



UTAH DEPARTMENT OF
HEALTH
Office of Health Disparities

Cross-Cultural Education and Training:

*Oral Health Education
Institutions of Utah*

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Defining Key Terms

Culture: “ ... the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs.”¹

Cross-cultural education or training in oral health: Instruction which enhances an individual's understanding of differing cultural beliefs, behaviors, traditions, languages, customs, norms, etc. and how they might affect oral health and providing oral health services. Cross-cultural education/training may be delivered in varying formats.^{2,3}

1 United Nations Educational, Scientific, and Cultural Organization. (2001). UNESCO Universal Declaration on Cultural Diversity. Retrieved from:

http://portal.unesco.org/en/ev.php-URL_ID=13179&URL_DO=DO_TOPIC&URL_SECTION=201.html

2 Rowland, M. L., Bean, C. Y., & Casamassimo, P. S. (2006). A snapshot of cultural competency education in US dental schools. *Journal of Dental Education*, 70(9), 982-990.

3 Saleh, L., Kuthy, R. A., Chalkley, Y., & Mescher, K. M. (2006). An assessment of cross-cultural education in US dental schools. *Journal of Dental Education*, 70(6), 610-623.

Executive Summary

“Oral health and general health should not be interpreted as separate entities. Oral health is a critical component of health and must be included in the provision of health care and the design of community programs.”⁴

Despite the emphasis on creating quality oral health guidelines, multiple barriers continue to impede adequate provision of oral health services. The impact of inadequate care is disproportionately experienced among populations who face oral health disparities. Health disparities are differences in health outcomes that are closely linked to economic, sociocultural, and environmental/geographic disadvantage. The U.S. Department of Health and Human Services (HHS) states that, “Though health inequities are directly related to the existence of historical and current discrimination and social injustice, one of the most modifiable factors is the lack of culturally and linguistically appropriate services.”⁵

Quality communication between provider and patient is essential for populations who face oral health disparities. Providers who have relevant communication skills can help populations experiencing oral health disparities navigate the oral health system and receive appropriate care. Yet, effective and appropriate communication between oral health professionals and their patients needs continued improvement and is still inadequate according to the HHS.⁶ Thus, the Utah Department of Health (UDOH) Office of Health Disparities (OHD) aims to improve the cultural and linguistic proficiency of current and future oral health providers.

In conjunction with the Utah Department of Health, Office of Health Disparities (OHD)’s White Paper: Addressing Oral Health Disparities in Urban Settings: A Strategic Approach to Advance Access to Oral Health Care, this report aligns with the purposes of the National Partnership for Action to End Health Disparities (NPA) framework. The NPA’s goals aim to eliminate health disparities through 1) awareness, 2) leadership, 3) health systems and life experience, 4) cultural and linguistic competency, and 5) data research and evaluation.⁷ This report supports each goal of the NPA framework and demonstrates the importance of cross-cultural oral health care. It includes a baseline of cross-cultural curricula within Utah’s oral health education institutions and outlines how this data will help to further the NPA goals.

“Oral health is a critical component of health and must be included in the provision of health care and the design of community programs.”⁴

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Executive Summary ...

Thirty-four of these programs met eligibility criteria and were sent the survey. Nineteen of the programs responded within the five-week window. The overall response rate of institutions was fifty-six percent (19 of 34).

Specific considerations include: 1) regular cross-cultural training, 2) community outreach and partnerships, and 3) continual data collection.

Data on Utah's oral health education institutions was collected via a survey administered by OHD. Institution types surveyed include dental residency programs, dental schools (DDS/DMD), dental hygiene schools, and dental assisting schools. Thirty-four of these programs met eligibility criteria and were sent the survey. Nineteen of the programs responded within the five-week window. The overall response rate of institutions was fifty-six percent (19 of 34). The response rates of each institutional type were; dental residencies: one hundred percent (3 of 3), dental schools: one hundred percent (2 of 2), dental hygiene schools: eighty-three percent (5 of 6), and dental assisting schools: thirty-nine percent (9 of 23). Seventeen of the 19 responses were used in the analysis. Key findings from the survey include:

- The majority of institutions address cross-cultural issues either in the classroom and/or in an extracurricular setting.
- The largest overall motivator for institutions to offer cross-cultural training to their students is a diverse patient population.
- The largest overall barrier to provide additional cross-cultural training for participating institutions is competing curricular time.
- Institutions with longer programs tend to offer students more cross-cultural opportunities and rate their level of cross-cultural competence as higher.

Despite institution motivations or curricula devoted to cross-cultural issues, data does not exist to support whether institution efforts are effective in meeting the needs of diverse communities.

Program-reported data enables OHD to recommend pertinent actions that will aid Utah oral health academic institutions in preparing students for a career of appropriate cross-cultural care. OHD invites oral health education institutions, oral health providers, the public health community, and other stakeholders to consider the information and resources found in this report. Specific considerations include: 1) regular cross-cultural training, 2) community outreach and partnerships, and 3) continual data collection.

Introduction

Background

The realization of oral health as a critical factor of health status has become a national health priority. Healthy People 2020 has made oral health one of its leading health indicators and proposes to increase the number of individuals, aged two years and older, who have not seen the dentist within the past 12 months.⁸ As of 2016, 27% of Utahns aged 18 and older, reported that they had not been to the dentist within the past 12 months.⁹ Utah residents who are between the ages of 18-34 or 65 and older, who are of lower socioeconomic status, who do not have dental insurance, and who have less formal education report fewer dental visits when compared to Utah as a whole.⁹ Characteristics including gender, age, educational level, income, race, and ethnicity, access to medical insurance, and geographic location are associated with the ability to access oral health care.⁸ Healthy People 2020 declares that, “Efforts are needed to overcome barriers to access to oral health care caused by geographic isolation, poverty, insufficient education, and lack of communication skills.”⁸

HHS has created the Oral Health Strategic Framework with the purpose of acknowledging, “... the need to undertake several different approaches concurrently that respect racial and cultural differences, language barriers, behavioral health, and the health literacy levels of diverse individuals in need of oral health services and education.”⁶ Increasing access to disadvantaged populations may be accomplished by improving, “the knowledge, skills, and abilities of providers to serve diverse patient populations,” and by promoting, “health professionals’ training in cultural competency.”⁶ Patient health literacy is often dependent upon the ability of providers to use culturally and linguistically appropriate communication methods. For this reason, HHS encourages providers to enhance their skills and strategies regarding communication.

