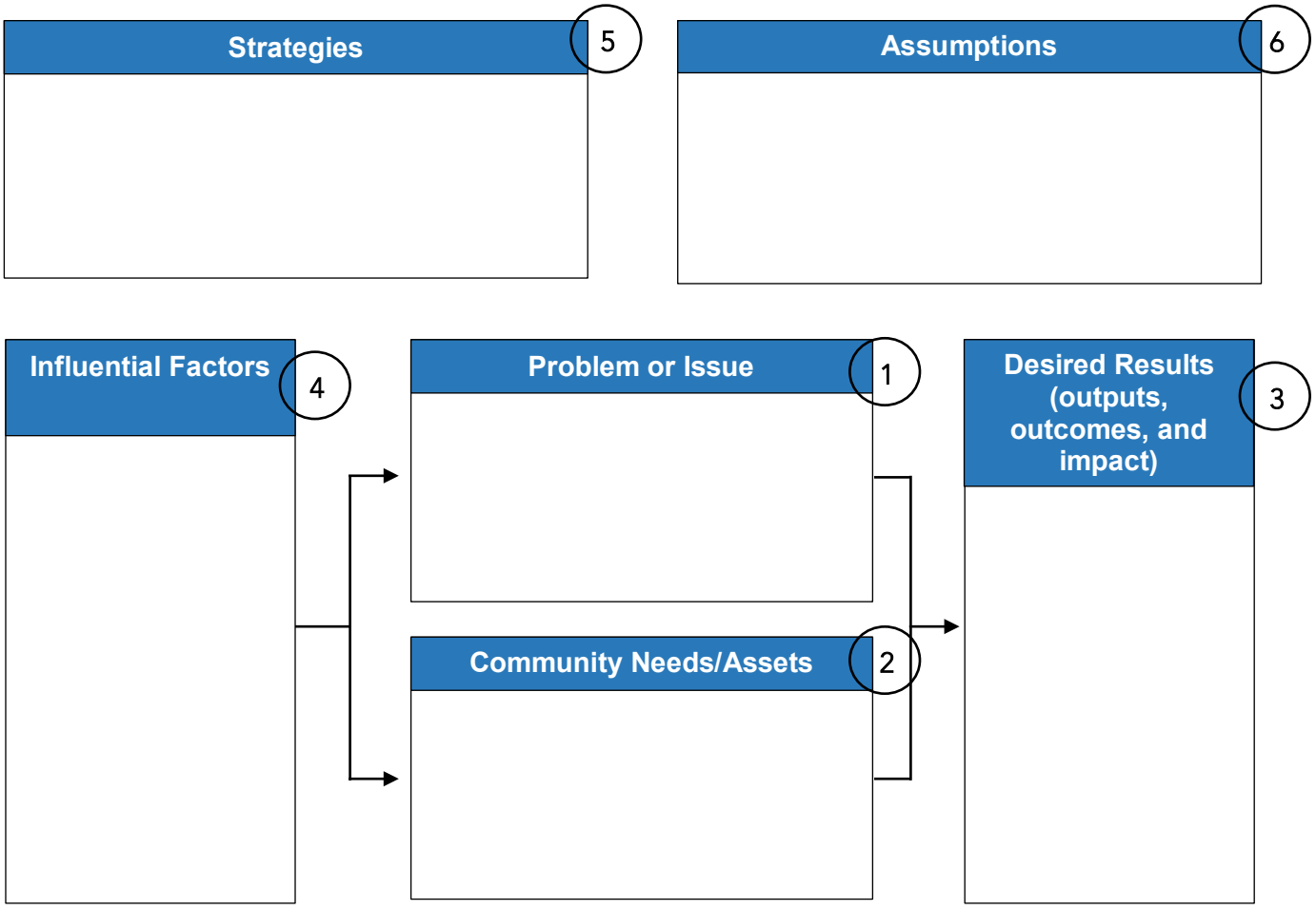
The example vastly simplified the required recordkeeping. The logic model calls for a far more rigorous accounting (e.g., 2% of faculty become active on panels and boards; one faculty member partnered with another institution to perform dental screenings on children attending the XYZ summer enrichment program).

The logic model is built on a team approach where each participant understands the workings of the program. Names are assigned to projects. Relevant performance data is kept and shared to help confirm the relationship between action and results. Evaluation, communication and marketing all provide ways to involve the stakeholders and convey the effectiveness of the program for the larger community.

The logic model also applies to sustaining the program once the grant is over. It recommends engaging in a process that clarified the theory behind the program, demonstrates the program's progress and evaluates the program. Help is available to ensure that data are collected and analyzed correctly. During the life of the grant, as unforeseen factors impact the plan, it is always possible to resubmit a modified plan to the sponsor of the grant.

Dr. West asked groups of six to work on a problem using the logic model template below.

Logic Model Development Program Planning Template—Exercise 3



He asked them to develop a plan for a business trying to diversify by developing a new product line. Products were assigned to the groups. Most had a health or ecological theme. Results had to be measurable and impacts had to be sustainable. Community assets were identified and so

were possible negative influences. One group used the logic model to imagine a healthy, cavity-reducing, weight-decreasing chocolate bar that became the #1 low-fat candy in the world. To help position the product for success, they envisioned kicking off a marketing campaign at the next ADEA Annual Session.

To summarize, the logic model is designed to engage teams in answering the following questions:

- Did we get to the BIG ideas?
- Did we answer questions on leadership and sustainability?
- Was our vision clear?
- Did we successfully communicate that vision to others?
- Were we creative thinkers?
- Did we empower people and enable them to carry out their responsibilities?
- Did we build coalitions and trust, and get high commitment to the program?
- Did we link our strategies to available resources?
- Will our program have a lasting effect on the community? In other words, have we created a legacy?
- Is there a leader who will carry the effort into the future?

If these questions can be answered "yes," then the path is clear for preparing and sustaining a mentoring and leadership program in dental education.

CHAPTER 3: PROGRAM REPORTS | ACADEMIC/COMMUNITY PARTNERSHIPS

Texas A&M University College of Dentistry

By Ernie S. Lacy, D.D.S.

Program Description

Texas A&M University College of Dentistry (TAMUCD), formerly Baylor College of Dentistry, started with one major objective over the six-year grant period—to admit one student per year (total of six) to the Comprehensive Dental Faculty Development Program (CDFDP). The program ultimately admitted seven fellows who received specialty or advanced training at the College of Dentistry.

Six of the fellows are in various stages of completion of their commitment to teach following their training at the college. The clinical disciplines in their training included orthodontics, pedodontics, periodontics and general dentistry. Four of the fellows continue as members of the faculty at TAMUCD, University of Texas School of Dentistry at Houston, Indiana University School of Dentistry and University of Washington School of Dentistry.

In 1905, TAMUCD opened its doors to its first 40 students as State Dental College, a private three-year dental school. With a commitment to excellence, the college evolved from its humble beginnings in 1905 to an affiliation with Baylor University from 1918 to 1971. The college existed for 25 years as an independent private institution. In 1996, the dental school entered an entirely new era as a public institution and member of the Texas A&M University System. On January 1, 1999, the college became one of five founding components of the Texas A&M Health Science Center. The arrival of 2005 ushered in a celebration of 100 years of educating dentists to serve the citizens of the state of Texas and beyond.

TAMUCD's mission is to improve the oral health of Texans and shape the future of dentistry by developing exemplary clinicians, educators and scientists. The College of Dentistry improves oral health by caring for the needs of a diverse community; seeking innovations in science, education and health care delivery; and serving as leaders in health professions education.

TAMUCD has engaged in diversity efforts over the years, with programs that begin in kindergarten and continue through the sixth grade with visits by students to the college-sponsored dental display at a museum in Dallas. TAMUCD outreach programs continue through the seventh through 12th grades with baccalaureate and postbaccalaureate programs if required. The diversity recruitment pipeline at the dental school has become an excellent infrastructure for future faculty development and recruitment. CDFDP provided a very suitable and important culmination to diversity efforts at TAMUCD.

Key Best Practices and Strategies

The CDFDP program was administered by a team of Baylor administrators comprised of Dr. Ernie Lacy, Director of Student Development and CDFDP; Dr. Ann McCann, Director of Planning and Assessment; and Dr. Claude Williams, Director of Community Outreach. This team provided the leadership and infrastructure for grant administration, implementation and reporting. Many other administrators and faculty provided support for the program through teaching and serving as mentors for the fellows.

Unique Features of CDFDP

- Fellows gained acceptance into CDFDP as fourth-year dental students or graduate students at the College of Dentistry or other dental schools or as dental practitioners.
- Fellows independently gained acceptance into specialty/advanced training programs at the College of Dentistry or other dental schools.
- Total/partial support was provided for the fourth-year of dental school and/or for advanced training.
- Fellows had to commit to teach one year for each year financial support was received.
- Fellows were required to repay TAMUCD's financial support if they did not honor commitment to teach.
- Fellows at the College of Dentistry earned an M.S. degree in Health Professions Education (HPE) from TAMUCD.

Outcomes

Table 1: Comprehensive Dental Faculty Development Program: Update on Kellogg/ADEA Minority Dental Faculty Development Program Trainees

Texas A&M University College of Dentistry

No.	Name	Previous Rank	Eligibility (Ethnicity)	Discipline	Year Completed (CDFDP)	Completed Teaching Commit-ment	On Faculty at: (Timeline)	Current Status
1	Jonathan Clemetson	Faculty	Black	General Dentistry	Spring 2010	Yes	TAMUCD (2003–present)	Still on faculty at TAMUCD
2	Christopher Rawle	Student	Black	Orthodontics	Summer 2007	Yes	University of Nevada, Las Vegas, School of Dentistry (2007–2010)	In private practice
3	Amber Callis	Student	Black	Pedodontics	Fall 2008	No	University of Texas School of Dentistry at Houston (2008–present)	Still on faculty at University of Texas School of Dentistry at Houston

No.	Name	Previous Rank	Eligibility (Ethnicity)	Discipline	Year Completed (CDFDP)	Completed Teaching Commit-ment	On Faculty at: (Timeline)	Current Status
4	Kelton Stewart	Student	Black	Orthodontics	Summer 2008	Yes	Indiana University School of Dentistry 2008–present)	Still on faculty as Graduate Orthodontics Program Director at Indiana University School of Dentistry
5	Donna Henley-Jackson	Student	Black	Pedodontics	Spring 2012	No	University of California, Los Angeles, School of Dentistry (2011–2012)	Completed one year of a two-year teaching commitment then fulfilled commitment to practice in underserved area. Currently on sabbatical, but will complete teaching commitment after sabbatical ends.
	Charmaine Thompson	Student	Black	Pedodontics	Summer 2015	No	None yet	In December 2016, fulfilled commitment to practice in underserved area. Will now seek a faculty position to fulfill teaching commitment.
7	Duane Bennett, III	Student	Black	Periodontics	Summer 2013	No	University of Washington School of Dentistry (2014–present)	Still on faculty at University of Washington School of Dentistry
Team of Mentors included a General Mentor and Team Leader, an Educational Mentor, a Clinical Mentor, and a Research Mentor Texas Partners: Texas A&M University College of Dentistry Advanced/Specialty Programs								

Environmental/Challenges/Opportunities

TAMUCD will continue to provide opportunities that allow highly qualified candidates to participate in CDFDP and pursue training in pedagogy that prepares them for academic careers.

Challenges at the College of Dentistry are similar to those of other academic institutions as we strive to contain costs, sustain quality and prepare to meet new challenges and opportunities. Diversity in the health care workforce, the aging population and continued federal support for education and training afford both challenges and opportunities to all of dental education.

The list of challenges for CDFDP at TAMUCD also includes:

- Securing finances to sustain the program.
- Sustaining the program without external financial support.
- Phasing out the college's M.S. degree in Health Professions Education program.
- Implementing an online Health Science Center-wide M.S. degree in Education for Healthcare Professionals (EDHP).

The lessons learned from CDFDP contribute to its sustainability as well as to program quality, improvement and value. Lessons learned include:

- Financial assistance for direct educational support is key for a commitment to teach.
- Support from the dean is a critical factor in program development and outcomes.
- Mentoring is essential during academic training and for faculty career development.

- Addressing issues pertinent to identifying, securing and maintaining faculty positions is extremely important. These issues include:
  - Evaluation of institutions and departments.
  - Negotiation strategies.
  - Workload and responsibilities of junior faculty.
  - Common pitfalls of junior faculty.
  - Salary compensation for junior faculty.

The CDFDP has become a part of TAMUCD's educational development strategies. The program is currently a component of the college's Center of Excellence. CDFDP eligibility requirements and program components are similar to those in the original program:

- Definite interest in academia.
- Earn M.S. in Education for Healthcare Professionals.
- Recipient of COE stipend (up to $15,000/year for a maximum of two years).
- Tuition and fees paid by TAMUCD.
- Must teach one year (PT/FT) for each year stipend is received.
- Must repay stipend funds if teaching commitment is not fulfilled.
- TAMUCD selects new fellow each year of five-year COE project period.

Current COE CDFDP trainees are listed in the table below.

Comprehensive Dental Faculty Development Program: Current COE CDFDP Trainees Texas A&M University College of Dentistry

	Year Admitted & Semester	Name	Race	Current Classification	Year Earned Certificate	Year Earned MS	Current Employment Status
1	Spring 2013	Patricia Adesanya	B	D.D.S.	Spring 2014	Spring 2016	In private practice but seeking a part-time faculty position at the College of Dentistry
2	Summer 2013	Crystal Johnson	B	D.D.S.	Spring 2014	Summer 2016	Completing Ph.D. at the College of Dentistry and was recently appointed as faculty at the college
3	Spring 2014	Abrefi-Kete Asare	B	D.D.S.	Spring 2015	In progress	In private practice
4	Spring 2014	Brenda Appiah	B	D.D.S.	Spring 2015	In progress	In private practice
5	Spring 2015	Ken Nwankwo	B	Fourth-year dental student	In progress	N/A	N/A
6	Fall 2015	Alma Salazar	H	Fourth-year dental student	In progress	N/A	N/A

University of Alabama at Birmingham School of Dentistry

By Madelyn Coar, D.M.D., M.S.

Program Description

The Minority Dental Faculty Development Program (MDFD) at the University of Alabama at Birmingham School of Dentistry (UAB SOD) has been recognized within the University as a program that promoted the growth of underrepresented minorities' representation in dental education. The MDFD program served to enhance the school's environment where underrepresented students saw and continued to see minority faculty serving as role models and leaders. The support provided by the MDFD program was instrumental in helping generate and support a more racially and ethnically diverse workforce to meet the oral health needs of Alabama's citizens.

Over the six years of the MDFD grant, the UAB SOD provided support to one predoctoral student, 13 postgraduate students and four junior faculty members. The involved disciplines included General Dentistry, Biomaterials, Pediatrics, Periodontics, Prosthodontics, Maxillofacial Prosthetics, Orthodontics, Oral and Maxillofacial Surgery, and Public Health. Currently, nine of the MDFD recipients are involved in academic careers; four of them full-time.

The UAB SOD is a small school, housed in a single building that includes the predoctoral program, the specialty programs, the Institute of Oral Health Research (IOHR), and the Dental Assisting program. No single formal program was instituted for the MDFD recipients. Instead, grantees worked with their respective chairpersons and their mentors, both formal and informal, to develop and pursue academic and clinical experiences to enhance and encourage their career interests. Opportunities for collaboration with research faculty in a number of UAB settings were available, such as the IOHR, the School of Public Health, the Minority Health and Health Disparities Research Center, and the Comprehensive Cancer Center, among others.

Key Best Practices and Strategies

Program and mentoring support of faculty, postgraduate students and undergraduate students will continue through general UAB entities as well as within the UAB SOD. Higher administration at UAB is very supportive of diversity issues. UAB's urban campus has been recognized as one of the most diverse college campuses in the United States. It is our hope that we can build upon what we have accomplished and develop more mature and successful programs in the future.

The MDFD program utilized several existing programs and funding sources as resources to support participants and facilitate faculty hiring at the SOD:

- The Academic Career Club—Led by the UAB SOD's Associate Dean for Research, this series of monthly seminars is designed to encourage and mentor predoctoral and

postdoctoral students on the preparation and progress toward academic and research careers, including the rewards and opportunities available.

- Comprehensive Minority Faculty Development Program (CMFDP)—Administered through the Office of the Vice President for Diversity, Equity and Inclusion, the CMFDP provides funding support to recruit a qualified African-American faculty candidate to a tenure or tenure-track position.
- Equity and Diversity Enhancement Program (EDEP)—Administered through the Office of the Vice President for Diversity, Equity and Inclusion, the EDEP provides a one-time award to a qualified minority or woman faculty candidate to a tenure or tenure-track faculty position.
- UAB Black Faculty Recruitment Initiative (BFRI)—Administered through the Office of the Vice President for Diversity, Equity and Inclusion, the BFRI provides salary support for African Americans recruited into full-time tenure-track faculty and senior administrative positions at UAB.
- UAB SOD Director of Diversity—This position, currently held by a MDFD grant recipient, Associate Dean Dr. Michelle Robinson, provides active support and mentoring of all minority and diverse students, both pre- and postdoctoral, as well as significant recruitment activity in addition to service on all UAB SOD faculty search committees.

Outcomes

UAB School of Dentistry MDFD Grant Trainees—Employment List 2015

Trainee Name	Discipline	Gender	Location and Position October, 2015	Eligibility
Harold Jackson	Biomaterials	Male	Meharry Medical College School of Dentistry, Assistant Professor, Department of General Practice, Residency Program	B/AA
Andrea Nunes	General Dentistry	Female	Private Practice, Birmingham, AL	H
Jonathan C. Matthews	Gen Dent, MPH	Male	Dental Provider	B/AA
Michelle Robinson	Info Technology, Business Practices, Diversity Officer	Female	UAB SOD, Associate Professor and Associate Dean for Health Information and Business Systems	B/AA
Shaunda Kelly-Pringle	Oral and Maxillo-facial Surgery	Female	UAB SOD and Veterans Affairs, Assistant Professor, Department of Oral & Maxillofacial Surgery	B/AA
Andre Ferreira	Orthodontics	Male	UAB SOD, Adjunct Assistant Professor, Department of Orthodontics	H
Adrian Miller	Pediatrics	Male	Private Pediatric Dental Practice, Atlanta, GA	B/AA
Lina Soler-Ballman	Pediatrics	Female	UAB SOD, Adjunct Assistant Instructor, Department of Pediatric Dentistry	H
Tabitha Jarman	Pediatrics	Female	UAB SOD, Adjunct Instructor, Department of Pediatric Dentistry	B/AA
Isabel Gay	Periodontology	Female	University of Texas School of Dentistry at Houston, Associate Professor, Department of Periodontics/Dental Hygiene	H
Juan Pardo	Periodontology	Male	Private Practice, Peru	H
Carlos Montes	Prosthodontics	Male	Private Practice, Winter Haven, FL	H
Fiorella Cabrejos de Pardo	Prosthodontics	Female	Private Practice, Peru	H

Trainee Name	Discipline	Gender	Location and Position October, 2015	Eligibility
Fiorella Potesta-Knoll	Prosthodontics	Female	University of the Pacific, Arthur A. Dugoni School of Dentistry, Adjunct Assistant Professor of Integrated Reconstructive Dental Sciences & Clinical Instructor, Department of Removable Prosthodontics	H
Jose Paiva	Prosthodontics	Male	Private Practice, FL	H
Ruben Sauceda	Prosthodontics	Male	University Texas School of Dentistry at Houston, Associate Professor, Department of Restorative Dentistry and Prosthodontics	H
Ruth Aponte-Wesson	Maxillofacial Prosthodontics	Female	University of Texas MD Anderson Cancer Center, Associate Professor, Department of Head & Neck Surgery, Oncology Dentistry, Prosthodontics	H
Tatiana Ramirez	Prosthodontics	Female	St. Johns River Rural Health Network, Health Educator, Jacksonville, FL	H

Environment/Challenges/Opportunities

UAB SOD is one of 38 institutions named to the Minority Access Inc. 2016 list of "Colleges and Universities Committed to Diversity" for its work expanding the pool of minority scientists, researchers and professionals in fields in which they are underrepresented. UAB and the UAB SOD continue their efforts to recruit, support, and retain minority students and faculty. The number of predoctoral underrepresented minority students has increased to the current highest ever. The number of underrepresented minorities in the post-doctoral programs have also increased slightly.

