



PROCEEDINGS

American Dental Education Association

**Second ADEA
Advanced Dental
Education Summit
*The Convergence of
Specialties in
Advanced Dental
Education: Challenges
and Opportunities***

December 7-9, 2006

PROCEEDINGS

The Convergence of Specialties in Advanced Dental Education: Challenges and Opportunities

December 7-9, 2006



Editor's Note

The recommendations and priorities reported in these Proceedings reflect the input, opinions, and voting of the individual participants attending the Second ADEA Advanced Dental Education Summit. The recommendations do not necessarily reflect the official position of the American Dental Education Association or any of the Summit's sponsoring organizations.

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INTRODUCTION

The American Dental Education Association (ADEA) hosted the Second Advanced Dental Education Summit on December 7-9, 2006, in Baltimore, Maryland. The Summit was a part of the ADEA 2006 Fall Meetings. Representatives from the entire advanced dental education community—deans, program directors, department chairs, division heads, chiefs, and faculty members—came together with representatives of all of the advanced education training and specialty associations, corporate representatives, and other key stakeholders to discuss the challenges and opportunities facing the advanced dental education community and to develop recommendations for the future of the profession.

Over the three days, attendees met in general sessions and in smaller, concurrently run working group sessions. In all, there were 16 90-minute working group sessions addressing the following key issues facing advanced dental education:

- A. The increasing overlap of educational standards and its impact on the dental education system and scope of practice.
- B. The increasing recognition of nonspecialty interest areas in general dentistry and its impact on the dental education system and scope of practice.
- C. The resources needed to maintain and sustain advanced education programs and how the dental professions, specialty groups, and academic dentistry will respond to this challenge.
- D. The role and responsibility of academic dentistry in improving access to care for the underserved and special needs populations.

Each working group addressed specific aspects of these issues and concluded with a list of multiple recommendations that were prioritized by the group, resulting in two primary recommendations for consideration by the general session. Summaries of all of the working group sessions and recommendations are included in this report.

During the general sessions, participants heard the reports and recommendations from the working groups, prioritized the working group recommendations, and discussed the implications for the future of advanced dental education. The use of an audience response system provided an immediate “sense of the group” about priorities for action, helped to focus the dialogue and discussion during the general sessions, and enabled ADEA to analyze the responses by specialty area and position within dental education—providing a more nuanced understanding of the priorities of each subgroup of stakeholders in addition to the group overall.

The key themes and recommendations emerging from the plenary discussions are reported in the “Overview of Summit Discussions” section of the report. The data from the prioritization process are also included as an appendix to this report. It should be noted that the recommendations and working group reports reflect the opinions and priorities of the Summit participants and do not necessarily reflect the official position of the American Dental Education Association or any of the sponsoring organizations.

The Summit concluded with a call by participants for the entire advanced dental education community to take individual, collective, and interdisciplinary action to advance the recommendations included in this report. The recommendations will be used by the ADEA

Council of Hospitals and Advanced Dental Education Programs as it develops its action plan for the upcoming years and are also intended to inform and stimulate the thinking and action of all individual advanced dental education programs, faculty members, leaders in academic dentistry, and the advanced dental specialty organizations.

The challenges and opportunities facing advanced dental education are significant. It will require the collective action of all stakeholders to successfully address them. By engaging the entire advanced dental education community in a discussion of these critical issues, the Second ADEA Advanced Dental Education Summit was an important first step in the process of creating change. The ultimate success of the Summit, however, will be related to the use of the ideas and recommendations by communities of interest in moving advanced dental education to the next level.

THANKS AND ACKNOWLEDGEMENTS

Second ADEA Advanced Dental Education Summit Sponsors

The Second ADEA Advanced Dental Education Summit was made possible by the generous support of the following partners and sponsors:

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Second ADEA Advanced Dental Education Summit Planning Committee

ADEA wishes to thank the Advanced Dental Education Summit Planning Committee for its efforts in making the Summit a success:

Dr. John R. Agar, University of Connecticut
Dr. C. Lynn Hurst, University of Nevada, Las Vegas
Dr. Vincent J. Iacono, Stony Brook University
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Dr. Todd E. Thierer, University of Rochester
Dr. Stephen Wilson, Cincinnati Children's Hospital Medical Center
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American Dental Education Association
Mr. Joshua S. Mintz, Partner, Cavanaugh, Hagan, Pierson & Mintz, Inc.
Dr. Richard W. Valachovic, Executive Director, American Dental Education Association

WELCOME

Kenneth L. Kalkwarf, D.D.S., M.S.

Dr. Kalkwarf is President of the American Dental Education Association and Dean of the University of Texas Health Science Center at San Antonio Dental School.

On behalf of the American Dental Education Association, I want to welcome you all—deans, program directors, department chairs, division heads, chiefs, faculty members, representatives from the specialty groups, corporate sponsors, and distinguished guests—to the Second ADEA Advanced Dental Education Summit: *The Convergence of Specialties in Advanced Dental Education*.



I am delighted to be here with you for this working session. Your active participation in discussing and deliberating the convergence of specialties in advanced dental education is truly important. Your input will help to inform both the ADEA Council of Hospitals and Advanced Education Programs as it plans for the future and the entire advanced dental education community. From here we can develop an action plan, individually and collaboratively, to address the challenges and opportunities facing advanced dental education.

The Council has been increasingly active over the last several years with the involvement of representatives designated by each of the recognized specialty groups in addition to Special Care Dentistry and the Academy of General Dentistry. These representatives have participated in the ADEA House of Delegates as voting members of the Council during the ADEA Annual Session and have actively helped to develop the Council's programming for our Annual Sessions. The Council has stellar leadership via its Council's Administrative Board. I thank them for their volunteer service to our Association.

Many of you may be aware of the work of the ADEA Commission on Change and Innovation, or ADEA CCI. It's an ADEA initiative that is near and dear to my heart. The Council has participated with CCI in discussions about the continuum of dental education and the competencies for the new general dentist. Advanced education has been very ably represented in ADEA CCI by Dr. Cyril Meyerowitz, who will be delivering the Summit's keynote address, as well as several members with extensive knowledge of and commitment to postdoctoral dental education. I assure you that I view ADEA CCI as an opportunity for continued dialogue. Predoctoral dental education is the single doorway to many opportunities in postdoctoral dental education. ADEA CCI welcomes the Council's feedback, and CCI and I welcome your individual feedback, as well.

ADEA has taken some amazing steps as an Association in the past couple of years. We have gone to an Open Membership system, which means that every faculty member, staff member, and student of an ADEA member institution may join the Association at no personal cost. Today we have 14,500 individual members—an approximately 500% increase in membership over the past year alone. As you can imagine, because of Open Membership, new programs are joining ADEA, as well, including two new hospital programs just this past month. We believe that Open Membership is a great benefit that will attract programs to become involved in the Association, and in 2007 we are embarking on a campaign to invite more advanced and hospital programs to join ADEA.

The theme of the 2006 ADEA Fall Meetings, of which this Summit is a part, is “converging, connecting, creating.” I know that over the next three days you will *converge* on interesting and important questions. You will have plenty of opportunities to *connect* during your working group sessions. And when you’re done, I’m certain you will *create* a body of knowledge for ADEA that will be of great value.

Thank you for the gift of your time and talent. Welcome to the Second ADEA Advanced Dental Education Summit.

KEYNOTE ADDRESS

Stepping Back to Move Forward: Pedomorphism in Advanced Dental Education Cyril Meyerowitz, D.D.S., M.S.

Dr. Meyerowitz is Professor and Chair of the Eastman Department of Dentistry and Director of the Eastman Dental Center at the University of Rochester.



It is a pleasure and honor to be delivering this keynote address for the Second ADEA Summit on Advanced Dental Education. As many of you know, I am filling in for Art Dugoni, who was unable to be here today. Standing in for Art is a formidable task, as you might imagine.

In preparing for this presentation, I called Art, as many do, to get advice. I asked him about the message he was going to send had he given the talk. He said that had he been here, he was going to remind us that as we deliberated on the important issues and opportunities that face postdoctoral education—issues such as overlapping standards, access to care, financing advanced dental education, and the challenge of faculty recruitment—we needed to remain focused on what was best for the patients we serve and public trust in our profession, rather than in our own narrow self-interests.

