INFORMATIONAL REPORT ON PEDIATRIC DENTISTRY PROGRAMS ANNUAL SURVEY CURRICULUM SECTION

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

The Curriculum Section of the Commission's Annual Survey is conducted for pediatric dentistry programs in alternate years. The next Curriculum Section will be conducted in August/September 2024. The draft Curriculum Section is provided in **Appendix 1** for review by the Pediatric Dentistry Review Committee.

Summary: The Review Committee on Pediatric Dentistry Education is requested to review the draft Curriculum Section of its discipline-specific Annual Survey (**Appendix 1**).

Recommendation:

Prepared by: Ms. Peggy Soeldner

Part II - Pediatric Dentistry Curriculum Section

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

21. What percentage of time do students/residents devote to each of the following areas during the entire program?

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

a. Clinical (include related laboratory activity)	%
b. Didactic (include assigned laboratory activity)	%
c. Research	%
d. Teaching	%
e. Other, please specify	%
Total	%

22. Instruction can be provided in a variety of settings. Please estimate the total number of clock hours (didactic and clinical) of instruction students/residents receive in each of the following subject areas during the entire program.

a. Biomedical Sciences (Biostatistics and Clinical Epidemiology, Pharmacology, Microbiology, Embryology, Genetics, Anatomy and Oral Pathology)	
b. Behavior Guidance (Non-pharmacological techniques, Sedation, and Inhalation analgesia)	
c. Growth and Development (Craniofacial growth and development/Normal and abnormal physical, psychological and social development)	
d. Oral Facial Injury and Emergency Care	
e. Oral Diagnosis, Oral Pathology and Oral Medicine and Radiology	
f. Prevention and Health Promotion	
g. Comprehensive Dental Care	
h. Management of a contemporary dental practice (e.g., Ethics)	
i. Patients with Special Care needs	
j. Hospital dentistry	
k. Pulp therapy	
l. Pediatric medicine (i.e., Speech and language development)	
m. Advocacy	
n. Other, please specify	
Total	

23. In which of the following minimal or moderate sedation techniques did students/residents receive instruction and clinical experience during the 2021-22 academic year?

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

24. What is the average number of general anesthetic patients managed by each student/resident during the 2021-22 academic year?

Make sure to enter the number of patients divided by the number of students/residents, NOT the total number of patients for the entire program.

	Patients per student/resident
a. Hospital-based general anesthetics	[ ]
b. Clinic/Office-based general anesthetics	[ ]
c. Other, please specify [ ]	[ ]

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

[ ]

25. How many patient visits were managed by all students/residents during the 2021-22 academic year?

26. Of all the patient visits identified in Question 25, what percentage were patients with diagnosed emotional, physical, or mental problems managed by the advanced pediatric dentistry students/residents?

27. Below are hospital service rotations. Please indicate whether the rotation is required or an elective, the total length of the rotation (in weeks), and the number of hours per week spent by students/residents on the rotation.

	Type of assignment			Length of rotation	Hours
	Required	Elective	Not applicable	(in weeks)	per week
a. Anesthesiology	○	○	○		
b. Emergency Room	○	○	○		
c. Pediatric Medicine	○	○	○		

27 (continued). Please identify hospital rotations not listed in lines a-c

above and indicate whether the rotation is required, elective, the total length of the rotation (in weeks), and the number of hours per week spent by students/residents on the rotation.

If any lines do not apply, leave the entire row(s) blank.

	Other rotation (please specify)	Type of assignment Required	Type of assignment Elective	Length of rotation (in weeks)	Hours per week
d.		○	○		
e.		○	○		
f.		○	○		

28. How many formal documented student/resident evaluations are conducted per year?

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

CONSIDERATION OF PROPOSED REVISIONS TO ANESTHESIA STANDARDS OF THE ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN PEDIATRIC DENTISTRY

Background: At its August 2021 meeting, the Commission on Dental Accreditation directed the establishment of a multidisciplinary Ad Hoc Committee composed of current and former Pediatric Dentistry Review Committee (PED RC) members as well as representation from the Dental Anesthesiology Review Committee and the Oral and Maxillofacial Surgery Review Committee to study the use of sedation in patient management, including the potential need for revision of the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry, as applicable, with a report to the Commission in Winter 2022.

