

MCHB/DRTE Webcast

MCHB/DRTE's Minority Faculty Development Model

December 1, 2005

MADHAVI REDDY: Hello, everyone. I'm Madhavi Reddy project officer in the MCH Training branch. Thanks for participating in the training webcast. We've been planning this webcast for a very long time so we're thrilled that Stuart was able to join us today. I'm also joined by Laura Kavanaugh who is the chief of the MCH Training branch and like I mentioned before, Mr. Stuart Weiss who is the project officer in the Division of Health Careers, Diversity and Development and the Bureau of health provisions. As a project officer he administers the minority development project. A national call to action.

Stuart is here to talk about the Minority Faculty Development Model developed with the assistance of an expert panel. With the model and accompanying recommendations health professionals will have more guidance on how to recruit, train and retain minority faculty members. By the end of the webcast the audience should see how the model can be utilized by the health professions in the training program. A transcript of the summit are available at <http://mchcom.com>. We'll take questions after Stewart's presentation but feel free to email questions as they arise.

Before I turn the webcast over to Stuart let me also tell you that Stuart served as the coordinator of health careers for kids including kids into health careers and the health careers adoptive pool demonstration grant program. He's worked in a 22 federal career

and worked for the U.S. Departments of Treasury and Education. He has a masters degree in economics from Virginia tech and a bachelors degree in economics from the warden school at the University of Pennsylvania. Now it is my pleasure to introduce you to Mr. Stuart Weiss.

STUART WEISS: Good afternoon. I appreciate this afternoon and on behalf of the HRSA Associate Administrator for Health Professions, Captain Kerry Paige Nessler, and thank you for being here today. The model was developed for the center of excellence education. A program that the Division of Health Careers, Diversity and Development administers and we have legislative purposes that include faculty development. These are for the five eligible health professions which are osteopathic medicine and behavioral and mental health. What has happened typically is that each school would do a case study of its own programs so they got deeper and deeper but there was no transcendent model which was used to retain, recruit and train faculty in the health professions in the clinical, research and academic functions that faculty pursue. This is important because right now, the average age of the baby boomers, nurses and federal employees is 49.

The fastest growing segment of the population are people 85 and over. So this issue is who is going to be around to take care of all of us, and how well are they going to be trained? So we came up with this model as a means to do it. I'm an economist by training. We worked with an attorney as our principal investigator, and recognizing our background we thought it was important to bring in a panel of three experts from each of these five health professions to give us guidance. And they were from an association of the schools,

a university in general, and one from a grantee from the centers of excellence. And after we worked to develop this model over the course of 2004, in three expert panel meetings, we produced the draft of the Minority Faculty Development Model focusing on some 14 different questions. Because of the different nature of these health professions, for example to be a retail pharmacist is very different than to study to be a neurosurgeon, for example, or an obstetrician. And so recognizing that, we developed a universal model and then from there stratified it for each of these models. Each of these five health professions. And recognizing that we needed feedback from our customers, and recognizing that 15 people were not enough to really tell us everything we needed to know, we convened this summit March 29 and 30 of this year in Washington, D.C., where this draft model was presented.

The keynote speaker -- the introductory speaker was HRSA administrator Dr. Elizabeth Duke who herself teaches at institutions of higher education in the Washington area. So this is something that interested HRSA across the board. Other folks spoke and we presented this at this two-day summit with the idea of gaining feedback. 187 educators from across the country paid \$150 plus expenses to come to this summit. We wanted to launch this and gain their feedback for a series of plenary presentations and a series of breakout groups over two days. I'm pleased to tell you that we had, on evaluations on a scale of 1 to 5 with 5 being the best the participants gave us a rating of about 4 1/2. This really empowered us to go on, in fact, since then in March, we've had six other health professions on their own develop models. We worked closely in partnership with the federation of association of schools of health professions and their president was the

keynote speaker for this. So -- and those comments and models are going to be included in a draft -- in the final model that will be released sometime this winter subject to HRSA and departmental clearance and we hope to pilot test the model in as many as ten schools around the country.

The -- what I'm going to do today is basically present to you what was presented the first morning. So to give you a sense of what was there. So the three pieces that I will be doing are the introductory speech which the model was presented. Then the three questions posed in that plenary session to everyone to think about, and then finally, the questions that were the basis for discussion at each of the breakout groups. This was following the tone, again, that Dr. Duke and Kerry Nessler said in their initial presentations. So ideally we would like to have as many people as possible to experience this. We're grateful to the Maternal and Child Health Bureau for giving us this opportunity to present this and it will be presented in tandem with this third draft of the model, which you can obtain. Because it is going to be an ongoing dialogue. It's the first time we've done this. You are our customers and we need to hear from you so we can make it work effectively. If that's OK with everyone, how does one condense a two-day summit into 90 minutes. Following that context that's what I would like to do. This is, I hope, a basis for an ongoing dialogue about this. My website -- my email address is sweiss @ hrsa.gov.

