FAMU

Florida Agricultural and Mechanical University

Proposal to Offer a Doctor of Dental Medicine Program

Submitted to:

State University System of Florida Board of Governors

August 12, 2011

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Proposal for a New College of Dental Medicine
Executive Summary

Program

Florida A&M University proposes to establish a College of Dental Medicine, drawing on its proven success in training health professionals in nursing, pharmacy, and allied health sciences. The College will provide dental students and residents an outstanding education and at the same time address three major health care delivery issues:

- disparities in access to dental care for low-income, rural, and underserved communities,
- a serious lack of diversity in the Florida dental workforce, and
- inadequate numbers of primary care dental residency positions.

Building on Florida's existing dental delivery system and collaborating with area medical and dental schools, the College will require only modest State operating subsidies compared to similar programs.

Access Disparities

The College of Dental Medicine is an educationally sound and practical means for the State to address a longstanding gap in basic health services—inadequate access to dental care in Florida. The poor, medically disabled, and those living in rural areas receive much less dental care and have more oral disease than other population groups. For example, fewer than 10 percent of low-income rural adults and children see a dentist annually, compared to 70 percent of those living in urban, affluent communities. Children have modestly better access to care than adults, but even so, disparities are especially acute in rural areas: only 12 percent of low-income children in Gadsden County visited a dentist in 2005. Recent State and national reports have noted Florida's dental access problems.

As a result, many low-income children and adults have serious oral health problems that cause pain, infections, eating problems, and facial disfigurement. These problems reduce the ability of children and adults to learn and to find work, respectively. They may also result in more severe systemic illnesses such as diabetes, oral cancer, coronary artery disease, and premature births.

As noted in a recent Board of Governor's report on the dental workforce and access disparities, low Medicaid reimbursement rates are the primary reason that dentists do not participate in the Medicaid program and, in turn, provide care to rural, poor, and minority populations. While in the long-run, Medicaid fees, enrollment, and benefits need to be increased, a great deal can be done to reduce disparities with existing resources. The College of Dental Medicine provides three innovative, practical, and implementable strategies to significantly reduce dental access disparities in the Panhandle.

First, the College of Dental Medicine has identified community dental clinics (Federally Qualified Health Centers and County Health Department Clinics) that serve low-income residents to collaborate with. Because these clinics receive some additional state and federal funding for Medicaid patients, they have modestly more resources to cover the cost of serving low-income patients (most are still hard-pressed to cover their operating costs, but they are

committed to serving this population). The College of Dental Medicine will partner with these clinics in which faculty, residents, and students will provide care in these facilities. This will greatly expand the capacity of these clinics to serve the rural poor.

As part of this strategy, the College of Dental Medicine will work with community partners to construct five clinics, each with 18 dental chairs. In addition, the College will work with existing clinics to expand their capacity. To keep the cost to the State low, non-state funds will provide much of the capital needed to expand the community clinics. Further, only 30 to 35 percent of Federally Qualified Health Center clinic patient reimbursements come from the State.

Second, the College will design the dental clinics on the University campus to operate as a real delivery system. Teams of faculty, residents, and students will provide care to large numbers of lower income patients in an efficiently run operation staffed with adequate numbers of allied dental health personnel. In comparison, traditional dental student clinics have limited capacity and see relatively few patients.

Third, the College will recruit the majority of dental students and residents from rural and disadvantaged backgrounds (low-income families and underrepresented minorities), and they will receive most of their clinical education in rural settings. Graduates are much more likely to practice in rural community clinics and private practices and serve more disadvantaged patients, if they are raised and trained in these communities.

Workforce Diversity

Florida's dental workforce does not reflect the diversity of the population. African-Americans make up 16 percent of the Florida population, but only four percent of dentists are from this community. Likewise, there is a disproportional lack of dentists from rural and lower income families. This lack of diversity is a significant problem in meeting the oral health needs of Florida's diverse population. For example, 40 percent of African-American dentists see significant numbers of Medicaid patients compared to 11 percent of White dentists. The workforce needs to reflect the diversity of the population it serves.

The College will enroll 70 dental students per year for a total of 280 students in the four-year program. Most will be Florida residents, and the majority will be from disadvantaged and diverse backgrounds. The recruitment strategies include a predental honors program for academically promising undergraduate students. Honors students will be guaranteed admission to the College of Dental Medicine a year early, if they have a high grade point average and Dental Admission Test board scores. The College of Dental Medicine will also offer a post-baccalaureate program for promising disadvantaged students who applied to dental schools but were not accepted. This 12-month experience will take students through a rigorous academic program in the sciences. Based on similar programs in other universities, 80 to 85 percent of these students will be accepted into dental school and will graduate.

Residency Programs

The College of Dental Medicine will significantly increase the number of in-state primary care dental residency positions, which is key to keeping more dental graduates practicing in Florida. Currently, there are only 79 primary care residency positions available each year in Florida for

the approximately 250 Florida graduates from in- and out-of-state dental schools. This is why many take their residency training out-of-state. The College of Dental Medicine's residency programs will provide 31 new residency positions annually. These new residency positions will be a valuable addition to the State's capacity to provide Florida dental graduates advanced clinical training in primary care.

In partnership with the Sacred Heart Health System and Tallahassee Memorial Hospital, two of the largest hospital systems in the Panhandle, the College will establish residency programs in General Dentistry and Pediatric Dentistry. These two disciplines provide primary dental care to families and children. Plans call for 20 first-year and five second-year General Dentistry residents. For Pediatric Dentistry, there will be six residents per year in the two-year program.

The primary sites for resident training include the five regional 18-chair dental clinics, the College of Dental Medicine dental practice in Tallahassee, Sacred Heart Health System, Tallahassee Memorial Hospital, community clinics, and private practices.

Collaboration

To use State resources efficiently and to develop strong basic science and clinical education programs, the College will collaborate with area medical and dental schools. Basic medical sciences courses will be taught by faculty from both the Florida State University College of Medicine and Florida A&M University.

For dental sciences courses, an effort will be made to have some lectures and seminars from Nova Southeastern University and the University of Florida Colleges of Dental Medicine faculty, using distance education technology. On a space available basis, students and residents will have the opportunity to rotate through the community clinic and private practice networks of the three dental colleges. Also, there are many opportunities for area health professional schools to cooperate in increasing the number and qualifications of disadvantaged students applying to dental and medical schools.

A Cost-Effective Solution

Because of its innovative, community-based clinical education model, the College of Dental Medicine will require much less State support than traditional schools. In 2011 dollars, an annual operating subsidy of about $10.3 million will be needed. This is substantially less than state support for dental schools of this size nationally and in Florida.

The capital construction costs for the College of Dental Medicine facility on the university campus is about $42 million. The College will secure some of the capital costs—$10 million—from private donations and other non-state sources. The cost for constructing the five regional dental clinics ($20 million) will also be raised from non-State sources. Approximately, $8 million is already available.

Impact

The impact of the College of Dental Medicine on access to care, the diversity of the dental workforce and the economic development of rural Panhandle communities will be significant. When fully operational, the College of Dental Medicine will provide care to about 100,000

additional patients each year. Further, the College will work with local rural communities and clinics to establish self-sustaining oral disease prevention programs in public schools, nursing homes, and Head Start programs.

Following a more than century-long Florida A&M University tradition of educating students from disadvantaged backgrounds, the College of Dental Medicine will significantly increase the number of minority, low-income, and rural dental students and residents. In 2009, there were 80 underrepresented minority students enrolled in Florida dental schools (17 African-American, 61 Hispanic, and two Native American). When fully operational, the College of Dental Medicine will enroll substantially more dental students from disadvantaged and diverse backgrounds.

In terms of economic development, the initial direct and indirect economic impact will be about $219 million and the continuing impact will be $94 million per year. This will mean over a thousand new skilled and professional level jobs in Panhandle communities.

Community Support

The University has worked closely with key stakeholder groups in planning a College of Dental Medicine that will meet community needs. It has received letters of support from an array of elected state, county and municipal officials, business and civic leaders, community clinics, private practitioners, and hospitals. Also, working with area dental and medical schools, the College has developed collaborative teaching and clinical partnerships that will strengthen academic programs and use limited resources more efficiently.

State University System of Florida Board of Governors

Request to Offer a Doctor of Dental Medicine Degree

Florida Agriculture and Mechanical University	August 2015
University Submitting Proposal	**Proposed Implementation Term and Year**

The submission of this proposal constitutes a commitment by the university that, if the proposal is approved, the necessary financial resources and the criteria for establishing new programs have been met prior to the initiation of the program.

8-4-11	James H. Ammons	8/4/11
Date Approved by the University Board of Trustees	**President**	**Date**
Signature of Chair, Board of Trustees 8/4/11 **Date**	**Vice President for Academic Affairs**	8-4-11 **Date**

ENROLLMENT AND COSTS SUMMARY

In the tables below, provide headcount and full-time equivalent (FTE) student estimates of majors for years one through five, eight, and ten. Headcount and FTE estimates should be identical to those in Table 1 in Appendix A. Calculate a cost per FTE for years one, five, eight and ten (Education and General Funding divided by FTE). Indicate the program costs for planning years and the first, fifth, eighth and tenth years of implementation (from Table 2 in Appendix A). Include capital costs for new facilities in the appropriate column and code them as "State" for state funds and "Non-State" for non-state funding.

	Projected Student Enrollment		
Implementation Timeframe	**Head-count**	**FTE**	**Cost per FTE (E&G/ FTE)**
Planning Year 1 - FY 2012			
Planning Year 2 – FY 2013			
Planning Year 3 – FY 2014			
First Year – FY 2015	35	35	$220,371
Second Year – FY 2016	105	105	
Third Year – FY 2017	175	175	
Fourth Year – FY 2018	245	245	
Fifth Year – FY 2019	280	280	$36,570
Eighth Year - FY 2022	280	280	$36,570
Tenth Year – FY 2024	280	280	$36,570

Projected Program Costs			
Education & General Funding	**Non-state Funding**	**Facilities Investments *State***	**Facilities Investments *Non-State***
$1,000,000	$0	$6,500,000 **	$2,000,000 *
$3,500,000	$0	$9,500,000 **	$4,000,000 *
$5,000,000	$0	$20,100,000 **	$14,000,000 * $10,000,000 **
$7,712,974	$3,842,460	$10,600,000 ***	$0
$10,239,702	$36,359,380	$0	$0
$10,239,702	$36,359,380	$0	$0
$10,239,702	$36,359,380	$0	$0

*Five Community Clinics
**Planning/Construction of CODM campus facility
***Dental Equipment
Table does not adjust for inflation

Note: This outline and the questions pertaining to each section must be reproduced within the body of the proposal to ensure that all sections have been satisfactorily addressed. Excel tables are to be included as Appendix A and not reproduced within the body of the proposals, because this often causes errors in the automatic calculations.

INTRODUCTION

I. Program Description and Relationship to System-Level Goals

A. Describe the degree program under consideration, including overall purpose; emphases, including concentrations, tracks, or specializations; and total number of credit or contact hours.

Florida A&M University (FAMU) proposes to establish a new College of Dental Medicine (CODM) that will offer a four-year program leading to the degree of Doctor of Dental Medicine (DMD). For the 70 students per class, the course of study includes two years of basic and clinical sciences and two years of supervised patient care experience. The program will be based in CODM facilities and a large network of Panhandle community dental clinics, hospitals, and private practices. In addition, the CODM will train residents in General (25) and Pediatric Dentistry (12). The proposed school and its programs are designed to respond to strong enrollment demand from students, the projected shortage of dentists in the State, and especially, disparities in access to dental care in the Florida Panhandle. The four year curriculum includes 5,600 class hour and 225 credit hours. Appendix B provides a detailed rationale for the proposed CODM education model.

B. Using the table below, build out a general timeline for full implementation that identifies key activities related to seeking funding, facilities planning and construction, faculty recruitment, curriculum development, admission and enrollment of a full complement of students, and achieving program accreditation. Add rows as necessary.

Activity	Timeline/Date Accomplished
CODM approved by the Board of Governors	November 2011
CODM initial state funding	May 2012
Recruitment of CODM Dean and core staff	December 2012
$20 million raised in external funds for community clinics	May 2013
Construction of five community clinics started	May 2013
Construction of CODM campus facility started	July 2013
Initial Commission on Dental Accreditation (CODA) accreditation site-visit residency program	September 2013
Honors program for predental students started	September 2013
Residency programs in General and Pediatric Dentistry started	July 2014
$10 million raised in external funds for CODM facility	July 2014

Activity	Timeline/Date Accomplished
Post-baccalaureate program started	June 2014
Operation of five community clinics commences	September 2014
Initial CODA accreditation site-visit DMD program	September 2014
Contracts completed for BMS faculty from FAMU and FSU	September 2014
Basic Medical Science curriculum development begins	September 2014
Second CODA accreditation residency programs	December 2014
CODM clinical courses development begins	January 2015
Third CODA accreditation residency programs	May 2015
Construction of CODM campus facility completed	May 2015
Enrollment of first class: 35 students	September 2015
Enrollment of second class: 70 students	September 2016
Second CODA accreditation visit DMD program	May 2017
Recruitment of CODM clinical faculty completed	September 2019
Third CODA accreditation visit DMD program	May 2019
First class of CODM students graduates	June 2019
Enrollment of full class of 280 students	September 2019

C. Identify educational sites at which the program is expected to be offered or which are associated with the proposed program, and whether the program will be associated with sites other than the main campus.

1. Basic Medical Science (BMS)
   Most didactic teaching in the first two years will take place in facilities on the main FAMU campus. Lecture and seminar rooms for BMS courses are currently available in College of Pharmacy buildings and other campus facilities. During the BMS years, students will spend about eight hours per week rotating through community clinics, dental and medical practices, and hospitals learning the basics of history taking, physical diagnosis, patient communications, and the structure and organization of the delivery system.

2. Clinical Dental Sciences
   Starting in the second semester of the second year, students will spend several hours each week learning the surgical procedures associated with the practice of dentistry. This will take place in preclinical laboratories in the CODM facility on the main campus. Third and fourth year students will also attend clinical dental science classes in this same building. When on rotation to community delivery sites, senior students will use distance learning technologies to continue class work in the clinical dental sciences.

3. Patient Care
   Patient care will take place in a network of community clinics, practices, hospitals, and in the CODM building on the FAMU campus.

   Community (Safety Net) Clinics - Florida has a relatively limited dental safety net system operated by County Health Department Clinic (CHDCs) and Federally Qualified Health Centers (FQHCs). See Appendix D for a detailed overview of these community clinics. Most CHDC and FQHC dental clinics have five or fewer operatories providing little opportunity for student and resident rotations. There are not enough large community dental clinics to

accommodate all planned CODM residents and students. To address this issue, the dental safety net system in the Panhandle needs to be expanded over the next 10 years.

Clinical facilities are needed to accommodate residents and faculty and to build a clinical infrastructure for the later involvement of dental students. The CODM will work with community partners to raise the funds needed to build four regional rural clinics each with 18 chairs. An additional clinic of similar size will be located in Tallahassee. They will provide general and some specialty dental services and function as regional referral centers for area safety net clinics. The clinics will be owned by the CODM but leased to CHDCs and FQHCs. Most dentists and all allied dental health personnel, and staff will be clinic employees. The CODM and the clinics will work out a joint arrangement to manage these facilities. Residents and students will also be assigned to area safety net clinics and hospitals that are not owned by the University.

In addition, the CODM will establish a unit to work with community clinics and county governments to obtain federal, private industry, and medical foundations funds to expand the number and size of safety net dental clinics that are not owned by the University. The strategy is to expand existing small clinics to 10 chairs from the current three to five chairs, so that two students can be assigned to each clinic.

Private Practices - Senior students and residents will also be assigned to private practices in the Panhandle area. The practitioners will come from the CODM's volunteer faculty. Mainly, General and Pediatric dental practices will participate in this program. This is an excellent way to familiarize students and residents with rural community practice and to develop long-term personal relationships between practitioners and trainees. This will lead to the formation of associateships and partnerships after graduation and eventually to increasing the number of primary care dentists in the area.

Community Hospitals - Sacred Heart Health System (SHHS) will partner with the CODM to sponsor residency programs in General and Pediatric Dentistry. SHHS is the areas' largest hospital system, and it has extensive experience delivering in and outpatient medical/dental care to low-income patients. SHHS currently runs an eight chair dental clinic in Pensacola in cooperation with the County Health Department.

Recently, Tallahassee Memorial Hospital (TMH) has indicated an interest in sponsoring dental residency programs and has donated a substantial piece of land for the CODM to build a clinic. Thus, it is likely that both SHHS and TMH will sponsor dental residency programs.

CODM Clinics - In the CODM facility on the main FAMU campus, there will be 112 dental operatories. Junior students will receive their patient care experiences in this facility, and faculty, residents, and students will provide care to patients in efficiently operated group practices.

INSTITUTIONAL AND STATE LEVEL ACCOUNTABILITY

II. Need and Demand

A. Need: Describe national, state, and/or local data relative to the need for more dentists, especially any relevant data from the March 2011 Florida Department of Health Dental Workforce Survey.

Consistent with Florida A&M University's historic mission as a land-grant institution, the proposed dental medicine program has three major components:

- *Instruction*, preparing students and residents for successful careers as health care professionals.

- *Research*, advancing knowledge to improve oral health and overall well-being.

- *Public Service*, applying the University's academic resources to improve the quality of life of the state's citizens by providing disadvantaged population access to dental care.

Each component is presented separately. Compared to other new doctoral programs, the need for a public service component is especially significant, and the CODM plans an aggressive effort to address dental access disparities in Florida's rural and underserved communities.

1. Need for Dental Graduates
   Dentists play an important role as front-line health care providers. Many common diseases are diagnosed during routine dental office visits and referred to physicians. This is especially important for disadvantaged populations who have more limited access to medical care. To the extent that increased numbers of dental graduates enable more low-income people to receive dental care, the overall health of the state and the nation is expected to benefit.

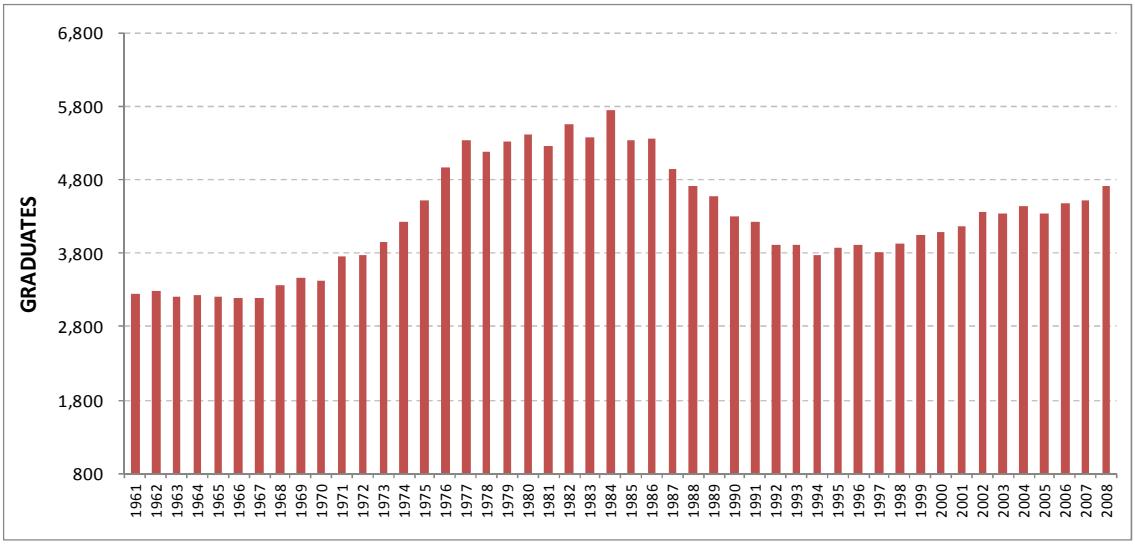
   The recently passed federal health care reform recognized the value of dental care, and will expand coverage for children. Implementation of the health care reform is clearly a work in progress, but the likely expansions of coverage will translate into additional demand for dental services and, thus, dentists.

   a. National Need for Doctor of Dental Medicine Professionals
      Over the past 35-plus years, the annual number of dental graduates has sharply declined and is just recovering. As seen in Figure 1, the nation's dental schools produced approximately 4,500 graduates in 1975, 5,756 in 1984, and about 4,500 in 2009.

      There is growing recognition of the need for more dental school graduates in many states, including Florida. New dental schools are planned and/or have been established in North Carolina, California, Illinois, Texas, Nevada, Pennsylvania, and Maine. Replacement of retiring dentists will absorb a significant portion of graduating dental classes each year. Further, population growth and increased demand from previously underserved populations will create demands well beyond expected

numbers of new graduates.

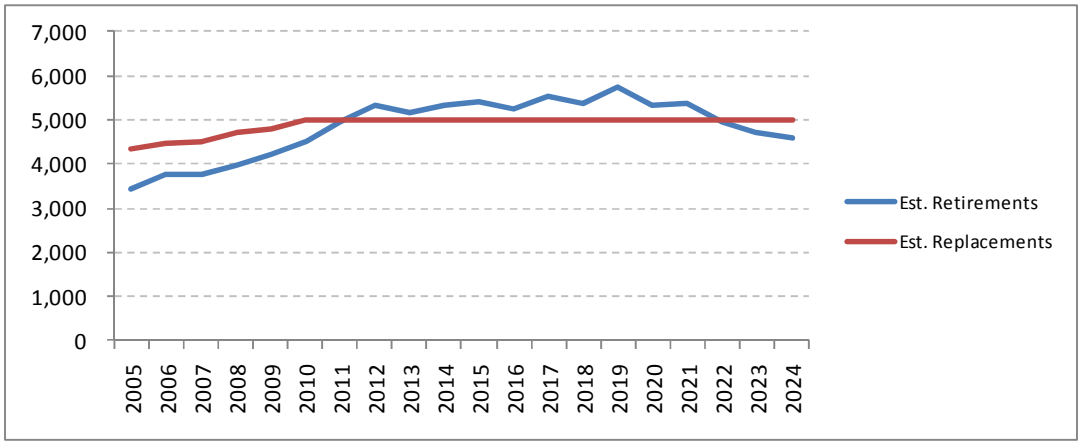
Figure 1
Annual Dental School Graduates, 1960-2009



Source: American Dental Education Association.

That is, relative to the size of the population and increased demand, the national dental workforce is expected to decline. Dentists who graduated during the peak production years in the late 1970s and the 1980s will retire in large numbers over the coming decade. Figure 2 illustrates that the number of retiring dentists is expected to exceed the number of graduates.

Figure 2
Projected Numbers of Retiring Dentists and New Dental School Graduates



Source: American Dental Education Association.

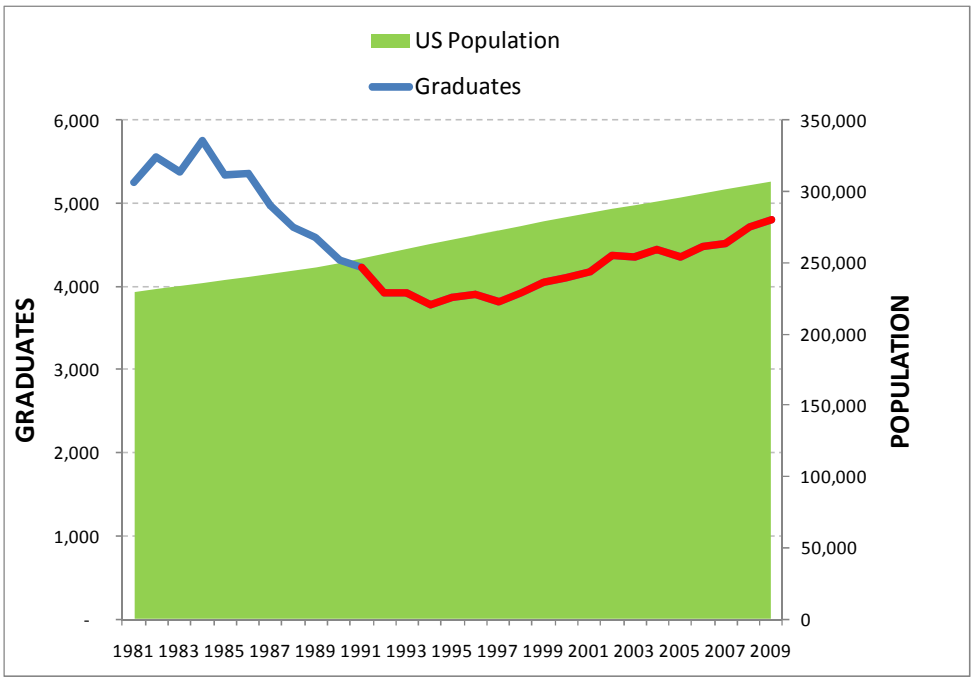
During the past 40 years, the population of the United States has increased by over 100 million. When this approximately 50 percent increase in population is contrasted to the 25 percent decrease in dental school graduates, the adverse impact on access is apparent – even after graduates from new dental schools are taken into account.

Indeed, the Bureau of Labor Statistics, U.S. Department of Labor reports the future employment outlook for dentists is very strong. In their *Occupational Outlook Handbook*, they conclude:

> *Employment (of dentists) is projected to grow faster than the average. Job prospects should be good, reflecting the need to replace the large number of dentists expected to retire. . .*

Figure 3 compares population and growth in the numbers of dental school graduates. Hence, the proposed CODM will directly address a significant national need for more dentists.

Figure 3
Growth Trends: U.S. Population and Dental School Graduates, 1981-2009



Sources: (1) U.S. Census; (2) American Dental Education Association.

b. Florida's Need for Dentists

The relative need for new dentists in Florida is greater than the national need. Many of the same factors that are driving the national need are more pronounced in Florida:

- Approximately one-half of Florida's practicing dentists are over 50 years old and 10 percent have indicated the intent to retire over the next five years.

- The U.S. Census projects that the Florida population will grow by 49 percent over the next 20 years (9.4 million additional residents), double the national rate.