The Ad Hoc Committee on Pediatric Dentistry Anesthesia Standards held two (2) meetings in November 2021 and determined that a definition of "Sole Primary Operator" should be added to the Definition of Terms within the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry. Additionally, the Ad Hoc Committee determined that an intent statement should be added to Pediatric Dentistry Standard 4-7 to clarify that "Each patient encounter shall have only one (1) sole primary operator." At its Winter 2022 meeting, the PED RC recommended adoption of these revisions with immediate implementation, and the Commission concurred.

The Ad Hoc Committee also believed that additional meetings were required to discuss outstanding issues related to its charge, with the inclusion of an additional member to provide further perspectives on the American Academy of Pediatric Dentistry anesthesia guidelines. As such, at its Winter 2022 meeting, the PED RC also recommended, and the Commission concurred, that the Commission invite the American Academy of Pediatric Dentistry's Chair of the Council on Clinical Affairs, Committee on Sedation and Anesthesia to join the Ad Hoc Committee as an additional member to provide a perspective on the potential revision to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry related to anesthesia education for pediatric dentistry. The Commission further directed the Ad Hoc Committee on Pediatric Dentistry Anesthesia Standards to continue its review of pediatric dentistry Accreditation Standards which may warrant revision, with a report to the Commission in Summer 2022.

The Ad Hoc Committee held two (2) additional meetings in May and June 2022. As the discussion continued, the Ad Hoc Committee reviewed components of Pediatric Dentistry Standard 4-7a and b, suggesting the revisions. The proposed revisions differentiate "minimal" and "moderate" sedation. The Committee also determined that the age of pediatric dentistry patients should be clarified to "patients 13 or under." Further, of the sedation cases not performed as the sole primary operator, beyond those 15 encounters that must involve direct patient care, the remaining may include simulation experiences. The Ad Hoc Committee

thoroughly considered the use of simulation in health care education. The Committee noted educational "simulation" methods ranging from written case studies that only address knowledge through simulation methods using high-fidelity mannequins that simulate a real patient experience and assess knowledge and hands-on skill. It was noted that, if used appropriately, simulation that models that real patient experience may provide a valid educational tool. The Ad Hoc Committee believed that case-based written and/or discussion simulation activities are not appropriate methods through which knowledge and skill can be fully assessed.

The Ad Hoc Committee further noted that in September 2011, the Association of American Medical Colleges (AAMC) published the "Medical Simulation in Medical Education: Results of an AAMC Survey" in which the AAMC, for the purpose of the survey, defined "simulation." Following discussion, the Ad Hoc Committee believed that the AAMC's definition should be added to the Definition of Terms in reference to simulation activities that are permitted within the Accreditation Standards for pediatric dentistry programs.

The Ad Hoc Committee also concluded and recommended that, with future enhancements in technology and changes in educational models, the Commission further study simulation and its implications to dental and dental-related education programs as it relates to all disciplines within the Commission's purview, through formation of an Ad Hoc Committee representing all disciplines, with a future report to the Commission.

At its Summer 2022 meeting, the PED RC carefully considered the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry submitted by the Ad Hoc Committee. Following discussion, the PED RC supported the proposed revisions to the standards submitted by the Ad Hoc Committee and recommended that the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry be circulated to the communities of interest for review and comment, with Hearings held in conjunction with the October 2022 American Dental Association and March 2023 American Dental Education Association meetings, with comments reviewed at the Commission's Summer 2023 meetings. The PED RC further believed that the Commission should study simulation and its implications to dental and dental-related education programs as it relates to all disciplines within the Commission's purview, through formation of an Ad Hoc Committee representing all disciplines, with a future report to the Commission.

As directed by the Commission, the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry were circulated for comment through June 1, 2023. No (0) comments were received at the virtual hearing in conjunction with the ADA meeting and no (0) comments were received at the virtual hearing in conjunction with the ADEA meeting. The Commission office received 20 written comments prior to the June 1, 2023 deadline.

At its Summer 2023 meeting, the Pediatric Dentistry Review Committee considered the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry and the comments received prior to the June 1, 2023 deadline.

