STRATEGIC ASSESSMENT
OF THE
SCHOOL OF DENTISTRY

FEBRUARY, 2007
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Introduction

The University of Michigan School of Dentistry (UMSD) initiated a strategic assessment in early 2005 in response to the Provost’s charge that each school or unit conduct periodic evaluations of its intellectual directions and priorities, its strengths and weaknesses, and its comparative advantages over other institutions. The Provost’s charge also called for us to consider ways in which the UMSD brings value to the University and what resources the University might provide to the UMSD that would foster mutual synergy and collaboration. This assessment process will culminate in the development of a strategic implementation plan that focuses on the goals and actions necessary to ensure continued excellence of the UMSD and the rationale for choosing those directions.

This report details the Provost’s charge to UMSD, the pressures and issues driving the strategic assessment process, and the activities and findings of the assessment to date. It also describes action steps that have already been initiated and considerations for developing an implementation plan. The reader will not find the detailed implementation plan described in this draft report. The implementation plan will emerge from action steps that have been triggered as a result of the assessment (e.g., recent retreats on the educational program, faculty funding model, and space and facilities), from additional input from the UMSD community after reviewing and commenting on the report, and from input and critiques provided by external reviewers.

Dean Polverini appointed a committee the Strategic Assessment Facilitating Committee (SAFCo), composed of faculty, staff, students, and alumni to assist him in conducting the strategic assessment (See Appendix 1, List of Committee Members). In developing the structure for the assessment, one of SAFCo’s guiding principles was to establish a process that would be inclusive and dynamic for the UMSD community.

SAFCo designed a systematic process to conduct the assessment and to develop the implementation plan. (The implementation plan will be developed following full review of the assessment report). The process involved conducting qualitative and quantitative data collection and analyses of our current realities. The information gathered and synthesized from all sources formed the basis for creating the proposed shared vision of essential goals and actions. The shared vision is a description of the picture of the future we want to create, and the one in which the UMSD community is willing to invest. The shared vision may also be considered the goals or targets on which we will focus in accomplishing the strategic imperatives.

This assessment supports a set of strategic imperatives that speak to where we should be concentrating our efforts and resources for both short and long-term achievement. As the word imperative implies, the strategic imperatives are important, urgent, and necessary actions or conditions that address where we must go in order to achieve the shared vision.

As the reader progresses through the report, he/she will encounter a number of important terms that can have multiple definitions or interpretations of their meaning. We have provided definitions for several of the terms used in this report in the body of the text and in Appendix 2.

The terms defined in Appendix 2 include:

1. Climate
By drawing on the multiple sources of input, and synthesizing the information gathered and processed during the strategic assessment, Dean Polverini has articulated the following statements of vision for our School of Dentistry to adopt as its shared vision:

- **Educational Program**: We will transform our hygiene, pre-doctoral, and graduate educational programs (i.e., both clinical and biomedical sciences components) such that they serve as role models for dental education in innovation and financial sustainability. These transformed programs will underscore our historic commitment to educate the oral health professional of the future, encourage exploration and discovery, and create excitement about academic dentistry as a career choice. To ease the national shortage of dentist/scientists and advance the public’s oral health, we will expand our emphasis on educating dental specialists, masters, and Ph.D. level dental scholars.

- **Research**: We will enhance our existing, internationally recognized research enterprise such that we have unquestioned preeminence in specific research focus areas, collaborative venues, and other outstanding projects or programs of investigation.

- **Space and Facilities**: We will implement short and long-range plans to renovate, maintain, and, where feasible, increase academic, patient care and research spaces.

- **Faculty Funding**: We will establish a new, sustainable funding model for faculty that is less dependent on general funds and provides significant opportunities for financial incentives.

- **External Influence**: We will expand our marketing strategies to ensure that UMSD is recognized across the State of Michigan, nationally and internationally as an outstanding resource for its education, research, patient care, and community service.

- **Culture and Climate**: Within five years, the environment at UMSD will be recognized both internally and externally as an exemplary place to study, work, and serve, and be especially inviting because of its success in embracing and processing differences in all dimensions of diversity, multiculturalism, and professionalism.

This shared vision is derived from strategic imperatives (the issues that address where we must go in the future) and operational issues (the means to accomplish the strategic imperatives as well as specific issues that are either problems in current activities or impediments to future progress) that SAFCo identified during the assessment process. The strategic imperatives and operational issues represent a synthesis of the many issues and insights discussed and reflected
upon during the topic-specific discussion group (TSDG) deliberations and in other venues (e.g., focus groups, forums, unit meetings) that were a part of the assessment process.

While conducting the assessment, SAFCo found it useful to categorize issues that arose as being more global (the strategic issues or imperatives) or, as everyday, nuts-and-bolts types of issues (operational issues). The strategic imperatives are detailed in section IV-B of this report. They address issues related to students, faculty, staff, research, organizational structure, external relations, clinical operations, and curriculum. The operational issues are provided in Appendix 16 and are discussed in more detail in section IV-C.

The following table summarizes the progress of the strategic assessment since its initiation and lists steps yet to be completed before its conclusion.

**Table 1. Strategic Assessment: Timeline of Progress and Future Steps**

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>February 2005</td>
<td>Dean Polverini convened SAFCo.</td>
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<td>March 2005</td>
<td>SAFCo begins meeting.</td>
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<td>April 2005</td>
<td>SAFCo retreat #1. Planning the strategic assessment process.</td>
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<tr>
<td>June 2005</td>
<td>SAFCo retreat #2. Planning the informational and invitation sessions to engage the UMSD community.</td>
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<tr>
<td>September 2005</td>
<td>Formal informational sessions and invitation to UMSD community to engage in the strategic assessment.</td>
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<tr>
<td>November 2005 - January 2006</td>
<td>Qualitative assessment sessions (discussion and focus groups) to address three broad questions regarding compelling topics and proposals for major changes.</td>
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<tr>
<td>December 2005 - April 2006</td>
<td>Establish and conduct topic specific discussion groups (TSDG) to explore in depth eight specific topics.</td>
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<td>July 2006</td>
<td>Meetings with Macy Study Group</td>
</tr>
<tr>
<td>September 2006</td>
<td>Retreat on clinical education program.</td>
</tr>
<tr>
<td>November 2006</td>
<td>Retreat on faculty funding models.</td>
</tr>
<tr>
<td>December 2006</td>
<td>Complete draft strategic assessment report</td>
</tr>
<tr>
<td>January 2007</td>
<td>Conduct UMSD community forums on draft report.</td>
</tr>
<tr>
<td>January 2007</td>
<td>Revise draft report based on feedback from UMSD community.</td>
</tr>
<tr>
<td>February 2007</td>
<td>Submit revised strategic assessment report to Provost.</td>
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<tr>
<td>February 2007</td>
<td>Conduct administrative retreat (deans and chairs) to begin dialogue on clinical, educational and research space planning needs.</td>
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<tr>
<td>Early Spring 2007</td>
<td>Engagement of University of Michigan reviewers external to UMSD</td>
</tr>
<tr>
<td>Late Spring 2007</td>
<td>Engagement of reviewers who are external to the University</td>
</tr>
<tr>
<td>Early Summer 2007</td>
<td>UMSD community forum to review external reviewer recommendations</td>
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<tr>
<td>Summer 2007</td>
<td>Conversations with central administration about strategic assessment and implementation plans and next steps.</td>
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I. Charge from the Provost

The Provost requires each academic unit at the University to engage in a process of strategic assessment periodically. The School of Dentistry was charged to initiate its strategic assessment early in 2005. The Provost’s charge directed that the process include discussions with University leaders, self-study, and advice and evaluation from expert colleagues both within and outside the University.

Further, the Provost’s charge stated that the purpose of this assessment is to ensure that the University of Michigan School of Dentistry (UMSD) takes a “clear-eyed” look at its intellectual directions and priorities, its strengths and weaknesses, and its comparative advantages over other institutions. Additionally, the self-assessment should include consideration of ways in which the UMSD and other University units can connect for synergy and collaboration (i.e., what the UMSD brings to the University and what the University can bring to the UMSD). It is expected that this assessment will help guide our decisions about future directions in a way that promotes focus on the pursuit of excellence.

The Provost designated the dean of each school to lead the assessments. In accordance with Dean Polverini’s commitment to engage the School of Dentistry community fully, he constituted the Strategic Assessment Facilitating Committee (SAFCo) to assist him in conducting the strategic assessment.

The Provost directed that the assessment take place in four stages:

1. Establishment of an information base and a shared context for discussion
2. Pursuit of unit assessment and planning
3. Review by experts, both internal and external to the University
4. Discussions with central administration, and, ultimately, agreement on priorities and directions

The full text of the Provost’s charge is included as Appendix 3.
II. Overview of the School of Dentistry

The School of Dentistry (UMSD) was founded in 1875 as the College of Dental Surgery. It was the second dental school after Harvard to be associated with a university. It is an important regional economic and health care resource.

Mission of the School of Dentistry

The mission of the University of Michigan School of Dentistry is to promote optimal oral health in a culturally sensitive manner within the state, national, and international communities through education, research, and service. To achieve its mission the School of Dentistry will:

• Educate oral health professionals and researchers in a model health care facility where students and clinicians emulate the highest standards of patient-centered care and acquire the most advanced knowledge and skills to meet the changing needs of a diverse patient population.

• Conduct research in the basic, behavioral, and clinical sciences, and encourage collaborative efforts for the discovery and application of new knowledge with awareness of multiple environmental and social conditions.

• Serve the University, the community, and the profession through the sharing of knowledge, participation in professional activities, and the establishment of linkages to promote innovation, and to encourage and address diversity in research, education, patient care, and health policy.

Inherent in the mission is a dedication to stimulate the development of the faculty and staff and to inspire students to develop attitudes and skills necessary for continued professional growth.

To pursue its mission, the School of Dentistry will foster and exemplify equity, diversity, and multicultural value.

Faculty and Staff

UMSD has one hundred and sixteen full-time faculty, eighteen primary research faculty, and two hundred and seventy adjunct/supplemental faculty. Among the full-time faculty, thirty-one percent hold both DDS and PhD degrees and forty-seven percent hold PhD degrees. Twenty-four percent of our full-time faculty have joint appointments with the Schools of Engineering, Pharmacy, Medicine or Public Health.

UMSD is organized into five academic departments, including: Biologic and Materials Sciences and the Division of Prosthodontics; Cariology, Restorative Sciences and Endodontics; Orthodontics and Pediatric Dentistry; Oral and Maxillofacial Surgery and Hospital Dentistry; and Periodontics and Oral Medicine.

To support UMSD’s operations our staff composition includes 133 in general administrative positions, 128 in patient services roles, 50 in research support, and 8 who belong to AFSCME.
Academic Programs

For the academic year 2006-07, the academic programs included 442 students in the DDS program (212 females and 230 males), 80 dental hygiene students (BS degree program), 82 Master’s degree students, and 12 doctoral students in our Oral Health Sciences PhD program (including 4 students in the DDS/PhD program).

UMSD offers a rich array of advanced education programs. These include:

- Advanced Education in General Dentistry (Certificate)
- General Practice Residency (Certificate)
- Endodontics (Certificate and MS)
- Pediatric Dentistry (Certificate and MS)
- Periodontics (Certificate and MS)
- Prosthodontics (Certificate and MS)
- Restorative Dentistry (MS)
- Dental Hygiene (MS, MPH, PhD)
- Oral Health Sciences (PhD)
- Oral and Maxillofacial Surgery (MD)
- Dental Public Health (MPH, PhD)

Patient Services

The UMSD provides oral health care to citizens from 74 counties in Michigan through its patient-centered pre-doctoral and dental hygiene, graduate specialty and advanced education residency, dental faculty practice, and community outreach educational programs. The philosophy for our patient care educational programs is that they are patient-centered and competency-based.

For the calendar year 2006, the pre-doctoral and dental hygiene program provided 61,834 appointments for 21,209 patients (from 74 counties), the graduate specialty and advanced education residency programs provided 49,776 appointments for 9,248 patients (from 68 counties), and the dental faculty practice provided 27,039 appointments for 4,418 patients (from 50 counties). Additionally, our Department of Oral and Maxillofacial Surgery and Hospital Dentistry provided care for 15,000 patients and the MDENT program provided basic dental care services for approximately 900 graduate students.

During the period, June 1, 2005 and May 31, 2006, our pre-doctoral students rotated to 9 community health center locations in Michigan cities, including Baldwin, Flint, Grand Rapids (2 centers) Jackson, Muskegon, Saginaw (2 center) and Traverse City. During their rotations at the outreach sites, our students treated 7,694 patients, of which 68% had Medicaid. This program provides both extensive clinical experiences in the community health center settings, as well as makes an important contribution to the oral health care of underserved residents of Michigan.
Research and Discovery

UMSD has a vibrant and distinguished program in research and discovery and in research training. Currently UMSD is ranked number one in NIH funding to schools of dentistry in the U.S. (2006), after having been ranked number two for 2004 and 2005. Major thematic areas of research activity include:

- **Mineralized tissue** bone biology and musculoskeletal disorders
- **Oral health disparities**
- **Microbiology and immunology** of oral disease
- **Oral sensory systems** and pain
- **Oral and pharyngeal cancer** and cancer therapeutics
- **Tissue engineering and regenerative biology**
- **Craniofacial development**

The research training at UMSD is multi-level, including active, formal programs for the following:

- DDS/Dental Hygiene Student Research
- DDS/Oral Health Sciences PhD
- MS/Oral Health Sciences PhD
- Oral Health Sciences PhD
- Postdoctoral trainees

Culture and Climate

As part of the strategic assessment, SAFCo has collaborated with the UMSD Multicultural Affairs Committee and the UM NSF ADVANCE Project to conduct a cultural climate survey (audit) to identify areas that may need improvement and to help the school make appropriate policy changes to enhance the environment for all members of the UMSD community. In order to maximize the information gained, the survey contains many of the same questions that were included in a 1994 cultural climate audit conducted by the Multicultural Affairs Committee as well as new items provided by the NSF ADVANCE Project to assess the climate with respect to factors affecting women and under-represented minorities in science and engineering.

The cultural climate survey, launched in October 2006, invites all recent graduates and current students, faculty and staff to participate. The on-line questionnaire has common items as well as specific items for each group.

The student questionnaire contains items related to: mentoring, satisfaction with training, diversity, experience of the environment in the UMSD, interactions with other dentistry students, interactions with the UMSD administration, personal life, demographics, and climate trust.

The staff questionnaire contains items related to: work history, career satisfaction, diversity, climate, interactions with other UMSD staff, interactions with the UMDS administration, demographics, and climate trust.
The faculty questionnaire contains items related to: professional employment, teaching and advising, service, resources, career satisfaction, mentoring, diversity, institutional climate, personal life, demographics, and climate trust.

This on-line cultural climate audit is administered by the UM NSF ADVANCE Project evaluation team at the Institute for Research on Women and Gender. Analysis of the data collected is being conducted by the NSF ADVANCE Project evaluation team, members of the Multicultural Affairs Committee, and the Strategic Assessment Facilitating Committee at UMSD.

While the survey is scheduled to remain active until March 31, preliminary analyses of data collected through the end of January have been conducted. The response rates as of the end of January were: students= 29%, faculty overall= 26% (faculty with appointments of 50% or greater had a response rate of 51% and faculty with appointments less than 50% had a response rate of 11%), staff= 53%. It is important to note for the faculty response rate that the maximum number of faculty responding to any of the items included in the preliminary analysis was 52, hence the effective faculty response rate for this preliminary report is 13%.

Preliminary analyses of the survey have focused on the cultural and climate items that were common to both the 1994 and current, 2006 surveys. Briefly, in comparing the results from 1994 and 2006, the report found an improvement of trust into the University of Michigan as a whole and the School of Dentistry specifically concerning their honest concern for diversity. However, both in 1994 and in 2006, the personal experiences, perceptions of others, and thoughts concerning diversity and change differ significantly between male and female respondents and ethnicity / race. The full preliminary report is presented in Appendix 4.

III. Pressures and Issues Driving the Strategic Assessment Process

Beyond the Provost’s expectation that we conduct a strategic assessment, additional factors compelled the UMSD to embark on a strategic assessment. These factors reflected general challenges to dental education, as well as specific challenges to the School.

The more general, broad-based challenges to dental education were articulated clearly by the Macy Study Group during their visit and presentation to the School and in their published reports (Appendix 12). The full record of the Macy Study Group presentations to our School on July 27-28, 2006 may be found on the UMSD intranet at: https://intranet.dent.umich.edu/SAFCO/. This site includes both video and PowerPoint slides of the Macy Study Group’s presentations to the UMSD community.

The Macy Study Group identified three key financial challenges that all schools of dentistry face. These challenges have a major impact on intermediate (operational) and long-term (strategic) outcomes, particularly for state-supported dental schools in major research institutions. The three challenges address income differences between full-time clinical faculty and private practitioners, four-year expenses for dental students, and the need for investment in infrastructure. Each of these challenges affects the missions of education, patient care, service, and research. The challenges articulated by the Macy Study Group for the entire dental education system are immediately relevant to our School of Dentistry.
Dean Polverini described several specific, compelling challenges our School of Dentistry faces during the recent (September 29 and 30, 2006) administrative retreat (for deans, chairs, Executive Committee members and selected directors) that was convened as part of the strategic assessment to initiate dialogue and plans for review and transformation of our clinical education program. During that retreat, he made it clear that we must take action now to subvert an impending crisis. He presented the following as challenges we must address now in order to sustain and build our excellence for the next 5-10 years:

A. We must develop new revenue streams to support our operations.

1. The General Fund supplement has not increased since the adoption of the value centered management (VCM) model in 1997. While net General Funds have increased, the increases were due to substantial tuition increases and increased indirect cost recovery as research activity has grown. These conditions are shown in Chart 1 at the end of this section.

2. Tuition income is approaching a critical level. We have the highest tuition among public dental schools nationwide and, due to limited tuition elasticity, we must not continue to rely on tuition increases to provide additional revenue. The tuition limitations are shown in Chart 2 at the end of this section.

3. Class size has reached its maximum. Due to constraints imposed by the facility and faculty size and composition, we cannot increase class size (as a way to increase revenue) and still maintain the quality that characterizes our educational program.

4. Indirect cost recovery is expected to remain flat and possibly decline due to the current NIH budget situation. Other sources of research support return substantially less indirect costs. The flattening of the indirect cost recovery is shown in Chart 1.

B. Our infrastructure is inadequate to support our mission in the future. As is the situation for most schools of dentistry, revenue limitations restrict our ability to update clinical and research facilities and associated technology. We have not made the necessary investments to maintain state-of-the-art facilities and information technology consistent with the needs to deliver quality teaching, service, and research. This affects our ability to remain competitive in recruiting and retaining the best students, faculty, and staff.

C. Our faculty are challenged not only due to class-size pressures, but also are challenged by a faculty appointment and funding model that limits opportunities for salary enhancement that is competitive with opportunities outside dental education.

Dean Polverini emphasized that these challenges limit our ability to play to our strengths in education, patient care and research. They also compromise our ability to develop new strengths in an increasingly competitive environment.
Chart 1.

Sources of General Funds - before General Fund Taxes

<table>
<thead>
<tr>
<th></th>
<th>FY98</th>
<th>FY99</th>
<th>FY00</th>
<th>FY01</th>
<th>FY02</th>
<th>FY03</th>
<th>FY04</th>
<th>FY05</th>
<th>FY06</th>
<th>FY07</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Funds supplement - before taxes</td>
<td>17,425</td>
<td>17,954</td>
<td>18,346</td>
<td>19,136</td>
<td>18,628</td>
<td>17,493</td>
<td>17,236</td>
<td>17,043</td>
<td>16,805</td>
<td>15,497</td>
</tr>
<tr>
<td>Tuition Total</td>
<td>5,000</td>
<td>10,000</td>
<td>15,000</td>
<td>20,000</td>
<td>25,000</td>
<td>15,000</td>
<td>15,000</td>
<td>15,000</td>
<td>15,000</td>
<td>15,000</td>
</tr>
<tr>
<td>Indirect Cost Recovery</td>
<td>1,998</td>
<td>2,194</td>
<td>2,492</td>
<td>2,409</td>
<td>2,828</td>
<td>3,564</td>
<td>3,663</td>
<td>4,757</td>
<td>5,209</td>
<td>5,160</td>
</tr>
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Chart 2.

DDS Tuition - 2 semesters

<table>
<thead>
<tr>
<th></th>
<th>FY97</th>
<th>FY98</th>
<th>FY99</th>
<th>FY00</th>
<th>FY01</th>
<th>FY02</th>
<th>FY03</th>
<th>FY04</th>
<th>FY05</th>
<th>FY06</th>
<th>FY07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident</td>
<td>25,048</td>
<td>26,048</td>
<td>27,056</td>
<td>28,122</td>
<td>28,979</td>
<td>30,863</td>
<td>32,111</td>
<td>34,051</td>
<td>35,767</td>
<td>37,573</td>
<td>39,470</td>
</tr>
<tr>
<td>Non-Resident</td>
<td>13,836</td>
<td>14,388</td>
<td>14,942</td>
<td>15,725</td>
<td>16,203</td>
<td>17,665</td>
<td>18,733</td>
<td>19,865</td>
<td>21,581</td>
<td>23,388</td>
<td>24,568</td>
</tr>
</tbody>
</table>

FY97 to FY07 - change = 78%
IV. Conducting the Strategic Assessment

A. Process of Conducting the Strategic Assessment

Dean Polverini assembled a twenty-two member committee composed of faculty, staff, students, and alumni to facilitate the strategic assessment process and gather information from the School’s community and other key resources. This committee was designated the Strategic Assessment Facilitating Committee (SAFCo). SAFCo’s key tasks were to assemble information, develop opportunities for all members of the School’s community to become engaged and provide informed input, and to analyze the accumulated input. A fundamental value that SAFCo embraced was that the assessment be designed to ensure maximum engagement of faculty, staff, and students, and that the process foster honest, open dialogue throughout. SAFCo was designed to be a facilitating committee rather than a decision-making body.

In developing the structure for the assessment, SAFCo established an inclusive and dynamic process. SAFCo recognized that it would be crucial for all members of the School community to have multiple opportunities for participation to ensure that their knowledge, insights, opinions and expertise could be engaged and heard in shaping the plan for our future.

A systematic process was followed during the assessment and the initial stages in the development of the implementation plan. Qualitative and quantitative analyses of our current realities were conducted, providing many opportunities for the UMDS community’s involvement and feedback. This process resulted in a thorough analysis of the key activities of UMDS.

The opportunities for the UMDS community’s involvement included focus groups, forums, unit meetings, and topic specific discussion groups (TSDGs). The TSDGs were charged with exploring in depth eight topics regarding the School’s current status and where it should be in five to ten years. The TSDGs deliberations resulted in reports that served as a major source for identifying the compelling strategic and operational issues that we must address. The detailed full reports of each of the TSDGs appear in Appendices 5 to 12. The eight TSDGs were:

- Clinical Operations
- Curriculum
- External Relations
- Faculty
- Organizational Structure
- Research
- Staff
- Students

SAFCo had a unique opportunity to examine the challenges of its peer institutions by engaging in a review and dialogue of the work of the Macy Study Group. By engaging the Macy Study Group we were able to attain an unusually well-informed view of the dental education system. This report presents a more detailed description of the Macy Study Group in section 6. Drawing on the rigorous work of the Macy Study Group allowed for an efficient assessment of the opportunities and challenges facing peer dental schools.
The information gathered and synthesized from all sources during the strategic assessment activities supports our creation of a shared vision reflecting essential values, and strategic imperatives addressing how we should concentrate our efforts and resources for both the short- and long-term.

Appendix 5 presents a detailed chronology of activities and accomplishments for the strategic assessment to date.

B. Findings

1. **Strengths**: One of the charges from the Provost in conducting the strategic assessment was to identify our most significant strengths. To address this issue qualitatively, one of the tasks assigned to each of the eight topic specific discussion groups (TSDGs) was to consider our strengths. Each of the TSDGs reported their perspectives regarding our strengths; these reported strengths are presented in detail in Appendix 15. The table below presents the categories of topics reported by at least one TSDG as an area of strength.

<table>
<thead>
<tr>
<th>Categories of Strengths reported by at least one TSDG</th>
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<tbody>
<tr>
<td>Continuing Education</td>
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<tr>
<td>Collaboration</td>
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<td>Climate</td>
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<td>PhD Program Impact</td>
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<tr>
<td>Collegiality</td>
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<td>Communication</td>
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<td>Curriculum</td>
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<tr>
<td>Dental Hygiene Program</td>
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<td>Diversity</td>
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<td>Educational Programs</td>
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<td>Student Involvement in Admissions</td>
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<td>External Relations Activities</td>
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<td>Facilities</td>
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<td>Faculty</td>
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<tr>
<td>Innovation Tradition</td>
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<tr>
<td>Integration of Science, Education, Patient Care</td>
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<tr>
<td>Leadership Development</td>
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<tr>
<td>Multiculturalism</td>
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<tr>
<td>Outreach</td>
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<td>Patient Centered Care</td>
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<td>Reputation</td>
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<td>Specialty Programs, Graduate Education</td>
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<td>Resources</td>
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<td>Specialty Representation and Availability in Clinics</td>
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<td>Student Quality</td>
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<td>Student Responsibility for Patient Care</td>
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<tr>
<td>Stability of Organizational Structure</td>
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<tr>
<td>Staff</td>
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**Major strengths of UMSD:**

**Research**

UMSD research spans a spectrum from basic molecular mechanisms to translational research to population-based interventions. One of the most visible indicators of the strength of our research enterprise is the consistent outstanding level of funding by NIH/NIDCR. The UMSD ranking in terms of NIH research funding has steadily increased from sixth (6th) in 2002 to second (2nd) for the years 2004 and 2005 to first (1st)
for 2006. Appendix 11 provides a summary of the depth and breadth of the research programs and projects conducted by faculty in each of our departments.

Another dimension of the strength of our research enterprise is revealed in the numerous formal opportunities for research training. As mentioned in the overview, research training opportunities are available for all levels of our students. The Oral Health Sciences PhD Program (OHS PhD) is designed to train outstanding students to become independent research scientists in the various disciplines that comprise the oral health sciences. This program is supported by Dean’s scholarships, the American Association of Dental Research (AADR), Rackham Awards, the NIH-funded Tissue Engineering and Regeneration T32 training program, the NIH-funded Regenerative Sciences T90 program, NIH-funded R01 grants held by UMSD investigators, NIH fellowships, and home governments of our international students. The OHS PhD program enrolled its first students in 1994 and has graduated 19 graduates to date. These graduates are now postdoctoral fellows, assistant to full professors (UM, UCLA, U of Maryland, UCSF and schools of dentistry in Saudi Arabia, Taiwan, and Thailand), or working in industry (places such as Henry Ford Hospital and GlaxoSmithKline).

Another component reflecting research training excellence at UMSD is the TEAM (Tissue Engineering at Michigan) Institutional National Research Service Award Training Program in Tissue Engineering and Regeneration, currently in its 30th year of training (DE007057-29). This program has a distinguished history, widely acknowledged as a premier program responsible for training several leading dental faculty in the field of dental materials. More recently the program was expanded to include the larger UM community and was transformed by adjusting its focus from a purely synthetic biomaterials solution for dental problems, to more general biological biomaterials applications that employ tissue engineering and regeneration technology. Our efforts have paralleled the NIDCR targeted funding initiatives in tissue engineering. Currently trainees in the program have academic homes in the Schools of Engineering and Medicine, as well as the School of Dentistry.

TEAM is administered through the School of Dentistry and is a University-wide pre- and post-doctoral training program making use of unique academic and research training environments across the Ann Arbor campus. Primary TEAM mentors (n=35) are affiliated with the School of Dentistry (n=15), the School of Medicine (n=8), and College of Engineering (n=8). Faculty comprising the TEAM Training Program mentors hold academic appointments in one or more of 7 Ph.D.-granting units and 11 different departments. Many of these faculty members participate in 5 interdepartmental programs that are Ph.D.-granting units within the Rackham School of Graduate Studies. These interdisciplinary programs add strength and diversity to the pool of trainees as well as to the pool of mentors who participate in TEAM.

Our trainees are engaged in research at the interface between the life sciences and the physical sciences. Therefore, TEAM provides a highly interdisciplinary training approach that requires exposure of trainees to the fundamental concepts underlying several disciplines and the research tools used in these various disciplines.
The Student Research Program is yet another component of research training at UMSD. This program provides opportunities for student dentists and hygienists to have formal research experiences with members of the faculty engaged in research. In 2006, thirty-nine dental and dental hygiene students applied for twenty-five funded projects. It is noteworthy that of 19 competitive American Association for Dental Research (AADR) fellowships awarded in 2006, UMSD students received eight. In past years it has not been unusual for UM students to receive as many as one third or more of the total number of awards funded by the AADR fellowship program.

UMSD supports two specialized research centers with programs that are consistent with NIH priorities and provide for collaborative opportunities with other units on UM campus and beyond. In January 2005, UMSD launched its clinical research center, Michigan Center for Oral Health Research (MCOHR), at the Domino’s Farms complex. MCOHR’s mission is to serve the University of Michigan School of Dentistry, the profession, and the public in the translation of basic knowledge into new clinical therapies, and to evaluate existing therapies in which there may be insufficient scientific evidence to support their use. MCOHR is housed the UM General Clinical Research Center’s satellite clinical facility, sharing space with the Department of Internal Medicine. Investigations at MCOHR involved 1,434 patient treatment visits as of late October 2006, with capacity for 7,800 patient visits per year. MCOHR provides a unique strength for enhancing UMSD clinical research in terms of providing and facilitating education and training for faculty and students, research support (core services support: biometrics and study design, regulatory compliance, subject recruitment and registry maintenance, project management and monitoring, and study coordination and conduct).

The other specialized UMSD center is the Detroit Center for Research on Oral Health Disparities, one of the five NIH/NIDCR-funded Centers for Research to Reduce Oral Health Disparities. This center was designed to identify social, behavioral, community and environmental risk factors to address the core research question of why some low-income African-American children and their caregivers have better oral health than others do, even when they all live in the same community and share similar socioeconomic factors. This center includes collaborators from UM Schools of Public Health and Social Work, the Institute for Social Research, and the Voices of Detroit Initiative, a community-based collaborative partnership among Detroit safety net providers that has created medical home for over 16,000 underserved residents of Detroit with no other access to health care coverage.

UMSD also has a major focus on head and cancer research. We believe that the breath and depth of the head and neck cancer program at the UMSD is unique among dental schools in the country and throughout the world. Head and neck cancer is the sixth most common type of cancer, and approximately 40,000 Americans die every year in consequence of this disease. Unfortunately, the five-year survival of patients with head and neck cancer has not improved significantly over the last 30 years. Recognizing the significance of the problem, the University of Michigan School of Dentistry (UMSD) has decided that head and neck/oral and pharyngeal cancer should be one of its major research foci. Our school currently has 14 full time faculty with research programs that involve studies of the pathobiology of cancer. We organized a cancer research focus group approximately 2 years ago that has monthly meetings to discuss projects, to
provide feedback among peers, and to foster collaborative research efforts among faculty. We are also currently working on the organization of the “head and neck cancer collaboratory”, where we will strengthen the interactions of the UMSD cancer research focus group with other national and international research groups with shared interests in head and neck cancer. This will be done through the systematic use of videoconferencing where researchers will exchange ideas and protocols in the context of projects performed in collaboration. We firmly believe that this multidisciplinary and multi-institutional effort will help us to accelerate the process of translating our laboratory research findings into clinical benefit for patients with head and neck cancer.

Faculty from the UMSD are involved in head and neck/oral & pharyngeal cancer research programs that extend from epidemiologic survey research and community-based interventions to molecular biology-based mechanistic studies of the pathobiology of cancer. For example, one of our faculty is the principal investigator of an NIH funded program entitled “Detroit Oral Cancer Prevention Project”, that involves a media campaign including radio and newspaper advertisements and outdoor signs promoting early screening, tobacco cessation and reduction in drinking of alcohol. This media campaign is coordinated with a community outreach educational program conducted in collaboration with churches and 144 local neighborhood organizations. An 800-toll free information telephone service is available to provide information and schedule patients for free screening at a network of clinics. We believe that this constitutes a major community outreach effort that has already allowed for early diagnosis of tumor lesions in patients from the Detroit area. Several of the UMSD faculty are active participants of the University of Michigan Head and Neck Specialized Program of Research Excellence (SPORE). The contributions of the dental school faculty involve work as co-principal investigator of one of the major SPORE II projects, participation in the career development and developmental projects, as well as work in the coordination of the SPORE tissue core. This clearly exemplifies how faculty from the dental and the medical school have been working together on a major NIH-funded research initiative at the University of Michigan. Furthermore, faculty from the UMSD participate in several multi-disciplinary research efforts. For example, one of our faculty members has been working together with a faculty colleague from the University of Michigan Department of Mathematics, and a researcher from the Los Alamos Institute (New Mexico) on a research project that aims to develop and characterize mathematical models that allow for the prediction of responses to anti-angiogenic therapies for head and neck cancer. Such mathematical models could help the determination of the therapeutic potential of new drugs, and assist in the decision of moving such drug into clinical trials or not. This work has been recently submitted as a new R01 grant application to the NIH.

Appendix 17 provides supplementary information, which further describes our research activities and funding support. Key points in Appendix 17 are:

- UMSD faculty members are involved in large numbers of federal and non-federal active research projects;
- UMSD research activity has more than doubled since 2001;
• UMSD ranking in terms of NIH research funding has steadily increased from sixth (6th) in 2002 to second (2nd) for the years 2004 and 2005 to first (1st) for 2006;

• UMSD ability to invest in research facilities and infrastructure has not kept pace with the needs concomitant with its growth in research activity and funding; and

• UMSD need to have faculty go outside the building for research space, which making it difficult for those faculty actively participate in the daily activities of the School.

Faculty

The strength of our faculty is manifested in many ways in addition to clinical and didactic teaching in our hygiene, pre-doctoral and graduate programs. Their scholarship contributes to the scientific knowledge base and teaching resources. UMSD faculty have authored numerous book chapters and textbooks, widely recognized as leading texts in their fields. UMSD faculty scholarship and contributions to their respective disciplines is recognized through their receipt of numerous prestigious awards. Our faculty provide leadership and service to the dental profession and the broader community of science and scholarship. The leadership and service occurs at multiple levels including: the University, State of Michigan, regionally, nationally, and internationally.

Community Outreach and Service

A strength of UMSD is its capacity to contribute to oral health in the State of Michigan through its community outreach program. The community outreach program provides opportunities for our students to have educational patient care experiences in community health centers across the state. Students live and practice for 1-2 weeks in settings where they are able to learn about socio-economic circumstances that affect decisions and quality of life in underserved communities. A major goal of the community outreach program is to stimulate a substantial proportion of our graduates to choose to serve in underserved communities. Indeed, many of our graduates have chosen to serve in underserved communities in Michigan and across the nation and some are now adjunct faculty members in Michigan community health center sites. As mentioned previously, during their rotations at the outreach sites across the State, our students treated 7,694 patients, of which 68% had Medicaid. This program provides both extensive clinical experiences in the community health center settings as well as makes an important contribution to the oral health care of underserved residents of Michigan.

The UMSD also has two NIH-funded research projects based in Detroit, the Detroit Dental Health Project (one of 5 NIH/NIDCR-funded Centers for Oral Health Disparities) that provides free dental care, and the Detroit Oral Cancer Prevention Project that provides free screenings and biopsies for oral cancer. The service components are realized through efforts over the past 9 years providing assistance and collaborating with the Detroit Department of Health and Wellness Promotion in community service and
development activities such as building dental clinics associated with three Federally Qualified Health Centers in Detroit.

Education

*Dental Informatics* - The School of Dentistry leads the campus and the nation in the use of podcasting to improve teaching and learning. The use of podcasting started as a student research project to explore techniques for improving the traditional lecture experience. When Apple, Inc. learned about the research project they invited the School of Dentistry to help them develop *iTunes U*. (The other institutions invited are Duke University, Brown University, Stanford University, the University of Wisconsin and the University of Missouri.) Based in our foundational work, *iTunes U* has been incorporated into Sakai (the software that CTools is written in) and through Sakai is now available to over 100 institutions across the country and around the world. On campus, *iTunes U* has been implemented in the Schools of Business, Medicine, Law, and a number of other schools and colleges. Another example of the school's strength in research, we are also leading the country in evaluating the impact of podcasting on teaching and learning.

*Scholars Program in Dental Leadership* - In August of 2006 the School of Dentistry launched the first program in leadership for dental and dental hygiene students, the University of Michigan’s Scholars Program in Dental Leadership (UM-SPDL). The goal of this program is to develop a cadre of graduates empowered with a unique set of skills and knowledge-base who are able to continue to develop and envision and promote cultural changes in the profession of dentistry. This program promotes development of leadership in dentistry. It is recognized that effective leaders require a multitude of skills to successfully lead change in complex and diverse situations in a flexible and accommodating manner. UM-SPDL is designed to provide opportunities for participating students to develop an understanding of the interplay between leadership and challenges that are faced by leaders as they develop value-creating opportunities through learning about leadership competencies. The program is intended to capitalize on human potential by developing a leadership mindset through activities such as coaching and counseling for maximal performance, fostering the power of working together, and managing change. We expect that upon completion of the program, participants will engage in leadership in dentistry, defined by the participants’ individual and community’s circumstances, which may include pursuits such as leading a successful practice, policy change initiatives, dental research, or academic dentistry, to name a few.

*Computing and Informatics*

UMSD Dental Informatics is a unique and valued resource. It is the only UM information technology unit that concurrently supports the School of Dentistry’s teaching and learning, patient care, research and administrative activities. In addition to its support responsibilities it is responsible for continual development of the school's computing infrastructure, improving the use of learning technologies, programming improvements to the patient care system and automating administrative tasks. One-half of the dental schools in North America use the same patient information system as UMDS. Building upon our NIH supported work Dental Informatics is the only school to
develop a secure Web interface to the patient information system. We are sharing this work with numerous other dental schools. Dental Informatics is involved in four NIH grants (totaling $1,011,705). The director, Dr. Lynn Johnson, is principal investigator on one of the NIH grants. Dr. Johnson has been recognized as a national leader in dental informatics and dental education's international leader in learning technology.

**Weaknesses identified during the assessment process** - Weaknesses identified so far from the multiple sources of our strategic assessment have been reviewed carefully and incorporated into the strategic imperatives (strategic issues) and in the operational issues articulated for this report. Therefore, we will not include a separate listing of the weaknesses in this section of the report. The strategic imperatives are described in section IV.-B and the operational issues are described in section IV.-C and in Appendix 16.
V. Considerations for Implementation

This section presents a description of the areas for strategic emphasis, the strategic imperatives, the operational issues, activities on going in the assessment, and a list of steps yet-to-be-completed for our strategic assessment. The report does not yet include an implementation plan because further discussion and feedback about the draft assessment report with the UMSD community is necessary at this stage.

A. Shared Vision

The shared vision is the description of the image of the future we wish to create and the one in which the community is willing to invest. It is the story that we intend to be able to declare about what will happen at the end of a certain time period. The statements describing the shared vision can also be considered the goals or targets on which we will focus in accomplishing the strategic imperatives. The vision statements are derived from the strategic imperatives and operational issues that SAFCo identified during the assessment process. They represent a synthesis of the many topics and insights discussed and reflected upon during the topic-specific discussion group (TSDG) deliberations and in other venues (focus groups, forums) that were a part of the assessment process. Based on the synthesis of this information through the date of this report, Dean Polverini has articulated the following six shared vision statements:

- **Educational Program:** We will transform our hygiene, pre-doctoral, and graduate educational programs (i.e., both clinical and biomedical sciences components) such that they serve as role models for dental education in innovation and financial sustainability. These transformed programs will underscore our historic commitment to educate the oral health professional of the future, encourage exploration and discovery, and create excitement about academic dentistry as a career choice. To ease the national shortage of dentist/scientists and advance the public’s oral health, we will expand our emphasis on educating dental specialists, masters and Ph.D. level dental scholars.

- **Research:** We will enhance our existing, internationally recognized research enterprise such that we have unquestioned preeminence in specific research focus areas, collaborative venues, and other outstanding projects or programs of investigation.

- **Space and Facilities:** We will implement short and long-range plans to renovate, maintain, and, where feasible, increase academic, patient care and research spaces.

- **Faculty Funding:** We will establish a new, sustainable funding model for faculty that is less dependent on general funds and provides significant opportunities for financial incentives.

- **External Influence:** We will expand our marketing strategies to ensure that UMSD is recognized across the State of Michigan, nationally and internationally as an outstanding resource for its education, research, patient care, and community service.
• **Culture and Climate:** Within five years the environment at UMSD will be recognized both internally and externally as an exemplary place to study, work, and serve, and be especially inviting because of its success in embracing and processing differences in all dimensions of diversity, multiculturalism, and professionalism.

**B. Strategic imperatives**

The *strategic imperatives* reflect the importance and urgency of necessary actions or conditions with respect to where we must go in order to address the *areas for strategic emphasis*. SAFCo found it useful to consider *strategic imperatives* as those issues that address where we want to go and the *operational issues* as specific issues that are either indicative of problems in current activities or impediments to future progress. In addition to the strategic imperatives listed below, the assessment identified over 300 operational issues, which are discussed in more detail in section IV-D of this report. Additionally, a full listing of the *operational issues* is provided in Appendix 16.

The following list presents the strategic imperatives categorized by the respective topic specific discussion group report from which they were derived. Table 3 summarizes the relationships between the strategic imperatives and shared vision statements.

**S1. Students:** We must foster an educational program in which students receive timely and effective feedback relative to their performance and in which they are active participants in the evaluation of courses, faculty, educational experiences (clinical/didactic/extracurricular) and mentoring activities.

  Note: The School of Dentistry educates several different categories of students. The term “students” in this listing of strategic imperatives refers collectively to student dentists (pre-doctoral); student hygienists; students and residents in certificate and masters specialty programs; residents in post-graduate programs; and students in our PhD program.

**S2. Students:** We must foster a climate where students feel a sense of value and are treated with respect as future colleagues, and where students assume responsibility in contributing to maintain the integrity of that climate.

**S3. Students:** We must create new opportunities to meet the financial needs of our students to ensure that all segments of the population have access to dental education.

**S4. Students:** We must ensure that our graduates are knowledgeable about the wide range of career opportunities, in addition to private practice, and must be able to make decisions about career opportunities without being constrained by debt incurred in school (e.g., having the desire to pursue an academic career, but financial obligations lead to career path in private practice).

**COM1. Community: Faculty, Staff, and Students:** We must cultivate an environment for all members of the community (faculty, staff, and students) in which they thrive and have a sense of partnership.
COM2. **Community: Faculty, Staff, and Students:** We must cultivate an environment for faculty, staff, and students that is attractive for recruitment and retention.

COM3. **Community: Faculty, Staff, and Students:** We must cultivate an environment for all members of the community to practice and model the highest standard of ethical behavior.

COM4. **Community: Faculty and Staff:** We must create an environment that includes opportunities for professional development, safety in communications, and an appreciation of the significance of everyone’s role to the mission of the University and the School of Dentistry. This imperative must reflect opportunities for appropriate compensation, incentives, and rewards for all faculty and staff.

R1. **Research:** We must continue to excel and maintain our competitive edge by concentrating our efforts in focused areas of research.

R2. **Research:** We must provide an outstanding research infrastructure to attract, retain and inspire the most outstanding scientists.

R3. **Research:** We must attain and preserve excellence in contemporary scientific teaching and PhD training to inspire the next generation of academic dentists.

