

**REPORT OF THE AD HOC COMMITTEE TO STUDY THE ACCREDITATION  
STANDARDS RELATED TO DIVERSITY AND PROGRAM DIRECTOR  
ON-SITE WORK EXPECTATIONS IN DENTAL, ADVANCED DENTAL  
AND ALLIED DENTAL EDUCATION PROGRAMS**

**Background:** At its Winter 2024 meeting, the Commission on Dental Accreditation (CODA) directed an Ad Hoc or Standing Committee to investigate in-person, on-site work expectations for program directors to determine if changes are needed in the discipline-specific Accreditation Standards for dental education, advanced dental education, and allied dental education programs. The Commission also directed establishment of an Ad Hoc Committee composed of all Commissioners who chair the discipline-specific Review Committees in dental, allied dental, and advanced dental education, and additional CODA Commissioners, to study the Accreditation Standards for possible revision related to the letter from The National Coalition of Dentists for Health Equity.

Program Director On-Site Work Expectations: At its Winter 2024 meeting, the Commission considered the New Business report of the Review Committee on Predoctoral Dental Education (PREDOC RC), which included a discussion about the possibility of program directors working remotely and not in-person, on-site at one of the program's approved educational sites. The PREDOC RC recognized the Commission does not have a defined policy or requirement in some discipline-specific Accreditation Standards that stipulates the program director must be in-person, on-site to fulfill the duties as written in the Accreditation Standards. The PREDOC RC believed that CODA should clearly define this expectation for future interpretation of program director qualifications in accordance with the discipline-specific Accreditation Standards. Through a discussion, the PREDOC RC recognized that new technologies and an increasing remote workforce may allow program directors to complete some job tasks remotely. However, tasks such as supervision of faculty and some day-to-day job responsibilities would require the program director to be in-person, on-site at the program's approved educational sites. Additionally, for programs that have multiple approved educational sites that may be geographically separated from the sponsoring institution, including those throughout an individual state or located in different states, it is not clearly defined how much time the program director should spend at each site for supervision over the day-to-day operations, as listed in the discipline-specific Accreditation Standards, or the requirement to delegate site supervision responsibilities. The PREDOC RC believed CODA may need to investigate and review the in-person, on-site work expectations for program directors to determine if changes are needed to the Accreditation Standards for dental education, advanced dental education, and allied dental education programs. Following consideration, the Commission directed an Ad Hoc or Standing Committee to investigate in-person, on-site work expectations for program directors to determine if changes are needed in the discipline-specific Accreditation Standards for dental education, advanced dental education, and allied dental education programs.

Additionally, at its Winter 2024 meeting, the Commission considered the New Business report of the Review Committee on Dental Hygiene Education (DH RC) related to program administrators that may be remotely located from the program's campus. The DH RC considered whether there should be oversight of remote program sites by an on-site individual who reports to the program director. The DH RC noted that some advanced dental education Standards require an on-site supervisor at remote program locations. The Commission noted that the Dental Hygiene Review Committee would monitor trends in remote program locations for dental hygiene education.

Accreditation Standards Related to Diversity: At its Winter 2023 meeting, the Commission on Dental Accreditation (CODA) considered the Report of its Review Committee on Predoctoral Dental Education (PREDOC RC) related to the November 4, 2022 request from Dr. Lawrence F. Hill, president of The National Coalition of Dentists for Health Equity (NCDHE), found in **Appendix 1**. The Commission directed the Ad Hoc Committee to Review Accreditation Standards for Dental Education Programs to consider the proposed revisions to Standards 1-3, 1-4 and 4-4 submitted by The National Coalition of Dentists for Health Equity (TNCDHE), with a future report to the Review Committee and Commission.

At its Summer 2023 meeting, the Standing Committee on Quality Assurance and Strategic Planning (QASP) discussed the February 16, 2023 letter (**Appendix 2**) and previously reviewed November 4, 2022 letter (**Appendix 1**) and materials from the NCDHE. The February 16, 2023 letter provided short term recommendations that would not require revision of the Accreditation Standards. The QASP members reviewed this topic again and believed that the TNCDHE letter appeared to focus on the enforcement of standards, calibration of site visitors, and diversity of CODA's site visitor volunteers. Following consideration of the QASP report, the Commission on Dental Accreditation directed a formal letter to The National Coalition of Dentists for Health Equity to inform the Coalition of the Commission's second review of its correspondence and actions that were underway by the Commission related to diversity, equity, inclusion and belonging.

On December 1, 2023, the Commission received a letter from TNCDHE (**Appendix 3**). In its letter, TNCDHE provided 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 included:

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 included:

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.

Each Review Committee of the Commission provided comment to CODA on TNCDHE letter, which was reviewed by the Commission in Winter 2024. Following consideration of Review Committee Reports, the Commission directed establishment of an Ad Hoc Committee composed of all Commissioners who chair the discipline-specific Review Committees in dental, allied dental, and advanced dental education, and additional CODA Commissioners, to study the Accreditation Standards for possible revision related to the letter from The National Coalition of Dentists for Health Equity.

**Report of the Ad Hoc Committee:** The Ad Hoc Committee, which was comprised of all current CODA Commissioners, met on August 7, 2024 at the ADA Headquarters. **Members of the Ad Hoc Committee:** Dr. Victor Badner (Ad Hoc chair, virtual), Dr. Evanthia Anadioti (virtual and in-person), Dr. Keith Beasley, Dr. Indraneel Bhattacharyya (virtual), Dr. Jessica Lee, Dr. Carolyn Brown, Dr. Ngoc Chu, Dr. Joseph Cohen, Dr. Scott DeRossi, Dr. Cherae Farmer - Dixon, Dr. Joseph Giovannitti, Dr. George Kushner, Dr. Cataldo Leone, Dr. Frank Licari (CODA vice-chair), Dr. Paul Luepke, Ms. Lisa Mayer (virtual), Dr. Keith Mays, Dr. Garry Myers, Dr. Monica Nenad, Dr. Lisa Nowlin, Dr. Cornelius Pitts (virtual), Dr. Jeffrey Price, Dr. Miriam Robbins (virtual), Dr. Nancy Rosenthal, Dr. Kenneth Sadler, Dr. Glenn Sameshima, Ms. Lonni Thompson, Dr. Deborah Weisfuse (virtual), and Mr. Noah Williams, were in attendance. Ms. Margaret Bowman-Pensel, Dr. Maxine Feinberg (CODA chair), Ms. LaShun James, Ms. Martha McCaslin, were unable to attend. **Commissioner Trainees:** Ms. Jill Day, Dr. Catherine Hayes, Dr. Renee McCoy-Collins, Dr. Kanthasamy Ragunathan, and Dr. Fabricio Teixeira, were in attendance. **Commission Staff:** Dr. Sherin Tooks, senior director, and Ms. Jamie Asher Hernandez, Ms. Katie Navickas, Dr. Yesenia Ruiz, Ms. Peggy Soeldner, Ms. Kelly Stapleton, managers, Ms. Marjorie Hooper, operations coordinator, and Ms. Samara Schwartz, senior associate general counsel, CODA, were in attendance.

The Ad Hoc Committee began its discussion with a review of the Commission's Winter 2024 charge related to each topic under consideration.

**Program Director On-Site Work Expectations:** The Ad Hoc Committee reviewed the background materials, which included the Commission's action leading to the Ad Hoc Committee, and the Standards for each discipline related to program director. The Ad Hoc Committee noted that the Advanced Education in General Dentistry, General Practice Residency Standards, and Pediatric Dentistry Standards include a requirement for a site director/site administrator at all off-campus clinical locations. The Committee discussed the changing environment in dental and dental hygiene education, noting increased establishment of off-campus sites where students spend a majority or all their time, much like a satellite campus. It was noted that while all CODA Standards have a requirement for clinical supervision at all educational activity sites, it was noted that most Standards do not address overall administrative oversight of the program, by the program director or a designee, at all sites where a student spends a majority or all their time. The Committee discussed whether virtual oversight or assignment of a responsible individual would be appropriate at all educational sites. The Committee believed there must be consistency in the educational program at all program sites.

Following consideration, the Ad Hoc Committee concluded that each Review Committee that does not currently have a Standard related to administrative oversight at major educational activity sites (e.g., off-campus sites where students spend a majority or all their time) should review this topic and determine whether a Standard is needed to address the Commission's expectation for administrative oversight, for consideration by the Commission in Winter 2025. In considering this matter, the Commission noted that inclusion of Intent Statements, in conjunction with proposed Standards, could further clarify the flexibility permitted for programs to oversee educational sites in a variety of ways, while ensuring administrative oversight and consistency in the educational program across all sites.

**Ad Hoc Committee Recommendation:** It is recommended that the Commission on Dental Accreditation direct each Review Committee that does not currently have a Standard related to administrative oversight at major educational activity sites (e.g., off-campus sites where students spend a majority or all their time) to review this topic and determine whether a Standard is needed to address the Commission's expectation for administrative oversight, with a report to the Commission in Winter 2025.

**Accreditation Standards Related to Diversity:** The Ad Hoc Committee reviewed the background materials, which included the prior work of the Commission on this topic, the letters from TNCDHE, CODA Standards related to diversity and the humanistic culture (including proposed revisions), Annual Survey data on dental programs related to diversity, and information from other accrediting agencies. The Committee engaged in extensive discussion related to TNCDHE's most recent letter of December 1, 2023, and the short-term and long-term

recommendations of TNCDHE. The Commission noted the Predoctoral Dental Education Review Committee submitted a report to the Commission for consideration at the Summer 2024 meeting, including significant revisions to the Accreditation Standards addressing diversity and the humanistic culture among other proposed changes, which address some of the recommendations of TNCDHE. Additionally, it was noted that the Oral and Maxillofacial Surgery Review Committee submitted a report on proposed revisions related to diversity and the humanistic culture, following a period of public comment, which would also be reviewed at the Summer 2024 meeting. The Committee noted that this is an important topic, but other considerations must also be acknowledged including differences among institutions related to missions, resources, funding, state and federal regulations, and legal considerations. It was noted that some states do not permit initiatives focused on diversity, and the Commission cannot impose Standards that would conflict with state or federal law. As such, the Committee noted the proposed predoctoral dental education Standard revision, which discusses diversity efforts, would be consistent with university policy and state law. The Committee also noted that other dental organizations such as the American Dental Association (ADA) and American Dental Education Association (ADEA) are working to enhance diversity and these agencies should continue to support this effort.

Following consideration, the Ad Hoc Committee concluded that all Review Committees of the Commission should consider the proposed revisions for the Dental Standards 1-2 and 1-3 and proposed revisions for the Oral and Maxillofacial Surgery Standards 1-11 and 2-1.7, for possible inclusion of similar Standards within the Review Committee's own discipline(s) to address diversity and the humanistic culture, with a report to the Commission in Winter 2025.

The Ad Hoc Committee also concluded that its work should continue with further consideration of TNCDHE's December 1, 2023, short-term and long-term recommendations, with additional work to occur prior to the Commission's Winter 2025 meeting. Finally, the Ad Hoc Committee believed that the Commission should communicate with The National Coalition of Dentists for Health Equity to provide an update on CODA's review of this matter, noting the topic's complexity and rapidly changing educational and regulatory environment, which must be monitored, while noting the Commission's commitment to a diverse academic environment.