Utah residents who are between the ages of 18-34 or 65 and older, who are of lower socioeconomic status, who do not have dental insurance, and who have less formal education report fewer dental visits when compared to Utah as a whole.⁹

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OHD's community partnerships were created and expanded due to participation in the Utah Oral Health Coalition and the partnership with the Utah Oral Health Program.

The purpose of this survey was to gain an understanding of the cross-cultural curricula within Utah oral health education institutions.

OHD and Oral Health Involvement

OHD has received funding from the State Partnership Initiative to Address Health Disparities (SPI) grant to aid geographic populations experiencing health disparities in Salt Lake City. The program that has been continued under the SPI funding is called Bridging Communities and Clinics (BCC) and addresses general and oral health disparities. BCC is a community outreach program started by OHD in 2012, which has provided screenings for individuals facing health disparities. In 2015, OHD was awarded the SPI grant, which specified the efforts of BCC to distinct geographic locations. Under the new provisions of the SPI grant, one goal of BCC is to increase the number of people who have been to the dentist within the past 12 months, as outlined in Healthy People 2020. Recent BCC oral health efforts have created partnerships between oral health academic institutions, local school districts, non-profit organizations, dental clinics, community partners, and state clinics to coordinate oral health services for underserved populations including the initiation of free dental day events. OHD's community partnerships were created and expanded due to participation in the Utah Oral Health Coalition and the partnership with the Utah Oral Health Program.

Survey Purpose

Gathering baseline data is an essential part of needs assessments and system improvements. In this case, baseline data is an important foundational step to acknowledge the efforts being made to accommodate cultural considerations and to evaluate areas for improvement. The purpose of this survey was to gain an understanding of the cross-cultural curricula within Utah oral health education institutions. Areas addressed within the survey include course availability, teaching methods, cross-cultural content, time parameters, and institutional priorities. The survey was also used to identify whether institutions were interested in furthering the cross-cultural experience of their students through community partnerships. In addition to gathering baseline data, OHD wanted to provide resources to enable institutions to continually improve cross-cultural curricula and opportunities. Institutions that are equipped to address cross-cultural issues will develop a generation of oral health professionals who can positively impact populations facing oral health disparities.

NPA Framework



Source: <https://minorityhealth.hhs.gov/npa/images/priorities.jpg>

Awareness: Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations.

Leadership: Strengthen and broaden leadership for addressing health disparities at all levels.

Health System and Life Experience: Improve health and healthcare outcomes for racial, ethnic, and underserved populations.

Cultural and Linguistic Competency: Improve cultural and linguistic competency and the diversity of the health-related workforce.

Data Research and Evaluation: Improve data availability and coordination, utilization, and diffusion of research and evaluation

NPA Framework:
(1) Awareness
(2) Leadership
(3) Health System & Life Experience
(4) Cultural & Linguistic Competency
(5) Data, Research & Evaluation

Cross-cultural training is an investment in future oral health professionals to improve their ability to give appropriate care.

Institutions are offered the opportunity to further educate their students so they become cross-culturally competent providers.

The publication of this report will promote data collection and its use for program evaluation.

Applying the NPA Framework

The survey administered to Utah oral health education institutions, this publication, and the recommendations found within the report all help to advance OHD's goal of eliminating oral health disparities using the NPA framework.

1. Awareness

- Institutions become more aware of oral health disparities through requested survey participation and consumption of the oral health disparities literature cited within this report.

2. Leadership

- Leaders of participating institutions are provided with resources that can be used to address health disparities. Resources are easily accessible and can be shared with leaders and faculty at all levels. Cross-cultural training is an investment in future oral health professionals to improve their ability to give appropriate care.

3. Health System & Life Experience

- Oral health outcomes for underserved populations will improve if there are providers in place who will consider patients' specific needs and adapt care to meet those needs. Institutions are offered the opportunity to further educate their students so they become cross-culturally competent providers.

4. Cultural & Linguistic Competency

- Cultural and linguistic competency and priority of students, faculty, and institutional leaders are assessed within the survey and resources are provided so these competencies can be expanded.

5. Data, Research, & Evaluation

- Limited data, research, or program evaluation has not been previously performed that would establish a baseline of cultural competency of Utah oral health education institutions. The publication of this report will promote data collection and its use for program evaluation.

Methodology

Survey Design

OHD created a cross-sectional survey to send to eligible oral health educational institutions. Each eligible institution received an email invitation to complete an anonymous online survey about their cross-cultural curricula. Institutions had five weeks to complete the survey, after which the survey was closed and results were analyzed.

Survey Creation

Survey questions were based on two studies published in the American Dental Education Association: Journal of Dental Education: (1) “A snapshot of cultural competency education in U.S. dental schools,”² and (2) “An assessment of cross-cultural education in U.S. dental schools.”³ Questions were modified to fit the characteristics of Utah’s educational institutions and the goals of the survey. OHD also created additional survey questions bringing the total to 22 questions. Prior to survey administration, questions were reviewed by OHD staff, the Utah Oral Health Program, a dental school administrator, and a dental hygiene program administrator. The finalized survey was uploaded to Survey Monkey. A copy of the survey can be found in the appendix of this report.

Survey Pool

Eligible oral health institution types included dental residency programs, dental schools (Doctor of Dental Surgery DDS/Doctor of Dental Medicine DMD), dental hygiene programs, and dental assisting programs. Only programs that enrolled post high school students were included. Utah oral health education institutions were identified through contact with the Utah Division of Occupational and Professional Licensing, the Utah Education Network, and the Utah Dental Association. The institution survey pool was validated by the Utah Oral Health Program.

Online survey invitations were sent to administrators with titles that indicated their involvement with course curricula e.g., department chair, program director, dean, course coordinator, owner, etc.

Contact information of qualified administrators was found on program websites. Programs that did not publicly post administrator contact information were reached via telephone to request that information. The original list of institutions totaled 49; three residency programs, two dental schools, six dental hygiene programs, and 38 dental assisting programs. Fifteen institutions were not included in the final contact list. Programs were disqualified for the following reasons; unable to obtain administrator contact information, duplicate entries, multiple locations sharing the same primary contact, programs had been discontinued, programs were for high school students only, or programs had not yet enrolled students.

Each eligible institution received an email invitation to complete an anonymous online survey about their cross-cultural curricula.

Questions were modified to fit the characteristics of Utah’s educational institutions and the goals of the survey. OHD also created additional survey questions bringing the total to 22 questions.

Eligible oral health institution types included dental residency programs, dental schools (Doctor of Dental Surgery DDS/Doctor of Dental Medicine DMD), dental hygiene programs, and dental assisting programs.

Of the thirty-four institutions contacted, nineteen responded. The overall response rate of institutions was fifty-six percent (19 of 34).

