REPORT ON ADVANCED EDUCATION IN GENERAL DENTISTRY PROGRAMS AND GENERAL PRACTICE RESIDENCY PROGRAMS ANNUAL SURVEY CURRICULUM SECTION

Background: At its Winter 2015 meeting, the Commission directed that each Review Committee review a draft of its discipline-specific Annual Survey Curriculum Section during the Winter meeting in the year the Survey will be distributed. The Commission further suggested that each Review Committee review aggregate data of its discipline-specific Annual Survey Curriculum Section, as an informational report, when the materials are available following data collection and analysis. The Commission noted that all survey data is considered confidential at the programmatic level.

The Curriculum Section of the Commission's Annual Survey is conducted for advanced education in general dentistry and general practice residency programs in alternate years. The next Curriculum Section will be conducted in August/September 2024. The draft Curriculum Section is provided in **Appendix 1** for review by the Postdoctoral General Dentistry Review Committee.

Summary: The Review Committee on Postdoctoral General Dentistry is requested to review the draft Curriculum Section of the Annual Surveys for advanced education programs in general dentistry and general practice residency **(Appendix 1)**.

Recommendation:

Prepared by: Ms. Peggy Soeldner

Part II - General Practice Residency/Advanced Education in General Dentistry (GPR/AEGD) Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

21. What percentage of time did FIRST-YEAR students/residents spend in each of the following areas during the 2021-22 residency year?

Column must add up to 100%. Do not enter percent signs.

a. Ambulatory dental care (treatment provided in the dental clinic, includes dental rotations)	%
b. Dental inpatient care (management of dental inpatients)	%
c. Management of dental inpatients or same-day surgery patients in the hospital operating room suite	%
d. Rotations/Assignments to other services (non-dental)	%
e. Didactics: courses/lectures/conferences/seminars	%
f. Responding to consults	%
g. Other, please specify	%
Total	%

22. Please indicate the total number of clock hours residents spent in formal courses, lectures and seminars receiving instruction in the following subject areas during the 2021-22 residency year.

If none, enter zero.

	Clock hours
a. Applied pharmacology (Standard 2-2)	
b. Endodontics (Standard 2-2)	
c. Hospital organization and function (Standard 2-10)	
d. Medical risk assessment (Standard 2-6)	
e. Restorative/Operative dentistry (Standard 2-2)	
f. Oral diagnosis/treatment planning (Standard 2-1)	
g. Oral and maxillofacial pathology (Standard 2-4)	
h. Oral and maxillofacial radiology/imaging (Standard 2-1)	
i. Oral and maxillofacial surgery (Standard 2-2)	
j. Pain and anxiety control (Standard 2-2)	
k. Patients with special needs (Standard 2-1)	
l. Periodontics (Standard 2-2)	
m. Physical evaluation (Standards 2-6, 2-7)	
n. Practice management (Standard 2-10)	
o. Preventive dentistry (Standard 2-1)	
p. Restoration of edentulous space (Standard 2-2)	
q. Other, please specify	

23. Indicate all rotations/assignments to non-dental services in either the sponsoring or affiliated institution(s) required of the residents. Give the length in weeks and hours per week for each assignment.

	Length of rotation/assignment (in weeks or equivalent weeks)	Average hours per week
a. Anesthesia (GPR Standard 2-5)		
b. Medicine (GPR Standard 2-6)		
c. Emergency Department (Standard 2-6)		
d. Other, please specify (GPR Standard 2-8, AEGD Standard 2-5)		

Use this space to enter comments or clarifications for your answers on this page.

24. Provide the following dental clinic statistics related to outpatient visits for the 2021-22 residency year. Include statistics for both sponsoring and affiliated institution(s). (Standard 2-1)

	Number of visits
a. Total number of outpatient visits to the dental clinic (include screening/consultative visits)	
b. Total number of outpatient visits managed by the residents	

25. How many patients with special needs did the residents treat during the 2021-22 residency year?

These are defined as patients whose medical, physical, psychological, or social situations make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, complex medical problems, and significant physical limitations. (Standard 2-1)

26. How many patients did residents provide comprehensive care to, from treatment plan to completion (as opposed to episodic or emergency care), during the 2021-22 residency year? (Standard 2-1)

27. Provide the following emergency care statistics for the 2021-22 residency year identifying the activity level(s) at both the sponsoring and affiliated institution(s). (Standard 2-1)