**Ad Hoc Committee Recommendations:** It is recommended that the Commission on Dental Accreditation direct all Education Review Committees to consider the proposed revisions for the Dental Standards 1-2 and 1-3 and proposed revisions for the Oral and Maxillofacial Surgery Standards 1-11 and 2-1.7, for possible inclusion of similar Standards within the Review Committee's own discipline(s) to address diversity and the humanistic culture, with a report to the Commission in Winter 2025.

It is further recommended that the Commission on Dental Accreditation direct the Ad Hoc Committee (i.e., all CODA Commissioners) to continue its review of The National Coalition of Dentists for Health Equity December 1, 2023, short-term and long-term

recommendations, with additional work to occur prior to the Commission's Winter 2025 meeting.

It is further recommended that the Commission on Dental Accreditation direct a formal communication to The National Coalition of Dentists for Health Equity to provide an update on the Commission's review of this matter, noting the topic's complexity and rapidly changing educational and regulatory environment, which must be monitored, while noting the Commission's commitment to a diverse academic environment.

**Commission Action:**



November 4, 2022

**NCDHE Executive  
Leadership**

Lawrence F. Hill DDS,  
MPH – President

Frank Catalanotto, DMD  
– Vice President

Caswell Evans, Jr., DDS,  
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Sherin Tookss  
Director, Commission on Dental Accreditation  
Commission on Dental Accreditation  
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Dear Dr. Tookss,

I am writing to CODA as President of the National Coalition of Dentists for Health Equity (<https://www.dentistsfortheequity.org>). Our mission is to unite dentists in support of evidence-based, high quality and cost-effective oral health services including disease prevention and treatment and care delivery models. One of our priorities is to advance racial and ethnic diversity in the oral health workforce which starts in the recruitment and retention of historically underrepresented racial and ethnic (HURE) dental students and faculty.

We are writing to express our concern that the current CODA predoctoral education standards do not appear to be assuring that academic dental institutions recruit a racially diverse student body or faculty; we are specifically referring to Black, Latinx, and American Indian/Alaska Native students and faculty. We know that CODA adopted the new diversity 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 rose 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 recruiting enough HURE students to meet the intent of the Standards. However, during that same time period, no dental schools that have completed self-studies and site visits have received a recommendation for not meeting the standards.

We are offering several suggestions to CODA. Two are short term with an understanding that CODA appropriately takes considerable time in changing standards, which entails seeking input from many individuals, communities, and entities before making changes

*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.*

in the Standards. The third is long term and recommends a number of direct changes to the language in some of the standards.

First, the short-term suggestions. These comments would imply that Standards 1-3 and 1-4 are in fact strong enough but only if they are enforced. In other words, policies for improvement exist, but there does not seem to be a CODA requirement for outcomes. We believe that schools must show evidence of improved diversity among HURE students and faculty. The problem is enforcement of those two standards as CODA has also included a strong statement on diversity under the general information on educational environment. We recommend that site visit committees be better trained and educated on how to assess whether a school has actually put into place a viable plan that achieves positive results. Further, site visit committees must be diverse and should be inclusive of representatives of HURE dental educators. Under the structural diversity section, it is stated clearly that the numerical distribution of students, faculty and staff from diverse backgrounds will be assessed. Assessment is good but showing an improvement based on the school's plans and policies should also be demonstrated. Schools should recognize that having a plan is not sufficient. These standards have been in place for at least a decade and the schools will have had seven years since their last self- study, so there should not be any excuse for actual improvement in the numerical distribution of HURE students, faculty, and staff.

Since site visit teams are different for each school there is no consistency in the assessment process unless there are explicit expectations of what schools should achieve from 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 to achieve the educational environment clearly stated in their requirements.

The second short term suggestion also would not require any changes in the Standards. It is the experience of the educators in NCDHE that Site Visit teams are not very racially diverse. If that is the general case, are site visit teams comprised to be able to make informed judgements regarding racial and ethnic diversity? Are site visitors selected from schools that excel in their racial and ethnic diversity to ensure that capacity/expertise to judge racial and ethnic diversity is present on-site visit teams? Are site visitors from dental schools with limited racial and ethnic diversity given responsibility to judge racial and ethnic diversity? We suggest that CODA make greater efforts to assure that site visit teams have racial and ethnic diversity among membership of the site visit team that determines how academic dental institutions meet the CODA diversity standards.

The longer-term suggestions build on the recommendations of the recent Journal of Dental Education paper by Smith, PD, Evans CA, Fleming, E, Mays, KA, Rouse, LE and Sinkford, J, 'Establishing an antiracism framework for dental education through critical assessment of accreditation standards.' We also recommend reviewing at least 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.' We have attached these three papers to this letter.

### **Standard 1-3**

**Comment** -Not much is known about how dental schools address racism in their humanistic environment policies and practices. Although policies exist and are evaluated for accreditation, HURE students and faculty may still experience microaggressions, discrimination, and barriers to socialization and mentorship. Those experiences can negatively influence student and faculty views on the academic environment as well as the profession. Such experiences may be underreported due to fear of retaliation and/or disbelief that such concerns will be adequately addressed. In addition, due to



low numbers of HURE students and faculty, even anonymous humanistic surveys may not allow them to voice their concerns.

#### **Proposed Strategies for Standard 1-3**

- Dental schools should acknowledge that racially motivated grievances may be underreported and actively seek feedback from HURE students and faculty on how to improve dental schools' prevention and reaction to such grievances.
- Dental schools must provide evidence of their methods and frequency of engaging HURE students and faculty to address racism in the humanistic environment, while also providing evaluation of the effectiveness of those methods.
- Dental schools should provide evidence of the number and types of racially motivated grievances that get reported with evidence of their effectiveness in mitigating student and faculty concerns.
- Dental schools must provide evidence of students' and faculty their knowledge of the personal and institutional consequences of racist violations of the humanistic environment.

#### **Standard 1-4**

**Comment-** Despite the historical lack of representation of HURE students and faculty, it appears that dental schools continually meet this standard. It is unknown if the accreditation process has held any dental schools accountable for not meeting the standard due to few HURE students and faculty. A limitation of this standard is that it 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 emphasize HURE students and faculty, which also undermines the collective priority among dental schools to increase the number of HURE dentists within the profession. Additionally, CODA provides no specificity for the level of engagement that dental schools should have with HURE populations for recruitment.

#### **Proposed Strategies for Standard 1-4**

- Dental schools should develop and support partnerships with pre-dental programs at Historically Black Colleges and Universities (HBCUs) and Minority Serving Institutions (MSIs). Identifying and addressing limitations of those partnerships should also be a major emphasis.
- Dental schools must show how they are progressing toward increasing HURE students and faculty longitudinally. If schools consistently fail to show improvement, they must provide evidence that new efforts are being implemented or existing efforts are being modified on a continual basis.
- Dental schools must demonstrate a school-based pipeline program to develop future dentists from the schools HURE community to the K-12 and baccalaureate level
- Dental Schools should provide evidence of financial commitment to support HURE students and faculty through such activities as direct support and development grants.
- Dental Schools must evaluate their home state's racial and ethnic demographic data compared to the dental school's racial and ethnic demographics for students, faculty, and staff.
- Dental Schools must evaluate the success of their policies and procedures related to improving diversity.

#### **Standard 4-4**

**Comment-** One issue with this standard is how dental school applicants' potential to successfully complete a dental education program is determined. Admissions decisions are made by committees of people, and although there are trainings and processes to address certain implicit biases toward HURE applicants, the process is still subjective. There are unique social and structural issues that exist for HURE applicants that must also be considered when assessing HURE applicants' potential for success. Those issues may influence HURE students' undergraduate academic performance. Additionally, HURE applicants may develop an interest in a dental career later in their academic journey, have few academic mentors to guide them in meeting pre-requisite requirements for dental school applications,

and have less access to Dental Admissions Test preparation programs. Because there are few HURE students and faculty in the learning and social environments of some dental schools, members of admissions committees could question whether HURE students will have the levels of peer and faculty support to mitigate microaggressions, and implicit and explicit biases that may negatively impact their academic performance. Another issue is that policies intended to reduce racial discrimination may exist, but dental schools do not have to provide evidence as to whether those policies are being assessed and are working.

**Proposed Strategies for Standard 4-4**

- Dental schools should identify, acknowledge, and address the full social and structural contexts that HURE applicants bring with them, and implement systems to include those contexts in decision making about applicants' potential to succeed and enhance learning and professional environments; rather than just their potential to fit in and/or matriculate their particular programs.
- Dental schools must have systems in place for faculty and administrators to know how to address the social and academic concerns of HURE students rather than view those types of issues as deficits. As it stands, the institutional power of dental education programs may require that students and faculty adjust to the needs and comforts of their systems rather than modifying their systems to achieve equity in opportunities for success. For example, some dental schools may provide special accommodations for students with test taking anxiety, but similar considerations may not be available for students experiencing anxiety due to microaggressions from other students and/or faculty.
- In lieu of the lack of HURE faculty, dental schools must show evidence that they are actively measuring the levels of implicit racial bias that exist among admissions committee members and if those levels are consistently balanced. Admissions criteria should further consider beyond which applicants might successfully matriculate their programs, but which applicants will have an interest, desire, and commitment to learn about issues or more socially aligned curriculum shifts, such as structural competency, community-based practice, and addressing racism in dental practice and policy.

As a component of 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.

We would be happy to discuss these recommendations in person or via a Zoom call. We recognize that we have covered a lot of ground in these recommendations, but this issue is important enough to warrant attention by CODA. We would be happy to be of assistance in implementation of any of these suggestions. I can be reached at [larryhill66@icloud.com](mailto:larryhill66@icloud.com) and [dmaywhoor@gmail.com](mailto:dmaywhoor@gmail.com) or via telephone at 513-544-8844.

Sincerely,  
Larry 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

**National Dental Association** - Dr. Nathan Fletcher, Chairman of the Board; Keith Perry, Executive Director; Dr. Cheryl Lee, President

**Diverse Dental Society** – Dr. Sheila L. Armstrong, Board Member; LaVette Henderson, President

**American Dental Therapist Association** - Rachel Pfeffer, Interim Executive Director

**Hispanic Dental Association** - Dr. Manuel Cordero, Director, and CEO; Mercedes Mota Martinez, 2022 President

**Society of American Indian Dentists** - Dr. Cristin Haase, President; Janice Morrow, Executive Director

**American Dental Association** - Jane Grover, Executive Director; Dr. George R. Shepley, President

**Americana Dental Hygiene Association** – Ann Battrell, Executive Director; Ann Lynch, Policy Director

**Community Catalyst** – Tera Bianchi, Program Director, Dental Access Project

**National Indian Health Board** – Brett Webber, Environmental Health Programs Director

**American Institute of Dental Public Health** – David Cappelli Co-Founder and Chair; Analise Cothron, Executive Director

Ad Hoc Diversity and Program  
Director On-Site Expectations  
Commission Only  
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# Gies re-visited

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## KEYWORDS

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A number of reports and studies including the Surgeon General's Report of 2000, "Oral Health in America", linked the poor oral health of Black Americans to a lack of Black American practitioners.\* This stark fact officially recognized what communities of color had been experiencing historically and called for changes to address the evolving social and health care environment in the United States.