R4. **Research:** We must strengthen our scientific collaborative relationships through effective engagement with partners throughout our many excellent centers and schools within the university as well as regionally, nationally and internationally. This will maximize our effectiveness and best use the resources at the University.

R5. **Research:** We must provide ample opportunities for all students to have meaningful research experiences through a more flexible curriculum. This will significantly and positively influence the way the student thinks and practices dentistry and dental hygiene.

R6. **Research:** We must establish a strategy to identify and pursue non-NIH funding opportunities to address the increasing competition for and decreasing availability of federal research funding support through NIH.

O1. **Organizational Structure:** We must have an organizational structure that supports flexibility and enhances cross-departmental and interdisciplinary collaboration. It must optimally facilitate linking necessary resources with critical missions. It must support increased efficiency and cost-effectiveness.

O2. **Organizational Structure:** We must establish a mechanism to institutionalize ongoing, periodic strategic assessment activities.

E1. **External Relations:** We must create a brand for the School of Dentistry in which we are clearly recognized for outstanding research, dental education and patient care, within patient and professional communities and the broader public. We must foster mutually beneficial relationships between the UMSD and external stakeholders.
CO1. **Clinical Operations:** We must provide clinical experiences that optimally prepare students for practice in an environment that both meets the needs of our patients and makes the best use of our faculty’s clinical expertise in meeting those patient care responsibilities.

CO2. **Clinical Operations:** We must develop self-sustaining clinical models that address the needs of students, faculty, staff, and diverse patient populations. These clinical models must foster faculty enthusiasm and student participation.

C1. **Curriculum:** We must have a curriculum that is adaptable in terms of student needs, student learning style, state of the art technology, patient populations and changing public health needs.

C2. **Curriculum:** We must have an evidence-based curriculum designed to provide optimal experiences for students to engage in active learning and to facilitate students taking increased responsibility for the learning and education process.

C3. **Curriculum:** We must have a curriculum that coincides with the University of Michigan’s mission and value for service learning.

C4. **Curriculum:** We must have a didactic and preclinical curriculum (in which basic and clinical sciences are integrally connected) designed to make the most efficient and effective use of resources without compromising excellence. These resources include faculty, staff, facilities, and technology.

C5. **Curriculum:** We must create a culture and climate that encourages cooperative learning, rather than competition.
C. Operational Issues

The operational issues reflect both the means to accomplish the strategic imperatives as well as specific issues that are either problems in current activities or impediments to future progress. The topic-specific discussion groups identified numerous operational issues that will require attention as we move forward in our strategic assessment and implementation activities. As mentioned earlier, the operational issues are defined as specific issues that must be addressed to support the strategic imperatives. The operational issues also reflect areas of weakness identified in the strategic assessment that have not been incorporated in the statements of strategic imperatives.

The operational issues were also categorized by the TSDGs. Because many of the operational issues were identified by more than one TSDG, we further categorized them by topic; this resulted in 42 categories, as shown in Table 3.

Table 3. Categories of Operational Issues

<table>
<thead>
<tr>
<th>Active Learning</th>
<th>Curriculum</th>
<th>Governance</th>
<th>Pedagogy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptable</td>
<td>Curriculum</td>
<td>Grants management</td>
<td>Pipeline issues</td>
</tr>
<tr>
<td>Administrative</td>
<td>Development</td>
<td>Guidelines</td>
<td>Reinforcement</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Equity</td>
<td>Innovation</td>
<td>Remediation</td>
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<tr>
<td>Benefits</td>
<td>Evaluation</td>
<td>Informatics &amp; IT</td>
<td>Rewards</td>
</tr>
<tr>
<td>Calibration</td>
<td>Facilities</td>
<td>Marketing</td>
<td>Staffing</td>
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<tr>
<td>CDE</td>
<td>Faculty Development</td>
<td>Mentoring</td>
<td>Student Responsibility</td>
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<tr>
<td>Climate</td>
<td>Finances</td>
<td>Outcomes Assessment</td>
<td>Sustainability</td>
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<tr>
<td>Clinical Models</td>
<td>Foci</td>
<td>Outreach</td>
<td>Vision</td>
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<tr>
<td>Collaboration</td>
<td>Funding</td>
<td>Partnerships</td>
<td></td>
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<tr>
<td>Communications</td>
<td>Fundraising</td>
<td>Patient-flow</td>
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</table>

To address the operational issues effectively in the subsequent implementation phase, each one will be classified further with respect to its urgency and importance; then the unit, group, or individual responsible for its attention will be identified and the item will be assigned for resolution. A timeline for addressing the issue will be established, and a tracking system for accomplishing each of the operational issues will be developed. Work on several of the operational issues identified during the strategic assessment already is complete or in-progress including, but not limited to, the following: Implementation of performance planning, professional development and incentive programs, attention to climate for staff; improved restroom maintenance; discussion of financial programs for faculty, staff, and students with TCF Bank.
A complete listing of the identified operational issues and their classification appears in Appendix 16.

**D. Next Steps**


2. Engagement of University of Michigan reviewers external to UMSD: early spring 2007. (Based on list of names of potential reviewers suggested by the Dean and SAFCo).

3. Engagement of reviewers who are external to the University: late spring 2007. (Based on list of names of potential reviewers suggested by the Dean and SAFCo).

4. UMSD community forum to review external reviewer recommendations:

VI. Summary

The School of Dentistry is recognized as one of the leading dental schools in the world. This is reflected in the scholarship, accomplishments, and leadership of the faculty, the quality of the educational and patient care programs, and the collaboration and integration with other components of the University as well as collaboration and impact beyond the boundaries of UM.

To maintain and continue to enhance our levels of excellence in dental education, research and patient and community service and realize our vision and greater potential, we must face, head-on, the strategic challenges for our future, including:

- Need for new revenue streams;
- Need for investment in the current infrastructure that is inadequate to support our vision and mission for the future;
- Need for faculty appointment and funding model restructuring to address differences in income for clinical faculty and private practitioners;
- Need to reduce educational costs to students to maintain the quality of applicants and enrolled students; and
- Need to transform our curriculum schedule to enable research training at an optimal level as well as greater flexibility for broader elective experiences for our students.
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Appendix 1

Strategic Assessment Facilitating Committee (SAFCo) Members, Titles and Department Affiliation

George Taylor, DMD, DrPH, Chair of SAFCo; Associate Professor, Cariology, Restorative Sciences and Endodontics

Alicia Baker, Administrative Assistant, Patient Services

Dennis Fasbinder, DDS, MS, Clinical Professor, Cariology, Restorative Sciences and Endodontics

Mark Fitzgerald, DDS, MS, Associate Professor, Cariology, Restorative Sciences and Endodontics

Suzanne Fournier, DDS (graduated April 2006)

Donald Heys, DDS, MS, Professor, Cariology, Restorative Sciences and Endodontics

Lynn Johnson, PhD, Associate Professor and Director, Dental Informatics

Darnell Kaigler, DDS, PhD, Resident in Periodontology

Paul Krebsbach, DDS, PhD, Professor and Chair, Biologic and Materials Sciences

Dennis Lopatin, PhD, Professor and Senior Associate Dean, ex-officio member

James McNamara, DDS, PhD, Professor, Orthodontics and Pediatric Dentistry

Diane McFarland, Assistant to the Dean

Rodrigo Neiva, DDS, MS, Clinical Assistant Professor, Periodontics and Oral Medicine

Jacques Nor, DDS, MS, PhD, Professor, Cariology, Restorative Sciences and Endodontics

Peter Polverini, DDS, DMSc, Professor and Dean

Cheryl Quiney, Patient Care Representative, Patient Services

Susan Guest, DDS, Resident in Orthodontics

Charles Shelburne, PhD, Assistant Research Scientist, Biologic and Materials Sciences

Jeffrey Shotwell, DDS, MS, Associate Professor, Biologic and Materials Sciences

Fernando Urzua, Fourth year dental student

Samuel Zwetchkenbaum, DDS, MPH, Clinical Assistant Professor, Oral and Maxillofacial Surgery/Hospital Dentistry

External:

Raymond Gist, DDS, alumnus
Appendix 2

Definition of Terms

1. **Climate:** The tone or atmosphere in the work and patient care environment that people experiencing the environment might use to describe the atmosphere, for example, is the tone inviting or hostile, formal or informal, jovial or sad? Climate is also the “feeling-body” of the work environment, for example, is the general feeling collegial or contentious, cooperative or competitive, consultative or authoritative.

2. **Culture:** Culture can be thought of as “the way of life” for our School of Dentistry’s community. It includes codes of manners, dress, language, rituals, norms/habits of behavior, and systems of belief. Culture can also be viewed as the ways we behave and interact, our individual and collective experiences, and the meaning and impact of those experiences on individuals and groups. These are major factors that really influence and define the day-to-day life in our School of Dentistry’s community. Climate and culture are inseparable.

3. **Diversity:** Diversity in this report refers to multiple dimensions in which variables or characteristics contribute to describing an individual or group, or the way in which an individual might identify oneself. These dimensions include: ethnography (nationality, ethnicity, language, religion), demography (age, gender, sexual orientation, place of residence), status (social, economic, education, functional), and affiliation (formal as well as informal groups). Diversity also refers UMSD’s practices and policies of accepting, integrating, and embracing differences in ideas, opinions, approaches, perceived meaning of experiences, as well as social, ethnic, racial, economic, and national backgrounds.

4. **Multiculturalism:** Multiculturalism in this report means sensitivity to the dynamics of diversity and an explicit commitment to sustain a diverse community in which personal and professional fulfillment is enhanced by the community’s diversity. It is the reflection of how we live diversity in our community. Multiculturalism, diversity, and culture are closely linked.

5. **Operational Issues:** These items reflect both the means to accomplish the strategic imperatives as well as specific issues that are either problems in current activities or impediments to future progress.

6. **Partnership:** Partnership is the spirit of collaboratively addressing challenges and opportunities, setting aside differences, especially those related to status, in the process of working together.

7. **Shared Vision:** Shared vision is the description of the picture of the future we wish to create and the one in which the community is willing to invest. It is the story that we intend to be able to declare about what will happen at the end of a certain time period.

8. **Strategic Imperatives:** The word imperative implies the importance and urgency of necessary actions or conditions that address where we must go in order to achieve the shared vision and areas of strategic emphasis.

9. **Students:** The School of Dentistry educates several different categories of students. When the term “students” appears throughout the report, unless specifically stated otherwise, it refers collectively to student dentists (pre-doctoral); student hygienists;
students and residents in certificate and masters specialty programs; residents in post-graduate programs; and students in our PhD program.
Appendix 3

Provost’s Charge
Provost Courant initiated a process to engage each academic unit in a strategic assessment involving discussions with the University's academic leadership, unit self-study, and advice and evaluation from expert colleagues within the University of Michigan and at other premier research universities around the world. The purpose of the strategic assessment is to ensure that each unit periodically takes a clear-eyed look at its intellectual directions and priorities, its strengths and weaknesses, and its comparative advantages over other institutions. Such assessment can guide the unit's future decisions and initiatives in a way that promotes focus in the pursuit of academic excellence. Further, this assessment provides an opportunity to identify points of potential contact between the unit's agenda and the strengths of other University of Michigan units for synergies and collaborations. Finally, this assessment provides the opportunity for the faculty of the unit and the University's academic leadership - president, provost, executive vice president for medical affairs - to achieve a shared understanding of the significant intellectual choices and trade-offs facing the unit.

Overview of the Process
The strategic assessment provides each school or college with an opportunity to take stock of its strengths and weaknesses, to evaluate its strategies and goals, and to receive assistance from external groups of academic leaders within the University and from other academic institutions. This process should help schools to articulate possible intellectual directions and to identify the most fruitful ones to pursue given their individual strengths and the strengths that the larger University can add to the unit's own resources. The process is flexible enough to adapt to the goals and operating style of individual schools. We expect two academic units to conduct strategic assessments each year, so that each school will assess itself approximately once every ten years. When appropriate, this process may be conducted simultaneously with an accreditation or other review, so that similar work may serve both purposes.

There is a standard process of four stages: 1) establishing an information base and a shared context for discussion, 2) unit assessment and planning, 3) getting external perspectives from within the University of Michigan and from outside the University, and 4) discussions with central academic leadership at the University, and agreement on priorities and directions.

The School takes stock of the present and will think hard about the future. The self-assessment provides an opportunity for the School to judge its success in meeting its past goals. More importantly, it prompts everyone to think about future goals, obstacles to achieving those goals, ways to overcome the obstacles, and the unit's capacity to improve along each dimension of performance. The self-assessment should include consideration of what the University can bring to the unit and of what the unit brings to the rest of the University.
CULTURAL CLIMATE SURVEY

University of Michigan - School of Dentistry

Report about the 2006 Questionnaire Study of
Current and Recently Graduated Students, Staff and Faculty
Concerning the Cultural Climate at the Dental School

c Conducted by the

SOD - Multicultural Initiatives Committee
SOD - Strategic Assessment Facilitating Committee
In collaboration with UM NSF ADVANCE

Report prepared by Marita R. Inglehart

February 15, 2007
BACKGROUND

During the fall of 1993, the administration of the University of Michigan School of Dentistry announced their plans to conduct a cultural audit of this school. Staff, students and faculty members from all different units were asked to volunteer for a committee that would conduct this audit. In February 1994, the Multicultural Initiatives (MCI) Committee was established. It originally consisted of two dental students, one dental hygiene student, one graduate student, three faculty members, four staff persons, and one administrator plus one resource person from the administration. Two consultants from other units in this university, namely from the Department of Sociology and the School of Social Work, were available at all times to assist the Committee with its efforts.

The committee was charged to assess the climate in the School of Dentistry concerning diversity and to come up with a report at the end of a one year period (in Spring 1995) that would (a) provide an assessment of the status quo concerning diversity in the School of Dentistry plus (b) give recommendations for future activities concerning diversity. This activity in the School of Dentistry can be seen in the larger context of the University of Michigan’s Initiative to achieve “excellence through diversity”.

The MCI committee started its activities with a retreat and then collected information from other units in this University who already had conducted cultural audits (such as the School of Public Health, the Library System, the Law School and the School of Social Work) in order to learn how to gather information optimally. It became obvious that data concerning these issues can be collected in different ways - such as with questionnaires, focus groups, interviews, observations or through the analysis of available records - and that each single method has its advantages but also its limitations and problems. It was therefore decided early on to take a multi-method approach, namely (a) to look at available statistics and resources, (2) to analyze the curriculum concerning issues of diversity, (3) to do one questionnaire study early on in the year to assess the attitudes, perceptions and experiences of students, faculty and staff in the School of Dentistry, and (4) one questionnaire study of former patients to assess their experiences in the School of Dentistry, plus (5) to conduct homogeneous focus groups of students, staff and faculty to get a more in depth understanding of cultural issues of concern to these specific groups.

Using this multi-method approach provided the MCI committee with an amount of information that was used to make a comprehensive assessment of the multicultural climate in the University of Michigan School of Dentistry, and to formulate a concrete set of recommendations. Based on these recommendations, the dean established a Multicultural Affairs Committee (MAC) as an advisory committee to the dean and charged this committee to recommend ways to implement the recommendations.

In 2006, the leadership of the School of Dentistry initiated the process of reassessing the cultural climate in the school. A collaboration between the Multicultural Affairs
Committee, the Strategic Assessment Committee and the ADVANCE Program led to a survey of the current and recently graduated students, staff and faculty members of the dental school community.

**OBJECTIVES**

*of the 1994 and 2006 Questionnaire Study of Students, Staff, and Faculty*

After a decision was reached in 1994 which objectives the multicultural audit in the School of Dentistry as a whole should have, a subgroup of these issues was selected and operationalized with questions in the 1994 questionnaire study. The goals of this study were to get a general assessment of how male and female students, staff and faculty members from different ethnic / racial, socio-economic and religious backgrounds with different sexual orientations and physical abilities

(a) perceive the climate in the University of Michigan, and especially in the School of Dentistry,

(b) how they perceived their own situation and which experiences they had had with students, staff, faculty and administrators that came from diverse groups,

(c) which perceptions these respondents had of the treatment and experiences of other persons in the school, and

(d) which recommendations for change these respondents would give concerning diversity issues in the School of Dentistry.

In 2006, two objectives were pursued, namely

(a) to again address the four objectives that were pursued in 1994/95 and thus repeat the original questions from the first cultural audit at the School of Dentistry that were asked in 1994 in order to assess whether change had occurred over the past 12 years, and

(b) to add the questions that are used by the ADVANCE Program at the University of Michigan to assess the climate for female versus male members of the university.

This report provides an overview of the responses to the questions of the original audit that were collected by the end of January 2007. The data collection will continue until March 31, 2007, and a final report will be provided at this point in time.
METHODS
Used in the 1994 and 2006 Questionnaire Study of Students, Staff and Faculty

1994 Student Questionnaire 1: A first short version of a questionnaire for students was developed early in April 1994. The questionnaire started with a short introduction that assured the respondents that their answers would be treated anonymously and would only be reported on an aggregate level that would not allow identifying any particular individual. The actual questions were mostly closed ended questions. Answers to these questions were given on 5 point rating scales. A few open ended questions were included to assess individual perceptions of the curriculum, personal (positive and negative) experiences with diversity, perceptions of potential benefits and recommendations for changes. At the end of the questionnaire, background information concerning the person's gender, age, ethnicity / race, religious denomination, physical ability, sexual orientation and year in school was included. This questionnaire was hand distributed to the graduating senior dental and dental hygiene students after they finished taking their Boards in late April / beginning May of 1994. A letter of support for the questionnaire by Dean Machen accompanied each questionnaire. It was argued that these senior students would have the most experience with the School of Dentistry, plus they would not be concerned with consequences for being critical of the school, because they would have left the school at this point. Therefore, each senior (dental and dental hygiene) student was provided with an envelope containing Dean Machen's letter, a stamped return envelope addressed to the co-chairs of the MCI-Committee plus a questionnaire and was asked to volunteer to answer the questionnaire and mail it back. This procedure assured that this survey did not interfere with their preparation for the Boards or their actual taking of the board exams.

This same questionnaire was mailed to all sophomore and junior dental hygiene students in early May 1994, because these students would otherwise be gone till the end of this summer and might forget valuable information that might be useful in the cultural audit. The D1 students received the questionnaire at the end of a lecture during the first week of classes of the Spring Term 1994 in early May and were asked to volunteer at this point.

1994 Staff and Faculty Questionnaire and Student Questionnaire 2: During the months of May and June 1994, a questionnaire addressing staff and faculty members was developed. It was based on the short questionnaire distributed to some student classes during April and May but included several additional questions. On July 18th, this version of the questionnaire was mailed to all 513 staff and all 173 faculty members in the School of Dentistry. Campus mail envelopes with return labels were attached to the questionnaires to facilitate the return of the questionnaires.

In order to facilitate comparisons between the responses of staff, faculty and students, it was decided to use this longer questionnaire version to survey the remaining students. During July and August of 1994, this questionnaire was hand distributed to the D2 and D3 undergraduate dental classes at the end of some
lectures. At the beginning of the Fall Term 1994, it was mailed to all graduate students.

All data were safeguarded carefully: Access to the raw data was only given to the co-chairs and some research assistants from outside the School of Dentistry who had no contact with anybody in the School of Dentistry. The data were coded and the computer file was not shared with anybody. By not sharing the data file with anybody and only reporting the data on an aggregate level, it was assured that no tracing back of individual responses to certain individuals was possible. Furthermore, any identifying information in the transcript of the open ended responses was erased.

2006/07 Surveys: After the decision was made that the 2006 surveys would be the result of a cooperation between the School of Dentistry’s Multicultural Affairs Committee and Strategic Assessment Committee and the University of Michigan – ADVANCE Program, members of all three groups met and decided which questions should be included in the final new surveys. Given that the two objectives were to (a) repeat as many questions from the 1994 surveys as possible in order to assess change over time, as well as (b) include as many questions from the ADVANCE Survey as possible, it is not surprising that the resulting 2006 surveys were rather long. The exact wording of all questions and answers of the four versions of the survey (for recently graduated students, current students, staff and faculty members) can be found in Part 1 of the attached Tablebook together with the responses to all questions.

A decision was made to again survey recently graduated dental and dental hygiene students as well as all current students, staff and faculty members. However, in contrast to the procedure in 1994 which consisted of distributing hard copies of the survey with return envelopes, a decision was made to administer the surveys in 2006 as web based surveys. A message by the dean of the School of Dentistry was therefore emailed to all members of the dental school community repeatedly. This message informed the recipients about the survey and encouraged participation. It stressed the fact that the participation would be anonymous.

Response rates: By September 31st, 1994, 102 of the 513 staff members (response rate approximately 20%), 53 of the 173 faculty members (response rate approximately 32%) and 196 of the approximately 500 dental hygiene, dental undergraduate and graduate students (response rate approximately 40%) had responded to the questionnaire. By February 1, 2007, 154 staff members (48%), 88 faculty members (26%) and 137 students (29%) had responded to the survey. However, the collection of data will continue until March 31, 2007. It is important to note for the faculty response rate that the maximum number of faculty responding to any of the items included in this preliminary analysis was 52, hence the effective faculty response rate for this preliminary report is 13%. However, the collection of data will continue until March 31, 2007.
RESULTS

Tablebooks: An accompanying Tablebook to this report contains (a) the frequencies of responses to all closed ended questions as well as a transcript of the answers to all open ended questions separately for each of the four surveys (for recently graduated students, for current students, and for staff and faculty members) (Part 1), plus (b) a detailed description of the findings of the responses to the questions which were asked in both 1994 and the 2006 (Part 2). In this second part, four separate tables are provided for the responses to each question. If the question was answered on a rating scale, the average answers were provided, and if the questions had categorical answer responses, frequency of response was provided. The first of the four tables for each question presents the answers of the four groups of respondents in 2006 (3 groups in 1994). The second table provides information concerning the answers of male versus female respondents. The third table informs about the responses of African American, Asian American, European American and respondents from other ethnic / racial backgrounds combined. The fourth table summarizes the findings broken down by type of respondent (student / staff / faculty) and gender. However, this table is incomplete for some of the questions in 2006, because for some questions, no female faculty members responded in this year. The tables also provide the number of responses on which each single average answer is based in parentheses behind these answers plus the level of significance of the differences between the means.

In 1994, the answers to the open ended questions were coded in appropriate categories and the frequencies of answers in these categories were also reported in the 1994 Tablebook. This tablebook was then widely distributed in the School of Dentistry and was available for example from department chairs, key administrators, student representatives, and in the library in the School of Dentistry.

Organization of the findings: This report will present the main findings in four sections.

- Section A summarizes answers concerning the general perception of the situation in the University of Michigan and in the School of Dentistry.

- Section B presents the results concerning the respondents’ own situation, their level of comfort, their personal experiences and their actual behavior.

- Section C focuses on answers concerning perceptions of the situation in which other students, staff, faculty members and patients in the School of Dentistry are, and the perception of their experiences.

- The last section is devoted to presenting the responses concerning the respondents’ general attitudes towards diversity and their actual suggestions for change. In each section the overall average findings as well as any significant differences in the
average answers of the subgroups (such as staff / students / faculty; men / women; persons from different ethnic / racial backgrounds) are reported.

A. Perceptions of the general situation: in 1994, the respondents largely agreed with the statement that the “University of Michigan has an honest interest / concern for diversity” (Question 1). The overall average score was 3.90 on a five-point scale on which “one” indicates strong disagreement with this statement and “five” indicates a strong agreement with this statement. In 2006, the respondents agreed even more strongly with this statement. The overall average response was 4.02. However, considering the answers of sub groups of respondents showed that, on one hand, differences between male and female respondents persisted over time: Women still agree less than men with this statement. On the other hand, one major shift occurred between 1994 and 2006 in the responses of African American participants. While African American participants strongly disagreed with this statement in 1994 (average response 1.21), they agree on average with this statement in 2006 (Mean = 3.92). This finding is quite noteworthy.

The responses concerning the University of Michigan School of Dentistry's concern / interest in diversity (Question 2) parallel the responses to the first question. Again, the overall answers in 1994 (mean = 3.76) showed lower agreement with this statement than the answers in 2006 (mean = 3.92). Again, male respondents are on average more positive than female respondents (4.14 versus 3.90; p=.066). In addition, it is interesting to point out that at both points in time and for both of these questions African American and Asian American respondents showed less agreement than white respondents, and this gap between, e. g., black and white respondents even slightly increased concerning the situation at the School of Dentistry. European American respondents have perceived and still perceive both the University as a whole and the School of Dentistry as more concerned with diversity (1994: 3.91 / 2006: 4.25) than African American respondents (1994: 3.08 / 2006: 3.54), Asian American respondents (1994: 3.14 / 2006: 3.63), and respondents from other groups (3.38 / 3.68).

It is interesting to note that these trends concerning the differences between the answers given by non-white respondents versus the answers of white respondents are repeatedly found throughout this study.

B. Assessment of the respondents' own situation: Three sets of questions were concerned with the respondents' evaluation of their own situation. These sets of questions were concerned with (a) the respondents' sense of feeling comfortable (Questions 8 and 19), with (b) their own experiences concerning their treatment by staff, students, faculty and patients (Questions 7, 11 to 14), and (c) their behavior (Questions 16 and 17 concerning including diversity content into teaching and research; these questions were only asked from faculty respondents).

B1. Comfort level: Overall there was and is a positive response to the statement "I am comfortable working in the School of Dentistry" (Question 19) (1994: 3.92; 2006: 4.19). These average responses show an even more positive response for 2006
when compared to 1994. However, the findings in 2006 show again that European American respondents had relatively more positive responses to this statement (1994: 4.03 / 2006: 4.35) than African American and Asian American respondents (3.30 / 4.00 and 3.25 / 3.60).

The overall pattern of responses found concerning Question 19 is repeated in the answers to the statement "I feel comfortable in going to somebody in a decision-making position in the School with my concern" (Question 8). Again, overall the level of agreement increased from 3.29 in 1994 to 4.00 in 2006. In addition, African American respondents in 2006 showed the strongest agreement with this question (mean = 4.23) which is a very encouraging finding. In addition, it is noteworthy that female students and staff agreed more strongly than male students and staff with this question.

B2. Personal experiences: Some personal experiences are shared by all groups of respondents and at both points in time. Overall, the experiences tend to be more positive in 2006 compared to 1994. Overall, the respondents feel that the staff in the dental school is mostly helpful when they go to them with questions or help (Question 7) (1994: 3.76; 2006: 4.03). However, again, female respondents tend to agree less with this statement compared to male respondents.

The findings concerning personal experiences with unequal treatment by students, (Questions 11a to 11f), faculty (Questions 12a to 12f), staff (Questions 13a to 13f) and patients (Questions 14a to 14f) are very interesting. The answers to these questions concerning how often unequal treatment by members of these different groups were experienced were given on a 5-point scale with "1" indicating "never" and "5" indicating "always". Overall low levels of unequal treatment from students (a) of another gender, (b) of another ethnic / racial background, (c) with a physical disability, (d) with a different sexual orientation, (e) from a different age cohort, and (f) from a different religious background were reported in 1994 and 2006 (means: gender: 1.87/1.73; ethnic/racial background: 1.89/1.85; physical disability: 1.30/1.14; different sexual orientation: 1.38/1.23; different age: 1.55/1.41; different religious background: 1.51/1.41), women report more unequal treatment from male students 1.60 vs. 1.24; p<.001), and African American and Asian American respondents report more unequal treatment from students of another ethnic / racial background 2.17 and 2.19 vs. 1.39; p<.001).

It is interesting that this pattern of answers is repeated for the questions concerning unequal treatment by faculty, staff and even from patients from different groups. While overall a relatively low level of unequal treatment by faculty, staff and patients of another gender, ethnicity / race, ability status, sexual orientation, age group and religious background was and is perceived, there was a trend for female respondents (especially female faculty) to perceive more unequal treatment than male respondents. African American and Asian American respondents perceive more unequal treatment from faculty and staff of another racial / ethnic background than European American respondents.
B3. Behavior concerning diversity issues: Only faculty respondents were asked questions concerning certain behaviors related to diversity issues, specifically how much they agreed with the statements that they include in their own teaching and in their own research issues concerning gender, ethnicity / race, ability status, sexual orientation, age and religious background (Questions 16 and 17). The response rates to these questions were relatively low: Only 41 respondents answered the question concerning teaching in 1994, and only 36 respondents in 2006; only 29 respondents answered the questions concerning including these issues in their research in 1994, and only 36 respondents answered in 2006. Overall, this small self-selected group of respondents seems to vary in their answers from nearly disagreeing to slightly agreeing with these statements that they include these issues in their teaching (means range from 2.34 in 1994 and 2.52 in 2006 for issues concerning sexual orientation to 3.46 in 1994 and 3.66 in 2006 for issues concerning age) and in their research (means range from 2.31 / 2.34 for issues concerning religious matters to 3.31 / 3.05 for issues concerning age). However, among the respondents there are some interesting group differences over time. While in 1994, female respondents were on the average more concerned with these matters than male respondents; this trend cannot be found in 2006, indicating a positive shift in male faculty members’ orientations towards these matters.

C. Perceived experiences of others:

C1. Perceived overall satisfaction of others: It is interesting that all groups of respondents seem to agree that most persons (staff, faculty, students) in the dental school tend to be more satisfied than unsatisfied with the present state of diversity in the School of Dentistry (Question 4) both in 1994 (mean: 3.27) and in 2006 (mean: 3.32). In addition, it was found both in 1994 and in 2006 that the perceptions are that others can feel comfortable in the School of Dentistry regardless of their gender (1994: 3.73 / 2006: 3.89), ethnicity / race (3.59 / 3.63), and ability status (3.64 / 3.63) (Question 18). In 2006, additional statements were added that asked the respondents to indicate their agreement with the statement that persons can be comfortable regardless of their age, sexual orientation, and religious background, and again the level of agreement with these statements was rather high (3.91 / 3.61 / 3.77). However, female respondents agreed less strongly with the statement that persons can be comfortable in the school independent of their gender compared to male respondents; African American respondents indicated less agreement with the statement that persons can feel comfortable regardless of their ethnicity / race compared to non African American respondents. One positive change in response to this last question was the fact that while Asian American respondents had the lowest agreement with this statement in 1994 (Asian American: 2.50 / African American: 3.00 / European American: 3.81), this was not the case in 2006. Asian American still indicated lower agreement than European American respondents. However, their agreement level had significantly increased from 2.50 in 1994 to 3.44 in 2006.

C2. Perceived experiences of students: The overall perception concerning encouragement for students to pursue career development independent of certain group characteristics such as gender, ethnicity / race, and ability status (Question 6)
had been quite positive in 1994, and was even more positive in 2006. The respondents indicated both in 1994 and in 2006 that on average students are equally encouraged to pursue their career development independent of their gender (1994: 3.38 / 2006: 3.76), ethnic / racial background (3.58 / 3.72), their physical ability (3.62 / 2.59), their sexual orientation (3.58 / 3.72), their age (3.58 / 3.79), and their religious background (3.71 / 3.77). However, again there are differences in the responses of members of certain groups. Women perceived a lower level of equal support for male and female students (female respondents in 1994 / 2006: 3.15 / 3.61 vs. male respondents in 1994 / 2006: 3.57 / 3.98) than male respondents. However, the gap in the perceptions of African American vs. Asian American vs. European American respondents seems to close over the years.

The responses concerning the statements that the curriculum prepares the students well to work with diverse patients independent of the patient’s group characteristics (Question 15) were already quite positive in 1994, and are now answered even more positively by the faculty. However, female faculty respondents on the average tended to agree with most of these statements less than male faculty, and show especially low agreement with the statement concerning treating patients with different sexual orientations in 2007 (male respondents 1994 / 2006: 3.21 / 3.71 vs. female respondents 1994 / 2006: 3.09 / 3.72).

It is interesting to analyze the open-ended answers concerning the questions which positive and negative experiences the students had, because they describe both positive instances such as observing attempts to raise awareness concerning diversity related matters as well as negative incidents of homophobia, sexism and racism. On the positive side, many instances of positive experiences both with curricular events such as the orientation session and experiences in specific classes as well as with extracurricular activities such as the Tastefest are reported. However, reading through the open ended answers concerning negative experiences - which are verbatim presented in Part 1 of the Tablebook - is a shocking and painful reality check for those community members who are unaware of incidents of discrimination and prejudiced behavior (see for example the student responses on p. 16ff. in the tablebook).

C3. Perceived experiences of patients: Overall, the respondents agreed even more strongly in 2006 than in 1994 with the statement that the School of Dentistry provides an environment for patients that is sensitive and affirming to differences by gender (1994: 3.74 / 2006: 4.15), ethnicity / race (3.67 / 4.15), physical ability status (3.63 / 3.89), sexual orientation (3.61 / 4.0), age (3.74 / 3.92), religious (3.74 / 4.04) and socio-economic background (3.64 / 3.96) (Question 20).

Responses concerning the statements of perceptions of unequal treatment of patients by students (Question 21) and by faculty (Question 23) indicate that on the average the respondents perceived that patients independent of their social characteristics are treated well. The answers to these questions were given on 5 point answer scales with 1 = “never” and 5 = “always”. On average, the respondents indicated that they rarely observed unequal treatment of a patient by a student
provider based on the patient’s gender (1994: 1.64 / 2006: 1.40), the patient’s ethnic / racial background (1.73 / 1.51), physical ability (1.55 / 1.39), sexual orientation (1.60 / 1.31), age (1.56 / 1.42) or religious background (1.41 / 1.30).

The questions concerning the respondents’ agreement with statements concerning whether faculty members provide equal treatment of patients independent of their group characteristics were also answered in a positive manner. The answers to these questions were again given on 5 point answer scales with 1 = “disagree strongly” and 5 = “agree strongly”. Overall, the responses were close to an average answer of 4 at both points in time and for nearly all patient groups, with the exception of patients from different socio economic backgrounds. This question resulted in a slightly lower response of 3.84 in 1994 and 3.89 in 2006.

C4. Perceived treatment of healthcare providers by patients: On the average, the respondents perceived infrequent discrimination against healthcare providers from patients both in 1994 and 2006 (Question 22). The responses to these questions how frequently the respondents observed unequal treatment of a healthcare provider by a patient based on the provider’s social characteristics were on average between 1.5 and 2 on a 5 point answer scale with 1 indicating “never” and 5 indicating “always”. However, two interesting trends can be observed when comparing the responses in 1994 and 2006 and the responses of participants from different groups. It seems as if European American respondents became more aware equal treatment of men and women and of providers from different ethnic / racial backgrounds in 2006 compared to 1994. In addition, female providers perceived less equal treatment of healthcare providers as a function of the provider’s gender. While Asian American respondents perceived less equal treatment of providers based on their ethnicity / race in 2006 compared to 1994 (1994: 1.75 / 2006: 2.60), African American respondents’ observation improved slightly (3.00 vs. 2.25).

C5. Responsiveness of administration: While the administration is overall seen as being responsive to faculty (1994: 3.52 / 2006: 3.40), staff (1994: 3.11 / 2006: 3.40), and students (1994: 3.24 / 2006: 3.56) (answer scale: 1= “disagree strongly” to 5 = “agree strongly”; see Question 9a, b, and c), different groups of persons largely disagree on the degree to which they perceive such support: Female respondents saw significantly less responsiveness on the administration’s side towards faculty than male respondents in 2006 (female respondents - 1994: 3.61 vs. 2006: 3.37; male respondents - 1994: 3.52 / 2006: 3.72). A big shift occurred in the responses of female staff members: while they perceived in 1994 that the administration was very supportive of faculty (mean = 4.21), they had a significantly less positive perception in 2006 (mean = 3.59). However, the opposite trend was found concerning staff members’ responses to the statement “I feel that the administration is responsive to staff”. While this perception was relatively low in 1994 (Mean = 2.70), the 2006 responses were more positive (Mean = 3.35). A shift in responses from 1994 to 2006 occurred also for the female respondents concerning the perceived support for faculty. While female respondents were more positive in 1994 than male respondents concerning the administration’s responsiveness to faculty members
(1994 / 2006: Male respondents = 3.52 / 3.72; female respondents = 3.61 / 3.27), they were less positive in 2006.

**D. Attitudes towards diversity and suggestions for changes:** The average answer to the question if a need for a diversity program in the School of Dentistry (Question 3) exists was on the positive side in 1994 (mean = 3.26) and was only slightly more positive in 2006 (mean = 3.36). While female respondents saw less of a need for such a program in 1994 (female = 3.19; male = 3.34), they now express about the same degree of support for such a program (3.34 / 3.35). In addition it is interesting to note that while in 1994 African American respondents (mean = 4.17) and Asian American respondents (mean = 4.14) were already more supportive of such a program than European American respondents (mean = 3.13), in 2006 African American respondents were even more supportive (mean = 4.54), while Asian American respondents were less supportive (mean = 3.69) and European Americans were the least supportive of all three groups again (mean = 3.28).

Overall, the respondents take a neutral attitude towards the statement that there is a need for more diversity in supervisory and administrative positions (Question 5a), in the student body (Question 5b), in the staff (Question 5c), and faculty (Question 5d) (1994: means = 3.25 / 2.88 / 3.03 / 3.27; 2006: 3.13 / 3.11 / 3.06 / 3.16). However, while male respondents perceive less of a need for diversity in supervisory and administrative positions in 2006 compared to 1994 (3.24 vs. 2.85), female respondents perceive the same need at both points in time (3.31 / 3.31). African American respondents already had perceived the highest need for more diversity in all four groups in 1994 and increased their perceptions of a need for diversity even more in 2006 (1994 / 2006: supervisory and administrative positions = 4.36 / 4.62; students = 3.82 / 4.15; staff = 3.64 / 4.54; faculty = 4.27 / 4.46). This pattern of responses was reversed for Asian American respondents who had perceived relatively high need for more diversity in all four groups in 1994 and were relatively lower in their responses in 2006 (1994 / 2006: supervisory and administrative positions = 4.14 / 3.56; students = 4.14 / 3.31; staff = 4.29 / 3.38; faculty = 4.43 / 3.50).

Answers to the open-ended questions concerning the benefits of diversity (Question 27) and the changes concerning diversity that should be made (Question 28 and 29) provide interesting insights: The most frequent response concerning the benefits of an ongoing diversity program in the school of dentistry were seen in reducing prejudice, and increasing knowledge and respect for others, as well as improving communication. However, it should be noted that some respondents made it clear that they did not perceive a need for a diversity program.

The answers to the question what the school of dentistry could do to address diversity issues (Question 28) were also quite interesting. Organizing programs and speakers, organizing discussions for all, and identify problems and address them were among the most frequent suggestions. These topics were also reflected in the responses to the questions which three things the respondents would change (Question 29). The open ended answers reflect that a very wide variety of opinions concerning these issues exists among members of the dental school community.
ranging from being absolutely negative towards these matters to being absolutely supportive of diversity and having very imaginative and creative suggestions. A detailed analysis of these responses after the end of the data collection on March 31, 2007, will be quite instructive not only about the status quo, but also which recommendations for the future can be made.

**DISCUSSION**

There are two main problems when interpreting these results. The first problem is that the **response rate** which was already relatively low in 1994 (Only 20% of staff, 32% of faculty and 40% of students), was even lower for students (29%) and faculty (26%) in 2006. In addition, most respondents did not respond to all questions of these very long surveys in 2006, resulting in even smaller response rates for some questions. Because the maximum number of faculty responding to any of the items included in this preliminary analysis was 52, the effective faculty response rate for this preliminary report is 13%. For a population study, these response rates are unacceptable. One can speculate about the reasons for such a low response rate. One argument might be that the interest in the topic of diversity is rather low and that some persons might perceive filling out a questionnaire concerning these issues as a waste of time. A second reason for a low response rate in 2006 could be the length of the surveys. The surveys were unusually long. Finally, a third reason might be that the level of trust of potential respondents is low - which might make them hesitant to respond. Especially when a survey is web based, a lack of trust could lead to speculations concerning the anonymity of the responses.

This third argument might actually be connected with the second problem found when interpreting the data. Quite a number of respondents refused to provide their **background information**. Refusing to provide background information can be interpreted as a sign of concern about the possibility to trace back responses to certain respondents.

On the positive side one might argue that both the low response rate plus the high degree to which personal background information was withheld are valuable pieces of information in themselves when assessing the cultural climate in the School of Dentistry. They indicate that interest and open support for activities concerning diversity in the School of Dentistry might be relatively low and not forthcoming and that any implementations of changes have to be planned carefully.

On the negative side it becomes obvious that these two problems stand in the way of optimally assessing the cultural climate in the University of Michigan School of Dentistry. Any conclusions drawn are based on a limited sample of respondents and have to be treated as such. However, one has to keep in mind that this study is not primarily research centered. There will be no attempts made to generalize these findings from these respondents to persons in other dental schools or academic organizations. The sole purpose of this study is to understand how persons in this one particular organizational unit perceive issues of diversity. With this clear focus in mind one can use these data as partial evidence and argue that they provide
valuable insights. However, it is important to understand that these results cannot
be seen as being representative for the populations of students, staff and faculty in the
University of Michigan – School of Dentistry as a whole. They reflect the
perceptions and experiences of one specific group of persons in the School of
Dentistry, namely those persons who were willing to take the time to fill out the
questionnaire in 1994 and 2006. Making comparisons between 1994 and 2006 can
therefore be quite interesting.

These comparisons show on one hand an improvement of trust into the University of
Michigan as a whole and the School of Dentistry specifically concerning their honest
concern for diversity. However, both in 1994 and in 2006, the personal experiences,
perceptions of others, and thoughts concerning diversity and change differ
significantly between male and female respondents and between, especially African
American and European American respondents. In 2006, as was the case in 1994,
personal experiences differ greatly as a function of a person’s gender and ethnicity /
race. It seems that African American respondents became even more aware of the
need for changes in 2006 compared to 1994, while European American respondents
did not change their views that dramatically. In addition, while in 2006, only
students were asked a question concerning their membership with respect to sexual
orientation, age and ability status, a comparison of responses in 1994 had made a
very clear point that differences in age, sexual orientation and ability status were
crucial determinants of personal experiences and observations of others.

Overall, this report should be interpreted as a preliminary report, because the data
collection efforts are continuing until March 31st, 2007. No in depth analyses of open
ended responses have therefore be conducted at this time. However, the trends in
the responses of different groups of respondents and a comparison of the responses
from 1994 and 2006 can provide a preliminary insight into the current situation at
the University of Michigan – School of Dentistry concerning the cultural climate in
this unit.
Table 1: Significant differences in the average answers of students, staff and faculty respondents

<table>
<thead>
<tr>
<th>Question</th>
<th>students</th>
<th>staff</th>
<th>faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think there should be more diversity in the faculty.</td>
<td>2.91</td>
<td>3.23</td>
<td>3.30**</td>
</tr>
<tr>
<td>Faculty encourage students equally to pursue career development</td>
<td>3.88</td>
<td>3.45</td>
<td>4.00**</td>
</tr>
<tr>
<td>independent of their gender.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faculty encourage students equally to pursue career development</td>
<td>3.84</td>
<td>3.43</td>
<td>3.91**</td>
</tr>
<tr>
<td>independent of their ethic/racial background.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faculty encourage students equally to pursue career development</td>
<td>3.65</td>
<td>3.43</td>
<td>3.78**</td>
</tr>
<tr>
<td>independent of their physical abilities.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faculty encourage students equally to pursue career development</td>
<td>3.77</td>
<td>3.48</td>
<td>3.83**</td>
</tr>
<tr>
<td>independent of their sexual orientation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faculty encourage students equally to pursue career development</td>
<td>3.94</td>
<td>3.44</td>
<td>3.90**</td>
</tr>
<tr>
<td>independent of their age.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faculty encourage students equally to pursue career development</td>
<td>3.89</td>
<td>3.49</td>
<td>3.91**</td>
</tr>
<tr>
<td>independent of their religious background.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The staff in general in the SOD are helpful to me when I go to them</td>
<td>4.09</td>
<td>3.96</td>
<td>4.38**</td>
</tr>
<tr>
<td>for help or with questions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel that in general a good relationship exists among students.</td>
<td>3.99</td>
<td>3.69</td>
<td>3.36***</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 1 continued: Significant differences in the average answers of students, staff and faculty respondents

<table>
<thead>
<tr>
<th>Question</th>
<th>students</th>
<th>staff</th>
<th>faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often have you experienced unequal treatment from students?</td>
<td>1.47</td>
<td>1.36</td>
<td>1.68***</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from students of another ethnic/racial group?</td>
<td>1.80</td>
<td>1.39</td>
<td>1.59***</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from students of a different sexual orientation?</td>
<td>1.11</td>
<td>1.17</td>
<td>1.11***</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from staff?</td>
<td>1.21</td>
<td>1.50</td>
<td>1.22***</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from staff of another ethnic/racial background?</td>
<td>1.23</td>
<td>1.51</td>
<td>1.36***</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from staff of a different age group?</td>
<td>1.09</td>
<td>1.44</td>
<td>1.18***</td>
</tr>
</tbody>
</table>

Legend:
Please note that the answers were given on an answer scale from 1 = “disagree strongly” to 5 = “agree strongly”.