Through review of the written comments received, the PED RC noted comments from the state of California related to the state's requirement for minimal and moderate sedation permits. The comments indicated that because of the administrative and financial costs of obtaining the sedation permits, the proposed revisions requiring minimal and moderate sedation experience could place an undue burden on clinical faculty who supervise residents, especially at affiliated clinical sites.

Other comments addressed the proposed revisions related to required patient encounters in which sedative agents are used and their relation to the current ADA Guidelines for Teaching Pediatric Pain Control and Sedation to Dentists and Dental Students, particularly as they relate to providing sedation to patients eight (8) years of age or younger. The comments indicated that the requirements in the Standards are less stringent than the ADA Guidelines and that the Accreditation Standards should at least meet or exceed the ADA Guidelines to ensure pediatric dentistry program graduates have more advanced training requirements than that of dental students or general dentists.

Following lengthy discussion, the PED RC believed the proposed revisions require further consideration and should not be approved at that time. Further, the PED RC believed a workgroup of the members of the Review Committee, including the current and incoming Review Committee chair, should further consider the proposed revisions with a report to the Winter 2024 meetings of the PED RC and Commission. Additionally, because the continued study of the Standards includes ensuring the requirements align with the ADA Guidelines, the PED RC believed it would be beneficial to consult, as needed, with one (1) of the pediatric dentists who was involved in the development of the current ADA Guidelines for Teaching Pediatric Pain Control and Sedation to Dentists and Dental Students.

Therefore, the PED RC recommended that the Commission on Dental Accreditation direct continued review of the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry (**Appendix 1**), through appointment of a workgroup composed of members of the Review Committee, including the current and incoming chair, with a report to the Winter 2024 meeting of the Pediatric Dentistry Review Committee and Commission. The PED RC also recommended, as needed, consultation with a pediatric dentist who was involved in the development of the current ADA Guidelines for Teaching Pediatric Pain Control and Sedation to Dentists and Dental Students. At its Summer 2023 meeting, the Commission concurred with the recommendation of the PED RC.

The Ad Hoc Committee conducted a virtual meeting on November 13, 2023. Members present included: Dr. Jessica Lee (chair), Dr. James Boynton, Dr. Ana Keohane, and Dr. Anupama Tate. Dr. Frank Licari, vice-chair, Commission on Dental Accreditation (CODA), *ex officio,* and Ms. Peggy Soeldner, manager, Advanced Dental Education, CODA, also were in attendance. Pediatric Dentistry RC members Drs. Tad Mabry and Ms. Lisa Mayer, were unable to attend. Additionally, Dr. Joel Berg, former chair, Pediatric Dentistry Review Committee and consultant to the Review Committee was not in attendance.

The Ad Hoc Committee reviewed its charge and discussed the Summer 2023 deliberations of the PED RC. Following discussion, the Ad Hoc agreed further consideration of the revisions of Standard 4-7.b.1, related to providing sedation to patients 13 or under was warranted. The Ad Hoc Committee reviewed comments noting concern that the proposed revisions to the Standards are less stringent than the ADA Guidelines and that the Accreditation Standards should at least meet or exceed the ADA Guidelines to ensure pediatric dentistry program graduates have more advanced training requirements than that of dental students or general dentists.

The Ad Hoc Committee discussed the proposed revision and believed identifying specific ages/age groups in the requirement is overly prescriptive. Further, the Ad Hoc Committee discussed that since pediatric dentistry patients could include individuals up to 18 years of age, programs should be encouraged to provide pediatric dentistry students/residents with educational experiences for patients between the ages of 13 and 18, not only those 13 or under as proposed in the revision. Therefore, flexibility is warranted. In addition, the Ad Hoc Committee believed programs should be encouraged to provide training to ensure competency in providing sedation to younger patients, including both pre-school or school-age patients and determined a sentence clarifying this should be added to the intent statement. Following discussion, the Ad Hoc Committee determined the proposed revision to Standard 4-7.b.1 should be further modified and a correlating "intent" statement be modified, as noted in green in **Appendix 2**.