Listen to this. We had court reporter describes the entire proceedings so I have verbatim the speech made by Jose Rivera, our principal investigator, and then you'll have the model to read that against. I hope you have that. And then following that, please write or

call me. My phone number is 301-443-5644. And you know, it's a 76-page document so I don't expect you to just have questions right away. This is an ongoing dialogue. It will be updated as necessary so that we can be responsive to the marketplace. If nothing else, when we test the model we're going to have feedback and outcomes that will allow us to modify it further. So this is stage one of this process for Minority Faculty Development, OK? Is that all right with you?

MADHAVI REDDY: That will be fine, thank you.

STUART WEISS: Here is -- here you are, it's March 29, 2005, and following great presentations by Dr. Duke and Captain Nessler here is Jose Rivera who developed this. What is this thing called Minority Faculty Development? An intriguing question. I remember the first time one of the panelists said well, Minority Faculty Development, isn't that like faculty development? Shouldn't Minority Faculty Development be faculty development? In some respects the simple answer is yes. The panel, thank you very much for going to write a one-par graph report and we're done. It's different than that. The reason why it's more different is the issue of race and ethnicity. Race, ethnicity is a phenomena. Now it's a phenomenon in this country and it's significant. I'm not talking about racism as such or bias as such but race ethnicity. Now, that's important to understand because once you understand it, then you understand the life experience of someone who might want to be a candidate and someone who is a candidate and why this issue of developing a minority faculty has a different meaning in the context of what we do every day in this country. And why the words Minority Faculty Development have a

different shading and different impact than faculty development in general. Now, having said that, is it the desire of faculty of color or minority faculty to be separate and distinct from other faculty? Absolutely not. The minority faculty member or candidate is a person who seeks greatly to be assimilated. Much desires to be part of the whole.

The issue is not separate status but those things that are necessary to create that parody, to create that assimilation are separate activities that we now come to recognize as Minority Faculty Development. The process that the panel engaged in was what we might call a consensus process meaning that the panel met together over three different occasions, struggled over some very difficult concepts and then in that process reached consensus around some approaches. So before I unveil that to you, I wanted to give you this preface, which I think is critical for you to understand. What you are about to see is not a fait accompli. What you're about to see is not a neat package that you can take today, walk back to your school and say we're ready to go. What this is is the beginning of a national dialogue. It is interesting, it's not the beginning of a dialogue like the American Psychological Association convened in 1991 or one the American dental association, diversity panels for the society of colleges of optometry have had similar activities.

Let me introduce you the product of a serious set of discussions by the expert panel. What you see in front of you is a relationship, first and foremost. People have the diagrams that are in this model as we speak. That was all included in the package at the summit and online. It's necessary -- it's a relationship between three critical considerations that are necessary for any institution to understand and appreciate in order to create a model that

is responsive to their institution. What it says is that there is a relationship between one, individual development, two, institutional culture, and three, institutional mission. And by the way, it's a dynamic relationship. First the words individual development. These words mean the minority faculty member is interested in their individual development but the diagram tells us that the institutional culture of the institution must also be interested in that individual's development for this to work.

When we speak of institutional culture, we're talking about the faculty lounge, the atmosphere, the support, all the things that, for example, a senior colleague recognizes that a junior colleague has just come onto the faculty and says you're pretty bright, I like your style, would you like to second chair an article I'm doing? I'd like you to second chair and that means you're going to do some of my backup and some of my research. All of a sudden the senior colleague is taking on as a junior colleague onto an article and now you're riding the coattails of some famous professor and you're on your way. There are some of the -- these are some of the informal things that go on day in and day out in institutions. I would like to appear in my course where I'm the chair and I would like you to do a lecture for me. That type of opportunity to shine and share some of the limelight of the senior person is part of the institutional culture that is supportive in nature and designed to enhance individual development. So individual development speaks to more than just the individual's desire for themselves. It also speaks to the institutional support within the faculty body politic of that. It also has other and very interesting considerations and that frankly are a reality of being a minority faculty member.

The minority faculty member is not and cannot be divorced from the community in which they come. What does that mean? I think the way that debate and discussion turned is what does it mean but here is the consideration. How do we give it value? How do we value this? How do we quantify it? How do we shape it in such a way it can now be part of your C.V. That's the part of development a model that actually makes sense. Now it's not reflected in the diagram, but it does become into sharper focus within the context of debating this model, the members of the panel said community has to be in here. Interestingly enough, that came up at the very first discussion of the panel, first of three, when in the first hour the first discussion the issue of what's in the center of all this was very interesting, very poignant and came back time and again to intellectualize about doing something and in the end the panel said it's community. We have to have community in this process.

Minority faculty not only come from the community but carry a mandate from the community. They feel very strongly that but for the efforts of those who lived and died before me I would not be here today. And that therefore it's not a burden so much as it's a badge of honor. Because of those who suffered before me, I'm here and that badge brings me something that I not only bring with me but also it becomes a sense of obligation. A sense that I owe those who suffered before me and struggled before me. And that's something that really is a major piece of what a minority faculty member brings. Yet our institutions aren't able to see this that easily. What this process is attempting to do is to help to start to quantify and give value to the contributions that one brings. It's no different that minority members and candidates bring with them value that comes from a

community of service and that value ought to be quantified, understood and incorporated. All of that is a process of relationship between individual development and institutional culture. Now the word institutional mission. Institutional mission. Note the words next to it. Resource, teaching and service. You'll see in your book that we created an academic triad that relates to those three elements, research, teaching and mission. They become the cornerstone of what teaching at an institution is all about. Research, teaching and mission. What we did in the panel is to recognize that these three factors, while they're embraced by mission, is what an institutional mission is all about.