	Sponsoring institution	Affiliated institution(s)
a. The number of dental emergencies treated in the dental clinic by residents		
b. The number of dental emergencies treated in the hospital emergency department by all residents		

28. In which of the following conscious sedation techniques did residents receive instruction and clinical experience during the 2021-22 residency year? (Standard 2-2g)

	Instruction provided?		Clinical experience provided?	
	Yes	No	Yes	No
a. Oral	○	○	○	○
b. Inhalation	○	○	○	○
c. Intramuscular	○	○	○	○
d. Intravenous	○	○	○	○
e. Intranasal	○	○	○	○
f. Other, please specify	○	○	○	○

Use this space to enter comments or clarifications for your answers on this page.

NOTE: The procedures listed in Questions 29-32 have been selected as indicators of the amount, variety, and complexity of clinical experience provided to residents. They are not intended to summarize students'/residents' total experience or to imply that all listed procedures are required for accreditation. (Standard 5-1 OR Standard 2-2)

29. Indicate the total number of each of the following procedures in Preventive Dentistry completed by residents during the 2021-22 residency year.

	Number of procedures
a. Prophylaxis (D1110, D1120, D4346, D4355)	
b. Topical fluoride treatments (D1026 - D1028)	
c. Sealants (D1351, D1353)	

30. Indicate the total number of each of the following procedures in Restorative/Operative Dentistry completed by residents during the 2021-22 residency year.

	Number of procedures
a. Amalgam Restorations (D2140, D2150, D2160, D2161)	
b. Anterior composites (D2330, D2331, D2332 and D2335)	
c. Posterior composites (D2391, D2392, D2393, & D2394)	
d. Single unit crowns (D2710, D2712, D2720-D2722, D2740, D2750-D2753, D2780-D2783, D2790-D2792, D2794)	
e. Crown cores (cast or prefabricated) (D2952-D2954, D2957)	
f. Crown core build-up, including pins (preparatory work before crown) (D2950)	
g. Inlay/Onlay (D2510, D2520, D2530, D2542-D2544, D2610, D2620, D2630, D2642-D2644, D2650-D2652, D2662-D2664)	

31. Indicate the total number of each of the following procedures in Endodontics completed by residents during the 2021-22 residency year.

	Number of procedures
a. Single canals (anterior) (D3310, D3346)	
b. Double canals (bicuspid) (D3320, D3347)	
c. Molars (D3330, D3348)	
d. Apicoectomies (D3410, D3421, D3425, D3426)	

32. Indicate the total number of each of the following procedures in Periodontics completed by residents during the 2021-22 residency year.

	Number of procedures
a. Scaling, root planing and curettage (D4341, D4342, D4346, D4910)	
b. Gingivectomies (D4210-D4211, D4212)	
c. Soft tissue grafts/gingival flap procedures (D4240, D4241, D4270, D4273, D4275, D4276)	
d. Crown lengthening/Bone grafts/osseous surgery/guided tissue regeneration (D4249, D4260, D4261, D4266, D4267)	
e. Apically repositioned flap (D4245)	
f. Bone graft replacement graft – first site in quadrant (D4263)	
g. Bone replacement graft – each additional site in quadrant (D4264)	
h. Biologic materials to aid in soft tissue and osseous tissue regeneration (D4265, D4266)	

Use this space to enter comments or clarifications for your answers on this page.

NOTE: The procedures listed in Questions 33-36 have been selected as indicators of the amount, variety, and complexity of clinical experience provided to residents. They are not intended to summarize students'/residents' total

experience or to imply that all listed procedures are required for accreditation.

33. Indicate the total number of each of the following procedures in Removable Prosthodontics completed by residents during the 2021-22 residency year.

	Number of procedures
a. Units/complete dentures (D5110-D5120)	
b. Units/immediate dentures (D5130-D5140)	
c. Units/overdentures (D5863-D5866)	
d. Interim complete dentures (D5810, D5811)	
e. Adjustment to dentures and partials (D5410-D5422)	
f. Complete denture repairs (D5511, D5512, D5520)	
g. Repairs to partials (D5611-D5671)	
h. Acrylic partial dentures (D5211-D5212, D5221, D5222, D5225, D5226, D5820-D5821)	
i. Conventional cast frame partial frame dentures (D5213-D5214, D5223-D5224)	
j. Precision or semi-precision partial dentures attachments (D5862)	

34. Indicate the total number of each of the following procedures in Implant Services completed by residents during the 2021-22 residency year.