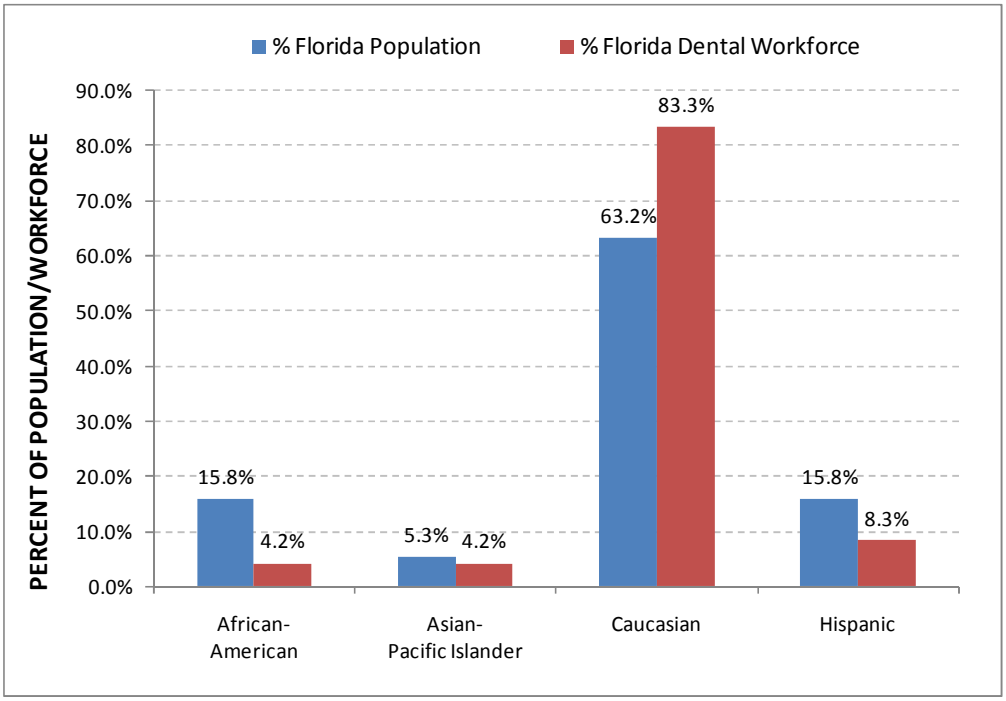
In addition, according to the Kaiser Family Foundation, Florida currently has about 81 dentists per 100,000 population – nearly the same as the national average of 80.

This number is misleading, however, due to the unique character of Florida's population as a retirement destination. According to a recent Florida Department of Health survey among licensed dentists, over 19 percent do not actively practice and another 21 percent practice on a part-time basis.

That is, the number of practicing dentists in Florida on a full-time-equivalent basis is in the range of 50 to 60 per 100,000 population. In fact, the Florida Department of Health estimates the State has only 51.3 actively practicing dentists per 100,000 population. As such, the State ranks 49th among all states and the District of Columbia. Indeed, with the retiree adjustment, Florida ranks a distant last. Further, Florida is at a disadvantage in producing new dentists to serve its population. When comparing states on their per capita number of dental students, Florida ranks 31st of the 35 states that have dental schools. Florida has 0.99 slots per 100,000 residents compared to the national average of 1.57 slots. Florida needs 112 and 126 additional dental school slots, respectively, to reach the national and populous state averages. As one of the fastest growing states, Florida's need for additional training slots will become even more pronounced without corrective action.

A special factor in assessing the need in Florida for dentists is the current lack of diversity in the dental workforce. The African-American population is particularly underrepresented among Florida's dentists. Only 4.2 percent of dentists are African-American compared to 15.8 percent of the population. Figure 4 compares the distribution of the State's dental workforce and its overall population by race-ethnic categories.

Figure 4
Dental Workforce Diversity



Sources: (1) Florida Department of Health; (2) U.S. Census.

Fully accredited first-professional degree programs in dental medicine are currently available at two universities in the State – the University of Florida, a public university located in north-central Florida, and Nova Southeastern University, an independent university in southeast Florida. Their ability to meet the growing demand for dentists in Florida is summarized below.

The College of Dentistry at the University of Florida (UF) was established in 1972 and is a component of the UF Health Sciences Center. Key characteristics of the UF dental program are:

- Student Enrollment
  - 328 students in 2008-09.
  - 83 students in the class of 2012.
  - 72 students (87%) in the class of 2012 were Florida residents.

- Residents
  - 26 general dentistry positions.
  - 77 specialist positions.

- Student Diversity, 2008-09
  - 63 percent Caucasian.
  - 15 percent Hispanic.
  - 6 percent African-American.

- Tuition, 2010-11
  - $30,936 for in-state students.
  - $57,416 for out-of-state students.

The College of Dental Medicine at Nova Southeastern University (NSU) was established in 1997. The dental program, along with programs in osteopathic medicine, pharmacy, optometry, allied health and nursing, and medical sciences, is part of the University's division of health professions. Key characteristics of the NSU dental program are:

- Student Enrollment
  - 423 students in 2008-09.
  - 108 students in the class of 2012.
  - 60 students (56%) in the class of 2012 were Florida residents.

- Residents
  - 9 general dentistry positions
  - 63 specialist positions

- Student Diversity, 2010
  - 59 percent Caucasian
  - 10 percent Hispanic
  - 2 percent African-American

- Tuition, 2011-12
  - $48,450 for in-state students
  - $50,950 for out-of-state students

The Lake Erie College of Osteopathic Medicine, a Pennsylvania-based institution with a Florida campus in Bradenton, has recently announced plans to offer a dental medicine program in 2012 at its Bradenton location. The Bradenton program will operate under the accreditation of the new program being developed concurrently at the College's main campus in Erie, Pennsylvania. According to published reports, a portion of the clinical training program for students at the Bradenton campus will take place in Pennsylvania. Also, only 44 percent of the osteopathic medical students at the Bradenton campus are Florida residents, so the contribution of the new school to the Florida dentist workforce remains to be determined.

Despite the many contributions of Florida's existing dental schools, only 40 percent of Florida's practicing dentists received their training in Florida. The two current programs have attracted relatively few underrepresented minority students, especially African-Americans. As seen in Table 1, the proportion of minority students in Florida dental schools falls far short of their representation among the State's young adult population.

Table 1
Distribution of Entering Florida Dental School Students by Race and Ethnicity, Entering Class, 2008

	UF College of Dentistry		NSU College of Dental Medicine		Florida Young Adult Population (20-29)	
Category	Number	Percent	Number	Percent	Number	Percent
African-American	4	4.8%	3	2.8%	474,371	18.7%
Asian	14	16.9%	24	22.2%	62,418	2.5%
Caucasian	53	63.9%	54	50.0%	1,241,482	49.0%
Hispanic	9	10.8%	14	13.0%	589,310	23.3%
All Other	3	3.6%	13	12.0%	165,190	6.5%
Total	83	100%	108	100%	2,532,771	100%

Sources: (1) 2008-09 Survey of Dental Education, American Dental Association, 2010; (2) U.S. Census, 2007-09 American Community Survey.

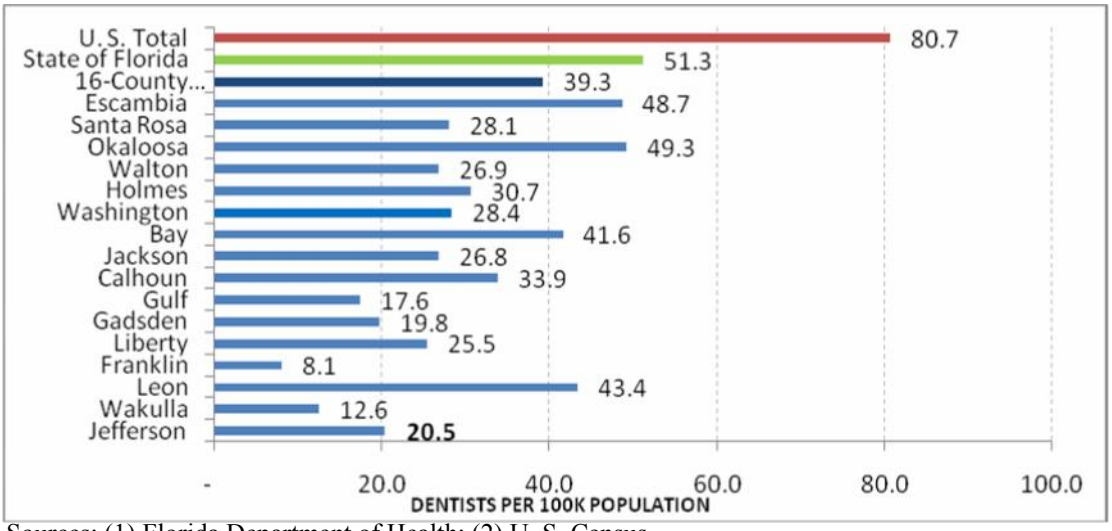
The proposed CODM will have a significant impact on the supply of locally trained dentists. With a planned enrollment of 70 per class, the CODM will supply 27 percent of the dentists trained in Florida each year. More importantly, FAMU's proven performance in attracting a diverse student body for its health professions programs will contribute significantly to needed improvements in workforce diversity.

c. Need for Dentists in Panhandle

In Florida Panhandle counties, especially the more rural ones, the low-income population has limited access to dental care. The per capita number of Panhandle

practicing dentists trails both statewide and national averages (see Figure 5).

Figure 5
Ratios of Dentists Per Capita: Nations, State and Panhandle Counties



Sources: (1) Florida Department of Health; (2) U. S. Census.

With the rates of dentists per capita so much lower across the region than either the State or national averages, it is not surprising that the U.S. Health Resources and Services Administration has designated much of the Panhandle as a Dental Health Professions Shortage Area (DHPSA). In fact, 14 of the 16 counties in the region have "whole county" DHPSA designations for special populations, while the other two counties have "partial county" designations.

Although students are expected to come from across the State, the CODM will pay special attention to recruiting students and residents from rural and disadvantaged backgrounds, and they will receive much of their clinical education in rural Panhandle settings. Research shows that graduates are more likely to practice in rural community clinics and private practices and serve more disadvantaged patients, if they are raised and trained in these communities.

Clearly, there is a need for more dental graduates. While much of the national need is based on anticipated retirements of current dentists and projected population growth, the needs in Florida are much more immediate. Large numbers of Florida residents, especially the disadvantaged in the Panhandle, currently do not have access to routine dental care. A carefully designed dental education program can play a significant role in reducing dental access disparities.

2. Need for Dental Medicine Research Programs
   The CODM will have an active research program focused on strategies for reducing access disparities and improving oral health in low-income Panhandle communities. Four full-time faculty positions are allocated for dentists with PhDs in health services research or epidemiology, and they will lead the research effort of many other faculty, residents,

and students who have an interest in these issues. CODM researchers will focus on the problem of social barriers to care. Several studies have shown that even when dental care is financially and physically available, utilization rates for low-income populations seldom reach 50 percent, and it takes many years to reach this level. The non-financial barriers to care include limited education, language, health literacy, transportation, fear, childcare, and loss of income during working hours. Many of these barriers are directly related to poverty.

The primary source of research support for dental projects is the National Institute of Dental and Craniofacial Research. Other government agencies that fund some dental research include the Agency for Health Care Research and Quality, the Heath Resource and Services Administration, and the Center for Disease Control. In addition, many national and local private medical foundations provide funds for dental research, including The W.K. Kellogg Foundation, The Pew Center for the States, The Robert Wood Johnson Foundation, and The California Endowment. With a special interest in disparities, close ties to disadvantaged rural, minority populations, and an innovative community-based educational delivery system, the CODM faculty is expected to generate substantial funds to support this research program. Indeed, the full-time research faculty members will be required to cover at least 50 percent of their salaries and benefits from external research funds. Overall, relatively little research has focused on strategies to reduce social barriers to access disparities. The CODM can make a major contribution, both scientifically and programmatically, directing their efforts to rural, underserved, and minority populations.

Since the proposed CODM will be built on FAMU's already established base in the health professions, the new dental faculty will have the opportunity to develop interdisciplinary research programs with their colleagues across campus. For instance, faculty members in the College of Pharmacy and Pharmaceutical Sciences, the School of Nursing, and the School of Allied Health Sciences have identified numerous areas for potential research collaboration. Similarly, the researchers in the FAMU Institute for Public Health look forward to the opportunity to conduct joint inquiries with dental school researchers through the network of community-based dental clinics.

3. Need for Dental Medicine Public Service Programs

State universities, and especially land-grant universities, have long and distinguished histories of addressing the critical needs of their states through public service programs. These programs not only provide valuable and critically needed services to the citizens of the state, but they also provide a platform for training students and an opportunity to test the results of the latest research in real-life situations. Perhaps the best known example of public service programs at land-grant universities is the agricultural extension service.

The lack of access to dental care for a wide segment of the Florida population provides an opportunity for the CODM to mount a strong public service program that will respond to a critical State health care problem. Indeed, the unifying concept that underlies the design of the CODM instruction, research, and public service programs is based on improving access to dental care for disadvantaged populations. While the CODM program will focus on providing a strong quality education and eliminating access to dental care in Florida's rural and underserved communities, the curriculum design is based on national studies and programs to reduce access barriers.

a. National Need to Improve Access to Dental Care

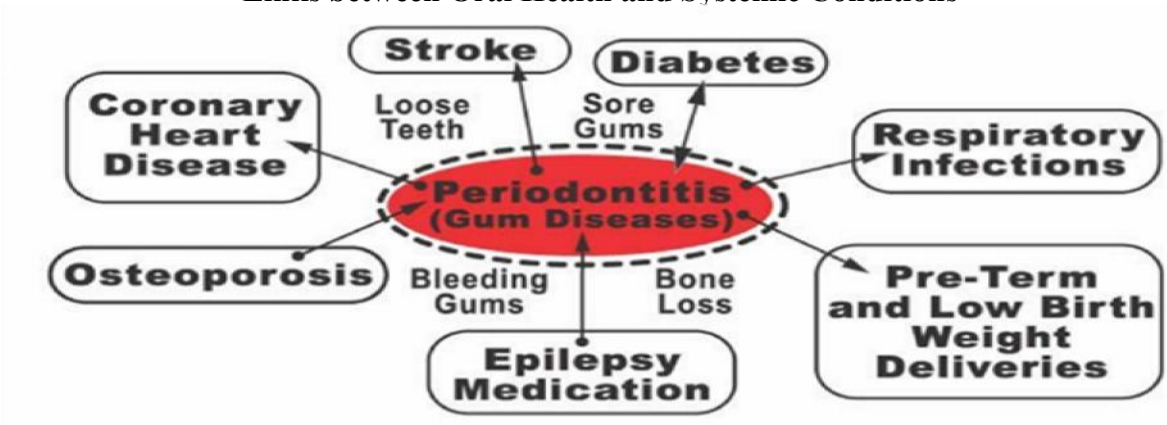
As noted in the 2000 report of the U.S. Surgeon General, "oral health is essential to the general health and well-being of all Americans." The report went on to note that there is a "silent epidemic" of dental and oral disease. Over the past decade, research has continued to reveal more evidence of the importance of oral health to overall health. According to a 2011 report from the American Dental Association (ADA), "Early diagnosis, preventive treatments and early intervention can prevent or halt the progress of most oral diseases-conditions that when left untreated can have painful disfiguring and lasting negative health consequences."

Unfortunately, not enough citizens and policy makers understand the economic benefits of good oral health and its importance to overall health. Among the long-term economic benefits are:

- *Improved health status* – Oral health status is a major determinant of peoples' overall assessment of their health and well-being.
- *Better school performance* – Children with untreated dental disease have difficulty learning and miss more school days than their healthier counterparts.
- *Employment* – People with missing teeth and other oral disabilities have a much more difficult time finding employment.
- *Increased productivity in the workplace* – Adults suffering from untreated oral disease are more likely to miss work and perform below par.

The State Oral Health Improvement Plan (SOHIP) for Disadvantaged Floridians (2005) also notes the importance of good oral health. Although more study is needed to fully understand the complex relationships between oral health and systemic health, the SOHIP report depicted how periodontitis links with other health conditions (see Figure 6).

Figure 6
Links between Oral Health and Systemic Conditions



Source: Florida Department of Health, 2005.

A majority of U.S. residents have access to some of the best oral health care in the world. As a result, most Americans enjoy excellent oral health, yet a significant number of residents do not. Oral health disparities can be seen across economic, geographic, and racial-ethnic lines, with minorities, people with disabilities, and the poor being especially hard hit.

In its assessments of the nation's health problems, the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services has conducted the Medical Expenditure Panel Survey (MEPS). One report series analyzed the utilization of dental care and the influence of socio-economic factors that influence utilization rates. These factors include family income, race and ethnicity, age, and urban or rural location.

The economic ability to pay for dental care is a major factor explaining disparities in access and oral health. According to MEPS data shown in Table 2, citizens categorized as "high income" were more than twice as likely to have visited a dentist during the past year as the "poor" across all age categories. The failure to visit a dentist during the past year was highest among those of traditional working age. Less than one-fourth (22.7%) of the poor ages 21-64 were found to have visited a dentist during the past year.

Table 2
Percentage of Population with a Dental Visit in the Past Year by Family Income and Age

Income Category	Age Category			
	0-20	21-64	65 & Over	All
Poor	30.8%	22.7%	28.2%	26.5%
Low Income	33.9%	26.9%	30.5%	29.9%
Middle Income	46.5%	39.7%	41.1%	41.9%
High Income	61.8%	56.2%	59.9%	57.9%
All	45.4%	42.9%	43.0%	43.6%

Source: Medical Expenditure Panel Survey (MEPS), Agency for Healthcare Research and Quality.

An individual's race or ethnicity is also a strong predictor of whether he or she has regular dental visits. While the MEPS survey found that just under half of White citizens (49.4%) had a dental visit during the past year, that rate was nearly double the rate for Blacks (30.2%) and Hispanics (28.9%). Elderly Blacks were the group least likely to have visited a dentist, as seen in Table 3.

Table 3
Percentage of Population with a Dental Visit in the Past Year by Race/Ethnicity and Age

Race or Ethnicity	Age Category			
	0-20	21-64	65 & Over	All
Black, non-Hispanic	34.1%	29.6%	18.1%	30.2%
Hispanic	32.9%	26.8%	22.7%	28.9%
White, non-Hispanic	52.5%	48.7%	47.3%	49.4%
Other	43.7%	40.8%	38.7%	41.5%
All Groups	45.4%	42.9%	43.0%	43.6%

Source: Medical Expenditure Panel Survey (MEPS), Agency for Healthcare Research and Quality.

The Center for Disease Control found that where one lives also has significant impact on the likelihood of visiting a dentist (see Table 4). Residents living within a Metropolitan Statistical Area (MSA) were 12 percent more likely to have visited a dentist within the past year than those living in more rural area. The place of residence seems to have the most impact on ability of the elderly to gain access to dental care. For those 65 years of age and over, the urban group was 20 percent more likely than their rural counterparts to have visited a dentist in the past year. Based on this evidence, the populations that will benefit most from FAMU's service learning programs are low-income, minority or reside in rural communities.

Table 4
Urban or Rural Residence on Likelihood of Annual Dental Visits, 2009

Urban or Rural Status	Age Category			
	2-17	18-64	65 & Over	All
Within MSA	79.0%	63.1%	61.8%	66.5%
Outside MSA	75.5%	55.9%	51.3%	59.5%
All	78.4%	62.0%	59.6%	65.4%

Source: Center for Disease Control.

b. Statewide Need for Expanded Access to Dental Care

Due in part to the large number of Floridians residents who are low-income, minority, or reside in rural communities, the State ranks poorly in terms of dental health. In fact, a recent study by the Pew Center for the State assigned Florida a grade of "F" for its performance in children's oral health care. Only eight other states received the same failing grade. The Pew report noted "the state falls especially short in its rate of Medicaid-enrolled children who received dental services" and found that Florida was one of only three states "where less than a quarter of children accessed dental services."

Studies by the United States Government Accountability Office (GAO) reached a

similar conclusion. In its November 2010 report on "Oral Health," Florida was found to rank last among the states on all three measures reported for children's oral health. The results summarized in Table 5 show utilization rates in Florida are typically half or lower than for the median for all fifty states.

Table 5
GAO Findings on States' Medicaid Dental Utilization

Measure	Median Utilization Rates for the 50 States and D.C.	Florida Utilization Rates	Florida Rank
Any dental service utilization	38.1%	20.9%	Last
Preventative dental services utilization	33.5%	13.8%	Last
Dental treatment services utilization	18.4%	7.8%	Last

Source: U.S. Government Accountability Office, 2010.

Numerous State studies have identified these oral health challenges. In 2009, the Florida Department of Health issued the report of its Health Practitioner Oral Health Workforce Ad Hoc Committee. The Committee observed "As the challenges of providing dental healthcare continue to grow throughout our country, Florida faces even larger challenges due to the diversity that exists in its 33 rural and 34 urban counties." Among its findings, the Committee concluded:

- New models for the delivery of dental health care services may be necessary to provide access to dental care for certain disadvantaged population groups in Florida.

- Safety net providers such as County Health Department and Community Health Center dental services are essential to providing dental care to underserved and disadvantaged populations.

- Most underserved populations (e.g., low-income children, individuals with special health care needs, seniors) require dental services provided by general dentists who receive additional training and experience in working with special populations.

The public service components of the proposed FAMU CODM build on these findings and significantly expand dental services for disadvantaged populations through innovative partnerships with existing safety net providers.

In an analysis of Florida's needs for dental education and dental care, the staff of the Florida Board of Governors joined in finding that the State has a severe access

problem for its disadvantaged populations and noted the structure and funding of the Medicaid program contributes to the problem. In this environment, the analysis concluded that the expansion of dental education would have little impact on this access problem. The staff analysis, however, appears to be based on the assumption of a traditional model of dental education. The proposal for a new FAMU CODM is based on a non-traditional model and is designed to have both an immediate and a lasting impact on access to dental care. The model avoids the Medicaid issue through its alliance with community healthcare partners (County Health Department Clinics and Federally Qualified Health Centers) who have significant non-state resources to provide care to disadvantaged populations.

c. Regional Need or Expanded Access to Dental Care

Residents of the Florida Panhandle have less access to dental care than populations in most other areas of the State, perhaps reflecting the socio-economic profile of the region. In particular, the Panhandle population differs from the rest of Florida in terms of its:

- Percent of population that is a racial or ethnic minority,
- Percent of population that is below 200 percent of the Federal Poverty Level.

Florida is a highly diverse state, with over 42 percent of its population reporting some type of minority status to the U.S. Census. The Hispanic and African-American populations are especially sizeable, but they are not evenly distributed across the State's 67 counties. The 16 counties in the Panhandle have a relatively high concentration of African-American residents (18.4 percent) compared to the rest of the state (14.9 percent). In fact, African-Americans comprise a majority of the population in one Panhandle county (Gadsden), as listed in Table 6.

The Panhandle counties also tend to have higher proportions of economically disadvantaged residents. Table 6 also shows that 13 of the 16 Panhandle counties have a higher share of their residents in the disadvantaged group than the state average. Overall, the relative size of the economically disadvantaged in the Panhandle is 10 percent higher than for the rest of the state regardless of age group.

Table 6
Comparison of Disadvantaged Populations: Panhandle versus State

Counties	Racial and Ethnic Minority Populations				% Economically Disadvantaged (< 200% Federal Poverty Level)		
	% African-American	% Hispanic	% Other	% Minority	Children	Adult	Total
Escambia	22.7%	4.7%	6.5%	33.8%	49.0%	30.5%	35.7%
Santa Rosa	5.5%	5.2%	3.9%	14.7%	39.3%	24.7%	28.7%
Okaloosa	9.0%	6.8%	7.0%	22.9%	36.7%	23.2%	26.8%
Walton	5.7%	5.3%	3.8%	14.9%	54.1%	35.1%	39.5%
Holmes	5.7%	2.2%	3.1%	11.1%	60.1%	38.1%	43.8%
Washington	14.9%	2.9%	3.7%	21.5%	61.3%	39.3%	44.8%
Bay	10.6%	4.8%	5.4%	20.8%	45.1%	28.8%	32.9%
Jackson	26.3%	4.3%	2.8%	33.4%	55.0%	35.6%	40.2%
Calhoun	13.6%	5.2%	3.6%	22.3%	66.5%	42.4%	48.5%
Gulf	18.5%	4.3%	2.3%	25.1%	51.3%	33.9%	37.4%
Gadsden	55.8%	9.5%	1.6%	66.9%	61.9%	38.7%	45.2%
Liberty	17.6%	6.2%	2.6%	26.4%	62.3%	39.9%	45.5%
Franklin	13.6%	4.6%	2.2%	20.4%	62.9%	41.7%	45.9%
Leon	29.9%	5.6%	5.2%	40.7%	46.0%	28.4%	33.6%
Wakulla	14.3%	3.3%	2.9%	20.5%	41.4%	26.7%	30.2%
Jefferson	35.9%	3.7%	1.7%	41.3%	52.9%	34.4%	38.6%
Total, Panhandle	18.4%	5.3%	5.1%	28.8%	46.6%	29.5%	34.1%
Other 51 Counties	14.9%	23.9%	4.4%	43.2%	42.3%	26.9%	30.9%
State Averages	15.2%	22.5%	4.5%	42.1%	42.7%	27.1%	31.1%

Sources: (1) U.S. Census; (2) Florida Department of Health.

The relative supply of dentists is another factor contributing to the problem of dental access in the Panhandle. On the supply side of the equation, counties in the Panhandle fare poorly in terms of the:

- Per capita number of dentists,
- Per capita number of dental specialists, and
- Percent of dentists actively participating in Medicaid.

The 16 county Panhandle region has only 76 percent as many dentists per capita as the rest of the state. As seen in Table 7, the Panhandle has 39.29 dentists per 100,000 population compared to the 52.25 rate for the other 51 counties. Likewise, the dentists who provide specialty care are underrepresented. Half of the counties in the region have only 1-2 dentists who are considered "active Medicaid providers."