The institutional mission finds its strength and its definition by its relationship to institutional culture and individual development. In other words, if you were to look at institutional mission merely as the reflection of research, teaching and service without looking at its impact in an institutional culture and how it affects institutional culture and without looking how it impacts and affects individual development, you would find yourself unable to effect significant changes in minority faculty development. It's the recognition of a bilateral relationship between all three elements that makes minority faculty development something that is achievable perhaps within our lifetime. Note here the fact that these arrows are bidirectional introduces a word that's very important to understand the model. That is the word interdependence. Not independence, not dependence, but rather interdependence. The concept that each of these components are inner dependent on each other and therefore need each other to create a whole. Thank you very much. It's very different when you listen to someone give this than giving it yourself, thank you, Laura. Note here the fact that these arrows are bidirectional introduces a word -- we were

just talking about the need for interdependence. And that's the beginning of this process that we want you all to appreciate. The interdependent relationship between these three components of this academic triad.

Let's move on to see how the model evolved. What you see in front of you is a reflection of what happens at the third and final meeting of the panel. It's a disclaimer for the panel that this diagram in and of itself is not actually designed by the panel but rather reflects what the panel deliberations were. What we've heard, what I heard as the author coming from the panel in terms of what they felt was needed in order to make a solid model that works. This becomes the model and now we can explain the three considerations in the context for this circle. This diagram reflects the non-linear thinking process that says -- this is interesting -- that the institution that we serve belongs to the community. So the centrality of community is not just about the individual person, it recognizes that institution Essex s - - exists within a community it serves it is our job to serve the community. Let me go to society so you can see the difference. Institutions exist within the context of a society. It's the context of an overall society.

There may be changes in structures, how society views things, how society views specific issues, for example, obesity, now tolerated as a disease, it may move to something else. People's body images may change. All those things have it's to serve our community of service and that's where the centrality becomes all important. Once you redefine the three concepts of individual development, institutional culture and institutional mission in the context of the circle, all of a sudden a new clarity comes into play that perhaps did not

exist in that initial triad model. That is that these are not only concentric circles which would be important, but the model is actually more like a Navajo basket because these are actually nested circles. Navajo artists make nested circles because the baskets they make are circles and the circles in and of themselves become larger and then smaller and then the circles are all tied together. Circles by themselves are very attractive-looking circles but only when nested together do they make a whole. That whole is the basket. Now, that's very important to understand that nested circle concept because it's not just concentric, though it is concentric but that they are nested together. That means that each one of them depends on the other to create a structure and a whole. That being said, surrounding the word community is the word individual development. And this recognizes the particularly for the minority faculty candidate or member directed into the relationship between that member and the community from which they come, and which they are serving.

So the community of service directly feeds the minority faculty member and in many respects it actually says to the minority faculty candidate, we charge you to move into this institution and make change that comes back to our community. An opportunity to see someone who is a model, to see a person who looks like you or almost like you, maybe you're a different gender but the point is it's a role model. So this relationship of individual development ties back to that centrality of community. By using this nested circle, then, institutional culture takes on a deeper meaning. Not a different meaning, but a deeper meaning in the sense that institutional culture now reflects what is around me in the culture of my institution. That in a nesting fashion supports individual development which

supports the centrality of the community we've seen for many years. The words, ivory tower, were significantly defined as a mechanism to reflect the removal from the centrality of community. We don't have to worry about that. But for the minority faculty member or candidate, that is not a reality that we have the luxury of exploring. Therefore the question becomes, how is the institutional culture supporting my development, your development, and how is that relevant to the centrality of community? The nesting becomes very, very important because each one supports the other.

There has to be not a dotted line, but a straight line linkage between the concepts of institutional culture, individual development and centrality of community. Then all of a sudden with great clarity we see what the problems are in institutional mission. We see what the problems are because no longer can you allow superficial platitudes in the form of one-paragraph statements, to define institutional mission. Those platitudes don't make sense if they're not connected and reflect themselves in the culture and reflect themselves in the individual development. How do you make that operational? It becomes operational in a couple of ways, many of you can say this as easily and quickly as I could. It becomes operational in programs that are supportive of the development of a person. For example, one of the really exciting ideas that was put together by the panel was the concept of portfolio. You read the report, you'll find here some wonderful nuggets of really exciting innovation that I think are ready for further explanation and one of those is in the portfolio.