Clearly, Art was stressing the importance of having us return to basic values and principles as we confront some difficult issues. I decided to extend his thoughts in my remarks and develop them further.

A number of people, including Arthur Koestler, have written about the phenomenon of pedomorphism in the creative process. In Zen it is called “the beginner’s mind.” By taking one step back in the intellectual process, we can simplify what seem to be complex issues by allowing ourselves to shed layers of possible misconceptions or bias as we try to move forward.

ped • o • mor • phism

Retention of juvenile characteristics in the adult.

The need when tackling difficult problems to return to an early or more basic stage in the thought process, i.e., more juvenile stage.

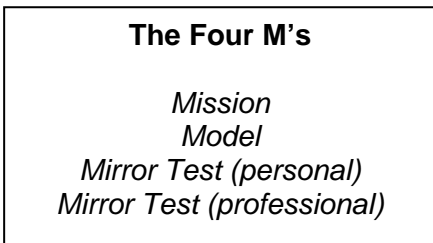
Perhaps the creativity of Einstein is a good example in this regard. Einstein had very little formal training and was outside the university system when he did some of his groundbreaking initial work on relativity. Not having had the formal education in this case might have given him an advantage in his thinking, as he was unencumbered by the current models of the time and biases from the formal educational process that might have limited him.

Of course, we are not Einstein. But it was Einstein who said that creativity and discovery were more about character than intellect. In a sense, Einstein’s lack of initial familiarity with the mature conventional thinking of his time was an example of pedomorphism. In our context, it is to tackle problems and seek solutions for all the difficult issues in advanced dental education by moving our intellectual starting point a little back and by returning to more basic values and principles that initially shaped our profession and helped it develop into what it is now: massively complex but outstanding and of great benefit to society.

Taking a step back to move forward is the central theme of my presentation. To do that, I will draw heavily from the work of ADEA’s Commission on Change and Innovation (ADEA CCI) and the report from the ADEA President’s Commission, *Improving the Oral Health Status of All Americans: Roles and Responsibilities of Academic Dental Institutions*, as well as many others.

I recognize that some might say that we simply need to stride into the issues and think pragmatically and realistically. I would argue that it is important to reevaluate periodically the intellectual biases we have, who we are, and what we believe in, particularly when things are changing rapidly and when we are tackling difficult questions. Doing that allows us to be very pragmatic, very realistic, and most importantly, very creative.

In a book on higher education, *Declining by Degrees*, Howard Gardner describes a project called the “good work project.” It is a research project looking at universities and the way they function. Good work is described as work that is excellent in quality and ethically responsible—work that any society should desire and honor across the professional landscape. Gardner and his colleagues interviewed thousands of individuals and asked the question, “How do individuals and institutions that seek to carry out good work succeed or fail at a time when conditions are changing and when market forces are extraordinarily powerful?”—recognizing that few, if any, forces can compete with the market.



For us this is important. Who can argue that dental education is not challenged now by market forces? Think of the issues in the education of implants or the Invisalign story. Both of these examples are driven by strong market force dynamics. Gardner recommends that when institutions or groups face these challenges, they should ponder “the four M’s”: mission, model, mirror test (personal), and mirror test (professional version). Let me put these in our terms.

Mission

It is important to define and periodically revisit what it means to be a dentist, an educator, a generalist, or a specialist. What is important about these professions? Are there similar characteristics? There are those of us who play many of these roles. We are educators, dentists, generalists, and specialists. It is helpful to think about the demands of these roles and where they might come into conflict. Regardless of the different roles each of us may play, we all share a common mission of serving the public.

Model

Who are the positive role models we can look to for guidance? Certainly, people like Art Dugoni come to mind. Many of us have succeeded in our professions because of the support, encouragement, and mentoring from those who have traveled this road before us. Each of us must look to find personal role models—and to learn from them. We should also remember that there are also the anti-mentors (or tormentors) who undercut the core of our profession. We all know them, and we have opportunities to learn (what not to do) from them, as well.

Mirror Test (Personal Version)

Each of us must ask ourselves, “Are we doing the best, most ethical job we can? Are we living up to the ideals we espouse? What changes do we need to make as individuals to achieve our goals for the profession?”

Mirror Test (Professional Version)

While it is hard enough to satisfy our own standards, we need also to remember that our personal interests are subservient to the overall direction of the profession. We need to ask, “Do we have a wider responsibility—and are we living up to it?” As the French playwright Molière said, “You are responsible not only for what you do, but for what you fail to do.”

As we discuss the issues facing advanced dental education during this Summit, it is instructive and illuminating to look at the vision, values, and principles put forward by the Commission on Change and Innovation. These reflect an approach which will serve us well in our dialogue. In a sense, let us move back to examine some basic guiding values and principles before we move ahead. Pedomorphism at work! ADEA CCI points out that dental education is a dynamic and innovative process characterized by critical thinking leading to preeminent scholarship, scientific discovery, humanism, pedagogy, and commitment to lifelong learning. The goal is to prepare oral health professionals to contribute to the health of individuals. This is the true challenge facing advanced dental education.

As we spend time over the next few days talking about the overlap of standards, curriculum, nonspecialty areas in general dentistry, workforce issues, access, and finances, it is necessary for us to have open communication, dialogue, and healthy debate. We need to stress the importance of collaboration among the educators in the specialties and general dentistry. We need to appreciate the diversity of educational methodologies that exist in all these programs and modify and modernize our curricula while looking for synergy in our educational processes. We need to be entrepreneurial, take risks, and be willing to establish alternative models of dental education. We need to understand the benefits of diversity and be united in our efforts to create a diverse workforce that resembles the diversity of the people we serve. And, of course, we need to be outcome-oriented and focus on those things that are tangible and recognize that workable assessment strategies are essential to determine whether we meet our goals.

Our principles need to include a recognition that professions exist to serve the needs of societies, communities, and individuals. We need to understand that as educators, an important part of our role is to safeguard this continued service to society, and we need to be responsive to evolving societal needs, practice patterns, scientific development, and economic conditions.

In our debate and dialogue over the next few days, let us try to mimic the important elements of a sound educational environment. Our dialogue should reflect the critical thinking that we expect from our graduates—an intellectual, disciplined process of actively and skillfully conceptualizing, applying, analyzing, synthesizing, and/or evaluating information gathered from or generated by observation, experience, reflection, reasoning, or communicating to guide our beliefs and actions.

Let us try to be humanistic in our approach in that we respect and understand different views, tolerate other opinions, and allow ourselves the freedom to explore different ideas. Let us take risks in our exploration and use sound scientific evidence to guide us. However, let us not be

seduced by the lack of adequate evidence, which leads us to hold on to concepts and solutions that are or appear to be self-serving.

There are many exciting challenges and opportunities in advanced dental education. We will have an opportunity to cogitate quite extensively on some of these. This is a “good work project.”

Remember pedomorphism! Good luck in your important work over the next few days.

CHARGE TO THE SUMMIT PARTICIPANTS

Stephen Wilson, D.M.D., M.A., Ph.D.

Dr. Wilson is Chair-elect of the ADEA Council of Hospitals and Advanced Education Programs and Director of the Division of Dentistry at the Cincinnati Children's Hospital Medical Center.

We are here at the Second ADEA Advanced Dental Education Summit to engage in a robust conversation about specific issues confronting the advanced dental education community and to identify steps that we can collectively take to meet these challenges. Each of us has an unprecedented opportunity to participate in shaping the debate and influencing the prioritization of recommendations that will be considered further by the ADEA Council of Hospitals and Advanced Education Programs as the Council develops an action plan to guide its work over the upcoming years. These recommendations will also be shared with the entire advanced dental education community and Summit sponsors. We all have a role to play in meeting and exploring the challenges together.