One of the major issues that continue to challenge this country is what is the best way to include Black Americans fully and equally into the life of the nation after a long legacy of segregation and subjugation? Although actions during the last quarter of the 20th century, prodded by legislation and Supreme Court rulings, opened the door for Black students to enroll in all institutions of higher education, including the professional schools, they were unable to create significantly greater equality in dental education. Indeed, the path to increasing more Black dental professionals is to build more positively on past successes and to reform the system of education that has the potential to make that happen. The history of Black Americans in the United States, their present position, and the current role of practicing dentists today serve to give context and an understanding of how to secure equitable access to dental care for Black Americans.

\*In addition to the year 2000 Surgeon General's Report, the Sullivan Commission on Diversity in the Health Care Workforce 2004, Solomon ES, Williams CR, and Sinkford JC. Practice locations characteristic of black dentists in Texas 2001 *J Dent Educ* 70: 398, the 2021 Report on oral health in America by NIH in collaboration with the Surgeon General provide background for this statement. We use the terms to refer to Black people as Gies and Flexner used when discussing their Reports, Negro and colored individuals. We place quotation marks around terms such as Negro and colored people when not part of a quote.

## 1 | UNDERSTANDING HISTORY

The 1926 Gies Report, *Dental Education in the United States and Canada*,<sup>1</sup> set the stage for dental education in the 20<sup>th</sup> Century as the 1910 Flexner Report<sup>2</sup> accomplished earlier for medical education. Gies traveled to all dental schools throughout the U.S. and Canada between 1919 and 1926 and evaluated each school based on its finances, facilities, research, and curriculum. His report evaluated the need for practitioners to base treatment on a scientific basis and identified the most pressing oral diseases impacting the oral health of the population. It established the blueprint for dental schools to become an integral part of the higher university system in the nation rather than for-profit or free-standing. The accrediting agency for dental schools initially prepared standards to evaluate schools based on the Gies Report. Most schools followed the recommendations in the Gies Report or closed. The Gies Report included the need to expand the enrollment of Black students in schools as there was only 1 Black dentist to about 8500 people in the "Negro population".

Gies<sup>1</sup> recognized that Howard University and Meharry Medical College were the only two dental schools that were devoted to the training of "colored" dentists at a high level. He called them the "pioneer Negro schools of dentistry"<sup>2</sup> and urged that they receive liberal [financial] support. But he noted as well that there were twenty-five dental schools that also admitted white and some "colored" students. Between 1919 and 1925, the years in which he collected data from the dental schools, 152 "Negroes" graduated from twelve of those 25 schools. Reflecting the times, Gies stated "General growth of sentiment for segregation has increased the tendency in many dental schools, to restrict

the attendance to white students, or to admit only the small number of colored students that may be useful for the treatment of a few Negro patients in the infirmary.<sup>3</sup> So, instead of urging all dental schools to admit students of color, he supported the need for additional dental schools for “Negros.”<sup>1</sup>

Gies ascribed the role of Black dentists as needed to treat the Black population. He also recognized that the White population at that time was generally indifferent to the welfare of the “colored” citizens, and the White population “fails to see the ends of enlightened self-interest, for every Negro having a communicable disease [which he states] is a menace to the health of all with whom he may be associated and particularly to the well-being of those he may serve personally and intimately.”<sup>4</sup> Essentially, Gies following the principle of separate but equal schools for the Black population that prevailed during his time, assigned the treatment of the Black population to Black practitioners. A close reading of the Gies report reveals some of his thinking on this subject. He thought that “...sick Negroes prefer to be treated and nursed by persons of their own group”... and “racial harmony between practitioner and patient could be expected.”<sup>5</sup>

Gies’ notions reflect the same general thought found in the Flexner Report of 1910<sup>6</sup>: “The negro must be educated not only for his sake but for ours. He is, as far as the human eye can see, a permanent factor in the nation. He has his rights and due and value as an individual; but he has, besides, the tremendous importance that belongs to a potential source of infection and contagion.”<sup>7</sup> Because of his ideology, Flexner called for medical education to ensure that “these men can be imbued with the missionary spirit...to serve their people humbly and devotedly, they may play an important part in the sanitation and civilization of the whole nation.”<sup>8</sup> A recent article in the New York Times Science Section entitled, “Black American Deaths, and a Paper From 1910<sup>9</sup>” described the “lesser-known side of the *Flexner Report*”, specifically the poor health of Black Americans, the segregated care they received, and the exclusion of Black medical students from training programs.

This history demonstrates the attitude of both Flexner and Gies, their social views, and the educational policies that prevailed in the US up until the 1950s. It was not until the Supreme Court struck down the pervasive attitude of “separate but equal” in the 1954 decision in *Brown versus Board of Education of Topeka* that the integration of schools became public policy. Beginning in the late 1960s and with civil rights legislation, higher education, including professional schools, understood the need for diversity in the academy. With Affirmative Action admission policies, approved by the Supreme Court, medical, law, and dental schools prompted by a changing social environ-

ment admitted students of color. The benefits of diversity in the student body “is the notion that features of the learning environment affect students’ mode of thought and that diversity produces more active thinking and can inspire intellectual engagement and motivation.”<sup>10</sup> The notion that black physicians and dentists should be trained to care for the black population began to fade to one of all practitioners who have an obligation to treat all patients regardless of race and ethnicity.

## 2 | WHERE DO DENTAL SCHOOLS STAND TODAY ON ENROLLING BLACK STUDENTS?

While there are notable efforts in some dental schools to create an encouraging environment or climate for students regardless of their ancestry, some schools have not moved the needle much beyond where they were in 1926. Why? One reason is that even with the recognition of the need to increase the number of Black practitioners in the United States, which had been recognized as far back as Gies, many schools have not increased their efforts sufficiently to recruit and enroll more Black students. In fact, in assessing the status of oral health, Warren et al., in 2009, noted:

“What is clear...is that the more disease is present, the more professional care is needed; few dental diseases heal independent of care. In this regard, because race/ethnicity and income are related to oral health status, and African Americans experience a disproportionately high prevalence of dental and oral disease, more dental professionals are needed to provide badly needed care. Moreover, because the race/ethnicity of the dentist is positively associated with the race/ethnicity of patient profiles, increasing the number of minority dentists will undoubtedly increase the oral health services that are available and accessible to underserved populations.”<sup>11</sup>

The Robert Wood Johnson Foundation-funded “Pipeline, Profession and Practice: Community Based Dental Education”, also known as the Dental Pipeline Program. It was a major national effort to increase the enrollment of historically underrepresented students. The ten-year project (2000–2010) was funded by the Robert Wood Johnson Foundation in collaboration with the California Endowment and the WK Kellogg Foundation. It funded dental schools in the nation to increase the recruitment and enrollment of URM students and to include community-based education as part of the curriculum. Fifteen of the participating dental schools were followed as part of an evaluation of the program. Over a period of 5 years, the fifteen schools employed the following strategies to increase the recruitment and enrollment of

underrepresented minority students: summer enrichment programs, postbaccalaureate programs, held meetings with preprofessional advisors from colleges with a major enrollment of URM students, created new recruitment materials directed to colleges with high enrollment of URM students, environment scans, attended admissions workshops directed to a whole-file review of candidates. Some formed collaboratives to work together on efforts.

Enrollment of URM students increased overall by 54.4% in the schools included in the evaluation. There was variability within the schools with four schools achieving 20% of their freshman classes made up of URM students and in two schools there was no change. Schools changed institutional policies related to admissions, and the internal school environment for student diversity, and added mentoring programs and scholarship funds to increase the diversity of the student body.<sup>12,13</sup> This program demonstrated that schools that desired diversity could achieve it if they expended the effort. However, it required schools to reform existing policies and practices in critical areas such as recruitment, admissions, and institutional climate for diversity and inclusion. The Commission on Dental Accreditation (CODA) has the responsibility to determine whether schools have accomplished reforms to satisfy two standards on diversity. The first standard, standard 1-4, states that schools must have policies and practices in place to achieve diversity among their students, faculty, and staff and comprehensive strategies to improve the institutional climate for diversity. The second standard, standard 4-4, states that schools must have admission policies and procedures designed to include recruitment and admission of a diverse student population. There is also a statement in CODA standards that expects the educational environment in schools to ensure an in-depth exchange of ideas and beliefs across gender, racial, ethnic cultural, and socioeconomic lines.<sup>14</sup> Whether schools achieve these standards or not is up to site visit teams who visit each school every 7 years. The standards on diversity were only added to the accreditation standards during the first decade of the 21st Century.

To move forward it is important to recognize that more needs to be accomplished. For example, in 2010–11 surveys of dental education, there were 10 dental schools that did not enroll any Black students, five that enrolled no Hispanic students, and two that enrolled not a single Black or Hispanic student.<sup>15</sup> A recent analysis showed that interventions to support diversity in dental schools showed little benefit to Black students over the past 20 years.<sup>9</sup> An analysis of annual ADA survey data from 2010 to 2020 showed that the percentage of enrollees who were Black in 2000 was 4.7% and in 2019 it was 5.7%, far below the 13.4% Black Americans in the population.<sup>16</sup>

Between 2010 and 2020, seventy-seven dental schools have been reviewed by CODA. CODA data shows that no dental school has been cited for not satisfying CODA diversity standards.<sup>17</sup> Are the standards too broad in their intent and interpretation? Can diversity be demonstrated in so many ways that preclude the consideration of underrepresented minority students and faculty as meaningful and essential elements? Are the standards true markers in the attempt to achieve greater racial equity among students, faculty, and ultimately the profession?

It will take greater sustained efforts by all dental schools to recruit and enroll Black students. Students of color recognize that more faculty of color are needed as mentors to improve the relationship between them and the predominantly white faculty.<sup>18</sup> The role of Black faculty members is critical to the sustained efforts needed. Between the 2015 and 2019 academic years, there was no change in the percentage of the full-time and part-time African American dental faculty, which was only 4% of the faculty.<sup>19</sup> Since full-time faculty carry much of the teaching, administration, and research responsibility, it is important to have an appreciation for those Black faculty members employed by the nation's dental schools and to assess how best to increase their numbers on the faculties nationwide. They are needed to assist in recruiting and mentoring Black students.

Currently, the American Dental Education Association is conducting a climate survey of all dental schools in the United States and Canada. We are hopeful that this new survey will provide useful information which will lead to a new emphasis on the importance of moving all dental schools in the right direction by including diversity and inclusion in their student body and their faculty. It is important for all schools to become aware of the successful strategies that have been shown to work.<sup>20,21</sup> There is no need to reinvent the wheel.

### 3 | THE ROLE OF ALL PRACTICING DENTISTS IS TO TREAT THE ENTIRE POPULATION

Unfortunately, there is still unequal access to oral health care in the United States. The reasons are complex, varied, and intertwined, ranging from social, financial, and racial issues. Black and other populations of color also face obstacles of equity to obtain the same quality of care as white patients.