For those who know something about fine arts the concept of a big, huge, black attaché case where you keep your drawings and paintings is what the portfolio is all about. It says

if you want to be an artist or be in the fine arts you bring your experience with you and you show off what you've done and that which you've reflected on. And regardless of whether it's poetry or paintings, that is your portfolio. The concept this panel came up with was the need to assist and work out an institutional mechanism for supporting the concept of portfolio as opposed to just the curriculum vitae. It represented an exciting innovation and it's something I wonder if you can walk away with the concept of portfolio I would say on behalf of the panel that I would be very, very excited. There is a way of making the model operational and thinking about making it operational in a way that would honor the contributions and be reflective of the value that a person has by service of their relationship to their community of service. It means that in the institutional culture circle, we make it operational. Not just by saying we have a policy against not discrimination and against discrimination broadly we don't discriminate but going beyond that to saying institutional culture must be supportive of recognizing the value and pulling that value out. Well, how do you do that?

First you recognize that it's done -- not done merely by saying minorities teach minority courses. It's not answered by merely saying we're going to create a minority course. You know what we'll do? We'll teach this course in cultural competence and you get to teach it. Try that when you come up for promotion. What it means is that we recognize the value that someone brings from that community and that we use that value in ways that support other areas of our academic endeavors. It means that maybe the minority student program academic standing failure committee may not be on the committee he should be on. Maybe you should be on the promotion and tenure committee. It's a different way of

looking at the issue of institutional culture because it's nesting and it's required it support individual development. It honors centrality of the community.

That brings us into the final nesting circle of institutional mission. That institutional mission says I said, requires making all the standards that we've talked about operational. So we've begun a national dialogue. What are the kinds of elements that our institution ought to be doing to create a nested relationship between institutional mission, institutional culture and individual development? At the core and at the heart of everything the panel did is the very simple concept which is not focused on negativism or pessimism. One charge from the panel was when you make your remarks, that is me speaking, Jose Rivera, you keep the tone that we've had throughout the panel discussion and that we fundamentally believe that our minority candidates, our minority faculty members, bring value to this process and that our institutions need that value when we're designing some concepts. One of them came out from our faculty members was adopted by the consensus of the panel and that's on page 13 of that report. It's a standard that we can borrow from the business world of total quality management and the phrase is called, continuous diversity improvement or CDI.

I want you to think about what CDI would mean for your institution and how we can go back and be CDI advocates as we move back to our various institutions. I would also commend to you if you look on the very next page, page 14, the panel took some of the standards that are normally appropriate for total quality management, applied them to CDI and came up with four bullets. What it says is CDI is fundamentally involved in assessing

where the institution is and where it should be. Valuing the contributions of its minority candidates. Implementing the strategies that emphasize minority representation and disseminating the policy that is informative. We've shortened that to AVID. I am an avid advocate of this model and I think it represents an exciting beginning of a national dialogue. That closes the remarks and the remarks are inherently limited because how do you take what is a model that should -- that's depicted graphically and comment on that in words? So what we did is a week before the summit was convened, we sent out this third draft of the model to all the 187 participants because we wanted them to have time to prepare so that we could -- they could respond to this and give us their feedback, give us the changes, give us the modifications, and so that we could incorporate those into this final draft. We seek this from you as well. So again, when this opening statement was prepared, everyone had already had a week to see this and they had it with them and they could follow along. So I regret that the one thing that's a little different from here is that it's not like you -- I think you sent it out.

MADHAVI REDDY: I did. All the materials are available on the website.

STUART WEISS: OK, that's great. Having said that, the three questions that were posed to each school in attendance were first of all, does the model, as presented, appear to be a viable approach to developing underrepresented minorities, that is URM faculty at health profession schools and universities? The center of excellence model is focused on giving it to represent minorities defined as African-American, Latinos, American Indians and Asians who are from Vietnam, Cambodia and LAOS. They're underrepresented in the

health professions. The second question that people were asked to reflect on, are there any specific suggestions which, in your mind, would make this minority faculty development model even stronger? The third question was, because we wanted to make this happen, is what actions would you need to advance at your institution in order to implement a model of this type and scope? At that point we had people get up, come to the microphones and present their comments, give us their feedback. All of that is being incorporated into this final draft. Most of it, what came out is that we really needed to expand to other health professions and we're thankful that we've had six other models prepared over the course of the summer which are going to be included in that final draft.

These are the professions of veterinary medicine, optometry, health administration, health management, allied health and nursing. And public health. So we basically got all -- out of the 300 health professions we got the major groups. The only ones that I think would still need to be included perhaps would be podiatry and social work. We had a person speak and recognize that they are partners and the rest of the model, the rest of the summit was spent with people in breakout groups for each of their health professions and they were mandated to answer the following questions over the next day and a half. That is, who are the critical stakeholders who need to be involved in order to properly operationalize a Minority Faculty Development Model?

Second question people were asked to answer is, in the healthcare educational institutions for your profession, what are three critical steps necessary to implement a Minority Faculty Development Model?

Then the third question was, what considerations of actions are necessary -- excuse me, do considerations of action necessary to implement a model change vary when you're looking at clinical versus teaching versus research activities? In other words, the matrix is on a 3 by 3 matrix is how do you recruit, retain and -- recruit, train and retain faculty and clinical research and academic teaching. It brings us to question four. The consideration of actions necessary to implement a model change when looking at recruitment, training and retention. Question three and four is looking at two parts of it. Then the rest of it, in order to begin the dialogue, was just have people go to breakout groups, report back to the groups and we did that over the next day so that it got the dialogue moving. Then once we saw that they accepted our recommendations and moved ahead we gave these other health professions who were interested the chance to come up with their own model that would be included in the final report. One of the things that was interesting is we also had a history of the -- of professions and that is going to be -- one thing we're doing is looking to publicize this in a way that will reach as many people as possible. That's why we're thankful for the chance to be here today.