+ = (p<.10);  * = (p<.05); ** = (p<.01); ***= (p<.001)
Table 2: Significant differences between male and female respondents

<table>
<thead>
<tr>
<th>Question</th>
<th>Male</th>
<th>Female</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>I believe that the School of Dentistry has an honest interest/concern for diversity in the School of Dentistry.</td>
<td>4.14</td>
<td>3.90</td>
<td>.066</td>
</tr>
<tr>
<td>I think there should be more diversity in supervisory and administrative positions.</td>
<td>2.85</td>
<td>3.31</td>
<td>.001</td>
</tr>
<tr>
<td>I think there should be more diversity in the student body.</td>
<td>2.71</td>
<td>3.09</td>
<td>.004</td>
</tr>
<tr>
<td>I think there should be more diversity in the staff.</td>
<td>2.79</td>
<td>3.20</td>
<td>.003</td>
</tr>
<tr>
<td>I think there should be more diversity in the faculty.</td>
<td>2.88</td>
<td>3.28</td>
<td>.004</td>
</tr>
<tr>
<td>Faculty encourage students equally to pursue career development independent of their gender.</td>
<td>3.98</td>
<td>3.61</td>
<td>.003</td>
</tr>
<tr>
<td>Faculty encourage students equally to pursue career development independent of their ethnic/racial background.</td>
<td>3.92</td>
<td>3.57</td>
<td>.005</td>
</tr>
<tr>
<td>Faculty encourage students equally to pursue career development independent of their physical abilities.</td>
<td>3.79</td>
<td>3.44</td>
<td>.002</td>
</tr>
<tr>
<td>Faculty encourage students equally to pursue career development independent of their sexual orientation.</td>
<td>3.87</td>
<td>3.56</td>
<td>.007</td>
</tr>
<tr>
<td>Faculty encourage students equally to pursue career development independent of their age.</td>
<td>3.95</td>
<td>3.62</td>
<td>.003</td>
</tr>
</tbody>
</table>
Table 2 continued: Significant differences between male and female respondents

<table>
<thead>
<tr>
<th>Question:</th>
<th>Male</th>
<th>Female</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faculty encourage students equally to pursue career development independent of their religious background.</td>
<td>3.97</td>
<td>3.60</td>
<td>.001</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from faculty?</td>
<td>1.39</td>
<td>1.78</td>
<td>.001</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from faculty of another religious background?</td>
<td>1.31</td>
<td>1.44</td>
<td>.078</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from students?</td>
<td>1.24</td>
<td>1.60</td>
<td>.000</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from students from a different age group?</td>
<td>1.16</td>
<td>1.32</td>
<td>.028</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from staff of another religious background?</td>
<td>1.25</td>
<td>1.43</td>
<td>.048</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from staff of a different age group?</td>
<td>1.11</td>
<td>1.32</td>
<td>.005</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from students from a different religious background?</td>
<td>1.08</td>
<td>1.22</td>
<td>.017</td>
</tr>
<tr>
<td>How often have you observed unequal treatment of a healthcare provider by a patient based on the provider’s - socioeconomic background.</td>
<td>1.52</td>
<td>1.43</td>
<td>.043</td>
</tr>
<tr>
<td>- racial/ethnic identification.</td>
<td>4.16</td>
<td>4.62</td>
<td>.018</td>
</tr>
<tr>
<td>How often have you observed unequal treatment of a patient by a student provider based on the patient’s gender?</td>
<td>1.35</td>
<td>1.82</td>
<td>.087</td>
</tr>
</tbody>
</table>
Table 2 continued: Significant differences between male and female respondents

<table>
<thead>
<tr>
<th>Question:</th>
<th>Male</th>
<th>Female</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>The curriculum prepares students very well to work with patients with different sexual orientation.</td>
<td>3.72</td>
<td>3.09</td>
<td>.055</td>
</tr>
<tr>
<td>I include in my own teachings issues concerning ethnic/racial backgrounds.</td>
<td>3.64</td>
<td>2.64</td>
<td>.002</td>
</tr>
</tbody>
</table>

Legend:
Please note that the answers were given on an answer scale from 1 = “disagree strongly” to 5 = “agree strongly”.
### Table 3: Significant differences in the average answers of African American, Asian American, European American respondents and respondents from other ethnic/racial backgrounds

<table>
<thead>
<tr>
<th>Question</th>
<th>African American</th>
<th>Asian American</th>
<th>European American</th>
<th>other</th>
</tr>
</thead>
<tbody>
<tr>
<td>I believe that most persons (faculty, staff, and students) are satisfied with the present state of diversity in the School of Dentistry.</td>
<td>3.15</td>
<td>3.63</td>
<td>3.57</td>
<td>3.16*</td>
</tr>
<tr>
<td>I think there should be more diversity in supervisory and administrative positions.</td>
<td>4.62</td>
<td>3.56</td>
<td>2.92</td>
<td>3.28***</td>
</tr>
<tr>
<td>I think there should be more diversity in the student body.</td>
<td>4.15</td>
<td>3.31</td>
<td>2.76</td>
<td>3.10***</td>
</tr>
<tr>
<td>I think there should be more diversity in the staff.</td>
<td>4.54</td>
<td>3.38</td>
<td>2.86</td>
<td>3.16***</td>
</tr>
<tr>
<td>I think there should be more diversity in the faculty.</td>
<td>4.46</td>
<td>3.50</td>
<td>2.97</td>
<td>3.16***</td>
</tr>
<tr>
<td>The staff in general in the SOD are helpful to me when I go to them for help or with questions.</td>
<td>4.23</td>
<td>4.14</td>
<td>4.26</td>
<td>3.79**</td>
</tr>
<tr>
<td>I feel that the administration is responsive to students.</td>
<td>4.00</td>
<td>3.50</td>
<td>3.64</td>
<td>3.10**</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from faculty of another ethnic/racial group?</td>
<td>2.08</td>
<td>2.00</td>
<td>1.35</td>
<td>1.84***</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from a different age group?</td>
<td>1.42</td>
<td>1.19</td>
<td>1.31</td>
<td>1.54**</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from students?</td>
<td>1.75</td>
<td>1.69</td>
<td>1.30</td>
<td>1.67***</td>
</tr>
</tbody>
</table>
Table 3 continued: Significant differences in the average answers of African American, Asian American, European American respondents and respondents from other ethnic/racial backgrounds

<table>
<thead>
<tr>
<th>Question</th>
<th>African American</th>
<th>Asian American</th>
<th>European American</th>
<th>other</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often have you experienced unequal treatment from students of another ethnic/racial group?</td>
<td>2.17</td>
<td>2.19</td>
<td>1.39</td>
<td>1.74***</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from staff?</td>
<td>1.42</td>
<td>1.25</td>
<td>1.17</td>
<td>1.50**</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from staff of another religious background?</td>
<td>1.42</td>
<td>1.69</td>
<td>1.74</td>
<td>1.61**</td>
</tr>
<tr>
<td>It is easy to feel comfortable in this school for persons regardless of their ethnic/racial background.</td>
<td>3.00</td>
<td>3.44</td>
<td>3.91</td>
<td>3.61**</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from patients?</td>
<td>3.00</td>
<td>1.00</td>
<td>1.32</td>
<td>2.00***</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from patients of a different ethnic/racial background.</td>
<td>3.00</td>
<td>2.00</td>
<td>1.32</td>
<td>2.20**</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from patients with a disability?</td>
<td>3.00</td>
<td>1.00</td>
<td>1.14</td>
<td>1.60***</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from patients of a different sexual orientation?</td>
<td>3.00</td>
<td>1.00</td>
<td>1.14</td>
<td>1.20***</td>
</tr>
</tbody>
</table>
Table 3 continued: Significant differences in the average answers of African American, Asian American, European American respondents and respondents from other ethnic / racial backgrounds

<table>
<thead>
<tr>
<th>Question:</th>
<th>African American</th>
<th>Asian American</th>
<th>European American</th>
<th>other</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often have you experienced unequal treatment from patients of a different age group?</td>
<td>3.00</td>
<td>1.00</td>
<td>1.23</td>
<td>2.00***</td>
</tr>
<tr>
<td>How often have you experienced unequal treatment from patients of a different religious background?</td>
<td>3.00</td>
<td>1.00</td>
<td>1.32</td>
<td>1.20**</td>
</tr>
</tbody>
</table>

Legend:
Please note that the answers were given on an answer scale from 1 = “disagree strongly” to 5 = “agree strongly”.

+ = (p<.10);  * = (p<.05);  ** = (p<.01);  *** = (p<.001)
Appendix 5

Chronology of SAFCo Activities and Accomplishments to Date

The following is a chronology of strategic assessment activities leading up to the current Topic Specific Discussion Group (TSDG) reports and this report draft:

- **February 2005.** Dean Polverini convened SAFCo.
- **March 2005.** SAFCo began meeting regularly to plan for the strategic assessment.
- **April 24 through 24, 2005.** SAFCo retreat #1 was held, facilitated by organizational development consultant Susan Rosenthal-Kraus, to accomplish several end results including:
  - SAFCo team building to effectively conduct the strategic assessment;
  - Declaration of SAFCo values for conducting the assessment;
  - Development of skills for SAFCo members to engage the UMSD community in meaningful dialogue for the strategic assessment;
  - Initial consideration of strategic goals/directions/initiatives for establishing a starting point and foundation for conducting the qualitative and quantitative components of the strategic assessment;
  - Dialogue on Dean Polverini’s view of the state of the School and his preliminary vision of challenges and opportunities for its future.
- **June 27, 2005.** SAFCo retreat #2 was held to plan the formal informational and invitation sessions to engage the UMSD community in the strategic assessment.
- **September 2005.** SAFCo held formal strategic assessment informational and invitation sessions between September 27 and 29, 2005, to formally engage the School of Dentistry community in the strategic assessment. A video recording of the presentation is available on the School of Dentistry’s intranet (https://intranet.dent.umich.edu/SAFCO/). The purpose of those sessions was to:
  - Inform the School of Dentistry’s community that we were conducting the strategic assessment and to invite the members of the community to participate fully;
  - Provide a general overview of the strategic assessment process;
  - Provide examples of how the School of Dentistry’s community would be involved;
  - Create enthusiasm for the assessment and fully engage the School of Dentistry’s community in the assessment process;
  - Provide sources of documentation about where one could get additional information about the assessment; and
  - Provide a venue to answer questions about the assessment (a link on the School of Dentistry intranet).
- **Nov 2005 through Jan 2006.** SAFCo established an initial set of three questions to be addressed in discussion groups and focus groups with different units and members of the School’s community. These three questions were placed on the intranet for anonymous, web-based responses and anonymous drop boxes were placed in three locations throughout the UMSD for individuals to leave hard copies of questions or responses. The questions were:
1. What is the most compelling topic of conversation that you think should be discussed if the School is going to be a leader in dental education?

   - Discussed by students…
   - Discussed by staff…
   - Discussed by research faculty…
   - Discussed by clinical faculty…
   - Discussed by administrators…
   - Discussed by the entire community…

2. If you had the power to make changes, what proposals would you make?  (Note: for proposals, we made it clear that we would be not be judging any proposals, just getting an understanding of any proposals offered)

3. If the School were to make a quantum leap in each of these areas, what would the leap be?

   - Educational Programs and Alumni
   - Scholarship and Discovery
   - Organization and Infrastructure
   - Culture and Climate
   - External Relationships and Service

- Dec 2005 through Jan 2006. Additional qualitative assessment information attained through conducting discussion and focus groups with various units and members of the UMDS community. SAFCo contacted unit administrators, department chairs, student organizations, faculty, staff and students to invite them to convene participants for in-depth discussions. The participating groups that provided valuable input into the qualitative assessment included the following:

   - Clinic Business Office (CBO)
   - Community Dental Center staff
   - Dental Faculty Associates Staff
   - Dental Informatics
   - Dental Roundtable
   - Department Administrators
   - Dispensing Staff
   - Information Desk
   - Michigan Center for Oral Health Research (MCOHR)
   - Patient Business Office (PBO)
   - Patient Care Coordinators
   - Patient Services
   - Pediatric Dentistry Staff
   - Student Council

- December 2005 through April 2006. Established topic specific discussion groups (TSDG): Eight TSDGs explored their assigned topics in-depth on where the School was at that time and where it should be in five to ten years. TSDG participants were also asked to compare our institution to the best of our peer institutions or outstanding
businesses and other organizations that represented excellence as it related to each of the eight topics. The topics were:

- Clinical Operations
- Curriculum
- External Relations
- Faculty
- Organizational Structure
- Research
- Staff
- Students

SAFCo asked the UMSD community to recommend individuals with expertise and insight to serve on each of the topic-specific discussion groups. After convening the eight topic-specific discussion groups based on the UMSD community’s recommendations, all interested members of the UMSD community were invited to participate in any or all of the TSDG group meetings and activities. The TSDG produced reports that served as a major source for the identification of compelling strategic and operational issues that must be addressed. The elements of the TSDG process included:

- Dialogue and Research on the Specific Topic
- Identification of Critical Focus Areas or Issues
- Proposal of a Vision for our School’s Future
- Indication of Strategic Imperatives for Action
- Definition of Requirements for Successful Implementation of Critical Actions
- Preparation of a Written Report to help Shape and Contribute to our School’s Strategic Assessment Report to the Provost

The full text of each TSDG report may be found in the following Appendices:

- Appendix 4: Students
- Appendix 5: Faculty
- Appendix 6: Staff
- Appendix 7: Curriculum
- Appendix 8: Clinical Operations
- Appendix 9: Research
- Appendix 10: External Relations
- Appendix 11: Organizational Structure

- July 27 and 28, 2006. The Macy Study Group provided a series of presentations to the UMSD community in a half-day symposium on July 27 entitled, “Challenges Facing the Financial Structure and System of Dental Education.” On July 28, the Macy Study Group met for a full day session with SAFCo, deans, directors, chairs, Executive Committee, and other members of the UMSD leadership. The purpose of the Friday session was to discuss progress of the UMSD strategic assessment, how to apply the Macy Study Group’s financial findings to UMSD, and to discuss the implications of the Macy Group’s findings for models of curriculum design, clinical operations and clinical education at UMSD.
The Macy Study Group’s presentations were video-recorded; the recording of their audio, video and PowerPoint slides of the Macy Group’s presentation are provided at the UMumd strategic assessment intranet site URL: https://intranet.dent.umich.edu/SAFCO/. Additional details of the Macy Study Group and their visit are provided in Appendix 12.

- **September 29-30, 2006.** Retreat on the clinical education program led to identification of potential models and creation of a design team charged to initiate in-depth development and consideration of detailed models for the clinical educational program transformation. Based on discussions from this retreat and initial findings of the strategic assessment, Dean Polverini charged a working group with the responsibility of developing proposals for new clinical education models.

- **November 10, 2006.** Retreat on faculty funding models to dialogue and identify the critical factors to consider in the development of a sustainable model for the support of faculty salaries and incentives. Based on discussions from this retreat and initial findings of the strategic assessment, Dean Polverini charged a working group with the responsibility of developing proposals for new faculty funding models.

- **January 25 and 29, 2007.** Three UMumd community forums to discuss the strategic assessment draft report findings, strategic imperatives, and proposed statements for shared vision.

- **February 2007.** Administrative retreat (deans and chairs) to begin dialogue on clinical, educational and research space planning needs.

- **February 2007.** SAFCo reviews and revises the draft report, shared vision, and strategic imperatives based on feedback from UMumd community.
Student Topic Specific Discussion Group  Final Report

I. What are the key issues facing us in this topic area?

As the Student Topic Specific Discussion group began its discussion about life for students and residents at the University of Michigan School of Dentistry, certain issues surfaced that emphasized both the dental school’s strengths and weaknesses. Our meetings ranged in attendance from 6 to 21 students, residents, faculty, facilitators and administrators. All agreed that the dental school has certain strengths that can be built upon. Those strengths include the school’s population of dedicated faculty, wonderful pre-clinical resources, early experiences in clinic as designed by the Vertically Integrated Clinic, extensive resources (such as many graduate programs, research, and the library), interaction among classes and between hygiene and dental students, and opportunities for participation in the admissions process. Overall, everyone was in accordance that the dental school is among the best in the country and that it provides an outstanding environment for clinical training, research experiences, and teaching opportunities.

Though students generally feel the dental school is strong in many areas, there were also areas of improvement that students believe, if addressed, would further strengthen an already strong dental education program. These areas were broad in range and the discussion groups spent the majority of time raising and discussing these issues. The first of these issues was related to the existing clinical and didactic grading mechanisms. Students and residents both felt that the current system of evaluation, both in and out of clinic, would benefit from restructuring. Additionally, many students expressed the need for a better overall system for providing remediation for those students who do not demonstrate proficiency in certain required competencies.

With respect to course evaluations, many students expressed the sentiment that students do not believe they have an adequate voice. While speaking with more senior students about concerns with certain courses, many beginning students hear that these students experienced some of the same frustrations with these courses. This fosters a feeling in the students that their input through course evaluations is not seriously considered and, in turn, can result in their harboring negative attitudes about administrative processes.

Students realize that there is a shortage of faculty and that some have outside commitments. Students also realize that faculty do not receive monetary compensation comparable to that received in private practice. This is indeed one reason why most graduates do not choose to go into academics. Due to the debt accrued from their dental education, many individuals find it difficult to pursue a career in academics after graduation.

There are some issues that are specific to the residents of the graduate programs. Overall, being affiliated with Rackham does not seem to have tangible benefits for dental graduate students/residents because there are issues unique to dental residents as distinct from other graduate students within other departments and units of the University. Currently, there is a grading system in residency programs which residents feel is unnecessary (i.e. medical residents do not receive grades).

The final major hindrance to a positive culture and climate for students at the
School of Dentistry is the competitive nature that is espoused. Generally, the culture of dental schools promotes individuality, which can breed tension among members of the dental community.

II. Which of the key issues raised do we need to make a priority and want to make a commitment to address?

The main areas that students believe need to be addressed are evaluations (clinic and didactic grading of students, progress assessments, as well as course evaluations), electives, culture and climate, opportunities for remediation, increased communication, financial burden, clinic organization, and community outreach/external rotations.

III. How are we currently positioned to address these key issues?

Students and residents desire that the dental school be a place where students are encouraged to learn for the sake of learning. The faculty as well as the students are significant strengths of the school and favorably position it to address the priority issues raised. Yet, in order to effectively deal with these issues, it is imperative that faculty and students work together to reach resolutions to these very challenging and complex issues.

IV. What are the consequences of not addressing those key issues?

Consequences of not addressing such key issues include: decrease in student morale; loss of learning opportunities; clinics that are not patient centered; further interdisciplinary disconnect.

V. How do we measure up to the best of our peer institutions or other outstanding organizations in performance on the key issues?

Simple changes that the school can make will distinguish the school amongst its peers. Such changes include moving towards a Pass/Fail system and increasing community health projects both locally and internationally.

VI. How do these key issues match the broader core values of the University?

These key issues address the first and third points of the Dental School Mission Statement - “Educate oral health professionals and researchers in a model health care facility where students and clinicians emulate the highest standards of patient-centered care and acquire the most advanced knowledge and skills to meet the changing needs of a diverse patient population;” and “the University, the community, and the profession through the sharing of knowledge, participation in professional activities, and the establishment of linkages to promote innovation, and to encourage and address diversity in research, education, patient care, and health policy”. The University of Michigan strives to be a leader in education. Generally, both the University of Michigan and the School of Dentistry value interdisciplinary approaches to teaching and are committed to producing ethical professionals.

VII. What changes would we like to see implemented

Students truly believe that implementing a Pass/Fail grading system for both clinic and classroom would be more conducive to learning. Electives for classes in the third and fourth years such as Practice Management and Grant writing, Special Patient
Care, Geriatrics, and International External Rotations should be offered. This would allow students to have a basic understanding of all topics from mandatory core classes followed by more in-depth study in areas that interest them.

Graduate programs would gain from separation (or modification of current system) from Rackham. There are currently many issues that the dental residents encounter that are not addressed by Rackham because the issues are specific to dental graduate students (dental graduate students are distinctly different from “traditional” graduate students of the University, for which Rackham is structured to serve). Many residents also desired more feedback mechanisms and greater interaction among residents, directors, and chairs. There is a need for better interdisciplinary relationships, and finally, for retention and recruitment, many residents felt full-time faculty should be able to participate in private practice outside the dental school (i.e. flexible appointment arrangements).

Overall, the students really embraced the opportunity to participate in the SAFCo Topic Specific Discussion groups and felt that these types of forums for communication should occur on a regular basis, long after the Strategic Assessment has been complete. These sessions would serve dual functions in that they would allow the school to continue to identify/monitor “key” issues and it would enhance/facilitate better communication between students and other members of the dental school community (faculty, administration, staff).
Faculty Topic Specific Discussion Group

Group Leaders: Lynn Johnson and George Taylor
Group Recorder: Ana Iacob
Participants: Monte Brown, Dan Chiego, HA Hamerink, GR Holland, Jan Hu, Keith Kirkwood, Deb Keedy, Christine Klausner, Kenneth May, Mary Ellen McLean, Jim McNamara, Hal Okray, Renee Ruff, Barbara J. Smith, Mark Snyder, Kenneth Stoffers, Russel Taichman, Ruwaida Tottla

The Faculty Topic-Specific Discussion Group was really two independent sub-groups. Each sub-group met weekly, either on Mondays or Wednesdays, for a total of 9 meetings. The minutes for these meetings are found in Appendix F—Meeting Minutes.

The two sub-groups initially had the same agenda. They each identified the key faculty issues that either we are or might be facing in the next 5-10 years. They then examined separate issues in detail.

I. What are the key issues facing us?

Both sub-groups first listed the faculty strengths and faculty issues that either are or might be facing the School in the next 5-10 years. Issues were then categorized and rank ordered by importance. Appendix A--Faculty Key Issues contains that list with its details. A summary of faculty strengths and the top six faculty issues follows.

A. Faculty strengths that we should leverage

The School’s faculty has a number of strengths. The strengths summarized below are the most prominent strengths that were discussed.

- **Dental Hygiene:** This is one of the few institutions to offer undergraduate and graduate degrees in Dental Hygiene.
- **Specialties:** Graduate programs in all dental specialties are offered. A large number of specialists teach at the predoctoral and graduate level as well as conduct research in their discipline.
- **Preeminent Reputation:** The school has an excellent reputation. Many dental educators use the word “preeminent” when referring the U-M School of Dentistry. This means that the graduates and the faculty are held in high esteem. It also means that there are high expectations for the school and its faculty, staff and students. This reputation extends to high expectations for quality teaching, research, patient care and community service. The school has an especially strong reputation for conducting innovative research in a large number of areas related to dentistry and dental education. The school’s preeminent standing has enabled it to hire strong researchers and clinicians to its faculty.
- **Expertise:** The breadth and depth of faculty expertise is witnessed in the number of faculty who are asked to be reviewers for journals, NIH study sections, write reviews of faculty at other institutions being considered for promotion, and serve on corporate advisory boards.
Our faculty often serve the profession as accreditation reviewers, specialty board examiners, National Board test authors, and national and international professional organization committee members and officers.

- **Embracing Change**: Most members of the faculty are not satisfied with the status quo. Faculty can be constructively critical of the current and proposed practices. However, when presented with solid research and data they are not afraid of change and even embrace it. One example of embracing change and innovation in dental education was being the first dental school to institute a Vertically Integrated Curriculum of comprehensive care for its clinical education.

- **Resources**: The School and University offer excellent resources. The Dental Library is one of the best dental libraries in the country, if not the world. Resources available to help develop teaching skills include Tom Green and CRLT. It is very rare that a faculty member cannot find the resources they require. At times the numbers of resources are so overwhelming that it may difficult to find the appropriate one. If a faculty member is not able to accomplish a task it rarely is due to a lack of resources.

- **Diversity and Collegiality**: The school embraces diversity (race, gender and nationality) while maintaining quality in its teaching, research, patient care and community service mission. This diversity has brought new ideas to the school, helped to create an environment for faculty to collaborate in new and different ways, and created an environment where innovation is supported and encouraged. Additionally, in 2005 the School of Dentistry received funding for the Gateway Faculty Development Program. This program is an ADEA/WK Kellogg-funded endeavor designed to facilitate access into careers in academic dentistry for underrepresented minorities and others typically underrepresented in the dental profession.

### B. Faculty Weaknesses that compromise our ability to leverage our strengths

1. **Faculty Recruitment**

   Faculty shortages are not specific to U-M, but U-M loses potential candidates because of low salaries, lack of flexibility (the inability to practice outside of the school), unclear expectations and lack of loyalty to the institution. The 2004 Faculty Salary Task Force made recommendations to change the salary structure that should be revisited (See Appendix B—Faculty Salary Task Force). Recruitment does not appear to be a problem for the research track. We need a culture similar to the research track for the clinical track. Also, clinical and teaching faculty should be seen as equal partners. Potential candidates are not always aware that they can negotiate start-up packages.

   The advantages of adopting a model such as the one described in Appendix C--Variability in Faculty FTE Profile include (a) potential improvements in the quality of clinical faculty that can recruited and retained, (b) consistency in practice because faculty will have the time to be trained and calibrated, (c) stability because faculty will have less of an incentive to move because they are financially invested in the community, (d) release of current pressure on the DFA, (e) clinical time is guaranteed to be fully scheduled with patients, (f) there is no promotion clock for <80%, (g) there would be a decrease of 1 day/week appointments.
MCOHR is the revival of clinical research at the School. Clinical research should evolve to create a clinical research culture similar to our strong traditional research culture.

2. Faculty Retention

The early discussion focused on the Clinical Track faculty. The criteria for promotion on the Clinical Track are not clearly defined, there is no calibration of faculty within disciplines and there is disparity between divisions and departments. There should be peer review in the promotion process for Clinical Track. The promotion clock is detrimental to some faculty, especially clinical faculty; the inability to have a private practice/flexible schedule is a big concern.

3. Definition of “Scholarly Activity” for Clinical Track

There is no clear definition of what constitutes “scholarly activity”. The new definition should include electronic publications and perhaps other types of formal, peer-recognized activities. Clinical Track faculty do not always have the time (because of teaching commitments) or the facilities to conduct research: there should be mentoring and infrastructure support for writing research papers. Clinical Track should be represented during the entire promotion and review processes just as Tenure Track faculty are. Should we eliminate tenure? Should there be a post-tenure review?

4. Salary Structure (X, Y, Z)

There appears to be inequity in salaries (disparities between divisions/departments, junior vs. senior faculty). There should be an annual salary review to ensure salary equity. Clinical faculty should be rewarded for students’ productivity and quality of care. There should be clearly described bonuses and incentives.

5. Faculty Development:

Faculty at all levels need to continually evolve and develop if the U-M is to remain preeminent in teaching, research, patient care and community service. Research faculty have developed mentoring and other processes to ensure that they remain at the forefront of their discipline. Clinical and teaching faculty need to do the same. For example, a Faculty Scholars program, similar to the one at the Medical School, would help develop preeminent teachers; and calibration of faculty who teach in the clinics and/or outreach programs might improve clinical teaching. The linking of improved development in teaching, research and patient care to some form of reward should be explored.

6. Faculty Governance:

Faculty Involvement: There is inadequate faculty involvement in governance possibly due to apathy, fear, frustration or other unidentified reasons. For a few consecutive years it has been challenging for the Nominations & Elections Committee to assemble a full slate of candidates for committees. When the number of assistant, associate and full professors are compared to the number of committee positions it is noted that assistant and associate professors comprise a larger percentage of committee positions than do full professors. (See Appendix D—2002-2006 Committee Membership by Rank.) Yet shouldn’t full professors be the most actively involved in the governance of the school? The source of this lack of involvement could not be identified by the discussion group, but needs to be more fully investigated.
**Redundancy:** It was noted that some faculty governance processes, e.g., promotion and academic performance, are redundant especially when compared with other institutions. This may explain in part the lack of faculty involvement in committee membership. There might simply be more committee work to do than the current number of faculty have time for. Our faculty recruitment and retention issues compound the redundancy issue.

One advantage of our redundancy is the involvement of “more eyeballs” in the review process. The disadvantages are numerous: (1) the redundant promotion and academic review processes are costly in terms of faculty time; (2) serving on the Executive Committee (EC) is not popular, it is hard work and EC faculty members often do not have time to advise the dean on other matters of substance; and (3) there is not the time for periodic reviews of full professors other than those conducted by chairs.

**Governing Faculty:** Part-time faculty members are not eligible as ‘governing faculty’ and clinical faculty are not allowed to vote; this should be changed. The definitions of associate chairs, vice chair and division head are vague and may lead to conflict of interest when they participate in various committees.

G. R. Holland has provided an in-depth review of Faculty Governance. It can be found in Appendix E—Faculty Governance in the U-M School of Dentistry.

The following issues were also identified, but the Faculty Discussion Group did not identify them as issues that they would address as priority faculty issues in their discussions for the Strategic Assessment. These issues included:

- **Faculty Communication:** There is perceived need to improve communication at all levels.
- **School Administration:** Appointed and elected leaders should strive to improve their leadership skills through training and feedback from faculty.
- **Faculty “Mix/Profile” & Roles:** The requirement of 100% full time for teaching faculty needs to be reviewed and potentially revised to allow for more flexibility, including time for private practice outside of the school.
- **Mission:** The mission statement to be revised to include a clear statement about the School’s goals. This may in part help with the recruitment and retention of faculty.
- **Diversity:** Our faculty is diverse although there remains a small number of under-represented minority faculty. This is a nationwide issue and not unique to our school. Diversity is being addressed in conformance with University policy. Concerns were expressed about pay equity, however. Diversity should be addressed as it applies to the other issues, like recruitment, retention, pay, etc. The Faculty Discussion Group also recognized that additional discussion of diversity pertinent to the strategic assessment would occur following completion of the cultural climate survey scheduled for implementation in the near future.

**II. Which of the key issues do we need to and want to make a commitment to address?**

The top six issues were discussed in detail. The Monday sub-group addressed the issues of Faculty Recruitment, Faculty Retention and Salary Structure. Faculty Recruitment and Faculty retention were combined as the single issue of Faculty Recruitment and Retention. Because a
new Appointment, Promotion and Tenure document was pending a faculty vote, it was decided to return to the issue of Definition of “Scholarly Activity” if a vote was not taken during this academic year. The Wednesday sub-group examined the issues Faculty Development and Faculty Governance.

**III. How are we currently positioned to address these key issues?**

The school is well positioned to address many of the top issues. It needs to be emphasized that the issue of Clinical Track representation on the Appointment, Promotion and Tenure (APT) committee and the definition of scholarship for the Clinical Track have now been addressed. In March 2006 the faculty voted to have two of the six APT members be from the Clinical Track. In June 2006 a new Appointment, Promotion and Tenure Guidelines document was approved by the faculty that more clearly defines scholarship for the Clinical Track.

**A. Faculty Recruitment & Retention:**

This is by far the most critical issue. However, it will be especially difficult to solve in this time of tight fiscal resources. A few ideas are proposed for exploration.

- **Promotion Clock:** The promotion clock is a detriment for some faculty, especially clinical faculty. It should be changed.

- **External Practice:** If the ability to practice outside of the school was added it could attract and keep more faculty because it offers flexibility, adds credibility and is fiscally attractive; faculty wouldn’t move because of their investment in their practice. This school is in the position to address this issue.

- **U-M Grads:** Until about 1989-1990 faculty tended to be hired from our graduate students. Then the policy was changed to NOT hire our own graduate students. This appears to have resulted in a lack of loyalty to the institution. Thus, the School has become a stepping-stone to other jobs as opposed to remaining at the U-M. We are in the position to hire the best of our graduates; we should explore ways to develop a graduate student pipeline in which we train our future faculty.

- **Clinical Track:** The school has already started to work on issues that hinder attracting and retaining clinical track faculty. This is seen in: (1) the new Appointment, Promotions and Tenure document, (2) the replacement of two Tenure Track faculty with two Clinical Track faculty on the APT committee, and (3) the Faculty Development series. Thus, we are posed to continue to improve conditions for Clinical Track faculty until a culture similar to the research culture can sustain the Clinical Track. An option to explore might be a position similar to a post-doc for research faculty. This could allow Clinical Track faculty to “jump-start” their career with the clock off.

**B. Salary Structure:**

While finances are definitely tight, a salary review to ensure equity within rank (X only) could be conducted.

**C. Faculty Development:**

A Faculty Development series was begun in the last academic year. Thus, we are poised to continue to further develop our entire faculty. Chairs should focus on developing mentoring programs targeted specifically for clinical track faculty.
D. Faculty Governance:

Faculty governance issues can be resolved through a review of the by-laws. It is recommended that the reason behind the unwillingness of faculty to participate in faculty governance be examined. Then a revision of the by-laws can propose a governance structure to resolve the lack of interest and other issues.

IV. What are the consequences of not addressing those key issues?

The consequence of not addressing the pressing problem of Faculty Recruitment and Retention as well as the problems of Salary Structure and Faculty Development will be a severe decline in the number and quality of our faculty. This would in turn lead to a decline in the quality of our teaching, research, patient care and community service. Thus, the school would no longer be preeminent among dental education institutions. This decline will also lead to a decline in our position within the university and within the dental profession.

The disadvantages of adopting a faculty model such as the example detailed in Appendix C—Variability in Faculty FTE Profile might include (a) a potentially negative reaction from the community, (b) decreased flexibility of chairs, (c) DFA will need to become more efficient, (d) there is more potential of abuse to unscheduled time that may require department chairs to be more diligent in supervision of faculty, (e) enormous financial hit for departments, (f) there would be no contributions to service and scholarship by part-time faculty, (g) it would decrease the loyalty to the institution, (h) the increase in part-time faculty would fragment the faculty more, thereby increasing the inconsistency between clinical faculty, and (i) there is inadequate time to build a practice while working part-time.

The consequences of not addressing the issues related to Faculty Governance mean that more and more of the governance would be conducted by an ever-diminishing group of junior faculty. Thus, we will not benefit from the wisdom and breadth of experiences of our world class senior faculty.

V. How do we measure up to the best of our peer institutions or other outstanding organizations in performance on the key issues?

A. What directions are our best competitors headed?

All dental schools are facing the problem of Faculty Recruitment and Retention. Many schools attempt to recruit our current faculty and look to our graduate programs as a source for faculty. An aggressive recruitment and retention program as well as a revised salary structure will ensure that we are able to recruit and retain the leaders and the best for our faculty.

Faculty Governance models appear to be unique for each institution. The Discussion Group identified three different faculty promotion models from other dental education institutions. Each of them has fewer levels of review than ours.

<table>
<thead>
<tr>
<th>Promotion Model</th>
<th>Location</th>
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<tbody>
<tr>
<td>Department &gt; Chair &gt; Faculty (APT) &gt; Faculty (EC) &gt; Dean &gt; Provost</td>
<td>U Michigan</td>
</tr>
<tr>
<td>Department &gt; Chair &gt; Faculty (APT) &gt; Dean &gt; Provost</td>
<td>U Iowa</td>
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</table>
B. What will set us apart from the crowd yet distinguish us among peers?

- Aggressive faculty recruitment and retention is paramount. This may include a changed salary structure. For example UofDM, UCSF and others have 80% appointments. A review should be conducted on a regular basis to ensure that faculty with similar responsibilities, qualifications and workload are similarly remunerated. Other rewards should be explored, e.g., rewarding clinical faculty for students’ productivity and quality of care.

- Continue to grow the Faculty Development program. Mentoring of Clinical Track faculty needs to be emphasized as well as supporting the development of senior faculty to become stronger clinical faculty. Increased support for faculty whose scholarship is teaching would help further distinguish our educational program.

- The school would be distinguished by an efficient faculty governance structure that encourages and enables broad participation at all ranks and levels.

VI. How do these key issues match the broader core values of the University?

The school and the university pursue leadership and quality in all aspects of education, research, patient care, and community service. Key to this leadership is a preeminent faculty. Hiring and retaining the best faculty is the key to maintaining our preeminent position. This may require changes to our salary structure and our support of faculty, especially Clinical Track faculty.

A revised faculty governance model would bring us closer to the model suggested by the Provost and the Senate. It should also encourage active participation by the broader faculty membership.

VII. What changes would we like to see implemented?

A. Faculty Recruitment & Retention: A task force should explore recruitment and retention hindrances and propose solutions to the problem with a focus on Clinical Track faculty.

B. Salary Structure: Faculty consideration of the 2004 Faculty Salary Task Force report (See Appendix B) and The Variability in Faculty FTE Profile (See Appendix C).

C. Faculty Development: Continued growth with an emphasis on Clinical Track mentoring.

D. Faculty Governance: An in-depth review of our current governance processes and by-laws. The primary focus should be to investigate the lack of faculty involvement in governance.
APPENDICES

Appendix 5A—Key Issues Facing Faculty Now and for the Next 5-10 Years

Appendix 5B—Faculty Salary Task Force

Appendix 5C—Variability in Faculty FTE Profile

Appendix 5D—2002-2006 Committee Membership by Rank

Appendix 5E—Faculty Governance (Graham R. Holland)

Appendix 5F—Meeting Minutes
### APPENDIX 5A – KEY ISSUES FACING FACULTY NOW AND FOR THE NEXT 5-10 YEARS

<table>
<thead>
<tr>
<th>Topic</th>
<th>Rank</th>
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<tbody>
<tr>
<td><strong>1. Faculty Recruitment:</strong></td>
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<tr>
<td>- How to make dental education attractive for private practitioners to come teach? Explore the opportunity for private practice inside and outside of the school</td>
<td>12</td>
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<tr>
<td>- ‘Faculty’ is too broad a term with a vague definition</td>
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<td>- Need to define roles when recruiting faculty:</td>
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<td></td>
<td>- For tenure track</td>
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<td></td>
<td>- For clinical track (high turnover is an issue → continuity loss)</td>
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<td></td>
<td>- For adjunct faculty (how do we recruit adjunct faculty? by word-of-mouth)</td>
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<tr>
<td>- Need to define expectations for ‘scholarly activity’</td>
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<td>- Research vs. clinical: what about people who do both?</td>
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<tr>
<td>- Struggling with the requirement of 100% for full-time faculty. We need to change the faculty profile. A Faculty Salary Task Force (in 2002?) made recommendations that were ignored by the chairs. It seems that no task force leads to cultural changes.</td>
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<tr>
<td>- Recruitment and retention is a problem across the country.</td>
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<td>- Need to balance academia and private practice</td>
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<td>- Conflict of interests</td>
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<td>- Some say that we lost the pre-eminence status as a clinical training institution; how can we measure that? How can we recruit faculty if that is true?</td>
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<tr>
<td><strong>2. Faculty Retention:</strong></td>
<td>12</td>
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<tr>
<td>- Clinical Track retention is key</td>
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<td>- Passing over excellent instructors for promotion → loss of good faculty</td>
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<td>- Clinical track committee: only extended the number of years faculty may work without promotion (‘use them up and spit them out’)</td>
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<td>- Opportunity for scholarship--clinical faculty may lack time or facilities</td>
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<td>- Mentoring:</td>
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<td>- Clinical track faculty need mentoring to write papers. They were never trained to do write like tenure track faculty.</td>
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Appendix 5

DRAFT Strategic Assessment Report to the School of Dentistry Community

- Some faculty refuse mentoring without consequences
  - Equity (disparities in rank and pay):
    - Reviews should be done once every 2 years to make sure people with similar responsibilities, qualifications and workload are similarly remunerated (this is done for staff, but not for faculty)
    - Women are paid less?
    - DFA paid better?
  - Conflicts of interests
    - DFA (same rules should apply to DFA as to the rest of faculty)
    - work done not for the University
    - patents
    - spin off companies
    - consulting
    - oversight
    - accountability
  - Make it clear that startup packages are up for negotiation or eliminate negotiation
  - Professional advancement: current criteria for promotion are not clearly defined, especially for clinical and research track, junior faculty, but also for tenure track “survival” issue for junior faculty

3. Definition of ‘Scholarly Activity’
   - Clinical track is defined differently by various schools on campus (Dentistry vs. Pharmacy vs. Medicine); need to (re)define it; for example, at some schools clinical track faculty are not/may not be course directors
   - Need to define ‘peer review’
   - Need to redefine ‘publications’: what about electronic publications? Aren’t they ‘scholarly activity’? What are other types of “acceptable scholarly activity”??
   - Adjunct faculty seen by some as “releasing faculty to be able to do research”; the school sees them as cheaper labor (no benefits)
   - Professional faculty is different from, say, English Language faculty: lots of extra responsibilities (mentoring, teaching, clinics, research, etc)
   - Clinical and tenure track faculty should be seen as equal partners.
   - Clinical Track should be represented during the entire promotion and review process. Currently they are not represented on APT.

4. Salary structure (X,Y,Z)

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DRAFT Strategic Assessment Report to the School of Dentistry Community

- Issue for recruitment, retention and appointments across departments
- Annual review: uniformity of the review process across departments
- Promotion and tenure criteria are not clear
- Calibration of faculty within disciplines
- Junior vs. senior faculty (rank, pay, promotion, recruitment, retention)
- Disparities among and within divisions/departments

### Faculty Development:

- Need calibration of all faculty who work in the clinics and even those in the outreach clinics
- All faculty must evolve and grow as the world and educational institutions change. This process can be managed systematically, or just left to evolve, or not. Educational institutions, just like all businesses, are at risk of decline if they only evolve through the early innovative stages, then growth, then success and stature. Decline, and irrelevance, is inevitable if they do not reinvent themselves.
- The attached draft document outlines a framework which might be useful.
- The School might position itself as a “center of excellence” for the training of health care educators. Such a program would not only serve the needs of the U-M, DDS School, but could also help to address the shortage of dental educators reported in other areas. Much of the required expertise and resources already exist within the School, or the broader University community. The Medical Educators SCHOLARS PROGRAM and the offerings from CRLT are examples.
- Development without rewards is not likely to be productive. The emerging evidence from the field of motivation can be useful here. It is clear that motivation and satisfaction is a very individualized process. This is relevant to both the design of instructional programs, as well as planning faculty compensation policies. Salary is always important, but so are the fringe benefits of interaction with peers, acknowledge professional achievement, association with the University, academic appointments, continuing education, etc.
- Many of the issues related to faculty are addressed in the emerging eclectic field of “Performance Technology” and through organizations such as The International Society for Performance Improvement, as well as the Association for Educational Communications and Technology.