Data Collection

The survey opened on April 17, 2018 and closed on May 15, 2018. Initial online survey invitations were sent to each administrator along with weekly reminder emails, which began April 17, 2018 and ended May 15, 2018. One week prior to closing the survey, all eligible institutions were given a reminder phone call in addition to the reminder emails. Copies of the email scripts can be found in the appendix of this report.

Data Analysis

Analysis was done using excel and Survey Monkey analytic tools. Descriptive statistic measures were calculated with these programs; averages, sums, and standard deviations.

Outcomes

Response Overview

Of the thirty-four institutions contacted, nineteen responded. The overall response rate of institutions was fifty-six percent (19 of 34). The response rates of each institutional type were; dental residencies: one hundred percent (3 of 3), dental schools: one hundred percent (2 of 2), dental hygiene schools: eighty-three percent (5 of 6), and dental assisting schools: thirty-nine percent (9 of 23). Two of the nineteen responses were incomplete and not used in the analysis. Responses used in the analysis included all three dental residency programs, both dental schools, five of six dental hygiene programs, and seven of 23 dental assisting programs. Institution administrator titles were appropriate across institution type and included dean, director, department chair, program coordinator, etc. When administrators were asked to list their responsibilities, the dental hygiene administrators listed responsibilities that were most related to curriculum creation and management. This difference may have impacted the accuracy of the responses when compared with other institution types.

Institutional Demographic Summary

Dental Residency:

All dental residency programs are located in Salt Lake County and have been in operation for more than 20 years. The programs last anywhere from five to 24 months with an average class size ranging from <ten to 20 residents. The residency programs reported there are three to five students per faculty member.

Dental School (DDS/DMD):

Both dental schools are located in Salt Lake County and have been in operation between three and eight years. The programs last from >two to four years with an average class size of greater than 40 students. The dental schools reported there are about four students per faculty member.

Dental Hygiene:

The five responding dental hygiene programs are located in Salt Lake, Washington, and Weber Counties. These programs have been in operation for nine to >20 years. The programs last between 19 months and four years with an average class size ranging from 11 to 30 students. The dental hygiene programs reported there are four to ten students per faculty member.

Dental Assisting:

The seven responding dental assisting programs are located predominantly in Salt Lake and Utah Counties, but Cache and Wasatch Counties were also represented. The responding dental assisting programs have been in operation from less than one year to >20 years. The programs last anywhere from one to 18 months with an average class size ranging from <ten to 30 students. The dental assisting programs reported there are four to 25 students per faculty member.

Results

Course Availability:

Institutions were asked if cross-cultural training is offered to and required of their students. Of the 17 responding institutions, 13 indicated they offer cross-cultural training and nine reported they require their students to participate in cross-cultural training.

Is cross-cultural training offered?		Is cross-cultural training required?	
Institution:	# that said yes:	Institution:	# that said yes:
Residency	2 of 3	Residency	2 of 3
Dental School	2 of 2	Dental School	2 of 2
Dental Hygiene	5 of 5	Dental Hygiene	4 of 5
Dental Assisting	4 of 7	Dental Assisting	1 of 7
Total:	13 of 17	Total:	9 of 17

Of the 17 responding institutions, 13 indicated they offer cross-cultural training and nine reported they require their students to participate in cross-cultural training.

Twenty-nine percent of institutions do not include cross-cultural topics within their curriculum.

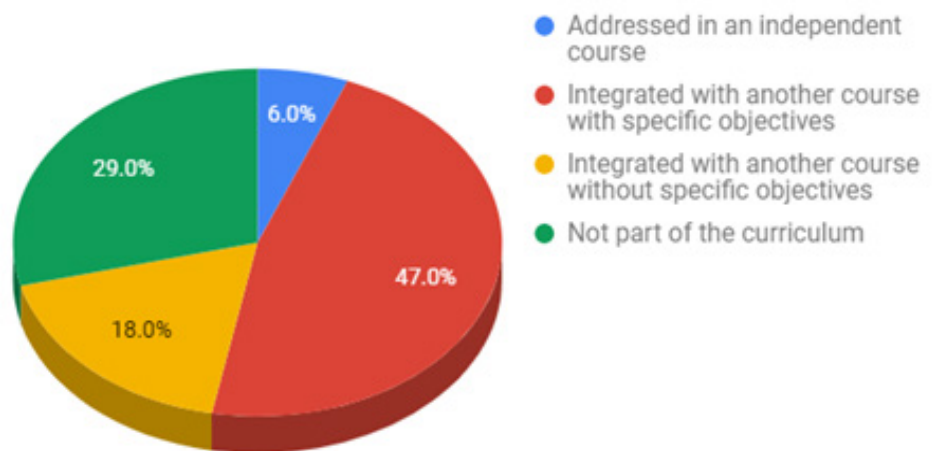
The only institution offering an independent course dedicated to cross-cultural topics is a dental hygiene school and the five institutions that do not include cross-cultural topics within their curriculum are dental assisting programs.

Teaching Methods:

Institutions were asked about the methods by which cross-cultural training is delivered to their students. They were asked whether they offer an independent course solely addressing cross-cultural issues, the type of in-class teaching methods, and the extracurricular opportunities given to students.

Course Type: When asked, “How is course material taught?,” institutions could choose from the following options; “Addressed in an independent course,” “Integrated with another course with specific objectives,” “Integrated without specific objectives,” or “Not part of the curriculum.”

How is course material taught?



Six percent of responding institutions indicated they offer an independent course to address cross-cultural topics. Forty-seven percent of institutions reported they integrate cross-cultural topics with another course with specific objectives and eighteen percent of institutions reported they integrate cross-cultural topics with another course without specific objectives. Twenty-nine percent of institutions do not include cross-cultural topics within their curriculum. The only institution offering an independent course dedicated to cross-cultural topics is a dental hygiene school and the five institutions that do not include cross-cultural topics within their curriculum are dental assisting programs.

In-class Teaching Methods: Institutions which address cross-cultural topics within their curriculum, were asked to choose from a list of teaching methods used in the classroom setting. Institutions could select from “lecture/seminar,” “case studies,” “problem based learning,” “small group discussion,” “role play exercises,” “presentations by community members,” or “other.” Overall, every teaching method type was selected; and at least five of six teaching methods are used per institution type. Dental and dental hygiene schools averaged the greatest variety of teaching methods given to their students. The top four overall teaching methods selected were (1) small group discussion; (2) lecture/seminar; (3) case studies; and (4) presentations by community members.