So the final draft will be an anthology. Each of these models is going to be a chapter, a stand-alone chapter that builds upon the pieces in this first -- in this third draft so that -- I'll be the editor, but so that people can take these different groups and while it's interdisciplinary across the universal model it's stratified for what will be in this final model 11 different models. Now, we're going to go out and test this. Then based on what we learn, bring it back, incorporate that next model and then hopefully -- I should say God and

budget willing begin the dialogue, begin the summit to reflect on this. But just like the model has concentric circles, we realize 15 people or 187 people are not -- this is something that has to grow over time and it will evolve over time. But the good news is, it's no longer something where people just do greater and greater in depth specialized studies of their own institutions. We finally have a transcendent and universal model that can then be applied based on what experts say. One thing that is very encouraging is at least three of the health professions are taking, over this coming winter, it used to be called a retreat. People from each of the schools are going to get together and discuss these issues. There were 14 of them included in the report. And see about applying them. In other words, what issues apply not just at their own schools, but also to the profession as a whole? So it's -- the tradeoff is we have a certain amount of time and you can't do everything, but at least it's moving forward.

The other issue is why not just look at faculty issues? Then move down into minority. This was being done very consciously as an inductive process. The reason is besides the legislation but just as a methodology, let's do this right. If you begin with minority issues, for example, we had 24 initial questions. They were collapsed to 14 because they saw a lot of them can affect the flight across the board. So the minority issues and concerns were built in and included, you know, as an inherent part of this structure from the outset. Then it could be expanded deductively to reflect broader concerns. If you do it the other way, where you start with the broad concerns and then work down deductively, because there is relatively few minorities that just as a matter of inertia and momentum if you did it the other way, then the minority concerns ran the risk of having them be a fringe or add-

on. That's part of the problem from the start. This way they're embedded in there and it grows that way. It's an ongoing process.

We're calling the people involved with these new models a review panel and total quality management. Takes seven years to implement before it becomes part of a corporate culture. It's understood this is a start and to make it work we're going to test it, things have changed so much. Just the fact that we're doing all this online, the fact that we could do the second panel all over the phone and all over the Internet. We have no in-person panel meetings. There is enhanced ways of communication. I have to tell you, I'm very excited about this here, frankly, because it's the first time I've participated in a webcast. This is really great and it is a real learning experiences for everyone and you know, my boss says oh, you got your power tie on today because it's like what do you wear if you're on TV? The point being we're all trying hard and looking to make this work. And, you know, the easy thing to do is say well, it's not perfect. There is an expression, perfect is the enemy of good or I joked with the panelists that well, I don't want to start an argument but in my opinion I'm not perfect, you know? If you just recognize that, then you can go forward and the one thing that -- while it may not be perfect, the one thing that won't happen as a result of this is eight years from now we won't have to say you know, we really should develop a Minority Faculty Development Model. So I thank you very, very much and I am at your service both now and on an ongoing basis. I appreciate being part of this team. Madhavi, Laura. How would you like to proceed from here?

MADHAVI REDDY: We have questions that have come in. I'll pose the questions to you and you can try to answer them for our audience here. I'll just mention again that if you have questions that come about after this webcast, you can reach Stuart. You can email him at sweiss @ hrsa.gov or call him at 301-443-5644.

STUART WEISS: If they're a hard question I'll forward it to M. Reddy.

MADHAVI REDDY: Thank you, Stuart. The first question comes from Shirley. She says as a minority I'm trying to understand the minority faculty mandate from the community. Do non-minority faculty also bring a mandate from the community from which they come from? If so, what is it?

STUART WEISS: There is this idea of cultural competence. And there are expectations. The best example that I can give is people from tribal colleges, Native Americans are often expected to return to their communities to practice medicine there. They could, if they go to Harvard, if they go to anyplace else, they could make salaries -- again I'm an economist. They could make salaries based on where they've done and what they've trained. That would be viewed as -- that would be viewed as assimilation. The cultural expectation is I think best defined by Princeton professor Richard Freeman in 1973 he wrote a book "the overeducated American." It says the greatest predictor of what you'll do for a living is what your parents do. And so it means that typically underrepresented minorities do not come home to the dinner table and hear about how daddy's day went in the hospital and what mommy's day was like in court. So again, that's a broad

generalization. It's obviously anecdotes but based on where you are on a percentage basis. Again we're targeting underrepresented minority, the majority culture is different. In fact, I'll give you a really great example from my own life.

I have a terrific dentist that I've been going to for 20 years. I said how did you get into it? He said went to my alma mater, University of Pennsylvania, his name is Stuart from Philadelphia, sounds great. I asked, how did you get into this? He said well, I had an uncle who said you know, you're good with your hands. So therefore, why don't you be -- in a minority community or a non-professional community, someone might say why don't you become an auto mechanic or a carpenter or go into the building trades? But because in this middle class suburban community someone who is good with their hands, why don't you become a dentist? I think that in my mind really illustrates the concept here.