### Faculty governance vs. top-down

- How much is faculty really involved in decision making?
  - People afraid to talk for fear of repercussions (especially non-tenured)
- Conflict of interest in roles of associate chairs/vice chairs/division directors, etc, with respect to faculty governance (e.g. from what types of committees and other faculty governance-type activities should they be...
### Appendix 5

DRAFT Strategic Assessment Report to the School of Dentistry Community

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<tr>
<td>o Vagueness in the definition of associate chair/vice chair/division head; maybe the bylaws should make it clearer.</td>
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<tr>
<td>事 is no need for departments, both APT and EC to review promotion and appointment materials. Get rid of at least one layer of repetition.</td>
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7. **Faculty Communication:**
- At every level, within every program or course, and across every departmental boundary, communication should be improved. Systematic faculty development will go a long way in addressing this, but there is more.
- Person to person contact seems like an essential prerequisite to good communication and interaction. Rather within departmental meetings, a retreat, informal lunches or coffee breaks, as part of a preclinical or clinical teaching team, or at a local pub, people need to meet each other face to face. Both time and facilities should be available for these interactions.
- With a foundation of personal contact established, technology can be utilized to conduct business. Newsletters can inform (but don’t provide interactivity), emails and videoconferences can be very interactive, as of course can phone conferences. The emerging field of distance learning, when rigorously designed and implemented can provide a framework for productive interactions. This SAFCo exercise can be an example.

8. **School Administration**
- Communication between faculty and administration requires improvement
- Improve leadership & expertise skills for elected leaders
  - Training opportunities
  - Faculty input on the choices
- Administrative reviews (of the dean and of chairs) should be open to all faculty

9. **Faculty “MIX/Profile” & Roles:**
- Acknowledging the obvious, the number, subject matter expertise, and assignments should be driven by the School’s mission and the curriculum. The work of the Curriculum Discussion Group is closely related to the role of this group.
- While the “subject matter” the School is responsible for is dentistry, the primary business of the School is education, not dentistry. The principles and methodologies of educational psychology and instructional design are the relevant disciplines to be used in designing the curriculum, and its implementation. As such, we are fortunate to have faculty and staff expertise in these areas, and their guidance should be used in all aspects of
### DRAFT Strategic Assessment Report to the School of Dentistry Community

- The “core” focal point of the School’s mission relates to the oral health of the public. To be effective, the School should have faculty with expertise and experience in addressing the public’s needs and demands at both the population, as well as the individual patient levels.
- A proper mix of full and part-time faculty is more than a matter convenience. Without full time faculty there would be little chance of continuity and coordination of the curriculum. Without part-time faculty the School would lose touch with the realities of providing health care within the community.
- All faculty should subscribe, and contribute to, a shared vision and commitment to a core curriculum. All faculty should also have the opportunity to express themselves and pursue individual academic goals.
- All faculty should assume, and be assigned specific responsibilities. Each should also be given the authority, and administrative support required in executing their duties.

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APPENDIX 5B—FACULTY SALARY TASK FORCE

Date:  May 10, 2004

Faculty Salary Task Force

Committee Members

- Dr. John C. Drach
- Dr. Robert M. Eber
- Dr. John P. Gobetti
- Ms. Wendy Kerschbaum
- Mr. Paul E. McGrath
- Dr. James A. McNamara
- Dr. L. George Upton
- Dr. Dennis J. Fasbinder, chair

Executive Summary

The Faculty Salary Task Force was charged with reviewing faculty salary structure and practices within the School of Dentistry. The primary focus of the Task Force was to ensure retention of current faculty and to enable recruitment of the finest dental faculty for the School of Dentistry.

To summarize the findings of the Task force:

- The general concept of the X-Y-Z salary structure does not need to be changed, but the management of the Y and Z components needs to be refined.
- Faculty should be expected to generate a portion of their salary. A significant minority of the faculty is not successful in generating sufficient revenue to cover the Y portion of their salary. A Z payment is not considered an incentive when this occurs.
- Two of the most common means for faculty to generate revenue are through Continuing Education courses and the DFA practice. Both of these are an inefficient use of faculty time relative to the amount of revenue generated.
The concept of Geographic Full-Time faculty, as defined as an 80% appointment within the School of Dentistry, should be strongly considered. Such an appointment would eliminate the Y portion of the faculty salary, the frustration of inefficient use of time to generate revenue, and maintain maximum faculty contribution to the mission of the school.

**Topics of Focus**

A questionnaire was emailed to the Faculty to gather feedback on the salary issues of most concern. A relatively small number of faculty responded to the questionnaire (N = 16), however, there was some degree of consistency as to the primary concerns of the respondents.

**X-Y-Z Structure**

In view of financial information provided to the Task Force, it seems reasonable to conclude that the General Fund Budget cannot pay for the entire faculty salary structure and that some portion of a faculty member’s salary will need to be generated by the individual faculty member. The Task Force has supported the premise that a faculty member should generate a portion of their salary. Currently, the percentages range between 18% and 40% depending on the type of faculty appointment (tenure track vs. clinical track) and distribution of effort.

*Faculty members are expected to generate revenue to cover the Y component of their salary through a variety of techniques. Continuing Education courses, research grants or contracts, DFA, or additional teaching opportunities outside their department seem to be the primary means mentioned and utilized by faculty.*

A review of the Continuing Education revenue per department indicates that very few faculty members generate any significant revenue to cover the Y component of their salaries through CE courses. Three departments generated less than $10,000 for the 2003-2004 year (BMS, CRSE, and OMPO). The significant overhead costs and department expenses in support of the Continuing Education function generally prevents this revenue source to be of much significant use for most faculty.

*Research grants and contracts generally have been useful to faculty in generating revenue to cover Y components of the salary. Research funding has been particularly useful to tenure track faculty, as would be expected. The availability of research funding to clinical track faculty seems to be limited, due to the amount of time devoted to their clinic/teaching duties, which leaves minimal time to compete for research grants.*

*DFA has significant overhead expenses for faculty within the practice. Although a number of faculty have generated sufficient revenue to cover their Y component, the vast majority do not. More important, it is perceived that DFA is not an efficient means to generate revenue for a variety of reasons.*
Appendix 5

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It is recognized that a variety of methods must be available for faculty to generate revenue to meet the needs of the diverse faculty within the dental school. However, the most common sources seem to be working successfully for only a minority of the faculty. This may be part of the reason many faculty feel that they do not have an acceptable means to generate their Y component of their salary. Any incentive the Z portion may represent is of no value if the Y portion cannot be generated.

Recommendation:

The review of the primary means faculty use to cover the Y portion of their salary emphasizes the variety of techniques utilized by faculty. This diversity is important to maintain due to the variety of faculty appointments and individual strengths of faculty members.

Each department has a minority portion of faculty members unable to generate the Y portion of their salary successfully. Both Continuing Education and the DFA are inefficient use of faculty time relative to the amount of revenue generated for these faculty members. Solutions to improve revenue-generating opportunities in Continuing Education or the DFA are not perceived by the Committee to be easy or immediate. Instead, consideration should be given to releasing faculty from the need to generate the Y portion of their salary and fully fund partial appointments within the school.

The Task Force recommends the establishment of a Geographic Full-time faculty position, defined as an 80% appointment (4 days per week) within the School of Dentistry. Such an appointment is commonplace in peer institutions. A Geographic Full-time position would receive total funding for the time spent at the school, primarily in a teaching role. This maintains the faculty commitment to the school and releases the school from the burden of the additional 20% of salary. The 20% time (or more) generally devoted to generating the Y salary would be then at the discretion of the faculty member. This option also may be beneficial in recruiting faculty, as it is perceived by many that the need to generate a portion of one's own salary at times is a deterrent to faculty recruitment.

Should the percentage of a faculty member's salary be reflective of a specific job title (clinical vs. tenure track) or reflective of the amount of time an individual is provided to generate funds?

A large number of clinical faculty members believe that the portion of their time available to generate funding is minimal relative to the opportunities they may have to do so. For example: tenure track faculty with significant time devoted to research have a "greater opportunity" to generate their Y portion as they are successful in competing for grants. Clinical Faculty do not benefit from their time assigned to the student clinics relative to generating funding or investing in endeavors that may lead to generate funding. Although a tenure track faculty generally has a greater Y component to their salary (25%-40%), they tend to have reduced teaching assignments that results in 60%-80% of their time available to generate funding through their research activities. Many clinical faculty (those assigned to student clinics 5-7 half days) generally have Y components of 18%. However, due to teaching commitments of generally 60%-70%, the 20% of their time available to generate funding is perceived to be inadequate in view of the other administrative tasks in preparing, directing, and coordinating clinical or didactic courses.
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It should be emphasized that this is not a clinical vs. tenure track issue. It is a result of the time assignment of a faculty member for their teaching and research responsibilities.

**Recommendation:**

The Task Force feels that in certain circumstances part-time faculty appointments would be a viable option, as mentioned previously. A part-time appointment would serve to maximize the faculty member’s contribution to the teaching mission of the school. It also would avoid the additional time faculty are scheduled generating revenue for salary to cover the additional time.

*Are the current X and Y percentages appropriate or are they serving as punitive and burdensome? Are the current percentages resulting in a general feeling of “to what degree will my Y be covered” for serving on committees, or collaborating on projects? Does the current X/Y split enhance or discourage collaboration between departments and/or faculty?*

Although not specifically polled on the issue, there was little discussion about the present 18% being burdensome for faculty. It seems the primary discussion centers on the available opportunities and effectiveness of those opportunities to generate revenue for the faculty member.

**Recommendation:**

The Task Force supports the concept of faculty generating a portion of their salary and current percentages seem appropriate. However, there were reports from faculty in several departments that clinical track faculty may be tasked to serve on committees, task forces, and perform other administrative functions at a greater rate than are tenure track faculty. There seemed to be a perception that clinical track faculty are not as successful in generating additional revenue so they would be “less costly” to fulfill these duties of the department. This trend would serve to continue the problem in generating revenue rather than improve it.

*Revenues that faculty members generate in excess of their Y component are available for Z payments. To what degree do they act as incentives for faculty?*

The “Z” component may serve as an incentive, however only to the degree to which the faculty perceives the opportunity to exceed the X-Y salary is possible. If the general perception is that the Y portion is difficult if not unreasonable to achieve, then the Z incentive is of little value. This sentiment seems to be shared by a number of clinical faculty, as they do not believe they have adequate time or opportunities to generate significant funding.

An opposing concern of the “Z” incentive is the degree to which efforts to generate funding are counterproductive to a faculty member engaged in the educational and curricular development of the dental school. Faculty will be involved in activities that will significantly enhance the
Appendix 5

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educational development of the school and yet do not generate revenue. These activities also must be supported to avoid faculty focusing their attention solely based on the potential for the activity to generate funding for their salary.

Another component of the “Z” incentive is the varied approaches described by the departments. A number of departments require faculty to set aside funds for protection against falling short of generating the Y portion of their salary, generally “rainy day funds”. These funds may or may not have funding caps or limitations as to how they are disbursed to the faculty. Some departments have limits as to dollar amounts, time, and frequency of usage limitations on withdrawing funds from these accounts. Another department has no limit on the amount of money or time, and faculty end up continually paying into the fund. This ongoing payment seems to undermine the stated reason for the fund. The “rainy day fund” generally is perceived as an additional “tax” prior to the faculty member receiving a “Z” salary component. Seeing 60%-70% of excess revenue that a faculty member generates go to the discretion of the department does not serve as an incentive for faculty to generate revenue. This arrangement leads to the feeling that more productive faculty may actually be paying to cover shortfalls of other faculty.

Recommendation:

Faculty will need to be creative to generate additional revenue in light of current economic pressures. The success of this revenue generation will continue only to the degree that the faculty believes the extra effort will be rewarded. For this reason, a minimum of 50% of the additional revenue either should be returned to the faculty in salary or should be placed in a discretionary fund under the control of the faculty member. To expect that faculty will accept less than 50% return on effort may work for the short term, but ultimately will result in talented faculty seeking opportunities elsewhere. To maintain and recruit the best faculty, each faculty member should reap the benefits of his or her extra effort to generate additional revenue.

The concept of a “rainy day fund” is perceived by some as being an additional burden on a faculty member to generate revenue with little return. These funds seem to be more under the discretion of the department chairs rather than the individual faculty. It is recognized that a portion of the extra revenue generated by the faculty in each department should remain in the department, in that the department plays a role in the ability of the faculty to generate the revenue through its resources. However, any reserve fund to cover department salary shortages would seem to be covered by the department’s split of the additional revenue and should not be an additional revenue burden to the faculty member.

To what degree does the “teaching function” of a faculty member have value in that teaching activities do not generate funding per se? Must the salary structure for part-time faculty be based on a sliding scale of the full-time faculty?

The “teaching function” generally is covered by the X component of salary and is a necessary and vital portion of the function of the dental school. This arrangement tends to form the basis for a faculty member’s assignment to teaching functions, especially for part-time clinical faculty. However, educational or teaching assignments to student clinics or courses do not generate opportunities for faculty revenue.

A number of departments have considered hiring part-time clinical faculty (0.6 FTE appointments) and paying a benefit package as an added incentive. Target groups for this appointment are the experienced clinician and the young dentist, both of whom may be encouraged to
consider an academic career. It also might be of value to consider a 4-day model (0.8 FTE) for clinical faculty as well. An eighty percent appointment would remove the perceived burden of faculty to generate revenue; he or she could be dedicated entirely to dental education.

Alternatively, the 0.6 FTE model may be an improvement over the 0.8 FTE model for some individuals. Several faculty members have indicated that with a 60% appointment, a productive private practice can be maintained compared to an 80% university commitment. This percentage of appointment may afford these faculty members opportunities to generate significant revenue to complement their time at the Dental School.

Recommendation:

Part time faculty appointments should be considered seriously at this time. A significant advantage is that this type of appointment eliminated the necessity of generating a portion of the faculty member's salary. It also serves as a method to recruit faculty for specific needs. The offer of a benefit package is a significant enticement for potential faculty and the lack of a Y salary portion would seem to be a cost savings for the school.

Equity

The concept of equity between gender, rank, part-time vs. full-time faculty, and clinical track vs. tenure track faculty needs to be ensured within the salary structure. Equity may require “separate but equal” approaches to the X-Y-Z guidelines beyond the current tenure track and clinical track differences.

To what degree should all departments have the same salary structure? Is it equitable for an individual to be treated differently because they happen to reside in a different department? To what degree is an individual faculty member responsible for generating funds to pay other faculty in the department? Should a productive person have a “Z” withheld or reduced due to “department” money management?

It is obvious that any salary structure should have as one of its core values that of equal treatment and opportunity for all faculty members. The Task Force feels that a single salary structure for the dental school is desirable. Such a structure, however, must take into consideration the unique skills and needs of the various disciplines and departments. Individual faculty members in financially limited departments should not be expected to carry increased financial demands compared to more financially well-off departments. For faculty to be productive, there must be adequate incentives or the expected additional work to generate revenue will not be invested. As general fund revenues decrease, the need for faculty to generate revenue only will increase. Faculty will invest the additional effort to generate revenue only if there is an adequate incentive from which they will benefit.

Recommendation:

Realizing the diversity of the various departments, the general salary structure should be such that faculty should feel that their salary would not be different if they were in another department. At this time, this feeling tends to focus particularly on the calculation of the Z component of the
salary. Some departments have “Rainy Day” funds that require faculty contributions, additional revenue is handled differently between departments, and faculty splits are different between departments. These items serve to work against the feeling of a single salary structure within the school. Although the departments have spent considerable time in some instances designing the salary guidelines, there has not been a similar effort to coordinate them within the school. Although this concern has not seemed to create any divisions within the faculty, a review of the various department salary guidelines would seem to be in order to ensure some degree of consistency within the school salary structure.

Summary

- The general concept of the X-Y-Z salary structure does not need to be changed, but the management of the Y and Z components needs to be refined. Although the diversity of the faculty would seem to preclude an identical salary structure for all departments, some consideration should be given to establishing consistency in the salary structure between departments.
- Faculty should be expected to generate a portion of their salary. A significant minority of the faculty is not successful in generating sufficient revenue to cover the Y portion of their salary. A Z payment is not considered an incentive when this occurs. Two of the most common means for faculty to generate revenue are through Continuing Education courses and the DFA practice. Both of these are an inefficient use of faculty time relative to the amount of revenue generated.
- The concept of Geographic Full-Time faculty, as defined as an 80% appointment within the School of Dentistry, should be strongly considered. Such an appointment would eliminate the Y portion of the faculty salary, the frustration of inefficient use of time to generate revenue, and maintain maximum faculty contribution to the mission of the school.
APPENDIX 5C—VARIABILITY IN FACULTY FTE PROFILE

Because of the well-documented shortage of academic and clinical faculty nationwide, it is imperative that the School of Dentistry expand the types of university faculty appointments available. A change in the appointment policy will make it easier for the School of Dentistry to attract new full-time and part-time faculty and also make it easier to retain the faculty who presently are affiliated with the School of Dentistry.

1. 100% Appointments. These types of appointments presently exist for both tenure track and clinical track faculty. Each faculty member is responsible for the 18% “y-component” of their salary. All funds for salary support are generated through the university (e.g., external grant support, Dental Faculty Associates, continuing education).

2. 80% Appointments. These types of appointments already are considered “fulltime” by the university, with one day per week available to all full-time faculty for “consulting,” according to the Standard Practice Guide. This profile exists at many other peer institutions and often is described a “geographic full-time.” The suggested model is four days per week at the university, with the fifth day left to the discretion of the faculty member (e.g., private practice, other interests). The university would cover the salary and benefits for four days of university employment.

3. 50% to 80% Appointments. There currently are several faculty within the School who have tenure with less than 100% appointments (these faculty were “grandfathered” according to current appointment and promotion policy). Whether tenure is available is of less importance than having these types of appointments available.

This type of arrangement would be of significant interest to clinical faculty whose primary focus is university teaching and research but who would like to keep significant ties with the private practice community. This type of appointment presumably would help close the financial gap between a clinician in private practice and someone teaching full-time at the university, a major reason why some full-time faculty have chosen to leave the School of Dentistry.

4. Less than 50% Appointments. These types of appointments already exist at the university. No specific changes are recommended.
## Appendix 5D—2002-2006 COMMITTEE MEMBERSHIP BY RANK

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APPENDIX 5E--FACULTY GOVERNANCE IN THE U-M SCHOOL OF DENTISTRY

(Graham R. Holland)

Introduction

The principles and practice of faculty governance are not universally appreciated in the School of Dentistry. They should be.

“Faculty participation in governance promotes and encourages diversity of ideas, a sense of shared responsibility, collaboration, collegiality, and institutional excellence. The faculty of the University of Michigan is encouraged to use these principles as a basis for the development of means for participation in governance in all units.”

This statement was endorsed by the Provost and entire Senate Assembly April 21 1997.

To partially remedy this deficiency it seems sensible to summarize what faculty governance means within the University in general before addressing its role in the School of Dentistry.

The University of Michigan has a special (though far from unique) form of governance. Each unit within the university has considerable autonomy (self government) and within these units the faculty participates in its governance.

This form of governance differs from other common models such as the top-down corporate administrative model or one based on collective bargaining. It has been a characteristic of this university since its foundation. The faculty’s participation in governance is defined in the Regent’s byelaws chapter V (http://www.regents.umich.edu/bylaws/). The most recent reaffirmation of this concept in toto (not Tonto) was by the Provost and Senate Assembly in 1997 and is reproduced below as being more digestible than the Regent’s byelaws. It can be found online at http://www.umich.edu/~sacua/AcadAff/aaacdoc.html. In fact one website http://www.umich.edu/~sacua/ contains virtually all the information pertinent to faculty governance.

GENERAL PRINCIPLES OF FACULTY PARTICIPATION IN GOVERNANCE

Unanimously endorsed by the Provost and Senate Assembly on April 21, 1997

I. General Principles for Faculty Participation in Institutional Governance

“1. The faculty has primary responsibility for such fundamental areas as curriculum, subject matter and methods of instruction, research, faculty status, standards and procedures for admission of students, and those aspects of student life which relate to the educational process.
2. The faculty sets the degree requirements, determines when the requirements have been met, and otherwise qualifies students and recommends them to the president and Board of Regents to grant the degrees thus achieved.

3. Considerations of faculty status and related matters are primarily a faculty responsibility; this area includes matters relating to academic titles, appointments, reappointments, decisions not to reappoint, promotions, the recommending of tenure and dismissal. Policies and procedures shall be developed for the implementation for these faculty responsibilities.

4. The faculty shall participate in the determination of policies and procedures governing compensation of faculty.

5. Agencies for faculty participation in the government of the college/school or university shall be established at each level where faculty responsibility is to be met. A faculty-elected campus-wide body shall exist for the presentation of the views of the whole faculty.

The agencies may consist of meetings of all faculty members of a department, school, college, division, or university system, or they may take the form of faculty-elected executive committees in departments and colleges/schools, and a faculty-elected body for larger divisions or for the institution as a whole.

6. Budgetary policies and decisions directly affecting those areas for which the faculty has primary responsibility -- such as, but not limited to, curriculum, subject matter and methods of instruction, research, faculty status, admission of students and those aspects of student life which relate to the educational process -- shall be made in concert with the faculty.

7. The preceding faculty responsibilities remain in effect when there is a delegation of faculty governance to agencies or administrative officers. Faculty must exercise diligence and provide oversight to ensure that its agencies act in keeping with its policies and recommendations, and that they are implemented in an appropriate manner.

FACULTY GOVERNANCE AT THE UNIT LEVEL

1) Although the principles of governance apply to all academic units the forms of faculty governance may vary among units.

2) Every academic unit at the University of Michigan shall have a set of written rules and procedures for its governance, copies of which are to be available to each faculty member.
3) The governing faculty of each academic unit shall establish the responsibilities and authority of each academic unit governance entity and each administrative entity within that unit. This applies to the lines of decision-making authority of these entities in relation to: curriculum; admission requirements; graduation requirements; major operating procedures such as departmental organization, committee organization, committee appointments; budget; faculty appointments, reappointments, decisions not to reappoint; faculty promotion and tenure; and policies concerning reviews of faculty for merit salary increases.

4) The governing faculty of each academic unit shall establish the operating procedures of its academic unit governance entities including, but not limited to: procedures for agenda setting, establishment of a quorum, determination of membership and voting rights, qualification of attendance by persons other than members, appointment of a faculty secretary, distribution of minutes, and the retention/filing of minutes.

5) For those academic units where the faculty delegates authority to an executive committee the following principles apply:

a. Procedures for nomination and election of executive committee members shall be determined by the governing faculty of the unit.

b. All recommendations to the Regents concerning a unit executive committee or other unit governance entity shall be based on a vote of the governing faculty of the unit.

c. The governing faculty shall establish the membership criteria for the executive committee with consideration for balance among various components of the unit, such as unit programs and departments, to make the executive committee representative of the governing faculty of the unit.

d. The governing faculty shall establish criteria for those eligible to serve on the executive committee, e.g., membership in the governing faculty or in the professional faculty, fraction of appointment, and holding of administrative positions.

e. The governing faculty shall establish policies and procedures by which a vote by secret ballot among nominees for membership on the executive committee will be conducted, and for the transmission of the names of those elected to the Regents.

f. The governing faculty shall establish policies and procedures to be used to fill a vacancy if a member of the executive committee must take a leave of absence or is otherwise unable to complete the original term of office.

g. The governing faculty shall establish policies and procedures regarding the term of office of elected members and any other restrictions on terms of office.”

FACULTY GOVERNANCE BEYOND THE UNIT
Appendix 5

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This begins with our two elected representatives to the Senate Assembly. Senate Assembly consists of 73 elected faculty members each serving a three year term. It meets monthly during the academic year and is charged by Section 4 of the Regents' Bylaws to represent the interests and concerns of faculty throughout the University of Michigan system. The two other levels of faculty representation are the Senate Advisory Committee on University Affairs (SACUA) and the University Senate. SACUA is the executive arm of the University Senate and of the Senate Assembly. SACUA meets weekly and consists of nine members of the Senate Assembly elected by the Assembly for three-year terms. SACUA advises and consults with the President, Provost, and the Executive Officers of the University on matters of University policy. SACUA also coordinates and initiates governance activities and serves as an instrument for implementing the actions of the University Senate and the Senate Assembly. The University Senate includes all members of the professorial staff, the executive officers of the university, the deans of the schools and colleges, such members of the research and library staff as may be designated and meets once a year in March. The detail work is done a number of Senate Assembly Committees staffed by volunteer (or invited) faculty appointed by SACUA.

<table>
<thead>
<tr>
<th>Academic Affairs Advisory Committee</th>
<th>Financial Affairs Advisory Committee</th>
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<tr>
<td>Administration Evaluation Committee</td>
<td>General Counsel's Advisory Committee</td>
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<td>Budget Study Committee</td>
<td>Government Relations Advisory Committee</td>
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<td>Civil Liberties Board</td>
<td>Medical Affairs Advisory Committee</td>
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<td>Committee on the Economic Status of the Faculty</td>
<td>Research Policies Committee</td>
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<td>Communications Advisory Committee</td>
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<td>Development Advisory Committee</td>
<td>Student Relations Advisory Committee</td>
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<td>Faculty Perspectives Editorial Board</td>
<td>Tenure Committee</td>
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This organization is cumbersome to describe verbally but is in fact efficient and effective. The Senate Assembly allows representatives informed by the Senate Committees from all units to interact and take action on issues put before them. The Senate Advisory Committee on University Affairs (SACUA) acts as the executive of the Senate Assembly and meets directly and frequently with the Provost. The University Senate is, to an extent, vestigial most matters requiring a vote being determined at the senate assembly level.
FACULTY GOVERNANCE IN THE UM SCHOOL OF DENTISTRY

The most obvious approach is to list the ‘General Principles of Faculty Governance’ and determine to what extent we satisfy these principles. From this review we can identify where enhancements are possible.

I. What are the key issues facing us in this topic area?
   A. Most significant strengths and most significant things (strategic imperatives) to do to build on those strengths
   B. Most worrying weaknesses and most important things (strategic imperatives) to address those weaknesses

“The faculty has primary responsibility for such fundamental areas as curriculum, subject matter and methods of instruction, research, faculty status, standards and procedures for admission of students, and those aspects of student life which relate to the educational process”

A. Curriculum is, very effectively determined by the faculty via the Curriculum Committee. Subject matter and methods of instruction are determined either at the Divisional level or by the individual course director, both faculty powered. Faculty status is established by the elected Appointments, Promotion and Tenure Committee.

B. The governance of Research seems largely out of faculty hands. Decisions on the allocation of laboratory space, for example, seem to be made on an ad hoc basis. Long term plans are not shared with the faculty as a whole and input seems limited and discussion minimal. Admissions is a very sensitive, intensive area handled well by an unelected committee but the criteria and process are not discussed openly with the faculty as a whole.

2. The faculty sets the degree requirements, determines when the requirements have been met, and otherwise qualifies students and recommends them to the president and Board of Regents to grant the degrees thus achieved.

We meet this requirement thoroughly and efficiently with full faculty involvement.

3. Considerations of faculty status and related matters are primarily a faculty responsibility; this area includes matters relating to academic titles, appointments, reappointments, decisions not to reappoint, promotions, the recommending of tenure and dismissal. Policies and procedures shall be developed for the implementation for these faculty responsibilities.
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We meet this requirement well. The APT Committee is elected. Its recommendations are reviewed by the Executive Committee. The guidelines are under constant review with vigorous faculty input. There is no weakness here.

4. The faculty shall participate in the determination of policies and procedures governing compensation of faculty.

A. Strength is missing here. These matters are determined by the Department Chair and Dean with selected faculty input.

B. The process is not uniform throughout the school. School guidelines similar to those in the apt document are required.

5. Agencies for faculty participation in the government of the college/school or university shall be established at each level where faculty responsibility is to be met. A faculty-elected campus-wide body shall exist for the presentation of the views of the whole faculty. The agencies may consist of meetings of all faculty members of a department, school, college, division, or university system, or they may take the form of faculty-elected executive committees in departments and colleges/schools, and a faculty-elected body for larger divisions or for the institution as a whole.

A. Our faculty meetings and Executive Committee organization meet requirements. We conform to the representation standards of SACUA.

B. The communication between the faculty and its elected executive is incomplete. The Dean controls the agenda for faculty meetings.

6. Budgetary policies and decisions directly affecting those areas for which the faculty has primary responsibility -- such as, but not limited to, curriculum, subject matter and methods of instruction, research, faculty status, admission of students and those aspects of student life which relate to the educational process -- shall be made in concert with the faculty.

A. Recently the School budget status has been revealed to the faculty in a fairly detailed form.

B. The faculty are not consulted prior to the making of budget decisions and are not privacy to expenditure plans.

7. The preceding faculty responsibilities remain in effect when there is a delegation of faculty governance to agencies or administrative officers. Faculty must exercise diligence and provide oversight to ensure that its agencies act in keeping with its policies and recommendations, and that they are implemented in an appropriate manner.

A. All faculty committees report on an annual basis some more often
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B. Communication between committees, especially the Executive Committee, could be improved.

FACULTY GOVERNANCE AT THE UNIT LEVEL

“1) Although the principles of governance apply to all academic units the forms of faculty governance may vary among units.

A. We recognize this. Unit autonomy is a great advantage for professional schools who commonly have problems convincing university administrators for their special or (in our case) unique character.

2) Every academic unit at the University of Michigan shall have a set of written rules and procedures for its governance, copies of which are to be available to each faculty member.

A. We have appropriate byelaws and a committee to oversee them.

B. Faculty do not seem to realize that they have considerable power to enhance the operation of the School by modifying the byelaws.

3) The governing faculty of each academic unit shall establish the responsibilities and authority of each academic unit governance entity and each administrative entity within that unit. This applies to the lines of decision-making authority of these entities in relation to: curriculum; admission requirements; graduation requirements; major operating procedures such as departmental organization, committee organization, committee appointments; budget; faculty appointments, reappointments, decisions not to reappoint; faculty promotion and tenure; and policies concerning reviews of faculty for merit salary increases.

A. We only partially fulfill this requirement. Certainly the lines of decision making are unclear but most seem begin and end in the Dean's office.

B. The faculty has never had any significant say in major operating procedures such as departmental organization, committee organization nor on budget or faculty reviews.

4) The governing faculty of each academic unit shall establish the operating procedures of its academic unit governance entities including, but not limited to: procedures for agenda setting, establishment of a quorum, determination of membership and voting rights, qualification of attendance by persons other than members, appointment of a faculty secretary, distribution of minutes, and the retention/filing of minutes.
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A. The School of Dentistry fails in some items on this list

B. The faculty has a minor role in setting faculty meeting or Executive Committee agendas. There is no faculty secretary.

5) For those academic units where the faculty delegates authority to an executive committee the following principles apply:

a. Procedures for nomination and election of executive committee members shall be determined by the governing faculty of the unit.

A. We comply well

b. All recommendations to the Regents concerning a unit executive committee or other unit governance entity shall be based on a vote of the governing faculty of the unit.

A. This has never been denied.

B. The faculty does not seem aware that it can ask the Regents to modify unit governance.

c. The governing faculty shall establish the membership criteria for the executive committee with consideration for balance among various components of the unit, such as unit programs and departments, to make the executive committee representative of the governing faculty of the unit.

This is not done but may be should not be in a small unit. The faculty should discuss it.

d. The governing faculty shall establish criteria for those eligible to serve on the executive committee, e.g., membership in the governing faculty or in the professional faculty, fraction of appointment, and holding of administrative positions.

A. This is done flawlessly

e. The governing faculty shall establish policies and procedures by which a vote by secret ballot among nominees for membership on the executive committee will be conducted, and for the transmission of the names of those elected to the Regents.

The names the top two vote winners for each position goes to the Provost first who can select from the two. It is not necessarily the candidate with the most votes who is appointed.

f. The governing faculty shall establish policies and procedures to be used to fill a vacancy if a member of the executive committee must take a leave of absence or is otherwise unable to complete the original term of office.
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We do this.

g. The governing faculty shall establish policies and procedures regarding the term of office of elected members and any other restrictions on terms of office.”

Done

II. Which of the key issues do we need to and want to make a commitment to address

Involve the faculty as a body in the governance of research

The admission criteria and process should be reviewed by the faculty perhaps annually

The faculty should participate in the determination of policies and procedures governing compensation of faculty

A faculty secretary should be appointed

The Executive Committee and faculty secretary should determine the agenda for faculty meetings

The governing faculty of should establish the responsibilities and authority of each unit governance entity and each administrative entity. This should apply to the lines of decision-making authority in relation to: curriculum; admission requirements; graduation requirement and major operating procedures such as departmental organization, committee organization, committee appointments; budget; faculty appointments, reappointments, decisions not to reappoint; faculty promotion and tenure; and policies concerning reviews of faculty for merit salary increases

III. How are we currently positioned to address these key issues

The governing faculty can implement all these recommendations by amendment of the byelaws.

IV. What are the consequences of not addressing those key issues

The status quo remains and the school is governed without faculty input in a number of significant areas.

V. How do we measure up to the best of our peer institutions or other outstanding organizations in performance on the key issues

The governance of other institutions may be designed along other lines. The faculty governance model has been in effect, at least in theory, since its foundation.

VI. How do these key issues match the broader core values of the University

They will bring the School into closer compliance with governance model approved by both the Provost and Senate
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VII. **Action Items: listing of recommendations for what needs to be done based on the topic specific discussion group’s assessment (added 5/16/06)**

Involve the faculty as a body in the governance of research

The admission criteria and process should be reviewed by the faculty perhaps annually

The faculty should participate in the determination of policies and procedures governing compensation of faculty

A faculty secretary should be appointed

The Executive Committee and faculty secretary should determine the agenda for faculty meetings

The governing faculty of should establish the responsibilities and authority of each unit governance entity and each administrative entity. This should apply to the lines of decision-making authority in relation to: curriculum; admission requirements; graduation requirement and major operating procedures such as departmental organization, committee organization, committee appointments; budget; faculty appointments, reappointments, decisions not to reappoint; faculty promotion and tenure; and policies concerning reviews of faculty for merit salary increases

**APPENDIX 5F–MEETING MINUTES**

SAFCo – Faculty Discussion Group

February 14, 2006, 5:30 – 7:00 pm, FAL
Main question: What are the main issues for faculty now and in the next 5 years; keeping in mind that we want to be/remain at the cutting edge?

The process for the SAFCo discussion groups: there will be another Faculty group on Monday, Feb 20, after that:

- decide which key points to concentrate on in more detail (this is the assessment phase, we are not looking for solutions at this time; we might be looking for metrics to develop these assessments); timeframe: two months
  - each group (faculty, staff, etc) will present a report, from which
  - a school wide assessment report will be drafted by late spring
  - external (3-6) reviewers (selected by the Provost and the Dental community) will review the report and make their recommendation
  - discussion of the external reviewers’ recommendations
  - further discussions with the Provost and President
  - implementation

At this point, the reports are written by the committee, but this could be changed. Either way the reports will be submitted for approval by participants to discussions.

A similar strategic assessment has been carried out in Iowa and the president there relied on its recommendations when deciding which programs to cut/develop.

Key issues facing faculty now and for the next 5 years

- faculty shortage
- faculty retention
- lack of communication between faculty and administration
- faculty recruitment
- professional advancement:
  - current criteria for promotion are not clearly defined, especially for clinical and research track, junior faculty, but also for tenure track
  - “survival” issue for junior faculty
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- is this a leadership problem?
- mentoring
- opportunity for private practice inside and outside the school
  - how to make it attractive for private practitioners to come teach?
  - transparent options
- faculty governance (lack of) vs. top-down
- equity (disparities in rank and pay):
  - reviews should be done once every 2 years to make sure people with similar responsibilities, qualifications and workload are similarly remunerated (this is done for staff, but not for faculty)
  - women are paid less
  - DFA paid less
- DFA paid better?
- conflicts of interests
  - DFA (same rules should apply to DFA as to the rest of faculty)
  - work done not for the University
  - patents
  - spin off companies
  - consulting
  - oversight
  - accountability
  - make it clear that startup packages are up for negotiation or eliminate negotiation
- nepotism
- administrative reviews (of chairs): not just by the faculty senate
- conflict of interest in roles of associate chairs/vice chairs/division directors, etc, with respect to faculty governance
  - vagueness in the definition of associate chair/ vice chair/division head; maybe the bylaws should make it clearer.
- How do we fulfill the state charter for U-M and for the school?
  - what IS the state charter?
- diversity
- salary structure (X, Y, Z)
  - issue for recruitment, retention and appointments across departments
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- annual review: uniformity of the review process across departments
- promotion and tenure criteria are not clear
- calibration of faculty within disciplines
- in-service for faculty
- junior vs. senior faculty (rank, pay, promotion, recruitment, retention)
- disparity between divisions/departments
- opportunity for scholarship
  - clinical faculty may lack time or facilities
  - people refusing mentoring without consequences
- how much is faculty really involved in decision making?
  - people afraid to talk for fear of repercussions (especially non-tenured)

- leadership & expertise skills for elected leaders
  - training opportunities
  - faculty input on the choice

Process for the Faculty Group
- have Pete visit
- have chairs visit to discuss evaluation systems
- getting the data we need (e.g., exit interviews with students and faculty)
- who is actually running the school? the clinic?
- curriculum content
- roadblocks to scholarship and education
- “dental care is incidental to the education process”

Dr. Wally McMinn (via e-mail):

The following are some observations which might be applicable to the Faculty Discussion Group. They are not in any particular order of importance, but rather, represent some brainstorming on my part. They may address several of the items cited in the discussion group “protocol”.

35
DEFINING A FACULTY “MIX” AND ROLES:

- Acknowledging the obvious, the number, subject matter expertise, and assignments should be driven by the School’s mission and the curriculum. The work of the Curriculum Discussion Group is closely related to the role of this group.

- While the “subject matter” the School is responsible for is dentistry, the primary business of the School is education, not dentistry. The principles and methodologies of educational psychology and instructional design are the relevant disciplines to be used in designing the curriculum, and its implementation. As such, we are fortunate to have faculty and staff expertise in these areas, and their guidance should be used in all aspects of the curriculum.

- The “core” focal point of the School’s mission relates to the oral health of the public. To be effective, the School should have faculty with expertise and experience in addressing the publics’ needs and demands at both the population, as well as the individual patient levels.

- A proper mix of full and part-time faculty is more than a matter convenience. Without full time faculty there would be little chance of continuity and coordination of the curriculum. Without part-time faculty the School would lose touch with the realities of providing health care within the community.

- All faculty should subscribe, and contribute to, a shared vision and commitment to a core curriculum. All faculty should also have the opportunity to express themselves and pursue individual academic goals.

- All faculty should assume, and be assigned specific responsibilities. Each should also be given the authority, and administrative support required in executing their duties.

FACULTY DEVELOPMENT:

- Whatever mix of faculty is currently in place, or recruited, this is just the starting point. All faculty must evolve and grow as the world and educational institutions change. This process can be managed systematically, or just left to evolve, or not. Educational institutions, just like all businesses, are at risk of decline if they only evolve through the early innovative stages, then growth, then success and stature. Decline, and irrelevance, is inevitable if they do not reinvent themselves.

- The attached draft document outlines a framework which might be useful.

- The School might position itself as a “center of excellence” for the training of health care educators. Such a program would not only serve the needs of the U-M, DDS School, but could also help to address the shortage of dental educators reported in other areas. Much of the required expertise and resources already exist within the School, or the broader University community. The Medical Educators SCHOLARS PROGRAM and the offerings from CRLT are examples.

- Development without rewards is not likely to be productive. The emerging evidence from the field of motivation can be useful here. It is clear that motivation and satisfaction is a very individualized process. This is relevant to both the design of instructional programs, as well as planning faculty compensation policies. Salary is always important, but so are the fringe benefits...
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of interaction with peers, acknowledge professional achievement, association with the
University, academic appointments, continuing education, etc.

- Many of the issues related to faculty are addressed in the emerging eclectic field of
  “Performance Technology” and through organizations such as The International Society for
  Performance Improvement, as well as the Association for Educational Communications and
  Technology.

FACULTY COMMUNICATION:

- At every level, within every program or course, and across every departmental boundary,
  communication should be improved. Systematic faculty development will go a long way in
  addressing this, but there is more.

- Person to person contact seems like an essential prerequisite to good communication and
  interaction. Rather within departmental meetings, a retreat, informal lunches or coffee breaks, as
  part of a preclinical or clinical teaching team, or at a local pub, people need to meet each other
  face to face. Both time and facilities should be available for these interactions.

- With a foundation of personal contact established, technology can be utilized to conduct
  business. Newsletters can inform (but don’t provide interactivity), emails and videoconferences
  can be very interactive, as of course can phone conferences. The emerging field of distance
  learning, when rigorously designed and implemented can provide a framework for productive
  interactions. This SAFCo exercise can be an example.
SAFCo Faculty Group meeting #2
Feb 20, 2006

The focus is on
(1) where the school is currently and
(2) compare out school with other institutions known for excellence

Today will be a dialog, we are not looking for consensus, decision, etc.
Next meetings (Mon and Wed) we will work on priorities.

Key issues related to faculty

Recruitment and retention of faculty is the #1 problem.
‘faculty’ is too broad and vague definition
Need to define roles when recruiting faculty:
   for tenure track
   for clinical track (high turnover is an issue → continuity loss)
   for adjunct faculty (how do we recruit adjunct faculty by word-of-mouth)
need calibration of faculty (especially in outreach clinics)
need to define expectations – faculty’s and institution’s
need to define expectations for ‘scholarly activity’
research vs. clinical: what about people who do both?

Struggling with the requirement of 100% for full-time faculty; teaching vs. private practice. We need to change the faculty profile. A Faculty Salary Task Force (in 2002?) made recommendations that were ignored by the chairs. IT seems that no task force leads to cultural changes.

Recruitment and retention is a problem across the country.
Need to balance academia and private practice
   - there were abuses in the past (due to management problems?)
   - conflict of interests
Retention problem
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Passing over excellent instructors for promotion ➔ loss of good faculty
Clinical track committee: only extended the number of years faculty may work without tenure (“use them up and spit them out”)

Need to redefine ‘scholarly activity’

Clinical track is differently defined by various schools on campus (Dentistry vs Pharmacy vs Hospital); need to (re)define it; for example, at some schools clinical track faculty are not/may not be course directors

Need to define ‘peer review’; release time for peer review

Need to redefine ‘publications’: what about electronic publications? Aren’t they ‘scholarly activity’?

Adjunct faculty seen by some as “releasing faculty to be able to do research”; the school sees them as cheaper labor (no benefits)

Mentoring is a huge issue
clinical track faculty need mentoring to write papers

Professional faculty is different from, say, English Language faculty: lots of extra responsibilities (mentoring, teaching, clinics, research, etc)

Clinical and teaching faculty should be seen as equal partners.

We need to redefine the faculty profile; need to reword the mission statement and revise the bylaws in order to create a faculty model viable now and for 2016, to attain a ‘pre-eminence’ status

Some say that we lost the pre-eminence status as a clinical training institution; how can we measure that?

We should start from the mission statement and work our way on how to achieve its objectives (although they are not very well defined in the current mission statement)

Where we are vs where we want to be in 2016

What is more important knowing: where we are now (= complaining) or knowing what we want to be(come)?
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The accreditation documentation: could we use it to document “where we are”? How do we get where we want to be in 2016?

What do we want to look like and to achieve in 2016?