The heart of the Advanced Education Summit is the 16 concurrent working groups, during which participants play a central role in considering issues facing advanced dental education and developing recommendations for the future. Among the issues and questions that we will explore during working group sessions are:

- First, the increasing overlap of educational standards. We will explore how this overlap affects our educational system and scope of practice.
- Second, the dental profession, specialty groups, and academic dentistry need to address a variety of issues related to the resources needed for maintaining and sustaining advanced education programs.
- Third, meeting the unique needs of dental residents and faculty is an ongoing challenge. We need to become much more creative and resourceful in this area. We will discuss and identify innovative methods to enhance faculty recruitment and retention, as well as resident recruitment.
- Fourth, academic dentistry needs to define its role in improving access to care for underserved populations. Graduates of advanced dental education programs can play a vital role in increasing access to dental care for underserved and special needs populations. Increased diversity in the practitioner workforce is one way to improve access. There is an underrepresentation of minorities in the dental profession and in predoctoral and postdoctoral dental education programs. The dental community needs to confront the challenges the future holds and needs to examine how we can address diversity together.

The Summit design is based on feedback from the inaugural ADEA Summit held in November 2004 in Tucson, Arizona. Participants told us that the working group sessions were among the most valuable parts of that first Summit, but they wished that further discussion and followup on

the working groups were possible. We heard you. This year there are three big changes to the Summit design.

First, all participants will help to prioritize recommendations during the Summit. Each working group will address specific aspects of the issues listed above and develop multiple recommendations, of which two from each working group will be forwarded for consideration and discussion at the general session. We will hear brief reports from the facilitators of the various working groups, and then using an audience response system, the entire group will help to prioritize the recommendations.

Second, we have assigned professional writers to each of the working groups. The writers' role is to capture and summarize the many recommendations and suggestions that will be incorporated into a final report from the Summit. Copies of the report will be shared with each of the sponsoring organizations and each Summit registrant.

Third, the ADEA Council of Hospitals and Advanced Education Programs' Administrative Board will closely review the recommendations, paying particular attention to the prioritization to help guide the development of a strategic plan to guide the Council for the next three to five years. There is a small disclaimer to this format: The charge to the Summit participants is to *inform* the thinking of the Council, not set policy.

An automated response system (ARS) will be used to facilitate the discussion, prioritization, and to address concerns that "large voting blocks" may skew the results. The ARS allows collection of demographic information on participants so that the results can be analyzed by subgroup (e.g., specialty area, role within dental education). This analysis permits the Council to hear the collective voice of a particular group without its being drowned out by the voice of another.

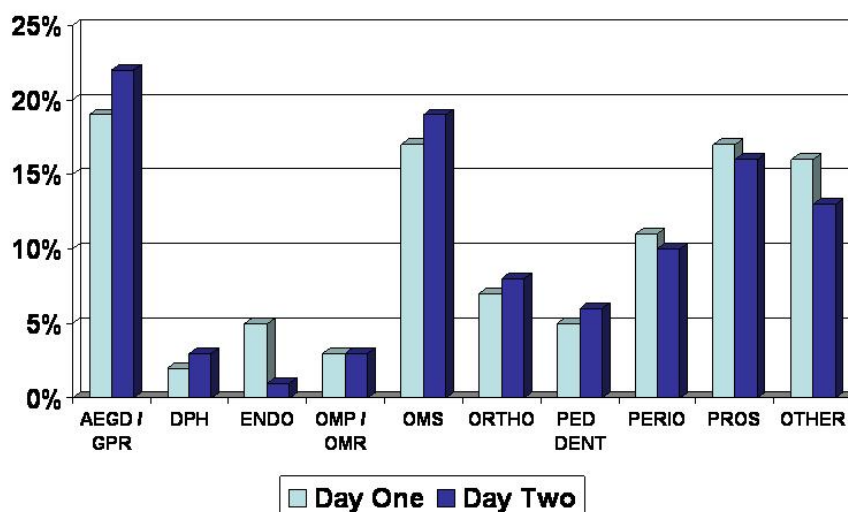
This is a different kind of meeting for our Council. We have brought you together to hear from you. The success of the meeting is dependent on your active participation, thoughtfulness, and willingness to share your expertise, your knowledge, and your opinions with us. We value our relationship with you and are committed to listening to you.

On behalf of ADEA and the Council, thank you for your active participation. We appreciate your attendance and the intellect that you bring to this Second ADEA Summit on Advanced Dental Education.

OVERVIEW OF THE SUMMIT DISCUSSIONS

Building on the theme of the Second ADEA Advanced Dental Education Summit, “The Convergence of Specialties in Advanced Dental Education,” participants in the Summit included representatives from the entire advanced dental education community, all of the specialty associations, corporate partners, and other key stakeholder groups. The Summit was an historic occasion as all of these diverse groups came together to engage in interdisciplinary discussions and dialogue about the critical challenges and opportunities facing the advanced dental education community—and to develop recommendations for the future of advanced dental education.

Participants by Specialty Area



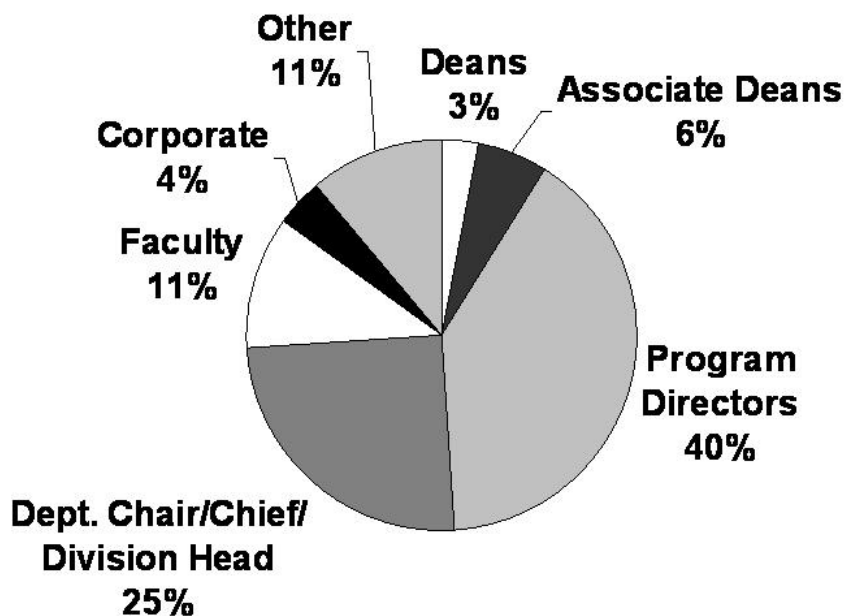
The design of the Second ADEA Advanced Dental Education Summit included a mix of general sessions and eight concurrent sessions on each of two consecutive days addressing the critical issues facing advanced dental education, including the following:

- A. The increasing overlap of educational standards and its impact on the dental education system and scope of practice.
- B. The increasing recognition of nonspecialty interest areas in general dentistry and its impact on the dental education system and scope of practice.
- C. The resources needed to maintain and sustain advanced education programs and how the dental professions, specialty groups, and academic dentistry will respond to this challenge.

D. The role and responsibility of academic dentistry in improving access to care for the underserved and special needs populations.

In all, there were 16 90-minute working group sessions over three days. Each working group addressed specific aspects of the issues listed above and concluded with multiple recommendations, of which two recommendations from each working group were forwarded for consideration and discussion at the general session.

Participants by Role in Dental Education



During the general sessions, participants heard the reports and recommendations from the working groups, prioritized the working group recommendations, and discussed the implications for the future of advanced dental education. Over the three days of the Summit, participants collectively considered 32 separate recommendations. In order to help focus the group's discussion, an audience response system (ARS, an electronic voting system) was used to prioritize these recommendations.

The ARS process was used as a tool to quickly identify the areas of high and low agreement, enabling the group to direct its attention to the recommendations that would benefit from further discussion and debate. The data from the prioritization process, for both the entire group and specific subsets of participants, is included as an appendix to this report.