No funding source has replaced the MDFD for aspiring faculty among dental students. Funding challenges continue, including increases in tuition and fees and living costs, making it harder for many underrepresented minority students to afford graduate and advanced dental education.

The disparity in private practice and academic incomes represents another financial challenge. Entry-level faculty positions typically require many years before attaining salary equity with private practice colleagues, as well as vesting and tenure and most of the major benefits of academic employment. Also, as schools struggle with their own financial constraints, fewer junior faculty positions seem to be available, and may require relocations of young families and dual career partnerships that are significantly challenging.

While several programs exist at UAB that provide funds for hiring minority faculty through the Office of Equity and Diversity, these funds are limited to tenure-track and tenure faculty positions. The UAB SOD hires most clinical faculty as non-tenure earning, so only one underrepresented faculty member has benefited from these funding sources.

Future Plans

It is UAB SOD's intent to maintain and support as many of the goals of the MDFD program as possible, primarily by enhancing the pipeline of underrepresented minority students in dental school and dental careers. The Director of Diversity position formed during the MDFD period will be continued. This position has been a valuable addition to diversity efforts within the UAB SOD

and at UAB. Several initiatives and activities of this office enhance the pipeline of minority dentists, as well as encourage dental students and residents to understand the cultural implications of and need for increasing the numbers of underrepresented minority and diverse dental providers.

Student National Dental Association (SNDA) Impressions Program (UAB SOD Sponsored)

SNDA Impressions is a one-day, hands-on experience targeting college students from area campuses. Organized and led by SNDA members, with participation by UAB SOD faculty and residents, the program intends to enhance the college students' knowledge of dentistry. Every aspect is covered—from careers in dentistry to becoming a successful applicant to dental school. A mock DAT helps students understand the necessary preparation; there is also a session on funding dental education. SNDA members share tips on the best study guides and financial resource data.

Lessons in a Lunch Box (UAB SOD Sponsored)

This is also an SNDA–led program. During visits to area elementary schools, young students are provided with a lunch-time introduction to dental care and nutrition, including some one-on-one time with dental students.

DentStay (UAB SOD Sponsored)

Minority students who are interviewing for acceptance into the UAB SOD are paired with SNDA members for an overnight stay. The applicant and the dental student get to focus on any particular questions or concerns the applicant may have, and interact with other minority students outside the formal interview schedule.

Summer Health Professional Education Program (SHPEP) (UAB SOD, SOM, and SHP Sponsored)

This newly funded grant in partnership with the UAB School of Medicine and the UAB School of Health Professions builds on the successes of the former Summer Medical and Dental Education Program (SMDEP) grant. SHPEP is a free six-week summer enrichment program focused on improving access to information and resources for college students from communities underrepresented in the health professions. The program will be supported by funding from the Robert Wood Johnson Foundation. Partnership with the federal TRIO Program, a combination of three programs, Upward Bound, Gear Up, and Student Support Services, will provide middle school through college students with opportunities to participate. Academic enrichment in basic sciences and math, clinical experiences, career development activities, learning and study skills seminars and financial planning workshops, along with interprofessional education and experiences will be included.

Dental Immersion Day (DID) (UAB SOD Sponsored)

Organized by the Hispanic Dental Association (HDA) members at the UAB SOD, the Dental Immersion Day provides Hispanic and Latino students from Alabama high schools with a hands-on introduction to dentistry and dental careers. Participants are identified by the AL Are Health Education Center. High schoolers are encouraged to keep in touch with HDA members for continued encouragement and information on academics and career planning.

Cultural Awareness Education (UAB SOD Sponsored)

Recognizing the benefits of cultural awareness in providing and improving dental care to vulnerable populations, UAB SOD offers two academic experiences for predoctoral students. Incoming D1 students are required to read a book before matriculation that is chosen for its focus on the impact of culture on health care. An eight-week course in the D2 year focuses on several related factors: cultural competence, health literacy, systemic barriers and patient-centered care.

Dental Academic Research Training (DART) (UAB SOD Sponsored)

Funded through an NIDCR T-90 training grant, the DART program is a comprehensive research-training opportunity within the Institute of Oral Health Research (IOHR) for collaborative, intensive clinical and basic science oral, dental and craniofacial research. The program has four tracks, including Ph.D., and D.M.D./Ph.D. opportunities.

Dual-degree Programs (UAB and UAB SOD Sponsored)

Opportunities are available to motivated selected dental students for attaining joint degrees either in Public Health, leading to the combined D.M.D./M.P.H., or in Business Administration, resulting in the combined D.M.D./M.B.A. The M.P.H. options include eight accredited postdoctoral areas of study. Courses of study are combined throughout the four-year dental curriculum, with many online and mini-term course options.

Sullivan Alliance Careers and Pipeline Education Partnership (UAB and UAB SOM Sponsored)

The Sullivan Partnership is a recent initiative from the highest levels of UAB administration. Named for Dr. Louis Sullivan, former secretary of HHS, Dr. Sullivan's vision is to end health disparities throughout the United States. Through strong leadership, deep commitment and sustainable efforts, the Sullivan Alliance aims to transform the health professions and help eliminate the gaps in health status and access to health care that affect too many Americans. The ODMA has hosted seminars for HBCUs in conjunction with the Alliance. The Partnership invites participation from all the HBCUs in Alabama. Leaders from each school are asked to meet with the Provost and the deans of the health professions schools.

Increasing Diversity in Dentistry (IDID) (Tufts University School of Dental Medicine and Atlanta University Center Co-sponsored)

Held each year at the Atlanta University's Morehouse College campus, this part of the IDID Dental Awareness Week pairs college students from Morehouse, Spelman, Clark and other colleges with faculty, students, and recruiters from dental schools across the nation. Organized and led by Dr. Robert Kasberg, of Tufts University School of Dental Medicine, and Dr. Jeanette Sabir-Holloway, a graduate of AU's Spelman College, the three-hour event gives each student an opportunity to talk with representatives of each dental institution and enhance the application process. The presence and input of dental students is well received and a highlight of each session.

Recruitment of underrepresented faculty and students will continue within the UAB SOD to increase the number of candidates from whom future faculty can be recruited. The UAB SOD looks forward to continuing the current programs, and to developing more mature and successful recruitment and training efforts, along with additional resources in the future.

Augusta University as Part of the Solution

Allied Recruitment/Advancement (GA)

By Ana Luz Thompson, RDH, M.H.E.

Recent changes in the name of Augusta University (AU) and the consolidation of two different universities have affected recruiting students at the undergraduate level. The number of new students decreased by about 200 in the fall of 2015, but in 2016, a slight increase in undergraduate students was noted. It is believed by administrators that the University is on track for continuous growth. Dr. Gretchen Caughman, the Provost at Augusta University, recently reported that what is also encouraging is the type of freshmen the University is attracting. "These new first-year students are arriving with a higher academic profile than ever before," she said. In one of her recent reports, Dr. Caughman mentioned that it is important the University recommits to local recruitment targeting the immediate area, and that recruiters must recognize just how many great students may be in the University's backyard. An expansion of the scope of AU recruiting will focus on encouraging recruiters to visit local schools. The plan is to recruit local students to start and complete their degrees at AU, rather than being a place for transfer students. This effort will, in turn, help increase the number of minorities entering the university. As a recruitment strategy, officials at College of Allied Health Sciences participate in Pre-Health Day. The day offers an opportunity for prehealth students on the Summerville campus, which houses humanities, education and mathematics, to spend a couple of hours with faculty and students on the Health Sciences campus where dentistry and dental hygiene are located.

Efforts to recruit students to the entry-level dental hygiene program at AU have also intensified, targeting local high schools and community colleges. Additionally, increased energy is now

placed on freshman students at Augusta University to guide them into selecting their majors early in their education. As a result, a high number of students have selected prehygiene as their major. One advantages has been an improvement in advising students into selecting the most appropriate courses for entry into dental hygiene, therefore resulting in less time and cost for students. The University and the Georgia Board of Regents are placing more emphasis on completion of bachelor's degrees in no more than four years. Furthermore, Augusta University leadership has worked to critically evaluate and understand its roles and responsibilities to its local, state and national communities. For that reason, there is a motivation to concentrate efforts on improving the undergraduate education experience in relation to retention, progression and graduation of AU students.

One of the greatest lessons learned by faculty in the department of dental hygiene during the last few years is that students' previous experiences in college play a major role in their progression from dental hygiene professionals into advanced education. In other words, their first two years of college may prepare and influence them into becoming knowledge seekers, or instead, workforce members. Consequently, it becomes the responsibility of educators to inform and guide students during their last two years of college about what they may pursue after graduation. Assumptions of dental hygiene faculty are that students may not be aware of the shortage of educators in their field if that information is not shared with them. Students seeking a dental hygiene degree may also give greater importance to science prerequisite courses, consequently, lacking in reading and writing skills. Lack of preparation in general education may in turn prevent new dental hygiene graduates from seeking progression into graduate education. This could be due to fear of not doing well in graduate school preadmission exams, which test their critical thinking and analytical writing skills and their ability to analyze and evaluate written material. At Augusta University, minority faculty have taken the task of informing students about the opportunities available. It has been their goal to mentor and motivate students about career advancement programs. Motivation from faculty has been stressed, not only to make sure students are successful in the program, but to increase their self-confidence and self-awareness.

The department of dental hygiene continues collaborating with the faculty of the A.R. Johnson Health Science and Engineering High School Dental Science program and their students, who learn by shadowing dental hygiene students during clinical procedures. This partnership exposes high school students to the dental hygiene profession.

Career Advancement—Bachelor of Science Degree-Completion Program

The entry-level dental hygiene program at Augusta University annually enrolls 30 new students. Opportunities to increase enrollment are currently not available due to limited space and faculty resources. What has slowly but continuously increased since its initiation in the fall of 2012 is the enrollment in the online Bachelor of Science Degree-Completion program. This program has

been designed for dental hygiene graduates of accredited associate degree programs wishing to complete a four-year degree. It is 100% online, and is intended for off-campus students or students who may work full time. The program utilizes D2L Learning Management System for course delivery.

The fully online degree-completion program has accepted students from 26 different cities/towns and 21 different counties in Georgia in addition to a few students from South Carolina. Sixteen percent of degree-completion students have been minorities. Based on a review of autobiographical essays submitted by minority applicants to the online degree completion program, faculty has obtained information about the reasons that motivate minority students into advancing their education.

Following are quotes and excerpts from several essays from minority students in the online degree-completion program:

- "I want to broaden my scope of practice to help others,"
- "I would like to pursue a Master's degree in Health Administration."
- "I will be able to use my knowledge to expand on my skills beyond the clinical aspect of my career."

Other students have expressed their desire to explore the educator, advocacy and public health side of dental hygiene:

- "I want to advance in my career to embark on a dream that is much more than I ever would have thought possible. I was raised by parents whose highest level education was a high school diploma. They have provided me with the inspiration to continue working hard and overcome the numerous challenges students face, and to provide myself with the best educational opportunities possible."
- "Teaching will give me the opportunity to challenge the minds and lives of those who want to spend their career time making a difference in preventive dentistry. I am excited about touching those who want to pursue a career in dental hygiene just as my professors did for me."

Another dental hygiene student who is pursuing a Master's in Public Health has shared his story. He is considered a minority in dental hygiene being a Hispanic male who started college with limited proficiency of the English language. "I chose public health to continue to aid in protecting and improving the health of families and communities through promotion of healthy lifestyles. I am currently practicing as a public health technician in the South Carolina Air National Guard. The experiences of struggles relating to poverty and poor access to health care, taught me to never accept the voices of 'no' in life's trials." He enjoys teaching and promoting a healthy lifestyle to his children and his patients. He excelled as a dental hygiene

student and after graduation has become an example for many other students while working at the Veterans Hospital and Clinics where dental hygiene students attend rotations.

Clinical re-entry program

Another area in which the department of dental hygiene at AU is contributing to career advancement is by offering a clinical re-entry program. Faculty have learned that for many different reasons, including raising a family, illness, and changes in marital status, it has been necessary for a number of dental hygienists to put their careers on hold. This program has aided numerous dental hygienists in their return to the workforce. It is designed for dental hygienists who have been out of practice for an extended period of time and who seek to re-enter private practice or apply for re-licensure in dental hygiene. However, this re-entry program is not designed to replace the rigorous curriculum of an accredited dental hygiene program and it does not guarantee success on National, Regional or State Board Examinations. Participants must be graduates of an American Dental Association (ADA) accredited dental hygiene program and must have a current or previous dental hygiene state license.

Involvement with the community in outreach programs

During the last three years, faculty and dental hygiene students have collaborated with the College of Nursing during their annual Women's Health Clinic event. Farm female workers from a nearby town in South Carolina are brought to the University for medical exams, dental screenings, and other services. Dental hygiene students provide oral hygiene instructions with the aid of volunteer interpreters. Students have expressed their interest in continuing to support the efforts of this clinic because they feel they gain a better understanding of migrant farm workers' health needs after participating in this rewarding experience. The clinic efforts of the Fall 2016 were featured in the local news. http://wjbf.com/2016/10/28/free-au-health-clinic-helps-women-farmers-live-healthier-lives.

Participation of faculty and students in community activities involving minority populations has increased with the efforts started during the ADEA Minority Dental Faculty Development grant period. The following are areas in which dental hygiene faculty and students have operated.

<u>Hispanic Health Fair</u>

Dental hygiene faculty and students have served at the Hispanic Health Fair for the last three years providing oral health education, dental screenings and fluoride varnish applications to attendees. Faculty from the dental hygiene department has also secured collaboration of dentists from the department of periodontics at the Dental College of Georgia (DCG) to help with dental screenings during this event. Many patients have been referred to the dental school for restorative care, periodontal treatment, and in some cases, as board patients. Fortunately, the number of minority-enrolled Spanish-speaking dental hygiene students has increased, which will help decrease barriers to scheduling patients due to language barriers. Patients whose

primary language is Spanish are assigned to these students. Recruitment of minority students is consistently assessed. An acceptable applicant pool has allowed for a more homogeneous cohort of students. The only minority group that continues being unrepresented is Native Americans, with only one out of 60 currently enrolled students. This is in part because there are no tribes nearby.

Outreach at Elementary Schools

Additional emphasis has been placed in students' participation in community outreach by significant modifications to the Community and Research Design course for senior dental hygiene students. This change has positively motivated students to seek involvement in as many outreach activities as possible. As a pivotal part of that course, continuous involvement subsists with Lamar Milledge Elementary leadership, for which more than 200 students were treated in collaboration with the Richmond County Health Department during the fall of 2015. New relationships were also strengthened with officials at Meadowbrook Elementary School to target 440 pre-K to fifth grade students during the fall of 2016.

Give Kids A Smile

Dental hygiene students have contributed with oral health education, dental sealants and fluoride varnish application to numerous participants at several health fairs and during various outreach events. In addition, there is a continuous effort of the department to collaborate with the DCG in planning and implementing dental and dental hygiene services during Give Kids A Smile annual events. Two elementary schools are targeted each year.

Department of Pediatric Dentistry

As a way to increase service to children younger than age 5, additional rotations have been scheduled for dental hygiene students to treat patients in the Department of Pediatric Dentistry at the DCG. This partnership is expected to facilitate access to a larger number of children, allowing dental residents to focus their efforts in restorative procedures while dental hygiene students perform dental prophylaxis, apply sealants and fluoride and devote additional time for oral hygiene education.

Christ Community Clinic

A recent contract has been completed with Christ Community Health Services Dental Clinic for dental hygiene students to attend rotations. Students will initiate participation in this clinic starting in January 2017. Christ Community Health Services Augusta is a Federal Tort Claims Act (FTCA) deemed facility that offers affordable, quality primary health and dental care to the uninsured and underserved. Patients with no health insurance are seen on a sliding fee scale that starts at $25 for an office visit. The efforts of the Christ Community Clinic target underserved populations of the Augusta area.

Lessons Learned

As an example of lessons learned during the past few years is that not all plans are 100% successful. The outcomes of the minority students' organization originally formed during the grant period did not turn out as expected. Expected outcomes were perhaps unrealistic, based on the response of minority students when invited to become members. Original expectations were that all minority students would be attracted and flattered to be invited to become members of the group; however, students were not always interested in becoming part of a minority organization. Stated reasons for not joining the group included not having enough free time to participate in additional activities when their schedules were too busy. Nevertheless, it is possible there were other hidden reasons for these students not to separate themselves from the rest of the class.

Some nonminority students asked faculty why they were not invited to join the new organization and asked if they needed to be minorities to participate. There was a certain exclusion of the rest of the students, especially when they found that faculty and members were bringing food and sweet treats to the meetings. And later, when minority faculty had other commitments that prevented them from fully committing to planning and conducting the meetings, there was no guarantee that other faculty would take the responsibility of the tasks at hand. In other words, nonminority faculty were not concerned or motivated to take on this work. When the Class of 2016 graduated, the last group of highly motivated students left. The following classes have not been as enthusiastic about meeting with faculty after hours. On a positive side, one of the original group members has maintained a closed relationship with faculty. She has taken the task of advising and bringing several prospective students interested in the dental hygiene program to the department for tours or shadowing experiences, all of them from underrepresented minorities.

In spite of students' indifference to becoming part of a minority students' organization, faculty intend to continue guiding and advising prospective students so they become strong applicants when the time comes. In addition, mentorship of enrolled minority dental hygiene students will continue to occur, even without the students noticing that by their interactions with minority faculty they learn to appreciate their profession and how they can advance in their careers.

Future Plans

While additional opportunities become available for newer generations of faculty, there is a greater emphasis placed on the career advancement of current educators and administrators in the department of dental hygiene at Augusta University. The program director was accepted to the Authentic Leadership Pipeline I and II training programs offered by the Office of Leadership Development, which prepare leaders in the promotion and facilitation of ongoing growth and development to lead others. More specifically, these programs teach administrators how to implement a guided and intentional way of thinking about how to lead others, describe

leadership content and experiences that have enhanced their ability to lead others, and interact with an expanded network of other leaders in the university with whom they can collaborate. Another minority dental hygiene faculty member has plans to advance her education to participate in research and scholarly activities, which in turn will aid in her pursuit of promotion opportunities.

Plans to increase outreach to underserved populations will continue by placing additional value on the community activities in which students participate along with dental and dental hygiene faculty. A new elementary school will be targeted each successive year where hygiene students will provide dental health education and offer dental sealants and fluoride treatments to as many children as possible. While students offer dental education, the department continues utilizing the coloring and activity book created during the grant period. Hundreds of coloring books and dental kits with toothbrushes and floss have been distributed and will continue to be distributed every year.

In summary, there has been an increase in outreach activities and community relations and partnerships that are greatly rewarded by the institution, but the main beneficiaries of these efforts have been the dental hygiene students and the patients they have served with treatment and oral health instruction. And now, more than ever, allied health and dental teams are increasingly culturally competent, since the implementation of a mandatory course for all health professions students and to the compliance training modules all health care employees must review as part of the University's annual mandatory training. The course's title is Healthy Perspectives. In it, students, faculty and employees learn more about stereotypes and bias, but most importantly, how the influence of culture and perspective play a vital role in the ability to communicate with others toward the common goal of better health.

In regard to recruiting efforts to increase minority dental hygiene students and inspire dental hygiene professionals interested in career advancement into becoming educators, there is still much to do. Nevertheless, faculty is highly motivated to pass on the knowledge to new generations of students, hoping that one day others will continue to strive for quality and diversity in higher education.