MADHAVI REDDY: Great. Thank you, Stuart. Let's see. I don't see any further questions and I'm going to wait a few minutes just to see if anyone else has a question they would like to pose to Stuart.

STUART WEISS: Or unless the presentation was so terrific and all encompassing that we answered everything.

LAURA KAVANAUGH: I have a question. Laura Kavanaugh, the Training Branch chief. You mentioned the possibility of exploring pilot testing of this model. Can you talk a little bit more about what those pilot tests would look like, what the scope of them would be?

You said you were hoping you would fund about ten. Would they be health professions area? Tell me more about what that would look like.

STUART WEISS: With the idea that it's still being developed, we are expecting that there would be enough money and that amount of test to be determined because of the budget crisis. The budget obviously is -- when this model was being developed, it was before the tragedies of the Gulf Coast. So to be realistic we have to be more flexible. But the logic is here is a model that you are aware of. Tell us how much it would cost to try it at your school and see how you would implement it. Typically our grants are one to three years and something like this would take a while to do. But the point is at the back of your -- at the back of the third draft of the report are two case studies that show how it's done at a university in Israel and the University of Texas San Antonio and see how it works in practice and recognizing that there is diversity and recognizing that there is different health professions.

Actually that's a very good point because I neglected to mention this. Speaking of diversity, with respect to this program, we are defining diversity as -- this became an issue in recruiting the panel. Diversity was with respect to health professions, race, ethnicity, age, gender, rural versus urban, and geographic. So the needs of -- the needs in the Pacific northwest, the rural part of that area than the needs of New York City and Washington, D.C. What it really made us conscious of is to assure that we didn't -- you know, it's not what you know, it's who you know. What we wanted to avoid and we saw it coming up with the first cut of people we would select or recruit was there was a real bias

towards having most of the people being somewhere between New York and Washington. So by putting it into practice in a diverse manner, we'll see what the results are. And the results and the expectations, in fact, that's why we had the panel do this, are that one of the main concerns I have is that this be done in an unbiased fashion. And actually the advantage in retrospect of having economists and an attorney be the project officer and the project principal investigator is that it's not like we had the bias of well in my profession. It so empowered people that the osteopathic professions with respect to this we can combine.

Because of our professions, we then presume to do that. And so that was the benefit and I could really -- we could really be the honest broker. It's things like this. One thing we don't want to happen -- not only do we not want this to still need to be done eight years from now but also I don't want this to be an interesting project that gathers dust on my bookshelf. This is reality. It's because of the shortage and quality. This is an issue. This was my closing remarks. These are issues that over time are going to be not only important, but increasingly urgent as well. You know, it's -- I don't know if those of you who are old enough to remember the Sputnik scare but it's not like you can just go and say wow, you shoot baskets, you score touchdowns, come on to our team. There is a lag in recruiting people who are going to become faculty. The other economic issue is because there are so few, we also have to do -- we're also in competition with law schools -- with the law profession, with business. This axis is not so much medicine as it is faculty. So if you have a small pie to begin with and there is competition for it, those are the factors.

MADHAVI REDDY: We have a question from Denise Roberts. She asked, was there any discussion in the summit and also in the draft report given to minority factors other than racial, ethnic, for example gender or disability or different abilities?

STUART WEISS: Yes, again, we define diversity with respect to health professions, gender, age. For example, we started pharmacy schools. We have underemployed Ph.D.s in the scientists maybe going back becoming pharmacists because they can make more money. Health professions, age, race, ethnicity, gender, geography and rural versus urban. As far as disability, there was one person that we were excited to have come down and be part of this and unfortunately, because of the -- her disability, she was unable to come. So that is something -- how would I say this? In the really, really broad universe of all types of diversity, the two issues that we did not -- we chose not to get into, or the three we chose not to get into were religion, disability and sexual orientation. We felt that's beyond the scope of what we're trying to do. It's embedded in issues about individual development or about -- in the institutional commitment, etc. But that was really beyond the scope because again, we have a very defined mission here. We're trying to create a skilled healthcare workforce. So we realize, you know, if you're from the Pacific Northwest, for example, our psychological expert is from not Chicago, but from Northern Illinois University, for example. So those were -- those issues were not factored in.

MADHAVI REDDY: OK. Next question, when do you expect to have the final draft of the model available?

STUART WEISS: Now that we have -- it's delayed a little because we had this huge response, and instead of having to go through an entire year to recruit other people, people at their own initiative more than doubled the scope of our work. So I gave people the whole summer to do that. Now we have that in. And also being federal employees, you know, we have a grant cycle. So I'm in the process of -- this is the value of the anthology -- of taking these documents, taking the feedback, putting it into the draft and then we have to circulate it back to the panel and then it has to go through our four-stage clearance process which is the panel, our internal management at HRSA and then the department. So optimistically I would say the winter of 2006. But my boss is a very wise man, they'd say 2006. Not just the winter.