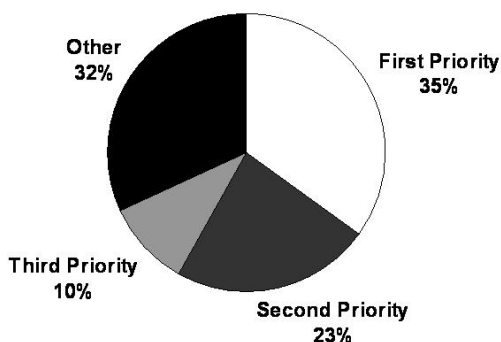
Five key themes emerged throughout the Summit discussions. They are listed in order of priority based upon the voting of the group at the conclusion of the Summit.

1. Advocate to **improve compensation and workforce conditions** within institutions, the government, and the specialty associations/foundations.
2. **Encourage uniformity (and reform) of national licensure** that will, at a minimum, favorably encompass components and aspects of access to care.
3. **Require an advanced postgraduate year** for all dental school graduates in an accredited clinical advanced dental education program prior to licensure.
4. **Promote interdisciplinary interaction** throughout all advanced education programs in didactic and clinical curricula.
5. Engage the Commission on Dental Accreditation in a discussion of the process and protocols used in the **accreditation of nonrecognized specialty interest areas**.

Theme One: Advocate to improve compensation and workforce conditions within institutions, the government, and the specialty associations/foundations.

The “resource challenge” is a common concern across all of dental education and throughout higher education in general. The dental professions, specialty groups, and academic dentistry need to address a variety of issues related to the resources needed for maintaining and sustaining advanced dental education programs, including but not limited to faculty recruitment and retention, recruitment of residents, patient pool, payment, and the infrastructure and administrative support needed to effectively carry out the mission of advanced dental education programs.

Percentage of Summit Participants Listing “Address Incentives and Compensation” among Their Top Three Priorities



Perhaps not surprisingly, the issue of compensation was rated among the highest priorities for action among all of the recommendations developed during the Summit. Participants noted that addressing compensation and related workforce issues was critical to efforts to attract and retain board-certified faculty and to attract residents to academic careers. Of all participants, 68.2% included “**address incentives and compensation**” among their top three priorities when voting on the recommendations related to resources—and 42% of participants rated this the single highest priority for the ADEA Council of Hospitals and Advanced Education Programs to address over the next three to five years.

Participants acknowledged that ADEA does not have a direct role in compensating faculty but recommended that ADEA support these efforts by **advocating to parent institutions, federal**

and state governments, and specialty associations to improve compensation and workforce conditions at educational institutions.

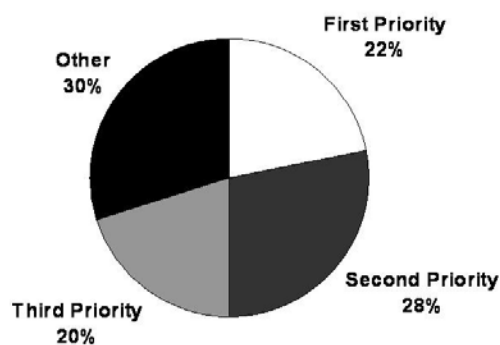
Participants also suggested that ADEA **investigate and share best practices in faculty compensation** so that programs can learn about successful compensation models and strategies. Examples of these practices are loan forgiveness programs, direct financial support to programs from alumni and specialty associations, allowing faculty to control intra/extramural practices with no caps, and minimizing the institutional taxes on clinical, research, and faculty practice income. The group recommended that nonfinancial practices such as workload flexibility, mentoring, and promoting the value of an academic career also be included in this effort.

Theme Two: Encourage uniformity (and reform) of national licensure that will, at a minimum, favorably encompass components and aspects of access to care.

While there are many aspects to the current debate over licensure, the focus of the discussions at the Summit centered on the implications of licensure on access to care for underserved and special needs populations. The discussion of licensure and credentialing took place within the framework of a larger question about the role and responsibility of academic dentistry in improving access to care for the underserved and special needs populations.

Participants noted that licensure is primarily a state's rights issue, making collective national action on the issue a challenge. That said, participants felt that the negative impact on access to care caused by the lack of national licensure requires action. Almost 70% of participants rated the recommendation to **"encourage uniformity (and reform) of national licensure that will, at a minimum, favorably encompass components and aspects of access to care"** among their top three priorities—the **highest percentage among all of the recommendations developed during the Summit.**

Percentage of Summit Participants Listing "Encourage Uniformity of National Licensure" among Their Top Three Priorities



Two key strategies were identified to encourage reform of national licensure. The first is the development of national licensure that would enable dentists to leave their home states to practice in other geographic areas—whether permanently relocating, providing regular service in a dental shortage area such as a rural community or low-income area, or volunteering their services during a crisis or in areas of high need. The current state-by-state licensure system restricts these opportunities, requiring the dentist to pass the state board before he or she can practice. Participants noted that passing the state boards is a particular challenge for specialists who may not have practiced general dentist procedures for many years.

The second strategy is also related to national licensure but is more narrowly focused on dental education. Dental schools and advanced dental education programs are a primary source of access to care for the underserved. However, the lack of national licensure makes the recruitment of faculty members a significant challenge. The need to take the boards and the inability to practice outside of the dental school environment are significant deterrents to faculty members' relocation. Participants noted Minnesota's innovative strategy of granting a dental license to any dentist associated with a dental college. With this licensure, the dentist is able to practice at the college and in private practice for as long as the person remains associated with the college. Participants recommended that more states adopt similar legislation.

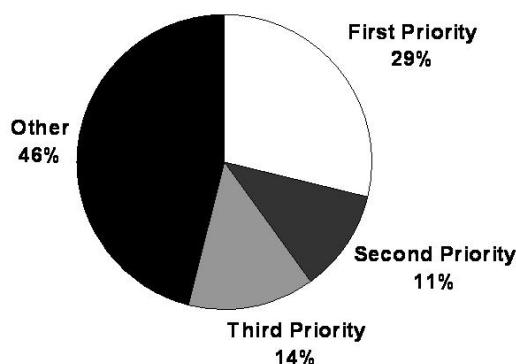
Theme Three: Require an advanced postgraduate year for all dental school graduates in an accredited clinical advanced dental education program prior to licensure.

There was a high level of support among Summit participants to **require that all dental students complete a mandatory postgraduate year (PGY-1) prior to licensure**. During the *initial* round of polling, 54% of participants rated this among their top three priorities, including a majority of participants from eight of the 10 specialty areas.

At the request of participants to more deeply examine the level of support for this issue, the forced-choice question, "Should PGY-1 be mandatory?" was specifically asked, and 69% of participants voted yes.

As the discussion of mandatory PGY-1 progressed, it became clear that participants had significantly different motivations for supporting this recommendation. For some, there was a sense that an additional year of training was needed to achieve mastery of an increasingly complex and overcrowded predoctoral curriculum. For others, it was the desire for a residency opportunity to better prepare graduates for the realities of practice. Still others saw PGY-1 as a potential solution to the issue of access to care by placing students in locations serving the underserved.

Percentage of Summit Participants Listing "PGY-1 Should be Mandatory for All Graduates" among Their Top Three Priorities



Responding to the suggestion that an additional year of training in dental school was needed because of the overcrowded curriculum, a number of participants noted that the efforts of ADEA's Commission on Change and Innovation (ADEA CCI) to rethink the predoctoral curriculum may minimize this driver for PGY-1 in the future. The participants recommended that advanced dental education have significant involvement in these discussions in all levels of the process.

As the discussion continued, a variation on the original recommendation for mandatory PGY-1 was proposed: requiring that all dental students complete an accredited advanced dental

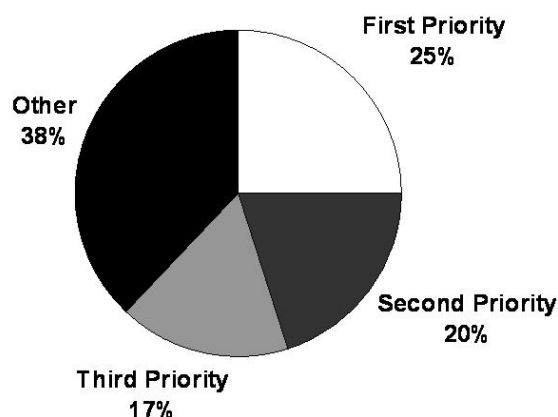
education *program* (AEGD/GPR or specialty program) prior to licensure (emphasis added), rather than just a single year of study. However, there was some concern that some students who complete one year of training in a specialty advanced education program may not have sufficient competencies in general dentistry to be licensed as a general dentist. After significant debate about the intended and unintended implications of this proposal, ultimately 79% of participants voted for requiring one year of study in an accredited program, rather than completion of a full program, prior to licensure.