Table 7
Active Licensed Dentists, Dental Specialists, and Dentists Participating in Medicaid Program, Florida Panhandle

Counties	Population	Active Licensed Dentists		Presence of Providers in Six Areas of Specialty						Active Medicaid Providers
		Number	Per 100K Population	Orthodontics	Oral/Max Surg	Periodontics	Endodontics	Pediatric Dent	Prosthodontics	
Escambia	314,085	153	48.71	X	X	X	X	X	X	23
Santa Rosa	145,718	41	28.14	X	X				X	2
Okaloosa	200,777	99	49.31	X	X	X	X	X	X	6
Walton	59,580	16	26.85	X	X			X	X	2
Holmes	19,569	6	30.66					X		2
Washington	24,624	7	28.43					X		4
Bay	170,497	71	41.64	X	X	X	X	X	X	8
Jackson	52,232	14	26.80	X	X			X		4
Calhoun	14,765	5	33.86							1
Gulf	17,085	3	17.56							5
Gadsden	50,463	10	19.82							2
Liberty	7,847	2	25.49	X						2
Franklin	12,368	1	8.09							-
Leon	276,533	120	43.39	X	X	X	X	X	X	11
Wakulla	31,689	4	12.62					X		1
Jefferson	14,649	3	20.48							4
Total, Panhandle	1,412,481	555	39.29							77
Other 51 Counties	17,702,788	9,249	52.25							1,018
State Averages	19,115,269	9,804	51.29							1,095

Sources: (1) U.S. Census; (2) "Report of the 2009-10 Workforce Survey of Dentists," Florida Department of Health, March 2011.

Low-income residents of the Panhandle have extremely low dental utilization rates for a number of reasons (see Table 8):

- The percentage of the population below 200 percent of the Federal Poverty Level (FPL) is higher in the Panhandle (34%) than the other 51 counties (31%), and for some Panhandle counties over 40 percent of the population is below the FPL. The 200 percent FPL cut-off point understates the problem, since national data indicate similar low levels of utilization below 250 percent of the FPL.

- Even though the poor are a higher percentage of the Panhandle population, a lower percentage of the Panhandle poor are enrolled in the Medicaid population.

- Dental utilization rates are very low in Florida and the Panhandle compared to national data. Only nine percent of the poor see a dentist, and even with Medicaid coverage, this only increases to 18 percent.

By any measure of access, Florida has a "crisis" level problem that needs to be addressed. The dental access problem is most severe in the Panhandle.

Table 8
Factors Influence Access to Dental Care for Low Income Residents in Panhandle Counties

		Low Income Population		Medicaid Enrollment		Documented Access to Dental Care		
Counties	Overall Population	Number Below 200% of Federal Poverty Level	Percent of Overall Population	Number Enrolled	Enrolled as Percent of Low Income Population	Number of Low Income with Access	Percent of Low Income with Access	Percent of Medicaid Ernollees with Access
Escambia	314,085	112,246	35.74%	65,530	58.38%	10,147	9.04%	15.48%
Santa Rosa	145,718	41,785	28.68%	20,823	49.83%	3,188	7.63%	15.31%
Okaloosa	200,777	53,854	26.82%	26,263	48.77%	3,538	6.57%	13.47%
Walton	59,580	23,547	39.52%	8,114	34.46%	1,436	6.10%	17.70%
Holmes	19,569	8,579	43.84%	6,338	73.88%	1,619	18.87%	25.54%
Washington	24,624	11,021	44.76%	6,098	55.33%	1,600	14.52%	26.24%
Bay	170,497	56,139	32.93%	35,156	62.62%	6,883	12.26%	19.58%
Jackson	52,232	20,977	40.16%	12,053	57.46%	3,226	15.38%	26.77%
Calhoun	14,765	7,164	48.52%	3,296	46.01%	1,323	18.47%	40.15%
Gulf	17,085	6,394	37.42%	2,961	46.31%	1,808	28.27%	61.05%
Gadsden	50,463	22,811	45.20%	13,276	58.20%	1,405	6.16%	10.58%
Liberty	7,847	3,570	45.50%	1,906	53.39%	518	14.51%	27.18%
Franklin	12,368	5,679	45.92%	2,182	38.42%	823	14.49%	37.71%
Leon	276,533	92,939	33.61%	36,260	39.01%	6,729	7.24%	18.56%
Wakulla	31,689	9,572	30.21%	4,871	50.89%	1,389	14.51%	28.51%
Jefferson	14,649	5,661	38.64%	3,042	53.74%	750	13.25%	24.66%
Total, Panhandle	1,412,481	481,938	34.12%	248,169	51.49%	46,382	9.62%	18.69%
Other 51 Counties	17,702,788	5,471,657	30.91%	3,227,814	58.99%	614,467	11.23%	19.04%
State Totals	19,115,269	5,953,595	31.15%	3,475,983	58.38%	660,849	11.10%	19.01%

Sources: (1) U.S. Census; (2) Florida Department of Health.

The need for new degree programs is typically based on student demand and employment opportunities. In the case of the CODM, the need is justified not only on these traditional metrics, but also on the valuable role that FAMU public service programs can fulfill in addressing a significant state health care problem. Just as the historic agricultural extension programs operated by FAMU and the University of Florida have benefited the State for many years, the proposed FAMU dental program will have a direct impact on the quality of life for significant numbers of Florida residents.

d. Regional Need for Economic Development

Many of the counties in the Florida Panhandle are among the most economically disadvantaged in the State. The CODM also brings benefits for the Panhandle economy. Analyses using the widely accepted input-output methodology and economic multipliers provided by the U.S. Bureau of Economic Analysis show that the proposed CODM will have a significant economic impact (see Table 9 and Appendix E):

- Over $219 million of regional economic impact resulting from the initial

development of the school.

- Nearly $95 million of annual economic impact in the region from ongoing operations.
- $864 million of cumulative economic impact statewide over the first ten years of operation.
- Nearly 2,300 jobs created in the region during initial development and over 1,100 well-paying new jobs on an ongoing basis.

Table 9
Economic Impact Analysis of Proposed College of Dental Medicine

Economic Measure	Initial Impact	Ongoing Impact	Ten-Year Impact
Direct Expenditures for Operations and Ongoing Activities	$8.0 M	$51.7 M	$308.9 M
Direct Expenditures for Facility Construction	$105.4 M	n/a	$105.4 M
Regional Economic Impact	$219.1 M	$94.6 M	$771.4 M
Regional Job Creation	2,092	1,027	n/a
Statewide Economic Impact	$243.7 M	$106.3 M	$864.0 M
Statewide Job Creation	2,294	1,121	n/a

Sources: CODM budget plans, Bureau of Economic Analysis regional multipliers, and MGT of America analysis.

The proposed dental program at FAMU has gained support from a cross-section of area leaders. They include elected and appointed county and municipal officials, social agencies, community organizations, and safety net clinics. Appendix F contains letters of support from key regional leaders and service delivery organizations.

The following excerpts from letters of support from local leaders in North Florida provide testimony to their perception of the need for greater access to dental care and for the development of the proposed FAMU CODM.

The Florida Dental Association Past President, Dan B. Henry, DDS, FACD, FIDC, wrote, "*to voice my support for the new FAMU Dental School program being set up in the Panhandle of Florida…it will bring innovation to dental education that is sorely needed.*"

Gadsden County Health Department Administrator-Health Officer, Marlon B. Hunter, BSEH, MAOM stated, "*we believe the challenges we face within oral healthcare provision should be approached through a collaboration of educational and community leaders. This is a welcomed initiative and the Gadsden County Health Department looks forward to the partnership in such a great community effort.*"

North Florida Medical Centers, Inc., (NFMC) is a leading provider of healthcare for the underserved as a Federally Qualified Health Center (FQHC) with 10 medical centers and two dental centers located throughout the Panhandle. NFMC President and CEO, Joel Montgomery, wrote, "*this is a welcomed initiative and NFMC looks forward to working with CODM in developing a longstanding partnership in such a great community effort…we know there will be many opportunities for collaboration between our organizations to address the specific aspects of the initiative.*"

Santa Rosa County Board of Commissioners unanimously approved submission of a letter of support for the CODM. Commission Chairman, Lan Lynchard, expressed interest in partnership opportunities with the County's Health Department and Escambia Community Clinic to build capacity to, "*provide the knowledge, values, and skills needed for people to make health choices as well as address the critical manpower needs of the 21st Century. [The CODM] is a welcomed initiative and the Santa Rosa County Board of Commissioners looks forward to the partnership in such a great community effort.*"

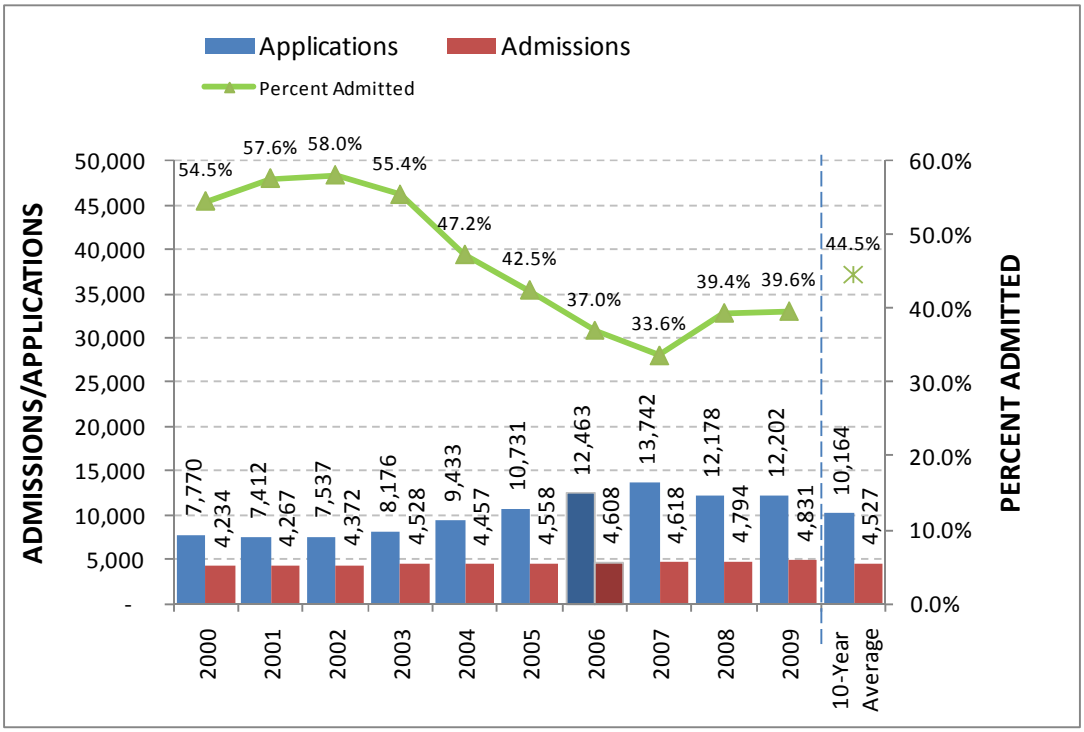
B. <u>Demand:</u> Provide data that support the assumption that students will enroll in the proposed program.

1. National Demand for Dental Education

Gaining acceptance into dental school is highly competitive. In recent years, it has been more difficult to enter dental than medical schools. Of the 42,742 students who applied to medical school through the Medical School Application Service (MSAS) in 2010, 19,641 (45.9 percent) were accepted. By contrast, only 39.6 percent of dental applicants (American Association of Dental Schools Application Service) were accepted (4,831 acceptances for 12,202 applicants).

Despite the increased number of dental school slots, the ratio of applicants to enrollees has not changed and, in fact, has slowly edged downward over the past 10 years. Details of this trend are seen in Figure 7.

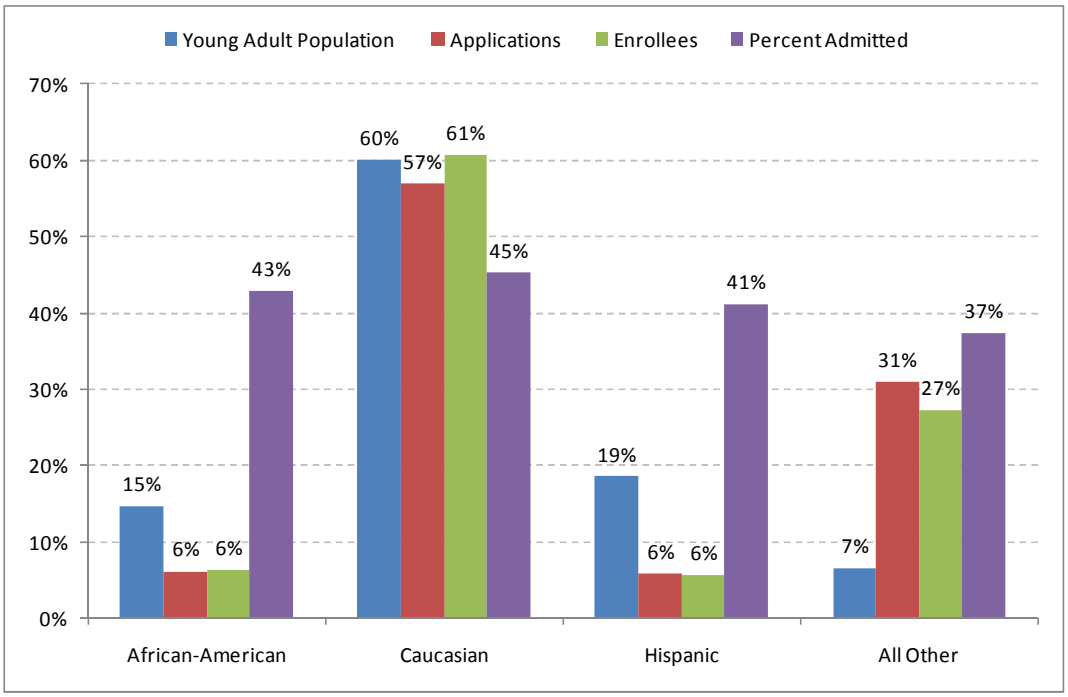
Figure 7
Trends in Applicants and Admissions to U.S. Dental Schools, 2000-2009



Source: American Dental Education Association.

Despite concerted efforts by some dental schools, enrollment of minority students in proportion to their representation in society remains a challenge. Figure 8 provides information on applicants and acceptances by race for the 2005 academic year, along with comparative data for the young adult population (ages 20-29) that makes up the typical applicant pool. Although African-American applicants are accepted into dental school at a rate typical for all applicants regardless of race, the proportion of African-Americans among all applicants (6.2%) is significantly lower than their representation in the young adult population (14.7%).

Figure 8
Minority Participation in Dental Education, 2005 Entering Class



Source: American Dental Association.

2. Demand for Admission to Dental School in Florida
Florida residents face strong challenges in gaining admittance to dental school. Regardless of whether applicants seek to attend in- or out-of-state schools, their acceptance probability trails national averages. With a strong backlog of demand, the CODM will have little difficulty attracting qualified students.

Table 10 shows the number of applicants to the State's two existing dental schools. The UF program has approximately 18 applicants for every first-year slot, and the NSU program has 26.

Table 10
Admissions at Florida Dental Schools, 2008-09

Program	Applications	Enrollees	Applicants per Slot	Percent Admitted
University of Florida	1,477	83	17.8	5.6%
Nova Southeastern University	2,804	108	26.0	3.9%
Total	4,281	191	22.4	4.5%

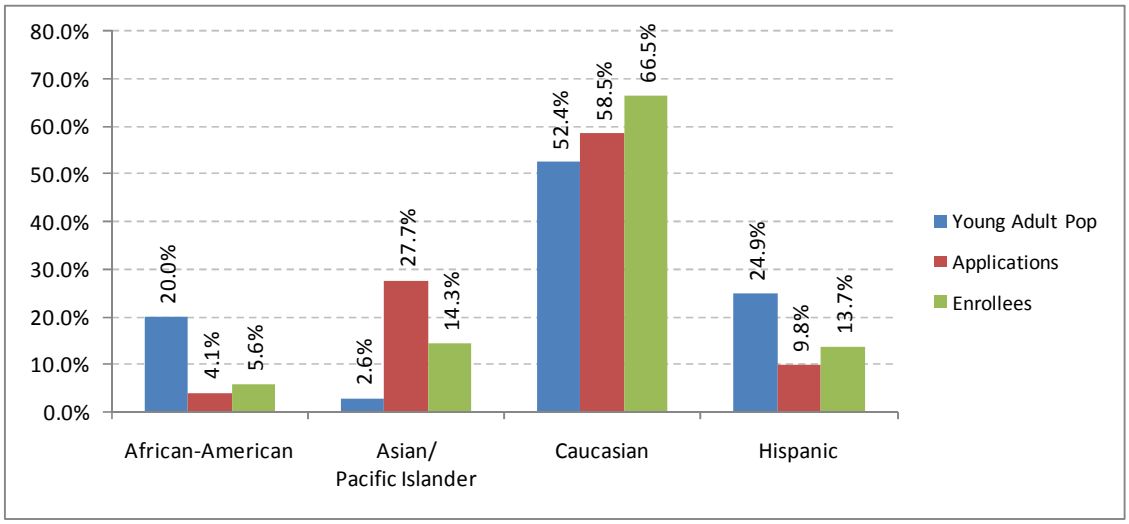
Source: ADA 2008-09 Survey of Dental Education, volume 2.

Given the low probability of obtaining admission to an in-state dental program, many Florida residents attend dental schools in other states. Due to the large out-migration, the likelihood of Florida applicants being accepted into dental school just approximates the national

average.

Minority students in Florida, and particularly African-American applicants, face even greater challenges in becoming dental students. Caucasians make up 52.4 percent of the young adult population (the pool of potential applicants), 58.5 percent of the actual applicants, and 66.5 percent of new enrollees in dental school. African-Americans make up 20.0 percent of the target population, only 4.1 percent of the applicants, and 5.6 percent of the new enrollees in Florida's dental schools. The fact that the proportion of African-American enrollees is so low suggests that pipeline programs and other strategies to build the applicant pool are needed. Figure 9 illustrates the distribution of young adults and the applicants and entrants by race for Florida dental schools.

Figure 9
Minority Student Access to Dental Education in Florida



Source: American Dental Association.

3. Local Support for CODM
The proposed CODM has received broad support from many community leaders, including elected and appointed county and city officials, social organizations, and businesses. Of special importance, the College has the enthusiastic support of the Florida Association of Community Health Centers and the many FQHCs and CDHCs. Letters of support are seen in Appendix F.

C. Summarize the outcome(s) of communication with the college of dentistry at the University of Florida with regard to the potential impact on its overall and minority enrollment. In Appendix B, provide a letter of support or of concern from the provost of the University of Florida.

The CODM planning team met with the Deans of the two other Florida dental schools, the University of Florida (UF) in Gainesville and Nova Southeastern University (NSU) in Fort Lauderdale and the College of Medicine at Florida State University (FSU) in Tallahassee. Efforts are underway to collaborate with these institutions in several educational, clinical,

and administrative areas that will strengthen academic programs and use public and private resources efficiently. The areas of cooperation are briefly described.

FSU (see letter of collaboration, Appendix F)

1. The CODM will purchase the time of basic medical science faculty from the College of Medicine. The FSU faculty will work with FAMU faculty in developing and presenting the basic medical science program to the CODM students. The program courses will have similar content and length to those taken by FSU medical students.

2. The CODM and FSU will collaborate in recruiting disadvantaged college students into dental and medical schools. This may include a cooperative post-baccalaureate and summer enrichment programs and joint meetings with preprofessional health advisors.

NSU (in discussion)

1. The CODM will ask selected clinical dental faculty to provide occasional lectures and seminars, using distance education technology.

2. Some NSU students and residents interested in practicing in the Panhandle area will have the opportunity to rotate through clinics, practices, and hospitals that are part of the CODM community network.

3. The two institutions will work cooperatively in the recruitment of disadvantaged students. Of special concern is making preprofessional health advisors throughout the State aware of career opportunities in dentistry and the process for applying to dental school.

UF (in discussion)

1. The CODM will ask selected clinical dental faculty to provide occasional lectures and seminars, using distance education technology.

2. The two dental colleges will work cooperatively to expand the safety net system in northern Florida and will rotate students and residents through each other's community networks on a space available basis.

3. The two institutions will work cooperatively to increase the number of dental school applicants from disadvantaged Florida families. FAMU will make a major effort to prepare disadvantaged students to become competitive applicants to dental school. This will be a major advantage to the UF. Specifically, the CODM will work closely with the UF College of Dentistry Admissions Office to assist them with recruiting African-American and other underrepresented minority students. The FAMU CODM is committed to increasing the diversity of the dental workforce in Florida and nationally.

A letter of support from the Provost of the UF is seen in Appendix G.

D. Use Table 1 in Appendix A to categorize projected student headcount (HC) and Full Time Equivalents (FTE) according to primary sources from the first year of enrollment through the year of full enrollment. Add or delete columns as necessary to indicate that span of time. Provide accompanying text to Table 1 here below, and describe the rationale underlying enrollment projections.

All CODM students are full time. The first class of 35 students will be enrolled in the fall of 2015. Thereafter, 70 students will be admitted annually. From 2019 forward CODM enrollment will be 280 students.

E. Indicate what steps will be taken to achieve a diverse student body in this program. The submitting university's Equal Opportunity Officer must review this section of the proposal and then sign and date in the area below to indicate that the analysis required by this subsection has been reviewed and approved.

1. Background
   a. Florida A&M University is a Historically Black College and University (HBCU) that has 124 years of experience educating a diverse student population. Indeed, it is the largest single campus HBCU in the nation. Nationally recognized for this commitment to diversity, the CODM expects to recruit a class of dental students largely from disadvantaged backgrounds.

   b. FAMU has programs in other health professions including pharmacy, nursing, and allied health. The pharmacy school graduates more African-American students than any other school in the country. This commitment to providing disadvantaged students an opportunity for careers in pharmacy and other health professions is a strong indication that the University will be successful recruiting disadvantaged dental students.

2. CODM
   a. The expectation is that at least 60 percent of the CODM class will come from disadvantaged families (e.g., low family income, rural community, underrepresented minority). To put this estimate in perspective, nationally, only 12 percent of dental students are underrepresented minorities and only seven percent, if Meharry and Howard Universities are excluded. A related problem is that the great majority of dental students come from families in the upper five percent of the income distribution. Clearly, to effectively address access disparities, the dental work force must be as diversified as the population.

   b. Primary recruitment strategies for disadvantaged students:

      1) Honors Program
      The CODM will identify academically promising students from the University's primary feeder high schools and recruit them into a predental honors program. Honor students will receive an academically enriched undergraduate program including, tutoring, counseling, summer experiences in research laboratories and community dental clinics, and access to advanced science courses. They will also be given priority for academic and need based scholarships. As a further incentive, honor students will be guaranteed admissions to the CODM after three years, if they

maintain high academic and science GPAs (e.g., 3.5 or over) and obtain high Dental Admission Test (DAT) board scores (e.g., 19 or over). Further, the first year of dental school will be considered their senior undergraduate year, so that honor students will receive a bachelor's degree (e.g., BS). Fifty freshmen students will be enrolled in the predental honors program each year, and 35 are expected to enroll in the CODM after three or four years.

2) Post-Baccalaureate Program (PB)
For promising disadvantaged students who applied to the CODM or other dental schools but were not accepted, the CODM will offer a 12-month PB program. This will provide students a rigorous academic program in the sciences and information and experiences related to a career in dental medicine. Students will be guaranteed admission to the CODM, if they maintain a 3.5 GPA and have DAT scores of 19 or greater. Twelve to 14 PB students will be admitted annually, and 10 are expected to enroll in the CODM. This PB program enrollment rate has been achieved at other dental schools including the University of California San Francisco and the University of Illinois-Chicago.

3) Tuition and Scholarships
In-state student tuition will be about $27,000 which is a little below the average for state dental schools. Equally important, some 40 percent of tuition dollars ($3M) will be set aside for student loans and scholarships. Thus, the CODM will be very competitive financially in attracting students from disadvantaged backgrounds.

4) Florida HBCUs
In addition to the Honors and PB programs, the CODM will work with other HBCUs and Florida universities to develop honor programs for undergraduate disadvantaged students interested in dentistry. Students who successfully complete these programs will be accepted into the CODM under the same conditions as Florida A&M honors students. They will also be offered the opportunity to spend the summer months working in University research laboratories and CODM clinics.

5) Other
The CODM will work with the other dental schools in the State to establish dental clubs in the major Florida universities and community colleges, to educate preprofessional health advisors in these universities and colleges about dental schools, and to run summer enrichment programs for promising students. National experience indicates that the majority of preprofessional health advisors know relatively little about careers in dentistry or dental school entry requirements. Once informed about careers in dentistry, these student advisors may become strong dental school advocates.

Carrie M. Farmer — August 10, 2011

Signature of Equal Opportunity Officer **Date**

III. Budget

A. <u>Create an Appendix C and provide a business plan for the proposed program from any planning year(s) through the first year of full enrollment.</u> The plan should include coverage of the source of revenues and expenditures associated with the initial creation and the continued operation of the program, including any capital construction assumptions. Use Table 2 in Appendix A to display projected operating costs and associated funding sources for the first year of student enrollment, and for the year in which full enrollment is realized. Use Table 3 in Appendix A to show how any existing Education & General funds will be shifted to support the new program in Year 1. In narrative form, summarize the contents of both tables in the context of the aforementioned business plan, identifying the source of both current and new resources to be devoted to the proposed program. (Data for Year 1 and for the year in which full enrollment is realized reflect snapshots in time rather than cumulative costs.) Indicate whether a special state appropriation will be required to develop and implement the program. If the university intends to seek Market Rate Tuition for the proposed program or operate the program on a cost recovery basis, provide a rationale for doing so and a timeline for seeking Board of Governors' approval, if appropriate.

1. Overview

   The business plan is divided into three sections. Appendix C1 provides a descriptive summary of CODM revenues and expenses for 2012-2014, the planning years, 2015, the year of first enrollment and 2019/2020, the first steady-state year when full enrollment of 280 CODM students is complete. Worksheet Table 2 presents projected costs and funding sources for years 2012/13 to 2019/20. Appendix C2 presents a detailed business plan for the five community clinics and the CODM clinical facilities on the main campus. This is important, since 70 percent or more of dental school expenses are associated with the operation of clinical programs. The residency programs are based at community hospitals which have the financial risk. The hospital business plans for the residency programs are available but are not presented. Finally, students and residents will rotate through community clinics and private practices that are not owned by the CODM. No transfer of payments is planned between these external sites and the CODM.