LAURA KAVANAUGH: When you say winter you mean January/February of 2006. Not December of 2006. Winter spans both end of the calendar.

STUART WEISS: I'm thinking fiscal year. In other words, in an ideal world it could happen that quickly. But that presumes -- this is the value of the clearance process -- in fact, what's inherent in all this and the reason we could make this work is from the start we could admit that we are not perfect and we didn't know everything and that each time, each contact. Each innovation that we have adds value to the process. That's why we're here today. That's why we're excited about this invitation. We realize this is new and therefore the strength that we have is we're willing to listen and to learn. And we view the clearance process as a chance to add value. I'll give you a perfect example. There is a clearance process on an adopt a school curriculum. We sent the process forward and it

was asked what is the effect on the process on recruitment? I went back and looked at all 66 applications. Turns out if we had funded all of them, it would have been taught to 24,000 people. There is just a really discrete event but really shows -- I don't view it so much as clearance but it's a chance for other people, you know, in these concentric circles to have us, to help us learn so that we can make not a perfect product, but a better product. So I speak of short term, mid term, long term. Short term this winter, and let's say realistically sometime 2006.

MADHAVI REDDY: When you say it's going to be available, how do you disseminate the final draft? Is it going to be available--?

STUART WEISS: Electronically. Whoever has paid -- once it's released, it would be a departmental product that's issued. So I think there is the HRSA clearinghouse that has cleared, we could have it on our website. It's really neat. I mean, that all of a sudden we have these new means of free and widespread distribution. Hopefully what I'm thinking is optimistically available on the website and whoever is registered for the conference, whoever contacts me, you know, I could send a copy to Laura and Madhavi and you disseminate it that way.

MADHAVI REDDY: We'd be happy to do that.

STUART WEISS: It's not so much the way as going back to the portfolio and it is -- it's sort of a poor analogy from my youth but we view it more like Mad Magazine than the evening

newspaper. There are no ads and let each copy be seen by ten people, that's fine with us. Leverage it, multiply it. We want it out there. Because I'll tell you what's going to happen here. The analogy here is somewhat similar to, of all things, traffic safety deaths. We know traffic safety deaths are down over the past 20 years. We don't know whether it's down due to better car design, speed limits, airbags or some combination. We know it's down. Well, it's impossible at this point to know 20 years from now what the outcomes will be. How many more people will be minority faculty in the health professions? And in what field? More importantly, how many would not have been if we didn't have this in place? So the recognizing that there is some unknown, recognizing that there is going to be some, you know, uncertainty or deferred gratification, you know, not using that as a barrier, we are moving forward and our hope is that just like this summit that it will be well received and it will create a certain momentum and that it will go typically like any other product or service. There is 2% to 3% of people or institutions that are innovators. That's what the grants do. And then if that works out, then 10 to 15% of the market that are early adapters and then whether it's cell phones or laptop computers or SUV's, then everybody else gets on. That's what we're hoping and that's why we've done the research and development stage, the testing will be the demonstration phase and then hopefully it will be adapted but more importantly parts of it that work will be adapted. It is not a binomial situation, where it's either zero or one.

LAURA KAVANAUGH: This is one of the priorities of the MCH strategic plan as well. And I've had this discussed at the all grantee meeting and hope we can continue to convene the workgroup for further discussion around this issue. It's a complex issue that some

universities have been very successful, I think. And I also would like to set up better mechanisms for sharing best practice. I think there has been a long history of some universities having wonderful, positive experience in minority faculty recruitment and something we're interested in the training program as well and excited about the collaboration with you.

STUART WEISS: I thank you for this opportunity. We're all excited about this. Also best practices are not just generic. We have the universal model but it also comes down to the community and, you know, we're all part of HRSA but yet your customers are different than ours. And so that's why the more we can work together, I guess what we're saying is we want people to be empowered, to be creative, to feel that they can collaborate with us with no hidden agenda on our part and to -- whatever adds value to this and makes it work is terrific.

MADHAVI REDDY: We have a couple more questions. So I'll try to go through them quickly. The next question comes from Susan and she says, you focus quite rightfully, I think, on the importance of working on CDI on the larger institutional level. I agree that CDI will best be achieved if it is institution-wide and if the tenor is set at the top. Obviously we would like to work on all levels simultaneously but local is probably the place we can have the most impact in the short run. I had to run out at this point so if you address this I apologize.

STUART WEISS: No, I didn't. As far as -- you know, as far as the tenor goes, this is a professional presentation. I'm not going to say well, I'm a bass or baritone. The point is, the community is where you are. That's the universal part and that's why it's stratified and that's why in diversity, rural versus urban could also be side and that's why we had a diverse panel so if you're a rural starkly black college and university you can also apply it. In other words, it's not one size fits all. And so it -- there is an expression, take what you need and leave the rest. And you would take this, see which of these apply and that's why it's important that we started from this universal model to stratifying it by health professions and now going down into the individual schools.