Summary: At this meeting, the PED RC and the Commission are asked to consider the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry, including the modified revisions recommended by the Ad Hoc Committee as noted in green found in **Appendix 2.** The Commission may wish to circulate the modified revisions to the communities of interest for an additional comment period. Alternately, if the proposed revisions are adopted, the Commission may wish to consider an implementation date.

Recommendation:

Prepared by: Ms. Peggy Soeldner

Commission on Dental Accreditation

At its Summer 2022 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry be distributed to the appropriate communities of interest for review and comment, with comment due June 1, 2023, for review at the Summer 2023 Commission meeting.

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link: https://surveys.ada.org/jfe/form/SV_0lm22grEOzgxgaN

Additions are Underlined;
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry

Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry

Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611-2678
(312) 440-4653
https://coda.ada.org/en

Definitions of Terms Used in Pediatric Dentistry Accreditation Standards

The terms used in this document (i.e. shall, **must**, should, can and may) were selected carefully and indicate the relative weight that the Commission attaches to each statement. The definitions of these words used in the Standards are as follows:

Must or Shall: Indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

***Intent*:** Intent statements are presented to provide clarification to the advanced dental education programs in pediatric dentistry in the application of and in connection with compliance with the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry. The statements of intent set forth some of the reasons and purposes for the particular Standards. As such, these statements are not exclusive or exhaustive. Other purposes may apply.

Examples of evidence to demonstrate compliance include: Desirable condition, practice or documentation indicating the freedom or liberty to follow a suggested alternative.

Should: Indicates a method to achieve the standards.

May or Could: Indicates freedom or liberty to follow a suggested alternative.

Graduates of discipline-specific advanced dental education programs provide unique services to the public. While there is some commonality with services provided by specialists and general dentists, as well as commonalities among the specialties, the educational standards developed to prepare graduates of discipline-specific advanced dental education programs for independent practice should not be viewed as a continuum from general dentistry. Each discipline defines the educational experience best suited to prepare its graduates to provide that unique service.

Competencies: Statements in the advanced dental education standards describing the knowledge, skills and values expected of graduates of discipline-specific advanced dental education programs.

Competent: Having the knowledge, skills and values required of the graduates to begin independent, unsupervised discipline-specific practice.

In-depth: Characterized by thorough knowledge of concepts and theories for the purpose of critical analysis and synthesis.

Understanding: Knowledge and recognition of the principles and procedures involved in a particular concept or activity.

Other Terms:

Institution (or organizational unit of an institution): a dental, medical or public health school, patient care facility or other entity that engages in advanced dental education.

Sponsoring institution: primary responsibility for advanced dental education programs.

Affiliated institution: support responsibility for advanced dental education programs.

Advanced dental education student/resident: a student/resident enrolled in an accredited advanced dental education program.

A degree-granting program is a planned sequence of advanced courses leading to a master's or doctoral degree granted by a recognized and accredited educational institution.

A certificate program is a planned sequence of advanced courses that leads to a certificate of completion in an advanced dental education program.

Student/Resident: The individual enrolled in an accredited advanced dental education program.

International Dental School: A dental school located outside the United States and Canada.

Evidence-based dentistry: Evidence-based dentistry is an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences.

Formative Assessment*: guiding future learning, providing reassurance, promoting reflection, and shaping values; providing benchmarks to orient the learner who is approaching a relatively unstructured body of knowledge; and reinforcing students' intrinsic motivation to learn and inspire them to set higher standards for themselves.

Summative Assessment*: making an overall judgment about competence, fitness to practice, or qualification for advancement to higher levels of responsibility; and providing professional self-regulation and accountability.

Resident Clinical Log (RCL): A secure and valid account of procedures and experiences of a student/resident maintained by the program for use in evaluation, accreditation, quality assurance and other purposes.

Treatment: Refers to direct care provided by the student/resident for that condition or clinical problem.

Management: Refers to provision of appropriate care and/or referral for a condition consistent with contemporary practice and in the best interest of the patient.

REFERENCE MANUAL: The most current version of The American Academy of Pediatric Dentistry Oral Health Policies and Recommendations.

Sole Primary Operator: The student/resident providing the assessment, drug delivery, treatment, monitoring, discharge and emergency prevention/management in conjunction with other medical personnel as required by institutional policies. Each patient encounter shall have only one (1) sole primary operator.