- faculty who can teach clinically (‘master clinicians’)
- develop a pipeline to train clinical faculty
- have a core of long-term faculty (people who look what they do AND are compensated fairly)
- including private practice patients in teaching program
- flexibility in administering faculty and appointments (‘nobody is good at doing everything’)
- rethink the practice model options/DFA/CE (currently burdensome)

Need to substantiate our recommendations to the provost, dean, chairs, etc.
We need bold initiatives, reshape what we (say we) do.
Following the ‘Proposed structure for discussion of key issues and final report for topic specific discussion groups’ we dealt with:

I. What are the key issues facing us
   A. Most significant strengths
   B. Most worrying weaknesses and most important things to address them

We don’t need to come up with the answers (implementation, budget, etc) – we need to triage the issues. Also, there may be more than one solution or path to a solution rather than “either/or” solutions (e.g., all faculty should be 100% or all faculty should be part-time).

Concern that the APT document in the works may already address the issues this group is discussing: according to Lynn and George, there is little overlap between the APT and SAFCo committees; APT does not cover all faculty concerns.

I. A. Strengths
   1. dental hygiene program
   2. specialists teaching their discipline (breadth in special areas, like genetics)
   3. reputation of school
      a. high expectations
      b. School graduates are big names
   4. research
   5. constructively critical faculty (not satisfied with status quo)
   6. faculty development resources
      a. library (one of the best in the country)
      b. Tom Green
      c. collaborations
   7. faculty expertise leading to
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a. journal reviews
b. peer reviews
c. NIH reviews/consultants
d. accreditation
e. board reviewers and examiners (also specialty boards)
f. membership in local, national and international organizations/assoc

8. collegial faculty
9. diversity

How do we benefit from these strengths?

Opportunities to share that expertise

1. faculty on boards can be beneficial to students
2. faculty, as players (not spectators) involved in policies
3. faculty willing to embrace innovation
4. faculty training faculty in other schools
5. publications in research and education

I. B. Weaknesses (list based on the two previous SAFCo faculty meetings) were ranked by those present (6 faculty members) as:

High = urgent and MUST be addressed asap, major impact
Medium = important, but other issues need to be addressed first
Low = it would be nice to be resolved

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<th>Topic</th>
<th>High</th>
<th>Med</th>
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<td>1. faculty “mix/profile” and roles</td>
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<td>2. faculty recruitment</td>
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<td>3. faculty retention</td>
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<td>4. diversity *</td>
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<td>5. salary structure (x,y,z)</td>
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<td>6. definition of “scholarly activity”</td>
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<td>9. mission</td>
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<tr>
<td>10. faculty development</td>
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<tr>
<td>11. faculty communication</td>
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* three people didn’t rank it
Following the ‘Proposed structure for discussion of key issues and final report for topic specific discussion groups’ we focussed on:

V. How do we measure up to the best of our peer institutions or other outstanding organizations in performance on the key issues

and

III. How are we currently positioned to address these key issues

I.A. Strengths

- ability to succeed under indifferent leadership
  (research, graduates are doing a good job despite any problems)
- excellent faculty as a group
- high experience level on the faculty
- ability to interact well
- research faculty strong ability to recruit strong researchers (unlike the clinical track, due to entry-level rank, promotion and political game for rank and promotion)
- internationally diverse faculty, bringing new ideas, etc.
- high energy level and enthusiasm (and frustration)

Back in the ‘70s and early 80s U-M clinical faculty was setting the standard for clinical dentistry:

80% of textbooks used in schools were written by U-M faculty
best dental materials meetings
top-notch clinical training
Ramsford & Ash – research
Craig & Asgar
clear standard of what was expected in the clinics
regular meetings
once/month clinics closed for calibration
What changed?

Research vamped up, following federal money: great research facility, but number of clinics changed from 8 to 4. Faculty on clinical track used to be able to get tenure for doing clinical work and writing textbooks, not anymore. Also, clinical track faculty used to get annual bonuses from the clinics’ income. New hires on clinical track not able to move us forward.

In the past, developing new materials did NOT involve clinical trials.
Clinical trials take time → delay in promotion.
Manufacturers are now in charge of clinical trials.

How can we build on what we have (a great research facility)?
Need to involve clinicians in research

I. B. Weaknesses (list based on the two initial SAFCo faculty meetings) were ranked by those present (5 faculty members) as:

High = urgent and MUST be addressed asap, major impact
Medium = important, but other issues need to be addressed first
Low = it would be nice to be resolved

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<thead>
<tr>
<th>Topic</th>
<th>High</th>
<th>Med</th>
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<tr>
<td>1. faculty “mix/profile” and roles</td>
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<td>2. faculty recruitment</td>
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<td>5. salary structure (x,y,z)</td>
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<td>6. definition of “scholarly activity”</td>
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<td>7. school administration</td>
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<tr>
<td>8. faculty governance vs. top-down</td>
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### Appendix 5

DRAFT Strategic Assessment Report to the School of Dentistry Community

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<td>9. mission*</td>
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<tr>
<td>10. faculty development</td>
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<td>2</td>
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<tr>
<td>11. faculty communication</td>
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</table>

* two people didn’t rank it
Following the ‘Proposed structure for discussion of key issues and final report for topic specific discussion groups’ we focused on:

V. How do we measure up to the best of our peer institutions or other outstanding organizations in performance on the key issues (A-C)

and

III. How are we currently positioned to address these key issues (A-E)

We decided to concentrate on recruitment, retention and “scholarly activity”, based on the responses to the 11 issues raised in the preliminary meetings:

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<tr>
<th>Topic</th>
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<tbody>
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<td>1. faculty “mix/profile” and roles</td>
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<td>2. faculty recruitment</td>
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<td>3. faculty retention</td>
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<tr>
<td>11. faculty communication</td>
<td>5</td>
<td>6</td>
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</tbody>
</table>

* some people didn’t rank it

New issue: should we get rid of tenure? Should there be a post-tenure review?

Tenure segregates faculty
Appendix 5

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Part-time faculty should be promoted even without tenure

It’s easier to have flexible schedule without tenure

Full-time clinical faculty should be protected

What about tenured faculty who are no longer productive?

We’ll postpone talking about “scholarly activity” until we review the new APT document (available online).

What other schools/organizations have no problems retaining/recruiting/promoting members?

- in our case, location is a problem
- need to find stats of schools with fewer openings
  - UDM: 80%-20% a plus
    - Completely flexible
    - More control over the 20%
- DFA: which schools have a successful DFA

Need flexibility for ‘Y’

V.A. What directions are our best competitors headed?

- DFA: check LSU business model
- Allow clinical faculty not to do DFA with only 80% salary
- Reward clinical faculty for students’ productivity and quality of care (e.g. few remakes): for example, ‘attending model’ as in Med School (what in private practice is called ‘delegation’); need to consider quality of instruction as well
- Bonuses or other incentives

V.B. What will set us apart from the crowd yet distinguish us among peers?

- Provide an infrastructure and service to support scholarly activity – a ‘safe’ environment (CRLT and CSCAR are not very helpful)
- Strong mentoring program
- System to calibrate faculty
- Core faculty competing for positions (at least 3 days/week): create an environment to support faculty who want to teach
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- Articulate clear expectations for core clinical faculty (calibration, participation, commitment, continuity, competitiveness)
- Develop a strong focus to support development of senior/mature/’seasoned’ practitioners into strong clinical faculty; develop institute to train our own seasoned faculty
- Need a different compensation program: ‘X’ needs to be more equitable
- Need full range of adjuncts (we have that, other schools are missing entire disciplines)

Next meeting, Monday, March 20, we’ll continue discussing III (A-E).
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SAFCo Faculty Meeting
March 20, 2006

I. Decisions

- The Monday group should continue focusing on Recruitment/Retention/Scholarly Activity and the Wednesday group should pick the other issues to discuss, to avoid overlapping.

- Wait until faculty discusses the APT document, before addressing ‘scholarly activity’.

II. Discussion of the impact of adopting the “Diversity in Faculty Profile” proposal by Jim McNamara on faculty recruitment:

<table>
<thead>
<tr>
<th>Pluses</th>
<th>Push-back</th>
</tr>
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<tbody>
<tr>
<td>improve clinical faculty</td>
<td>dental community reaction: probably none</td>
</tr>
<tr>
<td>K. Kelly has flexibility</td>
<td>decreased flexibility by chairs</td>
</tr>
<tr>
<td>consistency (able to do training &amp; calibration)</td>
<td>DFA will need to become more efficient</td>
</tr>
<tr>
<td>stability (people don’t move because of good financial position with investment in practice in town)</td>
<td>conflict of interest; open to abuse (of unscheduled time); department chairs will need to establish strong leadership</td>
</tr>
<tr>
<td>release current pressure on DFA in school</td>
<td></td>
</tr>
<tr>
<td>satellite DFAs (clinics are an option)</td>
<td></td>
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<tr>
<td>clinic time guaranteed to be full with patients</td>
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</tbody>
</table>

More on recruitment

- need to address the start-up packages (asst. professors need negotiation mentor)
- need to provide examples from other institutions (e.g. U of D, UCSF have 80% appointments) in the ADEA report?
- ability to practice adds credibility
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- one possible measure of loss of pre-eminence status as a clinical training institution: number of failures at clinical boards; seniors without enough experience (e.g., with crowns)
- one way to recruit faculty despite the loss of pre-eminence (real or perceived): benefits for faculty
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III. Retention

- need peer review in the promotion process
- clinical track represented in APT (by-laws)
- mentoring program
  - significant priority of chairs
  - affects scholarly activity (time allocation)
  - junior faculty need to be protected
- equity of pay within rank (X only)
  - in hospital divisions bonuses are divided equally

Next meeting: Monday, April 3, 5:30 pm, FAL.
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SAFCo meeting
Faculty Group
March 22, 2006

Diversity
- some people didn’t rank it, maybe they missed it (it was on the last line of the second page)
- diversity is talked about a lot on campus, so maybe it shouldn’t be a high priority on our list
- on the other hand, it is one of the possible questions the provost asked us to address: we could include it within other categories (e.g., recruitment, retention, salary structure)

Comments on the “Diversity in Faculty Profile” proposal:

50%-80% appointments
- new (not ‘grandfathered’) appointments in Cariology; a 3 yrs. pilot.
- at the discretion of the chair because of budget constraints (the department needs to absorb 50% of the benefits and the ‘y’)
- ‘close the financial gap’ argument: maybe for the individual, not for the department
- ‘major reason for leaving’ argument: the major reason may be lack of loyalty to the institution. Until 1989-1990 faculty was hired from among the graduate students. After that, the policy has been NOT to hire graduate students, which means that appointments with U-M are a stepping stone to other jobs, look good on résumés, but do not foster retention, continuity, etc.

Need to document this over past 10-15 years:
- # of faculty U-M grads
- # of faculty who left for academics, private practice
- # of foreign-trained faculty
- different impact for different specialties

<table>
<thead>
<tr>
<th>Pluses</th>
<th>Push-back</th>
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<tbody>
<tr>
<td>no promotion clock for &lt;80%</td>
<td>huge financial hit for departments (for 50%-80%)</td>
</tr>
<tr>
<td>decrease of 1 day/week appointments</td>
<td>no contributions to service, scholarship, etc. by part-timers</td>
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<tr>
<td></td>
<td>no loyalty to institution</td>
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<tr>
<td></td>
<td>more part-timers have fragmented the</td>
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<tr>
<td>Clinical Curriculum</td>
<td>Little Consistency Among Faculty</td>
</tr>
<tr>
<td>---------------------</td>
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<tr>
<td>Not Enough Time, Working Part-Time, to Build a Profitable Practice</td>
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‘Plus’ from last meeting questioned: ‘no reaction from dental community’?
‘Push-back’ from last meeting questioned: ‘time guaranteed to be full with patients’?

**More Recruitment Issues**

Major deterrents for clinical faculty: retention/promotion process and salary structure.

- Both issues were previously discussed with no results/change.
- NOT a problem for research faculty.
- MCOHR is the first revival of clinical research at U-M.
- Need a culture similar to research culture for the clinical track
  - Clinical track post-doc to jump start clinical faculty
  - Without clock on

What about the other issues, those ranked 7 and 5?

- Move as much as possible/relevant to recruitment/retention/scholarly activity
- ‘Faculty communication’ needs to be addressed internally

Next meeting, March 29, we’ll discuss faculty development and governance.
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SAFCo meeting
Faculty Group
March 29, 2006

Topic: Faculty Governance

How do we measure up to the best of our peer institutions?
(Question V in the “Proposed Structure for Discussion of Key Issues and Final Report…”)

First of all, which schools are our peer institutions?

- sources of “innovative & teaching breakthroughs”
- top 5 Dental Schools in the country
- private vs. state schools?
- Monte will bring next time the list of top 5 schools our faculty went to from U-M in the past 5 years
- Woolfolk will give us the list of top 5 schools that attract ‘our’ students

We’ll answer questions A, B and C after we get the list of top 5 schools.

U-M Governance
One comment to the Priorities List (re: the Faculty Governance): there is no need for departments, both APT and EC, to review promotion and appointment materials. Get rid of at least one layer of repetition.

Promotion review

<table>
<thead>
<tr>
<th>at U-M:</th>
<th>Dept &gt; Chair &gt; APT &gt; EC &gt; Provost</th>
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<tbody>
<tr>
<td>at UI (&amp; NYU?):</td>
<td>Dept &gt; Chair &gt; APT &gt; Provost</td>
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<tr>
<td>at UCSF:</td>
<td>Dept &gt; Chair &gt; Provost</td>
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<table>
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<tr>
<th>advantages (of having both APT and EC)</th>
<th>disadvantages (of having both APT and EC)</th>
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<tbody>
<tr>
<td>“more eyeballs”</td>
<td>too much redundancy: costly ($ and time)</td>
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<td>when EC and APT disagree, there is no real procedure to resolve (the Dean decides)</td>
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<td>no clinical track representation in the review process (APT)</td>
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<td>EC not popular, it’s hard work, doesn’t have time to advise on fiscal matters and other matters of substance</td>
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Related issues:

- there is no similar review post-tenure (it is between the chair and the faculty member):
  
  ▪ some tenured faculty members are still ‘productive’, others are not →
    the money spent on unproductive tenured faculty could be better spent on productive faculty

- what happens to promotion on research track?

- need to increase faculty involvement in governance:
  
  ▪ tenured faculty members are less likely to be involved in committees
  ▪ standing committees should be made up of senior faculty
  ▪ non-tenured faculty afraid of bringing up issues to discussion
  ▪ people not participating in committees or coming to meetings because of
    apathy? fear? frustration (of nothing being accomplished)
  ▪ the International program was approved by administration without faculty input:
    faculty members do not feel empowered, but they have more power than they think
  ▪ faculty elects EC, EC decides without faculty
  ▪ APT – not everyone is interested in the changes, so why come?

- nominations not making the slate → need to review the by-laws?
First, we reviewed the minutes from the last meeting (March 29, 2006) and brought to date the participants who were not at the last meeting.

- updated the chart representing the UMSD Faculty Governance (added the Admissions Committee and a line between Faculty ad PT): see below *
- the top 5 schools we are loosing students to (after they’ve been accepted at UMSD) are: UNC, Maryland, UConn, Harvard and UPenn.
- Updated the Promotion review process at UMSD (the Dean decides after EC and presents it to the Provost):
  Dept > Chair > APT > EC > Dean > Provost
- Re: nominations not making the slate, this is illegal (according to one of the participants); the case referred to was happening under a different Dean.
- We still need the top 5 schools we are loosing faculty to; we need to look at faculty leaving to take positions at other schools, not leaving for other reasons; also, it seems that those leaving are more likely to be on research and not clinical track

**Faculty Governance is regulated by**

1. Regents bylaws
2. Unit bylaws (any changes must be approved by the Regents)

A unit may have more stringent bylaws, but not more lenient, than the Regents bylaws.

U-M uses the ‘shared governance’ model (other models for faculty governance are: ‘top-down’ and ‘collective bargaining’).

Possible changes to our bylaws:

- APT Process. The “governing faculty” needs to approve it. “Governing faculty” is faculty appointed for at least one year and full-time (with a few exceptions – part-time grand-fathered tenure). Clinical faculty is not allowed to vote – there is a ballot to change this.
- Real ‘shared governance’ means discussing almost everything with faculty; the Chairs and Dean do not discuss all matters with faculty via EC, for example, budget and space issues. The Dean has the right to decide differently than the faculty, but discussions need to take place.
- EC and faculty do not communicate sufficiently, beyond the annual report
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- EC and Chairs should have periodic joint meetings; the minutes should be made available to faculty (with no names and with possible exceptions when ‘secrets’ are involved)

- Faculty does not set the agenda for faculty meetings; the Dean does:
  - need to talk with Pete about control of meeting agenda
  - recommend that EC sets the agenda

- Not enough time to deal with all issues in one-hour meeting:
  o should we have more meetings (the mandatory number is 10/year)?
  o Should we have a faculty secretary (as mandated by the Regents bylaws)? Rex will ask the Med School if they have one

Next steps:
  (1) Read the online materials on faculty governance (www.umich.edu/~sacua/):
      for example, “Principles of Faculty Governance” (www.umich.edu/~sacua/AcadAff/aaacdoc.html);
      Regents bylaws (www.umich.edu/~regents/bylaws/index.html);
  (2) Read “Remarks by Senate Assembly Chair Bruno Giordani at the Sept 26, 2005 meeting of Senate Assembly” (attached; it’s on the www.umich.edu/~sacua: lower part of the page)
  (3) Review the committee membership (file attached) – looking for trends in the distribution of membership by faculty rank (George)
  (4) Encourage more full professors to participate in governance committees

Next meeting: Wed, Apr 19, 2006, 6:30 pm, room B312B.

* U-MSD Faculty Governance
The University of Michigan School of Dentistry staff is comprised of approximately 340 diverse, passionate, experienced, capable, and loyal people. These staff come from diverse backgrounds, a variety of work experiences, happily work hard to serve the School’s public, and many have remained at the School for up to 30 years. The staff of the Dental School is proud to play a part in the mission of this great institution that is known nationally and internationally. Roles played by the members of the staff include patient care, education, and research. This report will reflect the proud voice of staff.

The staff committee identified seven (7) key issues for discussion. Those issues are: Clinical Staff Issues, Staff Development (includes mentoring and continuing education), Merit (Salary) Program, Tuition Reimbursement, Communication, Staff Strengths (what we are doing right), and Staff Impact on Dental Education. Six (6) questions were asked and answered during each of these discussions. They are:

- What is the current status?
- What do we want to look like in the future?
- How do we achieve this?
- What are the barriers to achieve our future state?
- How can the School of Dentistry help us achieve our goals?
- How can the University help us?

The following is the summary of these seven discussions.

**Staff Strengths**

**What is the current status?**

The University Of Michigan and the School of Dentistry are doing several things right. Dean Polverini receives credit and gratitude for including the staff in the strategic assessment process.

Other positive things that the staff members feel are being done right include:

- Newsletters from the Dean, Dr. Stefanac, Dental Informatics, MAC, and the Staff Forum Newsletter.
- MAC-sponsored events including the Disability Forum, Women’s Tea, Ida Gray Award, and the Taste Fest.
- School-wide events such as the School Picnic, Dean’s Holiday Party, Dr. Rife’s Holiday Caroling, 10-year service award reception, as well as the University-wide service reception.
- New initiatives such as the upcoming Staff Retreat.
- Jerry Mastey is an asset with the Dental UM, the Dental School Website, and the articles in the University Record.
- The Dean’s Town Hall Meetings.

**What do we want to be like in the future?**

In addition to a continuation of the above-mentioned items, there is hope that the Staff Retreat is a success and becomes an annual event. If it goes well, perhaps a joint retreat with other nearby health care units such as the University Health Service and the School of Pharmacy could be explored.

Other suggestions for the future include:

- Creating a Staff Endowment for ongoing funding.
- Giving formal recognition to the staff for participating in community outreaches like: Give Kids a Smile Day, Dental Health Day and the Mouth Guard Clinic.
- Giving public recognition for staff that go above and beyond.
- Creating more ways to encourage all staff to participate in School of Dentistry and University events and programs.

**What barriers do we see?**

Among the barriers to achieving these goals are limited funding from tight budgets and limited staff time for efforts that are deemed optional.

**What can the Dental School do to help?**

The School could consider the staff development endowment as mentioned above as well as telling the positive stories of the staff and their efforts. Members of the staff could practice “guerrilla recognition” – telling the positive stories they hear and passing them on so that the grapevine is filled with the good things that are going on in this building.

**What can the University do to help?**

The University could recognize that staff members are the “good will ambassadors” for the University, and that there are many loyal employees. Publishing more stories about staff in the University Record, Michigan Daily, and on the U of M website would also be beneficial to boosting staff morale.
Staff Development

This section of the Staff SAFCo work group focuses on the topic of Staff Development.

What is the current status?

The School of Dentistry does not have an overall formal or informal staff development program at this time. While certain positions and units have clear career paths or career ladders, most positions and units in the School do not. Most members of the staff at the School do not have a good understanding of the relationship between different jobs in the new classification system. With the University at the end of the calibration of the new classification system, this is a good time to focus energies and attention within the School on formalizing a staff development program.

What do we want to look like in the future?

The staff at the School of Dentistry wants to see a formal staff development program. The plan should provide a clear career path and career ladder for advancement not only within the School but also within the University at large. While there is an indication in some job titles and descriptions of the advancement levels (assistant to associate, intermediate or senior), the majority of the new job titles do not clearly provide a clear path.

A formal staff development program at the School should include:

- Opportunities for individuals to be program presenters
- UMSD staff who annually attend the Women of Color Task Force conference should present a summary of one of the seminars to the School staff community
- Establishment of a Staff Mentorship program
- Staff development goals should be a core component in staff performance plans for the following year
- Staff could earn continuing education credits for achieving Core Competencies
- A staff development opportunity should be available once a month for all staff

How do we achieve this?

Achieving this priority depends on the commitment of the School’s administration and the Dean to staff development. Reducing staff turnover and providing for an enriched
and engaged staff complement are just two results of a formal staff development program. The commitment to this formal program must be visible and tangible and not just given lip service.

**What are the barriers to achieve our future status?**

Development and implementation of a robust staff development plan will take time and a budgetary commitment. The scheduling of staff development programs at a time when staff can attend, especially in the clinical areas, is a key component to their success. The continued scheduling of events at the lunch time is a barrier. Staff members need this time to be refreshed from their work assignments. The costs to either contract with the University’s HRD office to develop and deliver programs or bring in outside speakers are a potential barrier to the successful implementation of a staff development program.

**How can the School help us to achieve our goals?**

The School can assist with the development of a formal staff development program by committing to the creation of a Staff Development program and making it a priority, identifying the resources required to fund a Staff Development Program, funding a budget for an annual staff development series for the School, and, most importantly, closing clinical hours so all staff can participate (such as is being done with the May 18 staff retreat).

There are staff members in the school with skills needed and desired by other staff members. A sharing opportunity needs to be implemented that would allow these skills to be shared (and allow the time used for this to count as work time). To implement this, the school would need to develop a resource list and help the “experts” to get the release time from their regular duties for this program, either as tutors or as program speakers. A Career/Skills fair would be a good way to help people make the needed connections.

Other suggestions include:

- Hosting Brown Bag Presentations at the School
- Scheduling program presentations during the work day and not at lunch
- Being aware of the impact on patient areas of the scheduled program time

Staff at the School will positively respond to a staff development program that will get them charged up and keep them connected and enthused to the School.

**How can the University help us?**

The University’s HRD area has a wealth of resources of programs, consultants, and speakers the School can utilize. The Staff SAFCo Work Group would like to see the School create a “Service Agreement” with the HRD office to provide at no charge a series of staff development seminars that will address staff core competencies for the School. Courses such as customer service, basic Excel or Word, and effective problem solving should be considered as elements of this Service Agreement arrangement. In the
absence of a “Service Agreement,” the School should contract with the HRD office to present seminars to a mass School staff group.

It is in the best interests of the University for members of the School of Dentistry staff to be successful in their careers. Establishing a formal staff development program would provide an effective vehicle for School staff members to not only meet their core competencies but excel and advance along their identified career path.

Clinical Staff Issues

What is the current status?

Members of the clinical staff report that there is a need for qualified clinical people (as opposed to clerical staff replacing clinical staff). Far too much time is spent with giving on-the-job training rather than hiring people with all the qualifications. By hiring fully qualified people, the School of Dentistry could reduce wasted human resource hours and increase clinic productivity. There is also a need for a better ratio of dental assistants-to-residents in the graduate clinics; this would help achieve greater productivity as well as helping us serve the needs of more patients, generating more revenue in the graduate programs, and eliminating a need for “Band-Aid” dentistry.

There needs to be recognition of the different educational attainments of dental assistants. At this time in the School of Dentistry dental assistants with expanded function credentials are not compensated financially for their additional training; nor are dental assistants with an education from an accredited school classified differently from those who went through vocational programs or on-line programs. It is important that universities, as places of higher learning, should recognize the educational achievements of all individuals and not just faculty and administrative employees. The current salary scale for dental assistants puts far more emphasis on years of experience rather than educational credentials. For the sake of fairness, both factors should figure into the pay scale equation.

An argument can be made that the outlook for attracting future employees in the clinics is dismal. There is real concern over the average age of our current clinical staff and the fact that the employment market will experience a severe shortage of dental assistants within the next fifteen years. Market indicators suggest that young people are not actively pursuing careers in dental assisting and, as a result, several dental assisting curriculums are being phased out because of decreased enrollment.

What do we want to look like in the future?

The University of Michigan School of Dentistry has a long-standing reputation of excellence among the ranks of dental schools. Being a model employment site for others to emulate is part of that reputation. This school should project an image of having a highly professional clinical component with competent clinical staff as an integral part of its program. The school should more closely resemble the real world of dentistry with a return to the values and concepts of four-handed dentistry and the dental team approach to patient care. The members of the clinical staff would like the School to be a place of
employment where everyone feels valued. They would also like to be proud of their work place and make others wish that they had the same privilege.

**How do we achieve this?**

It is time to make professional enrichment a reality for every full time employee (FTE) by removing department-dependent requirements (i.e. department budget constraints) so that every FTE has an equal opportunity to improve current skills and/or learn new ones. Going along with this, it is also time to make full-time employees accountable for their own professional development.

Other suggestions include:

- Have salaries competitive with the true job market
- Recognize dental assistants as a professional component of the dental team.
- Implement “morale boosting” social activities during the work day to allow employees a chance to remove themselves from their normal work activity for a while and interact with people from other units. (i.e. summer picnic, winter holiday party, workplace potlucks, etc.)
- Continue programs that include staff involvement and input for improvement in the workplace.

**How can the School help us achieve our goals?**

This would obviously require some directives from the top to the bottom. It would be necessary for the Dean and the Administration to actively encourage staff members to not become stagnant in their professional growth. Departments and/or units should be held accountable for making Human Resource Development a part of their overall budget and stress at all times the need to be professional. In response, all full-time employees should be held accountable for taking advantage of the professional development being offered and should uphold the standard of professionalism that the School desires to project.

A program in the school that works really well is the “Situation-Problem-Solution” program. This program is local to the Department of Orthodontics and Pediatric Dentistry, but it would be worth exploring on a wider basis.

**SPS Program**

**Situation-Problem-Solution program. Part I.** Create a form/document that allows a staff member to first state a situation. Then the staff member would indicate problems with the current situation. Finally, the staff member would offer what s/he believes to be a solution to the problems that arise out of the current situation. This would allow staff to have a voice in their work environment and feel a sense of empowerment, as well as a sense of being valued by others in the workplace. By forcing the staff member to complete all three requirements of the SPS program this does not become a vehicle for complaining or letting off steam. The participant absolutely must give serious thought to the problem and offer a reasonable solution before s/he could expect her/his issue to be considered. **Part II.** Create a committee that would meet regularly to address the
concerns submitted on the forms. Committee members should pledge to take all submissions seriously and to keep the confidence of the person making the submission in order to avoid possible retribution. Every effort should be made to ensure that staff members feel they will not suffer in any way for having questioned or raised an issue about situations in the work place.

**How can the University help us?**

The University should allocate money in the overall operational budget for professional development. There should have a budgeted dollar figure for every FTE much like the state assigns to students in public schools. What is not used could go back into the budget the following year.

The University should seek to institute a true merit-based salary increase program. The idea of merit is a good one, but the current salary program is severely inadequate and is often not tied to merit at all.

The University could start a radio/television promotional campaign emphasizing the “advantages” of being employed at the University of Michigan to offset the negative workplace bashing that goes on from time to time. This will help to change the mindset of current employees while attracting new employees.

It is important that state funding is distributed in the most equitable manner among the schools/colleges.

There is a perception that money is being spent for redecoration rather than needed clinic equipment, patient care, and adequate staff compensation. There is a need for greater transparency in the funding sources for office furniture and related items. This transparency would help to counter the negative perception that can result from such expenditures.

**Staff Impact on Dental Education**

**What is the current status?**

Staff serves as a conduit to ensure that the mission of the Dental School is achieved. Staff members are the wheels, spokes, hands, heart, engine etc. of the school. Staff members are the first and last contact most patients have with the school, and the school would not run without the staff. Staff Impact on the school can be discerned by looking at the following list of staff duties. This is not an exhaustive list.

<table>
<thead>
<tr>
<th>Order supplies</th>
<th>Grade students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validate parking for patients participating in studies and others as needed</td>
<td>Maintain credentialing of faculty, staff, and students</td>
</tr>
<tr>
<td>Procure patients</td>
<td>Lab day-to-day work</td>
</tr>
<tr>
<td>Maintain school calendar</td>
<td>Student guidance and support</td>
</tr>
<tr>
<td>Training and orientation</td>
<td>Cleaning and ordering instruments</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Personal life counseling</td>
<td>Student manuals</td>
</tr>
<tr>
<td>Answering telephones</td>
<td>Patient relations</td>
</tr>
<tr>
<td>Recruit prospective students</td>
<td>Liaison with other units on campus</td>
</tr>
<tr>
<td>Fundraising/development</td>
<td>Create travel reports</td>
</tr>
<tr>
<td>Alumni relations</td>
<td>P-Card handling</td>
</tr>
<tr>
<td>Taking and duplicating X-rays</td>
<td>Cubicle set-up</td>
</tr>
<tr>
<td>Filing/retrieving charts</td>
<td>Continuing education assistance</td>
</tr>
<tr>
<td>Handle bills</td>
<td>Support faculty</td>
</tr>
<tr>
<td>Handle complaints</td>
<td>Maintain IT infrastructure</td>
</tr>
<tr>
<td>Process patient adjustments</td>
<td>Prepare and manage grants</td>
</tr>
<tr>
<td>Manage facilities</td>
<td>Follow up with insurance carriers</td>
</tr>
<tr>
<td>Monitor HIPAA compliance</td>
<td>Collect monies owed</td>
</tr>
<tr>
<td>Manage accounts</td>
<td>Perform fiscally responsible practices</td>
</tr>
<tr>
<td>Prepare budgets</td>
<td>Appoint new students</td>
</tr>
<tr>
<td>Administrative/office support</td>
<td>Handle walk-in patients</td>
</tr>
<tr>
<td>Filing</td>
<td>Register patients</td>
</tr>
<tr>
<td>Hunt patient records</td>
<td>Enter and manage data</td>
</tr>
<tr>
<td>Hallway traffic director</td>
<td>Assign patients</td>
</tr>
<tr>
<td>Manage machines (copier, printer etc.)</td>
<td>Handle lab cases</td>
</tr>
<tr>
<td>Sort mail</td>
<td>Provide staff orientation</td>
</tr>
<tr>
<td>Deliver packages</td>
<td>Perform multi-media work</td>
</tr>
<tr>
<td>Transport patients</td>
<td>Perform dental materials technical work</td>
</tr>
<tr>
<td>Maintain crash cart</td>
<td>Provide dental informatics support</td>
</tr>
<tr>
<td>Maintain student records</td>
<td>Repair equipment</td>
</tr>
<tr>
<td>Provide/teach four-handed dentistry</td>
<td>Track student finances</td>
</tr>
<tr>
<td>Monitor security</td>
<td>Close out student files</td>
</tr>
<tr>
<td>Manage infection control</td>
<td>Transition graduates</td>
</tr>
<tr>
<td>Perform library duties</td>
<td>Coordinate community outreach</td>
</tr>
<tr>
<td>Dispense materials, instruments etc.</td>
<td>Recruit, train, and evaluate staff</td>
</tr>
<tr>
<td>Provide photography support</td>
<td>Serve as Dental School Ambassadors</td>
</tr>
</tbody>
</table>

**What do we want to look like in the future?**

What is being done now should continue; however, to develop more in the areas of collaboration, collegiality, and civility would be ideal.

To control the ebb and flow of work, more cross training is needed. There is also a need for more of a sense of everyone being on the same “side” where one group’s problems are seen to affect other groups as well. There needs to be a more global way of thinking
and problem solving – especially since patients see the school as a single entity, and not as a collection of departments.

Staff recognition, formal and informal, is also another goal for staff. There is a need for more multi-departmental teamwork in which staff-developed programs and ideas are highlighted and shared during faculty, student, and staff gatherings.

**How can the goals be achieved?**

These goals can be accomplished by addressing issues openly and honestly, in a cooperative manner without fear of voicing opinions. All participants, especially upper-level administration members, must agree from the outset to be receptive to differing viewpoints in these conversations. Developing rules of engagement for problem solving discussions, skill-building for some supervisors in listening and problem solving, and identifying the right venue for these discussions would also help.

A need for a true staff representative within the School was also voiced. This person would be someone like the equivalent of a student counselor or a patient advocate.

Also it is hoped the Staff Retreat will be helpful and if it is, we recommend that it be held annually.

**What are the barriers to achieve future status?**

It is believed there are not enough resources – either staff or money to achieve staff goals. More is being done with less, and staff members do not feel safe to discuss feelings and opinions openly. Other barriers include the perception that members of management do not want to hear staff problems and sometimes handle that by avoiding staff members. Other barriers include conflicting priorities concerning staff as well as the sense that staff needs and wants are not a priority.

The Staff committee agreed on the following definitions of co-workers versus colleagues:

- Co-worker implies someone who performs a discrete function and may be a competitor.
- Colleague implies an equal, a co-creator, someone for whom we have respect, someone who is watching out for our best interest, and whose best interest is our concern.

Collegiality was named as one the goals above. One of the barriers to achieving it is changing the mindset of staff members and others to reflect the idea that staff members are “co-equals.”

**How can the School help us achieve these goals?**

Staff representatives should be added to more of the broader committees of which administrators and faculty are participants.

The School should make a commitment to a formal staff development program. By allowing lengthened lunch hours (without patient appointments) once a quarter, done
similar to the Staff Retreat, this could be achieved effectively. Other units on campus, such as Parking Operations and Cashier’s Office, do this. Of course this needs to be sanctioned from the top down so that departments can free people to attend. Make Martin Luther King (MLK) Day a dental school holiday. It would be a mandatory attendance work day, but a staff enrichment experience with no clinics. The pre-doctoral programs already have MLK Day and Research Table Day without patient appointments; however, grad clinics and DFA keep on regular schedules those days. We should look at how much it would cost the Dental School to shut down DFA (someone offered the figure of $550/hour/provider) compared to the cost/benefit ratio of having better trained staff.

The School should develop a more robust staff recognition program. Staff who complete degrees or other accomplishments in higher education should be recognized school-wide from the dean’s office.

To foster relationships across departments, pilot a multi-department team to work on a specified topic. From this work core competencies could be developed.

**How can the University help us?**

The University could offer training in competencies at no or reduced charges. The training could take place at the School. Martin Luther King Day could be a true campus-wide holiday, but with regular work suspended and staff involved in an enrichment activity – either attending MLK events or doing in-service work.

**Communication**

Over the eight weeks of meetings (with the group meeting twice in some weeks), a consistent underlying theme emerged of difficulties with communication within the School of Dentistry. By and large, these difficulties were perceived to be mostly systemic; but the presence of isolated situations of poorly communicating individuals was also made apparent.

**What is the current status?**

The current status of communications according to the staff is mixed. Off-site people feel disconnected from the grapevine, and because the school now has several units – Community Dental, Clinic Billing Office, MCOHR, the research groups at Eisenhower Place, and the Development Office – offsite, this is becoming a wider issue.

Various forms of communication are used within the School, and each was examined in turn. Several groups within the school produce information-packed newsletters that are well done and mostly helpful. These groups include the dean, Jerry Mastey in Alumni Relations, the library, Patient Services, the Staff Forum, Dental Informatics, and the Multicultural Affairs Committee. DentalUM and Mr. Mastey’s press releases are especially helpful. Most of these newsletters are conveyed via e-mail, and it is clear that e-mail overall has benefits and drawbacks. It is fine for routine matters, for getting information out, and for clearing to-do lists. It does not work well with older faculty, with really important matters, or with people who do not regularly check their e-mail boxes. It
has become apparent that the leaving of an e-mail does not guarantee the reception of the relevant information. Also, e-mail communication is hampered for some staff members because it is generated in multiple places (the axiUm system and other systems within the school) and does not have a central end point, necessitating people to log in to various systems to gather all of their e-mail.

The group also examined meetings as a form of communication. Meetings also have benefits and drawbacks. Truly effective meetings involve thought-provoking conversations, discussions about greater ramifications, and a full sharing of views. Too many meetings here at the School of Dentistry are called simply to convey information that could be more effectively communicated via e-mail. On the other hand, in some departments, staff meetings are infrequent and fail to convey adequate information. It was the sense of the group that more of the communication to staff should include information about the process used and issues raised that led to certain decisions. It is not necessary that all of the details should be conveyed, but there is a concern about the dearth of appropriate staff input in decisions affecting daily work life. The group agreed that one very helpful meeting form is the Dean’s Town Hall meetings, and the desire was expressed that these were held more regularly.

For communicating really important matters, face-to-face communication is the best means, even if that communication is done while passing in the halls. Generally speaking, communication between supervisors and supervisees can be characterized as candid, honest, full sharing, mostly positive, not intimidating, in touch with problems and issues, leading by example, and not micromanaging. This list is noted with the caveat that it is created by a self-selected group of staff people, and that there are places in the School that do not follow this model. Some supervisors in the School do not respond well to “why” questions, either asserting authority or citing decisions beyond their control from higher up. For the most part, communications between staff and faculty are open and informal.

Difficulties are found in the area of communications between Administration (deans, administrators, academic administrators, department chairs) and staff. On important issues, staff members frequently experience silence; the information is sporadic, incomplete, last minute, and very broad-based (not specific). Information is conveyed via e-mail and memos with little personal follow-up, and it seems to follow a strict need-to-know protocol. Staff members have also experienced a lack of respect from school leaders with blame, finger pointing, inconsistency, and a perception of elitism between higher-ups and workers. Much of the negative communication is done through body language – lack of acknowledgement in hallways – no smiles or nods of recognition. There is the perception the administration does not look out for the needs and concerns of mid-management. It should be pointed out that communications have improved with the new dean and with Jerry Mastey’s ongoing work.

**What do we want to look like in the future?**

In the future there would be open, wide communications in a timely way at all organizational levels. This would be best facilitated by an information posting/sharing website within the school so that when staff members need to know something, there
would be a central place to check. More meetings need to be open, casting a wider information-sharing net. There should be more of the dean’s town hall meetings with the question and answer interchanges and the sense of community engendered thereby. There needs to be a single e-mail source. There needs to be a better way of getting written communications to students.

There should be a greater emphasis on participatory communication and decision making within units, between departments, and between upper administration and departments. There should be a greater emphasis on a collaborative model, including interdepartmental site visits in order to build better working relationships. There should be less territoriality within the School.

**How do we achieve this?**

The group generated several suggestions about how to achieve these goals. The first would be to practice collaboration among staff members. Staff members should be encouraged to make interdepartmental visits to get acquainted with various areas within the School. There needs to be more whole-school thinking in departmental decision making. It is important for supervisors to involve their staff in more decision-making discussions, and there needs to be more staff development during work time. Staff members need to begin to see themselves as catalysts for communication change within the School by fostering and sharing ideas.

**What are the barriers to achieve our future status?**

There are several apparent barriers to reaching these goals. Perhaps the most important is the attitudinal one of keeping information closed off, even when it does not need to be. Another barrier is that staff members feel intimidated in whole-school settings (such as the Town Hall meetings), and that prevents staff members from requesting information or offering insights. This sense of intimidation keeps many voices from being heard.

Time is also a barrier. There is limited time to read e-mails, and every staff member has experienced the hassle of returning to work after a few days to find an overflowing e-mail box – frequently with spam and junk mail. Plowing through that deluge of accumulated e-mail is a barrier to thoughtful communication. For the folks who have multiple e-mail systems to check, there are barriers every day to effective communication. An additional barrier is a lack of adequate computer access for all staff members, especially front-desk workers and clinic staff. The lack of computer access also points up the paucity of computer skills in certain groups of staff members, and those deficiencies serve as barriers for them. Yet another computer-related barrier is the time needed to input information to a shared website.

The issue of time also shows up in relations between staff members and their supervisors, staff members and faculty, and staff members and upper administration. Because collaborative decision making is a time-intensive process, it is easier to make decisions without staff input. This barrier is supported by a perceived hierarchical culture within the school (and this perception works both ways). There are clear lines perceived between administrators/top managers/dentists and everyone else. The cultural barriers also extend
sideways – people do not feel comfortable going into areas belonging to other departments without invitations. This precludes information sharing between departments on issues of shared interest.

A lack of supervisor training for people who become supervisors serves as a barrier. There is a lack of required training in basic communications skills for people who find themselves having to communicate with a variety of constituencies. This lack of training seems to be an underlying cause of many of the issues raised in this section.

The dental school laboratories hold cultural and language barriers as people from across the globe are mixed into the same research space. It is a sign of some of these barriers that this group’s participants, except for one meeting, did not include any of the laboratory workers, despite direct personal invitations being extended in addition to the global e-mail invitations.

**How can the School help us to achieve our goals?**

The Dental School could take several steps to help achieve these goals. The first is a simple hardware issue: provide more access to computers by turning older computers into staff-shared departmental computers. This would enable the front-desk and clinical staff members greater access. It would be helpful to have continued development of the Great Places to Work supervisor-training tool. Staff members should be sent to HRD classes to improve communication and interpersonal skills, and staff training time should be blocked out on a monthly basis. It is very important that communication should be considered a Core Competency for the School and should be tied to performance development. On the subject of training, CTools training should also be available.

The School needs to establish an effective communications method to get information to off-campus offices. Several current communication methods are working well and should be continued, including the dean’s newsletter, departmental newsletters, etc. A mechanism should be set up to allow staff members to submit questions anonymously for the dean ahead of town hall meetings so that he can respond more fully to staff concerns. Perhaps Dental Informatics could set up a wiki where people can post information of interest to other members of the school community.

Pediatrics’ SPS (Situation, Problem, Solution) program (described above in the Clinical Staff Issues section) should be considered as a possible model for resolving issues. This program is open to staff, faculty, and graduate students in the department; it gives a sense of empowerment, validates that everyone has something to offer, and gives everyone a chance to be heard. There is as much transparency as is appropriate. A team within the department examines issues that are brought forward, determines the underlying problem, and proposes a solution. Some issues are resolved quickly; others take years to resolve.

A recent meeting between staff members in the Clinic Billing Office and staff members in Patient Services gave each unit a better understanding of the issues facing the other unit. It allowed some shared decision making, and the meeting produced real solutions to problems affecting the School. This is a good example of the kind of inter-unit / interdepartmental meetings that the School could promote.
There is a need for the development of Continuous Improvement Teams that would gather statistics and information to assist in resolving issues. There are, of course, dangers in formalizing various mechanisms so that they become their own reason for being. Many people would experience information overload and would begin to tune out crucial information. This is a risk worth taking.