In the first instance, vestiges of the Gies and Flexner models of health care education for Black students are no longer valid today. Their ideas which ascribed the responsibility of Black dentists and physicians respectively to treat the Black population as the rationale for improving

the representation of Black practitioners in practice are no longer tenable. Both the Surgeon General's Report of 2000 and the 2021 NIH report, *Oral Health in America: Advances and Challenges*, released in collaboration with the US Surgeon General, cited the fact that Black youth had a significantly higher prevalence of untreated caries than White youth. Why? Because there continues to be a shortage of dentists in 5800 dental shortage areas in the US affecting approximately 58 million people. Three percent of the dentists are Black (2011–2015) while 13.3% of the population is Black. In comparison, 74.8% of dentists are white while 61.3% of the population is white.<sup>22,23</sup>

In the second instance, the need to treat all segments of the multiracial US population cannot be solved by segmenting practitioners' responsibility by race or ethnicity. All practitioners are responsible to treat patients from all aspects of the population.<sup>24</sup> But, there are barriers to fully embracing such an oral health system. For example, practitioners must recognize and accept the obligation to treat all the low-income Medicaid patients, including all historically underserved population groups. Currently, only less than half of the practicing dentists even accept Medicaid patients. At the same time, practitioners also need to understand that cultural bias for treatment options must be confronted in order for treatment outcomes to be equitable for all patients regardless of their individual characteristics.<sup>24,25</sup>

Therefore, to become an inclusive society, outreach is needed from our educational institutions to marginalized populations and ethnic groups. More specifically, a renewed commitment to bring parity to eliminate oral health inequities among Black Americans can only be rectified through a willingness to put into place policies and practices that include Black Americans fully in the academy and as patients in all dental practices.

In revisiting Gies Chapter V, "*Deficiency of Dental Service for the Negro Group*", the following question arises from the fact that he stated that the "general growth of sentiment for segregation has increased the tendency, in many dental schools, to restrict the attendance to white students ...".<sup>26</sup> Was he satisfied with the fact that in 1924–25 only 27 "Negros" were graduated from 12 dental schools of the 40 dental schools (exclusive of Howard and Meharry) that accepted both Black and White students?<sup>27</sup> What, if he had recommended that all of the then 40 dental schools admit Black dental students. By accepting the "prevailing sentiment for segregation" which "prevents admission of more than a few colored students to the existing medical and dental schools attended by white students", Gies,<sup>28</sup> unwittingly, gave legitimacy to the idea that Black dentists should be educated by Black dental schools to only provide care for the Black population. His support of Howard and Meharry as the "pioneer Negro schools of dentistry"

was correct. But, his inability to realize that the result of all of the public in the United States required a cohesive approach regardless of race and ethnicity in order that all people should and would receive the same level of prevention and care. The 1926 Gies Report set out the blueprint for dental education in the United States until the 1960s when the health science schools broadened the vision for their institutions and their professions. An opportunity was lost when the reports by the Carnegie Foundation for the Advancement of Dentistry and Medicine in the early part of the 20th Century failed to question the social convention of their day. It is time now to recognize the social movement of the 21st Century and, particularly that all dental schools in the United States must open their doors to all qualified Black applicants.

### EDITOR'S DISCLOSURE

This article is published in the *Journal of Dental Education* as part of a special issue. Manuscripts for this issue were solicited by invitation and peer reviewed. Any opinions expressed are those of the authors and do not represent the *Journal of Dental Education* or the American Dental Education Association.

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# Establishing an antiracism framework for dental education through critical assessment of accreditation standards

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## Abstract

**Purpose:** The purpose of this manuscript is to establish an antiracism framework for dental education. Since the accreditation process is an influential driver of institutional culture and policy in dental education, the focus of the framework is the Commission on Dental Accreditation (CODA) standards for predoctoral education.

**Methods:** The authors of this manuscript reviewed each CODA predoctoral standard for opportunities to incorporate antiracism strategies. Eight standards were identified under themes of diversity (Standards 1-3, 1-4, 4-4), curriculum development (Standards 2-17, 2-26), and faculty recruitment and promotion (Standards 3-1, 3-4, 3-5). Guided primarily by National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, a logic model approach was used to critically assess those standards for opportunities to establish antiracism strategies, with anticipated outcomes and impacts.

**Results:** Strategies highlighted a need to improve recruitment, admissions, and accountability among dental schools to address the low numbers of historically underrepresented racial and ethnic (HURE) students and faculty. They emphasized the inclusion of racism in curricula geared toward training dental students to provide care to HURE populations. Finally, there are opportunities to improve accountability that dental schools are providing equitable opportunities for career advancement among HURE faculty, with consideration of conflicting demands for scholarship with HURE student mentoring, role modeling, teaching, and/or service.

**Conclusions:** The framework identifies gaps in CODA standards where racism may be allowed to fester, provides specific antiracism strategies to strengthen antiracism through the accreditation process, and offers dental education programs, a process for evaluating and establishing their own antiracism strategies.

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**KEYWORDS**

accreditation, cultural diversity/cultural competency, dental education, minority recruitment, racism, underrepresented minority faculty, underrepresented minority students

**1 | INTRODUCTION**

Antiracism in dental education demands that institutions and policies counter the effects of racism while dismantling the systemic forces that perpetuate it. It is a process of promoting and advocating for policies and leaders that speak against racism, educate others about its harmful effects on the dental profession, and build institutional cultures that are intolerant of racist ideology and/or complacency toward racial inequity. Accreditation is one of, if not the most, influential driver of policy, procedures, and institutional cultures within dental education. The Commission on Dental Accreditation (CODA) is intended to serve the interest of the public and the profession by developing and monitoring standards to assess and verify the quality of dental education programs in the United States.<sup>1</sup> Dental education programs rely on the accreditation process for quality improvement, which assures affinity in their ability to train dentists who can address the oral health needs of the general population. The importance and influence of accreditation status on educational programs obliges accrediting agencies to establish the precedent for antiracism policy and accountability.

The educational environment section of CODA predoctoral standards states that, “each dental school must... have policies and practices to achieve an appropriate level of diversity among its students, faculty and staff (p. 12).”<sup>1</sup> However, current CODA predoctoral standards provide limited specificity and clarity on the level of commitment or precise levels that dental schools must demonstrate to address dimensions of racial diversity among students, faculty, and staff. There are no specific CODA-driven metrics to standardize how schools address race and ethnicity in curricula, that is, implicit bias, discrimination, and cultural competency. Additionally, expectations among dental schools for the recruitment, retention, and promotion of historically underrepresented racial and ethnic (HURE) faculty are also unclear. HURE is defined as American Indian/Alaska Native, Black/African American, Hispanic/Latinx, and Native Hawaiian or Other Pacific Islander population groups.

The framework presented in this paper is built with an assumption that dental education needs to: (1) provide rationale for the dental accreditation process to establish metrics that address dimensions of diversity and drive change in diversity initiatives, curricula, and faculty devel-

opment; (2) emphasize the role of accreditation standards in promoting or inhibiting the effectiveness of strategies and practices aimed at reducing the effects of racism within the dental education; and (3) provide the basis for a system approach to addressing institutional racism within dental education programs. The intention of this framework is to offer guidance for using the accreditation process to drive institutional policy changes that specifically address racism, and improve accountability that dental schools are working collectively to develop and achieve antiracist aims.

**1.1 | The need for antiracism in dental education****1.1.1 | Historical lack of diversity among students and faculty**

The 1926 Gies Report<sup>2</sup> iterated that poor oral health among Black people threatened the health of the general population, and that Black dentists were not being produced at rates that could keep up with the growth of Black populations in various parts of the country. At that time, most dental schools did not admit Black students into their programs, and most of the ones that did admitted a limited number of them solely to care for the Black patients who presented to their infirmaries. The majority of dentists were trained at two historically Black dental schools: Howard University College of Dentistry and Meharry Medical College School of Dentistry. Since then, the total number of yearly HURE dental school graduates has increased, with more diversity in aggregate at US dental schools. However, those changes are not substantial enough to significantly improve racial and ethnic diversity within the dentist workforce.<sup>3</sup>

The pretense that Black dentists were valuable in the limited context of only servicing the needs of Black infirm patients in 1926 aligned with the systemic practice of racial segregation of that time. The question to be asked now is: has the conceptual basis for that pretense changed over the past 100 years? It has been predicted that by the year 2045, people of color are expected to comprise the majority of the US population, yet racial inequity and underrepresentation in the oral health workforce will likely persist.<sup>3-5</sup>

## 1.1.2 | Lack of HURE dentists and poor quality of access to dental care among HURE populations

HURE populations experience more untreated tooth decay, tooth loss, and severe periodontal disease than non-Hispanic White populations.<sup>6–10</sup> Having HURE dentists improves the poor availability, affordability, and quality of dental care that occurs as a result of fewer dental providers in communities where higher concentrations of HURE populations reside, poor patient–doctor communication, discrimination, and HURE populations' historical mistrust of healthcare providers.<sup>11–16</sup> Yet, the number of HURE dentists are low relative to the total number of dentists in the US population. In 2021, the Health Policy Institute of the American Dental Association reported that relative to the racial mix of the US population, White and Asian dentists were overrepresented (88.2%), while Black (3.8%) and Hispanic (5.9%) dentists were underrepresented.<sup>17</sup> From 2010 to 2020, of the 63,583 dental school graduates, 54.07% identified as White/Caucasian, 23.6% Asian (non-Hispanic/Latino), 4.7% non-Hispanic Black, 7.23% Hispanic, and 0.45% American Indian/Alaska Native, with a reduction in the percentage of non-Hispanic Black and American Indian/Alaska Native graduates from 5.4% to 4.7%, and 0.7% to 0.4%, respectively.<sup>18</sup>

HURE dentists provide care to significant numbers of racially concordant patients, and greater percentages provide care to Medicaid patients, compared to White dentists.<sup>5,19</sup> Mertz et al.<sup>20,21</sup> reported that on average, Black and Hispanic dentists' patient mix was 44% Black and 42% Hispanic, respectively. There is a maldistribution of dentists providing routine care to underserved populations.<sup>22</sup> It has been reported that in 2017, only 25% of White dentists treated at least one Medicaid patient, compared to 46% of Black dentists and 33% of Hispanic dentists.<sup>18</sup> Only 12% of White dentists treated 100 or more Medicaid patients compared to 30% of Black dentists and 22% of Hispanic and Asian dentists, respectively. These data highlight the significant value of HURE dentists in improving access to care for lower income and HURE populations, and addressing oral health inequities.

## 2 | DEVELOPING THE FRAMEWORK

The antiracism framework presented in this manuscript was conceptualized using the logic model approach employed by the US Department of Health and Human Services, Office of Minority Health in the development of their strategic framework for improving racial/ethnic minority health and eliminating health disparities.<sup>23</sup> Each CODA standard for predoctoral dental education programs

was reviewed by the authors of this manuscript and standards that were closely associated with diversity, curriculum development, and faculty recruitment and promotion were critically discussed to identify opportunities to incorporate antiracist strategies (Table 1). Proposed strategies were then developed to offer guidance for how the accreditation process can incorporate antiracist language and processes for evaluating dental schools' progress toward positive outcomes (Figure 1).