the total number of each of the following procedures in Fixed Prosthodontics completed	Number of procedures
a. Surgical placement of implant body (D6010, D6013)	
b. Prefabricated abutment (including placement) (D6056)	
c. Custom abutment (including placement) (D6057)	
d. Implant retained Removable Prosthodontics (D6110-D6113)	
e. Implant retained Fixed Prosthodontics (D6058-D6077, D6114-D6117)	

35. Indicate by residents during the 2021-22 residency year.

	Number of procedures
Units/fixed bridgework (D6205-D6794)	

36. Indicate the total number of each of the following procedures in Oral and Maxillofacial Surgery completed by residents during the 2021-22 residency year.

	Number of procedures
a. Uncomplicated extractions (D7111, D7140, D7210, D7250)	
b. Extractions of impacted teeth (D7220, D7230, D7240, D7241)	
c. Oral Tissue biopsy (D7285, D7286)	
d. Brush biopsy (D7288)	
e. Surgical removal of lateral exostosis (maxilla or mandible) (D7471)	
f. Surgical reduction of osseous tuberosity (D7485)	
g. Surgical reduction of fibrous tuberosity (D7972)	
h. Incision and drainage (D7510, D7511, D7520, D7521)	
i. Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth (D7270)	
j. Alveoplasties (D7310, 7311, 7320, 7321)	
k. Removal of torus palatinus (D7472)	
l. Removal of torus mandibularis (D7473)	
m. Suture of recent small wounds up to 5 cm (D7910)	
n. Complicated suture, up to 5 cm (D7911)	
o. Complicated suture, greater than 5 cm (D7912)	
p. Frenectomy (D7960)	

q. Excision of hyperplastic tissue – per arch (D7970)

r. Excision of pericoronal gingiva (D7971)

Use this space to enter comments or clarifications for your answers on this page.

37. How many times during the 2021-22 residency year were formal documented evaluations of resident performance conducted? (Standard 2-15)

38. Please select the response below that best describes the intended outcomes of residents' education. (Standards 1-8, 1-9, 2-2, 2-3)

- ◯ Goals and objectives
- ◯ Competencies and proficiencies

Use this space to enter comments or clarifications for your answers on this page.

CONSIDERATION OF THE ACCREDITATION STANDARDS RELATED TO THE OPTIONAL SECOND YEAR FOR ADVANCED EDUCATION IN GENERAL DENTISTRY AND GENERAL PRACTICE RESIDENCY PROGRAMS

Background: At its Summer 2023 meeting, the PGD RC briefly discussed the optional second year that may be offered by advanced education in general dentistry and general practice residency programs, and noted the primary requirement is that the written goals and objectives or competencies for resident didactic and clinical training in the optional second year of training must be at a higher level than those of the first year of the program. Through discussion it was noted that some programs have designed the curriculum in the optional second year to focus on gaining additional experience in advanced general dentistry procedures beyond that gained through the first year of the program. The PGD RC also noted that programs have designed the curriculum of the optional second year to focus on gaining training and experience in specific areas of dentistry, such endodontics or oral surgery as well as additional experiences in treating a select population of patients, such as patients with special needs or geriatric patients. However, these programs have minimal expectations that residents should also gain additional experiences in advanced general dentistry treatment. No matter the specific focus, the PGD RC believed the optional second year should include experience in all areas of advanced general dentistry, in addition to more focused training and experience in other areas of dentistry or in treating select populations. Therefore, the PGD RC believed the Accreditation Standards related to the optional second year should be reviewed for possible revision to clarify the intent and expectations of the optional second year.

Summary: The Review Committee on Postdoctoral General Dentistry Education and Commission on Dental Accreditation are requested to review the Accreditation Standards related to the optional second year for Advanced Education in General Dentistry programs (**Appendix 1**) and General Practice Residency programs (**Appendix 2**) for possible revision. If revisions to the Accreditation Standards are proposed, the Commission may wish to circulate the proposed revisions to the communities of interest for review and comment.

Recommendation:

Prepared by: Ms. Peggy Soeldner

CONSIDERATION OF THE ACCREDITATION STANDARDS RELATED TO THE OPTIONAL SECOND YEAR FOR ADVANCED EDUCATION IN GENERAL DENTISTRY AND GENERAL PRACTICE RESIDENCY PROGRAMS

ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN ADVANCED EDUCATION IN GENERAL DENTISTRY

STANDARD 2 EDUCATIONAL PROGRAM

2-11 Programs **must** be designed as either a one-year program, a one-year program with an optional second year or a mandatory two-year program.