The Dental School Picnic should be structured so that people have to meet people from across the School – there is a need to mix people more. Similarly, there is a need to continue the cultural awareness activities. It would be helpful to have global staff meetings during non-clinic time (coffee and donuts and healthy snacks). It would be nice if there were a break room or conference room designated for staff use only that could serve as a central meeting point / information sharing location.

**How can the University help us?**

There are some simple, practical immediate solutions that the University could implement to assist the school in reaching these goals. There are also some long-range dreams. Of immediate help would be a partnership with the Human Resources Development office, creating a service agreement on core competency training in communication skills, and making those classes free to Dental School staff members. There needs to be funding to enable our IT people to simplify computer-based communications. It would be helpful to establish e-mail addresses dedicated to Dental School matters (whatshername@dent.umich.edu). The School/University should continue for many years the partnership with Great Places to Work. The University should continue to acknowledge employee achievements, including time-in-service awards. A regular column be set aside in the University Record to highlight staff-related events in the various schools and colleges.

Beyond these immediate solutions, it would be helpful to have a cafeteria (with real food) where students, staff, patients, and faculty could mingle. This clearly falls into the category of dreaming, but this would be very helpful in any event.

**Tuition Reimbursement**

This section of the Staff SAFCo work group focuses on the topic of Staff Tuition Reimbursement.

**What is the current status?**

The School of Dentistry does not have a formal policy for staff tuition reimbursement. It appears that annual budget allotment for tuition reimbursement varies by department. While staff members from the academic units (5 in all) spoke of no barriers to receiving tuition reimbursement, it appears that the administrative (includes patient care services) budget for staff tuition reimbursement is inadequate for the staffing levels in this area. In previous years, administrative tuition reimbursement dollars were disbursed on a “first-come, first-served” basis. This past school year, administrative tuition reimbursement dollars ($6000) were equally distributed, which was more equitable. Each unit paid out approximately $1000 to academic staff members. Currently, administrative staff
supervisors are reluctant to mention tuition reimbursement as a benefit when interviewing prospective job applicants because of the uncertainty of the availability of the funds. A negative message is being sent that the School of Dentistry does not support individual commitment to higher learning.

**What does staff tuition reimbursement look like in the future?**

All Dental School staff should have equal opportunity for tuition reimbursement. Without a stronger commitment by the School’s administration, inequities will continue to exist for administrative staff.

All School of Dentistry staff members wishing to continue or complete their degree programs should be able to rely on tuition reimbursement to offset the costs of a degree program. Continuing or completing a degree program requires both a time and a financial commitment by the individual. Continuing or completing a higher education program benefits the individual, the department, and the whole school.

**How do we achieve this?**

Administration needs to examine the school’s overall tuition reimbursement expense and make the same number of dollars available to administrative services/patient care staff. This will require an in-depth review of all departments’ payment of staff tuition reimbursement over the past several years to determine the actual usage of the benefit in the school.

**What are the barriers to achieve our future status?**

A successful tuition reimbursement program requires not only the commitment of Administration, but budgeted funds as well. Staff tuition reimbursement may not generate the priority of other dental programs and requests for funds. The relative priority of tuition reimbursement in the Administration department is not clear to members of the staff.

**How can the School help us to achieve our goals?**

School of Dentistry Administration staff account for 51.4% of dental school staff. Administration staff do not generate revenue by their departmental activities; rather, they support all School of Dentistry departments by providing services for their daily activities. One way to fund administration staff tuition benefits would be to levy a “tax” on each department using administration services to fund tuition reimbursements.

School of Dentistry administration department staff members should not be penalized for being hired by a department that does not adequately support staff education.

**How can the University help us?**

The University of Michigan already supports a tuition reimbursement program. (SPG 201.69) The University encourages work release time for educational purposes as well. The tuition reimbursement policy does state that the cost for tuition reimbursement will be borne by the staff member’s unit. Departments that have not adequately budgeted for
staff member tuition reimbursement should be able to turn to the University of Michigan for help in funding their tuition reimbursement program.

**Merit/Salary Program**

This section of the Staff SAFCo work group focuses on the topic of the staff salary increase program.

**What is the current status?**

What does the current merit program look like? Not good. The perception of staff members is that they are less valuable and less valued than either clinical track or research-based faculty.

The group agreed that the current salary increase program is not a merit-based recognition program. It is simply a salary increase program, and it is not tied to recognition of good job performance.

The School of Dentistry currently determines the direction of the staff salary increase program based on the state and university allocations for staff salaries. There does not appear to be a formalized program for performing or reviewing market-based equity for the staff salaries within the School. There exists a perception that people working for certain individuals or departments are recognized and rewarded through equity increases; however, not every department seems to have the knowledge and/or experience in this process. There is no merit program currently in place to reward the outstanding performers at the School. Some faculty members have an opportunity to increase their base pay through research or clinical revenues. One post-doctoral research fellow expressed the opinion that the least recognized or valued staff members are the people doing actual daily bench research work.

Over the last few years at the School, the average salary increase has been two percent (2%). This is not even a cost-of-living adjustment. In some units, the lack of difference in pay scale from one staff member to another serves to act as a disincentive to work smarter or work harder.

**What do we want to look like in the future?**

Staff members at the School of Dentistry would like to see an equitable salary program that rewards excellence in attendance, performance, and teamwork. Merit should be about accomplishment; they should not be across-the-board increases. Supervisors would like to have some flexibility to reward the top performers based on fair and widely published standards. Supervisors would like to be able to attract and retain quality staff. Rather than appear as an entrance-level portal to the University, the School of Dentistry should be able to retain a well-trained and enthusiastic staff. It would be nice to have one-time incentives that are tangible – such as getting paid parking for one year. It would be easier to have specific dollar figures to work with, not just percentages.
How do we achieve this?

The group generated several suggestions, including profit sharing, passing on cost savings of equipment and commodities, and a Suggestion Reward program. There is clearly a need to equalize increases between faculty and staff. Finally, finite dollar amounts and not percentage amounts should be used for the increases.

What are the barriers to achieve our future status?

The Comprehensive Care Clinic is not structured to make a profit; it is an educational endeavor. Increasing fees for patients may lead to a lack of patients for the educational benefit of our Comp Care students.

The graduate clinics use revenues to enhance their own clinical programs. This contributes to a perception of some clinics having more than others instead of all clinics being part of the same team.

The School has self-funded the merit program the last few years from tuition increases. Tuition costs for U of M School of Dentistry students are already among the highest in the nation. State funding is limited, so that funding stream is decreasing.

The high achievers will soon create an equity problem with staff members who are not able or willing to work at the highest level possible.

How can the School help us to achieve our goals?

There needs to be an examination of expenses that are “optional” – specifically where the general fund spending has gone. This information should be shared more widely. Perhaps different groups (faculty, staff, students) in the School could get the extra money in different years or share the money. Other suggestions include:

- Developing a staff reward and recognition program
- Developing a fair and equitable set of competencies that should be met and/or exceeded to qualify for salary increases
- Separate the salary increase program from the merit recognition program by scheduling these in different times of the year
- Perhaps using the merit program for conference opportunities

How can the University help us?

Questions were raised about the development and renovation projects currently in process or in the planning stages. Some staff members expressed concern about the University’s building programs taking priority over the development of staff resources.

Conclusion

In conclusion, Dental School staff members are very passionate about their work and highly motivated to continue what is going well, to improve what is not going so well,
and to create what is needed to make work life better for them and, ultimately, the School of Dentistry. There are areas that need financial assistance and/or administrative support: staff development (including a rationalized tuition reimbursement program and clearer assistant credentialing), a fairer and more transparent staff salary program, and better communication between administration and staff. There are many improvements that can be made with little or no expense such as staff recognition, cross training, redefining of staff relationships (“colleagues” vs. “co-workers”), and staff members making real efforts to communicate better with one another.

There is a tremendous amount of pride evident in the work done by staff members of the School of Dentistry. Those members who contributed to this report wish to thank the members of the SAFCO team for giving us the opportunity to reflect on our work and its environment. We wish to say to the University at large that the University of Michigan School of Dentistry is a well functioning community that truly does value each member’s voice.
Appendix 9

Curriculum Discussion Group Draft Report

Topic Area: Curriculum
Group Co-Leaders: Mark Fitzgerald, Jeff Shotwell
Group Recorder: Ruth Eberhart

The Curriculum Discussion Group met weekly, holding a total of 5 meetings. Attendance ranged from 16 to 25 and consisted of faculty, staff and students. A group of 12 to 15 faculty, staff and students were a consistent presence at all the meetings. The committee focused on a “10 years and beyond” approach – developing a vision of what our curriculum should look like 10 years from now and beyond. With this vision in place, the committee then identified key issues facing the school, prioritized those issues, discussed strategies that could be used to address the most important issues and identified what needs to exist to support those strategies. This report presents a summary of this process.

Vision of the University of Michigan School of Dentistry Curriculum

The curriculum will prepare our graduates (RDH, DDS, Post-Graduates and Specialists) to be dental health care professionals and leaders of the future. This curriculum will be:

- Focused on active teaching and learning processes
- A culture / climate that encourages learning not competition
- Centered on the principles of professionalism, life long learning and critical thinking as essential elements to its goal
- Patient and student centered in its decisions and design
- Distinguished by its innovative and collaborative methodologies
- Flexible and engaging
- Competency and evidence based
- Tailored to prepare students for contemporary health practice (one that includes a closer allegiance with our medical colleagues) and be leaders in dentistry
- Efficient

In order to achieve these goals, the School of Dentistry needs to:

- Promote active learning aided by IT
- Download basic science to pre-dental curriculum to allow higher level integration of basic, behavioral and clinical sciences in the dental curriculum
- Become more committed to its patient and student populations
- Be more cost efficient
- Provide better links between DDS/Hygiene programs and grad programs (specialists)
- Build better allegiances with our medical colleagues by demonstrating our value to the medical community
• Develop and incorporate a good Peer Evaluation System
• Connect pre-clinic and basic science with clinical practice in clinics
• Provide a learning and patient care environment that is current and adaptable for the future
I. Key issues facing the dental school in this topic area

A. Key Issues: Many issues were discussed at the meetings. The following is a list of issues that the committee used to craft its vision statement.

- Faculty:
  - Have to rethink their relationship with their own expertise and be willing to transfer control they have over student learning to the students
  - Need to create the next generation of educators (Faculty plus Research)
  - Insufficient time and ways to get better calibration among faculty and a strong understanding of what is being taught and when it is taught. – facilitate conversations among faculty
    - We do not have a culture or environment that allows meaningful dialogue between any groups
    - We do not have a culture that supports the needs of an educational system as big as ours
  - Improve faculty computer skills to all them to present material in ways that make it easy for students to use

- Facility
  - Network infrastructure limits our ability to provide educational experiences we want to provide
  - Clinics
    - Equipment and related support (e.g. electronic patient record, digital radiography) becoming outdated – possibly create a state of the art “Clinic of the Future”?
    - Configurations not patient friendly – especially for special needs patients
    - Clinical capacity limiting our ability to explore innovative teaching methods and to get students into the clinics sooner and be more productive sooner
  - Foundation Curriculum Laboratories
    - SimLab needs to have bench top access to axiUm and other programs designed to improve learning such as the 3D Interactive Tooth Atlas program
    - Capacity and current heavy use of SimLab limits class size and opportunities for use in other venues such as D3/D4 courses, dental hygiene, graduate programs and CE
  - Classrooms
    - Insufficient number of rooms that would effectively support small group sessions
    - Informatics support, although greatly improved, is inconsistent and limiting
• Student learning/
  o How much independence and control of their own learning do they want / should they have / are we willing to give them?
  o Getting students to take greater responsibility in the learning and education process is essential.
  o Do we need to look at the curriculum thru the eyes of the 21 year old?

• Curriculum
  o Dentistry is about the oral health and well-being of people and the curriculum should reflect that.
    ▪ The publics’ oral health needs and demands should be the reference against which the School’s competencies and curricular content are measured.
    ▪ The curriculum should focus on creating a better work force to serve the population.
    ▪ The patient should be the center point used to define our graduate’s competencies
    ▪ Patients, their needs and demands can be the thread that binds the entire curriculum together.
    ▪ Education “Meshes” with “real world”.
    ▪ Needs of the profession vs. the patient’s true needs for care must to be recognized and balanced.
    ▪ Improving the oral health of the public requires not only clinical knowledge and skills, but also the ability to manage the delivery of care. This is true for those planning to manage a practice as well as for those who are just managing the care of an individual patient. Management of care delivery competencies should continue to be addressed with supporting content and experiences.
  o Understanding how students learn and using that understanding to improve the curriculum.
  o Selective and appropriate repetition (what we need) at the appropriate time
  o Integration of the Curriculum – Getting basic and clinical sciences better integrated.
    ▪ Integration of science with clinical sciences
    ▪ Integration of information retrieval: ability to quickly retrieve information versus memorize
  o The curriculum should reflect the School and Universities’ missions. This does not suggest that education, research, and service should be equally weighted at the pre-doctoral level. It would seem that the initial emphasis must be related to the educational aspect of the mission.
  o Cost of curriculum: Costs must be controlled or else dental education will only be for the wealthy. Do we want dentistry to be a profession for the gentry?
    ▪ What specific technologies can we use to integrate and be more effective in creating a product (graduate) that is more suitable for the
year 2050? Because the people we graduate now will be practicing then
- The most finite resource within the School is the students’ time. Therefore a high priority should be placed on curricular efficiency, assuming effectiveness is achieved through mastery of content
- Partnership with other Dental Schools could help reduce costs

B. Most significant strengths and most significant things (strategic imperatives) to do to build on those strengths

1. Strengths
   - Strong clinical program that gives our graduates a broad base of experience and capabilities.
   - Resources of the School and University
     - SimLab
     - Library
     - Building
     - Partnership opportunities with other units on campus
   - Faculty (Who we are)
   - Great Students
   - History of willingness to innovate in dental education

2. Strategic imperatives
   - Greater integration of clinical and basic science in curriculum
   - Increased partnership with other units on campus such as Virtual Reality Lab and learning resource center at the medical school
   - Provide better links between DDS/Hygiene programs and grad programs (specialists) to optimize patient treatment and create a better mesh with “real world” dentistry

C. Most Worrying Weaknesses and most important things (strategic imperatives) to address those weaknesses

1. Weaknesses
   - Facilities limitations
     - IT infrastructure (network) does not currently support vision
     - Rooms for different teaching modalities – case based vs more simulation, etc.
     - Clinic space and ways to increase efficiency
   - How we fail to interact,
     - Lack of a coordinated interaction among disciplines in presentation of course materials.
     - Hidden curriculum (competition, non-collegiality, etc)
     - Interpersonal interactions: Faculty / Student, Faculty / Faculty, Student / Student, Faculty / Staff, Staff / Staff
   - We spend 80% of our time with the bottom 20% of the class
   - Too much Power Point not enough active learning
• Timing of information delivery

2. Strategic imperatives
• Upgrade facilities: IT infrastructure (network), room reconfigurations, clinic space modification, digital radiography, electronic patient record
• Improve interpersonal interactions among Faculty / Student, Faculty / Faculty, Student / Student, Faculty / Staff, Staff / Staff
• Faculty training on effective teaching modalities

II. Key issues we need to and want to make a commitment to address.
• Curriculum
  o Promote active learning aided by IT
  o Download basic science to pre-dental curriculum to allow higher level integration of basic, behavioral and clinical sciences in the dental curriculum
  o Become more committed to our patient and student populations
  o Be more cost efficient
  o Provide better links between DDS/Hygiene programs and grad programs (specialists)
  o Develop and incorporate a good Peer Evaluation System
  o Connect pre-clinic and basic science with clinical practice in clinics
  o Provide a learning and patient care environment that is current and adaptable for the future
  o Creating the next generation of teachers (Faculty plus Research)
  o Selective and appropriate repetition (what we need) at the appropriate time
  o Integration of the curriculum – getting basic and clinical sciences better integrated.
  o Cost of curriculum: Costs must be controlled or else dental education will only be for the wealthy.
  o Understanding how students learn and using that understanding to improve the curriculum.
  o Increase student independence and ownership of the learning and the education process
  o Students graduate saying “I liked Dental School”
• Faculty:
  o Changing our existing faculty to meet our immediate and future needs and creating a new generation of educators
  o Time and ways to get better calibration among faculty and a strong understanding of what is being taught and when it is taught.
  o Improve computer skills to present material in ways that make it easy for students to use
• Facility
  o Network infrastructure limits our ability to provide educational experiences we want to
  o Clinics:
- Equipment and related support
- Configurations made more patient friendly
- Clinical capacity needs to be increased
  - Foundation Curriculum Laboratories
    - SimLab needs to have IT capabilities enhanced
    - Other lab space needs to be improved to off load heavy use of SimLab
  - Classrooms
    - More rooms that would effectively support small group sessions
    - Increased IT capabilities
III. How are we currently positioned to address these key issues?

The School of Dentistry is well positioned to address these key issues. Although finances will probably be the most limiting factor, especially for issues requiring major upgrades or renovations, the School does have a vast array of resources at its disposal within the building, across the campus and with peer institutions. We have access to a wide range of expertise in many of the areas represented in the key issues list. That coupled with a history of willingness to innovate and implement new concepts and programs set the stage for progress and success.

IV. What are the consequences of not addressing those key issues?

The cost of inaction is great. The expense of dental education in general and specifically here at Michigan, if left uncontrolled, is going to quickly place us out of contention for the type of qualified students we have come to expect and have made us a top tiered institution in dental education. The rising costs of education place us at risk of becoming a profession of gentry. It will also place us in a poor position within the University. Failure also increases the risk of a loss of credibility for our profession. Dentistry is changing quickly and dental education should be leading the change, not following it. In some ways, we have been leaders, but in others we have not. Increasing our leadership role in dentistry and dental education will also position us favorably within the core values of the University – to be the Leaders and the Best.

V. How do we measure up to the best of our peer institutions or other outstanding organizations in performance on the key issues?

The University of Michigan School of Dentistry has a long history of being an innovator and leader in dental education. Many of our peer institutions look to us to see where they should go. However, although we have been leaders in many areas of education, we are behind the times in other areas. Many peer institutions are much further along in providing a state-of-the-art clinical treatment environment for their students. Our strengths have been our ability to innovate and implement curriculum change quickly and the vast breadth and depth of our internal and external resources. These will set us apart from the crowd as we move forward on our plans.

VI. How do these key issues match the broader core values of the University?

Two of the broader core values of the University are leadership and excellence. The key issues in this report address both of these values. Successfully addressing the key issues will result in a curriculum that will be focused on excellence in providing dental care for the greater community, excellence in creating the leaders for the future and excellence in leading the profession into the future.
Clinical Operations Topic Specific Discussion Group Report

What does the Clinic Operation area currently do well? What are the strengths to be maintained?

- Students are given significant responsibility to manage their patient families. This responsibility is viewed as a very positive aspect of the clinical curriculum as it helps students learn to interact and manage their patients treatment.
  - However, some students are not well prepared to manage this responsibility.
  - Some students do not have the management skills to schedule effectively and encourage patients to move forward with recommended treatment plans. Additional curriculum content should be invested in teaching the patient management skills students require.
- Students do not discuss fiscal issues with patients very well. It would seem prudent to offer some specific course to deal with this issue in an attempt to at least maximize the revenue that is being produced in the clinics.
  - The most productive students tend to carry the fewest patients but manage them better. If all students were better managers, would probably require fewer patients to satisfy educational experiences desired in the clinics.
  - Patient management is critical to success of the clinical curriculum; consider moving more responsibility to the faculty/staff, especially the Patient Care Coordinators (PCC’s) as they work closely with the students in monitoring their active patient families.
- Management of emergency patients is efficient; significant number of patients are managed daily.
  - However there are bottle-necks in the system, i.e. oral surgery, some graduate clinics, that do not have enough providers to handle to patient demand.
- The undergraduate clinics are focused on the needs of the patient and staffed to deliver comprehensive care on a daily basis.
- The clinical faculty members have excellent training and skill to provide support for the students during patient treatment.
  - All specialty disciplines are represented in the school clinics which is very valuable for the students and patients.
  - However, the more experienced and well-trained faculty are being stretched thin due to the demands of the clinic.
  - Need to invest in ongoing in-service training to ensure strong clinical faculty for the future. This applies to both full time and part time faculty and would include not only discipline specific education but also such things as patient payment arrangements, charge ticket management, and other clinic policies.
- There is a strong, well-qualified basic science faculty in the school.
  - However, there is very little translation of basic science information to the clinics or reinforcement of its applications.

What are the weaknesses of the Clinic Operation?
Current clinics are antiquated but have good potential for being updated
  - Clinics were not designed to accommodate modern technology at the chair to include computers, digital radiography, and intraoral cameras
  - Cubicles are not designed to accommodate four-handed dentistry; limited space for D1 and D2 students to interact with D3/D4 students in clinical treatment
  - Not well designed for efficient patient flow through the collections-treatment-appointment transactions; information desks are at a site distant from the clinic

Clinic space is at a premium, yet there is significant clinical space sitting unusable – ground floor NW clinic (old Pedo Clinic)
  - There is no published plan to utilize this space which would be of significant value to the clinical curriculum

The mission statement from the Provost Office indicates that the dental school should train oral health professionals in a model facility; this is not the case at present
  - Poor access for disabled patients; wheelchair access limited

Guiding Philosophy
- Desire to continue to be the leader in dental education
  - Desire for graduates of UMSD to be desired/recruited by private practitioners for the skills and knowledge they can bring to an existing dental practice
- An essential question is …. “Should patients be recruited and treated according to the needs of the existing faculty (number, discipline specialty, availability, etc) or should the faculty in the clinics be recruited/assigned to meet the needs of the patient’s demand in the clinic”??
  - This question may also be considered either Patient-centered clinics or Education-centered clinics
  - There is strong support for a patient-centered clinic arrangement as designed in the VIC’s. This focuses attention on the needs of the patient to render efficient care and works toward a positive attitude on the part of patients to return to the school.
  - A patient-centered clinic does not necessarily have a uniform demand for specialty faculty and the current patient treatment demand should be evaluated to consider an alternative mix of specialty faculty compared to general dentist faculty in the clinics.

Dental School Physical Plant
Advantages/Strengths:
  - Open clinic floor plan – modern appearance, bright
  - Hallways are wide permitting easy access and people movement
  - Esthetics – clinics look good and well cared for
  - Admin areas are located between clinics
    - PCC’s have good access to students and students have good access
  - Conference room is available for patient and student counseling
  - Building has good potential
Disadvantages/Weaknesses:
  Existing cubicles are 37 years old and are not designed for current delivery technology
  Clinical space per dental chair is limited
    Will have an impact on the ability to implement technology at the chair
    Insufficient space for four-handed techniques; insufficient space for dental assistants
  Parking is limited and is a barrier to recruiting patients to the school
  Need to upgrade the building in general – floors, walls
  Major infrastructure requirements for digital and computer use in the clinics
  Entrance is reverse from location of primary patient access (parking deck)
  Waiting areas are limited with particular problem in Oral Surgery
    Undergraduate areas crowded just before clinic sessions, but adequate otherwise
    Oral Surgery does not have adequate waiting room space

- Not particularly patient friendly; most patients enter from North side (parking deck) however building entry is on the South side
- Restrooms not barrier free
- Student clinics not easily wheelchair accessible
- Significant clinic space has been lost over the last 10 years with a significant increase in student population
  - Clinics were designed for 90-100 student population; at least 10-15% beyond this limit per class
  - D2’s have significantly increased clinic use which also impacts on student population

- Current clinic space limits ability of the curriculum to progress and improve
  - If working philosophy is to maintain 100% capacity of clinics, then there is no clinic space available for new or pilot coursework in the curriculum
  - Clinic space needs to be available for clinical faculty to be creative in clinical education similar to laboratory space is required for research creativity
  - Loss of clinic space has reached a level where it will negatively impact the curriculum
  - For Fall term, 2005 dental students utilized 112% of their assigned clinic time
  - The clinics are at maximum capacity to support the student population

Dental School Patient Population
Advantages/Strengths:
  Over 4500 patients were screened in 2005 for treatment in the dental school

Disadvantages/Weaknesses:
  The complexity and difficulty of patient treatment requirements have significantly increased over the last 10 years; cases previously treated in the graduate
clinics are being treated in the undergraduate clinics to ensure clinical experiences for students

Anecdotal comments on patient shortages; number of patients or numbers of specific clinic experiences (implants, veneers, crown and bridge, etc)

- Where do current patients actually come from? Geography? Financially?
  - Recommend investigating what type of patients are optimal for the dental school to treat and avenues to direct recruiting towards these types of patients
- What do patients need to offer for the benefit of the students/education?
- Generally only 25-35% of patients return for maintenance care once their immediate dental needs have been met. Is this a function of the patient population or are there impediments to ensuring maintenance treatment for patients?
- Student clinics generally have a poor recall system for patients. How many are lost from transition of classes?
  - Dental students are entrusted with the bulk of patient management responsibilities, should staff or faculty take a larger role?
  - Is the cost manageable to move to a more staff intensive system?
- To what degree does a patient’s financial limitation affect the student’s experiences? If there was unlimited funding for student procedures, would the patient population still provide the desired experiences for students?
- Would additional or different patients be attracted to the school with evening clinic hours?
  - Studies at other schools tend to indicate that the current patient population remains, but just shifts in scheduling and there is little improvement in recruiting new patients
  - Faculty view evening hours as a disincentive; potential impact on faculty recruitment

Undergraduate Clinics
Advantages/Strengths:
- Instruments and equipment are modern and well managed; students do not report shortages of instruments or materials for patient treatment
- Dental students are entrusted with significant responsibility for managing their patient families; planning treatment, scheduling, patient financial responsibilities, monitoring referrals

Disadvantages/Weaknesses:
- Dispensing is at maximum capacity to maintain instruments and materials for students; shortages of staff on some days
- Faculty coverage is problematic at times; no specific plan for accommodating faculty attendance at professional meetings, vacations, etc
- Student utilization of assigned clinic time was 112% for Fall term 2005; clinic space has no flexibility for the curriculum

- There has been a significant decrease in clinic space over the past 25 years; moved from 8 clinics (288 chairs) to 4 clinics (144 chairs) plus some additional chairs (20+) in the third floor Orange clinic (not staffed for D3-D4 clinic utilization)
- Dental student population has been reduced from 150 per class to 110-115 per class
- D2 students have significantly more clinic time presently
- Although clinic space has decreased 50%; student population has been reduced 30%
- The International Trained Dentist Program will add 16 additional students (8 D3, 8 D4) to the clinic demand with the required demand for patients as well

- Faculty staffing model calls for 5 faculty per clinic per half day
  - This level is not met consistently due to no plan for additional faculty coverage for faculty vacations, attendance at dental meetings, illness, etc
  - This results in faculty being stretched to the maximum in the clinics to support student dental treatment

- Wednesday demand for clinic chairs exceeds available space
  - There is no Pediatric Dental clinic rotations and no Oral surgery rotations so the only available clinic for students to work in is the VIC’s
  - An effort should be made to monitor student use of clinic time and space to ensure measures are developed to even out the demand for clinic chairs

- Should have an ongoing patient assessment system to consistently monitor patient satisfaction

- Digital dental records will offer efficiencies: what are they?
  - Records management now available in the clinics, staff not required to request, retrieve, or track records
  - Reduction in paper costs: records, forms, printing, and forms management
  - Efficiency in time; records always available for clinic use since all records online
  - Improved access to graduate clinic information; endodontics, orthodontics
  - Improved patient management between clinics due to better communication
  - Improved access for treatment specific information at the time it is needed during patient treatment
  - Improved integration of activities
  - Cost required for hardware implementation, training, and data storage

- Desire to be the leader in dental education; opportunity to shape the development of digital systems for clinical use
  - 22 dental schools currently using Axium; only 3 of them have started total digital implementation
  - this is an opportunity to shape the development of the system to meet UMSD needs if we are one of the early-implementers

- Referral system is poor within student clinics and between student and graduate clinics

- Clarify the role of the General Dentist faculty in the clinic environment
  - Students do not interact with Specialists in the clinic in a manner that models private practice
  - Students are not required to “refer” patients for Specialty faculty evaluation; they are present from the beginning of treatment instead

- Clinic productivity: are there enough patients and procedures for students? Grad students?
Need numbers on student productivity over the last number of years; D Heys, S Stefanec

Need numbers from PAES as to patients screened, etc; S Stefanec

Need numbers from G Kasko relative to student utilization of clinic time

**Graduate Clinics**

**Advantages/Strengths:**
- All ADA recognized dental specialty programs are represented in the dental school curriculum
- Additional graduate programs in demand by students are also available (GPR, AEGD, Graduate Operative, Post-Doctoral Scholars)
- Graduate clinics provide support and treatment for more difficult patient care to allow for all patients presenting to the dental school to be treated within the dental school; no external referrals are required
- Graduate programs provide significant specialty-based contributions to the undergraduate curriculum

**Disadvantages/Weaknesses:**
- Perception that patients referred to some graduate clinics are never returned to the undergraduate clinics; decreases clinical opportunities for dental students
- Minimal communication with undergraduate clinics; poor referral management and communication
- Increased demand for specialty care due to increasing complexity of patient needs, but minimum number of graduate students to provide the care

- **Patient referrals within the school are generally thought to be very poor relative to communication between providers; patients are referred among clinics, but providers do not communicate treatment to referring providers**
  - Students are given responsibility to manage referrals; should consider faculty and/or staff involvement in the process if the cost is manageable
  - PCC’s are uniquely positioned in their management of student patient families to play a more active role in managing referrals
  - Faculty can provide more assistance and reinforcement to the need for communicating in the referral process

**Vertically Integrated Clinic design**

- This is an effective system for the current focus on a comprehensive care philosophy for the students as they treat their patient families
  - Must invest additional in-service and training to calibrate part-time faculty to a consistent clinical approach to be taught in the clinics
  - Alternative approaches have value, however, students must have some degree of consistency initially as they work in the clinics

- **Core Faculty – ensure consistent teaching/treatment in the clinics**
  - Core Faculty should be consistently available in the clinics; minimum of 2 full days per week with additional time available for student consultation
Core Faculty should play a leadership role in calibrating part-time faculty, insuring preclinical-clinical consistency, and providing continuity of care with students and their patients.

- Frequency and degree of in-service training required to ensure consistent teaching by faculty

- The transition from the PreClinic to the Clinics should be mentored by faculty
  - Students receive significant information on technique in the PreClinic, but may wait months to implement them in patient care
  - Faculty/Students should mentor the transition to the clinics to provide students an opportunity to review/relearn techniques just prior to implementing them for patient care
  - Will require additional faculty time/input and may be a role for D4/Graduate students as well

- Faculty invest significantly more time working to remediate the weaker students in the clinics
  - Strong faculty desire to improve the emphasis and amount of time spent with the more productive/more skilled students
  - Desire to foster excellence rather than just competence; this requires an equal focus on both ends of the learning spectrum for students
  - Desire to develop an incentive rich clinic system for students rather than a penalty rich system that is currently in place; encourage student to progress and excel rather than just meet minimum requirements

- Can some disciplines be excluded in the VIC’s for more effective patient treatment? Would some disciplines be better served in isolated clinics out of the VIC’s?

**Community Outreach Clinics (COC)**

**Advantages/Strengths:**
- Provides clinical experiences outside the dental school in clinics with a more production oriented system
- Students are asked to become more independent in their patient treatment compared to the dental school
- Provides four handed dentistry experience for the dental students.
- Interaction with dentists, hygienists, and office staff help develop skills needed for practice management in a private practice setting.
- This is a very good adjunct to clinical teaching, not a replacement for UMSD clinical experiences

**Disadvantages/Weaknesses:**
- Rely on the COC as replacement clinic space for the undergraduate curriculum comes with significant risk that the curriculum cannot support the existing number of dental students if the COC are unable to accept dental students
- The needs of the COC will change more rapidly relative to the ability to support dental students than the dental school can alter class size to reflect these changes
The guiding philosophy of outsourcing student clinical experiences to off-site clinical settings should be considered enriching/additional educational opportunities. These rotations offer an important educational role for students as they transition from the close oversight available in the VIC’s to a more independent role. These settings offer an opportunity to observe how students do as they become more independent and still offer the chance to deal with deficiencies. To what degree can COC’s be counted on over the long-term? Loss of COC’s could affect the ability to teach all UMDS students in the VIC’s. To what degree should the COC’s be calibrated to the UMDS philosophy? Will COC’s move the most productive students out of the UMSD rather than allowing them to pursue more advanced clinical experiences through the VIC’s/grad clinics?

**Staff**

Advantages/Strengths:
- Dispensing staff is able to support the clinics relative to infection control, instruments, and materials

Disadvantages/Weaknesses:
- Dispensing Staff is at maximum capacity; occasional shortages can impact the dental student clinic treatment
- The only experience in utilization of dental assistants is in the Pediatric Clinic

Dental students will rely on dental assistants and dental hygienists in the delivery of care in most all clinical settings after graduation from school.
- Increased experiences with auxiliary staff should be included in the curriculum
- The Third Floor Orange Clinic could be considered for a reprisal of the DAU Clinic; it would provide an increased opportunity for clinic over-rides as well as offer experience in four-handed dentistry
- It could also be staffed with a hygiene model for a more stable recall system for dental student patients

**Where should the Clinic Operations be in 5 to 10 years?**

Desire a paperless clinical environment
- Maximize information collection and transfer in the most efficient manner
- All patient information available when and where it is required for optimum patient treatment
- Additional management capability than currently utilized with Axium

Desire comprehensive clinical curriculum in the D1-D2 program
- By integrating comprehensive patient treatment earlier in the curriculum, students should complete core competencies well in advance of graduation
- This would provide better experiences at Community Outreach clinics during D4 year
- Opportunities can be created for advanced focus on discipline specific experiences (oral surgery, periodontics, endodontics, i.e. mini-internships) or research/basic science opportunities
  - Desire a clinical program to foster critical thinking in professionals
    - Current system fosters learning and memorization with little emphasis on thoughtful application
  - Desire to continue to be the leader in dental education
    - Desire for graduates of UMSD to be desired and actively recruited by private practitioners for the skills and knowledge they can bring to an existing dental practice
Research Topic Specific Discussion Group Final Report

Topic Area: Research
Group Leaders: Jacques Nör
Paul Krebsbach
Group Recorder: Wanda Snyder

Attendees included:
Charlotte Mistretta
Steve Bayne
Elisabeth Rodriguez
Jim Simmer
Carol Anne Murdoch-Kinch
George Taylor
Renny Franceschi
Kathleen Neiva
David Kohn
William Giannobile
Wanda Snyder
Paul Krebsbach
Jacques Nör

Strategic Issues:
1. We need to identify and support a limited number of research foci (programs). The goal is that the school is clearly recognized as the leading institution in the world for research in 3-4 research areas.
2. We need to have a strategy to further enhance our competitiveness for extramural funding in a time of research budget cuts at the national level.
3. We must have adequate space to perform research that we have currently funded in a safe and effective way. Our research space should be conducive and stimulating for collaborations and discovery.

Operational Issues:
1. The identification of the research foci should be based on an in-depth analysis of existing expertise and potential for major impact in the improvement of oral health in the future. This analysis should start in the Research committee that will make recommendations to the Dean and Chairs. This should be followed by a commitment of institutional support for these areas. Once established, the research foci should have an impact on future recruitment of faculty/staff, and become organized centers of excellence and/or collaboratories.
2. A schoolwide system of internal peer review should be in place to provide support and guidance to faculty/staff/students submitting grant applications. The diversification of research funding sources should be stimulated and facilitated in order to minimize the school’s current dependency on NIH funding.
3. Effective PR should be in place to enhance the awareness of the impact that research that has been conducted in our school has on oral health throughout the world. A major fund raising campaign should be organized specifically to gather resources for the
renovation and amplification of our research facilities. In addition, the school should have a strategy in place to demonstrate unequivocally to the University the value of supporting our research mission.
The research topic-specific discussion group met six times. In the first meeting, the group identified broad areas for discussion that were addressed in more detail in subsequent meetings. The following are broad areas that were identified in regards to the research enterprise at the School of Dentistry:

- Mentoring
- Research environment
- Research infrastructure
- Research agenda
- Value, attitude, and culture of research

The following is a summary of these discussions:

I. What are the key issues facing us in the area of research?

Mentoring:
- There is a national shortage of dentist-scientists. We need to further enhance mentoring within the school to stimulate more dentists to choose a research career.
- We need a system throughout all departments to mentor junior faculty and give them the best possible conditions for a successful progression through the academic ranks.

Research environment:
- The current status of federal funding for research is challenging. We need to have a school-wide strategy to be competitive for funding over the next years. In addition, a plan should be in place to provide bridging funds for faculty who are caught between grants.
- Recognizing the increasing competition for federal funds, we need to have a strategy to identify and pursue non-NIH funding opportunities.
- Our recruitment strategy should take into account not only an individual department's needs, but also the impact of the recruit in the overall research mission of the school.

Research infrastructure:
- We must have research facilities that are compatible with research in the XXI century.
- We must have sufficient space to perform research in a safe and effective way.

Research agenda:
- The school should identify and support a limited number of (meaningful) research foci (programs). The initial identification of these foci should be based on existing expertise and potential for major impact in the improvement of oral health. This should be followed by a commitment of strong support for these areas that will allow them to evolve into nationally and internationally recognized centers of excellence.
- Research foci should serve as guidance for recruitment of faculty/staff. Participants of these foci should be actively engaged in the recruitment of new faculty/research staff.
- Research foci should serve as guidance for allocation of school’s resources.

Research: Value (what is important), attitude (way of thinking), culture (way of life)
- Research should provide the evidence for all clinical practice/teaching within the school (evidence-based dentistry). It is expected that all faculty, full-time and part-time, are updated with the evidence in their respective fields, and use it every time they interact with a student.
- Every student in the school should have ample opportunities to do research, since it will influence the way the student thinks through diagnosis, treatment planning, and the clinical practice of Dentistry.
- The students should be more engaged in the process of discovery, not only by doing research, but also through the study of virtual-based research problems and mock research cases to further the student’s knowledge about research principles/concepts.
- The dental students should have ample opportunities to interact with faculty and students from other schools (e.g., medical school, business school).
- Research should not be undervalued if it is not funded at the time, as long as there is a potential for funding in the future, and/or that the research project in question will be beneficial for the training of the students involved.

I.A. Research: Strengths
- The high quality of the dental and graduate students that the UM school of Dentistry is capable of attracting.
- The caliper of the faculty of the UM school of Dentistry, and the existing research collaborations among the faculty across all departments in the school.
- Existing research collaborations with other units of the University (e.g., Medical school, Biomedical engineering), with other dental schools in the US (e.g., University of Detroit), and with dental schools outside the country (e.g., University of São Paulo, Brazil).
- The University of Michigan School of Dentistry is highly regarded nationally and internationally as a leading institution for dental research for many decades.
- The impact of the Oral Health Sciences PhD program on research at the school of Dentistry.

I.B. Research: Weaknesses
- A major roadblock for the future of research in our school is the quality and quantity of the research space available.
- Lack of flexibility in the dental curriculum to allow for more research experiences for interested dental students.
- Lack of schoolwide mentoring plan for faculty.
- Lack of diversity in the research funding portfolio. Most of the funding for research is through the NIH.
- Lack of a coordinated infrastructure for grants management, and human resources that facilitates the research efforts of faculty throughout the school. Today, most of the support personnel for the PI comes from the individual’s department, and varies greatly among different departments in the school.

II. Which of the key issues do we need to and want to make a commitment to address?
- The infrastructure for research within the school should be improved. More specifically, we should work towards improving the extent and the quality of the space for research within the dental school. It is unreasonable to expect state-of-the-art competitive research in laboratories that were designed 30-40 years ago. While the funding received by school’s investigators has grown substantially over these years, the amount of space dedicated for research had minimal growth. Therefore, the research dollar/square foot of space has increased significantly within the school (I have asked the office of research to provide us with actual numbers to be included here). We have reached a plateau in terms of the number of investigators in the school, and can only grow with investment in the research infrastructure.
- The dental school curriculum should be more flexible to allow for more meaningful research experiences for dental students. These experiences can be either actually doing research, or through didactic content that provides an opportunity to understand the principles and concepts of research. The scholars program is certainly a step in the right direction, but it will only be available for a limited number of students. The opportunity to have a meaningful
research experience should be extended to all students. In addition, enhanced dental curriculum flexibility would allow for better integration between the DDS and the PhD components of the DDS/PhD program, which will be of benefit for these students.

- The diversification of research funding sources will be important to decrease the school’s dependency on NIH funding.
- The identification and support of a limited number of research foci within the school will be important to direct and optimize the use of resources available. We understand that we cannot make a major impact in every aspect of dental and craniofacial research. A targeted allocation of personnel and support to a finite number of foci will allow for the maximization of the use of the resources available.

III. How are we currently positioned to address these key issues?

- The school's research infrastructure has not received a significant upgrade over the last 30-40 years. We hired an architectural firm several years ago and have made extensive studies and planning for the upgrade of the research facilities in the 2nd and 3rd floors of the research tower. However, these renovations were not possible due to lack of funding for them. Therefore, the plans are ready for a significant portion of the work that has to be done in regards to research infrastructure at the school of Dentistry, but we need to find viable ways of supporting the renovation.
- There is some level of willingness to address the overcrowded state of the dental curriculum, and allow for more flexible time for creative (elective) activities. A curriculum committee is in place, and the recommendations of the school’s strategic assessment should have a strong impact on the work of this committee in the near future.
- We do not have a structure in place, neither do we have the culture of supporting major research efforts with non-federal sources. This would require a focused effort from the school and from the office of research.
- We have recently reduced the number of research foci in the school to a number that seems more reasonable (5?). However, these foci reflect primarily the existence of faculty within specific areas of dental and craniofacial research. The foci do not constitute actual programs, perhaps with the exception of MCOHR, and therefore have not had a major impact on the recruitment and allocation of resources as of today.

IV. What are the consequences of not addressing the key issues?

- We will not be able to be the number one research dental school in the country if no investment is made on our infrastructure. We have been near the top for the last several years, but without a strong commitment of resources on the upgrade of our research space, we will not be able to raise to the top, and run a serious risk of actually loosing ground to other emerging dental schools.
- We will not give equal opportunities for each student to have a meaningful research experience during dental school. It will be only with added flexibility in the curriculum that this can be created. A student that understands the principles of research is critical of the information gathered from literature, knows the value of evidence-based practice, and therefore will be a better self-learner and a better practitioner in the long run.
- Heavy dependency on NIH for funding is risky, especially in the current budgetary situation. A diversification of the portfolio of funding sources will minimize the impact of budget crises at the NIH.
- The absence of strong and supported research programs may lead to a progressive loss of depth. Contemporary research is multi-disciplinary, and the programs should reflect this nature. However, the depth will come from a coordinated effort in bringing together researchers whose expertise complement and hopefully synergize each other within specific programs.
V. How does the School measure up to peer institutions or other outstanding organizations in performance on key issues?

- The University of Michigan School of Dentistry is a leader in dental research. Many of the materials and techniques used throughout the world have been conceived by our faculty. Many of the textbooks used nationally and internationally for dental education have been written by faculty of this school.

- The University of Michigan School of Dentistry ranks second nationwide in the amount of federal funding for research among dental schools. To the best of our knowledge this is the highest ranking among peer institutions of any school at the University of Michigan.

- This school has been a leader in dental education for many years, and several innovations in dental curriculum have started here. Changes in curriculum leading to a more seamless integration between didactic courses, clinical training, and research and application of evidence-based Dentistry at all levels of the dental school experience would certainly be a major step forward in dental education.