Guidance for developing the antiracism strategies proposed in this framework were informed by the Liaison Committee on Medical Education standards, the American Dental Education Association (ADEA) Faculty Diversity Toolkit, the US Department of Health and Human Services National Standards for Culturally and Linguistically Appropriate Services (CLAS), and the ADEA Minority Faculty Development and Inclusion Program.<sup>24–28</sup> For primary guidance, we relied upon national CLAS standards, which were adopted by the US Department of Health and Human Services with the intention of establishing a blueprint for health organizations to advance health equity, improve quality, and help eliminate healthcare disparities.<sup>26</sup> There are 15 CLAS standards; seven of which have been mapped to CODA standards assessed for this framework (Table 2). The purpose of using CLAS standards was to align the proposed strategies for CODA standards with national priorities for addressing health equity.

## 3 | CRITICAL REVIEW OF ACCREDITATION STANDARDS

Eight CODA standards were identified for review. Concerns for each standard and proposed strategies to address them are outlined in Table 3 and discussed below.

### 3.1 | Racial diversity among students and faculty

#### 3.1.1 | Standard 1-3

Not much is known about how dental schools address racism in their humanistic environment policies and practices. Although policies exist and are evaluated for accreditation, HURE students and faculty may still experience microaggressions, discrimination, and barriers to socialization and mentorship. Those experiences can negatively influence student and faculty views on the academic environment as well as the profession. Such experiences may be underreported due to fear of

**TABLE 1** Summary of Commission on Dental Accreditation (CODA) standards and intent statements related to diversity, dental education curriculum, and faculty recruitment and promotion

CODA standards	Intent statements
<i>Racial diversity among students and faculty</i>	
1-3 The dental education program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.	The dental education program should ensure collaboration, mutual respect, cooperation, and harmonious relationships between and among administrators, faculty, students, staff, and alumni. The program should support and cultivate the development of professionalism and ethical behavior by fostering diversity of faculty, students, and staff.
1-4 The dental school must have policies and practices to: (a) achieve appropriate levels of diversity among its students, faculty, and staff; (b) engage in ongoing systematic and focused efforts to attract and retain students, faculty, and staff from diverse backgrounds; and (c) systematically evaluate comprehensive strategies to improve the institutional climate for diversity.	The dental school should develop strategies to address the dimensions of diversity including, structure, curriculum, and institutional climate. The dental school should articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. Schools could incorporate elements of diversity in their planning that include, but are not limited to gender, racial, ethnic, cultural, and socioeconomic. Schools should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty, and staff.
4-4 Admission policies and procedures must be designed to include recruitment and admission of a diverse student population.	The dental education curriculum is a scientifically oriented program which is rigorous and intensive. Admissions criteria and procedures should ensure the selection of a diverse student body with the potential for successfully completing the program. The administration and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures that are non-discriminatory and ensure the quality of the program.
<i>Race, racism, and curricula</i>	
2-17 Graduates must be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment.	Students should learn about factors and practices associated with disparities in health status among subpopulations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental education in: basic principles of culturally competent healthcare; basic principles of health literacy and effective communication for all patient populations recognition of healthcare disparities and the development of solutions; the importance of meeting the healthcare needs of dentally underserved populations; and the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multidimensionally diverse society.
2-26 Dental education programs must make available opportunities and encourage students to engage in service learning experiences and/or community-based learning experiences.	Service learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral healthcare workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.

(Continues)

TABLE 1 (Continued)

CODA standards	Intent statements
<i>Faculty recruitment and promotion</i>	
3-1	The number, distribution, and qualifications of faculty and staff must be sufficient to meet the dental school's stated purpose/mission, goals, and objectives, at all sites where required educational activity occurs. The faculty member responsible for the specific discipline must be qualified through appropriate knowledge and experience in the discipline as determined by the credentialing of the individual faculty as defined by the program/institution.
3-4	A defined evaluation process must exist that ensures objective measurement of the performance of each faculty member in teaching, patient care, scholarship, and service.
3-5	The dental school must have a stated process for promotion and tenure (where tenure exists) that is clearly communicated to the faculty.

FIGURE 1 Conceptual illustration of the logic model approach used to develop the antiracism framework for predoctoral dental education accreditation standards. CODA, Commission on Dental Accreditation



retaliation and/or disbelief that such concerns will be adequately addressed.<sup>29,30</sup> In addition, due to low numbers of HURE students and faculty, even anonymous humanistic surveys may not allow them to voice their concerns.

### 3.1.2 | Proposed strategies for Standard 1-3

- Dental schools should acknowledge that racially motivated grievances may be underreported and actively seek feedback from HURE students and faculty on how to improve dental schools' prevention and reaction to such grievances.
- Dental schools must provide evidence of their methods and frequency of engaging HURE students and faculty to address racism in the humanistic environment, while also providing evaluation of the effectiveness of those methods.
- Dental schools should provide evidence of the number and types of racially motivated grievances that get reported with evidence of their effectiveness in mitigating student and faculty concerns.
- Dental schools must provide evidence of students' and faculty their knowledge of the personal and institutional consequences of racist violations of the humanistic environment.

### 3.1.3 | Standard 1-4

Despite the historical lack of representation of HURE students and faculty, it appears that dental schools continually meet this standard. It is unknown if the accreditation process has held any dental schools accountable for not meeting the standard due to few HURE students and faculty. A limitation of this standard is that it 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 emphasize HURE students and faculty, which also undermines the collective priority among dental schools to increase the number of HURE dentists within the profession. Additionally, CODA provides no specificity for the level of engagement that dental schools should have with HURE populations for recruitment.

### 3.1.4 | Proposed strategies for Standard 1-4

- Dental schools should develop and support partnerships with predoctoral programs at Historically Black Colleges and Universities (HBCUs) and Minority Serving Institutions (MSIs).<sup>3</sup> Identifying and addressing limitations of those partnerships should also be a major emphasis.<sup>31</sup>

**TABLE 2** National Culturally and Linguistically Appropriate Services (CLAS) standards addressed in this framework

Standard Description	CLAS Standard Reference
Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.	1-3, 1-4, 2-17, 2-26, 3-1, 3-4, 3-5, 4-4
Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.	
Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.	1-3, 1-4, 3-1, 3-4, 3-5, 4-4
Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	1-3, 2-17, 2-26
Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all healthcare and services.	2-17
Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	
Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.	
Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	
Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	1-3, 1-4, 2-17, 2-26, 3-1, 3-4, 3-5, 4-4
Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.	1-3, 1-4, 2-17, 2-26, 3-1, 3-4, 3-5, 4-4
Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	
Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	
Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.	2-26
Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.	1-3
Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.	

- Dental schools must show how they are progressing toward increasing HURE students and faculty longitudinally. If schools consistently fail to show improvement, they must provide evidence that new efforts are being implemented or existing efforts are being modified on a continual basis.

### 3.1.5 | Standard 4-4

One issue with this standard is how dental school applicants' potential to successfully complete a dental education program is determined. Admissions decisions are made by committees of people, and although there are trainings and processes to address certain implicit biases toward HURE applicants, the process is still subjective. There are unique social and structural issues that exist for HURE applicants that must also be considered when

assessing HURE applicants' potential for success. Those issues may influence HURE students' undergraduate academic performance. Additionally, HURE applicants may develop an interest in a dental career later in their academic journey, have few academic mentors to guide them in meeting pre-requisite requirements for dental school applications, and have less access to Dental Admissions Test preparation programs.<sup>32</sup> Because there are few HURE students and faculty in the learning and social environments of some dental schools, members of admissions committees could question whether HURE students will have the levels of peer and faculty support to mitigate microaggressions, and implicit and explicit biases that may negatively impact their academic performance. Another issue is that policies intended to reduce racial discrimination may exist, but dental schools do not have to provide evidence as to whether those policies are being assessed and are working.

**TABLE 3** Example and summary of the antiracism framework for dental education accreditation

Problems	CODA standards	Proposed strategies and practices	Needed outcomes and impacts
<i>Racial diversity among students and faculty</i>			
Limited specificity and clarity on the intention of dental schools to address racial diversity among students and faculty	1-3	<p>Dental schools must provide evidence of their processes for systematically addressing race-related concerns for the humanistic environment while also addressing student and faculty concerns for retaliation</p> <p>Students and faculty must be required to provide evidence of their knowledge of and acceptance of the personal and institutional consequences of humanistic misconduct</p> <p>Dental schools must be required to provide evidence of the number and types of race-related grievances and how they were able to effectively mitigate those grievances</p>	<p>Written and enforced processes for addressing race-related concerns for the humanistic environment</p> <p>Accountability among students and faculty of their understanding that race-related humanistic misconduct will not be tolerated</p> <p>Accountability within dental schools that race-related grievances are being adequately addressed</p>
	1-4	<p>Dental schools must show benchmarks for racial representation and how they are progressing toward meeting those benchmarks longitudinally over time</p>	<p>Processes for increasing racial representation through pipeline programs</p> <p>Evaluation metrics that identify strengths and weaknesses of recruitment processes</p> <p>Evidence of pipeline program modifications over time</p>
	4-4	<p>Predocloral programs must have written standards, criteria, and evaluation metrics that account for applicants' social contexts</p> <p>Dental schools must have protocols and programs in place that specifically and effectively address the social and academic concerns of underrepresented minority students, that is, discrimination and microaggressions</p> <p>Dental schools must show evidence that they are annually measuring and balancing the levels of implicit racial bias that exist among admissions committee members</p>	<p>Processes for reviewing students holistically and based on addressing the dental profession's needs</p> <p>Underrepresented minority dental students will have adequate academic, social, and resilience supports in place to combat the effects of discrimination and microaggressions, that is, faculty and peer mentors, tutors, and wellness counseling</p> <p>Dental schools will have knowledge of the levels of implicit racial bias on admissions committees and will be required to show evidence that those levels are consistently balanced throughout the admissions process</p>
<i>Race, racism, and curricula</i>			
No curriculum standards for how dental schools should address race and issues related to racism, that is, implicit bias, discrimination, and cultural competency	2-17	<p>Dental students' must be knowledgeable of racialized oral health inequities and how racism intersects with structural and social determinants of health to influence differential access to care among various populations</p>	<p>Dental schools will have evidence-based content embedded in the curriculum that addresses how racism intersects with structural and social determinants of health to influence differential access to care among various populations by race</p> <p>Dental students will be assessed on their knowledge of how racism intersects with structural and social determinants to contribute to racialized oral health inequities</p>

(Continues)

TABLE 3 (Continued)

Problems	CODA standards	Proposed strategies and practices	Needed outcomes and impacts
	2-26	As part of their clinical training, dental students must provide dental care in community-based settings Community-based clinical experiences must provide opportunities for dental students to learn about structural and social determinants of health and cultural competency, while emphasizing the ethical obligation that dentists have to ensure adequate access to care to the entire population	All dental students will participate in community-based rotations Community-based rotations will educate students on structural and social determinants of health, cultural competency, and dentists ethical obligation to ensure access to dental care to the entire population
<i>Faculty recruitment and promotion</i>			
Lack of clarity on expectations for recruitment and promotion of faculty of color	3-1	Dental schools must be required to include underrepresented minority faculty in their definition of “sufficient” and show evidence of recruitment and hiring underrepresented minority faculty Dental schools must show evidence of quality improvement processes and longitudinal results of their hiring, recruiting, and retention of full-time underrepresented minority faculty and administrators	Evidence that dental schools are working toward increasing their number of underrepresented minority faculty Increased number and improved quality of faculty development training programs for underrepresented minority faculty
	3-4	At the onset of hiring and annual faculty reviews, dental schools must articulate expectations for faculty workload and performance that align with criteria for promotion and tenure Dental schools’ promotion and tenure guidelines must articulate how race-related demands for service, student mentorship, and peer mentorship are weighted for underrepresented minority faculty	All full-time underrepresented minority faculty will be given opportunities for promotion and tenure Increased numbers of underrepresented minority faculty on promotion and tenure tracks
	3-5	Dental schools must demonstrate that full-time underrepresented minority faculty are provided with annual updates to the promotion and tenure process and their eligibility	

Abbreviation: CODA, Commission on Dental Accreditation.