Extracurricular Programs: Cross-cultural topics are often learned outside the classroom in extracurricular activities. Institutions were asked to select any extracurricular programs they provide for their students from the following list: “public health or free/low-cost clinics,” “community health centers,” “mobile units,” “hospital clinics,” “private dental offices,” “screenings at health fairs/ special events/community events,” “other,” or “institution does not have such a program.” Every extracurricular program was selected at least once by the overall group; and each institution type provides at least five of eight options. Only two institutions, a dental assisting program and a dental residency program, reported they do not provide extracurricular programs for students to learn more about cross-cultural issues. The top three extracurricular programs selected were (1) free/low-cost clinics; (2) screenings at community events; and (3) participating at community health centers.

Top Four In-class Teaching Methods:	Top Three Extracurricular Programs:
1. Small group discussion	1. Public health or free/low cost clinics
2. Lecture/Seminar	2. Screenings at health fairs, special events, or community events
3. Case studies	3. Community health centers
4. Presentations by community members	
*In general, all institution types followed this pattern, however, the extracurricular program offered most by dental residency programs is “Hospital Clinics,” and the most offered by dental assisting schools is “Private Dental Offices.”	

The top four overall teaching methods selected were (1) small group discussion; (2) lecture/seminar; (3) case studies; and (4) presentations by community members.

The top three extracurricular programs selected were (1) free/low-cost clinics; (2) screenings at community events; and (3) participating at community health centers.

The top three overall most addressed cross-cultural topics were, “disabilities (physical and intellectual),” “awareness and respect of culturally different groups,” and “issues related to limited English proficiency of patients.”

The top three overall least addressed cross-cultural topics were, “ageism,” “gender issues,” and cultural barriers.”

Cross-Cultural Content:

Participating institutions were asked to self-evaluate how well they address the following cross-cultural topics: “definitions and/or concepts of culture, diversity, ethnicity, and cultural competency,” “concepts of culturally different health belief models,” “access issues,” “oral health disparities,” “communication and interviewing skills of culturally different populations,” “issues related to limited English proficiency of patients,” “awareness and respect of culturally different groups,” “ageism,” “gender issues,” “disabilities (physical and intellectual),” “racial/ethnic minority culture,” “linguistic barriers,” “cultural barriers,” and “interpretation services.” The following scale was used: 0=not addressed at all, 1=minimally addressed, 2=moderately addressed, 3=extensively addressed.

The top three overall most addressed cross-cultural topics were, “disabilities (physical and intellectual),” “awareness and respect of culturally different groups,” and “issues related to limited English proficiency of patients.” The top three overall least addressed cross-cultural topics were, “ageism,” “gender issues,” and cultural barriers.”

Cross-Cultural Topics Overall	
Most Addressed:	Least Addressed:
1. Disabilities (physical and intellectual) 2. Awareness and respect of culturally different groups 3. Issues related to limited English proficiency of patients	1. Ageism 2. Gender issues 3. Cultural barriers

Cross-Cultural Topics by Institution Type		
Institution Type:	Most Addressed:	Least Addressed:
Residency	<ul style="list-style-type: none"> • Disabilities (physical and intellectual) 	<ul style="list-style-type: none"> • Definitions and/or concepts of culture, diversity, ethnicity, and cultural competency • Concepts of culturally different health belief models • Ageism • Cultural barriers
Dental School	<ul style="list-style-type: none"> • Concepts of culturally different health belief models • Oral health disparities • Access issues • Awareness and respect of culturally different groups • Disabilities (physical and intellectual) 	<ul style="list-style-type: none"> • Ageism • Gender issues • Racial/Ethnic minority culture • Linguistic barriers • Definitions and/or concepts of culture, diversity, ethnicity, and cultural competency • Communication and interviewing skills of culturally different populations • Issues related to limited English proficiency of patients • Cultural barriers • Interpretation services
Dental Hygiene	<ul style="list-style-type: none"> • Oral health disparities • Racial/Ethnic minority culture • Cultural barriers 	<ul style="list-style-type: none"> • Ageism • Gender issues
Dental Assisting	<ul style="list-style-type: none"> • Disabilities (physical and intellectual) 	<ul style="list-style-type: none"> • Ageism

The programs with the highest self-evaluated averages, from programs that most address cross-cultural topics to programs that least address cross-cultural topics, are; dental schools, dental hygiene schools, dental residency programs, and dental assisting schools.

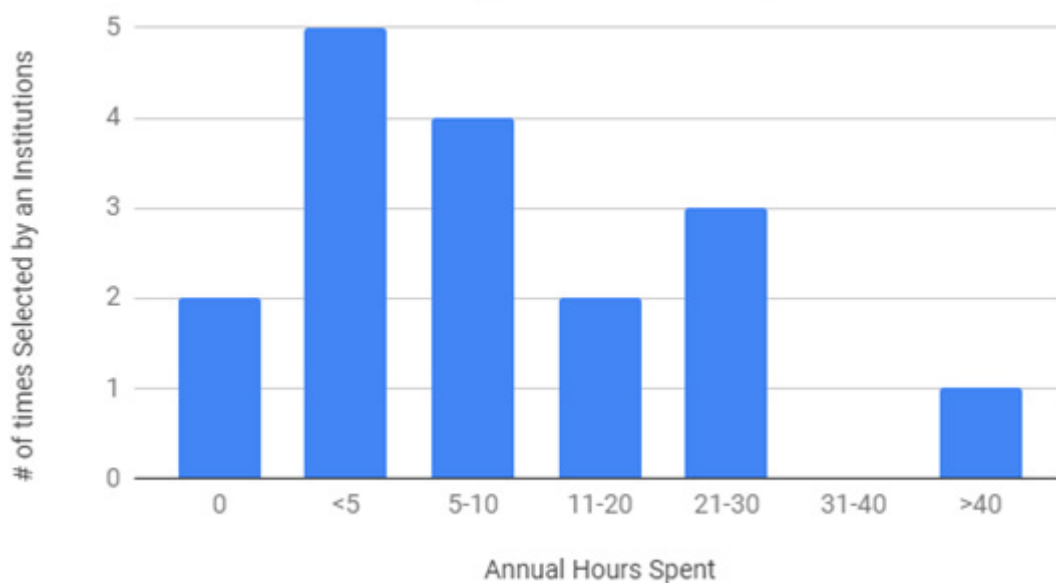
The majority of institutions (14 of 17) reported they spend anywhere from less than five hours to 30 hours annually addressing cross-cultural issues in the classroom.