VI. How do these key issues match the broader core values of the University?

- The University of Michigan School of Dentistry has a long history of leadership in dental research, and has had a direct impact in oral health throughout the world. Major advances in caries prevention (e.g. fluoride in the water), in Restorative Dentistry (e.g. high copper dental amalgams), and in the understanding of the impact of oral health on systemic disease have begun here. Therefore, this school is clearly doing its part to match the core value of the University of Michigan of striving to be a leader in research.

- However, addressing the key issues presented above have the objective of moving us forward to, not only maintain its leadership position, but enhance the impact of our research on the improvement of oral health throughout the world. And, at the same time, enhancing the impact of research in the educational experience of every student enrolled in our school.
External Relations Topic Specific Discussion Group

Group Leader: Dennis Lopatin
Group Co-Leader/Observer: Diane M. McFarland
Group Recorder: Jean Klark

Regular attendees included:
Dennis Lopatin, Leader
Diane McFarland, Co-Leader/Observer
Jean Klark/Recorder
Robert Bagramian
Sharon Grayden
Richard Fetchiet
Ron Heys
Alexandra Jacquery
Jerry Mastey
Debbie Montague
Shannon O’Dell
Benjamin Wikstra

The External Relations Topic-Specific Discussion Group met weekly, holding a total of eight meetings. The group defined the School’s audiences and sub-categorized them. Members were assigned to specific sub-topic groups for further exploration. Each group provided a report, which may be found in the appendix to this report.

This summary report provides an overview of the key points in the discussions that occurred during the committee meetings, and details of the individual reports that were submitted and subsequently discussed by the entire group. Due to the richness and depth of the discussion on the topic of external relations, we refer you to the minutes of each meeting for more thorough insight of the committee discussions.

In an attempt to focus the discussions, we challenged the group to address each category of partners with the School. We posed the questions below for each category. We must consider these questions when evaluating relationships with each partner.

1. Who are the “influencers” on each family?
2. What is the current message they are receiving? How do we know? How can we find out?
3. What message do we want them to receive?
4. What can (or should) we do to ensure that the influencers send the appropriate message?
5. How will we know which message is getting through?
The committee identified an extensive list of “external” relations. We grouped partners into categories for further exploration. The categories included (not in order of priority):

1. Agencies
2. Development and Continuing Education
3. Museum
4. Media
5. Peer Institutions
6. Government Relations
7. Students (current and prospective)
8. Patients and the Public
9. Faculty and Staff
10. Alumni
11. The University

In order to put these issues into a context, major points from discussions and group reports were used to provide responses to the questions in the format requested by SAFCo. The specific SAFCo questions are identified in *italics*.

I. *What are the key issues facing us in the topic area of External Relations?*

**Communications** with “partners” is a key issue

- We need a better plan to address external/internal influencers over which we have no control (Government/University policies, events in the news).
- We must improve our internal communications.
- We must improve faculty/staff recruiting and retention (Are we putting our best foot forward? What are we communicating to them once they are onboard?)
- We must communicate the influence of the offsite location of the Development Office. There are misconceptions regarding the reason for the move and the effect on interactions with partners.
- We must improve marketing of the School (CDE, clinical services, research partnerships, student recruiting, patients).
- We must maximize the potential of donors/collaborators.
- We must explore mutually beneficial relationships between the School of Dentistry and governmental agencies (officials, agencies and legislators).
- We must enhance the message that the School has clearly defined goals and guiding principles.
- We must enhance communications with students. This is a complicated issue. It includes how we interact with students during the recruitment process, the effects of faculty/staff interactions during the educational process (attitudes that we communicate), and the written and unwritten rules and expectations to which we hold them.

**Infrastructure** and location issues contribute to the “message”
Parking/accessibility for patients and other visitors
Limited resources/antiquated facilities/insufficient space (function and perception by partners)

A. Strengths that we should leverage in our external relations

1. We provide benefits and services to various agencies within Washtenaw County and throughout the state; we provide resources worldwide.

2. We are the primary Medicaid provider in the state and serve underserved populations.

3. We provide world-class resources, and excellent education and skill-building programs for professionals in a diverse environment.

4. We have a reputation of being one of the world’s leading institutions committed to oral health care education, patient care, research, and community service.

5. Our library and museum services provide an excellent exhibition of historical dental collections, reference services, artifacts, text and images for media.

6. We currently provide excellent publications via printed materials and are working to improve our internet services - Publications (average of 10,500 copies of DentalUM, average of 11,000 annual reports, fundraising brochures, 13,000 copies of DVD) to create awareness.

7. We measure up to peer institutions and in most instances meet or exceed what others are doing related to external relations.

8. The CE office mails two catalogs per year to over 28,000 alumni and CE participants, and numerous brochures promoting courses. The School offers over 75 CE courses per year. The School offers the largest number of courses to dental professionals.

B. Weaknesses that compromise our ability to leverage our strengths

1. We do not have a good understanding of the benefits, challenges or expectations in relationships with various healthcare or governmental agencies. We have not exhaustively defined mutual benefits that would/should be derived for those agencies with which we currently have relationships.

2. We lack the metrics (demographics/socioeconomic) with which we could demonstrate the benefit we provide, or could provide, to various agencies and populations (i.e., to support the statement that we are the primary Medicaid provider in the state).

3. There are formal and informal external influencers over whom we have no control (for example, University of Michigan policies, the economy, disgruntled patients).

4. There is a perception that the current Development Office location (off site) hinders external relations. The School needs to dialogue on this issue to alleviate the possibility of anyone sending negative messages, both internally and externally.
5. We have limited visibility among key university administrators and legislators. A recurring statement from Central Administration is that we are the most expensive school on campus. How do we address this perception?

6. The current venue for Continuing Education suffers from lack of meeting space and parking.

7. There is reluctance on the part of some faculty to participate in programming (faculty governance, CDE, student programs, etc.)

8. We rely on today’s strategies to meet tomorrow’s needs.

9. The School has pressing facilities and infrastructure needs that limit our ability to be innovative, to provide office and laboratory space, to provide patient care.

10. Parking and accessibility is a problem for patients and visitors.

11. The School does not currently market itself well.

12. There is a perception that the School’s goals are not well defined or well communicated internally.

13. There is the perception of insufficient involvement and support from department chairs and faculty leaders in external relation activities.

14. Way finding, both to the School and within the School is difficult.

15. First points of contact need improvement. Answering machine message is not welcoming to patients and visitors.

16. The school doesn’t have a clear identity or “brand.”

II. Which of the key issues do we need to and want to make a commitment to address?

1. List all agencies (healthcare, governmental) with which we currently have a relationship and determine if expectations are being met; define lines of communication with agencies and determine effectiveness; determine if there are additional agencies with which we can pursue a relationship in order to maximize mutual benefit.

2. Hold an open forum with members of key agencies to explore the potential benefits of existing or new relationships.

3. Invite the Provost, Mary Sue Coleman, legislators, society officials and other dignitaries for an informative visit with the dean and faculty/staff/students on site.

4. Invite one regent per month to visit and take a physical tour of our facilities, and to have a general discussion with our Dean and faculty/staff/students.

5. Explore the impact of the Development Office location and the perceptions regarding its location. Initiate dialogue with both internal and external partners to address the perceived negative impact of its location.

6. Explore the possibility of relocation of first floor reception, admitting and emergency services.
7. Conduct targeted recruitment of patients based on demographics, geography, etc. based on understanding of the source of our patients. Perhaps we need to establish satellite clinics in those communities.

8. Increase marketing and communications, both in written and electronic form in the target areas.

9. Implement better way-finding/signage - both internal and external.

10. Create a better system to gather and maintain statistical data on our patients that will provide more easily accessible metrics.

11. Improve/enhance Dental School website for students, patients, alumni, other professionals and the public. Include a searchable database for research projects and specialty care.

12. Develop a “brand” or “image” for the School of Dentistry; a good majority of the public is unaware of the things that the School has to offer.

13. Create newsletter that provides information to demystify our admissions process. There are many misunderstandings regarding the process. How is it impacted by the University’s/School’s commitment to diversity?

14. Educate faculty, staff and students about critical issues that the School faces (budget, University policies/mandates, and court actions). This hopefully would minimize having incorrect/damaging information relayed to external audiences. However, should this occur, our community has the information to correct it.

15. Use podcasting as another mode with which to communicate with alumni and other constituents. Podcast monthly/weekly on dental health and overall health issues.

16. Implement a strategic business plan that is adaptable to the changing environment.

17. Provide rewards to faculty who participate in continuing education and who serve Medicaid patients.

18. Educate U-Hospital physicians about the relationships between oral and systemic health; increase referrals.

19. Explore ways to provide dental services to more of the School and University community. Make the Dental School a preferred University of Michigan oral health care provider.

20. Improve our relationship with Delta Dental. Work to educate/encourage UM to adopt better oral health care insurance.

21. Move to an electronic patient record to more efficiently manage the patient care process and insure quality care for patients.

22. Partner more closely with the State of Michigan to provide care for underserved communities.

23. Provide dentists who accept Medicaid with value-added services such as special CE opportunities.
III. How are we currently positioned to address these key issues?

Like most businesses and agencies in the State of Michigan, the Dental School is currently experiencing a serious financial shortfall. This has the potential to impede our ability to make significant necessary changes to the infrastructure and expand programs. However, we have the personnel, expertise and ability to initiate most of the non-infrastructure issues related to communications. The results of this Strategic Assessment will provide the specific long-term goals that must be the heart of our communications plans.

We are gathering data that will enable us to identify the source of our patients and substantiate that we are the primary Medicaid provider in the state. The demographic and socioeconomic data on patients will help in future patient targeting and recruiting.

Currently, the School does minimal advertising. We believe the public, and indeed our own School community members have little or no knowledge of what the School can provide in terms of resources, education and patient care. We must step up our marketing and communications both internally (within the University) and externally. We have to decide what to market and to whom. Internally, this will include a monthly visit and tour of the School by a Regent or other administrative official to educate and inform them. Internally, this also means communicating with our faculty, staff and students. Communication is important at all levels of the School.

The School can and should plan to have topic experts develop brief videos to use for educational purposes. These might be made available by podcasting.

IV. What are the consequences of not addressing the key issues?

- Lost revenue
- Lost support from our partners
- Impaired communications; negative messages
- Compromised patient care
- Minimized potential
- Unsatisfied “customers” (Customers includes everyone; those in the School community, the University community, outside professionals, students, patients and the public, the world – everyone who currently or could potentially come in contact with the School or members of its community).

We must develop strong goals and set our sights high with faculty, staff and student commitment or lose leadership to mediocrity.

We must define/explore our external agency relationships, or we will not know if we are maximizing mutual benefits.

We must market ourselves better, or lose potential revenue and support.

We must decide what is critical to market, or become diffuse and lose our message.
We must address infrastructure issues, or we cannot function at our full potential.

We must develop a user-friendly website that is easily accessible and searchable by faculty, staff, students, alumni, professionals and the public, or we are not maximizing a potential revenue stream, nor are we marketing ourselves to the best of our ability.

We can only achieve the highest goals we set for ourselves; we must therefore develop a strong goals statement to which all faculty, staff, and students will aspire.

If we do not address issues of communication – in all areas – we will not maximize our potential in any area of operation. Students may opt to attend another university; patients may seek treatment elsewhere; professionals may not look to us as the best resource available; we may lose referrals from outside practitioners; faculty and staff will be divided in operation because there are no well-defined goals.

V. How does the School measure up to peer institutions or other outstanding organizations in performance on the key issues?

While committee members agreed that the School measures up to peer institutions and meets or exceeds what others are doing related to external relations, it was also acknowledged that we could market ourselves better both internally and externally.

Our Development Office is very effective in producing quality publications (DentalUM, Annual Report, CE Catalogs) in contributing to dental related publications (MDA, ADA), collaborating with U-M News Service and other external publications (The Ann Arbor News) and in producing brochures. They communicate our message to alumni, students, faculty, staff, the media, University officials, dental societies and organizations, legislators, prospective students and their parents, and prospective patients at outreach sites. They further reach audiences through the School web site and video.

The group acknowledged during the meetings that additional marketing techniques could be employed to target patients and to better inform the community to make them more aware of the services the School offers.

Printed materials will not go away, but web site development/enhancement is the future.

VI. How do these key issues match the broader core values of the University?

First, the School is dedicated to excellence and leadership in all aspects of education, patient care, research, and community service. A key component to excellence is effective communication. This is not only critical in internal communication, to enable the School community to work together, but in external communication to maximize mutual relationships with external partners.

Clearly, defining our role and maximizing the mutual benefits in our collaborations with external agencies and local officials will serve to cement our reputation and role in the community. This will formalize and document that we are not only the state’s primary Medicaid provider, but also it may enhance our ability to provide additional services to the underserved populations in the state.

Diversity remains a core value at the School of Dentistry. While the University’s stance on Affirmative Action has created some dissention among some of the School’s donors, we
believe that having a unified front and continuing to educate donors and the public on this issue may lead to understanding, resolution and acceptance.

Research and community service are University core values. By improving web access, and developing a searchable database that is accessible to outside professionals and the public, we may enhance our researchers’ ability to locate appropriate research subjects, provide specialized care for patients, add revenue, and further educate the public and professionals about the positive services the School has to offer. This could also enhance collaborative research opportunities if professionals are able to search by key word.
**Organizational Structure Topic Specific Discussion Group**

**April 2006**

<table>
<thead>
<tr>
<th>Topic Area:</th>
<th>Organizational Structure</th>
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<tbody>
<tr>
<td>Group Leader:</td>
<td>Peter Polverini</td>
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<tr>
<td>Group Co-Leader/Observer:</td>
<td>Sam Zwetchkenbaum</td>
</tr>
<tr>
<td>Group Recorder:</td>
<td>Erica Hanss</td>
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</tbody>
</table>

Regular attendees included:
- Peter Polverini, Leader
- Sam Zwetchkenbaum, Co-Leader/Observer
- Erica Hanss, Recorder
- Kumud Danak
- Doreen Graden
- Amid Ismail
- Sunil Kapila
- Lou Ann Lenio
- Christopher Nosrat
- George Taylor

The Topic Specific Discussion Group on Organizational Structure met six times in February and March of 2006. Discussions were broad and over a wide range of topics. No limits were placed on ideas that would be entertained for consideration. The study of organizational structure is a discipline itself, and while two of the participants are recent students in the area, none are experts. Two sessions were spent learning more about forms of organizational structure and comparing to peer institutions, the role of culture types and communication styles in organizations. Should deeper analysis of structure be desired, it may be beneficial to engage the assistance of an expert in this area.

The consensus of the group was that the current organizational structure of the School of Dentistry fulfills many of the ongoing educational and scientific needs and expectations of the School, however, there is a need for greater flexibility that is not present in the current structure.

Strengths of the current departmental structure included: thoughtful integration at the departmental level of scientific, education, and patient care programs; fostering and encouraging the emergence of leaders; and the structure being inherently stable. The major weakness cited is the lack of flexibility.

This lack of flexibility hampers cross-departmental and interdisciplinary collaboration and can lead to redundancy and confusion. A suggestion was the creation of Centers of Excellence/Centers of Discovery that would be cross departmental in structure, would
allow for independence in program development and would allow members of major scientific programs to play a role in the hiring of faculty for the Center. Areas suggested for CoEs were:

- Implant Dentistry
- Tissue Engineering
- Neuroscience
- Evidence-based Dentistry
- Oral Cancer
- Special Needs Dentistry

This adoption of Centers of Excellence/Centers of Discovery could empower faculty and research programs, but it would really be an “overlay” to the existing structure and organization of the School. A disadvantage of the organizational structure of CoEs lies in the difficulty in determining who is evaluating a worker’s performance. A more bold and innovative plan is really needed if we are to position the School to be a leader as we look ten to fifteen years ahead.

The Group proposed developing a model that would give the predoctoral education program greater independence from the research and discovery programs (and graduate education) and from the patient care programs. The three programs would be independent entities financially and structurally, yet run under the auspices of the School of Dentistry. Critical relationships would need to be maintained, but each would be able to act and react in a more nimble fashion. Each would be able to establish relationships outside the School of Dentistry, with other University units, e.g., the UMHS, or with other national and international institutions.
MACY GROUP VISIT

A. The following text was the content for the poster that invited the UMSD community to the Macy Study Group presentations held on July 27, 2006:

Title: Challenges Facing the Financial Structure and System of Dental Education

What: The Strategic Assessment Facilitating Committee invites all members of the School of Dentistry’s community to attend a program of presentations by the Macy Study Group on the challenges facing the financial structure and system of dental education.

When: Thursday, July 27, 2006: 1:00 p.m. to 5:00 p.m.

Where: School of Dentistry, G390

Who: The Macy Study Group is a team of experienced, forward thinking educators and scholars who have been rigorously studying the financial structure and system of dental education since 2004. Their research is supported by the Macy Foundation. Members of the Macy Study Group include Drs. Lisa Tedesco (Emory University and University of Michigan), Allan Formicola (Columbia University), Howard Bailit (University of Connecticut), and Tryfon Beazoglou (University of Connecticut).

What: The Macy Study Group will present to us the financial trend analyses and potential benefits of models/strategies that they have identified to improve finances and sustain the institutional and academic vitality of dental education as a scientifically based profession.

Why: SAFCo has invited the Macy Study Group to visit our school to engage in consultations and conversations on our strategic assessment. This visit will provide an opportunity for us to challenge our thinking, vision, and articulation of strategic imperatives beyond the concepts, perspectives, and programs we currently know, and about which we have been discussing. This will be an important opportunity to learn from their extensive work as we shape our School of Dentistry’s future.

B. The Macy Study Group made the following presentations on Jul 27, 2006. The full video recordings and PowerPoint slides for each of these presentations are provided at the UMSD intranet strategic assessment URL: https://intranet.dent.umich.edu/SAFCO/.

1. Introduction to the Macy Study

   Allen J. Formicola, DDS, MS

   Professor of Dentistry, Columbia University and

   Vice Dean, Center for Community Health Partnerships
2. Presentation and Discussion of the Problem Facing Dental Education.

Howard Bailit, DMD, PhD
Professor Emeritus
University of Connecticut

3. Presentation and Discussion of the Evolution of Dental Clinics toward Patient Centered Care and the Dental Pipeline Community-Based Education Program.

Allen J. Formicola, DDS, MS
Professor of Dentistry, Columbia University and Dean, Center for Community Health Partnerships

4. Presentation and Discussion of the Financial Analysis of Two New Models of Dental Education.

Howard Bailit, DMD, PhD
Professor Emeritus
University of Connecticut

5. Presentation and Discussion of the Need for Curriculum Change: The Macy Panels and Accreditation

Lisa A. Tedesco, PhD
Dean, Graduate School of Arts and Sciences
Professor, Rollins School of Public Health
Emory University

References for Macy Group documents:


# SUMMARY OF STRENGTHS

<table>
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<tr>
<th>TSDG Group</th>
<th>Strengths</th>
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| **Students**        | - The School has dedicated faculty  
- The School has exemplary pre-clinical resources  
- The School offers early experiences in clinic with the Vertically Integrated Clinic (VIC) model  
- The School offers extensive resources (e.g., many graduate programs, research, library)  
- There is very good interaction among classes and between hygiene and dental students  
- The School offers opportunities for participation in the admissions process  
- The high quality of the dental and graduate students that the UM School of Dentistry is capable of attracting.                                                                                                                                                                        |
| **Research**        | - The caliber of the faculty of the UM School of Dentistry, and the existing research collaborations among the faculty across all departments in the School.  
- Existing research collaborations with other units of the University (e.g. Medical school, Biomedical engineering), with other dental schools in the US (e.g. University of Detroit), and with dental schools outside the country (e.g. University of São Paulo, Brazil).  
- The University of Michigan School of Dentistry is highly regarded nationally and internationally as a leading institution for dental research for many decades.  
- The impact of the Oral Health Sciences PhD program on research at the school of Dentistry.                                                                                                                                                                                   |
| **Organizational Structure** | - There is thoughtful integration at the departmental level of scientific, education, and patient care programs  
- The School fosters and encourages the emergence of leaders  
- The current organizational structure is inherently stable                                                                                                                                                                                                 |
| **External Relations** | - We provide benefits and services to various agencies within Washtenaw County and throughout the state; we provide resources worldwide.  
- We are the primary Medicaid provider in the state and serve underserved populations.  
- We provide world-class resources, and excellent education and skill-building programs for professionals in a diverse environment.  
- We have a reputation of being one of the world’s leading institutions committed to oral health care education, patient care, research, and community service.  
- Our library and museum services provide an excellent exhibition of historical dental collections, reference services, artifacts, text and images for media.  
- We currently provide excellent publications via printed materials and are working to improve our internet services - Publications (average of 10,500 copies of DentalUM, average of 11,000 annual reports, fundraising brochures, 13,000 copies of DVD) to create awareness. |
- We measure up to peer institutions and in most instances meet or exceed what others are doing related to external relations.

### External Relations (continued)
- The CE office mails two catalogs per year to over 28,000 alumni and CE participants, and numerous brochures promoting courses. The School offers over 75 CE courses per year. The School offers the largest number of courses to dental professionals.

### Clinical Operations
- Students are given significant responsibility to manage their patient families. This responsibility is viewed as a very positive aspect of the clinical curriculum as it helps students learn to interact and manage their patients' treatment.
- Management of emergency patients is efficient; significant number of patients are managed daily.
- The undergraduate clinics are focused on the needs of the patient and staffed to deliver comprehensive care on a daily basis.
- The clinical faculty members have excellent training and skill to provide support for the students during patient treatment.
- All specialty disciplines are represented in the school clinics which is very valuable for the students and patients.
- There is a strong, well-qualified basic science faculty in the school.

### Curriculum
- The School has a strong clinical program that gives our graduates a broad base of experience and capabilities.
- There are excellent resources at the School and University:
  - SimLab
  - Library
  - Building
- The School offers partnership opportunities with other units on campus.
- The School has excellent faculty (Who we are)
- The School has great students.
- The School has a history of willingness to innovate in dental education.

### Staff
- Newsletters from the Dean, Patient Services, Dental Informatics, MAC, and the Staff ForUM.
- Inclusion in the Strategic Assessment Process.
- MAC-sponsored events including the Disability Forum, Women’s Tea, Ida Gray Award, and the Taste Fest.
- Schoolwide events such as the School Picnic, Dean’s Holiday Party, Dr. Rife’s holiday caroling, 10-year service award reception, as well as the University-wide service reception.
- New initiatives such as the upcoming Staff Retreat.
<table>
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<tr>
<th>Staff (continued)</th>
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</table>
| - The Dean’s Town Hall Meetings.  
| - Staff are dedicated, loyal, hard working, competent, take pride in the School and are a key to ensuring programs run smoothly |  