Interprofessional Education**: When students/residents and/or professionals from two or more professions learn about, from and with each other to enable effective collaboration to improve health outcomes. *(Adapted from the WHO 2010)*

Social Determinants of Health***: The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. *(From the WHO)*

Simulation****: A method used in health care education to replace or amplify real patient experiences with scenarios designed to replicate real health encounters, using lifelike mannequins, physical models, standardized patients, or computers.

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STANDARD 4 – CURRICULUM AND PROGRAM DURATION

CLINICAL SCIENCES

BEHAVIOR GUIDANCE

4-6 Didactic Instruction: Didactic instruction in behavior guidance **must** be at the in-depth level and include:

a. Physical, psychological and social development. This includes the basic principles and theories of child development and the age-appropriate behavior responses in the dental setting;
b. Child behavior guidance in the dental setting and the objectives of various guidance methods;
c. Principles of communication, listening techniques, and communication with parents and caregivers;
d. Principles of informed consent relative to behavior guidance and treatment options;
e. Principles and objectives of sedation and general anesthesia as behavior guidance techniques, including indications and contraindications for their use in accordance with the REFERENCE MANUAL; and
f. Recognition, treatment and management of adverse events related to sedation and general anesthesia, including airway problems.

Intent: *The term "treatment" refers to direct care provided by the residents/student for that condition or clinical problem. The term "management" refers to provision of appropriate care and /or referral for a condition consistent with contemporary practice and in the best interest of the patient.*

4-7 Clinical Experiences: Clinical experiences in behavior guidance **must** enable students/residents to achieve competency in patient management using behavior guidance:

a. Experiences **must** include infants, children and adolescents including individuals with special health care needs, using:
    1. Non-pharmacological techniques;
    2. Minimal ~~S~~sedation; and
    3. Moderate sedation ~~Inhalation analgesia~~.

b. Students/Residents **must** perform adequate patient encounters to achieve competency:

1.~~Students/Residents **must** complete a minimum of 20 nitrous oxide analgesia – patient encounters as primary operator; and~~

2. 1. Students/Residents **must** complete a minimum of 50 patient encounters in

which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used to sedate pediatric patients (patients 13 or under), or patients with special health care needs. The agents may be administered by any route.

a. Of the 50 patient encounters, each student/resident **mus**t act as sole primary operator in a minimum of 25 sedation cases.

b. Of the remaining sedation cases (those not performed as the sole primary operator), each student/resident **must** gain clinical experience, which can be in a variety of activities or settings ~~including individual or functional group monitoring and human simulation~~. At least 15 encounters **must** involve direct patient care, the remaining of which may include simulation experiences.

2.In addition to the above, students/residents **must** complete a minimum of 20 nitrous oxide patient encounters as primary operator; and

3. ~~c.~~ All sedation cases **must** be completed in accordance with the recommendations of the REFERENCE MANUAL and/or applicable institutional policies and state regulations.

***Intent**: Programs will provide or make available adequate opportunities to meet the above requirements which are consistent with those experiences required by jurisdictions with policies regulating pediatric sedation in dental practice. The numbers of encounters cited in the Standard represents the minimal number of experiences required for a student/resident. In the sole primary operator role, the student/resident is expected to provide the assessment, drug delivery, treatment, monitoring, discharge and emergency prevention/management in conjunction with other medical personnel as required by institutional policies. Each patient encounter shall have only one (1) sole primary operator.*

~~*In the remaining sedation cases, where the student/resident is not the primary operator, the supplemental cases provide the student/resident with:*~~

~~(1)*direct clinical participation in patient care in an observational, data-gathering, monitoring, and/or recording capacity,*~~
~~(2)*simulation experiences with direct clinical application to elements of the REFERENCE MANUAL, or*~~
~~(3) *participation in ongoing activities related to specific patient care episodes such as quality improvement and safety initiatives, apparent cause analysis, Morbidity & Mortality conferences, and/or clinical rounds that review essential elements of an actual patient sedation visit.*~~

In the remaining sedation cases, where the student/resident is not the primary operator, ~~T~~these experiences require documentation and inclusion in the RCL. It is not an appropriate learning

experience for groups of students/residents to passively observe a single sedation being performed. The intent of this standard is not for multiple operators to provide limited treatment on the same sedated patient in order to fulfill the sedation requirement.