2. Appendix C1

   <u>Operations</u>

   Overall, the CODM plans to generate most operating funds from efficiently run patient care activities mainly associated with community clinics. Clinical faculty will generate 50 percent or more of their salaries from patient care provided while they supervise residents and students. (Appendix B provides a detailed rationale for this educational model.) In addition, the CODM will generate revenues from resident Graduate Medical Education support from the federal government and students fees and tuition. Importantly, some 40 percent of tuition dollars will be allocated to student loans and scholarships. The educational subsidy from the State will not exceed $10.3 million, and the cost per student will be much lower (i.e., $36,570) than traditional dental schools. A brief summary of the operating budget is presented.

Operating Costs

Year	Comments
2012/2013	The 1st planning year covers six months. Faculty and staff are limited to three people, and all funds ($1M) come from the State.
2013/2014	In the second planning year there are 18.5 faculty and staff. All funds ($3.5M) come from the State.
2014/2015	There are 11.5 faculty and 21 staff. All funds ($5M) come from the State.
2015/2016	There are 18 faculty and 73 staff. Total income generated from clinical operations is $2.4M (includes resident GME support). Other sources of revenue include student tuition and fees ($1.2M), and research grants ($160K). State appropriations are $7.7 million.
2016/2017	There are 39.5 faculty, 175 staff, and 19 residents. The revenue sources include clinics ($15.9M), tuition and fees ($3.6M), and research grants ($400K). State appropriations are $9.2 million.
2017/2018	There are 55 faculty, 233 staff, and 27 residents. The revenue sources include clinics ($23.2M), tuition and fees ($6.0M), and research grants ($600K). State appropriations are $10.2 million.
2018/2019	There are 59.5 faculty, 253 staff, and 29 residents. The revenue sources include clinics ($25.7M), tuition and fees ($8.4M), and research grants ($800K). State appropriations are $10.2 million.
2019/2020	There are 60 faculty, 253 staff, and 29* residents. The revenue sources include clinics ($25.7M), tuition and fees ($9.6M), and research grants ($1M). State appropriations are $10.2 million.

*Although there will be a total of 37 residents, only 29 will be providing care in CODM facilities at anyone point in time.

Capital Construction Costs

Year	Facilities	
	CODM Facility ($10M external funds)	**Community Clinics ($20M external funds)**
2012/2013	$6.5M - planning/design	$2M – planning/design, purchase land
2013/2014	$9.5M – planning/design and construction	$4M – planning/design, purchase land, construction
2014/2015	$30.1M - construction	$14M – construction, equipment/furniture

3. Worksheet Table 2
   Data are presented for the years 2012 to 2019. After 2019 when full enrollment of 280 dental students is reached, the budget for the later years (2020 to 2026) remains constant except for changes in inflation. At steady state, the funds requested from the State are $10.3 million per year. All other funds come from clinical operations, tuition and fees, GME support, and research grants. The cost per FTE student is $36,570 (State funds), which is low for publicly supported dental schools.

4. Appendix C2
   The key factors used to develop a business plan for the CODM clinical operations are staffing and salaries, clinic productivity, charges per patient visit, and the clinical education model. These are all described in detail in Appendix C2. Briefly, the plan is to have CODM community and campus clinics operate as real delivery systems, so they are able to pick up a large percentage of clinical faculty salaries and faculty, resident, and student clinic expenses. In this model, faculty practice while they supervise senior students and residents, effectively use space and auxiliary staff, and have higher per visit reimbursement rates for low-income patients, because most care is provided in safety net clinics. This clinical education model is common in medical, pharmacy, and nursing education and is now making rapid advancements in dental education. In addition, to being less costly to operate, this model provides more clinical experience to residents and students, and many studies indicate that students prefer this educational model.

B. If other programs will be impacted by a reallocation of resources for the proposed program, identify the programs and provide a justification for reallocating resources. Specifically address any potential negative impacts that implementation of the proposed program will have on related undergraduate programs. Explain what steps will be taken to mitigate any such impacts. Also, discuss any potential positive impacts that the proposed program might have on related undergraduate or graduate programs.

There will be no reallocation of University resources to the CODM, and the CODM will not have a negative impact on existing undergraduate or graduate programs. Instead, it will have a substantial indirect impact strengthening biomedical education and research programs. As part of the CODM effort, the University is reorganizing the biomedical sciences and will establish a College of the Basic Medical Sciences (CBMS) that will serve the educational needs of all the health professional schools (e.g., dentistry, pharmacy, nursing, and allied health) and graduate biomedical science programs. The CBMS faculty and facilities will be phased in over the next 10 years. Within the CODM budget, funds are allocated to cover the costs of faculty from FAMU and FSU (See Appendix C).

In the near term, currently available funds will be used to recruit five additional biomedical faculty who will work with other University faculty and with basic medical scientists at FSU College of Medicine to teach basic medical science courses to CODM students. Space will soon be available for new faculty offices and research laboratories when the Phase II Pharmacy building is completed next year. Over a 10 year period, additional biomedical science faculty will be recruited. This faculty will have a positive impact improving undergraduate and graduate science education and research programs and will support a large group of post-doctoral fellows and graduate students.

C. Describe what steps have been taken to obtain information regarding resources (financial and in-kind) available outside the institution (businesses, industrial organizations, governmental entities, etc.). Describe the external resources that appear to be available to support the proposed program.

The University is making a major effort to obtain non-state funds to help cover the costs of establishing the CODM. As the first HBCU to start a dental school in 130 years, the proposed CODM has attracted considerable national attention from funders. The four main sources of external funds are: the federal government, private medical foundations, private industry, and University alumni. Over the next five years, the University is confident that it will raise at least $30 million from these external sources. Twenty million dollars will be used to cover the cost of the five regional 18-chair dental clinics and $10 million to offset the cost of constructing the CODM facility on the main campus. Because some FQHCs and CHDCs have facilities which can be expanded and other communities are willing to donate land for the clinics, some $8 million is already available, leaving $12 million to be raised in the next few years.

INSTITUTIONAL READINESS

IV. Related Institutional Mission and Strength

A. Describe how the goals of the proposed program relate to the institutional mission statement as contained in the SUS Strategic Plan and the University Strategic Plan.

1. Approved Institutional Mission

As part of its strategic planning process in 2005, the Board of Governors approved a "Shared Mission" for all SUS institutions. In the Plan, Goal D calls for "Meeting community needs and fulfilling unique institutional responsibilities." The mission statement also affirmed the University's "historic mission of educating African Americans, persons of all races, ethnic origins and nationalities." The proposal to establish a DMD program aligns squarely with the mission approved for FAMU in the strategic plans adopted by both the Board of Governors and the Board of Trustees. These mission directives align with the overall goal of the proposed CODM, which is to reduce disparities in access to dental education and service and oral health in the Florida Panhandle. The specific academic objectives of the CODM are to:

- Provide an outstanding dental education to Florida dental students and primary care residents, with special emphasis on attracting disadvantaged students, who are committed to addressing oral health disparities at the patient and community levels;

- Develop an educational delivery system that provides high quality dental care to thousands of underserved children, adults, medically disabled, and rural residents in the Panhandle; and

- Establish a strong biomedical and public health research program that will generate new knowledge to prevent and treat diseases at the patient and community levels.

B. Describe how the proposed program specifically relates to existing institutional strengths, such as programs of emphasis, other academic programs, and/or institutes and centers.

The CODM will complement and enhance existing University health professional degree programs (nursing, pharmacy, allied health, and public health). These programs produce a significant percentage of the State's and nation's African-American health care professionals and serve the public through a broad array of community outreach activities that address access disparities. The University's involvement in pharmacy clinics includes a significant level of administration and management – components important to the proposed dental program. Finally, these health-related public service programs have received national recognition (2009 President's Honor Roll for Community Service) and have demonstrated success in attaining coveted federally financed research moneys ($49 million in 2009). Thus, the CODM will build on a strong foundation and will contribute to achieving the goals established in the SUS strategic plan to meet statewide professional workforce needs and to increase the diversity of the dental profession.

C. In the table below, delineate the planning process leading up to submission of this proposal. Include planning activities, listing both university personnel directly involved and external individuals who participated in planning.

Date	Participants	Planning Activity
September 2008	James Ammons, Cynthia Hughes Harris, Donald Palm, Gita Pitter, Rosalind Fuse-Hall, Janet Southerland, Eric Rivera, Ed Scott, Greg Stoute, Phillip Woods	Discussed with several Dental Educators the possibility of establishing a CODM and FAMU.
October 2008	James Ammons, Cynthia Hughes Harris, Donald Palm, Gita Pitter, Rosalind Fuse-Hall	Developed a plan of action to proceed with development of CODM.
January 2009	Donald Palm, Gita Pitter, Shawnta Friday-Stroud, Maurice Edington, Maurice Holder, Rosalind Fuse-Hall	Planning committee meeting to discuss University, State and Accrediting (SACS) processes and procedures.
January 2009	Donald Palm	Presented the Concept of a CODM to the FAMU Faculty Senate for its approval to develop a planning proposal.
February 2009	James Ammons, Cynthia Hughes Harris, Donald Palm, Howard Bailit, William Butler, Ed Scott	Met with Consultant and Dean of Meharry Dental School to discuss establishing a CODM and FAMU and the type of CODM Model.
February 2009	Donald Palm	Presented the CODM concept to FAMU New Degree Programs Approval Committee for fits approval to develop a planning proposal.
April 2009	Cynthia Hughes Harris, Howard Bailit, Donald Palm, Gita Pitter, Amy Cober, Ana Viamonte Ros (Florida Surgeon General)	Discussed CODM model with the Department of Health (DOH).
May 2009	James Ammons, Cynthia Hughes Harris, Howard Bailit, Donald Palm, Gita Pitter	A planning grant for a CODM was prepared for submission to the BOG. BOG staff did not accept or review CODM planning grant.
October 2009	James Ammons, Cynthia Hughes Harris, Howard Bailit, Donald Palm, Gita Pitter, Frank Brogan and BOG Staff	Discussed proposed model of CODM and was requested to work with the BOG staff to submit a planning proposal to the BOG which would be considered for the BOG revised LBR.
October 2009	Cynthia Hughes Harris, Howard Bailit, Donald Palm, Gita Pitter, Tola Thompson, Amy Cober, Ana Viamonte Ros (Florida Surgeon General)	Discussed oral health disparities in Florida's Panhandle and how the FAMU CODM could assist with having a major impact in reduction of oral health disparities.
October 2009	Cynthia Hughes Harris, Howard Bailit, Donald Palm, Gita Pitter, Frank Brogan and BOG Staff	Discussed content of CODM Planning Proposal with BOG staff.
December 2009	James Ammons, Cynthia Hughes Harris, Donald Palm, Gita Pitter	Concept of CODM and a request for approval to submit planning proposal to the BOG was presented to the FAMU BOT.
January 2010	Howard Bailit, Donald Palm, Kent Caruthers, Fred Seamon, Cynthia Balogh	The team collected data on the dental care delivery and education systems and access disparities in Florida and the Panhandle. The data was obtained from written reports and meetings with staff of the Surgeon General's Office, the Florida Dental Association, safety net clinic directors, local elected officials, and the University of Florida.

Date	Participants	Planning Activity
July 2010	James Ammons, Rosalind Fuse-Hall, Donald Palm	A planning grant to develop a curriculum for CODM was prepared and submitted to the federal government. The grant was approved.
July 2010	Howard Bailit, Donald Palm, Kent Caruthers, Fred Seamon, Cynthia Balogh, and national experts such as Bjorn Olsen, Russell Taichman, Bruce Baum, Charles Alexander, Gregory Chadwick, William Butler, Brian Yachyshen, Kenneth Tomlinson	A national team of consultants, made up of experienced dental educators, clinicians, administrators, architects and financial members were appointed and met over a 12-month period to design the CODM, determine the capital and operating budgets, and prepare the CODM proposal.
September 2010	Howard Bailit, Donald Palm, Lona Ford, Brenda Spencer	Meetings were held with the safety net leaders in the Panhandle region, including the Florida Primary Care Association, the Sacred Heart Health System, County and FQHC Clinic Directors.
January 2011	James Ammons, Howard Bailit, Durrell Peaden, Donald Palm, Lona Ford, Brenda Spencer	Meetings were held with the leaders of the Florida Dental Association, local county dental associations and elected officials in the Panhandle area.
March 2011	Howard Bailit, Donald Palm, Brenda Spencer	Meetings were held with the Deans of Nova University dental school, the University of Florida dental school, and the Florida State University Medical School.
May 2011	Cynthia Hughes Harris, Donald Palm	FAMU Faculty Senate approves CODM proposal.
July 2011	Donald Palm	University Program Authorization Review Committee (UPARC) approves the CODM proposal.
August 2011	James Ammons	FAMU Board of Trustees approved CODM proposal.
September 2011	James Ammons, Cynthia Hughes Harris, Donald Palm, Howard Bailit	The CODM application was submitted to the Board of Governors.

Other national and local experts involved in designing the CODM include:

National

National experts in teaching the basic medical sciences and clinical courses to dental students and residents were employed as consultants. These include Drs. Howard Bailit, DMD, PhD, Professor Emeritus, University of Connecticut, School of Medicine; Bjorn Olsen, MD, PhD, Professor of Molecular Biology Harvard Medical and Dental Schools; Bruce Baum, DMD, PhD, Chief, Gene Transfer Section, the National Institute of Dental and Craniofacial Research; Russell Taichman, DMD, PhD, Professor of Periodontology, University of Michigan School of Dentistry; William Butler, DDS, Former Dean of Meharry School of Dentistry; D. Gregory Chadwick, DDS, Associate Dean, East Carolina University College of Dentistry; Charles Alexander, PhD, Assistant Provost for Diversity, University of California at Los Angeles; William Dodge, DDS, Commission on Dental Accreditation and Associate Dean, University of Texas at San Antonio, School of Dentistry; Kenneth Tomlinson, Chief Financial Officer, East Carolina University, College of Dentistry; and Cyril Myerowitz, DDS, MBA, Chief of the Dental Service and Professor, University of Rochester Schools of Medicine and Dentistry.

Local

Daniel Henry, DDS, Past President, Florida Dental Association; Allan Litvak, Jr., DDS, President of the Escambia Santa Rosa Dental Association; Edward Scott, DMD, Past President of the Sunshine Dental Association; Andrew Behrman, MBA, Executive Director of the Florida Primary Care Association; J. R. Richards, MBA, Bond Community Health Clinic, Tallahassee; Peter Heckathorn, MBA, Executive Vice President, Sacred Heart Health System; Mark O'Bryant, MBA, Chief Executive Officer, Tallahassee Memorial Hospital; John Fogarty, MD, Dean, Florida State University, College of Medicine; Terri Dolan, DDS, MPH, Dean, University of Florida, College of Dental Medicine; and Robert Uchin, DMD, Dean, Nova Southeastern University, College of Dental Medicine.

V. Program Quality Indicators - Reviews and Accreditation

A. Identify program reviews, accreditation visits, or internal reviews for any university degree programs related to the proposed program, especially any associated with tangential academic units. List all recommendations and summarize the institution's progress in implementing the recommendations.

The University does not have a dental program. Table 11 summarizes the accreditation status of the two health science programs related to the CODM, pharmacy, and public health.

Table 11
Accreditation Status of the Pharmacy and Public Health Programs at Florida A&M University

College	Program	Degree	Accreditation Agency	1st Year of Accreditation	Last Review	Expiration Date
Pharmacy	Pharmacy	P (PharmD)	Accreditation Council for Pharmacy Education	1957	2009	2013

Strengths	Recommendations	Actions Taken to Address Recommendations
Compliant with previous standards identified in 2007 as noncompliant and partially compliant. Currently only Standards 14, 24 and 28 require monitoring from initial 2006 review.	Standard 14: Improve balance between institutional and community hours in IPPE Program	Appropriate balancing will begin Spring 2012 with the P1 class that began Fall 2011. Changes submitted to ACPE in April 2011 and noted in their response July 2011 to the College
Improved assessment activities	Standard 24: Faculty strength should continue to be monitored;	Requests for additional faculty submitted to Administration. Vacancies identified also in April 2011 Interim Report
	Standard 28: Increase number of and diversity of training sites to continue to increase capacity	Newer sites added, especially in electives. New program beginning Fall 2012 where IPPE students will have greater opportunities for training in institutional settings

College	Program	Degree	Accreditation Agency	1st Year of Accreditation	Last Review	Expiration Date
Public Health	Public Health	M	Council on Education for Public Health	2001	2005	2012

Strengths	Recommendations	Actions Taken to Address Recommendations
Faculty Expertise; Practicum (federal, state, and national support) – strong linkages; highly competitive curriculum and addresses the core and emerging competencies in public health	Ensure measurability and consistency with program mission, goals and objectives. Learning objectives must also be directly linked with expected competencies.	Use of academic compact and stated learning objectives in each syllabus
Strong faculty and student governance; strong ambassadors of the program; very strong community support	Ensure assessment measures are directly linked to program mission, goals and objectives. Timeframes should also be indicated.	Use of FAMOUS Model and internal assessment measures are currently implemented

VI. Curriculum

A. Describe the admission standards and graduation requirements for the program.

A minimum of three academic years of study (90 semester hours or equivalent) is required at a college or university accredited by one of the regional accrediting bodies recognized by the U.S. Department of Education. A maximum of 60 semester hours earned at an accredited junior college is acceptable as partial fulfillment of this requirement. The last year of predental study must be completed at an accredited four-year degree-granting institution. Only those courses that carry credits toward a baccalaureate degree from the institution in which the candidate receives his or her predental instruction are acceptable. Exceptional students who meet all entrance requirements are considered for admission after three years of college. The course requirements include: biology (12 semester hours); chemistry (16 semester hours); physics (8 semester hours); mathematics (6 hours); and non-Science courses (30 semester hours). Also required are the Dental Admissions Testing program, letters of recommendation, and an interview. In terms of graduation requirements, candidates for the DMD degree must have:

- Complied with the rules and regulations of the College of Dental Medicine and Florida A&M University.
- Demonstrated sound moral character.
- Received a passing grade in all required courses.
- Completed all department clinical and competency requirements.
- Completed treatment of all clinical patients.
- Completed full-time clinic attendance for a minimum of five semesters.
- Returned all equipment and supplies assigned for their use.
- Earned a minimum GPA of 3.0.
- Discharged all financial obligations to the University.
- Been recommended by CODM faculty for the degree.

B. Describe the curricular framework for the proposed program, including number of credit/contact hours and composition of required core courses, restricted electives, unrestricted electives, etc. Identify the total numbers of semesters or semester credit/contact hours for the degree.

The course material presented in this section is based on the dental education program at the University of Connecticut, but includes elements from Harvard University, Columbia University and Stony Brook University. These four schools all have a fully integrated medical and dental school BMS programs and extensive community clinical rotations. The detailed courses and hours are likely to change when the CODM dean and senior faculty are recruited.

The CODM curriculum is designed to provide students with a comprehensive educational experience that allows them to master the knowledge, skills, and values associated with the practice of general dentistry. The curriculum consists of two major components, the Basic Medical Sciences and the Clinical Dental Sciences.

Basic Medical Sciences

Year 1

Courses	**Course Hours**	**Credit Hours***
Human Systems	760	30
Human Biology	260	
Organ Systems 1	140	
Organ Systems 2	180	
Organ Systems 3	180	
Human Development and Health	160	6
Epidemiology and Public Health	75	3

Year 2

Courses	**Course Hours**	**Credit Hours**
Mechanisms of Disease	600	24
General Pathology and Pharmacology	80	
Infectious Disease	80	
Diseases of Homeostasis	140	
Oncology	60	
Diseases of Metabolism	60	
Diseases of the Nervous System	80	
Immune, Non-Immune Mediated Diseases	40	
Research Project	60	2

Clinical Dental Sciences

Years 1, 2, 3 and 4

Course	**Course Hours**	**Credit Hours**
Introduction to Patient Care	500	20
Oral Anatomy	118	5
Oral Diagnosis and Clinical Medicine	200	8
Oral Disease and Infections	126	5
Restorative Sciences	307	12
Dentistry and the Community	126	5
Oral Surgery and Therapeutics	79	3
Critical Thinking in Dentistry	40	2
Clinical Practicum	2,500	100
Electives	Non-Credit	

*The American Dental Education Association or CODA does not issue guidelines on the awarding of course credit hours. This decision is left up to each school, and some dental schools do not list credit hours for their courses. New federal guidelines state that credit hours should be consistent with the Carnegie Unit ("one hour of classroom or direct faculty instruction and a minimum of two hours of out of class student work each week for approximately 15 weeks for one semester"). The average four year dental curriculum has 4,900 hours. Assuming 200 credit hours for the DMD degree, 25 hours of class time or patient care time is equal to one credit hour.

C. Provide a sequenced course of study for any concentrations, or areas of emphasis within the proposed program.

All dental students take the same courses, and there are no majors, concentrations, or areas of emphasis within the core program.

D. Provide a one-sentence description of each required or elective course.

Basic Sciences

Human Biology
This course covers the basic structure, biochemistry, and physiology of cells and tissues and includes human genetics, the immune response, histology, and human anatomy.

Organ Systems 1
This course covers the structure and function of the central nervous system, abnormalities of craniofacial development and gross anatomy of the head and neck.

Organ Systems 2
This course covers organ homeostasis including the heart, lungs and kidneys, and the gross anatomy of the thorax.

Organ Systems 3
This course covers the gastrointestinal track, endocrine organs, and reproductive organs and the gross anatomy of the abdomen.

Human Development and Health
This course covers the biological, psychological, and social development; the behavioral and social determinants of health and illness; health law; ethics; and the health care delivery system.

Epidemiology and Public Health
This course covers the distribution and measurement of major medical and dental diseases and conditions, biostatistics, and the organization and operation of community level public health programs at the national, state, and local levels.

Clinical Dental Sciences

Introduction to Patient Care
This course runs for the entire first two years and covers the basic collection and analysis of patient data and the operation of clinical programs in hospitals, clinics, and practices.

Oral Physiology and Anatomy
This course covers basic and applied dental anatomy/tooth morphology.

Oral Diagnosis and Clinical Medicine
This course covers oral and physical diagnosis, oral and maxillofacial radiology, and oral pathology.

Restorative Sciences
This course covers the restoration of diseased, damaged, and missing teeth. Subject areas include: operative dentistry, occlusion, dental materials, fixed and removable prosthodontics, and implants.

Oral Diseases and Infections
This course covers cariology, periodontology, endodontology, prevention, and the principles of oral health promotion, and treatment planning.

Dentistry and the Community
This course covers social issues relate to healthcare delivery; dental laws and regulations; risk management; information and business management systems; and interactions among healthcare providers.

Oral Surgery and Therapeutics
This course covers oral surgery, pharmacotherapeutics, pain and anxiety control, and management of medical emergencies.

Critical Thinking in Dentistry
This course covers the use of evidence-based and other analytical learning approaches to resolve clinical problems.

Clinical Practicum
The clinical training of students and general patient care activities include the introduction to patient care course, the preclinical technique laboratory starting the second semester of the second year and extending to the summer between the second and third years; the initial treatment of patients in the first six months of the third year; and community-based rotations for the next 18 months in safety net clinics, CODM clinics, private practices, and hospitals.

Electives
The electives program provides a broad range of opportunities, including funded summer research projects and internal and external experiences in all of clinical areas of dentistry.

E. Using the table below, provide a complete timetable specific to seeking accreditation, indicating all relevant milestones along the way to full accreditation.

CODA accredits dental programs leading to the DMD/DDS degree and dental residency programs. For schools that have not enrolled one class of students, there are three site visits. The first or "initial accreditation" takes place before the first class is enrolled. At this site visit, a committee reviews the plans for the school and the resources available to support the plan. If the plan and resources are acceptable, the dental student and residency programs receive initial accreditation. This accreditation classification provides evidence that the developing education program has the potential for meeting the standards set forth in the requirements for an accredited educational program. When initial status is granted to a developing education program, it is in effect through the projected enrollment date.

Once a program is granted "initial accreditation," the second site visit is conducted in the second year of programs that are four or more years in duration, and the third site visit takes place prior to the first class of students or residents graduating.

Accreditation Activity/Milestones	Timeline/Date Accomplished
DMD Program	**August 2015 Start-Date**
Accreditation Application Submission	April 1, 2014
Initial CODA Accreditation Site Visit	Fall 2014
Second CODA Accreditation Site Visit	Spring 2017
Third CODA Accreditation Site Visit	Spring 2019
General Practice Residency Program	**July 1, 2014 Start-Date**
Accreditation Application Submission	Spring 2013
Initial CODA Accreditation Site Visit	Fall 2013
Second CODA Accreditation Site Visit	Winter 2014
Third CODA Accreditation Site Visit	Spring 2015
Pediatric Dentistry Residency Program	**July 1, 2014 Start-Date**
Accreditation Application Submission	Spring 2013
Initial CODA Accreditation Site Visit	Fall 2013
Second CODA Accreditation Site Visit	Winter 2014
Third CODA Accreditation Site Visit	Spring 2015

F. Briefly describe the anticipated delivery system for the proposed program (e.g., traditional delivery on main campus; traditional delivery at branch campuses or centers; or nontraditional delivery such as distance or distributed learning). If the proposed delivery system will require specialized services or greater than normal financial support, include projected costs in Table 2 in Appendix A. Provide a narrative describing the feasibility of delivering the proposed program through collaboration with other universities, both public and private. Cite specific queries made of other institutions with respect to shared courses, distance/distributed learning technologies, and joint-use facilities for research or internships.