<table>
<thead>
<tr>
<th>Faculty</th>
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</table>
| - Dental Hygiene: This is one of the few institutions to offer undergraduate and graduate degrees in Dental Hygiene.  
| - Specialties: Graduate programs in all dental specialties are offered. A large number of specialists teach at the predoctoral and graduate level as well as conduct research in their discipline.  
| - Preeminent Reputation: The school has an excellent reputation. Many dental educators use the word “preeminent” when referring the U-M School of Dentistry. This means that the graduates and the faculty are held in high esteem. It also means that there are high expectations for the school and its faculty, staff and students. This reputation extends to high expectations for quality teaching, research, patient care and community service. The school has an especially strong reputation for conducting innovative research in a large number of areas related to dentistry and dental education. The school’s preeminent standing has enabled it to hire strong researchers and clinicians to its faculty.  
| - Expertise: The breadth and depth of faculty expertise is witnessed in the number of faculty who are asked to be reviewers for journals, NIH study sections, write reviews of faculty at other institutions being considered for promotion, and serve on corporate advisory boards. Our faculty serve the profession as accreditation reviewers, specialty board examiners, National Board test authors, and national and international professional organization committee members and officers.  
| - Embracing Change: Most members of the faculty are not satisfied with the status quo. Faculty can be constructively critical of the current and proposed practices. However, when presented with solid research and data they are not afraid of change and even embrace it. One example of embracing change and innovation in dental education was being the first dental school to institute a Vertically Integrated Curriculum of comprehensive care for its clinical education.  
| - Resources: The School and University offer excellent resources. The Dental Library is one of the best dental libraries in the country, if not the world. Resources available to help develop teaching skills include Tom Green and CRLT. It is very rare that a faculty member cannot find the resources they require. At times the numbers of resources are so overwhelming that it may difficult to find the appropriate one. If a faculty member is not able to accomplish a task it rarely is due to a lack of resources.  
<p>| - Diversity and Collegiality: The school embraces diversity (race, gender and nationality) while maintaining quality |
| in its teaching, research, patient care and community service mission. This diversity has brought new ideas to the school, helped to create an environment for faculty to collaborate in new and different ways, and created an environment where innovation is supported and encouraged. Additionally, in 2005 the School of Dentistry received funding for the Gateway Faculty Development Program. This program is an ADEA/WK Kellogg-funded endeavor designed to facilitate access into careers in academic dentistry for underrepresented minorities and others typically underrepresented in the dental profession. |</p>
<table>
<thead>
<tr>
<th>CODE</th>
<th>Organizing Topic</th>
<th>TSDG</th>
<th>Operational Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>CUR</td>
<td>Active Learning</td>
<td>Curriculum</td>
<td>Prepare Students for Critical Thinking</td>
</tr>
<tr>
<td>CUR</td>
<td>Active Learning</td>
<td>Curriculum</td>
<td>Student Independence in Learning</td>
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<tr>
<td>CUR</td>
<td>Active Learning</td>
<td>Curriculum</td>
<td>Student Responsibility in Learning</td>
</tr>
<tr>
<td>CUR</td>
<td>Active Learning</td>
<td>Curriculum</td>
<td>Focus on active learning and teaching processes (too much PowerPoint)</td>
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<tr>
<td>CLN</td>
<td>Adaptability</td>
<td>Clinical</td>
<td>Evaluate current patient demand for specialty faculty to consider alternative mix of fac.</td>
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<tr>
<td>CLN</td>
<td>Adaptability</td>
<td>Clinical</td>
<td>Discuss issues related to evening clinics</td>
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<tr>
<td>CLN</td>
<td>Adaptability</td>
<td>Clinical</td>
<td>Consistency in faculty staffing model</td>
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<tr>
<td>CLN</td>
<td>Adaptability</td>
<td>Clinical</td>
<td>Dispensing is at maximum capacity - Deal with related issues</td>
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<tr>
<td>CLN</td>
<td>Adaptability</td>
<td>Clinical</td>
<td>Monitor Needs in Community Outreach</td>
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<tr>
<td>CLN</td>
<td>Adaptability</td>
<td>Clinical</td>
<td>Monitor and assess because needs change rapidly and frequently</td>
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<td>CLN</td>
<td>Adaptability</td>
<td>Clinical</td>
<td>Faculty staffing model</td>
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<tr>
<td>CUR</td>
<td>Adaptability</td>
<td>Curriculum</td>
<td>Flexible Curriculum</td>
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<tr>
<td>CUR</td>
<td>Adaptability</td>
<td>Curriculum</td>
<td>Define the next generation</td>
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<tr>
<td>CUR</td>
<td>Adaptability</td>
<td>Curriculum</td>
<td>Focus on creating a better workforce</td>
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<tr>
<td>CUR</td>
<td>Adaptability</td>
<td>Curriculum</td>
<td>Education meshes with real world</td>
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<tr>
<td>CUR</td>
<td>Adaptability</td>
<td>Curriculum</td>
<td>Visioning for the year 2050; future needs; specific technologies</td>
</tr>
<tr>
<td>CUR</td>
<td>Adaptability</td>
<td>Curriculum</td>
<td>Provide an environment that is current and adaptable for the future</td>
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<tr>
<td>CUR</td>
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<td>Curriculum</td>
<td>Provide an environment that is current and adaptable for the future</td>
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<tr>
<td>EXT</td>
<td>Adaptability</td>
<td>External</td>
<td>To increase our ability to be innovative, provide office/lab space/excellent patient care</td>
</tr>
<tr>
<td>FAC</td>
<td>Adaptability</td>
<td>Faculty</td>
<td>Increase flexibility (allow to practice outside School)</td>
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<tr>
<td>FAC</td>
<td>Adaptability</td>
<td>Faculty</td>
<td>Define benefits of adopting a faculty FTE profile model</td>
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<tr>
<td>FAC</td>
<td>Adaptability</td>
<td>Faculty</td>
<td>Reduce faculty shortages due to low salary, lack of flexibility to practice outside</td>
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<tr>
<td>FAC</td>
<td>Adaptability</td>
<td>Faculty</td>
<td>Continuously evolve and develop to remain preeminent</td>
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<tr>
<td>FAC</td>
<td>Adaptability</td>
<td>Faculty</td>
<td>Requirement of 100% full time faculty model: review/revise for flexibility</td>
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<tr>
<td>ORG</td>
<td>Adaptability</td>
<td>Organizational</td>
<td>Greater Flexibility</td>
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<tr>
<td>ORG</td>
<td>Adaptability</td>
<td>Organizational</td>
<td>Diminish redundancy</td>
</tr>
<tr>
<td>ORG</td>
<td>Adaptability</td>
<td>Organizational</td>
<td>Allow independence in program development</td>
</tr>
<tr>
<td>ORG</td>
<td>Adaptability</td>
<td>Organizational</td>
<td>Develop a model for three programs (predoc, R&amp;D + Grad Ed., Patient Care)</td>
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<tr>
<td>STU</td>
<td>Adaptability</td>
<td>Students</td>
<td>Electives</td>
</tr>
<tr>
<td>STU</td>
<td>Administrative</td>
<td>Students</td>
<td>Grad programs separating from Rackham; too many issues specific to dentistry</td>
</tr>
<tr>
<td>STU</td>
<td>Administrative</td>
<td>Students</td>
<td>Ineffective administrators</td>
</tr>
<tr>
<td>STU</td>
<td>Advocacy</td>
<td>Students</td>
<td>Students need to provide feedback to someone who can take action</td>
</tr>
<tr>
<td>STU</td>
<td>Advocacy</td>
<td>Students</td>
<td>System of checks and balances in place to address issues with classes</td>
</tr>
<tr>
<td>STU</td>
<td>Advocacy</td>
<td>Students</td>
<td>Lack of empowerment of students</td>
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<tr>
<td>STU</td>
<td>Advocacy</td>
<td>Students</td>
<td>Creation of Grad Student Advocate</td>
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<tr>
<td>STU</td>
<td>Benefits</td>
<td>Students</td>
<td>Eligibility for health care for residents</td>
</tr>
<tr>
<td>CLN</td>
<td>Calibration</td>
<td>Clinical</td>
<td>Invest in ongoing in-service training</td>
</tr>
<tr>
<td>CLN</td>
<td>Calibration</td>
<td>Clinical</td>
<td>Alternative methods have value, but need more consistency in clinics</td>
</tr>
<tr>
<td>CLN</td>
<td>Calibration</td>
<td>Clinical</td>
<td>Core faculty have enhanced leadership role in calibrating part time faculty</td>
</tr>
<tr>
<td>CUR</td>
<td>Calibration</td>
<td>Curriculum</td>
<td>Problem of insufficient time and ways to get better calibration among faculty</td>
</tr>
<tr>
<td>EXT</td>
<td>CDE</td>
<td>External</td>
<td>Reluctance on the part of some faculty to participate in CE</td>
</tr>
<tr>
<td>CLN</td>
<td>Climate</td>
<td>Clinical</td>
<td>Student Satisfaction</td>
</tr>
<tr>
<td>CUR</td>
<td>Climate</td>
<td>Curriculum</td>
<td>Create a culture that encourages learning, not competition</td>
</tr>
<tr>
<td>CUR</td>
<td>Climate</td>
<td>Curriculum</td>
<td>Culture that allowed for meaningful dialogue among all groups</td>
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<tr>
<td>CUR</td>
<td>Climate</td>
<td>Curriculum</td>
<td>Deal with “hidden curriculum” (competition, non-collegiality, etc).</td>
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<tr>
<td>FAC</td>
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<td>Faculty</td>
<td>Create clinical research structure similar to research culture</td>
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<td>FAC</td>
<td>Climate</td>
<td>Faculty</td>
<td>Culture Change</td>
</tr>
<tr>
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<td>Climate</td>
<td>Faculty</td>
<td>Increase number of under-represented minority faculty</td>
</tr>
<tr>
<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Increase staff understanding of the new classification system</td>
</tr>
<tr>
<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Increase staff understanding of budget allocations/expenditures</td>
</tr>
<tr>
<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Better workplace</td>
</tr>
<tr>
<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Camaraderie</td>
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<td>Climate</td>
<td>Staff</td>
<td>Conflict Resolution</td>
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<td>Climate</td>
<td>Staff</td>
<td>Diversity</td>
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<td>Climate</td>
<td>Staff</td>
<td>Fairness</td>
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<td>Staff</td>
<td>Inclusion</td>
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<td>Staff</td>
<td>Morale</td>
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<td>Climate</td>
<td>Staff</td>
<td>Pride</td>
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<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Relationship Building</td>
</tr>
<tr>
<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Help create sense of unified goals</td>
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<tr>
<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Multi-departmental teamwork</td>
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<tr>
<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Annual staff retreat</td>
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<tr>
<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>More broadly utilize the SPS (Situation-Problem-Solution program)</td>
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<tr>
<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Eliminate cultural barriers</td>
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<tr>
<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Collaborative decision-making</td>
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<tr>
<td>CODE</td>
<td>Organizing Topic</td>
<td>TSDG</td>
<td>Operational Issues</td>
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<tr>
<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Provide Staff Lounge/Lunchroom</td>
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<tr>
<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Develop rules of engagement for addressing issues openly and honestly</td>
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<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Appoint/elect staff representative to serve as mediator/ombuds</td>
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<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Address perception that management does not want to deal with staff issues</td>
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<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Address staff fear of repercussion</td>
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<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Address avoidance v. open communication Address issues of respect/disrespect</td>
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<tr>
<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>More interactive meetings (not just relay information)</td>
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<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Develop ways to help offsite employees feel more connected</td>
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<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Promote Diversity</td>
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<td>STF</td>
<td>Climate</td>
<td>Staff</td>
<td>Increase cultural awareness</td>
</tr>
<tr>
<td>STU</td>
<td>Climate</td>
<td>Students</td>
<td>Too much competition between students and specialty programs</td>
</tr>
<tr>
<td>STU</td>
<td>Climate</td>
<td>Students</td>
<td>Population is diverse, but students don't mix; perpetuates a culture of individualism</td>
</tr>
<tr>
<td>STU</td>
<td>Climate</td>
<td>Students</td>
<td>Climate of unity among students, faculty and staff; everyone valued and respected</td>
</tr>
<tr>
<td>STU</td>
<td>Climate</td>
<td>Students</td>
<td>Free to ask questions without fear of failure</td>
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<tr>
<td>STU</td>
<td>Climate</td>
<td>Students</td>
<td>Separation-Cultural Issue</td>
</tr>
<tr>
<td>STU</td>
<td>Climate</td>
<td>Students</td>
<td>Positive Culture</td>
</tr>
<tr>
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<td>Climate</td>
<td>Students</td>
<td>Competitive Nature</td>
</tr>
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<td>Climate</td>
<td>Students</td>
<td>Culture of Individualism-Change</td>
</tr>
<tr>
<td>CLN</td>
<td>Clinical Models</td>
<td>Clinical</td>
<td>Patient-centered clinics</td>
</tr>
<tr>
<td>CLN</td>
<td>Clinical Models</td>
<td>Clinical</td>
<td>Clarify role of general dentist; students do not well with specialists</td>
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<tr>
<td>CLN</td>
<td>Clinical Models</td>
<td>Clinical</td>
<td>Potentially eliminate some disciplines from VICS for more effective patient treatment</td>
</tr>
<tr>
<td>CLN</td>
<td>Clinical Models</td>
<td>Clinical</td>
<td>Staff clinics with a hygiene model for more stable recall system for patients</td>
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<tr>
<td>CLN</td>
<td>Clinical Models</td>
<td>Clinical</td>
<td>Patient-Centered Clinics</td>
</tr>
<tr>
<td>CUR</td>
<td>Clinical Models</td>
<td>Curriculum</td>
<td>Patient Centered Care</td>
</tr>
<tr>
<td>STU</td>
<td>Clinical Models</td>
<td>Students</td>
<td>Students want a &quot;family&quot; in VICS</td>
</tr>
<tr>
<td>STU</td>
<td>Clinical Models</td>
<td>Students</td>
<td>VICs clinics not focused on patient families or promoting mentoring</td>
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<tr>
<td>STU</td>
<td>Clinical Models</td>
<td>Students</td>
<td>VIC Clinic Organization</td>
</tr>
<tr>
<td>ORG</td>
<td>Collaboration</td>
<td>Organizational</td>
<td>To enhance cross-departmental and interdisciplinary collaboration</td>
</tr>
<tr>
<td>CUR</td>
<td>Communications</td>
<td>Curriculum</td>
<td>Improve Interpersonal Interactions</td>
</tr>
<tr>
<td>EXT</td>
<td>Communications</td>
<td>External</td>
<td>Improve internal communications</td>
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<tr>
<td>EXT</td>
<td>Communications</td>
<td>External</td>
<td>Communicate influence of offsite location of Development Office</td>
</tr>
<tr>
<td>EXT</td>
<td>Communications</td>
<td>External</td>
<td>Increase communication at all levels</td>
</tr>
<tr>
<td>FAC</td>
<td>Communications</td>
<td>Faculty</td>
<td>Clearly define scholarly activity for all tracks</td>
</tr>
<tr>
<td>FAC</td>
<td>Communications</td>
<td>Faculty</td>
<td>Mission statement should be revised to include school goals.</td>
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<td>FAC</td>
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<td>Communication-Enhance</td>
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<td>FAC</td>
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<td>Faculty</td>
<td>Mission Statement Revision</td>
</tr>
<tr>
<td>RES</td>
<td>Communications</td>
<td>Research</td>
<td>Enhance awareness of impact of our research on oral health</td>
</tr>
<tr>
<td>RES</td>
<td>Communications</td>
<td>Research</td>
<td>Strategy to demonstrate to University value of supporting the School research mission</td>
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<td>STF</td>
<td>Communications</td>
<td>Staff</td>
<td>Develop better ways to communicate with all staff</td>
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<td>STF</td>
<td>Communications</td>
<td>Staff</td>
<td>Upgrade school monitors</td>
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<td>Communications</td>
<td>Staff</td>
<td>Enhance newsletters and electronic mediate</td>
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<td>STF</td>
<td>Communications</td>
<td>Staff</td>
<td>More frequent town hall meetings</td>
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<td>Communications</td>
<td>Staff</td>
<td>Develop in-house website for information sharing</td>
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<td>Communications</td>
<td>Staff</td>
<td>Interdepartmental visits</td>
</tr>
<tr>
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<td>Communications</td>
<td>Staff</td>
<td>Wiki sites for information sharing</td>
</tr>
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<td>Communications</td>
<td>Students</td>
<td>Increased feedback interaction between residents and their directors and chairs</td>
</tr>
<tr>
<td>STU</td>
<td>Communications</td>
<td>Students</td>
<td>Improved and increased communications</td>
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<tr>
<td>STU</td>
<td>Communications</td>
<td>Students</td>
<td>Communication Forums</td>
</tr>
<tr>
<td>CLN</td>
<td>Curriculum</td>
<td>Clinical</td>
<td>Better prepare students to manage patient care</td>
</tr>
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<td>CLN</td>
<td>Curriculum</td>
<td>Clinical</td>
<td>Enhance student management skills</td>
</tr>
<tr>
<td>CLN</td>
<td>Curriculum</td>
<td>Clinical</td>
<td>Enhance student ability to discuss fiscal responsibilities with patients</td>
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<tr>
<td>CLN</td>
<td>Curriculum</td>
<td>Clinical</td>
<td>Increase translation of basic science information to clinics</td>
</tr>
<tr>
<td>CLN</td>
<td>Curriculum</td>
<td>Clinical</td>
<td>Flexible Curriculum</td>
</tr>
<tr>
<td>CLN</td>
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<td>Clinical</td>
<td>Internationally Trained Dentist Prog.</td>
</tr>
<tr>
<td>CLN</td>
<td>Curriculum</td>
<td>Clinical</td>
<td>Decrease time between learning techniques and practicing them</td>
</tr>
<tr>
<td>CLN</td>
<td>Curriculum</td>
<td>Clinical</td>
<td>Opportunities to relearn/review techniques</td>
</tr>
<tr>
<td>CLN</td>
<td>Curriculum</td>
<td>Clinical</td>
<td>Remediation for weaker students</td>
</tr>
<tr>
<td>CLN</td>
<td>Curriculum</td>
<td>Clinical</td>
<td>Develop an incentive-rich clinic system for students</td>
</tr>
<tr>
<td>CLN</td>
<td>Curriculum</td>
<td>Clinical</td>
<td>Transition from preclinic to clinic monitored and mentored by faculty</td>
</tr>
<tr>
<td>CLN</td>
<td>Curriculum</td>
<td>Clinical</td>
<td>Four-handed dentistry experience</td>
</tr>
<tr>
<td>CLN</td>
<td>Curriculum</td>
<td>Clinical</td>
<td>Practice Management in a private practice setting</td>
</tr>
<tr>
<td>CLN</td>
<td>Curriculum</td>
<td>Clinical</td>
<td>Student preparedness</td>
</tr>
<tr>
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<td>Curriculum</td>
<td>Clinical</td>
<td>Enhance the educational experience</td>
</tr>
<tr>
<td>CODE</td>
<td>Organizing Topic</td>
<td>TSDG</td>
<td>Operational Issues</td>
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<tr>
<td>RES</td>
<td>Curriculum</td>
<td>Research</td>
<td>Evidence based dentistry</td>
</tr>
<tr>
<td>RES</td>
<td>Curriculum</td>
<td>Research</td>
<td>Students more engaged in process of discovery</td>
</tr>
<tr>
<td>RES</td>
<td>Curriculum</td>
<td>Research</td>
<td>Student interaction with faculty and other schools</td>
</tr>
<tr>
<td>RES</td>
<td>Curriculum</td>
<td>Research</td>
<td>Flexibility in the curriculum</td>
</tr>
<tr>
<td>RES</td>
<td>Curriculum</td>
<td>Research</td>
<td>Opportunity for students to have a meaningful research experience</td>
</tr>
<tr>
<td>RES</td>
<td>Curriculum</td>
<td>Research</td>
<td>Better integration between DDS/PhD components</td>
</tr>
<tr>
<td>CUR</td>
<td>Curriculum models</td>
<td>Curriculum</td>
<td>Curricular efficiency</td>
</tr>
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<td>CUR</td>
<td>Curriculum models</td>
<td>Curriculum</td>
<td>Competency based</td>
</tr>
<tr>
<td>CUR</td>
<td>Curriculum models</td>
<td>Curriculum</td>
<td>Evidence based</td>
</tr>
<tr>
<td>CUR</td>
<td>Curriculum models</td>
<td>Curriculum</td>
<td>Prepare students for contemporary health practice (closer allegiance w/medicine)</td>
</tr>
<tr>
<td>CUR</td>
<td>Curriculum models</td>
<td>Curriculum</td>
<td>Better links between DDS/Hygiene programs and grad programs</td>
</tr>
<tr>
<td>CUR</td>
<td>Curriculum models</td>
<td>Curriculum</td>
<td>Better integration of basic and clinic sciences</td>
</tr>
<tr>
<td>CUR</td>
<td>Curriculum models</td>
<td>Curriculum</td>
<td>Connect preclinical and basic science with clinical practice in clinics</td>
</tr>
<tr>
<td>STU</td>
<td>Curriculum models</td>
<td>Students</td>
<td>Outreach experiences are too few and limited in breadth</td>
</tr>
<tr>
<td>STF</td>
<td>Development</td>
<td>Staff</td>
<td>Staff Development Program</td>
</tr>
<tr>
<td>STF</td>
<td>Development</td>
<td>Staff</td>
<td>Staff Mentoring Program</td>
</tr>
<tr>
<td>STF</td>
<td>Development</td>
<td>Staff</td>
<td>Help staff develop career paths within School and/or within University</td>
</tr>
<tr>
<td>STF</td>
<td>Development</td>
<td>Staff</td>
<td>Staff as program presenters/share knowledge</td>
</tr>
<tr>
<td>STF</td>
<td>Development</td>
<td>Staff</td>
<td>Plan development programs at times when staff can attend</td>
</tr>
<tr>
<td>STF</td>
<td>Development</td>
<td>Staff</td>
<td>Outline staff development goals through annual performance planning</td>
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<td>STF</td>
<td>Development</td>
<td>Staff</td>
<td>Encourage staff participation in University programs and events</td>
</tr>
<tr>
<td>STF</td>
<td>Development</td>
<td>Staff</td>
<td>Staff Endowment for ongoing funding</td>
</tr>
<tr>
<td>STF</td>
<td>Development</td>
<td>Staff</td>
<td>Enhance awareness of credentialing</td>
</tr>
<tr>
<td>STF</td>
<td>Development</td>
<td>Staff</td>
<td>Time management</td>
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<td>STF</td>
<td>Development</td>
<td>Staff</td>
<td>Computer training to enhance skills</td>
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<td>STF</td>
<td>Development</td>
<td>Staff</td>
<td>Supervisor training</td>
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<td>STF</td>
<td>Development</td>
<td>Staff</td>
<td>Interpersonal skill training</td>
</tr>
<tr>
<td>STF</td>
<td>Development</td>
<td>Staff</td>
<td>Institute an equitable tuition reimbursement program for entire School, not just Depts.</td>
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<tr>
<td>FAC</td>
<td>Equity</td>
<td>Faculty</td>
<td>Continuous review for inequities/disparities</td>
</tr>
<tr>
<td>FAC</td>
<td>Equity</td>
<td>Faculty</td>
<td>Equity between clinical and research tracks</td>
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<td>Equity</td>
<td>Staff</td>
<td>Salary Equity - Formal Program</td>
</tr>
<tr>
<td>STF</td>
<td>Equity</td>
<td>Staff</td>
<td>Address perceptions re: salary structure and enhance understanding</td>
</tr>
<tr>
<td>CUR</td>
<td>Evaluation</td>
<td>Curriculum</td>
<td>Develop peer evaluation system</td>
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<tr>
<td>CUR</td>
<td>Evaluation</td>
<td>Curriculum</td>
<td>Review Systems of Evaluation</td>
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<tr>
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<td>Evaluation</td>
<td>Curriculum</td>
<td>Develop and incorporate a peer evaluation system</td>
</tr>
<tr>
<td>STU</td>
<td>Evaluation</td>
<td>Students</td>
<td>Students don't have opportunity to see their tests (includes D4 OSCE)</td>
</tr>
<tr>
<td>STU</td>
<td>Evaluation</td>
<td>Students</td>
<td>Grading system in residency is meaningless and useless</td>
</tr>
<tr>
<td>STU</td>
<td>Evaluation</td>
<td>Students</td>
<td>Determine how successful P/F system is in getting students into grad programs</td>
</tr>
<tr>
<td>STU</td>
<td>Evaluation</td>
<td>Students</td>
<td>Make clinic competencies graded but allow opportunity for retakes</td>
</tr>
<tr>
<td>STU</td>
<td>Evaluation</td>
<td>Students</td>
<td>Eliminate bubble sheet as they are ineffective at evaluation; replace with shadow charts</td>
</tr>
<tr>
<td>STU</td>
<td>Evaluation</td>
<td>Students</td>
<td>Implementing new eval. System</td>
</tr>
<tr>
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<td>Evaluation</td>
<td>Students</td>
<td>Course Evaluations</td>
</tr>
<tr>
<td>CLN</td>
<td>Facilities</td>
<td>Clinical</td>
<td>Better utilization of clinic space, and updated facilities</td>
</tr>
<tr>
<td>CLN</td>
<td>Facilities</td>
<td>Clinical</td>
<td>Cubicles designed for four-handed dentistry</td>
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<tr>
<td>CLN</td>
<td>Facilities</td>
<td>Clinical</td>
<td>Better access for handicapped patients (wheelchair access)</td>
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<tr>
<td>CLN</td>
<td>Facilities</td>
<td>Clinical</td>
<td>Model facilities</td>
</tr>
<tr>
<td>CLN</td>
<td>Facilities</td>
<td>Clinical</td>
<td>Increase clinic space per cubicle chair</td>
</tr>
<tr>
<td>CLN</td>
<td>Facilities</td>
<td>Clinical</td>
<td>Better parking for patients</td>
</tr>
<tr>
<td>CLN</td>
<td>Facilities</td>
<td>Clinical</td>
<td>Upgrade infrastructure in general</td>
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<tr>
<td>CLN</td>
<td>Facilities</td>
<td>Clinical</td>
<td>Barrier-free restrooms</td>
</tr>
<tr>
<td>CUR</td>
<td>Facilities</td>
<td>Curriculum</td>
<td>Clinic Upgrades</td>
</tr>
<tr>
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<td>Facilities</td>
<td>Curriculum</td>
<td>Foundation Curriculum Lab Upgrades</td>
</tr>
<tr>
<td>CUR</td>
<td>Facilities</td>
<td>Curriculum</td>
<td>Upgrade Classrooms</td>
</tr>
<tr>
<td>CUR</td>
<td>Facilities</td>
<td>Curriculum</td>
<td>State of the art equipment and clinics</td>
</tr>
<tr>
<td>CUR</td>
<td>Facilities</td>
<td>Curriculum</td>
<td>Change configuration in clinics - not patient friendly, especially those with spec. needs</td>
</tr>
<tr>
<td>CUR</td>
<td>Facilities</td>
<td>Curriculum</td>
<td>Increase clinical capacity; currently, limits ability to explore innov. Teaching</td>
</tr>
<tr>
<td>CUR</td>
<td>Facilities</td>
<td>Curriculum</td>
<td>Larger SimLabs; opportunities for use in D3/D4 courses, DH, Grad Programs and CE</td>
</tr>
<tr>
<td>CUR</td>
<td>Facilities</td>
<td>Curriculum</td>
<td>More classrooms that effectively support small group sessions</td>
</tr>
<tr>
<td>CUR</td>
<td>Facilities</td>
<td>Curriculum</td>
<td>Improve facilities (IT infrastructure-network, rooms, clinic space, etc.)</td>
</tr>
<tr>
<td>EXT</td>
<td>Facilities</td>
<td>External</td>
<td>Parking accessibility for patients and other visitors</td>
</tr>
<tr>
<td>EXT</td>
<td>Facilities</td>
<td>External</td>
<td>Limited resources/antiquated facilities/insufficient space (function and perception)</td>
</tr>
<tr>
<td>EXT</td>
<td>Facilities</td>
<td>External</td>
<td>Current venue for continuing ed suffers from lack of meeting space and parking</td>
</tr>
<tr>
<td>EXT</td>
<td>Facilities</td>
<td>External</td>
<td>Increase effectiveness of wayfinding/better signage</td>
</tr>
<tr>
<td>EXT</td>
<td>Facilities</td>
<td>External</td>
<td>Better CE Venue</td>
</tr>
<tr>
<td>CODE</td>
<td>Organizing Topic</td>
<td>TSDG</td>
<td>Operational Issues</td>
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<tr>
<td>EXT</td>
<td>Facilities</td>
<td>External</td>
<td>Update facilities and infrastructure</td>
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<tr>
<td>EXT</td>
<td>Facilities</td>
<td>External</td>
<td>Increase Parking</td>
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<tr>
<td>FAC</td>
<td>Facilities</td>
<td>Faculty</td>
<td>Maintenance of infrastructure for clinical research enterprise</td>
</tr>
<tr>
<td>RES</td>
<td>Facilities</td>
<td>Research</td>
<td>Research Infrastructure</td>
</tr>
<tr>
<td>RES</td>
<td>Facilities</td>
<td>Research</td>
<td>21st century research facilities; sufficient space to perform research safely, effectively</td>
</tr>
<tr>
<td>RES</td>
<td>Facilities</td>
<td>Research</td>
<td>Work towards improving extent and quality of space</td>
</tr>
<tr>
<td>STU</td>
<td>Facilities</td>
<td>Students</td>
<td>School needs cosmetic upgrades</td>
</tr>
<tr>
<td>CUR</td>
<td>Faculty Development</td>
<td>Curriculum</td>
<td>Faculty training on effective teaching modalities</td>
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<tr>
<td>FAC</td>
<td>Faculty Development</td>
<td>Faculty</td>
<td>Support for faculty (research papers, etc.)</td>
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<tr>
<td>FAC</td>
<td>Faculty Development</td>
<td>Faculty</td>
<td>Define criteria for promotion in clinical track</td>
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<tr>
<td>FAC</td>
<td>Faculty Development</td>
<td>Faculty</td>
<td>Clearly define scholarly activity for all tracks</td>
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<tr>
<td>FAC</td>
<td>Faculty Development</td>
<td>Faculty</td>
<td>Review - clinical faculty do not always have the time due to teaching commitments</td>
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<tr>
<td>FAC</td>
<td>Faculty Development</td>
<td>Faculty</td>
<td>Develop a faculty scholars program</td>
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<tr>
<td>FAC</td>
<td>Faculty Development</td>
<td>Faculty</td>
<td>Administration needs to strive to improve their leadership skills</td>
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<tr>
<td>FAC</td>
<td>Faculty Development</td>
<td>Faculty</td>
<td>Clinic Research - Evolve</td>
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<tr>
<td>FAC</td>
<td>Faculty Development</td>
<td>Faculty</td>
<td>Promote MCOHR</td>
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<tr>
<td>STU</td>
<td>Finances</td>
<td>Students</td>
<td>Financial problems for residents</td>
</tr>
<tr>
<td>STU</td>
<td>Finances</td>
<td>Students</td>
<td>Ability to treat case from start to end without concern for cost of treatment</td>
</tr>
<tr>
<td>ORG</td>
<td>Foci</td>
<td>Organizational</td>
<td>Centers of Excellence / Centers of Discovery</td>
</tr>
<tr>
<td>RES</td>
<td>Foci</td>
<td>Research</td>
<td>Enhance research competitiveness</td>
</tr>
<tr>
<td>RES</td>
<td>Foci</td>
<td>Research</td>
<td>Limit number of research foci</td>
</tr>
<tr>
<td>RES</td>
<td>Foci</td>
<td>Research</td>
<td>Diversity in the Research Portfolio</td>
</tr>
<tr>
<td>RES</td>
<td>Foci</td>
<td>Research</td>
<td>Foci should be based on existing expertise and importance/impact on overall health'</td>
</tr>
<tr>
<td>RES</td>
<td>Funding</td>
<td>Research</td>
<td>Bridging Funds</td>
</tr>
<tr>
<td>RES</td>
<td>Funding</td>
<td>Research</td>
<td>Effective PR and Fundraising</td>
</tr>
<tr>
<td>RES</td>
<td>Funding</td>
<td>Research</td>
<td>Diversification of research funding sources</td>
</tr>
<tr>
<td>RES</td>
<td>Funding</td>
<td>Research</td>
<td>Funds for faculty who are caught between grants</td>
</tr>
<tr>
<td>RES</td>
<td>Funding</td>
<td>Research</td>
<td>Strategy to identify and pursue non-NIH funding sources</td>
</tr>
<tr>
<td>RES</td>
<td>Funding</td>
<td>Research</td>
<td>Fundraising to provide resources for renovation/amplification of research facilities</td>
</tr>
<tr>
<td>RES</td>
<td>Funding</td>
<td>Research</td>
<td>Unfunded research should not be devalued if there is a potential for funding</td>
</tr>
<tr>
<td>EXT</td>
<td>Fundraising</td>
<td>External</td>
<td>Maximize potential of donors and collaborators</td>
</tr>
<tr>
<td>FAC</td>
<td>Governance</td>
<td>Faculty</td>
<td>Increased involvement in governance by faculty</td>
</tr>
<tr>
<td>FAC</td>
<td>Governance</td>
<td>Faculty</td>
<td>Investigate lack of involvement by faculty</td>
</tr>
<tr>
<td>FAC</td>
<td>Governance</td>
<td>Faculty</td>
<td>Define assoc. chair, vice chair, division head to eliminate committee conflict of interest</td>
</tr>
<tr>
<td>FAC</td>
<td>Governance</td>
<td>Faculty</td>
<td>Define redundancies in faculty governance procedures/processes</td>
</tr>
<tr>
<td>RES</td>
<td>Grants management</td>
<td>Research</td>
<td>Schoolwide system of internal peer review</td>
</tr>
<tr>
<td>RES</td>
<td>Grants management</td>
<td>Research</td>
<td>Coordinated infrastructure for grants management</td>
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<tr>
<td>STU</td>
<td>Guidelines</td>
<td>Students</td>
<td>Different guidelines for different residencies</td>
</tr>
<tr>
<td>STU</td>
<td>Guidelines</td>
<td>Students</td>
<td>Better defined thesis guidelines</td>
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<tr>
<td>CUR</td>
<td>Innovation</td>
<td>Curriculum</td>
<td>Distinguish curriculum through innovative/collaborative methodologies</td>
</tr>
<tr>
<td>CLN</td>
<td>IT</td>
<td>Clinical</td>
<td>Update IT - digital and computer</td>
</tr>
<tr>
<td>CLN</td>
<td>IT</td>
<td>Clinical</td>
<td>Digital dental records</td>
</tr>
<tr>
<td>CUR</td>
<td>IT</td>
<td>Curriculum</td>
<td>Bench top access to axiUM and other program to improve learning</td>
</tr>
<tr>
<td>CUR</td>
<td>IT</td>
<td>Curriculum</td>
<td>Greater informatics support; (greatly improved, but inconsistent and limiting)</td>
</tr>
<tr>
<td>STF</td>
<td>IT</td>
<td>Staff</td>
<td>Greater access to computers</td>
</tr>
<tr>
<td>STU</td>
<td>IT</td>
<td>Students</td>
<td>Digital radiography and computerized records</td>
</tr>
<tr>
<td>CLN</td>
<td>Marketing</td>
<td>Clinical</td>
<td>Define patient demographics</td>
</tr>
<tr>
<td>EXT</td>
<td>Marketing</td>
<td>External</td>
<td>Improve marketing of the School</td>
</tr>
<tr>
<td>EXT</td>
<td>Marketing</td>
<td>External</td>
<td>Enhance the message that the School has clearly defined goals and guiding principals.</td>
</tr>
<tr>
<td>EXT</td>
<td>Marketing</td>
<td>External</td>
<td>Enhance communications with students (during recruitment, attitudes, expectations)</td>
</tr>
<tr>
<td>EXT</td>
<td>Marketing</td>
<td>External</td>
<td>Define, gather and maintain metrics to demonstrate benefits we do/could provide</td>
</tr>
<tr>
<td>EXT</td>
<td>Marketing</td>
<td>External</td>
<td>Increased participation and support from department leaders in external rel. activities</td>
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<tr>
<td>EXT</td>
<td>Marketing</td>
<td>External</td>
<td>Increase visibility w/key influencers</td>
</tr>
<tr>
<td>EXT</td>
<td>Marketing</td>
<td>External</td>
<td>Clearly define School goals</td>
</tr>
<tr>
<td>EXT</td>
<td>Marketing</td>
<td>External</td>
<td>Create &quot;Brand&quot; or Identity for School</td>
</tr>
<tr>
<td>FAC</td>
<td>Mentoring</td>
<td>Faculty</td>
<td>Mentoring program specific to clinical track faculty</td>
</tr>
<tr>
<td>RES</td>
<td>Mentoring</td>
<td>Research</td>
<td>Schoolwide mentoring plan</td>
</tr>
<tr>
<td>STU</td>
<td>Mentoring</td>
<td>Students</td>
<td>Assisting other students must recognize/acknowledge time commitments</td>
</tr>
<tr>
<td>STU</td>
<td>Mentoring</td>
<td>Students</td>
<td>Time devoted to mentoring</td>
</tr>
<tr>
<td>STU</td>
<td>Mentoring</td>
<td>Students</td>
<td>Develop Student Mentoring Program</td>
</tr>
<tr>
<td>STU</td>
<td>Mentoring</td>
<td>Students</td>
<td>Students Serving as Mentors</td>
</tr>
<tr>
<td>CLN</td>
<td>Outcomes Assessment</td>
<td>Clinical</td>
<td>Metrics on student productivity</td>
</tr>
<tr>
<td>CODE</td>
<td>Organizing Topic</td>
<td>TSDG</td>
<td>Operational Issues</td>
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<tr>
<td>CLN</td>
<td>Outcomes Assessment</td>
<td>Clinical</td>
<td>Metrics to define what type of patients are optimal, and assist in recruiting patients</td>
</tr>
<tr>
<td>STU</td>
<td>Outreach</td>
<td>Students</td>
<td>Increase community health projects locally, nationally, and internationally</td>
</tr>
<tr>
<td>STU</td>
<td>Outreach</td>
<td>Students</td>
<td>Community Outreach/Ext. Rotations</td>
</tr>
<tr>
<td>STU</td>
<td>Outreach</td>
<td>Students</td>
<td>Increase comm. Health projects</td>
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<tr>
<td>CUR</td>
<td>Partnerships</td>
<td>Curriculum</td>
<td>Partner with other dental schools</td>
</tr>
<tr>
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<td>Partnerships</td>
<td>Curriculum</td>
<td>Incr. partnerships with other UM units</td>
</tr>
<tr>
<td>CUR</td>
<td>Partnerships</td>
<td>Curriculum</td>
<td>Improve alliance with medicine</td>
</tr>
<tr>
<td>CUR</td>
<td>Partnerships</td>
<td>Curriculum</td>
<td>Increase partnerships with other units on campus (e.g., Virtual Reality Lab)</td>
</tr>
<tr>
<td>EXT</td>
<td>Partnerships</td>
<td>External</td>
<td>Explore mutually beneficial relationships between Dentistry and governmental agencies</td>
</tr>
<tr>
<td>EXT</td>
<td>Partnerships</td>
<td>External</td>
<td>Exhaustively define mutual benefits for agencies with which we currently have relation.</td>
</tr>
<tr>
<td>EXT</td>
<td>Partnerships</td>
<td>External</td>
<td>Define Influencers over which we have no control; develop methods to handle</td>
</tr>
<tr>
<td>EXT</td>
<td>Partnerships</td>
<td>External</td>
<td>Define relationships with partners</td>
</tr>
<tr>
<td>EXT</td>
<td>Partnerships</td>
<td>External</td>
<td>Maximize potential of collaborators</td>
</tr>
<tr>
<td>CLN</td>
<td>Patient-flow</td>
<td>Clinical</td>
<td>Prevent bottle-necks in system (oral surgery, grad clinics-insufficient amt of providers)</td>
</tr>
<tr>
<td>CLN</td>
<td>Patient-flow</td>
<td>Clinical</td>
<td>Better design for patient flow</td>
</tr>
<tr>
<td>CLN</td>
<td>Patient-flow</td>
<td>Clinical</td>
<td>Eliminate competition between predoc and grad clinics</td>
</tr>
<tr>
<td>CLN</td>
<td>Patient-flow</td>
<td>Clinical</td>
<td>Enhance referral system</td>
</tr>
<tr>
<td>CLN</td>
<td>Patient-flow</td>
<td>Clinical</td>
<td>Eliminate any impediments to ensure maintenance treatment for patients</td>
</tr>
<tr>
<td>STU</td>
<td>Patient-flow</td>
<td>Students</td>
<td>Communication between Grad/Undergrad clinics is poor w/existing referral system</td>
</tr>
<tr>
<td>STU</td>
<td>Patient-flow</td>
<td>Students</td>
<td>Change in current referral structure</td>
</tr>
<tr>
<td>STU</td>
<td>Patient-flow</td>
<td>Students</td>
<td>Improve communications for referrals</td>
</tr>
<tr>
<td>STU</td>
<td>Patient-flow</td>
<td>Students</td>
<td>Create position for an interdisciplinary coordinator</td>
</tr>
<tr>
<td>CUR</td>
<td>Pedagogy</td>
<td>Curriculum</td>
<td>Understanding how students learn</td>
</tr>
<tr>
<td>CUR</td>
<td>Pipeline</td>
<td>Curriculum</td>
<td>Create next generation of teachers</td>
</tr>
<tr>
<td>CUR</td>
<td>Reinforcement</td>
<td>Curriculum</td>
<td>Selective and appropriate repetition in education</td>
</tr>
<tr>
<td>CUR</td>
<td>Remediation</td>
<td>Curriculum</td>
<td>80% of time with bottom 20% of class</td>
</tr>
<tr>
<td>STU</td>
<td>Remediation</td>
<td>Students</td>
<td>Better system for remediation</td>
</tr>
<tr>
<td>STU</td>
<td>Remediation</td>
<td>Students</td>
<td>Opportunities for Remediation</td>
</tr>
<tr>
<td>FAC</td>
<td>Rewards</td>
<td>Faculty</td>
<td>Clearly defined bonuses and incentives</td>
</tr>
<tr>
<td>FAC</td>
<td>Rewards</td>
<td>Faculty</td>
<td>Develop faculty reward/incentive program</td>
</tr>
<tr>
<td>STF</td>
<td>Rewards</td>
<td>Staff</td>
<td>Create a “true” merit increase program where staff are rewarded for actions</td>
</tr>
<tr>
<td>STF</td>
<td>Rewards</td>
<td>Staff</td>
<td>Flexibility in the salary program to reward top performers</td>
</tr>
<tr>
<td>STF</td>
<td>Rewards</td>
<td>Staff</td>
<td>Separate salary and merit programs</td>
</tr>
<tr>
<td>STF</td>
<td>Rewards</td>
<td>Staff</td>
<td>Staff Recognition Program</td>
</tr>
<tr>
<td>STF</td>
<td>Rewards</td>
<td>Staff</td>
<td>More recognition for participation in community outreach programs</td>
</tr>
<tr>
<td>STF</td>
<td>Rewards</td>
<td>Staff</td>
<td>More public recognition of staff</td>
</tr>
<tr>
<td>STF</td>
<td>Rewards</td>
<td>Staff</td>
<td>Address perception of salaries being non-competitive with job market</td>
</tr>
<tr>
<td>CLN</td>
<td>Staffing</td>
<td>Clinical</td>
<td>More dispensing staff needed; impacts patient care</td>
</tr>
<tr>
<td>CLN</td>
<td>Staffing</td>
<td>Clinical</td>
<td>Increase use of dental assistants</td>
</tr>
<tr>
<td>EXT</td>
<td>Staffing</td>
<td>External</td>
<td>Improve staff recruitment/retention</td>
</tr>
<tr>
<td>FAC</td>
<td>Staffing</td>
<td>Faculty</td>
<td>Faculty recruitment</td>
</tr>
<tr>
<td>FAC</td>
<td>Staffing</td>
<td>Faculty</td>
<td>Salary - Revise Structure</td>
</tr>
<tr>
<td>FAC</td>
<td>Staffing</td>
<td>Faculty</td>
<td>Develop graduate student pipeline</td>
</tr>
<tr>
<td>ORG</td>
<td>Staffing</td>
<td>Organizational</td>
<td>Allow members of major scientific programs input in hiring faculty</td>
</tr>
<tr>
<td>RES</td>
<td>Staffing</td>
<td>Research</td>
<td>Recruitment Strategy</td>
</tr>
<tr>
<td>RES</td>
<td>Staffing</td>
<td>Research</td>
<td>Consider impact of recruit on both department and on overall research mission</td>
</tr>
<tr>
<td>STF</td>
<td>Staffing</td>
<td>Staff</td>
<td>Increase ability to attract/retain staff</td>
</tr>
<tr>
<td>STF</td>
<td>Staffing</td>
<td>Staff</td>
<td>Pipeline program for dental auxiliaries</td>
</tr>
<tr>
<td>STF</td>
<td>Staffing</td>
<td>Staff</td>
<td>Increase ratio of dental assistants-to-residents in grad clinics</td>
</tr>
<tr>
<td>STF</td>
<td>Staffing</td>
<td>Staff</td>
<td>Attract future employees; make School resemble &quot;real world&quot; in Dentistry</td>
</tr>
<tr>
<td>STF</td>
<td>Staffing</td>
<td>Staff</td>
<td>Cross training (equitable distribution of workload</td>
</tr>
<tr>
<td>STU</td>
<td>Staffing</td>
<td>Students</td>
<td>Faculty leave clinics early</td>
</tr>
<tr>
<td>STU</td>
<td>Staffing</td>
<td>Students</td>
<td>Faculty in clinics for full session</td>
</tr>
<tr>
<td>CUR</td>
<td>Student responsibility</td>
<td>Curriculum</td>
<td>Faculty relinquish control they have over student learning to the students</td>
</tr>
<tr>
<td>CUR</td>
<td>Sustainability</td>
<td>Curriculum</td>
<td>Be more cost efficient</td>
</tr>
<tr>
<td>CUR</td>
<td>Vision</td>
<td>Curriculum</td>
<td>Prepare students to be leaders in Dentistry</td>
</tr>
</tbody>
</table>
Appendix 17

Dr. Charlotte Mistretta, Associate Dean for our Office of Research has provided information to describe and evaluate major aspects of our research activity and funding support. Key points summarizing this information are:

- UMDS faculty members are involved in large numbers of federal and non-federal active research projects
- UMDS’s research activity has more than doubled since 2001
- UMDS’s ranking in terms of NIH research funding has steadily increased from sixth (6th) in 2002 to second (2nd) for the years 2004 and 2005
- UMDS’s ability to invest in research facilities and infrastructure has not kept pace with the needs concomitant with its growth in research activity and funding

Chart 1. shows the 84 active research projects on-going as of July 1, 2006. 54% of the projects were federally funded by NIH, 4% were funded by other federal agencies, and 42% were funded by non-federal sources, primarily private industry. This chart shows strengths in breadth of funding with both NIH and industrial funding support as well as a strong commitment to supporting engagement in scholarship as reflected by the number of faculty involved in research projects.

**Chart 1. Active Research Projects for 7/1/2006. Total Active Projects: 84**
Chart 2. shows UMSD’s consistent pattern of growth in research expenditures, with a doubling over the 5-year period from 2001 to 2006. NIH funding is the clear primary detriment of total research expenditures. UMSD’s research funding stands well with other health science schools on campus as well as with our peers in dental educational institutions, where we have been ranked second in NIH awards since 2004.

**Chart 2. Research Expenditures for the Period, 2001 to 2006**

Despite the excellent, consistent pattern of growth in research activity and funding, we have been facing an important discrepancy between our research space development and our research activity over the past several years.

Table 1 provides information to describe this mismatch. It should be noted that from being a new building opened in 1968 to 2007 the School has filled virtually the same footprint. However, from analysis of data over a very recent period only, 2001 to 2006, it is apparent from Chart 2 that UMSD’s research expenditures doubled. Certainly if we look back to 1968 the increase in research activity has been more dramatic than the 2-fold increase from 2001 to 2006.

Table 1 also shows research space in the School. In 1968, of the roughly 68,000 sq ft of total space in the Research Tower, about 21,000 sq ft were dedicated to research. In the 1990’s and 2005, about 10,000 square feet of renovated space on Floors 2 and 3 of the School of Dentistry were dedicated to research; an additional 3,000 sq ft were assigned for core labs during this period. Importantly a bolus of about 10,000 square feet of additional research space was acquired in 2001 (at the Eisenhower site) and 2004 (at Domino’s Farms to conduct clinical research at the Michigan Center for Oral Health Research).
Table 1. Research Space 1967 to 2006

<table>
<thead>
<tr>
<th>Research Tower, Total 1967</th>
<th>67,700</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research Tower, Res. 1967</td>
<td>21,109</td>
</tr>
<tr>
<td>3rd floor renov 1993</td>
<td>4,395</td>
</tr>
<tr>
<td>2005</td>
<td>1,392</td>
</tr>
<tr>
<td>2nd floor renov 1996</td>
<td>4,698</td>
</tr>
<tr>
<td>Histo &amp; molec cores, B311, BioC Lab, 3355</td>
<td>3,060</td>
</tr>
<tr>
<td>Eisenhower renov 2001</td>
<td>6,898</td>
</tr>
<tr>
<td>MCOHR 2004</td>
<td>3,090</td>
</tr>
<tr>
<td></td>
<td>44,642</td>
</tr>
</tbody>
</table>

Starting from about 21,000 sq ft of research space in the Research Tower in 1968, the School now has about 45,000 sq ft of total research space. However, this doubling in space should be evaluated in the context of a report from outside consultants (Paulien and Associates Inc. with Rothman Partners Inc, January 2001) who were employed to conduct a thorough assessment of space usage and needs for our School. The Paulien Report in 2001 found that 23,000 sq ft of additional space was essential at that time to meet basic needs and projected needs from any increased research activity. As noted previously, research expenditures doubled from this period to the present and some space was added to address the growth in research. However, from 2001 the School in fact has added 11,400 square feet, not 23,000 square feet of dedicated research space. Furthermore, it is important to emphasize that of the added 11,400 square feet, 10,000 sq ft are in off-campus locations (Eisenhower and MCOHR).

Based on this information, the following should be considered:
- For the continued health of the School’s research enterprise, at least 12,000 square feet of additional research space are essential for current research projects.
- To bring off-site investigators back into the School, and thereby increase collaborative projects with these colleagues, a total of at least 23,000 sq ft of additional research space are needed within the School.

In addition we realize that most Research Tower laboratories have not been updated from 1968. To maximize productivity, deficiencies in these dated facilities must be addressed with major renovations.
August 2008 Administrative Retreat:
Curriculum – Setting the guidelines and
Expectations for Change

Overall expectations for retreat

*The Chairs and Deans:*

- Explore the necessary features of an new curriculum model
- Agree on the vision for the new curriculum model
- Explore what the leadership role is of the Deans and Chairs to make the transformation happen
- Identify and develop strategies to overcome the barriers to implementing the model
- Identify the outcomes that will measure the contrasting success between the existing and new model
- Identify the critical next steps to move toward implementation
- Understand and are on-board for the Dean’s expectation of all of us regarding our responsibilities in the implementation process
- Have clear messages to share about:
  - The core issues that drive the need for curriculum change
  - What changes in programmatic relationships will be necessary.
The VIT developed a preliminary set of questions and answers (FAQs) about the developing curriculum to provide information to everyone involved and interested outside parties. This information has been posted to the curriculum website since relatively early on in the development process.

**New Curriculum Overall**

*Why change? In strained economic times, why go through all this trouble?*

In order to remain relevant, all curricula need to undergo continuous review and refinement. This process is driven by 1) the vision of the faculty and dean; 2) changes in the health care system; 3) global and local economic realities; and 4) our leadership role in the dental community. Since one of the primary missions of the U-M School of Dentistry is to train clinicians we would be remiss if we merely accepted the status quo and assumed that we were meeting our responsibilities with the current curriculum and did not have a process that constantly challenged the existing educational model.

We cannot afford to stop refining our curriculum. The economic realities only make the process more critical since the health care needs in our global community have a greater urgency when the economy is strained. This is what a leading educational/research institution does, regardless of the economy.

*Will the new DDS curriculum be longer?*

A student following the “traditional” path to obtaining a DDS degree will complete the curriculum in four years. A student choosing tracks that incorporate additional educational or research opportunities may find that additional time may be required depending on the requirements of those tracks.

*When will the transition to new changes officially start?*

We expect that most of the changes will be in place for the entering class of 2010.

*Who is in charge of the new curriculum?*

The faculty is in charge of the curriculum. While there is a Vision Implementation Steering Committee overseeing the current process, there are also other sub-teams of faculty actively working on the curriculum now and all members of the faculty will be actively engaged in the process. Before significant changes are made to the curriculum, changes will be presented to the faculty for a vote to adopt them.

*Are economics a primary motivation for change?*

While economics influence all of our decisions, our primary objective is to develop the best curriculum possible. Financial efficiencies may create opportunities to engage in some new initiatives.

*What is the role of the faculty members?*

The faculty “owns” the curriculum and it is their responsibility to provide leadership to maintain quality and to deliver contemporary content in a manner that supports best educational practices. It is their responsibility to be engaged in the curriculum.
What is the role of the curriculum committee?

The curriculum committee is a standing committee in the Bylaws of the School of Dentistry whose responsibility is to monitor and evaluate the curriculum to ensure that it supports the mission of the school. The curriculum committee reviews all proposed changes to the curriculum and makes recommendations for change to the entire faculty. The curriculum committee is not charged with developing the curriculum.

Is this the Dean’s vision or a faculty vision?

It is both. The Strategic Assessment process, in which all faculty, staff and students were invited to participate, codified values, weaknesses and goals. As part of that process, we engaged consultants from both within the University of Michigan and outside to comment on our findings. Based on all of this feedback, the Dean formulated a vision and presented it to the School as any leader is expected to do. During the process, it is the faculty who will decide how best to implement the vision, what measures will be used to assess outcomes, and what refinements will be needed to keep the curriculum contemporary.

Does this mean that we will be training better dentists?

Each year, we make subtle and not so subtle changes to our curriculum designed to enhance the learning experience for our students and to better prepare them to practice dentistry. Our graduates must be able to meet both current and future challenges that they will encounter in practice. The changes we implement in the new curriculum will better prepare our graduating dentists for their future practices.

How do I find out about what is happening with all the different pieces of the new curriculum plan?

In addition, to the Convocation on August 28, we are planning two faculty retreats - on October 10 and following the end of clinics in December. We will also have several Town Hall meetings and updates will also be provided on the School of Dentistry website, on the TV monitors and via email. In addition, you should anticipate regular discussions and updates at faculty and department meetings. Should you have any questions that are still not answered, you may contact members of the Vision Implementation Steering Committee or its sub-teams (Committee membership is posted on the school website).

Will the nature of competencies change significantly?

The current list of competencies is periodically reviewed. Most likely the list will be basically the same but some provision needs to be made for the major goals of the curriculum of diagnosis, risk assessment, treatment planning, problem-solving, and critical thinking. These ideas could be incorporated within existing competencies or become additional ones.

Clinic Implementation

What is the team model and how will it be applied to our new curriculum?
All students working in the clinic will be part of both large groups and smaller working teams within their groups. Groups and teams will include D1, D2, D3, D4 students and dental hygiene students. Although all clinic patients will have a primary dental student to whom they are assigned, some patient care procedures may be shared with other team members. This should facilitate group-learning activities, promote patient-centered care, and more effectively distribute experiences to students working toward competency.

Management of the overall clinics may be very similar but students will no longer be assigned permanent chairs and will not schedule the majority of their own patient appointments. Patients will be assigned to teams of students. Patients and students will be assigned to faculty members. The details of the management of those teams are being developed.

**Will we still have comprehensive care approaches to patient management?**

Yes…the same hybrid model of comprehensive care that currently exists will continue in the clinics. Except for initial clinical experiences, test cases, and complex procedures in periodontics and prosthodontics, all dental care procedures that would typically be provided in a general dental practice will also be undertaken in the general dentistry clinics. Separate treatment environments to provide the specialized instruments and equipment required for orthodontics, pediatric dentistry, and oral surgery procedures will be continue to be maintained in a separate clinical environment.

Some system akin to having VIC directors will continue. Because of the earlier movement of some students into clinics and a number of proposed opportunities for more advanced practice downstream, management of the pieces of the system will need to be more sophisticated than in the past. A couple of different options are currently be explored.

**Will we still have comp care seminars?**

Yes…but current student-based or group-based patient care presentations will evolve to be focused in key case presentations that will include programmed multidisciplinary and biomedical science topics. In addition, a new set of “grand rounds” learning experiences will also included on a special basis throughout the year.

**Will we be using patient-focused or student-focused learning?**

Both of these can co-exist well together. - students will be encouraged to collaborate with their peers to efficiently and comprehensively manage the needs of their patients, while also actively guiding and nurturing their own learning goals.

**When will students first start in clinic?**

Students will begin performing a number of different patient care procedures in various clinical disciplines during their D1 year – earlier and to a much greater extent than in the past.

**When will the typical student finish their required participation in the clinics?**
The new curriculum is a 4-year one that contains a significant number of enhancements to produce an even more expert and confident new practitioner than in the past.

*Will all students be able to do extended rotations during the 4-year dental school experience?*

As students complete their competencies, they could qualify for additional experiences such as extended outreach or private practice rotations.

**Clinical Foundation Team**

*How are the decisions being made on changes to the preclinical courses?*

The Vision Implementation Steering Committee has created several subcommittees and charged them with the responsibility to review current content and delivery mode and make recommendations for models that would better serve the educational needs of our students. Each committee has been constituted with faculty members who have expertise in that curricular area. As part of the process, each committee has met with additional faculty, staff and students for advice and comments. In addition, there have been meetings between committees to support coordination of content and delivery. We are now engaging the entire school to ensure that all parties have had an opportunity to participate in the process. Since it is the faculty who “own” the curriculum, all of the proposed changes will be brought back to the faculty for vote and acceptance.

*What role will online courses play in the new curriculum?*

Implementation of online courses/content will take different forms depending on the topic. Some topics are highly amenable to online delivery; for example, delivery of basic, uncomplicated material, policies, or procedures. In other cases, online course material can be used to establish a baseline understanding of material that will be addressed during more formal classroom-based activities, to help students review concepts or topics delivered in the classroom, course orientation, quizzes, laboratory demonstrations, or videos of clinical situations, and to enable students to access course content when they are off-site when they are engaged in an outreach or other track activity. We do not envision online delivery as a replacement for faculty-led educational activities rather, as tools that support a more effective learning experience.

*Will we be eliminating lectures?*

No – there will still be classical lectures and we will also embrace other learning environments including interactive sessions, active learning, small groups, and/or learning within real-life situations.

*Will we be using problem-based learning approaches?*

We are not developing a problem-based learning (PBL) or using a problem-based curriculum. We will use features of all types of learning approaches. Our goal is to help students develop the tools to become good problem-solvers.
What content could go online?

Most course content will likely be accessible online; however, the intention is not to build an “online curriculum.” Rather some of the content within individual courses could be delivered online. For example: the course orientation session, review sessions, simpler content, quizzes, laboratory demonstrations, or videos of clinical situations. Some courses might be taught entirely online.

Will the major preclinical courses change titles, curriculum positions, and/or directors?

The goal is to create the best learning situation for students. It is likely that significant reorganization of content and delivery mode will occur that will result both in the creation of new courses and the administrative structure that supports them.

Will courses be stand-alone or highly coordinated with other activities?

The guiding principle will be to do what works best. If, for a specific topic, the best student learning experience is supported by coordinating activities across disciplines, rather than having stand-alone courses, that will be the goal. Alternatively, some topics might be best delivered best in stand-alone courses. Regardless, it is incumbent on us to ensure that all topics and experiences are documented and are delivered as a function of intention, rather than convenience or accident.

When will the preclinical part of the curriculum be primarily completed?

The first change, specifically the name, will become apparent almost immediately. After thoughtful discussion, we decided that it was more appropriate to refer to this aspect of the curriculum as the “clinical science curriculum”, since it supported student transition to actual clinical experiences. Some faculty members are already developing new content and delivery methods for implementation in the Fall 2009 term. Our goal, and a key feature of the new curriculum, is to enable earlier entrance of students into the clinics. To support this goal, “clinical science courses” will be staged to coordinate the “foundational experiences” with the actual patient experiences. Also, some experiences previously taught as “preclinical content” might be best taught as a “patient experience,” rather than in simulation. More advanced “clinical science” content might be delivered much later in the curriculum and require that the student dentist return to the simulation laboratory to learn a new procedure or technique. Additional supporting content may be delivered online so as to be available to the students as needed. You should begin to see subtle piloting and implementation of the features described above occurring during the 2009-10 academic year, with significant implementation of the model in the following year. It is also our expectation that the curriculum will continue to evolve and change as an ongoing process as we continuously review our models.

Science Foundation

Will IMS be divided up into new courses? Are we going back to the old way of presenting content?

IMS will be re-structured to a revised basic science foundations curriculum. New courses will be developed. Goals are for increased depth and excellence in a structure that optimizes content delivery and learning. Where applicable, courses will build on science requirements for dental school admission. The new curriculum not only will optimize teaching and learning in modern science but also
will be assembled to provide flexibility that can accommodate new pathways in the overall dental curriculum.

**Who is going to make the decisions about changes in the basic science courses?**

The Science Foundation Team and Vision Implementation Committee will make recommendations to the faculty of the School after ample discussion and consultation with faculty and students. Consultation and reports will go forward through School standing committees, student class leadership and standing committees, and a series of retreats for discussions among the faculty. The final decision on the new curriculum will require approval by the voting faculty of our school.

**If I were currently not teaching in the basic science curriculum, would I be teaching in the future?**

It is possible. Faculty members in the School will teach in their broad areas of expertise. Teaching will include participation in basic science courses, in preclinical and clinic courses and seminars, and in ‘Grand Rounds’ presentations. School faculty members will be responsible for designing, directing and delivering courses, with fewer courses that engage series of large numbers of different lecturers.

**TRACKS: PATHWAYS FOR TODAY’S DENTIST**

**What are the new tracks or paths open in the DDS curriculum?**

Students will choose among a “DDS Plus” four-year option; a “DDS/MS/Year Off-Campus” five-year option; or a “DDS/OHS PhD Dual Degree” seven to eight year option. Most students will be in the DDS Plus pathway. The DDS Plus pathway will include options for selectives that include in-depth exposures to research; the Scholars Program; community based practice; pre-specialization; clinical dentistry; hospital based dentistry; private practice dentistry.

**When will a student elect these options?**

Timing will vary according to pathway, with election ranging from time of admission or before entering the School through Year 3.

**Will the tuition for dental school increase if I engage a pathway?**

Tuition for the “DDS Plus” pathway will not increase in any way other than routine annual School/University increases. Tuition for out-of-School Master’s study, or an out year at NIH, is program specific; some pathways are fully supported, others are not. Tuition for the DDS/Oral Health Sciences Ph.D. is program specific; this dual degree program is strongly supported by NIH and other funding vehicles.

**Will I still graduate on time?**

Graduation will vary according to pathway, from a four year DDS, to five or more years.
Will this curriculum help to prepare more for graduate/specialty programs?

This is not a single curriculum but a set of pathways within our DDS curriculum. One of the pathways would provide experiences that could help a student in determining an interest in dental specialties. Students enrolled in the DDS Plus pathway might have the opportunity to participate in a pre-specialization experience that will enhance exposure to a selected specialty.

Are most of these opportunities focused in research experiences?

There is a mix of pathway options that include research-intensive time and experiences; clinical dentistry time and experiences; and, interdisciplinary study time and experiences. The mix of options reflects the School’s mission, the profession of dentistry and the Dean’s Vision.

What are the major advantages for someone focused on clinical dentistry?

Because clinical dentistry is not practiced as an island or in isolation from modern health and patient care, the pathways would each enhance the practice of dentistry. Notably, with the re-structuring of the curriculum additional opportunities for exposure to dental specialties (pre-specialization), community-based dental service (e.g. outreach clinics), hospital-based and private practice-based will be available to students focused on clinical Dentistry.

I.6 Curriculum committee executive summary of term-by-term curriculum reviews