CHAPTER 4: ACADEMIC PARTNERSHIPS | FACULTY PIPELINE

ADEA/MDFD Academic Partnerships

Background

In addition to the 139 academic/community partnerships that were created for experiential learning and patient care, Academic Partnerships (APs) were established for faculty recruitment development, leadership training and research. The APs provided models for "seamless" academic career development and progression across clinical departments and disciplines. APs were included in the MDFD program objectives in response to a special ADEA Task Force report, *Future of Dental School Faculty* (August 1999). In the report, the Task Force concluded that "dental education is now in a crisis" due to the shortage of dental faculty. The shortage was related to many factors, including the fact that insufficient numbers of faculty were being recruited from advanced dental education programs, private practice or the federal services, and retirements were contributing to the "graying" of the faculty workforce. The APs created an infrastructure for recruiting new faculty and advancing junior faculty in their academic career development.

Underrepresented Minority Dental Faculty Trends

Trends, challenges and updates with regard to dental faculty were reported in the *Journal of Dental Education* in September 2000, September 2002, February 2005 and March 2008. Diversity in the dental faculty workforce is seen in the underrepresented minority dental faculty (URM) trend data.

In 2000–01, the URM faculty composition in the U.S. dental schools was Native American 0.28%, Back/African American 3.8%, and Hispanic/Latino 4.0% (total 8.1%). Data for 2000–01, 2007–08 and 2010–11 show an overall increase in the representation of URM dental faculty from 8.1% to 10.4%.

Table 1: Underrepresented Minority Dental Faculty: 2001–02, 2007–08 and 2010–11*

	2000–01	2007–08	2010–11
Native American (AI/AN)	32 – 0.28%	30 – 0.26%	17 – 0.27%
Black/African American	436 – 3.8%	406 – 3.4%	373 – 3.7%
Hispanic/Latino	457 – 4.0%	655 – 5.6%	642 – 6.4%
Total URM	925 – 8.1%	1,091 – 9.3%	1,042 – 10.4%
Total Faculty	11,332	11,688	10,033

Source: American Dental Association, Comprehensive Faculty Salary Surveys, 2000–01, 2007–08, 2010–11.

A sustained effort is needed to support the trend for increased diversity in the dental academic pipeline.

Academic Partnerships

APs exposed dental schools to new sources of trainees from graduate programs and created rich collaborative environments for learning. Exchanges and contact between research universities and faculty increased the likelihood that minority fellows not only pursued graduate education but also considered academia as a profession. ADEA MDFD grantees developed a number of key partnerships along these lines. For example, the University of Oklahoma partners with the Native American Center for Excellence Consortium and the Leadership Program in the College of Medicine for faculty recruitment and development.

Two types of academic partnerships were formed by ADEA MDFD grantees—internal and external. Internal academic partnerships are defined as faculty working with other offices, departments or programs on campus to support research, clinical practice, mentoring and teaching. For example, academic partnerships among dentistry and medicine, nursing, pharmacy, public health and even graduate programs in education helped strengthen a program's diversity network. Internal partnerships foster collaborative research, teamwork and leadership that promote a university-wide commitment to diversity. For example, the University of Illinois at Chicago College of Dentistry (UC COD) partnered with the University's Office of Faculty Affairs Underrepresented Faculty Mentoring Program (UFMP). The UFMP is responsible for a university-wide minority faculty development program that includes mentoring and support resources. This partnership allowed the UIC COD ADEA MDFD program to access additional resources to support faculty mentoring and academic development. In addition to the grant funds, existing programs such as postdoctoral fellowships and research training grants provided supplemental support. Also, especially important were the salary-related incentives that included creative funding packages and appointment strategies used to attract and recruit junior faculty.

External APs are defined as reciprocal agreements with other universities or institutions that support tuition and/or other costs, learning/teaching opportunities, community-based research activities and mentoring associated with faculty development. External APs also help build bridges between dental education and other health science disciplines beyond the campus. For example, NYSADC collaborated across five partnering schools in New York in sharing trainee support for postdoctoral academic and research training. The University of Alabama at Birmingham School of Dentistry's partnerships are with Meharry Medical College School of Dentistry, University of Alabama School of Public Health and the University of Alabama Minority Health Research Center.

Such partnerships include student exchanges for specialty training, research and postgraduate placement. Approximately half of the ADEA MDFD mentees completed either undergraduate or

graduate school at a Historically Black College or University (HBCU), as well as a number of Hispanic-serving institutions.

Partnership agreements were, in most cases, formal written statements outlining in significant detail the objectives, accountabilities, and measures for success.

The table on the next page provides a summary of the institutional partnerships in the MDFD APs. They reflect a broad range of health disciplines, institutional resources and research collaborations.

Outcomes

The AcPs supported 124 URM trainees (see the Resources section) in seven clinical disciplines—pediatric dentistry, orthodontics, oral and maxillofacial surgery, prosthodontics, periodontics, endodontics and public health.

The seven models have recruited and developed URM faculty that now serve at their own and other dental schools. Others continue in inspiring roles in their communities, the U.S. military and in service as mentors and role models. Their profiles are found on the ADEA website: adea.org/MDFD/Growing-Our-Own.aspx

Table 2
W.K. Kellogg/ADEA Minority Dental Faculty Development (MDFD) Program
Awardee Summary

Awardees = 7 Total Schools = 11

Dental School Awardees	Academic/Institutional Partners
New York State Academic Dental Centers (NYSADC) PD: Dr. Stanley Handelman	Columbia University College of Dental Medicine, New York University College of Dentistry, University at Buffalo School of Dental Medicine, Stony Brook University School of Dental Medicine, University of Rochester/Eastman Dental Center
University of Alabama at Birmingham School of Dentistry PD: Dr. Mary Lynne Capilouto	Meharry Medical College School of Dentistry, University of Alabama School of Public Health, University of Alabama Minority Health Research Center
Texas A&M University College of Dentistry PD: Dr. Ernestine Brooks	Baylor Advanced Programs, M.S. in Dental Education at Baylor; other Texas Dental Schools, Howard University and Meharry College
Howard University School of Dentistry PD: Dr. Earl Kudlick	University of North Carolina at Chapel Hill School of Dentistry, Boston University School of Dental Medicine, University of Maryland School of Dentistry, New York University College of Dentistry
University of Michigan School of Dentistry PD: Dr. Marilyn Woolfolk	Health Professions School at University of Michigan (medicine, nursing, public health, pharmacy and dentistry), Kellogg Michigan Center for Minority Health and Health Disparities Research, Center for Research on Learning and Teaching (CRLT) – University of Michigan
University of Illinois at Chicago College of Dentistry PD: Dr. Darryl Pendleton	University of Illinois at Chicago College of Dentistry Office of Academic Affairs and Office of Graduate Studies
University of Oklahoma College of Dentistry PD: Dr. Kevin Avery	The Native American Center for Excellence Consortium, The Faculty of Leadership Program in the College of Medicine, The Native American Research Center for Health, The Center of Biological Research Excellence at the OU COD, The Statistical and Epidemiological Practice, Research, and Teaching Laboratory (SPERT) in the OU College of Public Health

Profiles of Successes

According to Stephen Denning, "Storytelling and leadership are both performance arts and like all performance arts, they involve as much doing as thinking."[1] The profiles of the MDFD trainees, as told in their reflective contemplations, tell more than graphs or figures that represent other ADEA MDFD outcomes. The art of storytelling became a challenge to MDFD leadership training in grantee meetings and skills training sessions. The profiles are "life stories" that are being shared for the humanistic and inspirational values that they continue to have in their daily encounters with students, colleagues, families, friends and strangers.

Twenty-one brief profiles were included in the leadership manual "Growing Our Own."[2] The profiles now provide an update of the life stories of the trainees and document the "cascading effects" that mentoring has had on their careers and the lives of others who continue to benefit from their leadership and mentorship.

Additional Profiles can be accessed on the ADEA website: adea.org/MDFD/Growing-Our-Own.aspx

Sources

6. Denning S. The Leader's Guide to Storytelling. Mastering the Art and Discipline of Business Narrative. John Wiley & Sons, Inc. Jossey- Bass. San Francisco, CA: 2005.
7. Sinkford JC, Valachovic RW. Growing Our Own. The ADEA Minority Dental Faculty Development Program. Project support from the W.K. Kellogg Foundation. American Dental Education Association. Washington, DC: 2011

Kandyce A'see, RDH, M.S.

Assistant Professor of Dental Hygiene
College of Allied Health Sciences at Augusta University

Ms. Kandyce (Mack) A'see's early influence in dentistry comes from her dentist, Dr. Willis J. Walker, Jr., who was both a role model and advisor. She attended A. R. Johnson Magnet School for Health Professions and Engineering in Augusta, GA before attending dental assistant classes at South Carolina State University where she received a bachelor's degree in Biology. She gained practical experience working in a dental office as a dental assistant before continuing her pursuit of additional education that culminated in her bachelor's degree in Dental Hygiene from the Medical College of Georgia. Her career placed her at the Georgia Regents University, now part of Augusta University, as a staff hygienist where she continued as a staff hygienist and part-time faculty member. During this time, she continued to move up the academic career ladder in pursuit of a master's degree in Allied Health and her appointment to a full-time faculty position.

Kandyce is currently a full-time Assistant Professor of Dental Hygiene. She attributes her success to her mentors such as Prof. Marie Collins and Ana Thompson, her department chair, whose guidance contributed to both her academic achievement" and successful grant-writing skills.

According to Ms. A'see, "Mentoring becomes natural to me." She currently finds mentoring others especially rewarding because their needs cover a spectrum of both personal and professional uncertainties. She is highly motivated to give back to others because of the help she received and continues to receive from colleagues and peers. Ms. A'see finds it especially rewarding being able to return to the high school she attended where she actively recruits students to health careers.

Ms. A'see recognizes the support received from MDFDI in her career development. The grant provided funds for her to attend the 2014 ADEA Annual Session & Exhibition in San Antonio, TX. It also provided funds for 20 hours of continuing education during a three-week online class through the Institute for Allied Health Educations, 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 development. She has been active in involving minority dental hygiene students in community events while being an outstanding role model for them. Her professional development gained through the MDFD grant 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, and invitation to recruit high school students at the Communities in Schools Conference at Augusta University and an invitation to be the keynote speakers at Communities in Schools

Conference at University of West Georgia. She enjoys her role as the Coordinator for the Give Kids a Smile Program. Ms. A'see has authored a book for primary ages titled *Tooth Tickler.*

Her advice to youth is, "Do not quit reaching for your dream. Take advice from mentors because of where they have been and remember to always be resilient."

Michelle A. Robinson, D.M.D., M.A.

Associate Professor, Clinical and Community Sciences
Associate Dean for Health Information and Business Systems
University of Alabama at Birmingham School of Dentistry

Dr. Michelle Robinson is a native New Yorker, graduating from the Bedford-Stuyvesant Preparatory High School in New York before receiving a baccalaureate degree in Biology from Adelphi University, Long Island. Her decision to study dentistry was influenced by a hospital internship that exposed her to clinical patient care and the desire for a career that would allow her to treat patients. She remembers Dr. Kenneth Chance as a role model and advisor during her years in dental school.

Following completion of her D.M.D. at the University of Medicine and Dentistry of New Jersey, Dr. Robinson spent eight years in private practice, then completed an M.A. in Medical Informatics at Columbia University. She came to the University of Alabama at Birmingham School of Dentistry (UAB COD) in 2005 to implement and guide transition to the current clinic information system. Dr. Robinson's special interests include high-tech approaches to patient health messages, technology to support improved access to care and online education pedagogies. She is currently an Associate Professor and Associate Dean for Health Information and Business Systems, which involves oversight of all information technology initiatives and related duties for the school, including specification and implementation of systems, patient information systems, course information systems, AV and classroom technologies, networking, imaging technologies, hardware and software support, clinic revenue analysis and reporting. She is also a member of the technical advisory committees for both medical and dental informatics. Dr. Robinson currently serves as the Diversity and Affirmative Action Officer at UAB COD, where she has responsibility for enforcement of policies related to equitable hiring and employment.

She continues to mentor students as a faculty advisor for both the SNDA and AAWD. Her insights with regards to mentoring current students: "It requires a mixture of compassion, anticipation of their needs, and tough love at times."

Dr. Robinson is currently involved in a state-wide recruitment effort with the Historically Black College and Universities in Alabama for underrepresented minority student recruitment. She is

also Principal Investigator for the Robert Wood Johnson Foundation Summer Health Professions Education Program (SHPEP) at UAB. Her work with AAWD is to lift the profile of women in dental education and support career development. In 2011, she launched a mentoring program for women in IT and serves on the UAB Campus Women in Technology Mentoring Program.

Her advice to others seeking academic/leadership careers is to "Be fearless with opportunities. Be willing to make a leap and then catch up."

Kelton T. Stewart, M.S., D.D.S.

Associate Professor of Orthodontics and Oral Facial Genetics
Indiana University School of Dentistry

In 2002, Dr. Stewart received a B.A. in Biology from Baylor University, a D.D.S. in 2006, an M.S. in Health Professions Education in 2008 and a certificate in Orthodontics in 2008 from Texas A&M University Baylor College of Dentistry. His immersion in dentistry began as a youth heavily influenced by a number of compassionate and influential dentists. For several years, he spent time in different dental offices, eventually choosing a career in dentistry.

Throughout his academic career, Dr. Stewart enjoyed tutoring and aiding the educational achievement of his peers. Once he began his dental education, several mentors encouraged him to capitalize on his passion and ability to help others strive for academic excellence by selecting dental education as a career. He identifies Drs. Ernie Lacy, Claude Williams and Reginald Taylor as both mentors and major influences.

Mentoring has been an invaluable constant in his life. It was the mentoring of his childhood dentist years ago that planted the initial seed. Mentors along his academic career path helped cultivate his interest in dentistry and in dental education. The ADEA MDFD program provided him with a unique opportunity to be successful in dental academia. His participation in the program prepared him well for the rigors of a life in education. The skills obtained during the program allowed him to positively impact his institution and to successfully compete for and secure an educational fellowship and research grant. Furthermore, the financial contribution alleviated the burden he accumulated after a decade of postsecondary education. Without such support, accepting a full-time faculty position immediately out of his residency would not have been possible.

Dr. Stewart is currently an Associate Professor and Orthodontics Graduate Program Director at Indiana University School of Dentistry. As a tenured faculty member, Dr. Stewart is motivated by the perpetual pursuit of personal excellence. He strives each day to become a better educator, clinician, researcher and herald for dentistry and orthodontics. Moreover, he feels obligated to

the profession and to the many individuals who supported him to serve as a mentor, a beacon of motivation and a support to those who helped him. He feels that the profession's torch has already been placed in his care. It is now his opportunity and responsibility to serve as a seed sower, cultivator and sustainer for the next generation. His biggest motivation is to inspire, guide and assist the next generation to not only dream great dreams but help make those dreams realities.

Dr. Stewart has found dental education to be an excellent decision, one that united his innate passion to help others with the challenges and rewards of patient care, research and dental administration. He is proud of his legacy of 63 orthodontic residents who now practice throughout the world delivering quality and compassionate care.

He continues his research interests through residents and collaboration with colleagues in engineering, biomechanics, imaging and cephalometrics. He is also studying postgraduate dental outcomes assessment, with hopes of influencing the manner by which postgraduate programs select and assess their students.

His advice to others seeking academic/leadership careers is to "Be intentional with your efforts; there are many wonderful opportunities ahead of you and your potential impact on our profession is limitless."

LaQuia A. Walker Vinson, D.D.S., M.P.H.

Assistant Professor, Department of Pediatric Dentistry
Assistant Program Director, Postgraduate Residency Program in Pediatric Dentistry
Indiana University School of Dentistry

Dr. Vinson is originally from Fort Wayne, IN. She attended Xavier University in Louisiana, where she received her bachelor's in Chemistry, magna cum laude. Dr. Vinson received a D.D.S. from the University of California, Los Angeles, School of Dental Medicine in 2004 and an M.P.H. in informatics from the University of Illinois at Chicago in 2010 after earning a Certificate in Pediatric Dentistry in 2004. She has continued her career development at Indiana University School of Dentistry (IUSD), receiving a Certificate in Online Teaching in 2013. Dr. Vinson is a Diplomat of the American Board of Pediatric Dentistry and a full-time tenure-track faculty member who is engaged in teaching, research and extramural practice.

Dr. Vinson reflects on her career with a feeling that she "grew up around dentistry." As an elementary school student, her father began dental school. He opened his general dentistry practice in Fort Wayne, and during high school she worked there after school. She initially considered a career in medicine, but during her junior year in college, she decided that medicine

wasn't her passion. Her interest became health care. After careful reflection and investigation, she chose dentistry. She specifically selected pediatrics as a specialty because she wanted to focus on prevention. The majority of what occurs with adult dentistry is trying to restore something to its normal form and function. She wanted her practitioner experiences to be maintaining original form and function and felt it could best be achieved by treating children.

Mentoring is a crucial and important part of her career. She has several mentors who play different roles in her academic and private practice life. She says "it is nice to have someone to turn to who understands where you are, be objective, as well as give you the support and encouragement that a life in academia requires." Dr. Shar Faiadi has been an important mentor and influence in her career development.

The ADEA MDFD encouraged her to pursue an additional level of study. She knew she wanted to teach after completing her residency, but she had not strongly considered the possibility of a career in academia until starting the M.P.H. program. The M.P.H. program plays a huge part in how she works with residents in their research as well as how she creates a treatment plan. Her research has focused on presurgical orthopedics in cleft lip and palate and on pulp therapy in pediatric patients.

Working with millennials has caused a modification in her teaching strategies to include technology and accommodate different learning styles. She now continues to mentor both dental and postdoctoral dental students and commits time to the IUPUI STEM Scholars Institute.

Dr. Vinson's motivation as a dentist, faculty member, and leader is student-driven. She finds the opportunity and ability to work with students fulfilling. Students challenge her to improve her teaching abilities and stay current on everything in the field. Being involved in different dental associations and committees also encourages her to do more to serve the profession.

Dr. Vinson summarizes her academic career as "providing an immense amount of fulfillment. I never thought I would enjoy it as much as I do!"

CHAPTER 5: PROGRAM SUSTAINABILITY | LOOKING FORWARD

Dental and Preventive Care for Children
University of Detroit Mercy School of Dentistry

Division of Dental Public Health & Outreach
Shield A Smile School Based Dental Sealant Program
By Divesh Byrappagari, B.D.S., M.S.D., D.P.D.

Program Goal

The Shield A Smile (SAS) School-Based Sealant Program in partnership with K-12 schools will work toward reducing oral health disparities among school-aged children.

Key Best Practices and Strategies:

- Models for culturally competent allied health and dental teams.
- Conducting outreach to children and their families in dentally underserved communities.

Activities:

The University of Detroit Mercy School of Dentistry's (UDM SOD) SAS Program is a well-established program operating successfully since 2008. This student-based model not only delivers the preventive care needed in Detroit area schools but also trains the next generation of dental hygiene providers to be 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 SAS Program provided preventive dental services in K-12 schools in underserved areas of Southeast Michigan. The program selects schools based on the percentage of children who participate in the Free\Reduced Lunch (FRL) program. Only schools and organizations with over 50% of their children in the FRL program are chosen for participation. The program is managed and operated by a dental hygiene faculty and a mobile 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 the classroom. A total of 24 dental hygiene students have participated in the community-based program in the current academic year. The faculty member also provides didactic instruction related to community programs. The following services are provided through the sealant program at the school location:

1. Oral health screenings
2. Oral prophylaxis
3. Fluoride varnish applications

4. Dental sealant applications
5. Oral health education

The program expanded to include Macomb and Oakland counties along with Wayne County for the 2015–16 academic year. The program also operated during the summer term and provided services in summer camps in partnership with Old Newsboys' Goodfellow Fund of Detroit, Delta Dental and Forgotten Harvest.