An average self-evaluation score was calculated after institutions assigned a scale value (0=not addressed at all, 1=minimally addressed, 2=moderately addressed, 3=extensively addressed) to each cross-cultural topic. An averaged score gives a picture of how well institutions address cross-cultural topics in general. e.g., if a program's self-evaluated average were 2.5, its overall level of addressing cross-cultural topics is between moderate and extensive. The programs with the highest self-evaluated averages, from programs that most address cross-cultural topics to programs that least address cross-cultural topics, are; dental schools, dental hygiene schools, dental residency programs, and dental assisting schools.

Time Parameters:

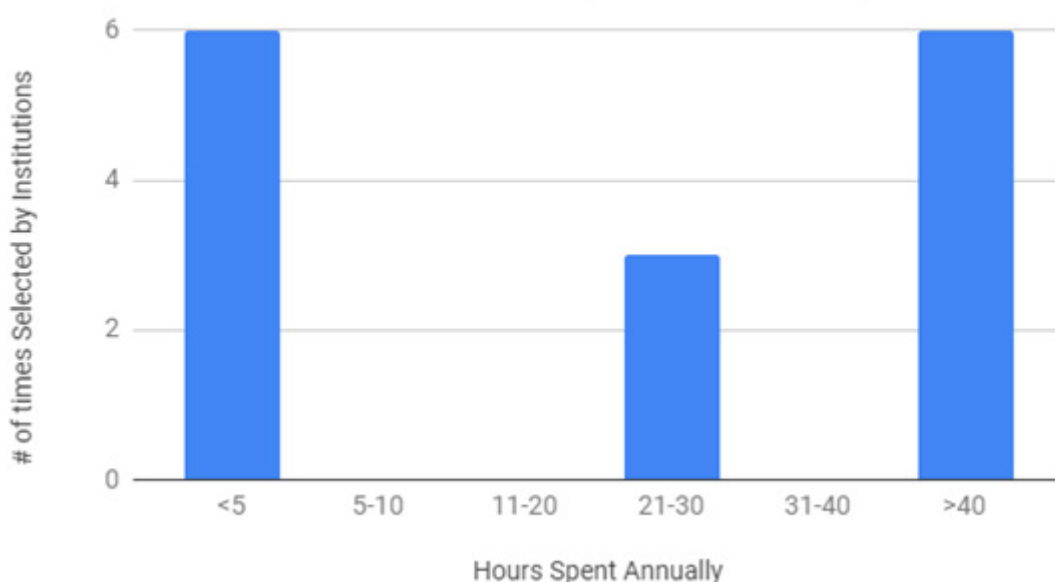
The amount of time spent addressing cross-cultural topics in the classroom and in extracurricular activities is an important measure. Eighty-eight percent (15 of 17) of institutions reported spending at least some time addressing cross-cultural issues in an in-class setting. The majority of institutions (14 of 17) reported they spend anywhere from less than five hours to 30 hours annually addressing cross-cultural issues in the classroom. Only one institution reported spending more than 40 in-class hours and two institutions reported spending no time on cross-cultural issues in the classroom.

Annual In-class Time Addressing Cross-cultural Topics



Extracurricular Annual Hours: Eighty-eight percent (15 of 17) of institutions reported their students spend at least some time in extracurricular activities with the purpose of increasing cross-cultural experience. Annual time spent addressing cross-cultural topics in an extracurricular setting was split among institutions between less than five hours annually and 21 to >40 hours annually. Of the six institutions that reported spending <five hours annually, five were dental assisting schools and one was a dental residency program.

Annual Extracurricular Time Addressing Cross-cultural Topics



Institutional Priority:

In addition to time devoted to addressing cross-cultural topics, institutions were asked about other factors involved in evaluating cross-cultural priorities.

Faculty Training: Faculty training and expertise is a key factor in ensuring students receive adequate instruction. Institutions were asked whether faculty members are required to take cross-cultural continuing education training. Thirteen of 17 institutions indicated they do not require their faculty to receive cross-cultural continuing education training.

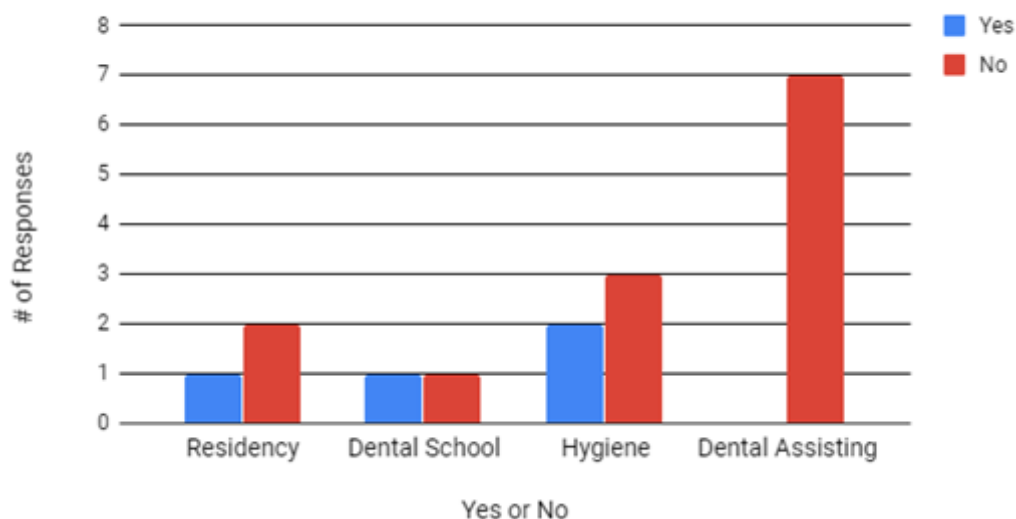
Eighty-eight percent (15 of 17) of institutions reported their students spend at least some time in extracurricular activities with the purpose of increasing cross-cultural experience.

Thirteen of 17 institutions indicated they do not require their faculty to receive cross-cultural continuing education training.

A “diverse patient population,” was the number one given reason why cross-cultural topics are addressed for all institutions.

“Competing curricular time” was the number one given reason that institutions do not devote more time to addressing cross-cultural topics.

Are faculty required to take cross-cultural continuing education courses/training?



Addressing Cross-Cultural Issues: Institutions were asked to choose (from provided lists) the three most important reasons their programs address and do not address cross-cultural issues. The three most important reasons, overall, that institutions address cross-cultural issues are: 1) diverse patient population, 2) leadership commitment, 3) student interest/request. The three most important reasons, overall, that institutions do not devote more time to cross-cultural issues are: 1) competing curricular time, 2) lack of leadership commitment/interest, and 3) limited financial Resources. When broken out, the institution types almost mirror this pattern. A “diverse patient population,” was the number one given reason why cross-cultural topics are addressed for all institutions. “Competing curricular time” was the number one given reason that institutions do not devote more time to addressing cross-cultural topics.