Theme Four: Promote interdisciplinary interaction throughout all advanced education programs in didactic and clinical curricula.

Participants discussed the overlap of educational standards among the dental disciplines and its impact on both the educational system and scope of practice. The group recognized that there is some value in the overlapping standards in that they promote interdisciplinary communication and interaction, potentially leading to more comprehensive patient care. Interdisciplinary interaction also brings diverse perspectives to our work, helping to advance knowledge, create best practices, and ultimately improve the quality of care.

While the overlap of standards may be beneficial to the advancement of science and practice, it presents a significant challenge for advanced dental education programs. In some instances, the overlap has resulted in the establishment of redundant curricular development efforts within institutions and competition for faculty and other resources within and among advanced dental education programs. Rather than competition for faculty and other resources, sharing would benefit quality of education and result in more efficient use of faculty.

Percentage of Summit Participants Listing “Promoting Interdisciplinary Interaction” among Their Top Three Priorities



Sixty-two percent of participants named “**promotion of interdisciplinary interaction, where appropriate, throughout all advanced education programs in didactic and clinical curricula**” among the top priorities for action as an outcome of the Summit.

Specifically, the group recommended that **ADEA promote and support collaborative efforts to identify and review shared education standards among specialties and determine best educational practices.** Participants recommended that ADEA assemble a working group representing all of the key stakeholders in advanced dental education to:

- evaluate standards that involve shared scope of practice;

- investigate the development of a shared core curriculum that promotes interdisciplinary knowledge, communication, and collaboration in academic and clinical education;
- explore opportunities for sharing faculty and resources across disciplines to improve training and address resource shortages; and
- promote the use of common diagnostic codes as a vehicle to facilitate a common language, support interdisciplinary communication, and improve the ability to evaluate treatment outcomes.

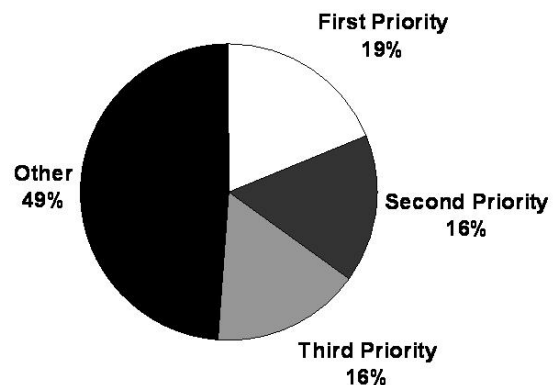
Summit participants noted that, given the interdisciplinary nature of this challenge, cooperation and collaboration—across disciplines, among institutions, and between divisions—are the keys to resolving the overlap of educational standards.

Theme Five: Engage the Commission on Dental Accreditation in a discussion of the process and protocols used in the accreditation of nonrecognized specialty interest areas.

The discussion of a proposed moratorium on the accreditation of nonrecognized specialty interest groups was among the most energetic dialogues at the Summit. It was also one of the few areas in which there was a significant difference of opinion between general dentists (AEGD/GPR) and some specialty groups about the most appropriate way for advanced dental education to move forward.

While acknowledging that the Commission on Dental Accreditation (CODA) is an independent body and that neither ADEA, individual advanced dental education programs, nor the specialty groups could tell CODA what to do, there was general consensus among Summit participants that CODA should **begin a moratorium on accreditation of nonrecognized specialty programs until a broad-based outcomes assessment is completed.**

Percentage of Summit Participants Listing “CODA Moratorium on Accrediting Nonrecognized Specialty Programs” among Their Top Three Priorities



The group recommended that the assessment examine the merit and need for recognition of these programs, the potential for public confusion and misunderstanding, and the impact on existing CODA-accredited advanced education training programs (e.g., dilution of current specialties, resources, and recruitment). New standards, effective on January 1, 2007, make oral medicine an accredited, nonspecialty program. New standards are in process to make dental anesthesiology an accredited, nonspecialty program.

The group also recommended that the Commission on Dental Accreditation **engage stakeholders in a discussion of the process and protocols used in the accreditation of**

nonrecognized specialty interest areas, maintain an open and transparent process as they evaluate accreditation of new programs, and hold nonspecialty disciplines to the same level of proficiency as the specialty areas when overlaps in standards do exist.

While there was strong overall support for the proposed moratorium (77% of participants), it was by no means unanimous. A vocal minority, composed primarily of participants representing AEGD, GPR, and some specialty programs, believed that CODA currently has an open and rigorous process in place—although it may not be well understood. They felt that these programs existed with or without accreditation and that having standards was preferred. This minority opinion held that accreditation of new areas helps to ensure a higher level of competency and proficiency and should be encouraged, assuming the area meets the existing standards for accreditation.

Summit participants recommended that ADEA, in its role as convener, could help to **bring together the various communities of interest to continue discussions about the accreditation of nonrecognized specialty interest areas**, including representatives from CODA, the general dentistry community, and the specialty groups.

REPORTS FROM THE WORKING GROUPS

At the core of the Summit were the 16 working group sessions, eight on each day, during which participants had the opportunity to explore key issues facing advanced dental education and develop recommendations for addressing these issues. The working group discussions focused on four key domains:

- A. The overlap of educational standards among the dental disciplines and its effects on the education system and scope of practice.
- B. The recognition of nonspecialty interest areas in general dentistry and its effects on the dental education system and scope of practice.
- C. The challenges faced by the dental professions, specialty groups, and academic dentistry in generating the resources needed to maintain and sustain advanced dental education programs.
- D. The role of graduates of advanced dental education programs in increasing access to dental care for underserved and special needs populations and the underrepresentation of minorities in the dental profession and in pre- and postdoctoral dental education programs.

Within each domain, four working groups were assigned specific questions to consider. The working groups were given approximately 90 minutes to discuss the issues assigned to them, develop recommendations for addressing these issues, and then select their top two recommendations to report back to the full group.

Working Group A

Working groups A1 through A4 focused on the issue of curriculum, particularly about maintaining the quality of advanced dental education, the impact on dental education programs of different dental specialties incorporating similar or identical education standards, the overlap in curriculum between predoctoral and advanced dental education, and the role advanced dental education programs should play in the community.

The reports that follow present in additional detail the question(s) each working group addressed, context for the discussions, and the recommendations put forward to the general session.

Working Group A1: Curriculum

Questions

There is an increasing overlap of education standards among the dental disciplines. How does this overlap affect our educational system and scope of practice?

How will adding new standards to advanced dental education programs affect the number of faculty needed for maintaining quality in these programs? Identify actions to address this issue.

The facilitator was James Q. Swift, D.D.S., Professor and Director of the Division of Oral and Maxillofacial Surgery in the Department of Developmental and Surgical Sciences at the University of Minnesota School of Dentistry, Diplomate of the American Board of Oral and Maxillofacial Surgery, and ADEA President-elect.

Introduction

The working group of 16 was asked to consider the questions above. Dr. Swift initiated discussion by posing the following about educational standards:

- Do the participants agree that there really is an increasing overlap of educational standards among the dental disciplines?
- What do we teach to—educational standards or accreditation standards?
- Are standards what they should be?
- Should ADEA take action on these issues?

The discussants agreed that there is overlap in dental education standards but also that everyone teaches beyond the accreditation standards. As programs exceed standards by teaching non-included material, this becomes a scope-of-practice issue.