1. CODM Campus Facility

The CODM will be one of several dental schools that base most of its clinical education programs in community clinics, practices, and hospitals (see Appendix B). It is also unique in that all school owned clinics (except for third year students) will operate as real delivery systems and not teaching laboratories. This strategy will significantly reduce access disparities in the Panhandle, provide residents and students an excellent clinical education, and reduce the need for State support.

a. Third Year Student Clinic

The CODM will have its primary building on campus, and it will house the preclinical technique laboratory and third year student clinic. The latter will have 40 operatories and will operate two five hour shifts per day, in order to accommodate all 70 third year students for at least six months. Some students may remain in this clinic for more than six months, depending on their rate of progress. This clinic will operate as a traditional dental school clinic (i.e., teaching laboratory), when used by third year students. When not in

use by third year students, the 40 chairs will become part of the faculty, resident, and student clinic described below.

b. Faculty, Resident, Student CODM Clinic
The CODM building will house a faculty, resident, and senior student clinic that will operate as a real delivery system. When third year students are in the community, their clinic will become part of this clinic. This will be a full service 58/98 chair clinic that will have faculty, residents, and students delivering care as a team. Faculty will practice as they supervise a few residents and senior students, and residents will help supervise senior dental students. This clinic will provide senior students and residents the opportunity to do more complex procedures which are generally not done in community clinics (e.g., bridges and implants).

c. Special Patient Care Clinic
The CODM clinic will also have another 14 chairs that will be allocated to the following functions:

Function	Operatories
Emergency Room	2
Surgery	2
Radiology	2
Oral Diagnosis	2
Special Patients (e.g., disabled, HIV/AIDS)	2
Orthodontics	4

2. Safety Net System Clinics
Florida has a relatively limited dental safety net system run by county health departments (but State financed) and FQHCs (see Appendix D). Most CHDC and FQHC dental clinics have five or fewer operatories providing little opportunity for student and resident rotations. There are not enough large community dental clinics to accommodate all planned CODM residents and students. For the proposed clinical education model to work, the dental safety net system in the Panhandle has to expand over the next 10 years.

Initially, clinical facilities are needed to accommodate residents and faculty and to build an infrastructure for the later involvement of dental students. The School will work with community partners to raise the funds needed to build four regional rural clinics each with 18 chairs. An additional clinic of similar size will be located in Tallahassee. They will provide general and some specialty dental services and function as regional referral centers for area safety net clinics. The clinics will be owned by the CODM but leased to CHDCs and FQHCs. Most dentists and all allied dental health personnel, and staff will be clinic employees. The CODM and the clinics will work out a joint arrangement to manage these facilities.

The five 18 chair clinics can accommodate about 15 FTE residents, 15 FTE faculty, and 20 plus FTE students. Residents and students will also be assigned to area safety net clinics and hospitals that are not owned by the University.

Next, the CODM will establish a unit to work with community clinics and county

governments to obtain federal, private industry, and medical foundations funds to expand the number and size of safety net dental clinics that are not owned by the University. The CODM will need the capacity to rotate some 100 students in community clinics, practices, and hospitals. The strategy is to expand existing small clinics to 10 chairs from the current three to five chairs, so that two students can be assigned to each clinic. Thus, at least 20, 10 chair clinics will be needed.

3. Private Practices
   Senior students and residents will also be assigned to select private practices from the Panhandle area. The practitioners will come from the CODM's volunteer faculty. Mainly, General and Pediatric dental practices will participate in this program. This is an excellent way to familiarize students and residents with rural community practice and to develop long-term personal relationships between practitioners and trainees. This will lead to the formation of associateships and partnerships after graduation and eventually to increasing the number of primary care dentists in the area.

4. Community Hospitals
   Sacred Heart Health System (SHHS) will partner with the CODM to sponsor residency programs in General and Pediatric Dentistry. SHHS is the areas' largest hospital system, and it has extensive experience delivering in and outpatient medical/dental care to low-income patients. SHHS currently runs an eight chair dental clinic in Pensacola in cooperation with the County Health Department.

   Recently, Tallahassee Memorial Hospital (TMH) has indicated an interest in sponsoring dental residency programs and has donated a substantial piece of land for the CODM to build a clinic. TMH participation in the CODM residency programs is still in discussion, but it is likely that both SHHS and TMH will sponsor dental residency programs.

VII. Faculty Participation

A. In the table below list all existing and anticipated ranked (not visiting or adjunct) faculty who will participate in the proposed program in any planning year(s), in the first year of student enrollment, and in the year in which full enrollment is attained. For each faculty member indicate rank and specialty/area of administrative responsibility, and whether each will be primarily housed in the College of Dentistry or off-site in clinical/education capacities. Enter an individual row for each faculty. The number of faculty listed, when added together, should equal the total number expected by the first year of full enrollment.

Most CODM clinical faculty will be expected to generate from 50 to 80 percent of their incomes from patient care and grants. Of the 60 full-time clinical faculty, five will fill the Dean and Associate Dean positions. Most of their salaries will come from State funds. Fifteen faculty will be based in the CODM clinics leased to FQHCs or CHCDs. They will receive 80 percent of their incomes from these organizations. For the remaining 40 clinical faculty, general dentists will be expected to generate 50 percent of their incomes from patient care or grants, and specialists 60 percent, respectively.

In addition to the full-time faculty, the CODM will have many adjunct clinical faculty who supervise students in non-University owned clinics, private practices, and the CODM clinics. These faculty will be volunteers and will not receive payment from the CODM.

For the basic medical sciences program, the CODM will purchase the time of faculty from FSU College of Medicine and the FAMU College of the Basic Medical Sciences (CBMS). The CODM budget includes funds to pay for these teaching services.

Ranked Faculty*	
Faculty for Planning (1.5) Years	**Physical Academic Home**
Dean	CODM
Associate Dean Academic Affairs	CODM
Associate Dean Student Affairs	CODM
Associate Dean Clinical Affairs	CODM
Associate Dean Finance/Administration	CODM
Additional Faculty for Years 1 and 2	**Physical Academic Home**
Basic Medical Sciences (Contract with FSU and FAMU)	
Professor	CBMS
Assoc. Professor	CBMS
Professor	FSU
Assoc. Professor	FSU
General Dentistry	
Chair	CODM
Residency Director	Hospital
Pediatric Dentistry	
Chair	CODM
Residency Director	Hospital

Ranked Faculty*	
Additional Faculty for Years 1 and 2	**Physical Academic Home**
Specialty Dentistry	
Chair	CODM
Assoc. Professor	CODM
Additional Faculty for Full Enrollment	**Physical Academic Home**
General Dentistry	
Assoc. Professor - Research	CODM
Asst. Professor - Research	CODM
Asst. Professor - Research	CODM
Asst Professor - Research	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	Community Clinic
Asst. Clinical Professor	Community Clinic
Asst. Clinical Professor	Community Clinic
Asst. Clinical Professor	Community Clinic
Asst. Clinical Professor	Community Clinic
Asst. Clinical Professor	Community Clinic
Asst. Clinical Professor	Community Clinic
Asst. Clinical Professor	Community Clinic
Asst. Clinical Professor	Community Clinic
Asst. Clinical Professor	Community Clinic
Pediatric Dentistry	
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	Community Clinic
Asst. Clinical Professor	Community Clinic
Asst. Clinical Professor	Community Clinic
Asst. Clinical Professor	Community Clinic
Asst. Clinical Professor	Community Clinic

Ranked Faculty*	
Additional Faculty for Full Enrollment	**Physical Academic Home**
Specialty Dentistry	
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM
Asst. Clinical Professor	CODM

*All positions are full time equivalents.

B. In the table below list the number of existing and anticipated <u>adjunct</u> faculty who will participate in the proposed program in any planning year(s), in the first year of student enrollment, and in the year in which full enrollment is attained. For each faculty member indicate rank and specialty/areas of administrative responsibility, and whether each will be primarily housed in the College of Dentistry or off-site in clinical/education capacities. Enter an individual row for each faculty. The number of faculty listed, when added together, should equal the total number expected by the first year of full enrollment.

Unranked Faculty	
Faculty for Planning Year	**Physical Academic Home**
Adjunct Asst. Professor	Community Clinic
Adjunct Asst. Professor	Community Clinic
Adjunct Asst. Professor	Private Practice
Adjunct Asst. Professor	Hospital
Adjunct Asst. Professor	Hospital
Additional Faculty for Year 1	**Physical Academic Home**
Adjunct Asst. Professor	Community Clinic
Adjunct Asst. Professor	Community Clinic
Adjunct Asst. Professor	Community Clinic
Adjunct Asst. Professor	Private Practice
Adjunct Asst. Professor	Private Practice
Adjunct Asst. Professor	Private Practice
Additional Faculty for Full Enrollment	**Physical Academic Home**
Adjunct Asst. Professor	Community Clinic
Adjunct Asst. Professor	Community Clinic
Adjunct Asst. Professor	Community Clinic
Adjunct Asst. Professor	Community Clinic
Adjunct Asst. Professor	Community Clinic
Adjunct Asst. Professor	Community Clinic
Adjunct Asst. Professor	Private Practice

Unranked Faculty	
Additional Faculty for Full Enrollment	**Physical Academic Home**
Adjunct Asst. Professor	Private Practice
Adjunct Asst. Professor	Private Practice
Adjunct Asst. Professor	Private Practice
Adjunct Asst. Professor	Private Practice
Adjunct Asst. Professor	Private Practice

C. Provide evidence that academic unit(s) potentially associated with this new degree have been productive in teaching, research, and service.

There are no CODM faculty at Florida A&M University.

VIII. Non-Faculty Resources

A. Describe library resources currently available to implement and/or sustain the proposed program. Provide the total number of volumes and serials available in this discipline and related fields. List major journals that are available to the university's students.

Existing University science, biomedical, and health sciences collections will support the CODM. The libraries have 82 percent of the journals recommended for an opening-day dental school collection. Journal back files and other teaching, learning, and research dental materials will be required. Table 12 shows the libraries' current dentistry holdings.

Table 12
Current FAMU Libraries Holdings in Support of Dental Medicine

Resources	General	Health Sciences	Dentistry
Volumes	1,006,756	51,145	266
Microforms	473,529	12,460	12
AV/Media	76,932	190	0
Electronic books	61,899	3,524	25
Serial/Periodical Titles	94,286	1,729	98
Electronic Journals (full-text)	103,688	1,622	111
Electronic databases	314	89	0

In addition, FAMU is a depository for United States government documents. This collection contains more than 4,891 full-text electronic titles and 156,949 print volumes. Of this number, 4,254 government documents are related to medicine and 70 are specific to dentistry.

The University has reciprocal borrowing agreements and memberships with the State University Libraries of Florida and the Florida College System Libraries. Memberships are with the Florida Center for Library Automation, the Florida Virtual Campus, and the Southern Regional Education Board. Table 13 details the additional resources and services available to FAMU students and faculty.

Table 13
Florida Public Postsecondary Institution Dental Related Holdings

Libraries	General Resources	Health Sciences	Dentistry
State Universities of Florida	22,497,518	966,278	2,063
Florida Colleges	4,486,813	10,518	1,052

Florida State University is the closest (1.6 miles) public postsecondary institution with libraries that hold resources in science and medicine. The closest public postsecondary institution with a College of Dentistry is the University of Florida in Gainesville (151 miles). FAMU students and faculty may borrow physical materials either onsite or through interlibrary loan from either

institution. Licensing restrictions limit the accessibility of most electronic databases to the students, faculty, and staff of the respective institution.

Library resources in science, medicine and dentistry are among the most expensive to acquire and sustain. Through membership in the Florida Center for Library Automation, FAMU has access to electronic resources, including several health sciences databases. FAMU will approach the other State University Libraries to obtain discounts on electronic databases.

B. Describe <u>additional</u> library resources that are <u>needed</u> to implement and/or sustain the program through the year in which full enrollment is reached. Include projected costs of additional library resources in Table 2 in Appendix A. Include a signed statement from the Library Director that this subsection and subsection A have been reviewed and approved.

Table 14 presents the funds needed to acquire and sustain CODM collections for five years ($905,971). Federal funds are available to cover these additional library expenses.

Table 14
Library Funds Needed to Support the CODM

Collections	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Books	$30,000	$20,000	$15,000	$16,000	$17,000	$ 98,000
Databases	$91,180	$96,752	$104,764	$111,447	$117,666	$521,809
Journals	$48,500	$50,925	$53,471	$56,142	$58,952	$267,990
Media	$7,172	$2,000	$2,500	$3,000	$3,500	$18,172
Total	$176,852	$169,677	$175,735	$186,589	$197,118	$905,971

Table 15 presents the additional library staff needed to support the CODM during this time period. The year one staff total is $212,974 and the five year total is $1,130,701.

Table 15
Funds Required for Staffing the SRC Library

Staffing	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Librarian	$87,085	$89,697	$92,388	$95,160	$98,014	$462,344
Support Staff	$125,889	$129,665	$133,554	$137,561	$141,688	$668,357
Total	$212,974	$219,362	$225,942	$232,721	$239,702	$1,130,701

Lauren B. Sapp
Signature of Library Director

8/10/11
Date

C. Describe classroom, teaching laboratory, research laboratory, office, and all other types of space that are currently available to implement the proposed program through the year of its full enrollment.

There is currently adequate lecture and seminar space available for teaching the basic medical sciences to dental students in the College of Pharmacy and Dyson buildings. In keeping with national trends, dental students will not require teaching laboratories, and all gross anatomy will be taught using computers and pro-sections.

D. Describe additional classroom, teaching laboratory, research laboratory, office, and all other space needed to implement and/or maintain the proposed program through the year in which full enrollment is reached. Include any projected costs. If a new capital expenditure for instructional or research space is required, indicate where this item appears on the university's fixed capital outlay priority list. Provide the estimated total project cost, gross square feet by space category, all funding sources, and the year that funding is expected to begin. Include a signed statement from the Director of Facilities that this subsection has been reviewed and approved.

1. CODM and Facility Overview
   The CODM will have a new facility on the Florida A&M campus that will serve as a base for clinical faculty, residents, and students. This facility will include patient care clinics totaling 112 dental chairs for third and fourth year students, residents, and faculty, clinical support labs, a preclinical technique teaching laboratory, an advanced simulation teaching laboratory, an interactive "virtual library," two didactic teaching halls and small group seminar and conference rooms, video conferencing center, a central sterilization facility, faculty offices, student and staff locker and lounge, and a public eating area. Based on detailed architectural estimates, the facility will require 87,650 NSF (net square feet) and 155,000 GSF (gross square feet).

2. CODM Advanced Simulation Teaching Laboratory
   Before they can perform surgical procedures on patients, dental students must practice these surgical techniques on manikins and in computer-based virtual reality "haptic" systems, which simulate the tactile response of working on human tissue and provide real time feedback on performance. The space needed for 15 Advanced Simulation Teaching Laboratory workstations is 1,055 NSF.

3. Preclinical Laboratory
   The preclinical laboratory will contain 70 workstations, including computers and monitors connected to an instructor's workstation who can receive and send information to individual students. This room, along with a wet clinical support lab for plaster models will have 4,925 NSF.

4. CODM Patient Care Clinics
   The teaching clinic for third-year students will have 40 dental operatories and will operate in two five-hour shifts to obtain maximum usage. This clinic will require 5,000 NSF.

   The full service clinic for faculty, residents, and students will have 98 operatories (includes the third-year student 40 chair clinic for six months) and will require 6,898 NSF (or 11,898

NSF when combined with third-year clinic). The associated support areas for these clinics (reception, public waiting areas, cashiers, consult rooms, dispensaries, and contaminated instrument holding areas) require 6,952 NSF. The special patient care clinic will require 2,025 NSF. The support areas, including emergency room, patient screening areas, etc., will require 3,430 NSF.

5. CODM Other Space
   The other space includes the administrative offices of the dean and associate deans and conference rooms (13,053 NSF), faculty offices (5,900 NSF), didactic teaching areas (10,735 NSF), and building support (26,692 NSF).

6. Community Clinics
   The CODM will build five regional 18 chair dental clinics that it will lease to FQHCs or CHCDs. Each clinic will require 8,500 GSF of space for a total of 42,500 GSF.

The construction costs for the CODM building is approximately $42 million. The cost of dental equipment is $10 million. The total cost of the five regional 18-chair dental clinics is $4 million per clinic for a total of $20 million. As previously noted, the University will raise $30 million in non-State funds to cover the costs of the five community clinics ($20 million) and part of the CODM facility ($10 million).

Signature, Director of Facilities

8/10/11
Date

E. Describe specialized instructional and research equipment that is <u>currently available</u> to implement the proposed program.

Currently, there is no specialized dental patient care equipment available on Florida A&M campus or in the proposed five regional dental clinics.

F. Describe <u>additional</u> specialized equipment <u>needed</u> to implement and/or sustain the proposed program through the year in which full enrollment is reached. Include projected costs of additional equipment in Table 2 in Appendix A.

Table 16 gives the estimated cost of dental equipment for the main CODM building and the five regional clinics. The cost of dental equipment for the CODM building is $10.6 million and for the five clinics comes to about $3.5 million. As previously noted, the community clinic construction and equipment will be financed with non-State dollars.

Table 16
Types of Equipment and Their Approximate Costs by Clinic Facility

Type of Equipment	CODM Building	Regional Clinics	
		Per Clinic	Five Clinics
Dental	$10,602,250	$700,000	$3,500,000

G. Describe any additional special categories of resources needed to implement the program through the year in which full enrollment is reached (access to proprietary research facilities, specialized services, extended travel, etc.). Include projected costs of special resources in Table 2 in Appendix A.

There are no additional special categories of resources needed to implement the CODM program through Year 5.

H. Describe any fellowships, scholarships, or other forms of student support to be allocated to the proposed program through the year in which full enrollment is reached. Include the projected costs in Table 2 in Appendix A.

Because a large percentage (e.g., 60%) of CODM students will come from disadvantaged backgrounds, funds are needed to assist these students financially to complete their dental education with the least debt possible. To that end, 40 percent of the revenues generated from tuition – about $3.2 million in current dollars - will be used for scholarships and loans. In addition, every effort will be made to obtain federal funds designated for disadvantaged students (e.g., Health Career Opportunity Program) and to encourage students to enroll in the National Health Service Corp, armed forces, and other government programs that assist health professional students with paying their tuition and living expenses.

I. Describe currently available sites for internship and practicum experiences, if appropriate to the program. Describe plans to seek additional sites in Year 1 through the year in which full enrollment is reached.

The community sites for dental student and resident patient care experiences were previously described.

IX. Residency Programs

In partnership with the SHHS and likely, the TMH, the CODM will establish residency programs in General Dentistry (General Practice Residency, GPR) and Pediatric Dentistry. These two disciplines provide primary dental care to families and children, respectively and support the CODM mission. Plans call for 20 first-year and five second-year GPR residents. The second-year residents will be selected from the first-year group based on their leadership ability and career plans. For Pediatric Dentistry, there will be six residents per year in the two-year program.

The two residency programs will help fill a major gap in the availability of residency training programs for Florida dental graduates. Table 17 lists the residency positions currently available in General and Pediatric Dentistry in the state of Florida.

Table 17
Primary Dental Care Residency Programs in Florida, 2011

Institution	General Dentistry Residents*	Pediatric Dentistry Residents*
University of Florida Gainesville	22	8
Nova Southeastern University	9**	12
Veteran's Administration Bay Pines Gainesville Miami West Palm Beach	 5 4 4 1	
Miami Children's Hospital Doral		7
Lindsey Hopkins Technical Education	7	
Totals	52	27

*Resident GME support ranges from $41,000 to $46,000 plus benefits.
**Nova General Dentistry residents do not receive GME support.

In total there are 79 primary care residency positions and each year 48 new positions. Considering that annually there are over 250 Florida dental graduates from Florida and out-of-state schools, the number of graduates greatly exceeds the number of residency positions. This is the reason that many Florida residents take their dental residency training out-of-state. This is a problem, since residents often stay in the area of their residency training. The CODM residency programs will be a valuable addition to the State's capacity to provide Florida dental graduates advanced clinical training in primary care.

The CODM residency programs will be based at SHHS located in Pensacola, Florida and very likely TMH located in Tallahassee. SHHS and TMH are the largest hospital systems in the Panhandle, and both have a long tradition of providing medical care to low-income patients. Currently, SHHS sponsors residency programs in Pediatrics, Internal Medicine, and Obstetrics

and Gynecology (OBGYN) and TMH offers residency programs in Family Practice and is working with Florida State University College of Medicine to start one in Internal Medicine.

SHHS and TMH will provide the dental residents Graduate Medical Education support to cover their stipends and fringe benefits. Residents will provide care within SHHS and TMH facilities, including in and outpatient operating rooms for patients requiring general anesthesia, emergency rooms, and other hospital facilities.

The CODM will provide the residents the didactic educational component of their programs, and CODM faculty will supervise their care of patients. The primary sites for resident training include the five regional 18 chair dental clinics, the CODM dental practice in Tallahassee, SHHS, TMH and other area hospitals and community clinics, and private practices.

The residents will play a critical role in the CODM's efforts to reduce access disparities and to increase the number of graduates working in safety net clinics and private practices serving low-income patients. Residents will also have an important role in dental student education, serving as role models and mentors.

For residents with academic, public health, and research career interests, the University will provide them the opportunity to get advanced degrees in relevant disciplines, including business administration (MBA), public health (MPH), and research (PhD). National training grant funds are available to support advanced education programs for dental graduates. The CODM will apply for these funds to support residents and to cover program costs, during this post-clinical training period.

Appendix A
Worksheet Tables 1-3

WORKSHEET TABLE 1
PROJECTED HEADCOUNT FROM POTENTIAL SOURCES

Source of Students (Non-duplicated headcount in any given year)*	2015-2016		2016-2017		2017-2018		2018-2019		2019-2020 (Full Enrollment)	
	HC	FTE	HC	FTE	HC	FTE	HC	FTE	HC	FTE
Individuals drawn from agencies/industries in your service area (e.g., older returning students)	0	0	0	0	0	0	0	0	0	0
Students who transfer from other graduate programs within the university**	0	0	0	0	0	0	0	0	0	0
Individuals who have recently graduated from preceding degree programs at this university	25	25	75	75	125	125	185	185	210	210
Individuals who graduated from preceding degree programs at other Florida public universities	8	8	25	25	40	40	45	45	50	50
Individuals who graduated from preceding degree programs at non-public Florida institutions	2	2	5	5	10	10	15	15	20	20
Additional in-state residents***	0	0	0	0	0	0	0	0	0	0
Additional out-of-state residents***	0	0	0	0	0	0	0	0	0	0
Additional foreign residents***	0	0	0	0	0	0	0	0	0	0
Other (Explain)***	0	0	0	0	0	0	0	0	0	0
Totals	**35**	**35**	**105**	**105**	**175**	**175**	**245**	**245**	**280**	**280**

* List projected yearly cumulative ENROLLMENTS instead of admissions.
** If numbers appear in this category, they should go DOWN in later years.
*** Do not include individuals counted in any PRIOR category in a given COLUMN.

WORKSHEET TABLE 2
PROJECTED COSTS AND FUNDING SOURCES

Instruction & Research Costs (non-cumulative)	First Year of Enrollment							First Year of Full Enrollment					
	Funding Source - 2015/16							Funding Source - 2019/20					
	Tuition	Reallocated Base (E&G)	Other New Recurring (E&G)	New Non-Recurring (E&G)	Contracts & Grants	Other (Non-State) Funds*	**Subtotal**	Tuition	Continuing Base (E&G)	Other (E&G)	Contracts & Grants	Other (Non-State) Funds*	**Subtotal**
Faculty Salaries and Benefits	0	0	3,251,700	0	45,563	772,988	**$4,070,251**	0	5,921,910	0	364,500	6,659,415	**$12,945,825**
A & P Salaries and Benefits	0	0	1,028,700	0	0	0	**$1,028,700**	0	1,149,350	0	0	0	**$1,149,350**
USPS Salaries and Benefits	0	0	2,246,725	0	0	820,300	**$3,067,025**	0	2,928,740	0	58,500	8,203,160	**$11,190,400**
Other Personnel Services	500,000	0	0	0	0	0	**$500,000**	750,000	0	0	0	0	**$750,000**
Assistantships & Fellowships	0	0	0	0	0	108,560	**$108,560**	0	0	0	0	1,561,140	**$1,561,140**
Library	0	0	212,974	0	0	0	**$212,974**	0	239,702	0	0	0	**$239,702**
Expenses	329,500	0	388,938	0	44,437	703,020	**$1,465,895**	3,300,000	0	0	263,000	7,137,172	**$10,700,172**
Operating Capital Outlay	0	0	200,000	0	50,000	70,092	**$320,092**	1,000,000	0	0	250,000	711,097	**$1,961,097**
Special Categories	378,000	0	383,937	0	20,000	0	**$781,937**	4,610,000	0	0	64,000	1,427,396	**$6,101,396**
Total Costs	**$1,207,500**	**$0**	**$7,712,974**	**0**	**$160,000**	**$2,474,960**	**$11,555,434**	**$9,660,000**	**$10,239,702**	**$0**	**$1,000,000**	**$25,699,380**	**$46,599,082**

*Note: Other (non-State) funds include clinical income and Graduate Medical Education support.

WORKSHEET TABLE 3
ANTICIPATED REALLOCATION OF EDUCATION & GENERAL FUNDS*

Program and/or E&G account from which current funds will be reallocated during Year 1	Base before reallocation	Amount to be reallocated	Base after reallocation
None	0	0	**$0**
Totals	$0	$0	**$0**

* If not reallocating funds, please submit a zeroed Table 3.

Appendix B
Rationale for Community-Based Education Model

This Appendix presents the strategy underlying the proposed CODM educational program and then considers national trends in dental education that support the proposed model.

Strategy

CODM Objectives

Academic - to provide an outstanding dental education to disadvantaged Florida dental students and primary care residents who are committed to addressing oral health disparities at the patient and community levels; and to develop an educational delivery system that gives students and residents more clinical experience and at the same time provides high quality dental care to thousands of underserved patients.

Societal - to reduce dental access and oral health disparities in the Florida Panhandle.

To achieve these objectives, the CODM is built around two strategies.

Strategy I: Expand Capacity of Dental Safety Net System

- *Problem.* About 34 percent of the Panhandle's 1.4 million people have low family incomes (200% below the federal poverty level) and have limited personal resources to purchase private sector dental care. Medicaid, the state-run public dental insurance program for low-income patients, has not been an effective insurance substitute for this population since it only covers emergency services for adults and has low reimbursement rates. It is no surprise that fewer than 15 percent of Florida dentists treat Medicaid patients. As a result, this large low-income population has low dental utilization rates, especially in rural areas (<10% visit a dentist annually compared to >70% in affluent communities) and poor oral health (e.g., pain, infection, eating problems, facial disfigurement) and possibly systemic health (e.g., coronary artery disease, diabetes, and premature births).