Examples of evidence to demonstrate compliance may include:
Written second year goals and objectives or competencies for resident training
Written curriculum plan
Schedules

2-12 Residents enrolled in the optional second year of training **must** have completed an accredited first year of Advanced Education in General Dentistry or General Practice Residency training at this or another institution.

Examples of evidence to demonstrate compliance may include:
Resident records or certificate

2-13 The program **must** have written goals and objectives or competencies for resident didactic and clinical training in the optional second year of training that are at a higher level than those of the first year of the program.

Examples of evidence to demonstrate compliance may include:
Written second year goals and objectives or competencies for resident didactic and clinical training
Written curriculum plan

CONSIDERATION OF THE ACCREDITATION STANDARDS RELATED TO THE OPTIONAL SECOND YEAR FOR ADVANCED EDUCATION IN GENERAL DENTISTRY AND GENERAL PRACTICE RESIDENCY PROGRAMS

ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN GENERAL PRACTICE RESIDENCY

STANDARD 2 EDUCATIONAL PROGRAM

2-15 Programs **must** be designed as either a one-year program, a one-year program with an optional second year or a mandatory two-year program.

Examples of evidence to demonstrate compliance may include:
Written second year goals and objectives or competencies for resident training
Written curriculum plan
Schedules

2-16 Residents enrolled in the optional second year of training **must** have completed an accredited first year of a General Practice Residency or Advanced Education in General Dentistry training at this or another institution.

Examples of evidence to demonstrate compliance may include:
Resident records or certificate

2-17 The program **must** have written goals and objectives or competencies for resident didactic and clinical training in the optional second year of training that are at a higher level than those of the first year of the program.

Examples of evidence to demonstrate compliance may include:
Written second year goals and objectives or competencies for resident didactic and clinical training
Written curriculum plan

CONSIDERATION OF PROPOSED REVISIONS TO IMPROVE DIVERSITY IN DENTAL AND DENTAL RELATED EDUCATION PROGRAMS

Background: On December 1, 2023, the Commission on Dental Accreditation (CODA) received a letter from The National Coalition of Dentists for Health Equity (TNCDHE). The request is found in **Appendix 1**. In its letter, TNCDHE provides short-term and long-term suggestions to CODA to improve diversity in all academic dental, allied dental, and advanced dental education programs.

The short-term suggestions from TNCDHE include:

1. Better training of site visit teams on how to assess whether an educational program has implemented a plan to achieve positive results.
2. Ensuring site visit teams are inclusive of educators who represent diversity, such as in race, color, national or ethnic origin, age, disability, sex, gender, gender identity, and/or gender expression, and sexual orientation. Further, when possible, site visit team members should be representative of dental schools with demonstrated success in increasing diversity and assuring a humanistic environment.
3. Redefining the meaning and intent of "diversity" in the Standards, considering the recent Supreme Court decision. While the term diversity can no longer specifically relate to race with respect to admissions other characteristics such as family income, first-in-college-in-family, socioeconomic status, birthplace, gender identity and sexual orientation, and other attributes might be used as hallmarks of diversity.

The long-term suggestions from TNCDHE include:

1. Achieving a humanistic environment, addressing discrimination in policies and practice. Suggested revisions to the Accreditation Standards for Predoctoral Dental Education Programs were provided.
2. Review of student admissions related to the underrepresented segments of the population enrolled in dental schools. Suggested revisions and additions to various Accreditation Standards were provided.
3. Considering Standards related to an inclusive environment in dental education. Suggested revisions and additions to various Accreditation Standards were provided.
4. Considering Standards related to access to care among diverse populations. Suggested revisions and additions to various Accreditation Standards were provided.

Summary: The Postdoctoral General Dentistry Review Committee and Commission are requested to consider the letter from The National Coalition of Dentists for Health Equity (**Appendix 1**). If proposed revisions are made to the Accreditation Standards, the Commission may wish to circulate the proposed revisions for a period of public comment.