Cross-Cultural Topics by Institution Type			
Three most important reasons why you address cross-cultural issues at your school:		Three most important reasons why you do not devote more time to address cross-cultural issues at your school:	
Overall	1. Diverse patient population 2. Leadership commitment 3. Student interest/request	Overall	1. Competing curricular time 2. Lack of leadership commitment/interest 3. Limited financial resources
Residency	1. Diverse patient population 2. Leadership commitment 3. Student interest/request	Residency	1. Competing curricular time 2. Lack of student interest 3. Lack of leadership commitment/interest
Dental School	1. Diverse patient population 2. Student interest/request 3. Faculty expertise/interest	Dental School	1. Competing curricular time 2. Lack of faculty expertise/interest 3. Lack of patient diversity
Dental Hygiene	1. Diverse patient population 2. Leadership commitment 3. Student interest/request	Dental Hygiene	1. Competing curricular time 2. Lack of leadership commitment/interest 3. Limited financial resources
Dental Assisting	1. Diverse patient population 2. Student interest/request 3. Faculty expertise/interest	Dental Assisting	1. Competing curricular time 2. Limited financial resources 3. Other- the responses described that their course is designed only to address radiology or basic dental assisting skills

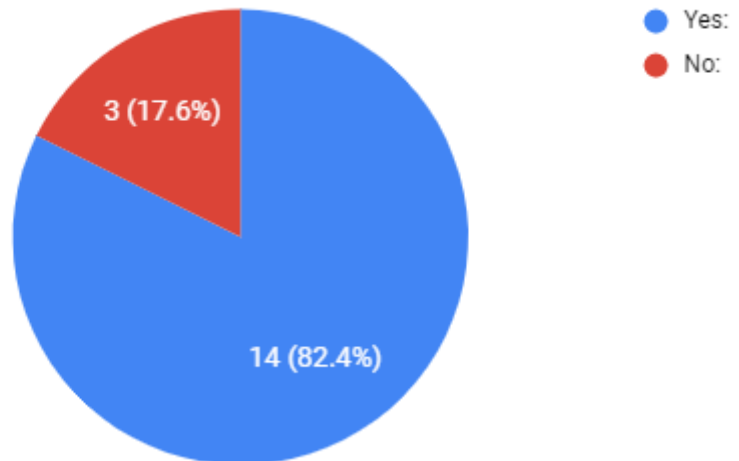
Future Curricula: When asked if institutions planned to offer a course solely dedicated to cross-cultural issues within the next year, four of 17 said yes (including one program from each institution type), 12 of 17 said no, and one of 17 said they already have one. The dental hygiene school that offers an independent cross-cultural course gives students credit for taking the course.

Level of Cross-cultural Training: From the beginning of their programs, ten of 17 institutions reported increases in their cross-cultural training, seven of 17 reported cross-cultural training has remained the same, while none of the programs reported that their cross-cultural training has decreased.

Fourteen of 17 institutions report they are interested in expanding community partnerships that will help students gain experience and improve their cultural and linguistic competence.

Expanding Community Partnerships: One priority of OHD is to help institutions find opportunities for their students to gain cross-cultural training through community partnerships. Fourteen of 17 institutions report they are interested in expanding community partnerships that will help students gain experience and improve their cultural and linguistic competence. The three programs that were not interested in expanding community partnerships for increased student cross-cultural competence were dental assisting programs.

Interested in Expanding Community Partnerships:



Key Findings and Analysis Within the NPA Framework

Awareness:

1. Institutions indicate that “diverse patient populations” is the primary reason they address cross-cultural topics. Institutions have demonstrated their awareness of oral health disparities by:

- Addressing cross-cultural issues in the classroom
- Teaching cross-cultural issues using varying methods
- Providing students with extracurricular cross-cultural experience
- Offering a variety of extracurricular cross-cultural experience

2. Institutions with programs that last longer tend to:

- Offer and require cross-cultural training more frequently
- Spend more time addressing cross-cultural topics in class
- Offer students more annual hours of extracurricular cross-cultural experience

3. Seventy percent of institutions report that oral health disparities are moderately addressed

4. Dental assisting schools offer fewer opportunities for their students to cultivate cross-cultural competency and develop awareness of health disparities and their significance.

- This difference may be due to program duration and financial resources.

5. Student cross-cultural competency levels were not recorded making it difficult to determine whether the amount of cross-cultural exposure is adequate to create health disparity awareness.

Leadership:

1. Thirteen of 17 institutions said they do not require faculty members to receive cross-cultural continuing education training.

- At least 50% of each institutional type reported they do not require faculty members to receive cross-cultural continuing education.

2. Required cross-cultural faculty training is sparse among all institution types. The impact of required cross-cultural faculty training, or the lack thereof, is unknown.

Health System & Life Experience:

1. Fourteen of 17 institutions report they are interested in expanding community partnerships that will help students gain experience and improve their cultural and linguistic competence.

2. Oral health outcomes of underserved populations will improve as oral health education institutions invest in their students’ ability to properly interact with diverse communities.

Institutions indicate that “diverse patient populations” is the primary reason they address cross-cultural topics.

At least 50% of each institutional type reported they do not require faculty members to receive cross-cultural continuing education.

Oral health outcomes of underserved populations will improve as oral health education institutions invest in their students’ ability to properly interact with diverse communities.

The overall average level for addressing cross-cultural topics was less than moderately addressed.

The survey response rate is an indicator that many institutions may be willing to further oral health disparity data collection, evaluation, and utilization of data.

Cultural & Linguistic Competency:

1. The overall average level for addressing cross-cultural topics was less than moderately addressed.
 - The programs with the highest self-evaluated averages are longer in program duration.
2. The top three overall most addressed cross-cultural issues include “disabilities,” “racial/ethnic minority culture,” and “awareness/respect of culturally different groups.”
3. The top three overall least addressed cross-cultural issues include “ageism,” “gender issues,” and “cultural barriers.”
4. Institutions report that the three main reasons they do not devote more time to address cross-cultural issues are “competing curricular time,” “lack of leadership commitment/interest,” and “limited financial resources.”
5. Institutions identified that the patient populations they serve have needs that may be atypical to the dominant culture.
 - Patient outcomes and experiences were not collected in this survey but it is worth considering if institutional efforts meet population needs. Influencing factors include:
 - Twenty-three percent of institutions require their staff to obtain cross-cultural training.
 - Fifty-three percent of institutions report spending from one to ten in-class hours annually addressing cross-cultural issues.
 - Cultural barriers are one of the least addressed cross-cultural topics.