Outcomes:

Program Objectives for 2015–16:

- Placement of dental sealants on 100 percent of the children with positive parent consent. *Completed.*
- Oral health education delivered to 100% of target children with 100% completing pre- and post-tests. *Completed*.
- Contact made with 100% of parents whose children were found to be in need of urgent care outside the school program. *Completed*.
- One hundred percent of sealant placements will be rechecked within six months and ensure a 90% retention rate. *Retention Rate: 86%.*
- One hundred percent of unretained sealants will be replaced at no cost to the child. *Completed*.
- Dental sealants will be placed on the molar teeth of 80% of the low-income children screened in the program. *Objective met: 100%.*

2015–16 School-Based Dental Sealant Program Data Summary

School	Oral Prophylaxis	Fluoride Varnish	Sealants	# of Children
Loyola*	26	26	86	26
Redford	149	149	316	149
Loving	108	108	183	108
Ross Hill Academy	66	66	157	66
Warren Mott*	28	28	98	28
Cristo Rey*	36	36	204	36
Holy Redeemer *	65	65	138	65
Burr	26	26	56	26
New Breed	38	38	85	38
Community of Christ	16	16	24	16
Burton Academy	144	144	263	144
TOTAL	702	702	1610	702

*High school programs

Dental Hygiene Student Evaluations of the Experiences in the SAS Program – 2014- 2015

QUESTIONS	YES	NO
Understand the role of a PA161 Collaborative RDH in a school based setting.	24	0
Apply basic principles of pediatric dentistry.	24	0
Perform a complete oral assessment on pediatric patients and accurately record the information.	24	0
Provide oral hygiene instructions and nutritional counseling to patients and, when appropriate, recommend and provide "OTC" preventive products.	24	0
Competently perform an oral prophylaxis and fluoride treatment on pediatric patients ranging from cooperative to mildly uncooperative.	24	0
Recognize the indications and contraindications of dental sealants and be competent in the placement of dental sealants.	24	0
Apply basic appropriate pediatric patient management techniques.	24	0
Understand when and how to appropriately refer pediatric dental patients.	24	0
Communicate with members of the interdisciplinary health care team and school personnel.	23	1
Recognize the extent of the dental needs of pediatric patients in the Detroit school-based populations.	24	0
Utilize mobile dental equipment and modify dental hygiene skills to meet the oral health needs of pediatric patients.	24	0
Improve time management skills and increase efficiency.	24	0

Short-term Outcomes:

- Strengthening school-based dental care.
- Supporting best-practice guidelines that result in preventive oral care for children and reducing dental caries of children in grades K-12.
- Establishing best practices for community-based and academic partnerships.
- Training culturally competent and community oriented allied dental professionals.

Long-term Outcomes:

Work toward Healthy People 2020 Oral Health Objectives.

- OH-1.2: Reduce the proportion of children aged 6 to 9 years with dental caries experience in their primary and permanent teeth.
- OH-1.3: Reduce the proportion of adolescents aged 13 to 15 years with dental caries experience in their permanent teeth.
- OH-8: Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year.
- OH-9.1: Increase the proportion of school-based health centers with an oral health component that includes dental sealants.

- OH-9.3: Increase the proportion of school-based health centers with an oral health component that includes topical fluoride.
- OH-12.2: Increase the proportion of children aged 6 to 9 years who have received dental sealants on one or more of their permanent first molar teeth.
- OH-12.3: Increase the proportion of adolescents aged 13 to 15 years who have received dental sealants on one or more of their permanent molar teeth.

Environment/Challenges/Opportunities:

- The major challenge the program met during current and past academic years has been the ability to recruit and retain schools in the program. Schools are under constant stress to perform well on benchmark tests and see the health care programs in schools as a distraction in achieving their goals. We have continued to work with them to explain the connecting between importance of oral health and learning.
- The program has also struggled with increasing participation rates. Focus groups of parents were conducted and several recommendations were implemented. In spite of these efforts the participation has not increased significantly.
- Michigan Department of Health & Human Services amended our mobile program permit to provide services in Macomb and Oakland counties and this has helped with recruiting additional schools to the program.
- Working with Detroit Public Schools Community District has been challenging as well. The program is in the process of signing a formal MoU with the school district to formalize the partnership.

Collaboration:

We have collaborated with several agencies and organizations in Michigan to enable us to sustain, improve and expand our SAS school-based program.

1. Wayne, Macomb and Oakland county schools: We have signed affiliation agreements with several schools to provide services in their schools.
2. Michigan Department of Community Health: Has been the major funding agency for the program. Their funding has been crucial to maintaining and expanding the program.
3. Old Newsboys' Goodfellow Fund of Detroit: Has provided funds to cover the costs of dental services to children without dental insurance. This has helped with the sustainability of the program as well.
4. Delta Dental Foundation: Delta Dental Foundation: Has provided several educational resources and supplies for the SAS program. We use Delta Dental's "Drool to School" and "Rethink Your Drink" education materials for oral health education. Delta Dental also provides supplies for oral health kits that are provided to children following dental services.

Team-Based Care Dental Therapy Model for Culturally Competent Allied Health and Dental Team

University of Minnesota School of Dentistry—Team-Based Care

By Karl D. Self, D.D.S., M.B.A., FACD

Program Description

This section will discuss the best practice and strategy of utilizing a new team-based care model to address limited availability of dental providers.

Despite recent gains in access to oral health care, many Minnesotans, particularly those from underserved communities, still lack access to care. Although the access to dental care issue is multifaceted, two reasons often cited as access to care barriers are (1) a shortage of dental providers, especially in rural areas, and (2) an insufficient number of providers willing to accept Medicaid or other Minnesota Health Care Program patients. As the University of Minnesota School of Dentistry (U of M SOD) is the only U.S. institution to educate dental (D.D.S.), dental hygiene (DH), and dental therapy (DT) students in the same facility, we felt that there was an opportunity to address the access to care issue from a different perspective. Team-based care delivery is common among medical providers and is recognized as an effective method for delivering high-quality healthcare to patients and to improving health care outcomes. While the value of interprofessional education and interprofessional care teams have attracted a lot of attention recently, the same cannot be said about the value of intraprofessional teams, specifically in the dental professions.

In dentistry, most financially successful dental practices will state that their success is due to the teamwork of their staff. In fact, research shows that staffing increases have had a significant impact on the productivity of dentists, increasing the number of dental visits per dentist from 1950 to 2009 by 85.6% Yet, teamwork is not the same as team-based care and currently there is a transition in the dental care delivery system from the traditional small practice that emphasized teamwork to larger group or corporate practices, many of which are interested in the delivery of team-based care. Team-based care is described as “the provision of health services by at least two health providers who work collaboratively with patients to accomplish shared goals.” Research also shows that the use of “expanded function allied dental personnel has a significant and positive impact on practice productivity and specifically total net income and net income per dentist hour.” In Minnesota, the use of expanded function dental personnel has been authorized for decades; still, surveys show that only 11–13% of those trained ever utilize those skills. Thus, the U of M SOD felt the need to do something different regarding team-based care.

From the beginning of the program in 2009, the education of dental therapists was designed to occur within the context of the dental team. Didactically, DT students would take courses with D.D.S. or DH students as it aligns with their scope of practice. Clinically, there were two initial efforts to promote team-based care:

1. A workgroup of faculty leaders convened to decide how DT students would be incorporated into the school's comprehensive care clinics. The workgroup's vision was to determine a process to educate the oral health team to deliver care to all Minnesotans in a way that optimizes the skills of every member in an economically viable model.
2. A five chair community-based outreach clinic was developed to allow all student groups the opportunity to experience team-based care in a setting that simulated a private practice.

While the integration of student groups occurred smoothly in the didactic settings, that was not the case clinically. Despite the support of the comprehensive care group leaders, the level of team-based care in the clinical setting was variable. Not only was it variable from group to group, each year the successful modeling of "team" was variable within each group. In hindsight, those initial clinical team-based care efforts were centered on examining the role of a DT in clinical care, educating faculty and students about the DT's scope of practice, and observing how the addition of a dental therapist impacts care delivery. Eventually it became apparent that the inconsistent implementation could be due to the same factors that have led to a lack of adoption of the use of expanded functions in dentistry. Thus, the U of M SOD recognized that it needed to take the next step in developing team-based dental care.

Activities:

Historically, there was limited and inconstant instruction in the curriculum for D.D.S. students on how to utilize and interact with DH and DT students in the clinic. It seemed that putting students together in a group and asking them to work effectively as a team was not enough. Students, specifically D.D.S. students, require education on how to work as a collaborative care team with each provider practicing at the top of their license. Therefore, the U of M SOD began a project to develop an educational program to teach team-based care. The emphasis would be on developing skills for D.D.S., DH and DT students to function as a unit to deliver optimal team-based dental care to their patient population.

The project developed the following activities in support of this effort:

a. Identify best practices in utilizing expanded functions hygienists and DTs through questionnaires and focus groups of existing dentists, hygienists, and DTs who are identified as innovative users and high utilizers of allied dental professionals.

   Even though this activity was important to the foundation of creating a team-based care curriculum, there were a number of challenges in identifying innovative users of allied

professionals who were also willing and able to participate in a focus group effort. Time constraints and logistical issues were the two biggest barriers. In the end, this activity occurred more informally with the project evaluator engaging select individuals in one on one conversation to elicit common best practices.

b. Create a new team-based care delivery curriculum that can be used to educate dental, dental hygiene and dental therapy students.

   Didactically, a team-based curriculum was developed within the Dental Professional Development (DPD) course structure. While the DPD series of courses is different for the different student groups, the topics are consistent and the different groups work together when content overlaps. Content for these courses are spread out over the duration of each educational program and focuses on issues such as personal finance, office finance, practice management and team-based care. As an example, team-based care learning for dental students begins in their DPD 1 and DPD 2 courses. In those courses they learn about collaborative practice and the various scopes of practice of each member of the dental team. Also, during the DPD 2 course they design a practice model. The DPD 3 course is devoted to the dental team (D.D.S., DH, and DT students). Topics include marketing, regulatory compliance, quality improvement, personality and teamwork, as well as leadership and teamwork. Team activities are a part of most of these topics; additionally, this course includes the development of a practice plan and a policy manual as a dental team. The goal of this didactic education is to facilitate the learning of team based strategies early in the program so when students reach the clinic they will be well versed in its merits.

   Once students have foundational knowledge regarding team-based care and have gained a better understanding of each other's skill sets and roles as a part of the care team, they are ready to put it into practice. To help ensure consistency in clinical practice, all students (D.D.S., DH, and DT) must review a document titled "Team Care Clinic Orientation—Best Practices" in preparation for their rotation through Team Care Clinic (TCC). The manual is specific to how they will interact in the TCC and was created utilizing the information gathered by the project evaluator.

c. Develop video presentations and other web-based tools to support the on-line delivery of applicable curricular components.

   Focus groups with students who had completed their TCC rotations provided feedback that team-based care is best learned experientially. Therefore, following the creation of the manual, the integration of a team-based curriculum into Dental Professional Development, and the student's early experiences with the TCC, a decision was made that no videos or additional web-based tools were needed at this time.

d. Pilot the implementation of the new curriculum for D.D.S., DT, and DH students in our Comprehensive Care Clinics. Pilot a pod of chairs (six of the group's 16 chairs) within one of the eight color groups to operate using the new team principles. Rotate a team of D.D.S., DH, and DT students into the pilot "mini-clinic." Instead of the traditional one-patient-per-student-per-session scheduling method, multiple patients will be scheduled in the pod such that the D.D.S. student will be able to learn delegation and team leadership skills while the DT/DH students get more experience collaborating with the dental students as a part of the team. This group will be supported by a dedicated dental assistant to allow the students to focus on providing patient care as a team.

   A TCC was created within one of the U of M SOD's current color groups on the comprehensive clinic floor. The team for the pilot project consists of one D.D.S. student, one DT student, and two to three DH students depending on the day. A dedicated faculty was assigned to manage the TCC to make sure the students worked together to provide efficient, quality care to more patients. Students collaborated with each other to meet the goal of delivering patient-centered care and they were encouraged to make real-time decisions regarding which provider was the most appropriate person to provide the needed care. TCC starts the day with a team huddle to develop a strategy for all appointments to flow smoothly and ensure a better experience and outcome for a patient. Students met in the morning to discuss their patients; they discussed whether there was a need or opportunity to better treat the scheduled patients and provide optimal care by working together. A simple example of this concept is where patients presenting only for a restoration were also able to get their teeth cleaned. This concept of maximizing care delivered during an appointment was appreciated by patients as it saved them from having to make an additional trip. During the huddle, the team also looks for opportunities to accommodate same day emergency/urgent care patients. This has led to the TCC playing a large role in accommodating unscheduled patients and it has allowed DH students and DT students to gain additional experience collecting initial data, identifying patient's chief complaints and then working with the D.D.S. student to formulate the proper plan of care.

Outcomes:

The initial TCC pilot created a great deal of excitement and positive reviews by patients, students, faculty and staff at the U of M SOD. In surveys and focus group discussions, students cited the following as some of the positive results:

- Patients are happier.
- Patients receive continuous care between providers.
- Students are gaining and honing skills faster.
- Team-based care results in significantly higher production.

TCC did in fact outperform our Traditional Group Clinics in patient volume and productivity. The increases in these two measures for six months of the project are noted in the following table.

Table 1: Percent Increase in Patient Visits and Productivity per Team Member*

Student Type	% Increase in Pt Visits	% Increase in Production (Dollars Generated)
Dental	43%	27%
Hygiene	19%	30%
Therapy	27%	23%

*Compares Team Care Clinic with average Traditional Group Clinics

Additionally, students felt that their experiences in TCC have influenced their future practice as professionals. They expressed that they enjoyed clinic more and felt more supported by each other and less stress than the traditional clinic experience. The following comment by a D.D.S. student is representative of the feedback received:

> "I really like working in a team setting, being on the same page, being able to collaborate like that versus having someone watch over me and me doing my own thing. I like that family group concept. And in my resume right now I'm 'Team-care centered,' that's pretty much what I'm looking for."

Due to the overwhelming positive responses to the pilot project, the TCC was expanded to two teams each working with eight chairs. Each team (Team A and Team B) is designed to consist of six students: three D.D.S., one DT and two DH students. The TCC is now supervised by a combination of dental and dental hygiene members as well as a designated dental assistant.

Environment/Challenges/Opportunities:

During the implementation of the pilot, due to the U of M SOD's academic calendar, there was a lull in student participation in the TCC during April as senior dental students graduated and clinics were not fully staffed. New ways of ensuring a full complement of providers needed to be developed. Also, while TCC continued to outperform the Traditional Clinics, the differences became less over time as students who have already rotated through the TCC brought back some of the skills and concepts they have learned to the Traditional Clinics.

The TCC is an all-inclusive, all hands on deck approach where faculty, patient coordinators, students and staff must come together to achieve a patient-centered care approach to dentistry. The type of student that works best in the TCC environment is not only team oriented but also flexible, open-minded, decisive and able to look at the "big picture," which is patient-centered care. Students need to be able to see a gap and fill it to allow for efficient delivery of care. Communication skills that are clear, concise and precise are critical for all team members.

Other factors noted that affected the project included:

- A paid, high-quality assistant is essential.
- A student needs some clinical experience before TCC to make it worthwhile and effective (at least one semester to "figure yourself out").
- Previous outreach experience is helpful.
- TCC required more hours from the supervising dentist.
- Difficulty with establishing and/or maintaining strong team relationships if student rotations are frequent or not on the same cycle.

Future Plans:

The success of the team care project within the U of M SOD has laid the groundwork for two future directions. The first is to focus more attention on evaluating the project outcomes. While the project has generated descriptive data regarding students' attainment of team-based care competencies, it is important to objectively assess their attainment of competency with the following five domains:

- Role Clarification—understanding their own roles and the roles of other professionals.
- Team Functioning—understanding the principles of team work dynamics and group processes.
- Patient-Centered Care—seeking out and valuing as a partner the input and engagement of patients in designing and implementing care.
- Collaborative Leadership—supporting shared decision-making and leadership as well as accountability for one's actions within one's professional scope of practice.
- Interprofessional Communications—communicating with other professionals in a collaborative, responsive and responsible manner.

Additionally, it would be important to assess the impact of the team care curriculum on improving access to underserved populations. This could be accomplished by looking at the five chair community-based outreach clinic that was developed specifically to allow all student groups the opportunity to experience team-based care in a setting that simulated a private practice. A retrospective look at patient visits and productivity before and after the implementation of the TCC could provide information about the performance of the team in situation that mirrors their post-graduation world.

The second future direction of the project is to plan the expansion of the TCC within the U of M SOD as a larger supplement to or even a replacement for the Traditional Comprehensive Care clinics. An economic analysis needs to occur to determine what additional resources, if any, are needed to make this happen. If additional resources are needed, the U of M SOD will need to look for those resources.

Interprofessional Education/Collaborative Care

Interprofessional Practice and Education at Howard University College of Dentistry

By Donna Grant-Mills, RDH, M.Ed., D.D.S. and Leo E. Rouse, D.D.S., FACD

Program Description

Interprofessional practice and education (IPE) at Howard University has progressed significantly since 2012 through a variety of combined efforts between institutional leadership, curriculum development, and academic/community partnerships. Support from the W.K. Kellogg Foundation and the American Dental Education Association (ADEA) for the Minority Dental Faculty Development (MDFD) Program has been pivotal in building and ensuring sustainability.

Team-based, collaborative approaches for educating health professionals to work in teams to improve health care outcomes[1] is a hallmark at Howard University (HU). For more than three decades, students across the health science disciplines have experienced an interactive and collaborative educational space through the course "Health Care Ethics" taught in the fall and spring semesters each year. This course provides the HU Health Sciences Division an internal resource net for expanding IPE. It also introduces the various health science students to ethical and bioethical issues confronting health care providers in the context of health care delivery and research.

Through a series of interdisciplinary lectures and small group case presentations facilitated by faculty from each health science discipline, students are exposed to theories and principles of bioethics. Students also become familiarized with the foundations of patient-provider relationships, professionalism, relevant ethical and legal considerations, and the concepts of moral reasoning.

The curricular infrastructure in health care ethics coupled with commitment from the academic/community leadership created an environment for the MDFD grant to steadily promote and advance IPE at HU over a four-year period.

The Howard University College of Dentistry Integrative Center (HUCD-IC), operating under the MDFD grant, was established in 2012 to expand IPE and implement the following activities:

a. Cross-training of Nurses

- The Howard University College of Nursing Family Nurse Practitioner Program revised its curriculum in pediatrics to include a rotation at the College of Dentistry for the training of students by dental residents (Advanced Education General Dentistry [AEGD] and Pediatric) to assess the oral cavity. The community partnership with the Colgate/Palmolive Bright Smiles Bright Futures Van allowed the nurses to apply their

knowledge and skills while engaging interprofessionally with the residents, dental and dental hygiene students.

- The District of Columbia Foster Care Nursing Group collaborated with the HUCD-IC to coordinate oral health training sessions for nurses working in foster homes. These sessions conducted by dental residents prepared nurses to make assessments and link children to services within the health care safety net.
- The District of Columbia Health Services for Children With Special Needs Incorporated arranged for the care management staff to participate in the HUCD-IC oral health training sessions to improve the oral health of children with special needs.

b. The HUCD-IC IPE Team

- A collaborative team comprising the HU Departments of 1) Communication Sciences and Disorders, Speech Language Pathology Program; 2) Family Nurse Practitioner Program; 3) Nutritional Sciences; 4) Orthodontics; 5) Pediatric Dentistry; and 6) Dental Hygiene.
- The HUCD-IC IPE team conducted eight health assessments for children that link oral health to systemic health with follow-up recommendations on a status report to parents. Health assessments included 1) Oral Mechanisms; 2) Oral Health Education; 3) Body Mass Index; 4) Nutritional Counseling; 5) Hearing; 6) Speech and Language; 7) Orthodontics; and 8) Pediatric Dentistry. Following the health assessment, HU students representing the IPE team actively engaged the children in a lunch and learn session about health career opportunities, and life experiences that led them to choose a career in the health professions. Referrals were made to the Howard University College of Dentistry and Hospital, and the Maryland Department of Public Health. The oral health liaison continued after the program to ensure children and their families in need of care were linked to services. Health science students completed pre- and post-interdisciplinary health assessment tests. Two community partnerships support this collaboration: The National Congress of Black Women, Maryland Chapter and the Colgate/Palmolive Bright Smiles Bright Futures Van.

c. IPE Health Disparities Simulation Workshops

- The goal of the simulation workshops, coordinated in 2015 and implemented in 2016, was to provide medical and dental students a “close up” and realistic view of what health disparities may look like from the patient’s perspective. This was achieved via simulation workshops that utilized scenarios involving standardized patients and provider/health care system interactions. Two simulation workshops were held: Simulation Workshop I focused on Patient & Team-Based Provider Interactions,

while Simulation II focused on Patient & Individual Provider Interactions. The workshops served to demonstrate the impact of health disparities on issues around:

- Efficiency of health care access.
- Trust in the health care system.
- Understanding of health care information.
- Appropriate utilization of health care information.