- *Safety Net Clinics.* Federally Qualified Health Centers (FQHCs) and County Health Department Clinics (CHDCs), collectively known as the safety net system, were established in the 1970s to provide dental and medical care to low-income families. These clinics receive additional State and federal grants to provide services to low-income patients. Unlike most private dentists who cannot support their practices with Medicaid fees, these clinics have modestly better financial resources to provide care to the underserved and cover their expenses. (Because of low Florida reimbursement rates, they are still hard-pressed to cover their operating costs.) There are 35 Panhandle safety net dental clinics that currently treat about 59,000 patients per year.

- *College of Dental Medicine.* The CODM will build its educational delivery system in partnership with Panhandle safety net clinics. Over the next several years, the CODM will work with county governments and community clinics to increase the number and size (additional dental operatories) of FQHC and CHDCs. CODM faculty, residents, and senior dental students will provide care in these clinics, greatly increasing their capacity to care for low-income patients. Importantly, a substantial portion of the funds needed to expand the

dental safety net system will come from non-State sources**.**

- *Impact on Disparities*. The expansion of the safety net system in partnership with the CODM will result in close to 100,000 additional patients receiving care. Approximately 65 to 75 percent of the cost for providing care in safety net clinics is covered by the federal government and other non-State sources.

- *Other Advantages.* This educational delivery system will lead many graduates to seek careers in safety net clinics. Further, the expansion of the safety net system will have a significant impact on the economic development of rural and low-income communities providing employment to hundreds of additional people.

Strategy II: Increase Diversity of Dental Workforce

- *Problem.* Nationally, most dental students come from upper income, majority, and urban/suburban families. These students have had many educational advantages, have competitive academic credentials, and can become excellent dentists. The problem is that relatively few graduates from such backgrounds open practices in rural, low-income, and minority communities or seek employment in community clinics. Thus, the traditional model for selecting and training dental students does little to address the significant access problems of rural and disadvantaged citizens.

- *CODM Students and Residents.* Following a 124-year Florida A&M University tradition of educating disadvantaged students, the CODM will recruit dental students and residents who represent the Panhandle population in terms of family income, ethnicity, gender, and geography. This will increase the number of disadvantaged Panhandle students who receive a dental education and provide care to low-income patients in underserved areas of the State, working in safety net clinics and private practices. As noted in a recent State of Florida report, African-American and Hispanic dentists provide substantially more care to low-income patients than non-minority dentists.

National Trends in Dental Education

All dental schools own and operate their own patient care clinics where junior and senior students receive most of their clinical training. These clinics operate as teaching laboratories in that their primary goal is to educate students. With this educational focus, the faculty that supervise students do not provide care to patients while they teach. Students generally treat one patient in a three hour session in the morning, and one in the afternoon. Students do not have access to dental assistants and must wait for an instructor who usually manages six to seven other students to check each major treatment step. To attract patients under these conditions, schools usually set student patient fees at 50 percent of usual and customary fees charged by private practitioners.

This is an expensive educational model, because student clinics run large operating losses (about $40,000 per chair) that must be made up from tuition, State funds, and gifts. This is the primary reason that dental students pay the highest tuition compared to other health professional students, and graduate with the highest average debt of over $200,000.

Further, dentistry is the only major health profession that uses this model of clinical education.

Medicine, pharmacy, and nursing have students provide care in real delivery systems (e.g., hospitals, outpatient clinics, and pharmacies). In this educational model faculty practice while they supervise students. Most significantly, the delivery system covers most of the expenses associated with clinical education. This system also provides a better education, because students learn to deliver care in an efficiently run delivery system, and as a result, gain more clinical experience.

Community-Based Dental Education

In this model senior dental students spend most of the year providing care in community clinics that dental schools do not own or run. A variant of this education model involves dental schools owning and operating community dental clinics in partnership with FQHCs and CHDCs.

These safety net clinics receive higher Medicaid reimbursement rates from the State than private practitioners, and they receive federal grants. Further, they are paid per visit rather than per service. As a result, most are able to provide basic dental services to low-income patients. Usually one community clinic dentist supervises one student and continues to provide care to his/her own panel of patients. Clinics provide students full time dental assistants and other administrative staff. In this setting, students see seven to 10 patients a day and rapidly gain the skills, knowledge and self-confidence that come from caring for many patients. In addition to providing students more clinical experience, students greatly prefer this form of clinical education, and importantly, it results in many more underserved patients obtaining care.

In terms of existing dental schools, several have operated with the community model for many years. This includes some of the nation's premier dental schools, including Harvard, Colorado, Boston, Michigan, East Carolina, and North Carolina. Further, the American Dental Education Association recently reported that in the last few years many schools have expanded the time that junior and senior students spend in community-based dental education. Finally, most new dental schools are based on students spending a large part of their senior year in community clinics.

CODM

In partnership with FQHCs and CHDCs, the CODM will build five regional clinics in underserved areas of the Panhandle, lease them to the clinics, and work cooperatively to manage them. In addition, the CODM will rotate students and residents in other community clinics that it does not own or run. This strategy will greatly expand the capacity of the safety net system to provide care to the underserved, offer students and residents an outstanding clinical education, and greatly reduce the cost of dental education and the public funds needed to run a college of dentistry.

Conclusion

The trends are clear. The traditional model of clinical dental education is changing to the model used by the other health professions. The primary reasons are community-based dental education programs provide students more "real world" clinical experiences, offer more care to the underserved, and significantly, are much less expensive to operate.

Appendix C
CODM Business Plan

C1 – CODM Summary of Revenues and Expenditures

This section presents the budget narrative for the CODM and is divided into three sections: planning years (2012/13 to 2014/15); the first year of enrollment (2015/16); and the steady state year when full enrollment is reached (2019/2020 and beyond).

Planning Years (2012/13 to 2014/15)
The planning years cover approximately three fiscal years. The projected operational expenditures for these years are $9,500,000. The main source of revenues comes from State appropriations and University fundraising for the capital budget. During this period, 11.5 faculty positions and 21.25 staff positions will be added to the CODM. These positions include the Dean, Associate Deans, Department Chairs, and some clinical faculty. The major programmatic activities of this period include the development of the basic medical sciences curriculum; design of the clinical curriculum; construction of the five community clinics; establishment of the Honors and Post-baccalaureate programs; and initiation of the two residency programs.

The construction of the CODM campus facility begins in 2013 and is completed by summer 2015. The initial Commission on Dental Accreditation (CODA) site visit takes place in 2014, the year before the first class of 35 students is enrolled.

First Year Enrollment (2015/16)
The expenditures for the first year of enrollment (2015/16) are $11,668,176. The main sources of revenue are from clinic operations ($2.3M), federal GME funds ($138K), research grants ($160K), tuition and fees ($1.2M), and State appropriations ($7.5M).

Full Enrollment and Beyond (2019/20 to 2026/27)
The expenditures for the FAMU CODM at full capacity are $46,359,380. The revenue sources include clinics ($23.7M), tuition and fees ($9.6M), GME support ($1.9M), research grants ($1M), and State appropriations ($10.3M). There are 60 faculty, 253 staff and 29 residents.

See Section III Budget, page 33.

Table C1 - CODM Revenue and Expenditure Table

	Planning Year 1	Planning Year 2	Planning Year 3
	FY 2012	**FY 2013**	**FY 2014**
OPERATING EXPENSES			
Faculty Salary and Benefits	$ 376,650	$ 2,168,775	$ 2,703,376
A&P Salary and Benefits	$ -	$ 20,638	$ 552,450
USPS Salary and Benefits	$ 91,000	$ 486,525	$ 808,275
Other Personnel Services	$ 100,000	$ 250,000	$ 300,000
Resident Stipends & Benefits	$ -	$ -	$ -
General Expenses	$ 347,350	$ 439,062	$ 435,899
Operating Capital Outlay	$ 75,000	$ 100,000	$ 150,000
Electronic Data Processing (IT)	$ 10,000	$ 35,000	$ 50,000
Library Resources	$ -	$ -	$ -
Total Operating Expenses	**$ 1,000,000**	**$ 3,500,000**	**$ 5,000,000**
FACILITIES INVESTMENTS			
Leased Space / New Building (State)	$ 6,500,000	$ 9,500,000	$ 20,100,000
Leased Space / New Building (Non-state)	$ 2,000,000	$ 4,000,000	$ 24,000,000
Total Facilities Investments	**$ 8,500,000**	**$ 13,500,000**	**$ 44,100,000**
Total Expenses	**$ 9,500,000**	**$ 17,000,000**	**$ 49,100,000**
REVENUE			
Tuition and Fees	$ -	$ -	$ -
Financial Aid	$ -	$ -	$ -
Community Donations	$ -	$ -	-
Clinical Practice/GME**	$ -	$ -	$ -
Contract and Grants	$ -	$ -	$ -
Total Revenue	**$ -**	**$ -**	**$ -**
Net Income (Loss)	**$ (9,500,000)**	**$ (17,000,000)**	**$ (49,100,000)**
STATE APPROPRIATIONS*	$ 7,500,000	$ 13,000,000	$ 25,100,000

Financial Worksheet does not adjust for inflation
Operating Capital Outlay is the cost for new and/or replacement capital equipment at a rate of 2.5%
Other Personnel Services includes Basic Medical Science contracts
*State Appropriations include Total State Operating Expenses (e.g. Year 1 - $1,000,000) and Facilities Investments: (e.g. Year 1 -$6,500,000)
**Clinical Practice includes patient care revenues (faculty, residents and students) and resident Graduate Medical Education support

Table C1 - CODM Revenue and Expenditure Table

	Year 1	Year 2	Year 3
	FY 2015	**FY 2016**	**FY 2017**
OPERATING EXPENSES	**First Year Enrollment**		
Faculty Salary and Benefits	$ 4,070,251	$ 8,890,763	$ 11,922,188
A&P Salary and Benefits	$ 1,028,700	$ 1,149,350	$ 1,149,350
USPS Salary and Benefits	$ 3,067,025	$ 7,618,650	$ 10,275,850
Other Personnel Services	$ 500,000	$ 700,000	$ 750,000
Resident Stipends & Benefits	$ 108,560	$ 1,023,060	$ 1,452,580
General Expenses	$ 2,110,300	$ 8,269,576	$ 12,424,976
Operating Capital Outlay	$ 320,092	$ 940,629	$ 1,291,005
Electronic Data Processing (IT)	$ 137,532	$ 426,172	$ 595,971
Library Resources	$ 212,974	$ 219,362	$ 225,942
Total Operating Expenses	**$ 11,555,434**	**$ 29,237,562**	**$ 40,087,862**
FACILITIES INVESTMENTS			
Leased Space / New Building (State)	$ 10,600,000	$ -	$ -
Leased Space / New Building (Non-state)	$ -	$ -	$ -
Total Facilities Investments	**$ 10,600,000**	**$ -**	**$ -**
Total Expenses	**$ 22,155,434**	**$ 29,237,562**	**$ 40,087,862**
REVENUE			
Tuition and Fees	$ 1,207,500	$ 3,622,500	$ 6,037,500
Financial Aid	$ -	$ -	$ -
Community Donations	-	-	-
Clinical Practice/GME**	$ 2,474,960	$ 15,995,700	$ 23,224,420
Contract and Grants	$ 160,000	$ 400,000	$ 600,000
Total Revenue	**$ 3,842,460**	**$ 20,018,200**	**$ 29,861,920**
Net Income (Loss)	**$ (18,312,974)**	**$ (9,219,362)**	**$ (10,225,942)**
STATE APPROPRIATIONS*	$ 18,312,974	$ 9,219,362	$ 10,225,942

Financial Worksheet does not adjust for inflation
Operating Capital Outlay is the cost for new and/or replacement capital equipment at a rate of 2.5%
Other Personnel Services includes Basic Medical Science Contracts
*State Appropriations include Total State Operating Expenses and Facilities Investments
**Clinical Practice includes patient care revenues (faculty, residents and students) and resident Graduate Medical Education support

Table C1 - CODM Revenue and Expenditure Table

	Year 4	Year 5	Year 6
	FY 2018	**FY 2019**	**FY 2020**
OPERATING EXPENSES		**Full Enrollment**	
Faculty Salary and Benefits	$ 12,854,700	$ 12,945,825	$ 12,945,825
A&P Salary and Benefits	$ 1,149,350	$ 1,149,350	$ 1,149,350
USPS Salary and Benefits	$ 11,190,400	$ 11,190,400	$ 11,190,400
Other Personnel Services	$ 750,000	$ 750,000	$ 750,000
Resident Stipends & Benefits	$ 1,561,140	$ 1,561,140	$ 1,561,140
General Expenses	$ 14,866,276	$ 16,128,506	$ 16,128,506
Operating Capital Outlay	$ 1,911,097	$ 1,961,097	$ 1,961,097
Electronic Data Processing (IT)	$ 668,917	$ 673,062	$ 673,062
Library Resources	$ 232,721	$ 239,702	$ 239,702
Total Operating Expenses	**$ 45,184,601**	**$ 46,599,082**	**$ 46,599,082**
FACILITIES INVESTMENTS			
Leased Space / New Building (State)	$ -	$ -	$ -
Leased Space / New Building (Non-state)	$ -	$ -	$ -
Total Facilities Investments	**$ -**	**$ -**	**$ -**
Total Expenses	**$ 45,184,601**	**$ 46,599,082**	**$ 46,599,082**
REVENUE			
Tuition and Fees	$ 8,452,500	$ 9,660,000	$ 9,660,000
Financial Aid	$ -	$ -	$ -
Community Donations	-	-	-
Clinical Practice/GME**	$ 25,699,380	$ 25,699,380	$ 25,699,380
Contract and Grants	$ 800,000	$ 1,000,000	$ 1,000,000
Total Revenue	**$ 34,951,880**	**$ 36,359,380**	**$ 36,359,380**
Net Income (Loss)	**$ (10,232,721)**	**$ (10,239,702)**	**$ (10,239,702)**
STATE APPROPRIATIONS*	$ 10,232,721	$ 10,239,702	$ 10,239,702

Financial Worksheet does not adjust for inflation
Operating Capital Outlay is the cost for new and/or replacement capital equipment at a rate of 2.5%
Other Personnel Services includes Basic Medical Science Contracts
*State Appropriations include Total State Operating Expenses and Facilities Investments
**Clinical Practice includes patient care revenues (faculty, residents and students) and resident Graduate Medical Education support

C2 - Clinical Business Plan

This section presents a steady state business plan for CODM operated clinics. This includes the five community clinics that will be owned by the CODM but leased to community clinics and the clinics in the CODM campus facility. The clinical business plan is divided into three sections: 1) staffing, 2) assumptions on the operation of the clinical programs, and 3) projected clinic revenues and expenses.

A. Clinic Staffing

As seen in Table C2-1, each of the five community clinics are staffed with four provider groups (three faculty, two residents, four dental hygienists, and four dental students) and one clinic manager, two patient coordinators, three front desk staff, and 10 dental assistants. These clinics operate as real delivery systems and faculty practice as they supervise residents and students, and residents assist in the supervision of students.

Table C2-1
Staffing for CODM Clinics

Staff	Community	College of Dental Medicine			
	18 Chair Clinics (5)	29 Chair Full Service Clinics (2)	14 Chair Special Patient Clinic	40 Chair Student Clinic (6 months)	40 Chair Full Service Clinic (6 Months)
Faculty	15 FTE	8 FTE	4 FTE	-	8 FTE
Residents	10 FTE	12 FTE	4 FTE	-	6 FTE
Dental Students	20 FTE	4 FTE	-	70	10 FTE
Dental Hygienists	20 FTE	8 FTE	-	4	4
Clinic Managers	5	2	1	1	1
Patient Coordinators	10	4	2	3	3
Front Desk	15	6	2	3	3
Dental Assistants	50	26	10	14	12

For the dental clinics in the CODM campus facility, there are two 29-chair clinics, one 14 chair special patient clinic and a 40 chair third year student clinic. The later clinic will operate for about six months in two shifts per day for third year students. During this time, the clinic will operate as a conventional dental school clinic, and faculty will not practice while they supervise students. For the remaining six months this 40 chair clinic will be incorporated into the two 29 chair clinics and will operate as a real delivery system, thus for six months, there will be a total of 98 chairs used by faculty, residents, and senior students. As can be seen, all clinics will operate with a large group of dental hygienists, and administrative staff to assure effective use of provider time and student and resident experience working with a clinical and administrative support staff.

B. Operating Assumptions: Patients

Table C2-2 presents assumptions about the number of expected patient visits per year.

Table C2-2
Estimated Annual Patient Visits

Providers	Number	Chairs Per Provider	Patients/ Chair/ Day	Patient Visits/ Day	Maximum Days Available	Effective Utilization Rate	Patient Visits/Yr
Community Clinics (5)							
Faculty	15	2.0	6	180	220	80%	31,680
Residents	10	1.5	6	90	220	65%	12,735
Hygienists	16	1.3	6	150	220	80%	26,400
Dental Students	20	1.0	6	120	220	60%	15,840
29 Chair CODM (2)							
Faculty	8	2.0	6	96	220	80%	16,896
Residents	12	1.5	6	108	220	65%	15,444
Hygienists	12	1.3	6	60	220	80%	10,560
Dental Students	4	1.0	6	24	220	60%	3,168
14 Chair CODM Special Clinic							
Faculty	4	2.0	6	48	220	80%	8,448
Residents	4	1.5	6	36	220	65%	5,148
Hygienists	-	-	-	-	-	-	-
Dental Students	-	-	-	-	-	-	-
40 Chair Student Clinic (6 months)							
Faculty	-	-	-	-	-	-	-
Residents	-	-	-	-	-	-	-
Hygienists	4	5.0	6	30	110	80%	2,640
Dental Students	70	0.5	4	140	110	50%	7,700
40 Chair Full Service (6 months)							
Faculty	8	2.0	6	96	110	80%	8,448
Residents	6	1.5	6	54	110	65%	3,861
Hygienists	4	1.3	6	30	110	80%	2,640
Dental Students	10	1.0	4	60	110	60%	3,960
TOTAL							175,568

It is important to note the conservative assumptions underlying these visit estimates. Namely, clinics will only operate 220 days per year, and the effective utilization rates for faculty, residents, and students are low. If the clinics are well-run, the number of patient visits should be substantially higher than this estimate.

Under these conservative assumptions, the clinics should have 175,568 patient visits annually. The average patient can expect to have 2.3 visits, so the clinics will treat approximately 76,333 patients annually. In addition, residents and faculty will also be rotating through non-CODM clinics, hospitals, and private practices. As such, the total number of Panhandle patients treated annually is expected to approach 100,000.

C. Operating Assumptions: Salaries and Fringe Benefits

1. All faculty in the five community clinics will be expected to generate 80 percent of their salaries from clinic patient care revenues. Twenty percent will come from the CODM.

2. All faculty providing care in the CODM clinics will be expected to generate revenue, general dentistry 50 percent and specialists 60 percent from clinic patient care revenues. The remaining percentage will come from the CODM.

3. Faculty fringe benefit rates are 21.5 percent of salaries.

4. The average annual salary of general dentists is $165,000.

5. The average annual salary of specialists is $210,000.

6. All clinical support staff (clinicians and administrators) are funded 100 percent from patient care revenues.

7. Clinical support staff salaries are based on the market average for the Panhandle area.

8. Clinical support staff fringe benefit rates are 30 percent of salaries.

9. Resident will receive GME support to cover their salaries ($45,000) and fringe benefits.

10. GME support will provide $15,000 administrative support per resident.

D. Operating Assumptions: Charges and Fees

1. The average per visit reimbursement rate in community clinics is estimated to be $120. A survey of clinics indicated a range of rates around $120 for Medicaid patients that make up about 70 to 80 percent of patients. A few CHDCs have rates of over $175 per visit. This takes into account the reduction in reimbursement rates since the recession. In general, CHDCs have much higher per visit rates than FQHCs. However, for the 20 to 30 percent of patients not covered by Medicaid, FQHCs receive a 330 grant to cover indigent care; a small percentage of patients (e.g., 5%) have private insurance and much higher fee-for-service reimbursement rates; and some patients pay on a sliding scale. Taking all these different factors into account, the $120 estimate is conservative and is likely to increase by the time the CODM clinics begin operations.

2. The CODM clinics are likely to serve faculty, staff and students of the University. Some chairs may be leased to FQHCs or CHDCs. The expectation is that the CODM will keep faculty and resident fees/charges relatively low, and therefore, the $160 per visit estimate is used in the financial calculations. This is a higher rate than the community clinics, because more specialty care will be provided, and more patients will have private dental insurance or the capacity to pay low fees/charges. The latter include University faculty, staff, and students.

E. Revenues and Expenses: Community Clinics

1. Revenues – Table C2-3 presents expected revenues from one of the five community clinics owned by the University but leased to a community clinic. As can be seen most revenues are generated by faculty, residents, and hygienists. Only 10 percent of the budget comes from State educational support to cover 20 percent of faculty salaries.

Table C2-3
Revenues from One University Owned Clinic but Leased to an FQHC or County Clinic

Revenue	FTEs	Budget
Faculty Clinical Income	3	$1,013,760
Resident Clinical Income	2	$308,880
Hygienist Clinical Income	4	$663,600
Senior Student Clinical Income	4	$380,160
Junior Student Clinical Income	-	-
Graduate Medical Education		$138,560
State Support		$195,810
Total		**$2,670,770**

2. Expenses – Table C2-4 presents expected expenses from one of the five community clinics owned by the University, but leased to a community clinic. The major expenses are related to personnel costs. Each clinic is expected to generate a small surplus.

Table C2-4
Expenses from One University Owned Clinic but Leased to an FQHC or County Clinic

Expense	FTE	Budget
Faculty Salaries	3	$535,000
Faculty Benefits		$117,700
Staff Salaries	18	$631,000
Staff Benefits		$189,300
Resident Stipends	2	$92,000
Resident Benefits		$16,560
Patient Care Contracts		$46,728
Supplies		$303,732
Lab Bills		$93,456
Repairs and Maintenance		$70,092
Sterilization		$46,728
Faculty Malpractice		$1,500
Resident Malpractice		$600
Facilities		$210,276
Information Technology		$46,728
Equipment Capitalization		$70,092
Miscellaneous		$46,728
Dean's Administrative Fee		$70,092
University Administrative Fee		$46,728
Total		$2,635,040

F. Revenues and Expenses: CODM Clinics

1. Revenues - This is a steady state estimate of revenues when the CODM clinics are fully staffed and operating. The data is for all CODM clinics combined. A more detailed estimate of revenue and expenses by CODM clinic is available each year for a seven-year period.

   Table C2-5 presents CODM clinic revenues. As can be seen, clinically generated revenues come to $12 million. The other major source of revenue is GME support and State appropriations for a total $14.5 million.

Table C2-5
CODM Clinic Revenues

Revenue	FTEs	Budget
Faculty Clinical Income	16	$5,406,720
Resident Clinical Income	19	$2,934,360
Hygienist Clinical Income	12	$1,900,800
Senior Student Clinical Income	9	$855,360
Junior Student Clinical Income	70	$924,000
Graduate Medical Education		$1,303,340
State Appropriations		$1,233,725
Total		$14,558,305

2. Expenses - The steady state estimate of expenses is seen in Table C2-6. As expected, the major expenses are mainly related to faculty, staff, and resident salaries. Other notable expenses include supplies, facilities, and prosthetic laboratory charges.

Table C2-6
CODM Clinic Expenses

Expense	FTE	Budget
Faculty Salaries	20	$3,505,000
Faculty Benefits		$771,100
Staff Salaries	81	$ 2,785,000
Staff Benefits		$835,500
Resident Stipends	19	$863,000
Resident Benefits		$155,340
Patient Care Contracts		$240,425
Supplies		$1,562,761
Lab Bills		$480,850
Repairs and Maintenance		$360,637
Sterilization		$240,425
Faculty Malpractice		$10,000
Resident Malpractice		$5,700
Facilities		$1,081,912
Information Technology		$240,425
Equipment Capitalization		$360,,637
Miscellaneous		$240,425
Dean's Administrative Fee		$360,637
University Administrative Fee		$240,425
Total		$14,340,198

Appendix D
Panhandle Dental Safety Net System

Estimation of Patients Treated

1. Based on FQHC data, 4.96 dentists and 10.84 hygienists provided care to 14,713 patients or 931.20 patients per provider.

2. Assuming Bond clinic has one dentist and one hygienist, this adds 1,862 additional patients to FQHC output for a total of 16,575 patients.

3. For the CHDCs, there are a combined total of 45.82 dentists and hygienists. Assuming the same patient care output as FQHCs, the estimated number of patients treated annually is 42,668.

4. The total Panhandle dental safety net system is caring for about 59,243 patients annually with 34.88 dentists.

Data

FQHCs

Center	County	Dentists	Hygienists	Patients	Operatories
PanCare Community Health Center	Bay	0.94	0.83	2,273	8
Family Health Centers Columbia County	Columbia	0.00	0.00	0	0
Escambia Community Clinics	Escambia	0.00	0.00	0	0
Trenton Medical Center	Gilchrist	0.00	0.00	0	0
St. Joseph's Care of Florida	Gulf	2.00	6.24	7,783	4
Bond Community Health Centers *	Leon	1.00	1.00	1,862	4
Liberty CHDC - FQHC	Liberty	1.00	1.00	700	3
North Florida Medical Centers	Taylor	1.02	2.77	3,957	4
Totals		5.96	11.84	16,575	23

*Estimate.