Every place is different and just look at the college guides how many different sizes are there? So it's not so much does it have one size fits all but the diversity enables it to work and you have to apply it in a way that will work for you. And frankly that's one of the reasons in the appendices we show a small college in Israel and this huge land grant university in Texas so that there is a range in there. Some things will apply more than others and that's where we're looking to learn from you, because ultimately you're the ones that have to implement it in a way that's effective for you. That's actually what this CDI is based from. It's from a concept -- the concept in total quality management is this. It's defined as meeting your customer's expectations and requirements the first time and every time and then you have this continuous process. What we did is starting from that same rationale. Who are your customers? Instead of total, continuous process improvement this is continuous diversity improvement.

MADHAVI REDDY: We have another question. Basically the question is you just mentioned the example of a dentist in whom role models in his family played an important part in deciding his career choice. Do you have any comments in role models for pediatricians, coaches, etc. Are you aware of any studies in this regard?

STUART WEISS: Well, anecdotally, who is your role model, who inspires you? Does somebody go into biology because they have a good biology teacher? Pediatricians, we've done so much to eradicate what were childhood diseases. I don't worry about my daughter in kindergarten getting chicken pox and mumps and measles. Community, institutional mission and that's why the community and society is there at the center but it is -- it's out of calculus it's these variables as applied to and it's your area.

LAURA KAVANAUGH: Do you know of any literature? Do you know of any citations from the literature that talk about other role models and entry into the health professions? I'm not aware of any.

STUART WEISS: No, we did a literature search but the scope of this is so big that we had to limit it somewhere. There is a program called the health careers opportunity program which speaks about creating the pipeline. At this level the center of excellence we're already at the health profession school. That's why in the introduction these other issues, kids in health careers, adopt a school is designed to broaden the pipeline. One of the points they made in the model is that it's an artificial distinction. It's a very insightful and terrific comment. While we have divided the two. In practice they're not. And you have to

have the pipeline to get to that point. But just to make it manageable, we couldn't do everything so we're focused on that. Actually, one of the feed backs that we got from the third draft that is going in the last draft is that you can't say well, in effect it's in there. The pipeline, cultural competence are beyond the scope of the report. It has in there, embedded and infused throughout and that's an issue for further study. It's why it's an ongoing process.

MADHAVI REDDY: Thank you. We have another comment. When and where will the winter retreat be held?

STUART WEISS: No, no, these are -- each of the health professions associations, the schools of public optometry, the Schools of Public Health are conducting these retreats from their deans and presidents. So it's significant and it is going forward because again these aren't things that you can write -- that you can identify and solve neatly in the scope of a 60-minute news broadcast or a 90-minute webcast. It's an ongoing process. What we're trying to do here is just get the process moving but at this -- let's say more generalized level. In fact, I think it's interesting that you're hosting this because a lot of our panel, not so much the health professionals, this is a training and education mission in a lot of ways.

MADHAVI REDDY: OK. It doesn't look like there is any other questions from the audience but if Laura or the director of the Division of research training and education has also joined us. Do you have any final comments you'd like to share with the audience?

STUART WEISS: I'm honored to be invited and included. This is new, this is exciting. And please write for the -- please write for the model if you haven't received it already. Please review it carefully. And if you have any additional comments, you know, the window doesn't close at 3:15. That's why we have websites. It's why we have email. We're at your service and frankly, how many participants do we have?

MADHAVI REDDY: We did have approximately 45.

STUART WEISS: See, that's great. That's -- that's essentially 25% increase in addition to these that we've had. We're looking to learn for you to be effective we have to do this and we're solving our role because we have this unique capability to speak to all of you. And it's got to work to be effective. So just please work with us. And thank you.

MADHAVI REDDY: OK, great. If you have further questions for Stuart, we've been sending emails to you to remind you that Stuart can be reached at his email address and 301-443-5644.

STUART WEISS: One thing I should add, I would be remiss if I didn't. I want to really thank and commend Madhavi Reddy for the fantastic job she did in prepping us for this. She asked me would I like to do this. Because of the hurricanes we had to reschedule this from October. She is just a terrific professional in terms of telling me exactly what to do,

when to do it and I think you are really lucky to have her here in this role. And I want to thank you very much for all of your help and support.

MADHAVI REDDY: Thank you, Stuart. I really appreciate that.

STUART WEISS: It's inspiring us for those who have to give service to be on the receiving end to see what good quality is.

MADHAVI REDDY: Thank you. I think that will conclude our webcast for today.

STUART WEISS: That's fine.

MADHAVI REDDY: Just want to remind you that an evaluation form will come up on your computer after the webcast ends this afternoon. Please remember to fill out the evaluation form and submit it to us so that we can see where your comments were from the webcast and also if you have recommendations for future topics for future webcasts, please email myself at mredy @ hrsa.gov. I would once again like to thank Stuart Weiss on a topic near and dear to the MCH Training Program that they've struggled with for a number of years and hopefully with the model being out there and the recommendations from the draft report they'll be useful to you as you approach this topic in your program. I would just like to say and thank the Center for the advancement of distance education at the University of Illinois at Chicago for working with the bureau on coordinating these webcasts. They really

do a great job. Thanks once again. Happy holiday season. We'll be scheduling another webcast sometime early next year. So we'll see you then. Thank you. Goodbye.