- These workshops were also designed to demonstrate socioeconomic, cultural and bias-based dynamics of the patient, provider and health care system interactions. The scenarios demonstrated how a member of a disparate group might interact with health care providers in multiple health care settings. Each workshop included a moderator to facilitate attendee dialog in discussing both the inappropriate and appropriate scenario depictions. These workshops were supported by the HU Research Center in Minority Institutions Supplemental Grant from the National Institute on Minority Health and Health Disparities (NIMHD).

d. HU Interprofessional Education Working Group

- At the request of the Provost, in 2015, a working group comprising faculty representatives of the health sciences was formed to design an interprofessional curriculum for Howard University Health Sciences (HUHS). The disciplines included social work, clinical psychology, divinity and law.
- The working group organized an inaugural event of a one-day IPE workshop to occur in the spring of 2016 to provide health sciences learners with baseline knowledge, and an immersive experience on the core competencies for interprofessional collaborative practice. This workshop emphasized the roles, responsibilities and team work essential for patient care.

e. Recruitment/Academic Enrichment Programs

- The HUCD-IC collaborates each summer with the Colleges of Pharmacy and Medicine to expose preprofessional students to careers in the health sciences with an emphasis on a team-based approach to advancing the health of the public.
- Premedical and predental students participating in the Robert Wood Johnson Foundation (RWJF) Summer Medical and Dental Education Program (SMDEP) at HU were given the opportunity in 2015 and 2016 to experience team-based interprofessional research through the William Montague Cobb Research Lab (CRL). The Cobb Lab houses human skeletal remains from the New York African Burial Ground and African Americans who lived in the District of Columbia during the 19th and 20th centuries. Scholars observed a comprehensive examination of human remains of 19th and 20th century human skeletal and dental materials at the CRL. Individual case studies depicting a broad range of conditions, including

cardiovascular disease, cancer, diabetes, and trauma were distributed, one to each research team. Students researched databases that documented injuries; migration patterns, familial relationships, relevant biomedical articles; U.S. Census Bureau records; historical texts, public databases (e.g., Ancestry.com, Family Search.com); periodicals; and case-specific medical, birth, and death records. Analysis included application of scholars' knowledge from SMDEP courses in genetics, communications, health disparities,; health care ethics and the civil rights workshop. Scholars constructed 2,000-word biohistories on each case study individual. Scholars were surveyed to assess their experiences. Results: 27 biohistories, produced in 14 days, compared public health disparities, disease incidence and prevalence, and standard of care in the case studies with those of the current African-American population. The scholars found similarities between the case studies and the current African-American population regarding social determinates of health. Additionally, similarities were found in hypothesizing how death occurred, why treatment may have failed, or availability of treatment. Seven biohistories were published in *The Backbone*, an online, open-access peer-reviewed CRL journal. 100% of the SMDEP scholars reported the experience as beneficial and relevant to their intended health careers.

f. Introduction to Interprofessional Practice and Education for SMDEP Scholars Pilot Course

- The HU SMDEP participated in the 2016 SMDEP Interprofessional Practice and Education Pilot Course sponsored by the National Center for Interprofessional Practice and Education and the RWJF. The course design presented activities appropriate to the SMDEP audience focused on IPE to ensure that participants develop the knowledge, skills, and attitudes that will contribute to success in their chosen careers as the U.S. health care delivery system transforms. This six-session IPE course was made available online.

g. Faculty Development

- The HUCD-IC hosted a one-day College of Dentistry interdepartmental faculty development workshop. The workshop included lessons learned from MDFD leadership training with an emphasis on the importance "intraprofessional practice and collaboration" as a sound base for interprofessional practice and collaboration. The participants were provided with tools to increase intra- and interprofessional collaboration across health science disciplines.

Outcomes:

As a result of the combined efforts between the academic leadership and academic/community partnerships, HU has realized the following in advancing IPE:

1. The HU Interprofessional Education Working Group is now the Simulation & Clinical Skills Center Steering committee. The committee's purpose is to assist in making strategic decisions about the learners, curricula and resources including space, funding, faculty/staff, technologies and devices, and to evaluate the Center's effectiveness in meeting its mission, including review of assessment data.
2. Building on the success of the SMDEP, HU has been selected to participate in the 2016 RWJF Pilot Summer Health Professions Education Program (SHPEP).
3. The Pilot SMDEP IPE course will be integrated into the curriculum for the SHPEP beginning summer 2017.

Future Plans

1. Devise a curriculum for IPE across disciplines at HU.
2. Continue engagement of high-level administrative leadership to support IPE.
3. Continue to build and strengthen community partnerships.
4. Develop assessment for the IPE.
5. Establish best practices for community-based and academic partnerships that promote eliminating health disparities.

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1. University of Minnesota. National Center for Interprofessional Practice and Education. About IPE, 2015. At: https://nexusipe.org/informing/about-ipe. Accessed: September 7, 2016.

Recruiting URM and Low-Income Students – University of Michigan School of Dentistry

Educating High School Students From Disadvantaged Backgrounds About Careers in Dentistry and Allied Dental Professions: The Ypsilanti High School Program

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Program Description

In January 2009, the W.K. Kellogg Foundation in collaboration with the American Dental Education Association (ADEA) published a request for proposals (RFP) from U.S. dental schools, asking them to design an educational program that would address the three major challenges facing dentistry in the United States. These challenges were that certain population groups, such as patients from minority and/or socioeconomically disadvantaged backgrounds, experienced disparate amounts of oral disease and severe challenges with gaining access to dental care;[1] the lack of diversity among dental care providers;[2] and the shortage of dental faculty in general and the significantly lower numbers of faculty members from underrepresented minority (URM) backgrounds.[3,4] The University of Michigan School of Dentistry (U-M SOD) responded to this RFP with a proposal that focused on addressing all three challenges,[5] and received funding in February 2009. This funding allowed the development and conduct of the Ypsilanti High School Program (see Figure 1 for the timeline).

Key Best Practice and Strategy: The central Key Best Practice addressed by this program was to engage children and their families in a dentally underserved community in an outreach program aimed at not only educating them about dental care, but also about dental careers. Additional Key Best Practices were to develop a strategy for building a school-based program that would (1) address the dental health education resource gap, and (2) engage parents while doing so.

Activities: From the start, the goal was to create a program that would take a “recruitment through engagement” approach to the topics covered in this program (see Table 1 for the content covered on each of the Saturdays during the Fall and Winter terms). Instead of using a hierarchical top-down approach in which dental and dental hygiene faculty members and students would educate high school students about dentistry and dental hygiene, the objective was to create a cooperative and action-oriented program where high school students and dental school community members would collaborate with each other to achieve certain goals. Two strategies were important to successfully achieve engagement. First, during the 3.5-hour Saturday sessions, lecturing or presentations were kept to a minimum. Instead, high school and dental and dental hygiene students were involved in collaborative explorations of relevant

content by jointly seeking web-based information. Second, hands-on activities were prioritized. During the Fall term, the high school students were challenged to prepare and conduct an oral health fair on a Saturday morning in their high school. They designed different types of advertising materials for this event, created educational materials to educate any children and adults coming to the oral health fair, and brainstormed jointly on how to set up the available space for the fair, organize the flow of patients arriving, and how to support volunteer dentists who conducted oral exams. During the Winter term, the high school students came to the dental school environment and were prepared to participate in a "Give Kids a Smile" clinic on one Saturday plus a volunteer free clinic for adult patients on another Saturday morning. Table 1 provides an overview of the specific topics covered in each Saturday workshop.

Outcomes: A previous publication[5] describes the outcomes of this program in detail. It shows that in the academic year 2009–10, data were collected from 23 high school, and 21 dental, and 5 dental hygiene students, and that in the academic year 2010–11, 27 high school, 11 dental and 3 dental hygiene students responded to the evaluation surveys. These students participated in 15 Saturday sessions from October through March in each year. Survey data were collected before and at the end of the program as well as at the end of each Saturday session. The data showed that mentees and mentors were very interested in participating in the program and in getting to know each other at the beginning of the program. Lectures, general program activities, and patient-related events such as organizing the health fair and shadowing during two free clinics in the dental school were evaluated quite positively by both high school mentees and dental school mentors. The end of program evaluations showed that the program and the mentee/mentor relationships were rated very positively, and that the mentees had an increased interest in oral health-related careers. The open-ended responses provided some additional information about the program. For example, while the attempt to match up specific mentees with specific mentors at the beginning of the first year, not formally arranged mentoring relationships developed over time. The use of cell phone communications outside of class and during the week was described as especially helpful.

Environment/Challenges/Opportunities: Describe factors or circumstances (positive and/or negative) within your environment affecting progress toward achieving goals either generally or as they relate to specific activities. What challenges and opportunities have developed and how are they being approached?

Collaboration: A program such as the Ypsilanti High School Program cannot be developed without the strong support of the school district superintendent and a solid collaboration with the high school administration. At every step of the way, it was crucial to have the high school principal's expertise as a guiding principal. For example, when the question arose about how high school students could be informed and recruited into the program, the high school principal offered to have pairs of dental/dental hygiene students rotate through all first class periods on one given day and give a 10-minute presentation to each class about why they were in dental

school/a dental hygiene program and what the upcoming program would be about. When parent involvement was discussed, the expertise of the high school principal provided the basis for creating a successful evening meeting with parents of interested students. The Saturday morning sessions and especially the oral health fair in the high school could not have taken place without the high school principal's strong support.

When no funding was available for the activities in Year 2, the director of the University of Michigan Center for Educational Outreach (CEO) was supportive and paid for the bus transportation of the high school students during the Winter term. Support from university offices involved in recruitment of students can definitely contribute to the success of such programs.

Finally, it was a real pleasure to see how willing colleagues were to visit the Saturday morning classes and tell the students about their dental specialty or dental hygiene profession. Complementing the information that dental and dental hygiene students provided with personal stories of faculty members about their way into the profession and why they love what they do, was received very positively by the high school students.

Observations: Some lessons learned were based on observations. First, it was exceptionally gratifying to see how both dental and dental hygiene students took on leadership roles in this program. The coordinating/organizing faculty member (first author) is a psychologist and therefore told the dental and dental hygiene students that they were the experts about dental care and dental careers right at the start. The students embraced this call to action full heartedly. Despite having very busy schedules in the junior and senior year of their programs, they attended Tuesday lunch time meetings to discuss the activities at the upcoming Saturday, and volunteered to prepare educational materials. Their interactions with the high school students took time away not just during the Tuesday preparation meeting and the Saturday workshop time, but also during the week when they communicated with the high school students, and when they invited them to dental school events such as the Martin Luther King celebration. Enthusiastic dental and dental hygiene students made this program successful.

A second lesson learned was concerned with the summer research internships that were developed. Several colleagues in the dental school were willing to have high school students spend six to eight weeks in their labs over the summer break. When this opportunity was discussed with the high school students, the majority was enthusiastic and interested. However, when the summer arrived, only three students followed through with this unpaid opportunity. Most other students had found jobs and needed to earn money.

A third observation was the fact that the parents/guardians were quite interested in the program and expressed their sincere gratitude for the program.

Future Plans

The Ypsilanti High School Program worked out very well in Year 1 when funding was available. This funding allowed paying for healthy food during the 3.5 hour Saturday workshops, which was quite needed because most high school students arrived hungry and needed breakfast. Leftover food was very willingly taken home. The funding also paid for supplies such as folders, paper pads, pens, etc., which made learning easier. It also provided a small stipend for the dental and dental hygiene students who had to find transportation to the high school in the Fall term.

In Year 2, no funding was available and some innovative ways had to be found to replace funding with other incentives. For example, an elective course "Educational Outreach" was created to allow the dental and dental hygiene students to at least receive credit for their activities. However, no source of support for the much-needed food and supplies could be found, so private funds covered these expenses.

The lack of financial support stopped the program after Year 2. However, the experience was overall so positive that discussions are currently under way concerning the creation of a modified high school program at clinical sites where our students are placed for community-based education. Finding ways to have dental and dental hygiene students present to high school students about dental careers in the high school setting would be Part 1 of such a program. Part 2 would then be to engage dentists and dental hygienists in community-based clinics to offer shadowing experiences for interested high school students. Dental and dental hygiene students and professionals could thus serve as role models for high school students from disadvantaged backgrounds and thus ultimately contribute to overcoming the challenges dentistry still faces today.

REFERENCES

1. Oral health in America: A report of the surgeon general. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research, 2000.
2. Missing persons: Minorities in the Health professions. A report of the Sullivan Commission on diversity in the healthcare workforce. http://www.aacn.nche.edu/media-relations/SullivanReport.pdf. Last accessed on March 9, 2013.
3. Okwuje I, Sisson A, Anderson E, Valachovic RW. Dental school vacant budgeted faculty positions, 2007-08. J Dent Educ 2009;73(12):1415-1422.
4. John V, Papageorge M, Jahangiri L, Wheater M, Cappelli D, Frazer R, Sohn W. Recruitment, development, and retention of dental faculty in a changing environment. J Dent Educ 2011;75(11);82-89.
5. Inglehart MR, Stefanac SJ, Johnson KP, Gwozdek AE, May KB, Piskorowski W, Woolfolk MW. Recruiting URM High School Students into Dental Professions and Educating Dental Students about Academic Careers. J Dent Educ 2014;78(3):423-436.

Figure 1: Timeline of the Ypsilanti High School Program Activities

Time: Year 1: Academic 2009–10	Activity	Faculty, 21 dental and five dental hygiene students	High school students	Parents/ Guardians
February to August	Program preparations	Yes	n/a	n/a
October 1	Recruitment visit to high school	Yes	Students in 1st hour	n/a
October 5	Parent information evening	Yes	23 interested students	Parents/guardians of 23 students
Fall semester	Six Saturdays: Dental careers and dental health fair	Yes	Yes	Weekly updates—postal letters
Winter semester	Nine Saturdays in dental school	Yes	Yes	Weekly updates—postal letters
End of program celebration	Graduation lunch and ceremony	Yes	Yes	Yes
Summer internships	Research lab activities and classes	Faculty and students	Three students	Information mailed
Year 2: Academic Year 2010–11	Activity	Faculty, 11 dental and three dental hygiene students	High school students	Parents/ Guardians
October	Recruitment visit to high school	Yes	Students in 1st hour	n/a
October	Parent information evening	Yes	27 interested students	Parents/guardians of 27 students
Fall semester	Six Saturdays: Dental careers and dental health fair	Yes	Yes	Weekly updates—postal letters
Winter semester	Nine Saturdays in dental school	Yes	Yes	Weekly updates—postal letters
End of program graduation	Graduation lunch and ceremony	Yes	Yes	No
Summer internships	Research lab activities and classes	Faculty & students	2 students	Information mailed

Table 1: Overview of the Ypsilanti High School Program Activities

Year 1: Fall term[1]: 9:00 a.m. – 12:30 p.m.	Theme: Getting to know dental careers and organizing an oral health fair
Saturday 1:	Getting to know each other and dental careers
Saturday 2:	Oral health and dentistry for children and Preparing Health Fair
Saturday 3:	Oral health and dentistry for adults
Saturday 4:	Oral health education and Preparing Health Fair
Saturday 5:	Conducting oral health fair for children and parents
Saturday 6:	Debriefing of Health Fair activities and Outlook
Year 1: Winter term[2]: 9:00 a.m. – 12:30 p.m.	**Theme: Getting to know the life of a dentist/ dental hygienist**
Saturday 7:	HIPAA certification/Patient care coordinators/Relationship with patients
Saturday 8:	Instrument dispensing and sterilization and Working in a simulation lab
Saturday 9:	Clinical chart information/Working with X-rays/Clinic tours
Saturday 10:	Preparing the "Give Kids a Smile" event
Saturday 11:	"Give Kids a Smile" clinic
Saturday 12:	Debriefing of "Give Kids a Smile" participation/Dental specialties
Saturday 13:	Preparation of Taft Clinic (Volunteer clinic for adult dental patients)
Saturday 14:	Taft clinic for adult dental patients
Saturday 15:	Debriefing of Taft clinic participation/End of Program Celebration

Legend:

1. The Fall term activities took place in the high school library.
2. The Winter term activities took place in the dental school.

CHAPTER 6: ORAL HEALTH AND EXPANSION OF COMMUNITY HEALTH/HEALTH CARE UNDER THE ACA

Building on the Strengths of Community-Based Dentistry for Better Oral Health Care

By Joseph F. West

Significant gaps in dental care can be closed through the expansion of community-based dentistry, dental education and preventive services. While community-based services may not fully address financial stressors of co-pays, low-reimbursement or limited dental Medicaid or Medicare coverage, they can extend access to education, some treatments and preventive care.

The dental safety net is a system comprised of in-kind offerings by dentists, university-centered dental practices and affiliated hospital clinics, community clinics and mobile dental units. These institutions provide care to approximately 8 million low-income and uninsured patients annually. More than 47 million people live in rural and urban communities where it is difficult to access dental care. Most of the more than 830,000 visits to emergency rooms are for nontraumatic dental conditions, pain symptoms or antibiotics for infections.

The Patient Protection and Affordable Care Act (ACA) provides opportunities to increase much-needed dental coverage, and bring medical and dental care into closer alignment. In 2014, the ACA extended health insurance to over 6 million Americans and 1.1 million gained stand-alone dental benefits through the health insurance marketplaces. The ACA focuses on improving quality of care while containing costs via patient-centered medical homes, care coordination, health care delivery modification and accountable care. The Act also boosts coverage through Medicaid expansion, key dental benefit extensions and incentives for integrated care models. However, through Medicaid expansion and other ACA-related programs, only about 80,000 adults and children gained dental benefits. In most cases, medical and dental care are offered

Strengths of Community-Based Dentistry

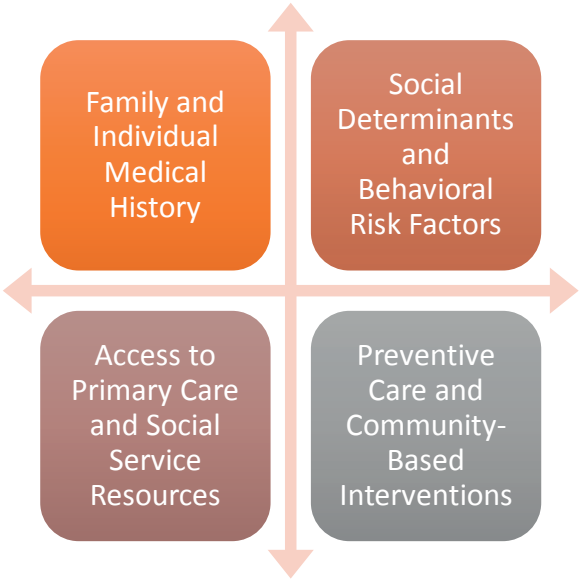
- Address gaps and financial shortfalls in Medicaid dental coverage by expanding access and strengthening utilization for low-income and vulnerable populations.
- Remove barriers to coverage awareness, oral health literacy and perceptions of oral health as secondary to general health.
- Develop stronger collaborations between primary care providers, hospitals, mental and behavioral health, long-term services and dentistry.
- Advance culturally competent knowledge, skills and attitudes toward oral health.
- Enhance multidisciplinary and interprofessional education, alongside community partnerships and investment.
- Broaden range of learning opportunities and increase recruitment into dental education, community-based health, primary care and specialties.

and delivered separately and disjointedly. Thus, there remains significant gaps and disparity in insurance coverage, reimbursement and access.

Community-based dentistry can pull together all the best aspects of the ACA oral health provisions to address social determinants, reduce risks in value-based and accountable care organizations, and spur effective collaboration between healthcare providers. Training dental students, dental faculty and other dental personnel to better understand community needs and how to collaborate more with hospitals, social service agencies, specialists and other service providers such as transportation and food delivery is a core aspect of community-based dentistry. Developing and disseminating preventive dentistry training materials and serving as a a referral center for patients with complex health needs are also important components. Academic and community partnerships capable of launching dental screening and triage clinics, and establishing quality preventive and therapeutic dental services, are yet other crucial areas for community-based dentistry.