County Health Department Clinics

County Health Department Clinic	Operatories	Dentists	Hygienists
Baker County Health Department	4	1	1
Baker County Health Department	2	0.8	1
Dixie County Health Department	5	1	1
Dixie County Health Department	2		
Escambia County Health Department	3	0.2	
Escambia County Health Department	7	3.42	1
Escambia County Health Department	2		
Escambia County Health Department	3	1	
Escambia County Health Department	3	1	
Gadsden County Health Department	4	2	1
Gilchrist County Health Department	2		
Gulf County Health Department	4	1	1
Gulf County Health Department	4	1	1
Holmes County Health Department	3	0.9	1
Jackson County Health Department	3	0.9	1
Jackson County Health Department	2	0.9	1
Jefferson County Health Department	3	1	0.4
Jefferson County Health Department	2	1	
Lafayette County Health Department	4	1	1
Leon County Health Department	12	3	3
Liberty County Health Department	2	1	1
Madison County Health Department	3	1	
Okaloosa County Health Department	4	1.8	
Santa Rosa County Health Department	3	1	0.5
Taylor County Health Department	4	1	
Wakulla County Health Department	2	1	
Washington County Health Department	3	1	1
TOTALS	95	28.92	16.9

APPENDIX E:
Estimates of FAMU CODM Economic Impact

June 13, 2011

I. EXECUTIVE SUMMARY

As part of a contract with Florida A&M University to determine the feasibility of and potential models for the addition of a College of Dental Medicine (CODM), MGT of America (MGT) was asked to determine the economic impact of this prospective entity on the State and the Panhandle region that it would serve.[1] Using standard economic impact models and multipliers published by the United State's Bureau of Economic Analysis, MGT determined the estimated direct and indirect impact associated with initial development of the CODM, through its first 10 year of operation, in terms of total economic activity (dollars) and contributions to the labor force (jobs).

The study revealed that, over its first 10 years of operation, the CODM's development and operation would yield a total statewide impact of **$868 million**, of which **$775 million** would occur locally within the Panhandle region. This economic activity would result in the creation of nearly **2,300 short-term jobs** (2,100 locally) as the facilities are designed and constructed, and over **1,100 sustained jobs** (1,000 locally) at full operating capacity.[2]

Included below are the various components of development and operation considered in this analysis, along with associated dollars and jobs created by respective market area.

- Construction and development of the main campus and regional clinics involving $105 million in direct expenditures would yield:
  - $206 million in activity and 1,998 short-term jobs in the region.
  - $228 million in activity and 2,188 short-term jobs in the state.
- Cumulative operations involving $269 million in direct expenditures would yield:
  - $496 million in activity and 868 sustained jobs in the region.
  - $557 million in activity and 945 sustained jobs in the state.
- Student living expenses in the communities amounting to $41 million in direct expenditures would yield:
  - $71 million in activity and 164 sustained jobs in the region.
  - $81 million in activity and 182 sustained jobs in the state.

1 Impacts for more comprehensive (larger) geographic regions entail larger dollar amounts due to a broader service array available (and therefore less leakage of expenditures to outside areas). A detailed explanation of economic impact, as well as the counties included in the Panhandle region for this analysis, is included in *Section II: Methodology*.

2 Estimates for job creation were 2,092 jobs in the region, or 2,294 across the state, for facility development and construction, and 1,035 regional jobs, or 1,130 across the state, for ongoing operations.

- Visitor expenditures and impact amounting to $759 thousand would yield:
  - $1.3 million in activity and 3 sustained jobs in the region.
  - $1.5 million in activity and 3 sustained jobs in the state.

- Grand total development and operations over 10 years resulting in:
  - $775 million in activity and 3,127 short-term or sustained jobs in the region.[3]
  - $868 million in activity and 3,424 short-term or sustained jobs in the state.

A summary of various impacts associated with the construction and operation of the CODM is presented in Exhibit 1.

EXHIBIT 1
SUMMARY OF ACTIVITY AND ASSOCIATED IMPACT
FAMU CODM, FULL OPERATING CAPACITY AND CUMULATIVE FY2013 THROUGH FY2022

COMPONENT	ANNUAL ACTIVITY AT FULL OPERATING CAPACITY	CUMULATIVE (10-YEAR) ACTIVITY AND IMPACT
Direct Expenditures for Operations and Ongoing Activities*	$52,044,459	$310,584,225
Direct Expenditures for Facility Construction**	n/a	$105,385,572
Total Regional Economic Impact	$95,235,755	$774,639,386
Regional Short-Term Job Creation (Construction)	2,092	n/a
Regional Sustained Job Creation (Operations)	1,035	n/a
Total Statewide Economic Impact	$106,999,418	$867,623,464
Statewide Short-Term Job Creation (Construction)	2,294	n/a
Statewide Sustained Job Creation (Operations)	1,130	n/a

Source: Estimates of employment, enrollment, and expenditures per FAMU; associated impact estimated per RIMS II multipliers developed by Bureau of Economic Analysis.
*Includes cumulative CODM operating expenses, student living expenses, and assorted visitor expenses.
**Includes one-time expenditures for FAMU CODM main campus and regional clinic development and construction.

[3] Represents the sum of short-term jobs associated with development and construction of CODM and all permanent positions associated with its full scale (ongoing) operations.

II. METHODOLOGY

The total output or economic impact associated with the FAMU CODMs development and operation amounts to the sum of its direct impact (all attributed expenditures) plus its indirect impact, or the successive spending that is induced by the original investments. MGT derived its estimates of impact utilizing a standard, conservative methodology for impact relying on economic multipliers published by the United States Bureau of Economic Analysis.

Indirect or induced spending is estimated via application of a multiplier to the direct expenditure values. Multipliers are derived based on market-specific estimations of how much "leakage" occurs each time dollars are spent on particular goods or services (that have to be sought outside of the local market), versus how many of those dollars are retained and spent again in the local economy.

- ***Illustration:*** *Assume that for every $100 invested in a community by the focus organization, the recipients of those funds will spend $60 in the local economy, while $40 is spent on goods or services outside of the market area. The $60 that is reinvested into the local economy endures a second cycle of spending, losing another 40 percent in magnitude, but leaving the remaining 60 percent ($36 at this stage) invested back into the local economy. This process is repeated until all the dollars have effectively leaked out of the local market, with the effect being that the cumulative impact is much greater than the initial investment.*

  In this example, with 60 percent of funds being retained in each transaction, the multiplier can be estimated to have a value of about 2.50 – which is to say, every $100 spent in the market results in approximately $250 of output in the local economy.

Related multipliers can also be developed and used to estimate the employment impact of the expenditures associated with the organization's operation. In this context, the dollars invested into the regional economy are used to estimate the number of jobs that can be generated or sustained in the selected labor market.

The Panhandle region impacted by the CODM is defined by the areas either housing or served by the FAMU CODM main campus or regional clinics. These include:

- Bay
- Calhoun
- Dixie
- Escambia
- Franklin
- Gadsden
- Gulf
- Hamilton
- Holmes
- Jackson
- Jefferson
- Lafayette
- Leon
- Liberty
- Madison
- Okaloosa
- Santa Rosa
- Suwannee
- Taylor
- Wakulla
- Walton
- Washington

The components included in the assessment of financial impact include:

- Construction costs and associated equipment expenditures for both the biomedical sciences facility and dental clinic on FAMU's main campus as well as the five regional dental clinics.

- Annual operating expenditures for the CODM including personnel, utilities, equipment leasing, maintenance, etc.

- Student and resident living expenditures including housing, food, retail, and other miscellaneous costs.

- Visitor expenditures, or an account of dollars associated with unofficial or official visitors to the area, that have come to see friends, family or colleagues represented in the CODM community of faculty, staff, residents, and students. Encompassed within these expenditures are costs for lodging, food, travel, and other retail purchases.

III. COMPONENT ANALYSIS

Exhibit 2 presents an account of expected operating expenditures, by category, alongside their estimated regional and statewide impact. Both annual (full capacity) and 10year cumulative totals are depicted.

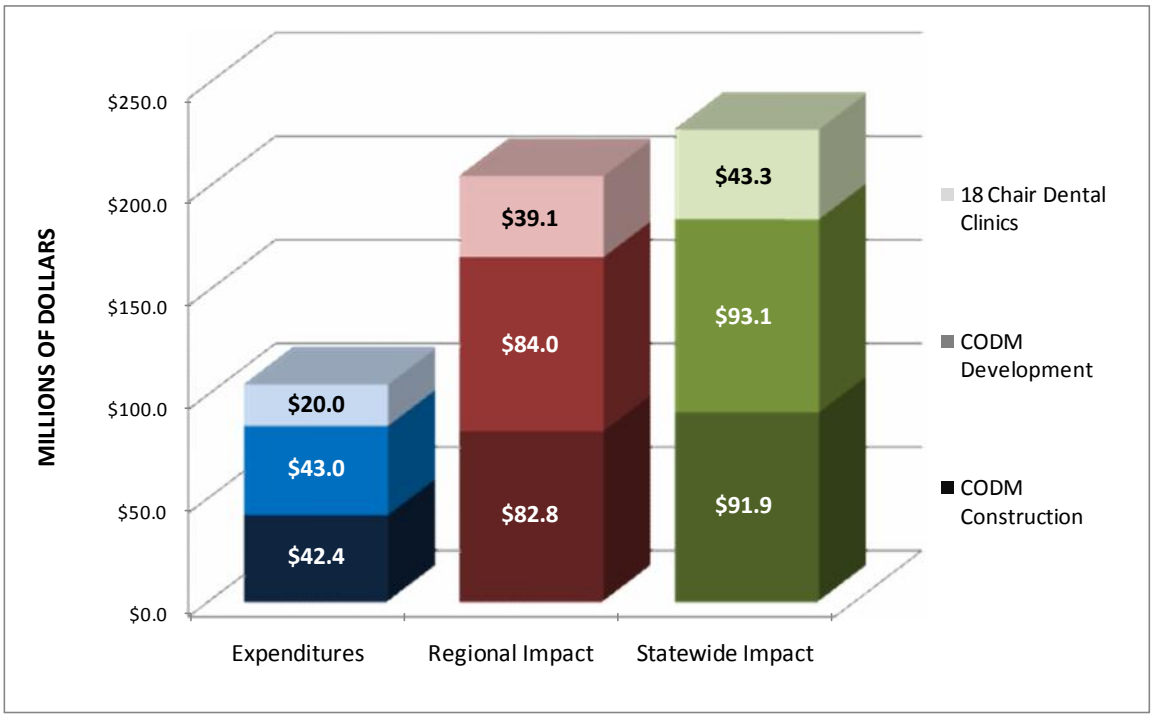
EXHIBIT 2
OPERATING EXPENDITURES AND ASSOCIATED ECONOMIC IMPACT: ANNUAL LEVELS AT FULL CAPACITY (FY2020-) AND TEN-YEAR CUMULATIVE (FY2013-FY2022)

	EXPENDITURES		REGIONAL ECONOMIC IMPACT		STATEWIDE ECONOMIC IMPACT	
COMPONENT	At Full Operating Capacity	10-Year Cumulative (FY2013-22)	At Full Operating Capacity	10-Year Cumulative (FY2013-22)	At Full Operating Capacity	10-Year Cumulative (FY2013-22)
Faculty Salaries	$10,655,000	$67,345,000	$20,206,142	$127,713,058	$22,379,762	$141,451,438
Faculty Benefits	$2,290,825	$14,479,176	$4,428,852	$27,992,591	$5,057,225	$31,964,229
A & P Salaries	$905,000	$6,691,250	$1,675,517	$12,388,180	$1,916,609	$14,170,729
A & P Benefits	$244,350	$1,806,638	$472,402	$3,492,772	$539,427	$3,988,333
USPS Staff Salaries	$2,668,000	$18,433,250	$4,870,701	$33,651,741	$5,543,304	$38,298,764
USPS Staff Benefits	$800,400	$5,529,975	$1,547,413	$10,691,101	$1,766,963	$12,207,973
Clinical Staff Salaries	$5,940,000	$33,189,000	$11,372,130	$63,540,341	$12,985,434	$72,554,473
Clinical Staff Benefits	$1,782,000	$9,956,700	$3,445,141	$19,249,288	$3,933,943	$21,980,411
Resident Stipends	$1,323,000	$7,482,000	$2,532,884	$14,324,289	$2,892,210	$16,356,400
Resident Benefits	$238,140	$1,346,760	$460,396	$2,603,691	$525,718	$2,973,107
Basic Science Teaching	$750,000	$5,600,000	$1,422,300	$10,619,840	$1,575,300	$11,762,240
Operating Expenses	$8,600,172	$48,631,374	$16,309,366	$92,224,538	$18,063,801	$102,145,338
Capital Equipment	$1,961,097	$17,412,964	$3,172,761	$28,171,564	$3,698,629	$32,840,850
Facilities Operating Cost	$2,960,259	$16,370,306	$4,442,461	$24,566,918	$4,647,607	$25,701,380
Instrument Leasing	$2,100,000	$10,500,000	$3,551,048	$17,755,238	$4,147,658	$20,738,288
Library	$340,779	$3,268,437	$646,253	$6,198,264	$715,772	$6,865,025
Budget Reserve	$117,137	$600,055	$198,360	$1,016,133	$253,531	$1,298,759
TOTAL OPERATING	**$43,676,159**	**$268,642,885**	**$80,754,125**	**$496,199,546**	**$90,642,893**	**$557,297,737**

Source: Expenditure levels per preliminary estimates by FAMU. Economic impact levels generated via RIMS II multipliers developed by the Bureau of Economic Analysis.

Exhibit 3 shows the expected capital expenditures alongside estimated regional and statewide impacts. This account includes development and construction of both the CODM main campus facilities as well as the regional dental clinics, and represents a single (non-recurring) impact associated with the development of the CODM.

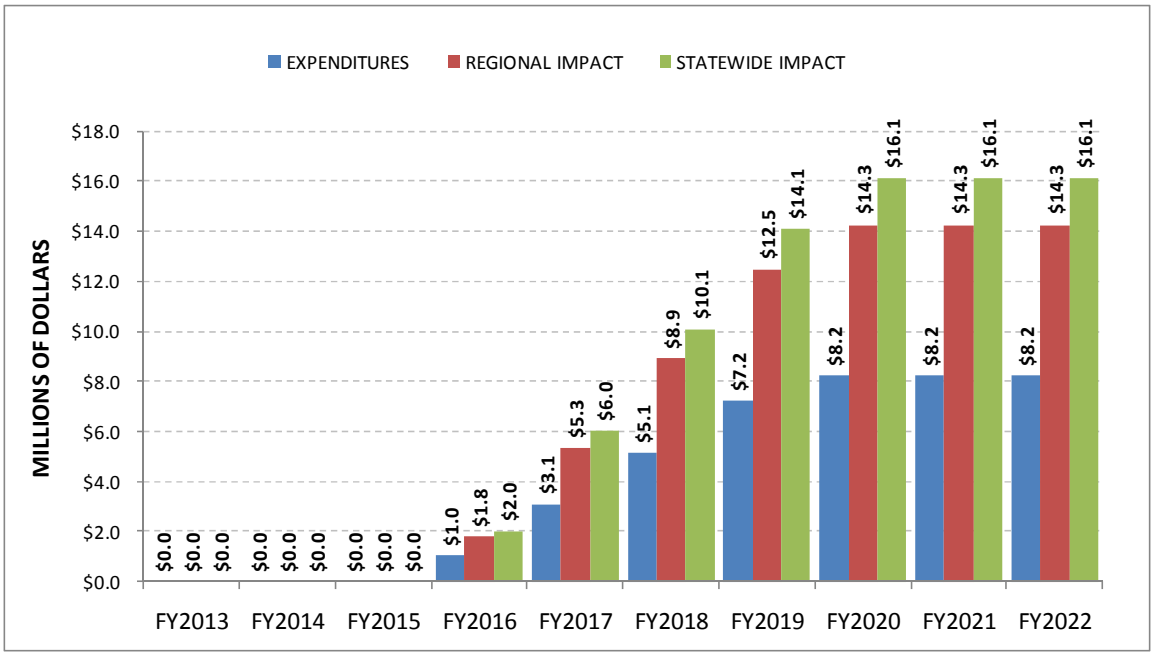
EXHIBIT 3
CAPITAL EXPENDITURES AND ASSOCIATED ECONOMIC IMPACT
FY2012-13 (MILLIONS OF DOLLARS)



Source: Expenditure levels per preliminary estimates by FAMU; economic impact levels generated via RIMS II multipliers developed by the Bureau of Economic Analysis.

As noted previously, a third component of expenditures and impact associated with operation of the CODM are the living expenses incurred by students and residents. The anticipated enrollment build-out entails an initial class of 35 students enrolling in 2015-16, and an additional 70 students enrolling in the four-year program each year thereafter, which entails 280 students living in the communities, generating economic activity, when operating at full capacity. Exhibit 4 shows the expected amounts of dollars invested into the local economy by these students, as well as the associated estimated regional and statewide impacts. The amounts per student were determined based on the Florida State University College of Medicine's estimates of its students' total cost of attendance, isolating dollars that would be distributed into local businesses, versus being absorbed back into the institution. (For example, the figures include items such as room and board, but exclude items such as tuition and fees.)

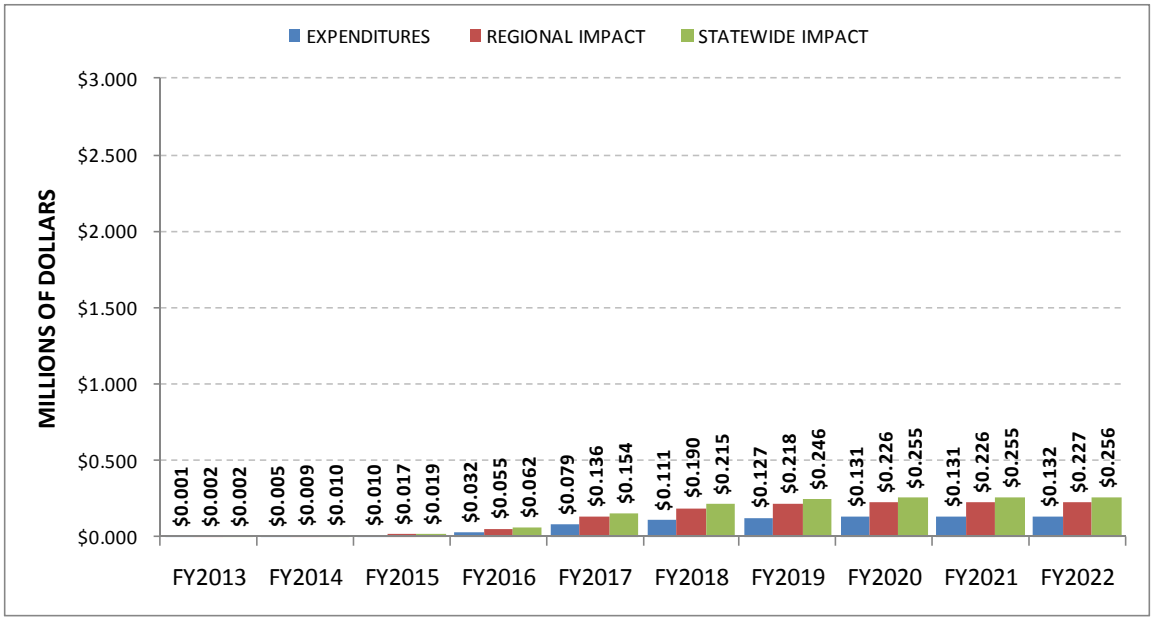
EXHIBIT 4
ESTIMATED STUDENT LIVING EXPENDITURES AND ASSOCIATED IMPACT
FY2013 THROUGH FY2022 (MILLIONS OF DOLLARS)



Source: Enrollment levels per FAMU; economic impact levels generated via FSU COM estimates of annual student expenses (excluding tuition and fees) and RIMS II multipliers developed by Bureau of Economic Analysis.

A final category of economic impact is the expected dollars invested into the local economies by colleagues, friends, and family members as they visit the students, residents, and employees of the CODM (Exhibit 5). The amounts depicted are based on very conservative estimates of the number of visitors to each segment of individuals, in conjunction with estimates of typical travel expenses including hotels, food, and other miscellaneous items.

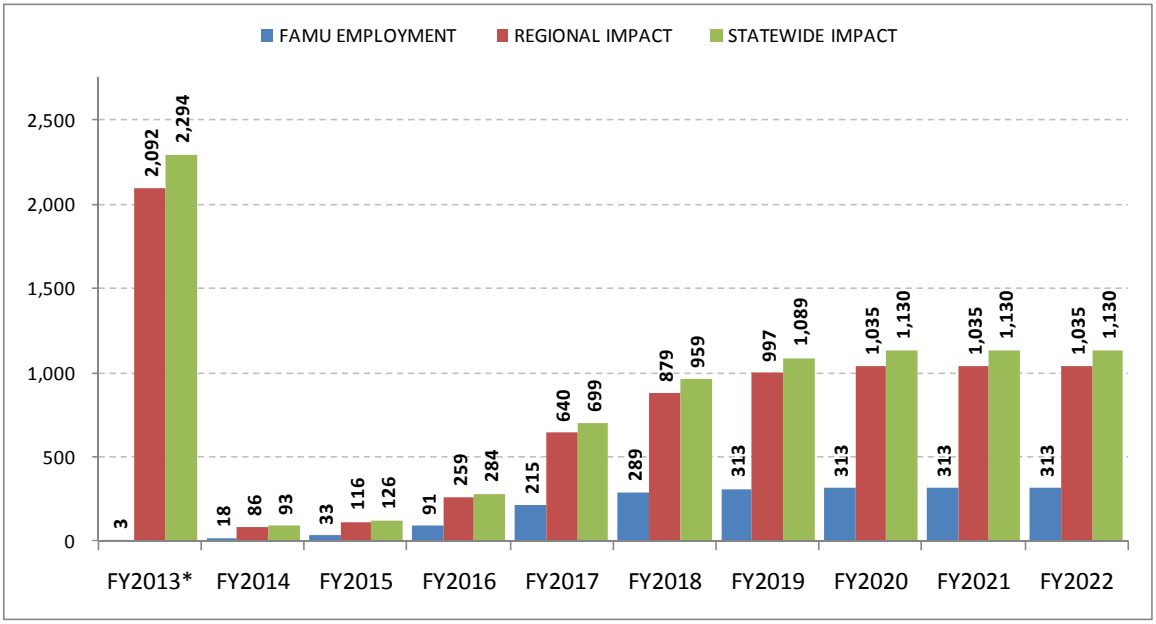
EXHIBIT 5
ESTIMATES OF STUDENT, RESIDENT, AND STAFF VISITOR EXPENDITURES FY2013 THROUGH FY2022 (MILLIONS OF DOLLARS)



Source: Based on FAMU estimates of students, residents, and faculty/staff, estimates of numbers of and typical expenditures by visitors per each group, and associated impact for activities per RIMS II multipliers developed by the Bureau of Economic Analysis.

The impact noted above also can be translated into an estimate of job creation. Exhibit 6 presents the estimated trend in total employment impact (jobs created in local economies) from the CODM's construction through its tenth-year of operation. Note that the initial job creation associated with development and construction of the CODM is considered to be short-term (i.e., not expected to persist beyond completion of facilities), while jobs associated with operations are expected to persist through the life of the CODM.

EXHIBIT 6
DIRECT JOB CREATION AND STATE AND REGIONAL EMPLOYMENT IMPACT (NUMBER OF JOBS) FROM ALL FAMU CODM OPERATIONS AND ASSOCIATED ACTIVITIES, FY2013 THROUGH FY2022



Source: Per expenditure and impact levels noted above and associated impact per RIMS II multipliers developed by the Bureau of Economic Analysis.
*Includes all jobs created as a function of construction of FAMU CODM main campus facilities and regional clinics.

Appendix F
Letters of Support

MEHARRY
MEDICAL COLLEGE

SCHOOL OF DENTISTRY
Office of the Dean

April 20, 2011

Dr. James H. Ammons
President
Florida A& M University
Office of the President
1601 Martin Luther King Jr. Blvd.
Suite 400, Lee Hall
Tallahassee, Florida 32307-3200

Dear President Ammons,

It is with great pleasure that I offer my support for a planned new school of dentistry at Florida A&M University (FAMU). This will mark the first time since 1886 and the founding of the Meharry Dental Department at Meharry Medical College that there has been a dental school opened at a Historically Black Institution. With access to oral health care at the forefront of national conversations and the largest burden of oral disease found in minority and underserved populations, it is imperative that we increase the number of minority and other providers who will be able to address the issues facing oral health care access in the nation.

A 2005 Multicultural Survey by the American Dental Association (ADA) showed that minority dentists are more likely to serve patients of their own racial/ethnic background. Based on the number of private practitioners in the U.S. population by race, Blacks and Hispanics are under-represented in the dental profession. In addition, the numbers of minority students enrolled in dental schools in the country also remain very low. As you are aware, Meharry has for over a hundred years produced a significant number of the minority dentists in the country. It is critical that as we move closer to a model of providing more comprehensive health care, including oral health, where we are producing an adequate number of oral health practitioners that will service our most vulnerable populations.

The need for a more robust workforce in dental health care is clear. The proposal for a new school of dentistry at FAMU will surely help to improve the numbers of minority practitioners in the country. While this will not serve as a definitive solution, it will go a long way in addressing the needs associated with access to care and workforce issues in dentistry. The issues surrounding access to oral health care is complex and multifactorial. As we continue to grapple with health care reform and how it will shape the health of our nation over the next decade, we must not forget the millions in our communities who continue to suffer from the lack of much needed dental care.

1005 DR. D.B. TODD JR. BOULEVARD
NASHVILLE, TENNESSEE 37208-3599
T:615.327.6207| F:615.327.6213|www.mmc.edu

Dr. Ammons, your support in bringing a dental school to FAMU is to be commended as well as your interest in improving oral health in your community and the country. I wish you and your team well in this endeavor and am happy to assist you if needed as you move forward in this process.

Sincerely,

Janet H. Southerland, DDS, MPH, PhD
Dean and Professor
School of Dentistry
Meharry Medical College

/scs

HOWARD
UNIVERSITY

College of Dentistry
Office of the Dean

April 12, 2011

Dr. James H. Ammons
Office of the President
Florida A & M University
1601 Martin Luther King Jr. Blvd.
Suite 400, Lee Hall
Tallahassee, Florida 32307-3200

Dear President Ammons:

It is my pleasure to write a letter of support for the development and establishment of a College of Dentistry at Florida A & M University in Tallahassee, Florida; an institution that prepares its' graduates with the knowledge, skills and values for leading in national and global communities.