The working group felt that most new skills added to accreditation requirements for any particular specialty are already a part of another specialty's requirements; therefore, every effort must be made to maximize efficiency and minimize duplication in educating specialists. The working group recommended that specialties first collaborate on core curricula and work out boundaries in scope of practice. Next, interspecialty cross-pollination can be fostered for better serving patients without overstepping boundaries. In the words of a discussant, "There are simple cases and complex cases, and specialists can tell them apart." Simple cases, in other words, could be handled by many specialty types, with complex ones referred appropriately. Other discussants added to that thought, saying they see the concept of "exposure" as being a useful model. In an exposure model, specialists in training can be exposed to a larger scope of practice with interspecialty rotations without having a competency or proficiency requirement relating to specialties outside their own.

Dr. Swift asked the group to consider which areas could benefit from collaborative education between the specialties. The group named nine educational areas: pharmacology, patient assessment, biomaterials, diagnosis and treatment planning, evidence-based medicine, treatment considerations of special needs patients, history and physicals, basic science, and disease prevention. A pediatric dentist pointed out that core courses tend to be taught with a focus on treating adult patients, which is not appropriate for pediatric specialists.

The group identified an additional problem during the discussion: If a program is required to add new standards, then new faculty may be needed. If this is an unfunded mandate and a particular program cannot afford to add additional faculty, then this stretches the existing faculty.

Recommendations

1. ADEA should lead a collaborative effort to identify and review shared education standards among specialties and determine best educational practices. By encouraging core courses and collaborative teaching, faculty workloads could be optimized, students could be better served, and the patients could benefit.
2. ADEA should assemble a representative working group to evaluate standards that involve shared scopes of practice (including impact on projected resources). This recommendation is designed particularly to address the problem of unfunded mandates. The participants are concerned that new standards can stress programs' resources and faculty and need to be adequately considered.

The group weighed a third recommendation:

3. ADEA should consider setting up a national curriculum data bank to allow programs to share resources for education. Several discussants described existing or planned lecture banks, websites, or PowerPoint banks. The discussants see a role for ADEA in setting up such a centralized, shared resource.

Summary

Clearly, the participants felt the need for increased collaboration to make educational practices and faculty requirements more efficient and to reduce overlap among individual specialties' scopes of practice. Participants were highly aware that patients need to be served in the best possible way; collaboration rather than competition advances this goal. The discussants ask ADEA to take a leading role in increasing collaboration and make the three recommendations above to ADEA.

Working Group A2: Curriculum

Questions

There is an increasing overlap of education standards among the dental disciplines. How does this overlap affect our educational system and scope of practice?

As different dental specialties incorporate similar or identical clinical education standards within their advanced dental education programs, what impact will this have on advanced dental education programs? What role could ADEA play in resolving this issue?

The facilitator was John Agar, D.D.S., Program Director of the Advanced Education Program in Prosthodontics at the University of Connecticut School of Dental Medicine and Member at Large of the ADEA Council of Hospitals and Advanced Education Programs.

Introduction

Dr. Agar invited his 21-member working group to discuss these questions and give concrete recommendations about ADEA's role.

The group agreed that interdisciplinary collaboration is critical for setting the stage for communication and cooperation among all dental specialties and between specialties and general practice dentistry. In real practice, complex cases need input from many sectors, and interaction during training would translate into cooperation later in patient practice. An interdisciplinary approach should begin early and be promoted throughout all advanced educational programs—in both didactic and clinical curricula. Students should look at cases together and make decisions jointly. A basic, interdisciplinary core curriculum should be developed for all students; specialty curricula would be introduced as students advance through their specialty programs.

The group further discussed reimbursement issues. It is anticipated that insurance companies will require diagnostic coding for reimbursement for dental procedures. Unlike medicine, dentistry does not have ICD-9 series coding. Standard codes will have to be developed, students and practitioners will have to be trained in the use of this coding system, and proficiency will need to be developed around them.

Codes will help track outcomes, and students will need to be trained to a competency and proficiency level defined by outcome measures. This would be a positive development, because new technology allows practitioners to perform procedures with little peripheral knowledge. Positive outcomes for patients depend on correct diagnoses.

Glossaries, which will result from the development of standard codes, will help build a common language for the interdisciplinary efforts.

The working group also discussed the impact that using diagnostic codes will have on the efficiency of a dental practice. They anticipated that billing to these new codes will result in a 30% loss in productivity.

Recommendations

1. Promote interdisciplinary interaction where appropriate throughout all advanced education programs in didactic and clinical curricula. Interdisciplinary collaboration will improve communication, enhance educational quality, and reduce faculty workload.
2. ADEA should actively promote diagnostic codes, which facilitate a common language. This will improve the ability to evaluate treatment outcomes, translating into better care for patients.

Additional Discussion

Overlap in the core curriculum is largely positive. Overlap in the core curriculum for students in advanced dental education programs promotes interdisciplinary communication, which translates into improved patient care. Overlap promotes interdisciplinary communication for comprehensive patient care among the various advanced programs. Specialties should combine what they can in an interdisciplinary core curriculum that promotes interdisciplinary communication and collaboration in academic and clinical education. This would also help significantly with faculty staffing. Faculty acceptance of an overlap would help promote it among students. Overlap would not be good if it created a scope of care that is not backed up by training (e.g., prosthodontic diagnoses by someone without adequate training in the specialty). Overlap exists now in dental schools, driven by market needs in current practice, particularly in the areas of implants and pain control.

A shortage of specialists and academicians makes teaching difficult. Having enough dental school faculty is a problem in some specialty programs. One reason is the income gap between private practice and academia. Inviting private practitioners to teach in specialty programs as part-time instructors could help address the shortage.

We need to identify learning expectations that will best meet patients' needs.

Accreditation standards define each specialty; therefore, scope of care is defined by state laws. Standards need to be identified that will best serve patient needs. Developing proficiency for different patient diagnostic levels is important in ensuring patient comprehensive care. Having diagnostic codes will allow interventions to be tested; thus, data will be developed on the best outcomes.

Learning opportunities should not be withheld from students because of university politics.

Gaps in education would translate into unacceptable outcomes for patients.

Summary

The recommendations of working group A2 address the impact on dental education of the overlap in education standards. The group suggested (1) advancing interaction among students at all levels of dental education and (2) developing a common language of diagnostic codes, which should drive particular specialty definitions and interdisciplinary training. Overall, the overlap in training that exists today is considered a positive development. Discussion also focused on ensuring that patients' needs are met in all proposed changes in educational course designs. A shortage of faculty in dental schools is an obstacle to meeting objectives; the group discussed ways to solve this problem.

Working Group A3: Curriculum

Questions

There is an increasing overlap of education standards among the dental disciplines. How does this overlap affect our educational system and scope of practice?

Is the overlap in the curriculum between predoctoral dental education and advanced dental education significant? Is it a concern for program directors? If so, identify the areas of concern, and suggest positive actions for addressing the overlap.

The facilitator was C. Lynn Hurst, D.D.S., Associate Dean for Advanced Dental Education and Director of the Advanced Education in Orthodontics and Dentofacial Orthopedics at the University of Nevada, Las Vegas School of Dental Medicine and Secretary of the ADEA Council of Hospitals and Advanced Education Programs.

Introduction

It is generally accepted that there is an overlap of education standards among the dental disciplines and among predoctoral and postdoctoral education. The question is whether this overlap is significant in a negative way. Many postdoctoral educators believe they repeat what is taught in the predoctoral programs and question the necessity of these educational experiences.

Fifteen people attended this working group session. Approximately one third of the participants were program directors. The participants represented academia, hospital practices, postdoctoral training programs, and the dental industry. The facilitator encouraged participation from all attendees.

The group agreed that the overlap between predoctoral and advanced dental education is significant but not necessarily negative. Some overlap is necessary for students to be able to integrate knowledge of the basic sciences into the clinical care of patients. The significant problem, however, is the gap in student knowledge of basic sciences. Many students are unable to apply their knowledge in basic sciences to patient care.

A primary issue appears to be the lack of retention from predoctoral to postdoctoral education, and the main weakness is in the biomedical sciences. The group agreed biomedical sciences should be better integrated with clinical education to allow students to better care for patients, especially those who are medically compromised.