Data, Research, & Evaluation:

1. Survey response proportions were high (83% or higher) for dental residency programs, dental schools, and dental hygiene schools.
2. The survey response rate is an indicator that many institutions may be willing to further oral health disparity data collection, evaluation, and utilization of data.

Considerations Within the NPA Framework

Awareness:

1. In conjunction with the NPA framework, OHD recommends the use of the Cultural Competency Program for Oral Health Professionals created by HHS.¹⁰ The program is a free online course based upon updated National Culturally and Linguistically Appropriate Services Standards (CLAS).⁵

- The Cultural Competency Program for Oral Health Professionals can be found at <https://oralhealth.thinkculturalhealth.hhs.gov/>.

2. Oral Health is another organization that offers ready-to-use online resources.¹¹ Oral Health aims to aid in the development of oral health programs for older adults; the program includes guidelines to create needs assessments and deliver cultural trainings.¹¹

- Oral Health resources can be found at <https://oralhealth.acl.gov/>.

Leadership:

1. Institution leadership are invited to take advantage of the free online training resources provided in this report and help coordinate extracurricular cross-cultural experiences which are discussed further in “Health System & Life Experience: Considerations.”

Health System & Life Experience:

1. OHD has developed an oral health model using state and institution resources to provide free dental days for underserved populations. OHD has also partnered with local oral health education institutions to have their students provide care and interact with diverse communities at these free dental days. The model is sustainable and reproducible because it can satisfy the oral health needs of underserved populations and gives students and professionals the clinical hours and cross-cultural experience they need.

Cultural & Linguistic Competency:

1. The training resources given under “Awareness” will help develop cultural and linguistic competency. These trainings are a simple way to further address cross-cultural topics for students, faculty, and professionals. Due to easy access and online learning, the training does not have to compete for time with other curricular objectives.

Data, Research, & Evaluation:

1. Survey results will be published on OHD’s website and will be sent to participating institutions to encourage data availability, coordination, utilization, and dissemination.

2. OHD promotes further data collection in order to measure the effectiveness of cross-cultural education programs on students and oral health outcomes. Data may be collected by oral health education institutions, clinical providers, state and local agencies, etc.

OHD recommends the use of the Cultural Competency Program for Oral Health Professionals created by HHS.¹⁰

These trainings are a simple way to further address cross-cultural topics for students, faculty, and professionals.

Survey results will be published on OHD’s website and will be sent to participating institutions to encourage data availability, coordination, utilization, and dissemination

Inter-institutional comparisons are difficult to make when the qualities and characteristics of each institution type vary greatly.

Regardless of educational or occupational attainment, all surveyed institutions graduate professionals who will have direct patient contact and consequently direct patient impact.

Limitations

- Collected data was self-reported. As with any self-reported data, the responses are subjective to the respondents' knowledge, memory, or interpretation of the questions.
- Outcomes, such as students' cultural competence or patient experience, were not measured which limits the ability to measure the effectiveness of institutional efforts.
- Among residency programs, dental schools, and dental hygiene schools there was a ninety-one percent response rate, but the dental assisting school response rate was thirty percent.
- Dental assistants in Utah are not required to be licensed, which means they are not required to attend an accredited program. Without licensure and required accreditation, it is difficult to be certain that all existing Utah dental assisting programs were contacted for the survey.
- Inter-institutional comparisons are difficult to make when the qualities and characteristics of each institution type vary greatly.

Moving Forward

Many individuals from non-dominant cultures experience health inequities resulting in health disparities.⁵ Factors that contribute to health inequities and disparities are difficult to control and may include social and physical environments, socioeconomic status, education, availability of services, etc.⁵

HHS states that, “... one of the most modifiable factors (regarding health inequities) is the lack of culturally and linguistically appropriate services.”⁵ Regardless of educational or occupational attainment, all surveyed institutions graduate professionals who will have direct patient contact and consequently direct patient impact.

There are many steps organizations, stakeholders, and institutions may take in order to positively impact the oral health care environment. OHD recognizes that change, although important, can be difficult to achieve; for that reason OHD recommendations are sensitive to institutional challenges. The changes and considerations found in this report address all of the NPA framework goals. OHD invites oral health education institutions, oral health providers, the public health community, and other stakeholders to consider how the information and resources found in this report can help reduce or eliminate oral health disparities using the NPA framework approach.

Acknowledgements

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Appendix

Email Scripts

Survey of Utah's Oral Health Professional Training Institutions' Cross-Cultural Education or Training

Email:

Dear [FirstName] [LastName],

We're conducting a survey on cross-cultural education and training in Utah's oral health educational institutions. The Office of Health Disparities in the Utah Department of Health has been involved in providing oral health services to underserved minority populations in Utah for three years and we value your efforts to build the newest generation of oral health providers.

The survey's aim is to learn about the cross-cultural education and training in oral health educational institutions in Utah and see what additional community partnerships might be available to students. We thank you for your time and we appreciate your input.

The survey is anonymous and opens today (insert date) and closes (insert date) at midnight. You can take the survey anytime during this period.

The survey is about 20 questions long and will take 10-15 minutes to complete.

Please use the link below to take the survey:

{INSERT LINK}

Thank you again for participating in our survey. Your feedback is important.

Survey Introduction:

This survey gathers information on the cross-cultural education and training within oral health educational institutions in Utah.

The survey is about 20 questions long and will take 10-15 minutes to complete.

This questionnaire is completely anonymous. Please fill out the questionnaire completely and to the best of your ability.

*If your institution has multiple campuses please fill out one survey for the institution.

Defining terms:

Cross-cultural education or training: Instruction which enhances a student's understanding of differing cultural beliefs, behaviors, traditions, languages, customs, norms, etc. and how they might affect oral health and providing oral health services. Cross-cultural education/training may be delivered in varying formats.

Thank you for participating in our survey.