### 3.1.6 | Proposed strategies for Standard 4-4

- Dental schools should identify, acknowledge, and address the full social and structural contexts that HURE applicants bring with them, and implement systems to include those contexts in decision making about applicants’ potential to succeed and enhance learning and professional environments; rather than just their potential to fit in and/or matriculate their particular programs.
- Dental schools must have systems in place for faculty and administrators to know how to address the social and academic concerns of HURE students rather than view those types of issues as deficits. As it stands, the institutional power of dental education programs may require that students and faculty adjust to the needs and comforts of their systems rather than modifying their

systems to achieve equity in opportunities for success. For example, some dental schools may provide special accommodations for students with test taking anxiety, but similar considerations may not be available for students experiencing anxiety due to microaggressions from other students and/or faculty.

- In lieu of the lack of HURE faculty, dental schools must show evidence that they are actively measuring the levels of implicit racial bias that exist among admissions committee members and if those levels are consistently balanced. Admissions criteria should further consider beyond which applicants might successfully matriculate their programs, but which applicants will have an interest, desire, and commitment to learn about issues for more socially aligned curriculum shifts, such as structural competency, community-based practice, and addressing racism in dental practice and policy.



## 3.2 | Race, racism, and dental school curricula

### 3.2.1 | Standard 2-17

Most dental students are exposed to HURE populations during their clinical education. Yet, students may not have a full understanding of how structural racism, bias, and discrimination negatively impact oral health.<sup>33</sup> This standard does not require that dental schools educate students on topics such as racism, bias, and discrimination.

### 3.2.2 | Proposed strategies for Standard 2-17

- Dental schools must provide evidence of what is being taught about race and racism in their curricula, as well as the pedagogy and purpose for incorporating such content.
- Dental schools must provide evidence of who, how, and where such content is being taught, with reporting of faculty qualifications to deliver such content.

### 3.2.3 | Standard 2-26

Students have opportunities to witness how structural racism contributes to racialized oral health inequities through community-based experiences. However, the standard only requires that dental schools present “opportunities” for students to have community-based experiences. Dental schools need to only encourage students to take advantage of such opportunities, and the level of student engagement varies, which may eviscerate the intentionality of the standard. Additionally, the curricular focus of community-based experiences varies among dental schools.<sup>34</sup> For example, curricular content to support community-based experiences may only focus on individuals with special healthcare needs or rural populations. Finally, the intent of this standard is that dental students develop an appreciation for community service rather than competency working in community-based environments. As written, this statement minimizes the role of dentists in improving access to care among HURE populations through conventional provision of care and policy development.

### 3.2.4 | Proposed strategies for Standard 2-26

- Dental schools should expose students to community-based settings where HURE populations receive dental care, so that they can experience how racism affects oral health and how real-world antiracism

approaches function to improve oral health in clinical settings. Community-based programs should also develop students’ confidence in their ability to incorporate antiracist approaches to dental care.

- Dental schools must provide evidence of how their community-based programs are measuring and improving students’ self-efficacy in providing dental care to HURE populations in community-based settings.

## 3.3 | Faculty opportunity and development

### 3.3.1 | Standard 3-1

How dental schools determine faculty qualifications that are “sufficient” for their programs is the concern for this standard. There are few full-time HURE faculty to assure racial representation in research, curricula development, institutional policy development, and student mentorship/role modeling.<sup>35</sup> This standard gives dental schools leniency to not hire or engage with scholars who have expertise in issues of race and racism if they deem those aspects of dental practice and policy of lesser importance. This standard also does not address the unique needs that HURE students may have for mentorship, academic support, and role modeling. For example, a dental school with few HURE students may not need any full-time HURE faculty to meet its definition of “sufficient.” Also, a dental school with no HURE faculty may not deem it necessary that they have HURE administrators. What must be considered is that students and faculty may choose to not attend or work in environments where they feel the racial disparity in power among faculty and administration will place them at a disadvantage.

### 3.3.2 | Proposed strategies for Standard 3-1

- The antiracism approach to this standard should recognize how misinterpretation of “sufficient” may perpetuate cycles of inequity. Dental schools must include HURE faculty in their definition of “sufficient” and show evidence of how they are meeting this standard in their hiring and recruiting practices.
- Dental schools must show evidence of quality improvement processes and longitudinal results of their hiring, recruiting, and retention of HURE faculty.

### 3.3.3 | Standards 3-4 and 3-5

Because they are few in number, HURE faculty may be hired and/or called upon for roles that other faculty

members may not. For example, they may be asked to teach at various and multiple levels of the curriculum where racial representation is lacking. Their positions may demand more service to provide adequate racial representation on committees. In addition, the needs for student mentorship and role modeling at dental schools with few HURE students and faculty may place extraneous demands on their time. Thus, the amount of time devoted to teaching, scholarship, and service may vary from their non-HURE colleagues, which demands either a more subjective approach or a unique set of objectives for faculty evaluations. Some HURE faculty may choose not to pursue academic careers due to potential limits imposed by such factors on their ability to progress in an academic career. This not only hinders faculty recruitment and retention, but may subsequently limit the recruitment and retention of HURE students due to their preferences to learn in environments with better racial representation.

### 3.3.4 | Proposed strategies for Standards 3-4 and 3-5

- Dental schools must routinely and directly communicate their intentions for faculty performance with HURE faculty, with reasonable expectations for promotion and tenure. Such intentions and expectations must also exist within written policies that outline criteria for faculty promotion and tenure.

## 4 | CONCLUSION

The framework presented in this manuscript offers suggestions for enhancement of CODA standards to enable dental schools to use accreditation as a guide for evaluating and addressing areas where institutional racism may be having an effect. It also provides an aspirational vision for how the accreditation process can universally drive change toward antiracism in dental education. To achieve that vision, the framework proposes explicit attention to several issues, which is also consistent with national CLAS standards, to identify and adjudicate potential factors of institutional racism. Among them are:

1. Beyond evidence of plans and procedures, dental schools should be held accountable for outcomes.
2. Diversity is defined too broadly and without specificity.
3. Collaborative partnerships with HBCUs and MSIs hold promise for attracting HURE students into dental schools.
4. Composition and implicit biases of admissions committees should be regularly assessed and balanced

by dental schools, and evaluated during accreditation reviews.

5. There is insufficient intentionality in the CODA standards regarding race, oral health inequities, social justice, and access to care in dental school curricula.
6. There is insufficient emphasis on ensuring that dental students have community-based experiences with HURE so that they can see and experience racialized oral health inequities in unfiltered environments.
7. There is too little emphasis on the need to ensure that racial diversity of faculty include HURE, and that faculty from HURE have equitable opportunities to achieve promotion and tenure.
8. While the paper focuses more on CODA accreditation standards than the site visit process, it is worth noting the value of accreditation site visit teams being structured in a manner that ensures inclusion of people fully versed in antiracist considerations.

As educators, a question that should challenge and haunt us is: Why has so little changed since the findings made clear in the 1926 Gies report regarding the numerical capacity of dentists of color to meet the needs of populations dependent upon them for oral health services? After nearly 100 years, many of the report's findings could be used to describe dental education today. Like most societal issues, there are numerous facets contributing to this outcome. However, a closer look at the systems and essential structures we rely upon to provide guidance is mandatory. W. Edward Deming's statement that "every system is perfectly designed to get the results it gets," has been applied to numerous aspects of the health system, and its application to the context of institutional racism within dental education seems appropriate. CODA, by providing standards and setting expectations, directly determines the quality of the dental education system. Thus, it is incumbent upon CODA to assess the system of dental education relative to its potential contribution to institutional racism.

To date, the dental literature is sparse in its attention to antiracism issues, relative to medicine.<sup>36,37</sup> However, the papers to follow in this compendium present a strong launching point for necessary antiracism considerations in dental education, and ultimately for the dental profession.

### EDITOR'S DISCLOSURE

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# Perspectives on Justice, Equity, Diversity, and Inclusion (JEDI): A call for oral health care policy

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## Abstract

Educational Institutions in the U.S. have responded to government policies that called for more inclusive educational systems. The goal is to reduce the oppression created by “racism” and enhance the environmental trajectory toward equity and justice. Although significant social and economic advances have been made, these have not been sustainable, and disparities remain. As educational systems have not kept pace with the demographics and economic trends, there is a call to action to affirm the need to establish policies that support diversity within pipeline pathways, faculty recruitment, and retention. Leveraging knowledge and networking across institutions with communities can transform academic cultures, reduce unconscious/implicit bias, and microaggression. As racism exists in every segment of our culture, building sustainable capacity and a system proportional to the populations’ relative needs can help chart a direction forward for policies that support justice, equity, diversity, and inclusion among dental institutions.

## KEYWORDS

academic institutions, dental schools, justice, equity, diversity, and inclusion, oral health, policies, underrepresented minorities

## 1 | INTRODUCTION

Dental workforce diversity is a nationwide priority. Currently, the United States (U.S.) population is facing a diversity shift, where one in four Americans identify as Black, African American, Hispanic, Asian, or other.<sup>1</sup> Unfortunately, the U.S. dental education and workforce are not mirroring the nation’s demographics, which leaves significant gaps demanding to be filled in order to effectively address the critical needs of the diverse populations and their health disparities.

### 1.1 | History of racism in healthcare and dental education

Black Americans and all other underrepresented minorities (URM) have historically sought a way out of oppression in the form of unfair treatment and searching for employment and education opportunities, as well as equitable healthcare. The “supremacy model” incorporates racism, which justifies oppression in many forms, disparities in opportunities, denial of quality healthcare, and even slave labor in many parts of the world. This is a critical

global problem.<sup>2</sup> Exploitation and discrimination methods manipulate people so that the power of ownership and control remains with those who perpetuate superiority. Higher education was originally designed to educate White people to hold leadership positions. In order to achieve equity, inclusion, and justice, it is required that the control of institutions be divided proportionally. The fear or hesitation to share the power, consciously or subconsciously, would mean a monumental change in the entire global system. This is too large to tackle without major chaos. Therefore, it would be feasible to agree to redevelop a proportional healthcare system that matches the percentages of the population in the U.S. (i.e., if Black Americans make up 12% of the U.S. population, then we should produce 12% of the graduating doctors/dentists, supported by at least 12% of the faculty and administration).