I have the distinct privilege to serve as the Dean of the Howard University College of Dentistry, one of two Historically Black College and University Dental Schools. The other institution is Meharry Medical College's School of Dentistry. Florida A & M University has the proud historic tradition of educating African Americans, while embracing persons of all races, ethnic origins and nationalities. A third HBCU Dental School will serve our community well, especially in ensuring the continued pipelining of underrepresented minorities and underprivileged persons into communities that are underserved. I would anticipate that the FAMU program would engage in new models of dental education; such as partnerships with Community Based Health Centers with Interprofessional Collaborative practice models.

I also believe that this initiative lends itself well to the FAMU Strategic Initiative 1, Goal 1.5 of their Strategic Plan – Develop and implement new degree programs based on University priorities. In my opinion, that priority lends itself well to implementing a new Dental School focused on the needs of our community in access to care and student demands.

Please let me know how I can be of further assistance to you as you develop this rich opportunity for your institution.

Sincerely,

Leo E. Rouse, DDS, FACD
Dean

600 W Street, NW
Washington, DC 20059

Telephone 202 806 0440
Facsimile 202 806 0354
www.howard.edu

TAMPA BAY AREA DENTAL ASSOCIATION

March 19, 2010

To Whom It May Concern:

By understanding the disparities in oral care for the poor, some minorities, the elderly and the other groups, we have a moral obligation in making dental treatments available by creating strategic partnerships between dental institutions and the community.

We the members of the Tampa Bay Area Dental Association support FAMU in its endeavors to build a dental school in the Panhandle Area.

Respectfully Submitted,

Dr. Clarence L. McNair

Dr. Clarence L. McNair

President

CLARENCE L. McNAIR D.D.S.,M.S,D.,M.P.H. PRESIDENT

WILLIAN MARSAH D.D.S.,M.S. VICE PRESIDENT

DURO OGUNTEBI D.D.S., M.S. SECRETARY

FREDRICK PRATT D.D.S. TREASURER

18123 Kara Ct. Tampa Fl. 33647

813-408-5371

Sunshine State Dental Association

March 20, 2010

Dr. James H. Ammons, President
Florida A&M University
1601 Martin L. King Blvd.
Tallahassee, Florida 32307

Dear Dr. Ammons:

As one of the premier professional dental organizations in the country, representing the concerns of minority constituents throughout the State of Florida, the Sunshine State Dental Association enthusiastically supports the establishment of a dental training program at Florida A&M University.

For well over 120 years Florida A&M University has been changing families and lives all over the country and the world by providing opportunities for minority students to further their educational goals and provide unlimited lifetime opportunities. It has also been more than 120 years since the formation of a minority dental program in the United States. Meharry Medical College School of Dentistry was established in 1886 and Howard University College of Dentistry was established in 1881. The development of a FAMU dental school would impact the lives of thousands of patients as well as providers by increasing the number of minority dentists produced annually, decreasing oral health disparities among minorities and greatly increasing access to dental care for underserved populations.

For a number of years, Florida A&M University has been the number one producer of African American Baccalaureate Scholars in the United States. It is an institution of higher learning that attracts some of the best and brightest students in the country. It would be ideal for an institution of its caliber to ignite the flame that sparks a change in the bleak outlook of oral healthcare among minority populations. The formation of a dental program at Florida A&M University would be instrumental in making a shift in the train of thought as related to dental health.

Producing more minority dentists is pivotal to increasing access to care, as trends show that dentists from minority populations are more likely than whites to practice in underserved, lower-income minority communities.

In the United States the burden of sickness and early death is distributed along racial lines. The burden is especially heavy for African Americans who suffer disproportionately from nearly every major cause of death. The principle is the same as it relates to oral disease. Among Florida adults, 59% of Asian Americans are diagnosed with destructive periodontal disease, 34% of older Black Americans lose all of their teeth and Black men have the highest rate of oral cancer diagnosis but the lowest survival rates. In more recent times, research has increasingly shown that there is a direct correlation between poor oral health and heart disease, strokes and other diseases.

The establishment of a dental program at FAMU would be an enormous asset to Tallahassee as well as the surrounding underserved communities. The student dental clinic would be a great source of dental care for the uninsured as well as the lower income families.

It is therefore, with great pride that the Sunshine State Dental Association enthusiastically supports the development of a dental program at Florida A&M University.

Sincerely,

Robbin Quarterman, President
Sunshine State Dental Association

FROM THE GOVERNING BODY OF THE CITY OF TALLAHASSEE

PROCLAMATION

RESOLUTION

A RESOLUTION OF THE CITY COMMISSION OF THE CITY OF TALLAHASSEE SUPPORTING THE CREATION OF A COLLEGE OF DENTAL MEDICINE AT FLORIDA A&M UNIVERSITY TO ADDRESS THE ORAL HEALTH CARE NEEDS OF FLORIDA'S RURAL AND UNDERSERVED COMMUNITIES.

WHEREAS, the Pew Center on the States in February 2010 issued a report entitled "The Cost of Delay: State Dental Policies Fail One in Five Children"; and,

WHEREAS, Pew assessed and graded all fifty states and the District of Columbia on eight oral health categories and Florida was only one of six states to receive an "F" grade, passing only two of the eight benchmarks aimed at addressing children's dental health needs; and,

WHEREAS, the Pew study also determined that less than a quarter of Florida's children have access to dental services and that the Sunshine State faces a severe dental workforce shortage and needs at least 750 new dentists – almost one-tenth of all of the new dentist needed nationwide--- to provide care to underserved citizens; and,

WHEREAS, Florida has only 49.4 dentists per 100,000 residents, according to the Florida Department of Health; and,

WHEREAS, high quality oral health has been linked to good overall health and the prevention of heart disease; and,

WHEREAS, a lack of oral health care has been linked to diabetes, respiratory diseases, pregnancy problems, and other health care issues; and,

WHEREAS, Florida A&M University has a longstanding history in health education dating back to 1936; and operates a School of Nursing, College of Pharmacy, School of Allied Health, and an Institute of Public Health; and,

WHEREAS, Florida A&M University has undertaken a rural health care initiative to address some of the critical health care shortages in Florida's rural and underserved communities by creating strategic partnerships with local governments, county health departments, federally qualified health clinics, hospitals, safety net clinics, and other health providers; and,

WHEREAS, Florida A&M University proposes to establish dental clinics in rural and underserved areas of our state and to help expand the offering of existing county health departments, federally qualified health clinics, safety net clinics, and hospitals; and,

WHEREAS, preventive care saves city, county, and state dollars designated for health care;

IT IS HEREBY RESOLVED BY THE CITY COMMISSION OF THE CITY OF TALLAHASSEE AS FOLLOWS:

(1) The City supports the goals and ideals of the establishment of a College of Dental Medicine at Florida A&M University and its rural health care initiative; and,

(2) Calls upon the Florida Board of Governors to authorize the establishment of a College of Dental Medicine at Florida A&M University; and,

(3) Calls upon the Florida Legislature to provide appropriate funding to establish a College of Dental Medicine at Florida A&M University, with the understanding that the school will be created with the expressed purpose to address the needs of rural and underserved populations within our state.

IN WITNESS WHEREOF I HAVE HEREUNTO SET MY HAND AND CAUSED THE SEAL OF THIS CITY TO BE AFFIXED.

SEAL OF THE CITY OF TALLAHASSEE INCORPORATED A.D. 1825

MAYOR _____

DATE February 29, 2011

SANTA ROSA COUNTY
BOARD OF COMMISSIONERS

Santa Rosa Administrative Offices
6495 Caroline Street, Suite M
Milton, Florida 32570-4592

JIM WILLIAMSON, District 1
ROBERT A. "BOB" COLE, District 2
W. D. "DON" SALTER, District 3
JIM MELVIN, District 4
R. LANE LYNCHARD, District 5

HUNTER WALKER, County Administrator
ANGELA J. JONES, County Attorney
JOEL D. HANIFORD, OMB Director

April 13, 2011

Dr. James H. Ammons, President
Florida A&M University
1601 Martin Luther King Jr. Blvd.
Suite 400
Tallahassee, Florida 32307

Dear President Ammons:

At the April 14, 2011 meeting the Santa Rosa County Board of Commissioners unanimously approved submission of this letter of support to the College of Dental Medicine (CODM) at Florida A & M University (FAMU). The mission of the CODM is to serve the citizens of Florida by recruiting students and residents from disadvantaged backgrounds and producing graduates who are committed and prepared to practice in underserved rural and urban areas. Access to care is a critical issue for the citizens of Florida, especially those who reside in rural, underserved areas including Santa Rosa County, and there is no doubt that some specialties are over burdened and unable to meet the demands of care in a timely manner.

The CODM is an innovative approach to community based education, scholarly research, patient services, and oral health education. As a part of this innovative approach, the CODM will partner with the Santa Rosa County Health Department and the Escambia Community Clinic, a Federally Qualified Health Center which encompasses the Santa Rosa Community Clinic. If FAMU is successful in securing the College of Dental Medicine, there are many opportunities for collaboration between the two organizations to address the specific aspects of the initiative.

The University will partner with community based organizations such as the Santa Rosa County Health Department and Escambia Community Clinic in capacity-building efforts which will provide the knowledge, values and skills needed for people to make healthy choices as well as address the critical manpower needs of the 21st Century. We believe the challenges we face within oral healthcare provision should be approached through a collaboration of educational and community leaders.

This is a welcomed initiative and the Santa Rosa County Board of Commissioners looks forward to the partnership in such a great community effort. Thank you for your consideration, this matter of mutual interest.

Sincerely,

R. Lane Lynchard

Lane Lynchard, Chairman
Santa Rosa County Board of Commissioners

FACHC

THE VOICE OF PRIMARY CARE

Florida Association of Community Health Centers, Inc.

Dr. James H. Ammons
President
Florida A&M University
1601 Martin Luther King Blvd.
Lee Hall, Suite 400
Tallahassee, FL 32307-3200

Dear President Ammons:

We are pleased to provide this letter of support to the College of Dental Medicine (CODM) at Florida A & M University (FAMU). The mission of the CODM is to serve the citizens of Florida by recruiting students and residents from disadvantaged backgrounds and producing graduates who are committed and prepared to practice in underserved rural and urban areas. Access to care is a critical issue for the citizens of Florida, especially those who reside in rural, underserved areas, and there is no doubt that some specialties are over burdened and unable to meet the demands of care in a timely manner.

The CODM is an innovative approach to community based education, scholarly research, patient services, and oral health education. The Florida Association of Community Health Centers is excited to have some of our Federally Qualified Health Center (FQHC) members as partners in this important endeavor. If FAMU is successful in securing the College of Dental Medicine, there are many opportunities for collaboration between our organizations to address the specific aspects of the initiative.

The University will partner with these community based FQHCs in capacity-building efforts which will provide the knowledge, values and skills needed for people to make healthy choices as well as address the critical manpower needs of the 21st Century. We believe the challenges we face within oral healthcare provision should be approached through a collaboration of educational and community leaders.

This is a welcomed initiative and the association and members look forward to the partnership in such a great community effort.

Sincerely,

Andrew R Behrman
President and CEO

2340 Hansen Lane • Tallahassee, FL 32301 • Phone (850) 942-1822 • Fax (850) 942-9902 •
www.fachc.org

North Florida Medical Centers, Inc.

535 John Knox Road • Tallahassee, FL 32303 • Phone (850) 385-4494

April 5, 2011

Office of The President
Suite 400, Lee Hall
Florida A&M University
Tallahassee, FL 32307-3200

Dear President Ammons:

North Florida Medical Centers, Inc (NFMC) is pleased to provide this letter of support to the College of Dental Medicine (CODM) at Florida A&M University (FAMU). The mission of the CODM is to serve the citizens of Florida by recruiting students and residents from disadvantaged backgrounds and producing graduates who are committed and prepared to practice in underserved rural and urban areas. The mission of NFMC is to increase access to quality healthcare for the underserved and to improve stake-holder value in a quality work environment with a motivated and prepared workforce. NFMC is a Federally Qualified Health Center (FQHC) with 10 Medical Centers and 2 Dental Centers located throughout the panhandle of North Florida. We as a community health center, also provide comprehensive primary care services to all people regardless of their ability to pay.

The CODM is an innovative and hopeful approach to community based education, scholarly research, patient services, and oral health education. As part of this innovative approach, the CODM will partner with area FQHCs. If FAMU is successful in securing the College of Dental Medicine, we know there will be many opportunities for collaboration between our organizations to address the specific aspects of the initiative.

This potential collaboration will provide FAMU an excellent opportunity for training community based organizations in capacity-building efforts which will provide the knowledge, values and skills needed for people to make healthy choices as well as address the critical manpower needs of the 21st Century. We believe the challenges we face within oral healthcare provision should be approached through a collaboration of educational and community leaders.

This is a welcomed initiative and NFMC looks forward to working with CODM in developing a longstanding partnership in such a great community effort.

Sincerely,

Joel Montgomery, President/CEO

Dr. Patrick Brown, Chief Medical Officer

BOND COMMUNITY HEALTH CENTER, Inc.

Dear President Ammons:

The Bond Community Health Center, Inc. (BCHC) a Federally Qualified Health Center (FQHC) located in Tallahassee Florida is pleased to provide this letter of support to the College of Dental Medicine (CODM) at Florida A & M University (FAMU). The mission of the CODM is to serve the citizens of Florida by recruiting students and residents from disadvantaged backgrounds and producing graduates who are committed and prepared to practice in underserved rural and urban areas. Access to care is a most critical issue for the citizens of Tallahassee Florida, especially those who reside in rural, underserved areas. FQHC's such as ours provide comprehensive primary care services to all people regardless of their ability to pay, and operate in over 300 underserved communities throughout Florida. It is the mission of the Bond Community Health Center, Inc. is to provide the highest quality of care to the uninsured and underinsured population of Leon and surrounding counties with particular interest in those in the lower socio-economic class.

In 2010, BCHC implemented for the first time in its history, dating back to 1978, a dental clinic staffed with four dental operatories. Since its inception in January of 2010 the center has seen an overwhelming demand for services and is currently seeking to expand the hours of operation to accommodate this demand.

The CODM is an innovative and hopeful approach to community based education, scholarly research, patient services, and oral health education and will truly be an asset to BCHC as we collaborate to meet the needs of the growing population in need of dental care. As a part of this innovative approach, the CODM will partner with Bond CHC to expand the current services. In the hopes that FAMU is successful in securing the College of Dental Medicine, there will be many opportunities for collaboration with other FQHC's in the state that will address this continued growing need for oral health interventions.

BCHC has collaborated with FAMU on many initiatives in the past including pharmacy services and research projects, and we look forward to yet another successful partnership with the CODM. This partnership will provide an excellent opportunity for training, capacity-building efforts that will provide the knowledge, values and skills needed for people to make healthy choices as well as address the critical manpower needs of the 21st Century.

As one of Florida's community health centers, we support the mission of your institution and appreciate the opportunity to work collaboratively with you as we fulfill the goal of providing needed medical services and increasing access for underserved and uninsured populations.

Sincerely,

J.R. Richards, MPA, CEO

1720 S. Gadsden Street • Tallahassee, FL 32301
Telephone:850.576.4073 • Fax: 850.576.2824

DAN B. HENRY DDS PA

4627 NORTH DAVIS HWY

BLDING A

PENSACOLA, FLORIDA 32503

850-477-1120

golddoc@bellsouth.net

To Whom It May Concern,

I am pleased to voice my support for the new FAMU Dental School program being set up in the Panhandle of Florida. I am excited to see new ideas for a non-traditional program of dental education. In my opinion, it will bring innovation to dental education that is sorely needed.

Most importantly, it will bring the private practicing community and academia together to educate and mentor dental students in ways where a strictly academic program alone cannot compete. Students should have a better understanding of how their technical skills along with their responsibilities as dentists and citizens should be ordered.

Furthermore, I feel this program has the added bonus to positively influence changes in dental education throughout Florida; changes that will benefit both our profession and the citizens of Florida.

For these reason I support this program and wish it success.

Dan B. Henry DDS, FACD, FICD

Past President,

The Florida Dental Association

FLORIDA DEPARTMENT OF HEALTH

Rick Scott
Governor

Marlon Hunter, M.A.
CHD Administrator

June 2, 2011

Dr. James H. Ammons
President
Florida A&M University
1601 Martin Luther King Blvd.
Lee Hall, Suite 400
Tallahassee, FL 32307-3200

Dear President Ammons:

We are pleased to provide this letter of support to the College of Dental Medicine (CODM) at Florida A & M University (FAMU). The mission of the CODM is to serve the citizens of Florida by recruiting students and residents from disadvantaged backgrounds and producing graduates who are committed and prepared to practice in underserved rural and urban areas. Access to care is a critical issue for the citizens of Florida, especially those who reside in rural, underserved areas, and there is no doubt that some specialties are over burdened and unable to meet the demands of care in a timely manner.

The CODM is an innovative approach to community based education, scholarly research, patient services, and oral health education. As a part of this innovative approach, the CODM will partner with Gadsden County Health Department. If FAMU is successful in securing the College of Dental Medicine, there are many opportunities for collaboration between the two organizations to address the specific aspects of the initiative.

The University will partner with community based organizations such as the Gadsden County Health Department in capacity-building efforts which will provide the knowledge, values and skills needed for people to make healthy choices as well as address the critical manpower needs of the 21st Century. We believe the challenges we face within oral healthcare provision should be approached through a collaboration of educational and community leaders.

This is a welcomed initiative and the Gadsden County Health Department look forward to the partnership in such a great community effort.

Sincerely,

Marlon B. Hunter,BSEH,MAOM
Administrator-Health Officer
Gadsden County Health Department
Florida Department of Health
Ph: 850-875-7200
visit us at: www.gadsdenhealth.com

FLORIDA DEPARTMENT OF HEALTH

Rick Scott
Governor

H. Frank Farmer, Jr., M.D., Ph.D.
State Surgeon General

May 31, 2011

Florida A&M University
Dr. James H. Ammons, President
1601 Martin Luther King Blvd
Lee Hall, Suite 400
Tallahassee, FL 32307-3200

Dear President Ammons:

The Jackson County Health Department is pleased to provide this letter of support to the College of Dental Medicine (CODM) at Florida A&M University (FAMU). The mission of the CODM is to serve the citizens of Florida by recruiting students and residents from disadvantaged backgrounds and producing graduates who are committed and prepared to practice in underserved rural and urban areas. Access to care is a critical issue for the citizens of Florida, especially those who reside in rural, underserved areas as there is no doubt that many medical specialties are over burdened and unable to meet the demands of care in a timely manner.

The CODM is an innovative approach to community based education, scholarly research, patient services, and oral health education. As a part of this innovative approach, the CODM will partner with area *{County Health Departments/Federally Qualified Health Centers}*. If FAMU is successful in securing the College of Dental Medicine, there are many opportunities for collaboration between the two organizations to address the specific aspects of the initiative.

The University will partner with community based organizations like CHDs and FQHCs in capacity-building efforts which will provide the knowledge, values and skills needed for people to make healthy choices as well as address the critical manpower needs of the 21st Century. We believe the challenges we face within oral healthcare provision should be approached through a collaboration of educational and community leaders.

This is a very worthwhile initiative and as the administrator of one of Florida's 67 county health departments and as a graduate of FAMU, I look forward to the partnership in such a great community effort.

Sincerely,

William H. Long
Administrator

Jackson County Health Department
P.O. Box 310
Marianna, FL 32447
(850)526-2412

Rick Scott
Governor

H. Frank Farmer, Jr., M.D., Ph.D.
State Surgeon General

July 1, 2011

Dr. James H. Ammons
President
Florida A&M University
1601 Martin Luther King Blvd.
Lee Hall, Suite 400
Tallahassee, FL 32307-3200

Dear President Ammons:

I am pleased to provide this letter of support to the College of Dental Medicine (CODM) at Florida A & M University (FAMU). The mission of the CODM is to serve the citizens of Florida by recruiting students and residents from disadvantaged backgrounds and producing graduates who are committed and prepared to practice in underserved rural and urban areas. Access to care is a critical issue for the citizens of Florida, especially those who reside in rural and underserved areas.

The CODM is an innovative approach to community based education, scholarly research, patient services, and oral health education. As a part of this innovative approach, the CODM will partner with t*he Dental clinics of the Jefferson and Madison County Health Departments.* If FAMU is successful in securing the College of Dental Medicine, there are many opportunities for collaboration between the organizations to address the specific aspects of the initiative.

Sincerely,

S. McNelis

Sonia McNelis, M.D., M.P.H.
Operations & Management Consultant Manager
Jefferson and Madison County Health Departments

Appendix G
Letters of Collaboration from Area Universities, Hospitals, and UF Provost

1300 Miccosukee Road
Tallahassee, Florida 32308
850 431-1155

Tallahassee Memorial Hospital

Tallahassee Memorial HealthCare

July 7, 2011

Dr. James H. Ammons
President
Florida A&M University
1601 Martin Luther King Blvd.
Lee Hall, Suite 400
Tallahassee, FL 32307-3200

Dear Dr. Ammons:

Tallahassee Memorial HealthCare and its Foundation are pleased to provide this letter of support for the proposed College of Dental Medicine at Florida A & M University. Tallahassee Memorial agrees that access to dental care is a significant problem for low-income Floridians who reside in rural, inner city and other underserved areas. We support the College of Dental Medicine's mission to serve these citizens by basing its clinical education programs in safety net clinics and hospitals and by recruiting students and residents from disadvantaged backgrounds who are more likely to care for low-income patients.

To better serve our region and State, Tallahassee Memorial wishes to collaborate with the College of Dental Medicine by:

- Donating land on the TMH education campus to the University
- Working with the University to develop dental residency programs in General and Pediatric Dentistry
- Applying for Graduate Medical Education funds to support the residency programs with residents providing care to underserved patients in safety net clinics, College of Dental Medicine clinics, private practices and hospitals.

Tallahassee Memorial is committed to serving all the people in the Panhandle and is enthusiastic about collaborating with the College of Dental Medicine at Florida A & M University.

Sincerely,

G. Mark O'Bryant
President & Chief Executive Officer
Tallahassee Memorial HealthCare

Paula S. Fortunas
President & Chief Executive Officer
Tallahassee Memorial HealthCare Foundation

THE FLORIDA STATE UNIVERSITY
COLLEGE OF MEDICINE
Office of the Dean

July 27, 2011

James H. Ammons, Ph.D.
President
Florida Agricultural and Mechanical University
Tallahassee 32307-311

Dear Dr. Ammons,

This letter confirms the support of the Florida State University College of Medicine (FSU COM) to collaborate with FAMU on the development of a proposed College of Dental Medicine at Florida A&M University (FAMU). I have had several meetings with representatives from FAMU who described the scope of the plan and we identified several areas that would fit nicely with our respective schools in support of this project. These include:

- Working with FSU COM's very successful pipeline programs (SSTRIDE, Pre-Health Advising and Medical Honors Programs) to identify and support underrepresented and underserved students who desire to attend professional schooling. We identified a significant number of students already in these programs that have interest in attending dental school.
- Potential participation of our basic science/biomedical science faculty in the early basic science curriculum for the dental school.
- Potential sharing of facilities, particularly our anatomy dissection laboratory or Clinical Skills and Simulation Center.

I have enjoyed meeting your leadership of this project and your national consultant guiding you in its development. I believe that we share a common vision to produce clinicians for the underserved here in Florida, particularly in the panhandle. I am very proud of the early success of the FSU COM in producing the kind of physicians that Florida needs and was very pleased that four of your students joined our Class of 2015 this summer.

Best wishes in your pursuit of this program. I would be happy to discuss this with you at your convenience.

Sincerely,

John P. Fogarty, M.D.
Dean

cc: Eric J. Barron, Ph.D., President, Florida State University
Robert Bradley, Ph.D., Interim Provost, Florida State University

Sacred Heart
Health System

5151 N. Ninth Avenue • P.O. Box 2700
Pensacola, Florida 32513-2700
850-416-7000
www.sacred-heart.org

July 19, 2011

Dr. James H. Ammons
President
Florida A&M University
1601 Martin Luther King Boulevard
Lee Hall, Suite 400
Tallahassee, FL 32307-3200

Dear Dr. Ammons:

Sacred Heart Health System is pleased to provide this letter of support for the proposed College of Dental Medicine at Florida A&M University. Sacred Heart agrees that access to dental care is a significant problem for low-income, rural Panhandle residents. We support the College of Dental Medicine mission to serve these citizens by basing its clinical education programs in safety net clinics and hospitals and by recruiting students and residents from disadvantaged backgrounds who are more likely to care for low-income patients.

To better serve our region and State, Sacred Heart wishes to collaborate with the College of Dental Medicine by working with Florida A&M University to develop dental residency programs in General and Pediatric Dentistry.

Sacred Heart Health System is committed to serving all people in the Panhandle and is looking forward to collaborating with the College of Dental Medicine at Florida A&M University.

Sincerely,

Peter Heckathorn
Executive Vice President

UF UNIVERSITY of FLORIDA

Office of the Provost
and Senior Vice President

235 Tigert Hall
PO Box 113175
Gainesville, FL 32611-3175
352-392-2404 Tel
352-392-8735 Fax

August 8, 2011

Cynthia H. Hughes Harris
Provost
Florida A&M University
1700 Lee Hall Drive
301 Foote-Hillyer
Tallahassee, FL 32307

Dear Cyndy,

I am responding to your request for the University of Florida's endorsement of FAMU's College of Dental Medicine proposal that you intend to bring before the BOG this fall.

We do not believe that establishment of this new College would impinge on the educational programs currently in place at the UF College of Dentistry (although we are concerned about potential dilution of state funding for dental education). Its establishment would increase the pool of trained dentists in the state.

UF Dentistry Dean Terri Dolan and Dr. Donald Palm at FAMU are in preliminary discussion about how the UF and FAMU programs might interact. Our participation with FAMU may lead to increased diversity in the UF program. FAMU may be able to leverage UF's long- established pedagogical programs and highly ranked dental research enterprise to the advantage of its students.

If the BOG and Legislature approve FAMU's request, we will be happy to engage with you in this initiative to the benefit of the citizens of the State of Florida.

Sincerely yours,

Joseph Glover
Provost