Survey

Cultural Competency Training
<p>1. Is cross-cultural education or training offered to all students?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>2. Is cross-cultural education or training required for all students?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>3. In what format is cross-cultural education or training taught/lectured at your school? (Check all that apply)</p> <p><input type="checkbox"/> Addressed in a separate, independent course</p> <p><input type="checkbox"/> Integrated with other course(s), with specific goals, objectives, and evaluation (Skip to question 5)</p> <p><input type="checkbox"/> Addressed with other course(s), without specific goals, objectives, and evaluation (Skip to question 5)</p> <p><input type="checkbox"/> Not part of the curriculum (Skip to question 6)</p>
<p>4. Do students receive academic credit for taking the cross-cultural education or training course?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>5. What are the methods of teaching cross-cultural education or training in your school? Check all that apply:</p> <p><input type="checkbox"/> Lectures/seminars</p> <p><input type="checkbox"/> Case studies</p> <p><input type="checkbox"/> Problem-based learning</p> <p><input type="checkbox"/> Small group discussions</p> <p><input type="checkbox"/> Role play exercises</p> <p><input type="checkbox"/> Presentations by community members</p> <p><input type="checkbox"/> Other: _____</p> <p>*If "other" was selected please specify (if "other" was not selected please skip to next question):</p>
<p>6. Is there a plan to offer a separate, independent course in cross-cultural education or training within the next year?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Our program offers a separate, independent course in cross-cultural education or training and will continue to do so.</p>

7. How well does your school address the following issues: (0=not addressed at all, 1=minimally addressed, 2=moderately addressed, 3=extensively addressed)

- ☐
- ☐ _____ Definitions and/or concepts of culture, diversity, ethnicity, and cultural competency
- ☐ _____ Concepts of culturally different health belief models
- ☐ _____ Access issues
- ☐ _____ Oral health disparities
- ☐ _____ Communication and interviewing skills of culturally different populations
- ☐ _____ Issues related to limited English proficiency of patients
- ☐ _____ Awareness and respect of culturally different groups
- ☐ _____ Ageism
- ☐ _____ Gender issues
- ☐ _____ Disabilities (physical and intellectual)
- ☐ _____ Racial/Ethnic minority culture
- ☐ _____ Linguistic barriers
- ☐ _____ Cultural barriers
- ☐ _____ Interpretation services

8. Overall, how much time annually (i.e. clock hours) do you think is spent in class, addressing cross-cultural education or training at your school?

- ☐ 0 hours
- ☐ Less than five hours
- ☐ From 5–10 hours
- ☐ From 11–20 hours
- ☐ From 21–30 hours
- ☐ From 31–40 hours
- ☐ More than 40 hours

9. In what type of community outreach/extramural programs do your students participate? Check all that apply:

- ☐ Public health or free/low-cost clinics
- ☐ Community health centers
- ☐ Mobile units
- ☐ Hospital clinics
- ☐ Private dental offices
- ☐ Screenings at health fairs, special events, community events
- ☐ Other: _____
- ☐ Institution does not have such a program (skip to 11)

10. How much time is spent annually per student in extramural/outreach programs?

- ☐ Less than five hours
- ☐ From 5–10 hours
- ☐ From 11–20 hours
- ☐ From 21–30 hours
- ☐ From 31–40 hours
- ☐ More than 40 hours

<p>11. Are faculty required to take cross-cultural continuing education courses/training?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>12. What do you think are the three most important reasons why you address cross-cultural issues at your school?</p> <p><input type="checkbox"/> (Assign your reasoning as follows: 1=most important, 2=second most important, 3=third most important)</p> <p><input type="checkbox"/> _____ Financial resources (i.e., grants, contracts, etc.)</p> <p><input type="checkbox"/> _____ Leadership commitment</p> <p><input type="checkbox"/> _____ Students' interest/request about this subject</p> <p><input type="checkbox"/> _____ A diverse patient population</p> <p><input type="checkbox"/> _____ Faculty expertise/interest</p> <p><input type="checkbox"/> _____ Other: _____</p> <p><input type="checkbox"/> _____ My school does not address cross-cultural issues</p>
<p>13. What do you think are the three most important reasons why your school doesn't devote more time to cross-cultural issues?</p> <p><input type="checkbox"/> (Assign your reasoning as follows: 1=most important, 2=second most important, 3=third most important)</p> <p><input type="checkbox"/> _____ Competing curricular time</p> <p><input type="checkbox"/> _____ Limited financial resources</p> <p><input type="checkbox"/> _____ Lack of leadership commitment/interest</p> <p><input type="checkbox"/> _____ Lack of students' interest</p> <p><input type="checkbox"/> _____ Lack of patients' diversity</p> <p><input type="checkbox"/> _____ Lack of faculty expertise/interest</p> <p><input type="checkbox"/> _____ Other: _____</p>
<p>14. Since the beginning of your program, has cross-cultural education or training at your school:</p> <p><input type="checkbox"/> Increased</p> <p><input type="checkbox"/> Decreased</p> <p><input type="checkbox"/> Remained the same</p>
<p>Community Partnerships</p>
<p>15. Is your institution interested in expanding community partnerships for students to gain experience and improve their cultural and linguistic competence:</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>

Institutional Information

16. School Location:

- ☐ Beaver
- ☐ Box Elder
- ☐ Cache
- ☐ Carbon
- ☐ Daggett
- ☐ Davis
- ☐ Duchesne
- ☐ Emery
- ☐ Garfield
- ☐ Grand
- ☐ Iron
- ☐ Juab
- ☐ Kane
- ☐ Millard
- ☐ Morgan
- ☐ Piute
- ☐ Rich
- ☐ Salt Lake
- ☐ San Juan
- ☐ Sanpete
- ☐ Sevier
- ☐ Summit
- ☐ Tooele
- ☐ Uintah
- ☐ Utah
- ☐ Wasatch
- ☐ Washington
- ☐ Wayne
- ☐ Weber

17. Programs offered by your institution:

- ☐ Dental Residency
- ☐ Doctor of Dental Surgery or Doctor of Dental Medicine
- ☐ Dental Hygiene
- ☐ Dental Assisting

18. Number of years that your program has been in operation:

- ☐ 0-2
- ☐ 3-5
- ☐ 6-8
- ☐ 9-11
- ☐ 12-15
- ☐ 16-20
- ☐ >20

19. Length of program:

- ☐ 1-4 months
- ☐ 5-12 months
- ☐ 13-18 months
- ☐ 19-24 months
- ☐ >2-4 years
- ☐ >4 years

20. Average number of students per cohort/class or program/license/certification (if multiple cohorts/classes are in progress simultaneously, please give the average number of students per cohort/class rather than the cumulative total of all enrolled students):

- ☐ <10
- ☐ 11-20
- ☐ 21-30
- ☐ 31-40
- ☐ >40

21. Student-to-Faculty Ratio (if this ratio is unknown please write n/a):

#__ students to 1 faculty member

Please list your title and responsibilities over cross-cultural education or training objectives and content:

Title:

Responsibilities:

Thank you for completing the survey!

If you have any questions, feel free to contact Dulce Díez at (801) 538-6773 or Brittney Okada at (801) 538-6779.