Care Coordination and Oral Health

Care coordination is a multifaceted concept. In general, it is defined as meaningful communication and cooperation among health care, social service and other providers to improve the health of individuals. Care coordination entails assessment of health status and developing and executing a care plan to monitor specific health-related outcomes. Care coordinators may be lay health persons with a high school diploma, nurses, social workers or other highly skilled health care professionals. Care coordination begins with gathering various streams of data, such as family and individual medical history, behavioral health status, social needs, primary care history, claims and insurance coverage history and current access to preventive health services. Patients with complex illnesses or one or more chronic conditions can benefit the most from care coordination. Lack of coordination of care can lead to more serious or difficult health situations, including preventable hospital readmissions, frequent emergency room visits, poor discharge planning, medication and diagnosis errors, and unnecessary pain and suffering. Most patients struggle to navigate complicated and fragmented health care systems. They require culturally competent and trained professionals and allied health workers to guide them toward the most efficient, easily accessible and cost-effective care points. Many of these points of entry in care are very sensitive and tangentially related to medicine or dentistry. For example, legal services,



immigration services, elementary and high schools, churches, civic and social groups, housing and homeless outreach, and justice system and re-entry programs may serve as critical touch points for dental care. Consulting with local agencies and organizing a consortium of providers to coordinate dental school resources across contexts is important to addressing diverse determinants of health outcomes. Insurers and payors are increasingly interested in outcomes-based dental care delivery systems where integrated care management and self-management intersect for greater value.

The most indispensable contractual arrangements in value-based care are those that address the costs and care needs of high-risk patients. Community-based dentistry can shape value-based programs centered on enhancing member access to high-quality dental services, provider and patient education measurement and population health management. Private practice and academic dentistry alike can enter pay-for-performance contracts with higher reimbursements and per-member-per-month payment agreements.

Strengths of Care Coordination			
Patients and caregivers are aware of care plan and active in achieving objectives.	Patient and caregivers play a role in developing an individualized care plan that reflects the patient's health care needs and priorities.	Communication and coordination between health care professionals to address the patient's needs.	Readily identify psychological, social, financial, and environmental barriers to care affecting the patient's ability to adhere to treatments or maintain his or her health.
Use and exchange of electronic health record (EHR) data across different systems.	Team-based approach to care involving a wide range of services, including medical, behavioral health, social, legal services, and long-term supports.	Emphasis on integrated care management and self-management. Engagement of insurers and payors in outcomes-based contracting and reimbursement.	The wide array of potential skills and training of care coordinators, many of whom reside and socialize in vulnerable communities with the greatest disparities.

Community-based dentistry benefits most from coordinated community outreach. Recruitment and training of care coordinators to tailor comprehensive care plans strengthens accountability for population outcomes. Care coordination efforts in dentistry can help initiate a fundamental shift in approaches to care delivery boosting performance measures and elevating uptake in vital population health policies.

References

1. Kamyar Nasseh, K, Vujicic, M, O'Dell, A. Affordable Care Act Expands Dental Benefits for Children But Does Not Address Critical Access to Dental Care Issues. http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/HPRCBrief_0413_3.ashx. Accessed January 5, 2017.
2. Wall, T, Nasseh, K, Vujicic, M. Majority of Dental-Related Emergency Department Visits Lack Urgency and Can Be Diverted to Dental Offices. http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0814_1.ashx. Accessed January 5, 2017.
3. Anderson A. The impact of the Affordable Care Act on the health care workforce. The Heritage Foundation Backgrounder. March 18, 2014;2887:1-20.
4. Affordable Care Act dental coverage. ObamaCare Facts. http://obamacarefacts.com/dental-insurance/dental-insurance/. Accessed April 9, 2015.
5. Affordable Care Act, dental benefits examined. ADA News. http://www.ada.org/en/publications/ada-news/2013-archive/august/affordable-care-act-dental-benefits-examined. Published August 19, 2013. Accessed January 5, 2017.

CHAPTER 7: RESOURCES

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 the *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.

Revised Statement of ADEA Policy on Diversity and Inclusion

(As approved by the 2016 ADEA House of Delegates)

Excerpted from the *Journal of Dental Education,* July 2016
(http://www.jdentaled.org/content/80/7/874.full.pdf+html)

The need for such a statement:

1. To facilitate communication of the ADEA Principles of Diversity and Inclusion through a common language.
2. To lend support to ADEA's mission, policies and programs that promote diversity and inclusion throughout dental, allied dental and advanced dental education.
3. To meet the current and expanded role of ADEA in promoting diversity and inclusion now and in the future.

Diversity and inclusion are critical components of success in a global context and in an ever-changing world. ADEA, in its leadership role, will constantly strive to be a model of diversity and inclusion. ADEA's ability to promote effective inclusion practices is necessary to fulfill our mission and to the quality of the dental education system. ADEA's Board of Directors, faculty, staff, students and members, therefore, must resemble the diversity that is so proudly reflected in the citizenry of our nation.

ADEA's value of diversity is embedded in respect and appreciation 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 and perspectives of each individual. To be inclusive is to collectively utilize the unique talents and perspectives from the diverse array of individuals that constitute the dental education community and its partners. Thus, ADEA believes that the number of graduates of dental and allied dental programs should reflect their representation in the population and the communities in which they will serve. Recruitment, retention and graduation of practitioners from diverse groups are goals that are important for the public's health. ADEA is committed to developing and sustaining institutional environments within the dental education community that are inclusive and supportive of all diverse groups of students, faculty, employees and patients. Dental education can show leadership in the following ways:

- Continued effort to gain visibility for dentistry/dental education where the mission of diversity and inclusion can be advanced in an interprofessional healthcare environment.
- Sponsorship for faculty training and best practices in the creation of an inclusive supportive environment.
- Faculty and staff recruitment must visibly announce the institution's nondiscrimination policy.

- Benefit plans should include benefits that allow same-sex partners to participate in all benefits available to spouses and dependents.
- Become recognized as visible partners in the community to foster visibility, engagement, and support.
- Enact student support systems to fully support LGBTQ students during their education.
- Create an accessible structure for counseling and mental health support for students for all aspects of their gender and sexuality.
- Support ongoing conversation for students who may request help in deciding whether or not to become visible in the postgraduate applications and other academic milestones.
- Support for transgender students who may have medical needs because of transitioning and who may wish to change "gender" on their records.
- Include curriculum time devoted to diversity education, including time to teach about the needs of the LGBTQ communities, unique cultural characteristics and challenges they face in the community. This may include programs like Safe Zone training to facilitate sensitivity, understanding, acceptance and cultural competency.
- Provide a clinical environment that supports LGBTQ patients by being open, accepting and culturally competent to manage unique needs.
- Engage members of the community to evaluate success in meeting the needs of patients.

Diversity within dental education plays a critical role in the professional development of a culturally competent dental workforce for the future. Additionally, ADEA's ability to advocate for effective inclusion practices throughout dental education positions our members to be of value to the increasingly diverse system of higher education in the United States and to the oral health imperative of the nation.

ADEA strongly endorses the continuous use of practices that achieve excellence through diversity and inclusion.

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. Leadership 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.pdf
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

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

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).

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.

ADEA MDFD/MDFDI Awardees

Dental schools, principal investigators, deans and program directors:

University of Alabama at Birmingham School of Dentistry
Dr. Steven J. Filler
Dr, Huw F. Thomas, Dean (2004–2011)

Texas A&M University College of Dentistry
Dr. Ernestine S. Lacy
Dr. James S. Cole, Dean (2000–2011)

University of Detroit Mercy School of Dentistry
Dr. Deirdre Young
Dr. Divesh Byrappagari
Dr. Mert N. Aksu, Dean

The Dental College of Georgia at Augusta University
Dr. Anna Luz Thompson
Dr. Connie Drisco, Dean (2003–2013)

Howard University College of Dentistry
Dr. Earl M. Kudlick
Dr. Donna Grant-Mills
Dr. Dexter A. Woods, Dean

University of Illinois at Chicago College of Dentistry
Dr. Darryl D. Pendleton
Dr. Bruce S. Graham, Dean (2000–2013)

University of Michigan School of Dentistry
Dr. Marilyn W. Woolfolk (Ret.)
Dr. Todd Ester
Dr. Kenneth May
Dr. Peter J. Polverini, Dean Emeritus (2003–2013)

University of Minnesota School of Dentistry
Dr. Karl D. Self
Dr. Leon Assael, Dean (2012–2016)

University of Oklahoma College of Dentistry
Dr. Kenneth S. Coy
Dr. Dunn Cumby
Dr. Marsha Beatty
Dr. Raymond A. Cohlmia, Dean

New York State Academic Dental Centers (NYSADC):

Stony Brook University School of Dental Medicine
Dr. Christopher W. Cutler
Dr. Ray C. Williams, Dean (2008–2014)

Columbia University College of Dental Medicine
Dr. Dennis A. Mitchell
Dr. Ira B. Lamster, Dean Emeritus (2001–2012)

New York University College of Dentistry
Dr. David A. Sirois
Dr. Charles N. Bertolami, Dean

University of Rochester
Dr. Stanley I. Handelman (Ret.)
Dr. Cyril Meyerowitz, Director, Department of Dentistry

University at Buffalo School of Dental Medicine
Dr. Richard Buchanan
Dr. Joseph J. Zambon
Dr. Richard N. Buchanan, Dean (2001–2008)

Associated Medical Schools of New York
Ms. Jo Wiederhorn

Health profession association:

Association of American Medical Colleges
Dr. Marc Nivet

Constellation of Core Diversity Collaborations and Partnerships

Cultural Competence in Dental Education and Other Health Professions Annotated Bibliography

Initial Annotations by Dariann Malloy, Howard University, Health Career Connection Intern 2016

Acquavíva, K. D. & Mintz M. (2010). Perspective: Are We Teaching Racial Profiling? The Dangers of Subjective Determinations of Race and Ethnicity in Case Presentations. *Academic Medicine*. 85.4, 702-705. Retrieved from http://journals.lww.com/academicmedicine/Fulltext/2010/04000/Perspective__Are_We_Teaching_Racial_Profiling__The.37.aspx

This source examines the necessity of physicians' visual race assessments of their patients, which the authors consider to be racial profiling. The authors point out that ethnicity rather than race determine a patient's vulnerability to certain health outcomes. It is suggested that physicians instead ask patients to self-report their race, geographic ancestry, family and social history, cultural beliefs, dietary habits, access to care, and more. This way patients are not put in a racial box and physicians can get a more accurate picture of the patient. This article may not be well received because it challenges a common practice in health professions, but it raises the concerns of many who feel that the practice is antiquated.

Alexander, C. J., Brody, H.A., Gansky, S. A., Mertz, E. A, & Wides, C. D. (2013). Long-Term Outcomes of a Dental Postbaccalaureate Program: Increasing Dental Student Diversity and Oral Health Care Access. *Journal of Dental Education*. 77.5, 537-547. Retrieved from http://www.jdentaled.org/content/77/5/537.full.pdf+html?sid=9ee62acf-d91b-4b99-8a2e-b1dcd9bd0ccb

A study was done to examine the short-, mid- and long-term effects of the Dental Postbaccalaureate Program at the University of California San Francisco. The purpose of this study was to determine if this postbaccalaureate program has been influential in the admittance and graduation of socioeconomically and educationally disadvantaged students to US dental schools. The results show that students who have finished the program have been able to raise their DAT scores by an average of 1.9 points, get accepted to and graduate from dental school, pass their board exams and practice in underserved communities, while increasing minority enrollment at their dental schools. Many graduates even reported working and mentoring with students interested in dentistry as a career. Although this study focuses on one small postbaccalaureate program, the same results could be applicable to other postbaccalaureate programs. The success of this program also makes the case for more programs like it.

Anderson, E. L., Cook, B. J., Valachovic, R. W., & Wanchek, T. (2016). Annual ADEA Survey of Dental School Seniors: 2015 Graduating Class. *Journal of Dental Education*, 80.5,612-629. Retrieved from http://www.jdentaled.org/content/80/5/612.full.pdf+html?sid=dd30f6a6-5b0e-48af-9f8b-f8580a990298

The Annual ADEA Survey of Dental School Seniors looks at many characteristics of the senior class such as race, gender, reason for choosing dentistry, and more. In this survey the importance of service to vulnerable and low income populations is presented. This data can be used to make a case for the necessity of cultural competence. Although white students make up 54% of the 2015 senior class only 63% of white students marked service to vulnerable and low income populations as important or very important, compared to 88% of black students who only make up 4% of the senior class. It has been proven by many other sources that underrepresented minority students are more likely to serve vulnerable and low income populations, but because underrepresented minorities only make up less than 12% of dental students there needs to be more of a push for non-URM students to serve low income and vulnerable populations.

Arato, N., Latimore, D., Moreland, C. J., Sen, A. & Zazove, P. (2013). Deafness Among Physicians and Trainees: A National Survey. Academic Medicine. 88.2, 224-232. Retrieved from http://journals.lww.com/academicmedicine/Fulltext/2013/02000/Deafness_Among_Physicians_and_Trainees___A.27.aspx

Although the disabled population is recognized as a minority group and are often included in cultural competence and diversity efforts there is very little literature on their representation in health care. A study was conducted to examine the quality of the accommodations for deaf and hard of hearing (DHoH) physicians and students, as well as the characteristics of this subgroup. The study was also used to determine whether DHoH physicians were more likely to serve the DHoH population. The results showed that the most commonly used accommodations were modified or amplified stethoscopes, but many trainees devoted between 2 and 10 hours of time to arranging these accommodations. If dental schools would like to be more inclusive to DHoH students, they should strongly consider making accommodations more readily available. The results also showed that similar to other underserved minority students, DHoH students are more likely to serve DHoH patients.

Arnett, M. R., & Forde, R. (2011). Increasing Student Diversity and Cultural Competence as Part of Loma Linda University School of Dentistry's Service Mission. *Journal of Dental Education*, 76.6, 721-727. Retrieved from www.jdentaled.org/content/76/6/721.full.pdf+html?sid=e6ab82ba-3523-4c29-afb5-6b1d4948b8e8

This article discusses the relationship between underrepresented minority dentists and treating health disparities, specifically in the state of California. Authors Arnett and Forde determined that an increase in student body diversity, cultural competence based curriculum, and community involvement across dental schools will eventually lead to a decline in health disparities. They support this claim with ample evidence from Loma Linda University's School of Dentistry (LLUSD) and its participation in the Pipeline, Profession, and

Practice: Community-Based Dental Education program. One important thing to notice about LLUSD is that the focus is not on numerical data, but more on an overall improvement in diversity and cultural competence. Although the Pipeline program ended on July 31st, 2010, it can still serve as a template for other dental schools that wish to become more culturally competent and diverse institutions.

Association of American Medical Colleges. (2014). Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender Nonconforming, or Born with DSD. Washington, DC: Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development.

This publication from the AAMC covers all the bases of including LGBT, gender nonconforming, and/or those born with DSD into medical education. The Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development provides a comprehensive glossary of relevant terminology as well as an appendix of additional resources that particular medical schools have provided. This publication also suggests the implementation of competencies that are vague enough to be applicable to any minority, but can be interpreted to support the inclusion of LGBT, gender nonconforming and/or those born with DSD. The advisory committee also makes it clear that this source is applicable to interdisciplinary health fields, and it is written in language that can be understood by many audiences outside of academia.

Barnett, K., Eaglen, R. & Hattis, P. (2010). Health Professions Accreditation and Diversity: A Collaborative Approach to Enhance Current Standards. Retrieved from California Health Workforce Alliance: http://calhealthworkforce.org/wp-content/uploads/2010/06/HealthProfessions-Accreditation-and-Diversity_8-30.pdf

This report commissioned by the California Endowment and the W. K. Kellogg Foundation calls for accrediting agencies, professional organizations that represent institutions, and the institutions themselves to come together to identify diversity as crucial to health profession education, and to write policies, practices, standards, etc. that clearly articulate institutions' diversity goals. This report provides recommendations for institutions to address four areas of concern: institutional commitment and leadership, admissions, institutional climate, and social contract.

Beagan, B., Frank, B., Kumaş-Tan, Z., Loppie, C., & MacLeod, A. (2007). Measures of Cultural Competence: Examining Hidden Assumptions. *Academic Medicine Journal of the Association of American Medical Colleges*, 82.6, 548-557. Retrieved from file:///C:/Users/Malloyd/Downloads/Measures_of_Cultural_Competence__Examining_Hidden.5%20(2).pdf

In this source authors who are also health professions educators reviewed 10 of the most popular methods for evaluating cultural competence used by health professions. This study was prompted by a lack of literature on how to measure cultural competence, and inconsistency among measurements that are in place. The results revealed some frequent

assumptions that are made by many of the cultural competence evaluation methods. The article then goes on to provide suggestions to circumvent these assumptions that include expanding the definition of culture and examining the reasons behind racism and ethnocentrism. I think this source will be valuable to dental educators when assessing cultural competence by specifically telling them what not to do. Sometimes cultural competence training methods may cause exactly what it is that they are trying to prevent, which isn't easily detected. Forming a cultural competence evaluation method that follows the guidelines of this article could help to keep training efforts on track.

Bickel, J. & Rosenthal, S. L. (2011). Difficult Issues in Mentoring: Recommendations on Making the "Undiscussable" Discussable. *Academic Medicine*. 86.10, 1229-1234. Retrieved from http://journals.lww.com/academicmedicine/Fulltext/2011/10000/Difficult_Issues_in_Mentoring__Recommendations_on.19.aspx

This source explores the many factors that can cause conflict between mentors and their mentees including differences in gender, race, ethnicity, language, and generations. Often times the participants do not feel comfortable expressing their concerns due to power differences, and the relationship suffers. In this article the authors offer common examples of mentor-mentee conflicts and as well as solutions to these conflicts. This article provides alternatives to simply matching students with race, ethnicity, language and gender concordant mentors. These strategies could be crucial to the retention of URM students.

Commission on Dental Accreditation. (2016). Accreditation Standards for Dental Education Programs. Retrieved from www.ada.org/~/media/

The CODA standards are the accreditation standards that all dental schools in America, as well as a few in Canada, must meet in order to maintain status as an accredited dental school. Within the past decade CODA revised the standards to include diversity and cultural competence. Although CODA does not tell institutions exactly how to implement programs dealing with cultural competence, it does provide clear definitions to terms like diversity, cultural competence, and the three dimensions of diversity. This could be particularly helpful for institutions that need guidance when creating their own tailored definitions. CODA also requires that dental schools adopt policies that support the diversity of the institution. Through the enforcement of diversity policies CODA is closing a loophole that allowed schools to ignore the need for diversity in dental education.

Davis, J. & Eckstrand, K. (2014, March). A Leader's Role in Addressing LGBT Health [Webinar]. *In Diversity 3.0 Learning Series*. Retrieved from https://www.aamc.org/initiatives/diversity/learningseries/370012/aleadersroleinaddressinglgbthealth.html

This source does an incredible job of explaining LGBT terminology and health disparities. This source also expands on what it calls "big wins" which address the current status of LGBT in academic medicine and ways that institutions can improve (big wins) to be inclusive to LGBT students, faculty, staff, and patients. I think this source is invaluable because it

addresses ways to increase LGBT inclusion on all dimensions of diversity: structural, curriculum, and institutional climate. Institutions who want to increase diversity and cultural competence should also want to increase their inclusion of the LGBT community because LGBT members often experience health disparities and lack access to care because of discrimination, similar to underrepresented minorities. In addition, many members of the LGBT community also identify as members of underrepresented minority groups, and it would be inefficient for institutions to not take an intersectional approach.