Program directors of postdoctoral specialty programs find they have to repeat what students are taught in their predoctoral education regarding biomedical sciences. This may not necessarily be all negative. There has to be some reinforcement of this knowledge, but the question is whether postdoctoral programs just reinforce this knowledge or whether they provide remedial education. If too much time is spent on remedial education, it decreases the time available for clinical experiences. The basic sciences can't completely be eliminated from advanced education, and postdoctoral students and residents must ensure the appropriate level of competency in the basic sciences to maintain specialty education. One question, however, is whether advanced programs are truly teaching the basic sciences at a higher level, allowing students to apply that knowledge to patient care, or whether this education is redundant.

The degree of remediation required varies depending on which predoctoral program the graduate attended, with some of the variation exacerbated by diminishing faculty resources. Dealing with this variation causes difficulties for advanced educational programs. The group agreed there is a definite need for more consistent predoctoral education and training to improve postdoctoral training programs. Knowledge in specialty areas continues to expand, often requiring an increase in the time needed for specialty educational programs. Postdoctoral educational programs cannot advance if they do not begin with consistently well-educated students. This problem will continue to grow as more states start to require PGY-1 programs for licensure and the top students are no longer the only ones applying for advanced educational programs.

Another problem discussed was the separation between competency and proficiency and where in the educational process each should be developed. Predoctoral students may become competent in doing a particular procedure, but they do not develop proficiency in that procedure until their postdoctoral education or training experience. Another view is that postdoctoral students do not consistently achieve competency in general dentistry during their predoctoral training. If the medical model is followed, students do not develop competency until their nonspecialty postdoctoral program, either a General Practice Residency (GPR) or Advanced Education in General Dentistry (AEGD) program. They then achieve proficiency in specialty programs. There needs to be consistency in outcomes of the different educational levels.

The group agreed that additional input concerning changes in predoctoral education is required from postdoctoral educators if positive change is going to occur in advanced programs. One suggestion was more postdoctoral representation on the ADEA Commission on Change and Innovation (ADEA CCI).

The group further stressed that the focus of ADEA CCI should be on teaching strategies that promote the retention of biomedical sciences and on the integration of biomedical sciences with the clinical sciences. Students need to be able to retain and integrate knowledge from predoctoral education to apply it in advanced programs.

Recommendations

1. It is necessary for advanced dental education programs to have input into the ADEA Commission on Change and Innovation process from its inception. More input is necessary from postdoctoral educators concerning changes to predoctoral education, specifically in the progress of ADEA CCI.
2. Develop new strategies for integration of biomedical sciences and professional studies with the applied clinical sciences. This second recommendation reinforces the first recommendation. New strategies are needed for improving predoctoral education, specifically in improving the integration of biomedical and clinical sciences. New strategies (e.g., evaluation of teaching strategies) are needed for improving retention of this information from the predoctoral level to the postdoctoral level.

Summary

These recommendations arise from the agreement that input from postdoctoral educators is needed in predoctoral education, since postdoctoral educators are the “consumers” of predoctoral education. There is a lack of consistency between predoctoral programs in terms of graduates’ knowledge retention and competencies. Postdoctoral programs need a common

starting point, and more standardization is needed among predoctoral programs. There is a realization that predoctoral programs do need some flexibility, but a lack of standardization makes postdoctoral education more difficult. Predoctoral programs need more consistency if advanced educational programs are going to progress appropriately.

Working Group A4: Curriculum

Questions

There is an increasing overlap of education standards among the dental disciplines. How does this overlap affect our educational system and scope of practice?

Should advanced dental education programs play a greater role in community settings? If so, what paradigm shifts and resource and workforce issues need to be addressed in order to broaden the educational and training experience?

The facilitator was Vincent J. Iacono, D.M.D., Chair of Periodontics and Implantology at the Stony Brook University School of Dental Medicine and American Academy of Periodontology delegate to the ADEA Council of Hospitals and Advanced Education Programs.

Introduction

Working group A4 addressed whether advanced dental education programs should play a greater role in community settings and, if so, what paradigm shifts and resource and workforce issues must be addressed to broaden the educational and training experience.

The group agreed that, for numerous reasons, advanced dental education should play a greater role in community settings. For example, within community settings, dental residents would be able to provide basic dental care, including caries restoration, preventive services, exodontia, and fabrication of removable prostheses. In doing so, the residents would gain exposure to diverse patient populations and would learn to appreciate the needs of the underserved, while the underserved would benefit in getting the dental care that they might not otherwise receive. Dr. Lily Garcia, Chair of the Department of Prosthodontics at the University of Texas Health Science Center at San Antonio, described a successful community dental program run by her department. Every few weeks, teams of faculty, residents in prosthodontics and periodontics, dental assistants, and lab technicians make a 200-mile trip to a rural area of Texas. Because the cost of maintaining the program is higher than the government funding received, the Methodist Ministries of Texas provides supplemental funding. Outside funding such as this is key for success of the program. In addition, key elements for success include sufficient faculty supervision, the ability to maintain educational standards, and cooperation on the part of the dental school administration.

The working group agreed that the quality of education in community settings must match that of hospitals and dental schools for the community programs to succeed. To ensure success, there must be sufficient faculty supervision of dental residents. Currently, there is a shortage of supervisors willing to travel off site, and those who do often do so without financial remuneration. Telemedicine was proposed but was regarded as more likely to be effective for didactic purposes than for clinical supervision.

Attracting faculty to work in community settings will require financial incentives. It is also important to emphasize the unique educational opportunities presented by participation in community programs. For example, residents in prosthodontics would receive extensive experience in removable prosthodontics in community settings as compared with fabrication of veneers for esthetics in a dental school environment. Similarly, residents in periodontics would obtain greater training in nonsurgical procedures and periodontal medicine in community

settings as compared with school-based postdoctoral clinics. In the same vein, pediatric residents would gain more experience in treating rampant caries in community-based clinics.

All agreed that the significant impediment to implementing a community program is the mindset that “a dollar made in the community means one less dollar for the school or hospital.”

Postdoctoral and resident clinics are major sources of income for dental schools. Many schools can't afford to take the loss of this income. This situation will change by identifying alternative sources of funding. One way of garnering alternative funding is to solicit the government for more funding based on the assumption that dental schools are an asset to the community and state. If the dental school administration would promote itself as such, more funding might be obtained while at the same time reinforcing the importance of community dental programs. Stakeholders in the community—including nursing home representatives, concerned citizens, and elementary schools that stand to benefit from the specialty services of dental residents—must also become involved in the process. The more concerned voices the decisionmakers hear, the more likely it will be that funding will be appropriated in support of community dental programs.

Recommendations

1. Identify and develop financial incentives for educators providing service in community settings. Financial incentives should be identified for dental residents and faculty to provide services in community settings (e.g., rural areas, indigent populations, nursing homes).
2. Increase advocacy by academic dentistry and intensify lobbying efforts by ADEA, stakeholders (e.g., dental specialty groups, nursing home representatives, concerned citizens), and others at local, state, and federal levels and in corporate and private sectors. Petition local, state, and federal agencies, corporations, and private sector groups to increase funding and other support for community dental programs.

Summary

Many mutual benefits arise when dental education takes a role in the community. Dr. Garcia's program is one example. The working group identified factors necessary for a successful community program and made recommendations in the hope that community programs will soon be the norm.

Working Group B

Like working group A, working group B focused on curriculum. Participants compared the academic standards of nonspecialty interest areas with the academic standards of the nine recognized dental specialties and addressed the potential impact that recognizing nonspecialty areas would have on advanced dental education and access to care, as well as the responsibility of academic dentistry to prepare a workforce capable of meeting the needs of a changing U.S. patient population.

The reports that follow present in additional detail the question(s) each working group addressed, context for the discussions, and the recommendations put forward to the general session.

Working Group B1: Curriculum

Questions

There is increasing recognition of nonspecialty interest areas in general dentistry. What are the effects on the dental educational system and scope of practice?

What are the areas of overlap in the academic standards of the newly recognized areas of general dentistry and the standards of the recognized specialty programs?

The facilitator was Zakariah Messieha, D.D.S., Clinical Associate Professor of Anesthesiology at the University of Illinois at Chicago College of Dentistry.