Commission on Dental Accreditation

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At its Summer 2023 meeting, the Commission directed further study of the proposed revisions through the appointment of an Ad Hoc Committee. This document includes proposed revisions by the Ad Hoc Committee following its November 2023 meeting, as noted in green. This document will be considered by the Review Committee and Commission in Winter 2024.

Additions are Underlined;
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c. Principles of communication, listening techniques, and communication with parents and caregivers;
d. Principles of informed consent relative to behavior guidance and treatment options;
e. Principles and objectives of sedation and general anesthesia as behavior guidance techniques, including indications and contraindications for their use in accordance with the REFERENCE MANUAL; and
f. Recognition, treatment and management of adverse events related to sedation and general anesthesia, including airway problems.

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    1. Non-pharmacological techniques;
    2. Minimal ~~S~~sedation; and
    3. Moderate sedation ~~Inhalation analgesia~~.

b. Students/Residents **must** perform adequate patient encounters to achieve competency:

1. ~~Students/Residents **must** complete a minimum of 20 nitrous oxide analgesia patient encounters as primary operator; and~~

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which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used to sedate pediatric patients ~~(patients 13 or under),~~ or patients with special health care needs. The agents may be administered by any route.

a. Of the 50 patient encounters, each student/resident **mus**t act as sole primary operator in a minimum of 25 sedation cases.

b. Of the remaining sedation cases (those not performed as the sole primary operator), each student/resident **must** gain clinical experience, which can be in a variety of activities or settings ~~including individual or functional group monitoring and human simulation~~. At least 15 encounters **must** involve direct patient care, the remaining of which may include simulation experiences.

2.In addition to the above, students/residents **must** complete a minimum of 20 nitrous oxide patient encounters as primary operator; and

3. ~~c.~~ All sedation cases **must** be completed in accordance with the recommendations of the REFERENCE MANUAL and/or applicable institutional policies and state regulations.

***Intent**: Programs will provide or make available adequate opportunities to meet the above requirements which are consistent with those experiences required by jurisdictions with policies regulating pediatric sedation in dental practice. The program should provide experiences to ensure competency in moderate sedation of pre-school or school-age patients. The numbers of encounters cited in the Standard represents the minimal number of experiences required for a student/resident. In the sole primary operator role, the student/resident is expected to provide the assessment, drug delivery, treatment, monitoring, discharge and emergency prevention/management in conjunction with other medical personnel as required by institutional policies. Each patient encounter shall have only one (1) sole primary operator.*

~~*In the remaining sedation cases, where the student/resident is not the primary operator, the supplemental cases provide the student/resident with:*~~

~~(1)*direct clinical participation in patient care in an observational, data-gathering, monitoring, and/or recording capacity,*~~
~~(2)*simulation experiences with direct clinical application to elements of the REFERENCE MANUAL, or*~~
~~(3) *participation in ongoing activities related to specific patient care episodes such as quality improvement and safety initiatives, apparent cause analysis, Morbidity & Mortality conferences, and/or clinical rounds that review essential elements of an actual patient sedation visit.*~~

In the remaining sedation cases, where the student/resident is not the primary operator, ~~T~~these experiences require documentation and inclusion in the RCL. It is not an appropriate learning experience for groups of students/residents to passively observe a single sedation being performed. The intent of this standard is not for multiple operators to provide limited treatment on the same sedated patient in order to fulfill the sedation requirement.

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

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

The short-term suggestions from TNCDHE include:

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

The long-term suggestions from TNCDHE include:

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

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

Recommendation:

Prepared by: Dr. Sherin Tooks

The National Coalition of DENTISTS for HEALTH EQUITY

December 1, 2023

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

Dear Dr. Tooks,

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

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

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

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

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

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

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

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

SHORT-TERM SUGGESTIONS

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

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

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

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

LONG-TERM SUGGESTIONS

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

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

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

2) Student Admissions

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

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

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

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

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

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

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

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

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

3) Inclusive Environments in Dental Education

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

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

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

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

4) Access to Care among Diverse Populations

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

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

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

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

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

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

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

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

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

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

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