Donate-Bartfield, E., Lobb, W. K., & Roucka, T. M. (2013). Teaching Culturally Sensitive Care to Dental Students: A Multidisciplinary Approach. *Journal of Dental Education*, 78.3, 454-464. Retrieved from http://www.jdentaled.org/content/78/3/454.full.pdf+html

This source suggests a multidisciplinary approach to cultural competence training as an alternative to training that focuses on the social norms of specific races and ethnic groups. The authors of this source recommend a combination of curriculum from behavioral science, public health, and ethics classes to shape cultural competence curriculum. The combination of these subjects gives students context of the cultural differences that may arise, helping them to understand why they exist, why students are obligated to provide culturally sensitive care, and how providing culturally sensitive care is essential to the community. The multidisciplinary approach teaches generic skills including "…communication skills, identifying areas where cultural differences might be an issue, developing awareness of one's own cultural values and biases, and understanding the need for adopting a nonjudgmental stance with patients."

Espinoza, L. L, Gaertner, M. N. & Orfield, G. (2015). Race, Class, & College Access: Achieving Diversity in a Shifting Legal Landscape. American Council on Education. Retrieved from https://www.acenet.edu/news-room/Documents/Race-Class-and-College-Access-Achieving-Diversity-in-a-Shifting-Legal-Landscape.pdf

This report is gives a detailed description of the legal cases that have affected higher education admissions policies. Many schools are apprehensive to include diversity efforts in their admissions process because of, legality and this source explains the implications of cases as recent as the first *Fisher V. University of Texas at Austin* ruling. This report also provides alternative diversity strategies that could be beneficial methods of URM recruitment.

Evans, L. & Hanes, P. J. (2013). Online Cultural Competency Education for Millennial Dental Students. *Journal of Dental Education*, 78.6, 867-875. Retrieved from http://www.jdentaled.org/content/78/6/867.full.pdf+html?sid=5ff7b19b-23be-4ee9-9e08-726c62880597

This source expands on using technology as opposed to lectures to deliver cultural competence training to millennial students (students born after 1982). Millennials are the only generation that have grown up with cell phones, computers, and other forms of technology, which has influenced their learning styles. Because of this the program Healthy

Perspectives was created. Healthy Perspectives combines multimedia links, group discussion boards, virtual patient simulations working with a translator, and personal e-logs to approach cultural competence from an intersectional framework. Healthy Perspectives' goal is to increase students' cultural self-awareness, cultural competence, and cross-cultural communication skills. It encourages students to avoid the "do's and don'ts" method which focuses on the idiosyncrasies of other cultures.

Gonthier, M., More, F. G. & Whitehead, A. W. (2004). Strategies for Student Services for Lesbian, Gay, Bisexual, and Transgender Students in Dental Schools. *Journal of Dental Education*, 68.6. 623-632. Retrieved from http://www.jdentaled.org/content/68/6/623.full.pdf+html?sid=81280646-4c94-481a-a185-070680ee83a1

A survey was sent to the student affairs officers of U.S. dental schools to assess institutional climate for LGBT students and faculty. Forty-five of the fifty-two U.S. dental schools responded. The results showed that 11 dental schools have nondiscrimination policies that do not include sexual orientation, twenty-one dental schools were aware of students treating LGBT individuals in the clinic, and twenty-two dental schools spend between zero and two hours devoted to the health disparities or distinctive qualities of LGBT people. Surprisingly, many of the student affairs officers were unable to answer questions on the survey. This source includes a copy of the actual survey which could be helpful for faculty members other than the student affairs officer to assess the institutional climate. This study could also be distributed to students to include their perspective. This source also provides a list of suggestions for institutions to enhance their institutional climate.

Henshaw, M. & Mascarenhas, A. K. (2010). Infrastructure for a Community-Based Dental Education Program: Students and Clinics. *Journal of Dental Education*, 74.10, 517-524. Retrieved from http://www.jdentaled.org/content/74/10_suppl/S17.full.pdf+html?sid=423bd002-a59d-47a6-9d0b-408ca62484a8

This source explains the vital link between community-based dental education programs (CBDEPs) and the cultural competence knowledge of the student. CBDEPs allow students to practice the cultural competence skills that they have gained before they enter the workforce. This source also plainly outlines points for an institution to remember when creating a community-based dental education program. Authors Henshaw and Mascarenhas do so using data from surveys like the 2003 ADEA senior survey. Henshaw and Mascarenhas expand on the importance of matching students with suitable sites, creating a contractual agreement between the site and the institution, considering location of the site as well as transportation for the student, properly communicating the responsibilities of site preceptors as mentors, and lengthening shorter programs to increase student productivity. Lastly, Henshaw and Mascarenhas provide specific examples of schools that have implemented similar programs like Boston University, the University of Iowa and more.

Holyfield, L.J. & Miller, B. H. (2013). A Tool for Assessing Cultural Competence Training in Dental Education. *Journal of Dental Education*, 77.8, 990-997. Retrieved fromhttp://www.jdentaled.org/content/77/8/990.full.pdf+html?sid=17efd9cc-5a3b-4c19-90bf-e02b1fb60452

In this article authors Holyfield and Miller examine the Dental Tool for Assessing Cultural Competence Training (D-TACCT), based on the Association of American Medical Colleges' Tool for Assessing Cultural Competence (TACCT). The D-TACCT was sent to 71 dental schools as a survey to define best practices for cultural competence training. The survey revealed that although the majority of the participating dental schools prioritized the best practices for cultural competence training outlined in the survey, a much smaller number of participating dental schools were ready to implement programs addressing these issues. Miller and Holyfield go on to suggest key discussion points when using the D-TACCT to tailor cultural competence training. This article is particularly helpful because, unlike CODA, it provides specific suggestions and material to help develop an institution's cultural competence training.

The University of Texas at Austin, Office for Inclusion and Equity. Division of Diversity and Community Engagement (2015). Inclusive Retention Toolkit for Faculty, Graduate Students, and Postdoctoral Fellows. Retrieved fromhttp://ddce.utexas.edu/strategicinitiatives/wp-content/uploads/2015/11/OIE-Retention-Toolkit-NOV-2015-FINAL.pdf

UT Austin's Inclusive Retention Toolkit focuses on strategies to increase retention of URM faculty, graduate students, and postdoctoral fellows. The toolkit sites four areas that schools should improve in order to increase retention: climate and culture, leadership development, opportunities for professional development, and mentoring. Each section lists detailed suggestions. The suggestions are then supported with examples of successful implementation. This source stands out to me because of its brevity and plain language. It is easily understood and heavily supported with evidence of achievement, which makes the goal of retention more attainable.

The Sullivan Commission (2004). Missing Persons: Minorities in the Health Professions. A Report of the Sullivan Commission on Diversity in the Healthcare Workforce. Retrieved from http://www.aacn.nche.edu/media-relations/SullivanReport.pdf

The first chapter of the Sullivan Commission's report is entitled Rationale for Increasing Diversity in Today's Health Workforce, and in that chapter the Sullivan Commission uses data to make the case for cultural competence and diversity in healthcare. The commission cites the census projections for the year 2050 to compare the percentage of minorities in the U.S. population to the percentage of minorities in healthcare. The commission also references ways that diversity directly influences cultural competence. The commission also speaks on the relationship between diversity and language competence. This source focuses on the need for cultural competence from a statistical perspective. Cultural competence is often misunderstood because the supporting evidence is mostly literature.

People tend to trust numerical evidence more than literary evidence because numerical evidence leaves little room for interpretation or bias from the author.

U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health. (2000). Oral Health in America: A Report of the Surgeon General. Retrieved from http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf

The surgeon general's report on oral health in America could be particularly useful to improve cultural competence training in dental education because it explains health disparities specific to dentistry and who they affect. Dental institutions are addressing health disparities by increasing their diversity efforts and by improving or implementing their cultural competence training, but it seems that there is little literature dedicated to health disparities in dentistry. The distinctions made in this report could help educators give some context to students who only have a vague understanding of what health disparities are, and why it is important that they are addressed through cultural competence training.

U.S. Department of Health and Human Services, Office of Minority Health (2001). National Standards for Culturally and Linguistically Appropriate Services in Health Care. Retrieved from http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

The National Standards for Culturally and Linguistically Appropriate Services in Health Care, also known as the CLAS standards, were created to try and establish universal guidelines for health providers who serve a culturally and linguistically diverse population. Although the CLAS standards are mostly geared toward current providers, they provide an outline of what is expected from students as they enter the workforce. These standards can be a useful source to guide faculty in the creation of culturally competent curriculum. It is much more productive to introduce cultural competence to students who are not fully aware of dentistry outside of the classroom than it is to train established dental professionals. The standards have often received criticism that they are too vague or too narrow because of the wording, however, many professionals think that the wording allows for flexibility of the provider.

2016–2017 Diversity Officers

Case Western Reserve University
School of Dental Medicine
Kristin Williams
Director, Diversity, Equity and Inclusion

Columbia University
College of Dental Medicine
Dennis Mitchell
Vice Provost, Diversity and Inclusion

Creighton University School of Dentistry
Allison Taylor
Executive Director of Equity and Inclusion

Herman Ostrow School of Dentistry of USC
Sandra Clark Bolivar
Assistant Dean of Admissions, Minority and Student Life

Howard University College of Dentistry
Dexter Woods
Dean

Indiana University School of Dentistry
Pamella Shaw
Associate Dean
Diversity, Equity and Inclusion

Loma Linda University School of Dentistry
David Conkerite, II
Program Manager
Talent Management and Diversity

Louisiana State University Health New Orleans School of Dentistry
Stephanie DiMattia
Director, Diversity and Minority Affairs

Medical University of South Carolina
James B. Edwards College of Dental Medicine
Gwendolyn Brown
Director, Minority Affairs

New York University College of Dentistry
Staci Ripkey
Assistant Dean, Minority Affairs

Oregon Health & Science University
School of Dentistry
Mark Mitchell
Associate Dean, Minority Affairs

Stony Brook University
School of Dental Medicine
Fred Ferguson
Faculty Advisor, Minority Affairs

The Ohio State University
College of Dentistry
Canise Bean
Director, Diversity Programs

The University of Iowa
College of Dentistry & Dental Clinics
Catherine Solow
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Tufts University School of Dental Medicine
Robert Kasberg
Associate Dean, Minority Affairs

University of Alabama at Birmingham
School of Dentistry
Madelyn Coar
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University of California, Los Angeles
School of Dentistry
Edmond Hewlett
Associate Dean for Outreach and Diversity

University of California, San Francisco
School of Dentistry
George Taylor
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University of Colorado
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Ken Durgans
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Marja Hurley
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Health Career Opportunity Programs

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School of Dentistry
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Director of Diversity, Intercultrual and Sponsored Programs

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Patricia Xirau-Probert
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University of Illinois at Chicago
College of Dentistry
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University of Louisville School of Dentistry
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University of Missouri - Kansas City
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John Cottrell
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University of Nevada, Las Vegas
School of Dental Medicine
Christopher Kypuros
Director of Financial Aid, Diversity and Inclusion

University of Oklahoma College of Dentistry
Kevin Haney
Assistant Dean, Student Affairs

University of Pennsylvania
School of Dental Medicine
Beverly Crawford
Director of Diversity and Community Outreach

University of Tennessee Health Science Center
College of Dentistry
Michael Alston
Assistant Vice Chancellor for Equity, Diversity and Student Rights

West Virginia University
School of Dentistry
Shelia Price
Associate Dean
Women and Minority Affairs

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

Academic Leadership for Diversity: Suggested Reading List

ASAE and the Center for Association Leadership, Seven measures of success. Foreword by Jim Collins, author of *Good to Great* and *Built to Last*. 2006.

Bowen WG and Bok D. The shape of the river: long-term consequences of considering race in college and university admissions. Princeton University Press, 1999.

Bulger RJ, Osterweis M, Rubin E. Management: a new synthesis. Association of Academic Health Centers, 1999.

Collins FS. The language of life. DNA and the revolution in personalized medicine. Harper Collins Publishers. New York, N.Y. 2010.

Fluker WE. Ethical Leadership. The quest for character, civility and community. Fortress Press Minneapolis. 2009.

Friedman TL. The world is flat: a brief history of the twenty-first century. Farrar, Straus and Giroux, 2005.

Gawande A. Better. A surgeon's notes on performance. Picador. Metropolitan Books. Henry Holt and Company. New York. 2007.

Kaplan RS and Norton DP. The balanced scorecard: translating strategy into action. Harvard Business School Press, 1996.

Keohane NO. Higher ground: ethnics and leadership in the modern university. Duke University Press, 2006.

Kouzes JM, Posner BZ. The leadership challenge, fourth edition. John Wiley & Sons, 2007.

Li C, Bernoff J. Groundswell: winning in a world transformed by social technologies. Harvard Business School Press, 2008.

Page SE. The difference: how the power of diversity creates better groups, firms, schools, and societies. Princeton University Press, 2007.

Thomas RR Jr. Beyond race and gender: unleashing the power of your total workforce by managing diversity. American Management Association, 1991.

Wolverton M and Gmelch W. College deans leading from within. The Oryx Press and the American Council on Education 2002.

Diversity Resources

Bird W, Clayton LA. An American health dilemma: race, medicine and health care in the United States. Rutledge Press, 2000.

Policy paper: a 21st century imperative: promoting access and diversity in higher education. The College Board, American Council on Education, and Education Counsel, LLC, October 2009.

Grumbach K, Mendoza R. Disparities in human resources: addressing the lack of diversity in the health professions. Health Affairs 27(2):413-422, 2008.

Unequal treatment. Institute of Medicine. National Academy Press, 2002.

In the nation's compelling interest: ensuring diversity in the healthcare workforce. Institute of Medicine, National Academy Press, 2004.

Landfeld T. Mentoring and diversity: mentoring in academic and industry 4. Springer Science and Business Media, LLC, 2009.

Policy brief: creating an agenda to provide for equal opportunity in the states. Leadership Conference on Civil Rights, 2007.

Malcolm SM, Chubin DE, Jesse JK. Standing our ground: a guidebook for STEM educators in the post Michigan era. American Association for the Advancement of Science. 2004.

Nivet MA, Taylor VS, Butts GC et al. Diversity in academic medicine: no. 1 case for minority faculty development today. Mt. Sinai Journal of Medicine 75:491-498, 2008.

Perez T, Hallis P, Barnett K. Health professions accreditation and diversity: a review of current standards and processes. Study commissioned by the W.K. Kellogg Foundation, May 2007.

Satcher D, Paimes RJ. Multicultural medicine and health disparities. McGraw-Hill Companies, Inc., 2006.

Sinkford JC, Valachovic RW, Harrison S. Continued Vigilance – Enhancing Diversity in Dental Education. Journal of Dental Education 70 (2):199-203, 2006.

Missing persons: minorities in the health professions. Sullivan Commission on Diversity in the Health Workforce, September 2004.

Sullivan LW, Suez Mittman I. The State of Diversity in the Health Professions a Century After Flexner. Academic Medicine 85(2):246-53, February 2010.

Oral health in America: a report of the Surgeon General. U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

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

Web portal for information on disparities in oral health. Division of Oral Health, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Accessed at: www.cdc.gov/oralhealth/oral_health_disparities.htm

Advancing Oral Health in America. Committee on an Oral Health Initiative, Board on Health Care Services. Institute of Medicine of the National Academies. The National Academy Press. Washington, D.C. 2011.

Framing the Dialogue of Race and Ethnicity to Advance Health Equity: Proceedings of a Workshop. The National Academies of Sciences, Engineering and Medicine. National Academies Press, Nov 10, 2016

Guide to Best Practices in Faculty Mentoring. Office of the Provost, Columbia University, New York, NY. August 2016. This is a living document. Address comments and suggestions to Dennis A. Mitchell at dmitchell@columbia.edu

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

Schools	Location
ADEA/WKKF Minority Faculty Development Phase II (2 Schools)	
University of Detroit Mercy School of Dentistry	Michigan
Howard University College of Dentistry	Washington, DC
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 MDFD Trainee List, 2005–10

Baylor College of Dentistry—total 6

Rank	Discipline	Eligibility	Gender
Junior Faculty	Pediatric Dentistry and Health Professions Education	B	Female
Graduate Student and Junior Faculty	Health Professions Education	B	Male
Junior Faculty	Orthodontics and Health Professions Education	B	Male
Junior Faculty	Orthodontics and Health Professions Education	B	Male
Graduate Student	Pediatric Dentistry and Health Professions Education	B	Female
Graduate Student	Pediatric Dentistry and Health Professions Education	B	Female

New York State Academic Dental Centers—total 6

Rank	Discipline	Eligibility	Gender
Assistant Professor/ Postgraduate	Clinical Dentistry	B/AA	Female
Research Assistant Professor	Periodontics and Implantology	H	Male
Clinical Assistant Professor	Master's of Public Health	B/AA	Female
Resident	TMD and Oral and Maxillofacial Pathology	H	Female
Resident	Advanced Oral and Maxillofacial Pathology	B/AA	Male
Postgraduate	Oral Science/Periodontics	H	Female

University of Alabama at Birmingham—total 17

Rank	Discipline	Eligibility	Gender
Junior Faculty	Prosthodontics/Maxillofacial Prosthetics	H	Female
Graduate Student	Periodontics	H	Female
Junior Faculty	Orthodontics	H	Male
Junior Faculty	Biomaterials	B/AA	Male
Graduate Student	Pediatrics	B/AA	Female
Graduate Student	Oral and Maxillofacial Surgery	B/AA	Female
Graduate Student	Public Health	B/AA	Male
Graduate Student	Prosthodontics	H	Male
Senior Dental Student	General Dentistry	H	Female
Junior Faculty	Prosthodontics	H	Male
Graduate Student	Periodontics	H	Male
Graduate Student	Prosthodontics	H	Female
Graduate Student	Prosthodontics	H	Female
Graduate Student	Prosthodontics	H	Male
Junior Faculty	Master's of Public Health	B/AA	Female
Graduate Student	Pediatrics	H	Female
Graduate School	Implant Fellowship Program	H	Female

University of Oklahoma—total 11

Rank	Discipline	Eligibility	Gender
Senior Dental Student	Dentistry—teaching intern	NA	Female
Senior Dental Student	Dentistry—teaching intern	NA	Male
Senior Dental Student	Dentistry—teaching intern	NA	Male
Senior Dental Student	Dentistry—teaching intern	NA	Male
Postgraduate	AEGD	NA	Male
Senior Dental Student	Dentistry—teaching intern	NA	Female
Junior Faculty—Assistant Professor	Education Psychology Ph.D.	B/AA	Female
Senior Dental Student	Dentistry—teaching intern	NA	Male
Junior Faculty—Assistant Professor	Dentistry—Fixed Prosthodontics	NA	Female
Postgraduate	AEGD	NA	Male
Senior Dental Student	Dentistry—teaching intern	NA	

University of Michigan—total 32

Rank	Discipline	Eligibility	Gender
Junior Faculty	Periodontics and Oral Medicine	B/AA	Female
Senior Dental Student	Periodontics	B/AA	Male
Graduate	Community-Based Practice	B/AA/LI	Female
Graduate Student	Pediatric Dentistry	B/AA	Female
Graduate	General Practitioner	B/AA	Male
Graduate Student	Ph.D. program	H	Female
Graduate	Pending licensing	B/AA	Male
Graduate	General Practice (not involved D3 and D4 years)	B/AA	Male
Predoctoral Student	Public Health interest	LI	Female
Graduate	Pediatric Dentist (not currently teaching)	B/AA	Female
Predoctoral Student	Considering Periodontics	B/AA	Female
Junior Faculty	Periodontics	B/AA	Male
Graduate	D.C. area	B/AA	Female
Graduate Student	Periodontics residency	B/AA	Male
Predoctoral Student	Public Health/Radiology interest	B/AA	Female
Postdoctoral Fellow/ Junior Faculty	OSM/M.D. program	H	Male
Predoctoral Student	Public Health Dentistry	B/AA	Female
Predoctoral Student	Public Health/Oral Surgery interest	H	Male
Predoctoral Student	Undeclared Interest	LI	Female
Junior Faculty	Adjunct Clinical Lecturer/Pediatric Dentistry	B/AA	Male
Graduate	Specialty Periodontal Practice	B/AA	Male
Graduate	Completed AEGD	B/AA	Female
Graduate	Low-income inner-city clinic	B/AA	Female
Graduate Student	Completing Oral Surgery program	H	Male
Graduate Student	Oral Surgery resident	B/AA	Male
Predoctoral Student	Pediatric Dentistry/Orthodontics interest	B/AA	Female
Graduate	GPR	B/AA	Male
Graduate	Community Health Clinic Director/General Practitioner	B/AA	Male
Graduate	Part-time practice/theology training	B/AA	Male
Predoctoral Student	Considering community-based clinic	B/AA/LI	Female
Graduate	Specialty Endodontics practice (not currently teaching)	H	Male
Junior Faculty	Adjunct Clinical Lecturer/Prosthodontics	B/AA	Male