Recommendation:

Prepared by: Dr. Sherin Tooks

The National Coalition of DENTISTS for HEALTH EQUITY

December 1, 2023

Dr. Sherin Tooks, EdD, MS
Director, Commission on Dental Accreditation
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611
tookss@ada.org

Dear Dr. Tooks,

Recommendations to increase diversity in dental education and practice via the Commission on Dental Accreditation Standards

The National Coalition of Dentists for Health Equity's mission is to support and promote evidence informed policy and practices that address inequities in oral health. One of our priorities is to advocate for greater diversity among dental students and faculty to better reflect the diversity of the US population in the oral health workforce.

In November of 2022, we wrote to the Commission on Dental Education (CODA), expressing concerns about the lack of diversity in predoctoral dental education and the apparent lack of enforcement of the CODA standards on diversity (hot link to our letter on our website). We observed that despite these standards, no dental schools (as of 2022) had received a recommendation related to diversity over the ten years that the standards had been in place. Our letter recommended new standards, policies, and procedures that would enhance diversity in predoctoral dental education. We were pleased to learn that CODA accepted our letter and referred it to a committee reviewing potential changes in the predoctoral standards and that the committee's report will be considered in the early 2024 CODA meetings.

Since 2022, we have spent additional time reviewing CODA standards for the other academic dental educational programs including dental hygiene, dental therapy and advanced education programs and realized our recommendations should also apply to these other programs. In this letter, we review our original recommendations, and propose additional ones for all educational programs.

We believe that the dental school accreditation standards utilized by CODA serve a vital role in achieving a diverse oral health workforce. However, we also believe that the current CODA predoctoral education standards do not appear to be encouraging academic dental institutions to recruit a more diverse student body or faculty. CODA adopted the new diversity predoctoral education standards 1-3 and 1-4 about ten years ago. However, recent data from the American Dental Education Association shows that "between 2011 and 2019, the percentage of HURE applicants increased only 2.2% annually on a compounded basis, Additionally, the proportion of all HURE dental school first-year, first-time enrollees for the entering class increased by only 3% between 2011 (13%) to 2019 (16%) (ADEA Report-Slow to Change: HURE Groups in Dental Education, https://www.adea.org/HURE/)" The conclusion we draw is that dental schools are not doing enough to recruit more HURE students to meet the intent of the CODA Standards.

We recognize that the recent Supreme Court decision to abolish the use of race in making admission decisions will prevent academic dental institutions from using race as a determining factor in admissions. The recommendations we make below do not suggest or presume that strategy.

In this letter, we are offering several additional suggestions to CODA to improve the diversity of all academic dental education programs, including predoctoral, dental hygiene, advanced educational programs and dental therapy. Three of these are short term recommendations that are not related to changing accreditation standards, with the understanding that CODA appropriately takes considerable time in changing standards which entails seeking input from many individuals, communities, and entities. In addition, we make another set of suggestions that are long term and include modifications to the “Examples of evidence to demonstrate compliance” for some of the standards. Our recommendations are based on papers found in recent Special Editions of The Journal of Public Health Dentistry and the Journal of Dental Education.

In particular, the longer-term suggestions build on the recommendations of the paper by Smith, PD, Evans CA, Fleming, E, Mays, KAI Rouse, LE and Sinkford, J, 'Establishing an antiracism framework for dental education through critical assessment of accreditation standards, as well as two additional papers in the Special Edition including Swann, BJ, Tawana D. Feimste, TD, Deirdre D. Young, DD and Steffany Chamut, S, 'Perspectives on justice, equity, diversity, and inclusion (JEDI): A call for oral health care policy;' and Formicola, AJ and Evans, C, 'Gies re-visited.' Note that some of these recommendations were included in the previous letter to CODA sent on November 4, 2022

SHORT-TERM SUGGESTIONS

Suggestion 1: We recommend that site visit teams be better trained on how to assess whether an educational program has implemented a viable plan that achieves positive results. Under the structural diversity section of the Standards, it is stated clearly that the numerical distribution of students, faculty and staff from diverse backgrounds will be assessed. Assessment is appropriate but showing an improvement in the diversity of the dental schools’ academic communities based on the school's plans and policies should also be demonstrated.

Since site visit teams are different for each school, there can be no consistency in the assessment process unless site visitors are given explicit expectations of what schools should demonstrate to comply with each of the two standards. CODA should develop a specific detailed orientation for each site visit team on what is acceptable and what is not acceptable for each of these two standards.

Suggestion 2: To be better able to assess whether schools meet diversity and humanistic standards, site visit teams should be inclusive of educators who represent diversity, such as in race, color, national or ethnic origin, age, disability, sex, gender, gender identity, and/or gender expression, and sexual orientation. Wherever possible, site visit team members should also be representative of dental schools that have demonstrated success in increasing diversity and assuring a humanistic environment.