It is important to understand the history relative to great strides in American educational systems and the reactions to major social and economic movements. To begin, Harvard was America's first college. In 1639, its founder, John Harvard, donated resources that initiated an integrated educational system for both European immigrants and the indigenous Native Americans from the Wampanoag tribe. Before any Wampanoag graduated, the King of England restricted this program to include only Europeans. Secondly, the Civil War (1861–1865) was largely fought to stop the expansion of slavery and eventually created laws to end the practice of slavery for Blacks, Africans, and Native Americans in 1865. The Harvard School of Dental Medicine (HSDM), opened in 1867 as the first university-based dental in the country. The first two dental classes included a Black male, whose parents were former slaves. The first graduate went on the practice in the Washington D.C. area, and the second became one of Harvard's first Black professors and practiced in the Boston area. Due to several policy changes, different administration, increased academic costs, and changes in the admission process, it would be 104 years before the next person of color would graduate from HSDM.

The Civil Rights Movement of 1960–70s was a racial and economic revolution that eventually led to U.S. policy changes and increased civil rights for all Americans. After countless deaths, arrests, destruction of property, and eventual peaceful protests, policies were created whereby institutions received federal funding to encourage integration of their student populations.

As a result of the Civil Rights movement, fundamental changes around structural racism and policies began setting the path to improve access to opportunities and reduce racial inequities. For HSDM, that included admitting three Black students, of which one would be the first Black female to enter and graduate from the program. Throughout the country, institutions began opening their

doors for Black, Hispanic, Asian, Native American, and female students. But, they were eventually hindered by the Bakke Case (1978), which lobbied against affirmative action.<sup>3</sup> The notion of reverse discrimination swept across the nation when the U.S. Supreme Court ruled against the policy of a “quota” system which held a certain number of seats to be filled by underrepresented students to help ensure a diversity mix. Consequently, the number of students of color stagnated contradicting equity and causing this opportunity to spiral off course.<sup>4</sup>

Currently, the Black Lives Matter Movement is the result of heightened violence toward Black Americans. The heart of the problem continues to be the oppressive system of racism that seems driven by fear of change. In 2020, over 200 health care organizations declared “racism” as a public health crisis.<sup>4,5</sup> The lack of sustainable organizational structures and processes continues to limit opportunities to create mechanisms for creativity and innovation. These are necessary to support the advancement of culturally sensitive care delivery, and a range of talent to develop bold inclusive ideas and national strategies that would lead to equitable healthcare and health outcomes.

A more immediate cure for this dilemma is not only to produce providers based on demographics, but to reduce the cost of dental education, patient care costs, and to increase health insurance benefits that emphasize prevention.

## 1.2 | The state of dental education, workforce diversity, and oral health equity

The national focus to address the disparities in oral health faced by URM students dates back to 1926 when William Gies authored the landmark report on “Dental Education in the U.S. and Canada”. This recognition was finally moved forward following the 2000 U.S. Surgeon General's Report on Oral Health, which stated oral health is essential for overall health and well-being; therefore, a person cannot enjoy a healthy life and have the foundation to achieve healthy aging without oral health<sup>6</sup>; and in 2005, good oral health was acknowledged as a basic human right during the Liverpool Declaration, and supported by the World Health Organization.<sup>7,8</sup> Just as these recognitions highlighted access to oral health, we must also consider the impact on overall access and equity. A current challenge and concern from the Global Congress on Dental Education include inequities in access to education and oral health care.<sup>9</sup>

Oral health care disparities amongst racial, ethnic, and socioeconomic sectors are prevalent worldwide that limit dental safety nets and access to dental care resources for rural and underserved populations. This is evident

in workforce shortages and health professional shortage areas (HPSAs).<sup>10</sup> For appropriate access to dental care, the population to provider ratio must be at least 5000:1, and 4000:1 for communities facing high needs. In 2021, there were 6,906 dental HPSAs requiring about 11,416 dental workers to meet the access to dental care needs.<sup>10</sup>

To meet future dental care needs, the graduating dental workforce must consider existing and predicted changes in the aging and diverse demographic population trends. Recognizing the influence of public and private dental educational institutions, as well as, disparities, inequalities and social conditions is key toward leveraging the planning and future of dental education in terms of diversity, inclusion, equity, and belonging, as well as the goal to advance access to dental care for all.<sup>9,11</sup>

According to the 2021 Oral Health in America: Advances and Challenges report a diverse workforce will increase the likelihood of having more providers working in rural and underserved areas while providing culturally sensitive services to aid toward longer-term health outcomes.<sup>12,13</sup> With changes in U.S. demography and needs, institutions must have a sustainable plan to address the insufficient number of URM students being admitted into dental schools.<sup>13</sup> Despite the Commission on Dental Accreditation (CODA) Standards 1–4, requiring dental schools to make appropriate efforts to maintain a diverse faculty, staff, and students in dental medicine, URM groups remain low in comparison to the U.S. population.<sup>14</sup>

### 1.3 | Pipeline programs and their limited success

It is recognized that dental pipeline programs are effective in strengthening dental school applications, increasing dental entrance exam scores, growing diverse dental

cohorts, and increasing access to care.<sup>15</sup> In 2019, 5.8% of the students admitted were Black or African American.<sup>1</sup> At high school and college levels, pipeline programs for students from URM groups have been established; however, limited programming has been developed for middle school students. Earlier health career exposure can increase middle-grade students' awareness of oral health professions and ultimately enhance recruitment efforts.<sup>16</sup> Successful models include the HRSA's Health Careers Pipeline and Diversity Program, which aimed to increase the national health workforce that is reflective of the U.S. population. For example, HSDM HRSA-funded "Catalyzing Oral Health Workforce for Rural and Vulnerable Populations" training programs aim to train URM in rural areas to address the oral healthcare needs of aging and underserved populations. Pathway programming advances the delivery of effective, culturally sensitive, and patient-centered care with an emphasis on high-need areas.

## 2 | CHALLENGES

Some of the challenges that are faced while addressing oral health care policy stem from the disparities between the proportions of racial and ethnic populations that have been historically underrepresented in the dental profession relative to their number in the U.S. general population. In 2019, there were 9.5% of U.S. dentists from the Historically Underrepresented Racial and Ethnic (HURE) group while almost 31.9% of this same group made up the U.S. population.<sup>1</sup> (Figure 1).

Black and African American dentists (3.6%) are less than one-third of the share of the U.S. served population, while Hispanic/Latinx (5.6%) are 18.5%, three times larger. The 3.6% of Black and African American in the dental profession is less than one-third of the share of Black or

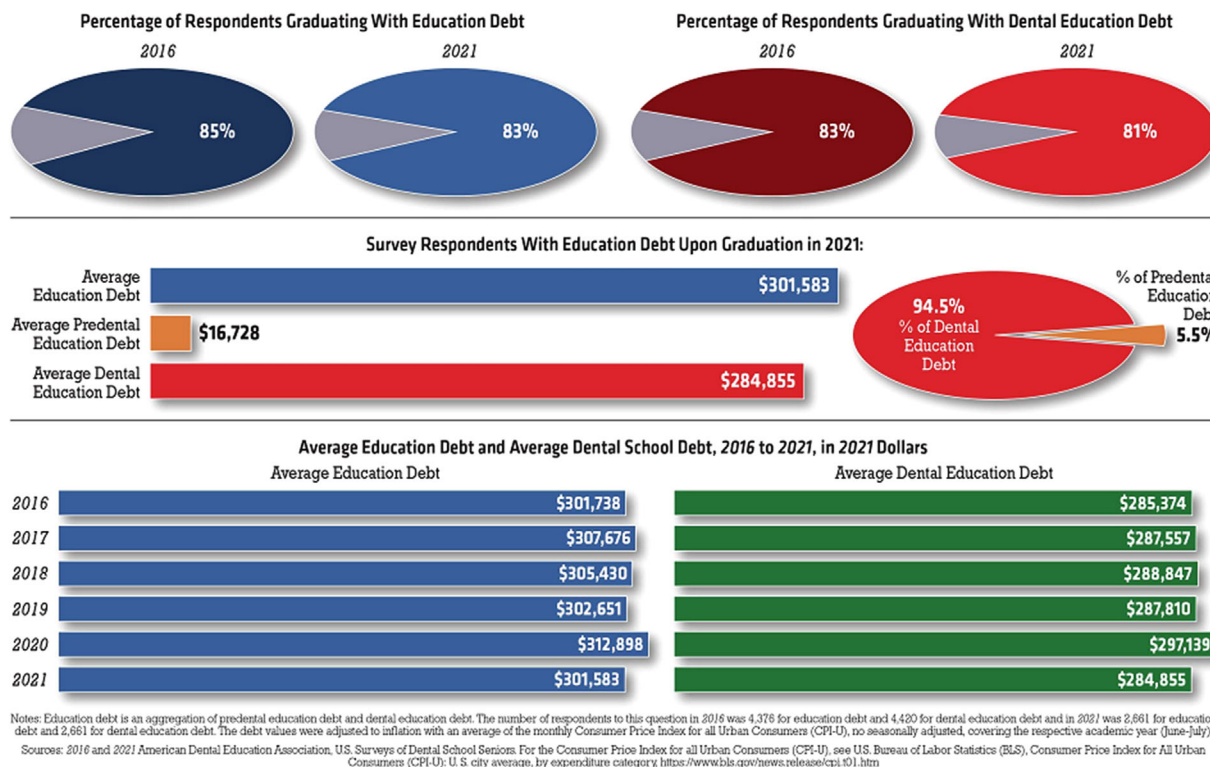
**Table 1.1. HURE Groups, Count and Percent of U.S. Population and of Professionally Active Dentists, 2011 and 2019**

HURE GROUPS	2011		2019	
	COUNT	%	COUNT	%
U.S. Population	93,036,828	29.9%	104,750,541	31.9%
Professionally Active Dentists	16,077	8.6%	19,329	9.5%
Parity Gap		21.2%		22.4%

FIGURE 1 Table of hure groups, count and percent of U.S. population and of the professionally active dentists, 2011 and 2019



## A Look at Education Debt



ADEA Trends in Dental Education 2021-22

FIGURE 2 Education debt

African Americans in the served population, and Hispanics trail closely with 5.6% of U.S. dentists identifying as Hispanic/Latinx with their proportion of the U.S. population being 18.5%, three times larger. There has been an increase in the parity gap over the past decade between HURE groups as a percentage of the U.S. population and HURE groups as a proportion of professionally active dentists. The parity gap has increased from 21.2% in 2011 to 22.4% in 2019.<sup>1</sup> (Figure 1).