Howard University—total 16

Rank	Discipline	Eligibility	Gender
Postgraduate/Faculty	Pediatric Dentistry	B/AA	Male
Postgraduate/Faculty	Orthodontics	B/AA	Male
Postgraduate	Orthodontics	B	Male
Postgraduate	Endodontics	B/AA	Female
Postdoctoral Fellow	Orthodontics	B/AA	Male
Senior Dental Student	GPR	B/AA	Male
Postgraduate	Pediatric Dentistry	B/AA	Male
Senior Dental Student	Pediatric Dentistry	B/AA	Female
Senior Dental Student	AEGD	B/AA	Male
Postgraduate/Faculty	Periodontics	B/AA	Female
Postgraduate	Ph.D./Clinical Research		Female
Postgraduate	Orthodontics	B/AA	Female
Postgraduate/Faculty	Orthodontics	B	Female
Senior Dental Student	GPR	B/AA	Male
Senior Dental Student	Pediatric Dentistry	B/AA	Female
Postgraduate	Prosthodontics	B/AA	Male

University of Illinois at Chicago—total 36

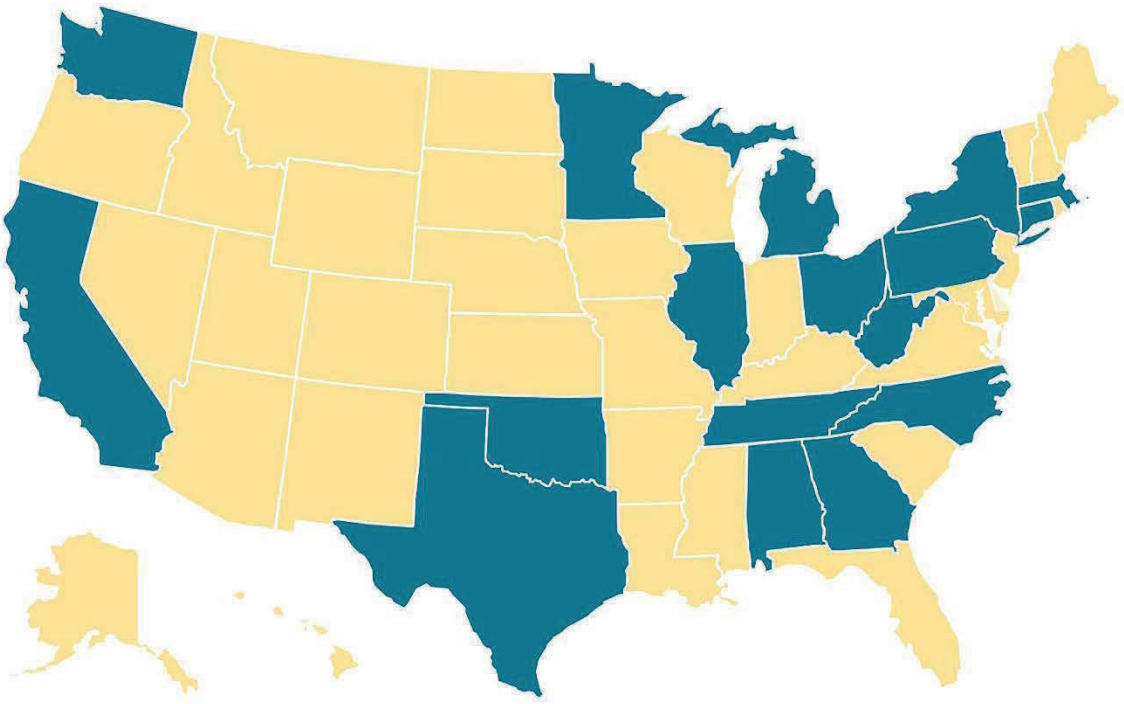
Rank	Discipline	Eligibility	Gender
Fourth-Year Student	Dental Student	B/AA	Female
Second-Year Student	Dental Student	B/AA	Male
First-Year Student	Dental Student	B/AA	Male
Third-Year Student	Dental Student	B/AA	Female
Associate Professor/ Director	Dental Public Health	B/AA	Male
First-Year Student	Dental Student	NA	Male
Fourth-Year Student	Dental Student	B/AA	Female
Graduate Student	Endodontics	B/AA	Male
Clinical Instructor (20%)	Endodontics	B/AA	Male
Second-Year Student	Dental Student	B/AA	Female
Fourth-Year Student	Dental Student	H	Female
Graduate Student	Pediatric Dentistry	B/AA	Female
Clinical Assistant/ Professor (60%)	Restorative Dentistry	B/AA	Male
Associate Dean/ Professor	Dental Public Health	B/AA	Male
Clinical Assistant Professor	Pediatric Dentistry	H	Female
Clinical Instructor (60%)	Restorative Dentistry	B/AA	Female
Second-Year Student	Dental Student	H	Female
Graduate Student	Pediatric Dentistry	H	Male
Clinical Assistant Professor	Restorative Dentistry	B/AA	Male
Graduate Student	Pediatric Dentistry	B/AA	Female
Graduate Student	Pediatric Dentistry	B/AA	Male
Postgraduate	Pediatric Dentistry	H	Female
Clinical Instructor (20%)	Pediatric Dentistry	H	Female

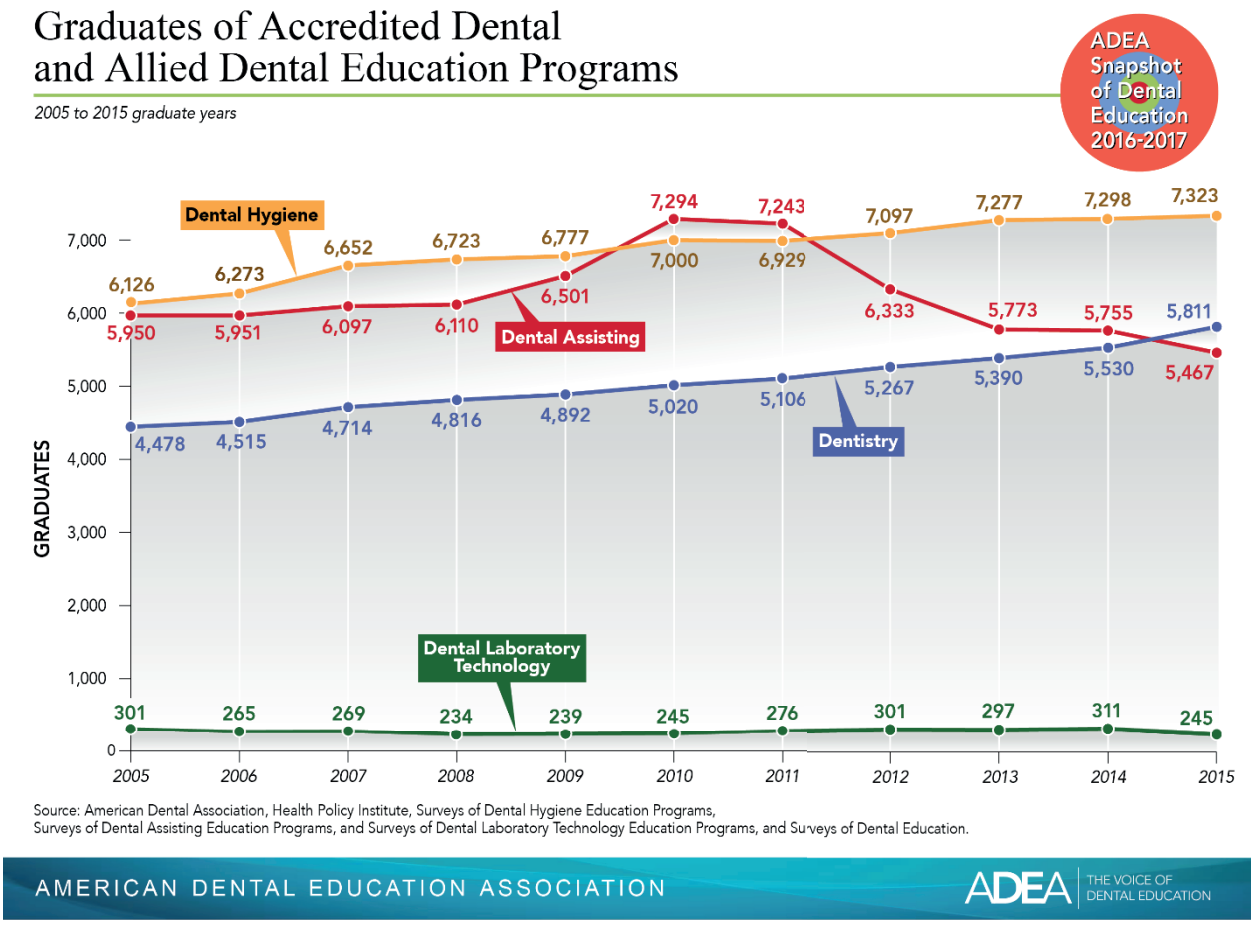
First-Year Student	Dental Student	H	Female
Third-Year Student	Dental Student	H	Female
Graduate Student	Oral Surgery	B/AA	Male
Second-Year Student	Dental Student	H	Male
Clinical Assistant Professor (20%)	Pediatric Dentistry	H	Male
Third-Year Student	Dental Student	B/AA	Male
Associate Dean/ Assistant Professor	Pediatric Dentistry	B/AA	Male
Clinical Assistant Professor	Endodontics	H	Female
Clinical Assistant Professor	Restorative Dentistry	H	Female
Clinical Assistant Professor	Restorative Dentistry	H	Female
Clinical Assistant Professor (20%)	Pediatric Dentistry	B/AA	Female
Graduate Student	Pediatric Dentistry	B/AA	Female
Clinical Assistant Professor (60%)	Restorative Dentistry	B/AA	Female
Assistant Professor/ Associate Program Director	Pediatric Dentistry	B/AA	Male
University of Indiana College of Dentistry	Pediatric Dentistry	B/AA	Female
Postgraduate	Master's of Dental Informatics	B/AA	Female
Clinical Instructor (60%)	Oral Medicine	B/AA	Female

100% unless otherwise noted

Discipline Indicates specialty training/field of study
Eligibility Black/African American (B/AA); Hispanic (H); Native American (NA); Low-Income (LI)

ADEA/WKKF Programs:
States Impacted by Community Outreach




Graduates of Accredited Dental and Allied Dental Education Programs
2005 to 2015 graduate years
ADEA Snapshot of Dental Education 2016-2017
Dental Hygiene
Dental Assisting
Dentistry
Dental Laboratory Technology
GRADUATES
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
6,126
6,273
6,652
6,723
6,777
7,000
6,929
7,097
7,277
7,298
7,323
5,950
5,951
6,097
6,110
6,501
7,294
7,243
6,333
5,773
5,755
5,811
4,478
4,515
4,714
4,816
4,892
5,020
5,106
5,267
5,390
5,530
5,467
301
265
269
234
239
245
276
301
297
311
245
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
Source: American Dental Association, Health Policy Institute, Surveys of Dental Hygiene Education Programs,
Surveys of Dental Assisting Education Programs, and Surveys of Dental Laboratory Technology Education Programs, and Surveys of Dental Education.
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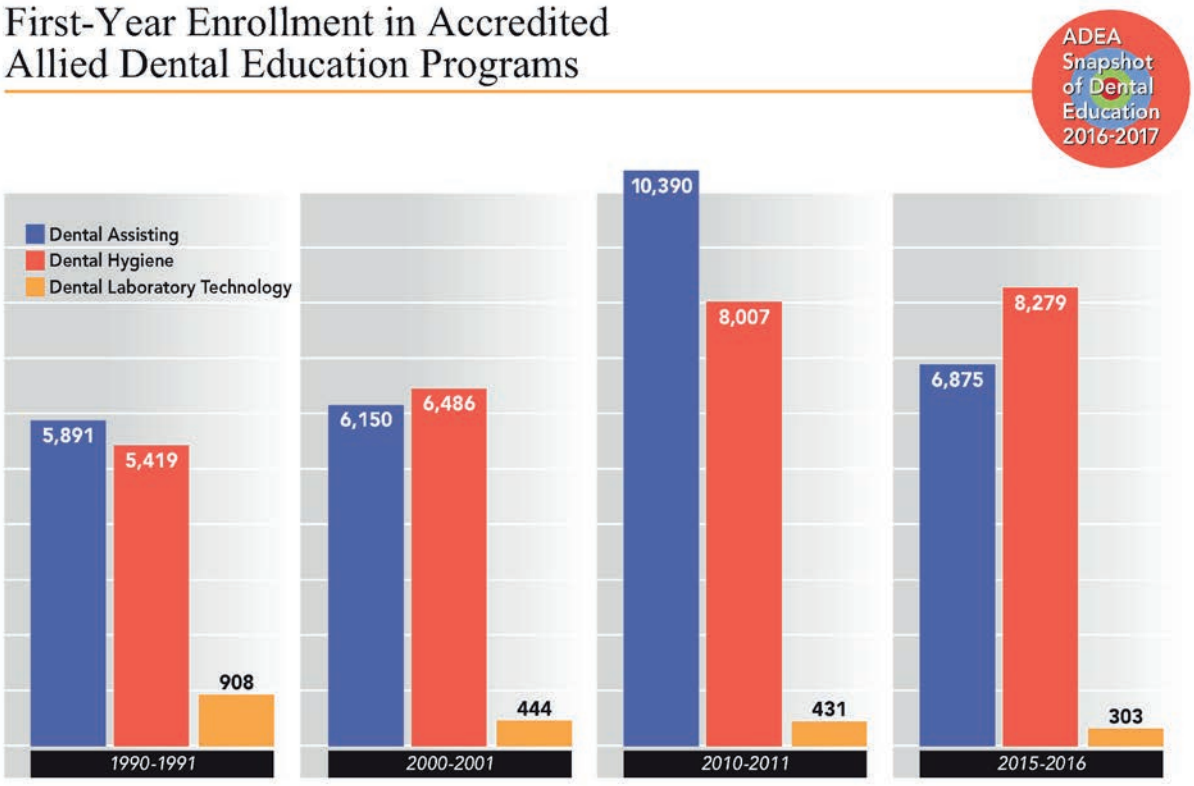

Source: American Dental Association, Health Policy Institute, Surveys of Dental Hygiene Education Programs, Surveys of Dental Assisting Education Programs, and Surveys of Dental Laboratory Technology Education Programs.

Additional Affordable Care Act Provisions

Prevention

The Affordable Care Act (ACA) helps make prevention affordable and accessible for all Americans by requiring health plans to cover preventive services and by eliminating cost sharing. If an individual or family enrolls in a new health plan, that plan will be required to cover recommended preventive services without charging a deductible, copayment, or co-insurance. The ACA provides 15 prevention services for adults, from blood pressure to colorectal cancer screenings for adults over 50. There are 22 covered preventative services for women including pregnant women. They include contraception services to gestational diabetes screening. For children, there are 26 covered services including alcohol and drug abuse and fluoride chemoprevention.

Women's Health Issues

- Women can no longer be denied coverage or charged more just because of their gender.
- **6.8 million** women and girls selected coverage in 2016.
- Between 2010 and 2015, the uninsured rate among women ages 18 to 64 decreased from 19.3 percent to 10.8 percent, a relative reduction of 44 percent. Access the PDF at this site https://aspe.hhs.gov/sites/default/files/pdf/205066/ACAWomenHealthIssueBrief.pdf
- An estimated 55.6 million women with private health insurance have access to recommended preventive services like mammograms or flu shots with no co-pay or deductible. Access the PDF at this site https://aspe.hhs.gov/pdf-report/affordable-care-act-improving-access-preventive-services-millions-americans
- As many as 65 million women with pre-existing conditions can no longer be discriminated against or charged higher premiums for their health coverage. Access the PDF at this site https://aspe.hhs.gov/basic-report/risk-pre-existing-conditions-could-affect-1-2-americans
- An estimated 8.7 million American women with individual insurance coverage gained coverage for maternity services because of the health care law. Access the PDF at this location https://aspe.hhs.gov/basic-report/essential-health-benefits-individual-market-coverage

Minority Health Issues

- Since the passage of the Affordable Care Act, America has experienced the largest reduction in the uninsured in four decades, a large majority of them being minorities—with about **16.4 million** uninsured people gaining health coverage. Access this information from this site https://aspe.hhs.gov/pdf-report/health-insurance-coverage-and-affordable-care-act
- Health care reforms associated with the ACA reduced the percentage of uninsured African Americans from 24.1 **percent to** 16.1 percent through 2014. Access this information from

this site http://www.nytimes.com/interactive/2014/10/29/upshot/obamacare-who-was-helped-most.html?abt=0002&abg=0&_r=1

- Almost 6.8 million African Americans have become eligible for health coverage since the implementation of the ACA due to Medicaid expansion and the financial assistance.
- Of the approximately 9.9 million people who purchased coverage through the Marketplace as of June 30, 2015, nearly 8.3 million (84 percent) received a tax credit to help them pay their monthly premium. In 2015, nearly 90 percent of Marketplace shoppers using HealthCare.gov could purchase coverage for $100 a month or less after tax credits**.** Access this information respectively from these three sites: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html, https://www.hhs.gov/about/news/2015/06/02/march-effectuated-enrollment-consistent-with-departments-2015-goal.html and https://aspe.hhs.gov/pdf-report/health-insurance-marketplace-2015-open-enrollment-period-march-enrollment-report.
- After years of dropped coverage and barriers to care, everyone's coverage has improved because people, including those who get health insurance through their employers, have new protections. No one can be dropped just because they get sick, and millions of people now have coverage for trips to the emergency room, filling out their prescriptions and getting the preventive services they need.

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

ADEA AMERICAN DENTAL EDUCATION ASSOCIATION The Voice of Dental Education

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/

Recommendations From *Growing Our Own*: *The ADEA Minority Dental Faculty Development Program—A Manual for Institutional Leadership in Diversity*

Recommendations

1. Continue to build evidence for the value of diversity in a broad context that add quality to educational objectives and outcomes for all students.
2. Continue to establish diversity initiatives with clear structural, curriculum, and institutional climate components that add quality to educational objectives and outcomes for all students.
3. Create academic partnerships that provide seamless transition in career development for potential dental URM faculty including: recruitment, advancement, and retention.
4. Elevate the recognition of and rewards related to effective faculty mentoring.
5. Establish mentoring programs that help facilitate positive collegial relationships with transparent outcomes focused on academic achievement and advancement.
6. Continue to recruit, develop, and advance part-time clinical faculty as valued members of the academic community of scholars and culture.
7. Enhance the value of community partnerships with academic programs through: experiential learning, patient care, student recruitment, and improved oral health literacy in partnering communities.
8. Reduce stereotype threats that influence trainee performance, self-value, evaluation, and professional development.
9. Engage dental schools in the broader university-sponsored efforts and events that foster the success of campus diversity.
10. Increase service interactions and communications between academic and community leadership that build trust and create a sense of “shared power” in partnerships and a sense of empowerment within communities.
11. Review advanced dental educational programs, including dental diagnosis and therapy, for policies and practices that contribute to diversity in the workforce and community.
12. Advocate for sustaining funding from federal, state, and private sources for advanced dental education to support infrastructure, innovation, research, and educational costs of trainees.
13. Support curriculum innovations that promote the value of diversity throughout academic programming and assure cultural competency of all graduates in the future.

The above content is reprinted from *Growing Our Own: The ADEA Minority Dental Faculty Development Program—A Manual for Institutional Leadership in Diversity*. Washington, DC: American Dental Education Association, 2011, p. 80.

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