Suggestion 3: Especially in light of the recent Supreme Court decision, CODA should redefine the meaning and intent of the term "diversity" in the Standards documents. While the term diversity can no longer specifically relate to race with respect to admissions other characteristics such as family income, first-in-college-in-family, socioeconomic status, birthplace, gender identity and sexual orientation, and other attributes might be used as hallmarks of diversity.

LONG-TERM SUGGESTIONS

1) Achieving a humanistic environment- Not much is known about how dental schools address discrimination in their humanistic environment policies and practices. Although school policies on anti-discrimination might exist, students, faculty, and staff from underrepresented populations may still experience microaggressions, discrimination, racism, and barriers to socialization and mentorship. It has been suggested that such experiences may be underreported due to numerous factors, including fear of retaliation and/or disbelief that such concerns will be adequately addressed by the dental school. Because there are small numbers of underrepresented students, faculty, and staff in some dental schools, even anonymous humanistic surveys may not reveal these issues.

Suggested new "Examples of evidence to demonstrate compliance with Predoctoral Education Standard 1-3 may include:"

- Policies and procedures (and documentation of their effectiveness) implemented to seek feedback from traditionally underrepresented individuals concerning their experiences with the school's environment.
- Results of feedback that the school has sought from underrepresented students, faculty, and staff about their experiences with the school's environment.
- Documentation of the number and types of problems, complaints, and grievances reported about the school's environment, together with documentation of the school's effectiveness in addressing these issues.

2) Student Admissions

Despite the historical lack of students and faculty from underrepresented segments of the population enrolled in US dental schools, it appears that dental schools are rarely cited for not meeting Standard 1-4. One reason for this may be that the standard allows dental schools to set their own interpretations and expectations for student and faculty diversity. As a result, diversity at some dental schools may not appropriately emphasize certain specific underrepresented segments of the population and/or entirely represent the diversity of the local and regional population surrounding the schools, and/or reflect the national demographics in which the schools' graduates will practice their profession. Additionally, CODA provides no specificity for the level of engagement, with respect to recruitment, that dental schools should have with underrepresented populations

Suggested new "Examples of evidence to demonstrate compliance may include".

- Documentation that the school has implemented policies, procedures, and strategies to attract and retain students, faculty and staff from diverse backgrounds in order to achieve parity with the diversity profiles of the school's local, regional or national populations
- Documentation of longitudinal improvement in the diversity of the school's students, faculty, and staff. Where improvement is absent or minimal, documentation of the evaluation of strategies to improve diversity and of modifications made to these strategies to improve outcomes.

The intent of Standard 1-4 states that "admissions criteria and procedures should ensure the selection of a diverse student body with the potential of successfully completing the program". A problem is that the interpretation of this intent can vary dramatically from school to school. Admissions decisions are made by committees of people, and although there are trainings and processes to address implicit biases toward traditionally underrepresented applicants, the admissions process is still largely subjective. There are unique social and structural issues that exist for underrepresented applicants that must also be considered when assessing their potential for success. Those issues may influence undergraduate education academic achievements including GPA's and standardized tests. The question to admissions committees shouldn't necessarily be which applicant has the higher score, but rather does an applicant demonstrate appropriate academic achievements, despite a history of significant barriers, to successfully negotiate the curriculum.

Suggested new "Examples of evidence to demonstrate compliance may include:"

- Documentation of policies and procedures used to consider the unique social and structural constructs that affect traditionally underrepresented applicants in the admissions decision-making process.

- Documentation of procedures used to educate admissions committee members to implicit biases that may exist with respect to the potential of underrepresented applicants to excel in the academic program.
- Documentation of admissions criteria intended to assess not only academic achievements, but also the interest, desire, and commitment of applicants to learn about issues such as cultural competency, community-based practice, and addressing inequities in oral health within the population.

Standards 4-4 for Predoctoral Dental Education programs and Standard 4-2 for Dental Therapy programs state "Admission policies and procedures must be designed to include recruitment and admission of a diverse student population". There are no accreditation standards for Dental Hygiene or Advanced Educational programs that mandate that these programs have policies and practices to achieve a diverse student population. It is recommended that CODA add these standards with appropriate intent statements and examples of evidence to document compliance.