Deans commonly say there are not enough qualified URM dental school applicants and faculty to fill these positions. As a result, the lack of diversity at dental schools has a downstream effect on addressing access to care in URM communities.

It also affects the learning outcomes of every dental student because a diverse faculty have a direct impact on the learning outcomes of all students.<sup>1</sup> Addressing and eliminating these disparities, will increase the number of URM dental providers to address problems seen with access to care in underrepresented communities and produce better learning outcomes for the students.

Dental schools’ deans need assistance in finding URM students and faculty. For many finding URM students or faculty has not been a priority, or they only follow the status know where to look. Still, others fail to use the Toolkit provided by the American Dental Education Association (ADEA), and/or do not allocate funds and resources to find qualified URM students and faculty. Another challenge that has been recognized is the impact that influential alumni, donors, and dental societies have on the policies surrounding diversity, equity, and inclusion at dental schools. Because financial donors maintain a certain amount of control, if they do not agree with diversifying the field of dentistry, this creates a major barrier to increasing diversity. Additionally, other dental school gatekeepers such as board of directors and university senior administration can be influenced by state and local politics.

Among the most significant challenges to increasing diversity at dental schools are the actual high tuition and operational costs. The average investment toward dental school tuition for the graduating class of 2020 was \$284,855,



**Table 2.1. Annual Change Rate of the Number of HURE Predoctoral Applicants, First-time, First-year Enrollees and Graduates, 2011–2019**

RACE AND ETHNICITY	APPLICANTS	FIRST-TIME, FIRST-YEAR ENROLLEES	GRADUATES
American Indian or Alaska Native	-10.5%	-14.2%	1.0%
Black/African American	0.4%	4.3%	1.8%
Hispanic or Latinx	3.9%	5.6%	5.3%
Native Hawaiian or Other Pacific Islander	-1.9%	6.6%	27.5%
<b>HURE Groups</b>	<b>2.2%</b>	<b>4.8%</b>	<b>4.0%</b>
<b>Total</b>	<b>-1.0%</b>	<b>2.0%</b>	<b>2.8%</b>

Note: The annual change rate is a compound annual growth rate between 2011 and 2019.

Source: Analysis of American Dental Education Association U.S. Dental School Applicants and Enrollees, 2011 and 2019 Entering Classes.

FIGURE 3 Annual change rate of the number of HURE predoctoral applicants, first-time, first-year enrollees, and graduates, 2011-2019

a cost that has continued to increase over the years.<sup>17</sup> (Figure 2). The high costs of dental education directly impact dental school admissions and attendance. URM students without adequate finances or those who have been denied equal access to education find it challenging or even impossible to gain entry to dental programs. Those who do manage acceptance and successful completion, leave with considerable debt.<sup>8</sup> Students seeking to satisfy their investment will be less likely to work in underserved communities where oral health care is most needed.

With barriers hindering URMs' applications and acceptance into dental schools, the increase in the number of URM applicants between 2011 and 2019 was minimal. With a HURE annual 4.8% growth rate applying to dental school between 2011 and 2019, by the end of the 2010s, 993 HURE students were starting their dental doctoral degrees. The increased enrollment led to a 4% annual increase in HURE graduates between 2011 and 2019.<sup>1</sup> (Figure 3). Based on the 2017 U.S. Census population projection, the HURE proportions of the U.S. population will continue to increase and will reach 34.7% in 2030 and 42% in 2060.<sup>1,18</sup> The majority of the growth will come from the Hispanic/Latinx while Black or African American numbers will grow at a much slower pace.

With demographic shifts impacting access to care, dental schools must examine the educational debt that students face after graduation.<sup>10</sup> Public university graduates and those who often join loan repayment programs after graduation have a wider selection of options due to lesser financial constraints, which is a significant predictor for public service.<sup>10</sup>

On the contrary, as a result of high student debt, evidence suggests that graduates would rather practice in wealthy areas, instead of selecting academia, public health, or serving in underserved communities.<sup>12</sup> ADEA has explored the idea that the Dental Admission Test could be a way of eliminating a certain portion of the applicant pool.

As a resolve, most dental schools are using a holistic process including application, grade point average, DAT test scores, recommendation letters, personal statements, and students/faculty/administrators' interviews. One of the biggest barriers in this process is getting an interview.

Retention is a barrier depending on the student's experiences. Students with documented learning disabilities should be given special consideration especially when testing. It would be best that there is a written and a signed document indicating that a student's learning disability will be considered during the entire educational process. Practically speaking, the level of sensitivity and experience from administration can be enhanced through required continuing education.

Dental education and policies have not kept pace with demographic and economic trends.<sup>11</sup> To meet future dental care needs, the graduating dental workforce must consider existing and predicted changes in the aging and diverse demographic population trends. Recognizing the influence of public and private dental educational institutions, as well as, disparities, inequalities and social conditions is key toward leveraging the planning and future of dental education in terms of diversity, inclusion, equity, and belonging, as well as the goal to advance access to dental care for all.<sup>9,11</sup>

## 2.1 | Recommendations

Finally, institutions must overemphasize recruitment and retention efforts. Inclusive programming and policies can enhance community members' sense of belonging, thus, impacting retention. Institutions must consider campus culture and students' well-being through the development of JEDI activities. As we think more broadly about retention strategies, academic units should work toward greater transparency and foster a community of inclusion that is free from harassment and discriminatory practices. Some strategies to address retention include establishing advisory councils, dedicated JEDI offices, and employee resource groups with the goal of collectively examining barriers and implementing best practices. Training toward addressing micro-aggressions and unconscious/explicit bias is crucial for the development of strong retention programming.<sup>19</sup> Research has shown that faculty and staff participation in town hall meetings, focus group discussions, surveys, and community-building activities help foster stakeholder engagement and identify areas for improvement in JEDI integration. Using best practices in the hiring process can improve the number of faculty, and JEDI's recognition and contributions.

URM faculty and administrators are crucial to attracting and retaining URM students. The current dental education workforce has to make room for more diversity on this level. Otherwise, we may continue the patterns we have historically seen. Meaning that not much happens until there is a major movement. But in the meantime, things remain the same because the incentive for change is not present. Having one or two faculty within an entire school creates problems of backlash and lack of promotion. It becomes a vicious cycle. Head administrators including deans and boards have to be willing to give power by increasing the pace of diversity and inclusion.

Although clinical care represents a large portion of oral healthcare, it is not the entire oral healthcare picture. As it relates to dental faculty, there is a need for role models that address oral healthcare beyond the "status quo". This means focusing more on public health, policy, research, academia, and advocacy.

## 3 | CALL TO ACTION

All institutions of higher education must examine policy and practices at each level ranging from equitable recruitment and retention efforts for staff, faculty, and students, holistic admission processes, sustained community outreach investment, and co-creating community building activities.

Best practices in higher education that advance recruitment and retention of a diverse candidate pool include job postings that explicitly encourage women, minorities, people with disabilities, veterans, and intersectional individuals to apply. Institutions must recognize the value diversity brings to making, designing, creating, and expanding spaces for social discourse through committing to equitable hiring practices and training for all hiring managers on implicit bias and standardized interviewing procedures.

Through the recruitment of diverse educators that have demonstrated commitment to excellence by providing leadership in teaching, scholarship, research, or service, institutions can build a diverse scholarly environment and deepen their investment in the community it serves. By partnering with other health sciences or other colleges on campus, dental institutions can sustain impact through a diverse curriculum, experiential learning, and community outreach.

Dental institutions must move beyond statements that support CODA standards, and establish programming, policy, and procedures, then disseminate findings that actually lead to a shared understanding and establish best practices. To overcome the problem of a small pool of eligible applicants from underrepresented racial/ethnic populations, dental institutions should have policies that grow the pool of eligible students by preparing them through pipeline programs starting as early as grade school.<sup>15</sup>

Investment in retention programming should be clearly articulated in strategic planning with actionable metrics that have financial support. Retention efforts should be publicized with college stakeholders to allow for all parties to participate in the achievement of identified strategies and action steps.

In the development of pipelines, there needs to be a broader explanations that consider and respond to the following questions:

1. What is dentistry and what is oral health?
2. What are the types of jobs associated with dentistry and with oral health?
3. How does one prepare for dental school and eventually for these associated jobs?
4. What about the costs of getting this education and what options exist for repayment and long-term opportunities for a good and sustainable income?

With changes in U.S. demography and needs, institutions must have a sustainable plan to address the insufficient number of URM students being admitted into dental schools.<sup>13</sup> Nationally, institutions have pledged to address racism and inequities on college campuses. The pledges to address barriers have varied, and the short-term programs with verbal commitments require sustained assurances

to unravel structural imbalances and uneven practices. Over 200 health care organizations pledged to take action toward eliminating racial health inequities by tackling systemic barriers impacting URM.<sup>5</sup> At this pivotal juncture, it is time to elevate the conversation to action and reaffirm institutional pledges of dismantling systemic barriers in higher education. In dental education, there are several strategies that can be implemented to confront these challenges and advance JEDI with students and faculty.<sup>20,21</sup> It is essential that dental institutions establish or re-establish policies that strengthen pathway programming and foster a community that supports and advances a diverse and equitable campus.

Substantial evidence notes that diverse faculty are more likely to develop curricula advancing health equity, educating and conducting research toward the elimination of health disparities, and creating cultural sensitivity strategies.<sup>22</sup> Developing a well-defined roadmap for individualized mentorship and career development aid toward a longstanding, highly individualized minority student-faculty career-mentoring program within an academic medical-centered setting.<sup>23</sup> Additionally, a leadership development task force and/or a faculty-led diversity liaison program model could promote pathways to leadership positions within the academic environment.<sup>20</sup>

Case Western Reserve University led a group of six universities to develop a project entitled “Institutions Developing Excellence in Academic Leadership–National (IDEAL-N)”. Over 3 years, the program leveraged knowledge, skills, resources, and networks to develop academic leaders and institutional gender equity transformation for women faculty in science, technology, engineering, and math (STEM).<sup>23</sup> Institutions must strengthen inclusive policies when engaging and retaining URM students and faculty and supporting their advancement.

## ACKNOWLEDGMENTS

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## EDITOR'S DISCLOSURE

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February 16, 2023

Sherin Tookss  
Director, Commission on Dental Accreditation  
Commission on Dental Accreditation  
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Dear Dr. Tookss,

A representative of the National Coalition of Dentists for Health Equity (NCDHE) attended the Feb 10 CODA meeting. We are very pleased that CODA voted to accept the recommendations of the Predoctoral Review Committee to forward our letter to the ad hoc Predoctoral Revision Committee.

This is significant progress. As a reminder, we want to point out that our letter also contained a number of short term recommendations that would not need Accreditation Standards revision. We hope that the ad hoc Committee or some other component of CODA will give due consideration to these other recommendations as well.

The NCDHE stands ready to assist in any way we can as CODA moves forward to discuss these important and timely issues of diversity. Thank you for your consideration.

Sincerely,

Lawrence F. Hill DDS MPH  
President, National Coalition of Dentists for Health Equity  
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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](mailto: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.

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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.

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## 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.

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- 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.

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#### 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

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**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 Cohlma, 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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