Generally, with respect to Standards 1-3, 1-4, and 4-4, we recommend that CODA strengthen the accountability that should undergird the standards. There must be accountability around these standards. Accountability must be built into the process of reviewing the standards, supporting site visitors in their work, and making sure that dental schools who fail to meet the standards are required to improve their practices and those dental schools who are exceeding the standards should be encouraged to continue to grow.

3) Inclusive Environments in Dental Education

Underrepresented students have a more difficult time achieving both success and a feeling of belonging in dental educational programs for a myriad of reasons.

To improve retention of students in dental education programs facing academic, social or emotional challenge, it is recommended that CODA strengthen the intent statement for student services (Standard 4-7 for predoctoral programs and Standard 4-12 for the dental therapy programs).

The intent statement should state "programs should have policies and procedures which promote early identification and subsequent mentoring/counseling of students having academic and/or personal issues which have the potential of affecting academic success or the personal well-being of students".

Dental Hygiene and Advanced Education programs have no accreditation standards that address academic or personal support for students having difficulties. It is recommended standards be added.

4) Access to Care among Diverse Populations

Access to dental care, and therefore oral and systemic health, is significantly compromised by a number of factors including race, gender, sexual orientation, economic status, education, and neighborhood environment, among other factors.

CODA should strengthen the intent statements with respect to graduates being competent in treating patients in all life stages (predoctoral standard 2-22, dental hygiene standard 2-12 and dental therapy standard 2-20) to assure that foundational knowledge is taught and clinical competence is assessed with respect to changes in oral physiology, the management of the various chronic diseases and associated therapeutics associated with aging, as well as psychological, nutritional and functional challenges manifested in many of these patients.

The intent statement of predoctoral standard 2-17, which addresses student's competence in managing a diverse population, is vague. It is recommended CODA strengthen predoctoral standard 2-17 by stating that "graduates MUST (currently reads should) learn about factors and practices associated with disparities in health status among vulnerable populations, including structural barriers, and must display competency in understanding how these barriers, including prejudices and policies regarding, but not limited to race, gender, sexual preferences, economic status, education and neighborhood environment, affect health and disease and access to care".

There are no standards for dental hygiene or advanced education programs that mandate that graduates be competent in treating a diverse population. CODA should add such standards to these programs.

According to the intent statement of predoctoral Standard 2-26, students working in community health care or service-learning settings are essential to the development of a culturally sensitive workforce. However, the standard merely states that the program makes available such learning environments and that students be urged to avail themselves of such opportunities. CODA should mandate the student’s participation in service-learning and/or community-based health centers clinics.

We are pleased to submit these suggestions to CODA and we hope they will be considered by CODA in our mutual efforts to increase the diversity of the dental workforce.

Sincerely,
Dr. Lawrence Hill DDS MPH
President, National Coalition of Dentists for Health Equity

cc:
American Dental Education Association - Dr. Karen West, President; Sonya Smith, Chief Diversity Officer, American Dental Education Officer

The National Coalition of Dentists for Health Equity is a national organization of accomplished dentists dedicated to assuring that everyone has an equitable opportunity to access high quality, affordable dental care.

National Dental Association - Tammy Dillard-Steels, MPH, MBA, CAE, Executive Director; Dr. Marlon D. Henderson, President; Dr. Kim Perry, Chairman of the Board
Diverse Dental Society – Dr. Tamana Begay, President
American Dental Therapy Association – Cristina Bowerman MNM, CAE, Executive Director
Hispanic Dental Association - Dr. Christina Meiners, 2023 President; Juan Carlos Pierotti, Operations Manager
Society of American Indian Dentists - Dr. Cristin Haase, President; Janice Morrow, Executive Director;
American Dental Association – Dr. Ray Cohlmia, Executive Director; Dr. Jane Grover, Council on Advocacy for Access, and Prevention; Dr. Linda J. Edgar, President
American Dental Hygienists' Association – Jennifer Hill, Interim CEO; JoAnn Gurenlian, RDH, MS, PhD, AAFAAOM, FADHA Director, Education, Research & Advocacy
Community Catalyst – Tera Bianchi, Director of Partner Engagement; Parrish Ravelli, Associate Director, Dental Access Project
National Indian Health Board – Brett Webber, Environmental Health Programs Director; Dawn Landon, Public Health Policy and Programs Project Coordinator
American Institute of Dental Public Health – David Cappelli Co-Founder and Chair; Annaliese Cothron, Executive Director

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