Introduction

A group of 13 dental school professors and deans discussed academic standards of various advanced dental education programs. The discussion focused on comparing the academic standards of nonspecialty interest areas to the academic standards of the nine recognized dental specialties. The nonspecialty interest areas are advanced dental education programs offered by academic dental institutions that were not initially accredited by the Commission on Dental Accreditation (CODA). In recent years, CODA has evaluated and accredited some nonspecialty interest areas, provoking discussion among dental educators and ADEA board members about the role of these nonspecialty training programs in the field of dentistry.

Oral medicine and anesthesiology are two of the CODA-accredited nonspecialty interest areas, and Dr. Messieha led the discussion as an advocate of education programs in these areas. Dr. Messieha invited participants to introduce themselves and state their accreditations. Each was a general dentist or was board-certified in a recognized dental specialty. What follows is a list of recommendations made by members of this working group reflecting their concerns about the standards of education of the nonspecialty training programs, the costs and benefits of CODA accreditation, and even about the existence of such training programs.

The group agreed that CODA should continue to evaluate and accredit programs in oral medicine and anesthesia and that these programs should be held to the same standards of competency and ethics as recognized medical specialties.

Participants felt that oral medicine and anesthesia fill needs within the field of dentistry. Although some dental specialties provide the majority of their own anesthesia care (e.g., oral

and maxillofacial surgery), the level of proficiency and expertise of the dental anesthesiologist as the anesthesia provider for other dentists and dental specialists has to be ensured. In addition, these two interest areas are well established and accepted among a significant portion of practicing dentists. Since oral medicine and anesthesia training programs are well established and the graduates of these programs are perceived by their colleagues to contribute positively to the field of dentistry, attendees agreed that the programs should be CODA-accredited.

The working group also agreed that CODA should not accredit any of the other nonspecialty programs. They perceived that other interest areas provide training adequately supplied by existing specialties. Moreover, participants agreed that existing specialties divide dental skill sets more logically than do nonspecialty interest areas. For example, cosmetic dentistry training programs might teach skills that are more masterfully taught in the context of orthodontics and dentofacial orthopedics or prosthodontics. A patient with misaligned teeth might consider the problem cosmetic when it accurately falls within the realm and specialty training of an orthodontist. Similarly, a patient who needs veneers might consider the problem cosmetic, but a prosthodontic specialist can provide the expert care required. Participants agreed that it is more logical to train a dentist in either orthodontics or prosthodontics than to approach the skill sets of these two specialties and of the practice of general dentistry through cosmetic dentistry.

The majority of the working group agreed that nonspecialty interest area training programs do not provide dentists with the same level of expertise as do recognized dental specialty programs and that if CODA accreditation were available to training programs such as cosmetic dentistry, it could confuse the public about dentistry and compromise the quality of dental healthcare. However, it is important to note that there was a strong dissenting opinion on this issue, particularly among the generalists in the group.

Recommendations

1. Programs need to be held to a similar level of competency as that set by the existing specialties (not unanimous).
2. With the exception of oral medicine and dental anesthesiology, it is undesirable to accredit more general dentistry special area programs (not unanimous). CODA accreditation for other nonspecialty interest training programs is discouraged. It is potentially confusing to the public, may decrease the quality of patient care, and may interfere with the ability of recognized dental specialty training programs to recruit students.

Summary

Members of ADEA are concerned about the ethical implications of recognizing nonspecialty interest area training programs, because they perceive the quality of training to be inferior to the quality of training of recognized dental specialty training programs. They believe that CODA accreditation of oral medicine and anesthesiology is beneficial, because these fields fill needs within the dental profession and because the programs are already well established.

Working Group B2: Curriculum

Questions

There is increasing recognition of nonspecialty interest areas in general dentistry. What are the effects on the dental educational system and scope of practice?

What potential impact (positive and negative) would the recognition of nonspecialty areas have on the process of advanced education? What impact would it have on the training of residents? What impact would it have on access to dental care? What actions should be taken to prepare for the recognition of nonspecialty areas?

The facilitator was Todd Thierer, D.D.S., M.P.H., Chief Quality Officer for Dentistry, Director of Ambulatory Dental Services, and Director of General Practice Residency Program at the University of Rochester Medical Center, Medical Director of the Eastman Dental Center, and Chair, ADEA Council of Hospitals and Advanced Education Programs.

Introduction

Dr. Thierer opened the session by explaining to the 15 participants that the purpose of the discussion was to arrive at two recommendations in answer to the above questions. He put the questions in context by explaining that they are based on a process that the Commission on Dental Accreditation (CODA) has started to accredit programs (from nonspecialty interest areas) that are not ADA-recognized specialty programs. Two nonspecialty interest areas have been accredited, oral medicine and dental anesthesiology. Programs are seeking accreditation in part because accreditation is required for obtaining federal funding of education.

Participants agreed that accredited programs in nonspecialty interest areas should have standards as high as those in recognized specialties. Concerns the working group expressed about accredited programs in nonspecialty interest areas are as follows:

- Are these programs going to confuse the general public as to who is considered a specialist?
- Are separate standards needed? If there are no standards, who is ensuring that the students are properly trained? Standards need to be applied to ensure that students are properly trained. Some training, such as learning about new procedures and materials, can be obtained through continuing education.
- Who will teach these programs?
- Could accrediting the programs in nonspecialty interest areas have an unfavorable impact on recognized specialties?

Participants also considered that accrediting programs in unrecognized specialties could have possible favorable effects:

- Could access to dental care be improved?
- Could these programs provide more educational opportunities for dentists who do not want to complete longer formal programs?
- Would it not be better to accredit programs that are in demand by dental graduates who would seek training in unaccredited programs anyway?

Recommendations

1. CODA should begin a moratorium on accrediting nonrecognized specialty programs until an outcomes assessment is performed and shared with the communities of interest. Outcomes assessment would be broad-based and include the possible effects on the public and other existing CODA-accredited advanced dental education training programs.
2. Develop, through ADEA leadership, a public and professional education program to increase awareness of the advantages of advanced dental education specialty training and the differences there are in the scope of training and education provided.

Summary

The working group discussed the potential impact that CODA recognition of nonspecialty areas would have on the process of advanced education. In addition to the above two recommendations to ADEA, the group believes that appropriate representatives (content experts from other CODA-accredited training programs with overlapping standards) should be appointed to CODA review committees. Furthermore, dental students should be educated about the differences in the programs that are available to them.

Working Group B3: Curriculum

Questions

There is increasing recognition of nonspecialty interest areas in general dentistry. What are the effects on the dental educational system and scope of practice?

What is the perceived value or harm in seeking recognition for nonspecialty interest areas?

The facilitator was Stephen Wilson, M.A., D.M.D., Ph.D., Director of the Division of Dentistry at the Cincinnati Children's Hospital Medical Center and Chair-elect of the ADEA Council of Hospitals and Advanced Education Programs.

Introduction

Dr. Wilson opened the session with a warm welcome, a statement of the purpose and the goal of the meeting, and a request that the 14 participants introduce themselves. He then invited discussion of the question "What is the perceived value or harm in seeking recognition for nonspecialty interest areas?"

The question immediately drew many responses; however, all wanted clarification of "recognition by whom?" A few participants acknowledged the potential value of recognition for nonspecialty interests, such as more educational opportunities, extra resources, and access to government and public funding for those nonspecialty interest groups. However, the majority of the group worried that recognizing and accrediting nonspecialty interest areas would harm the public and dentistry. The number-one harm to the public and even to dental professionals themselves would be confusion. The group was concerned that recognizing nonspecialty areas would divide the dental community, cause more legal issues for general family dentists, and harm the image of dentistry as a whole.

Many participants were deeply concerned about the issue. The discussion was energetic, to last one and a half hours, thoughtful, and insightful. Many participants felt they needed more time to discuss the issue. To stay within the allotted time, Dr. Wilson steered the focus of the meeting from debating potential harm and value in recognizing nonspecialty interest areas to recommendations for the issue.

The group arrived at several recommendations. Its recommendations included (1) clarification of recognition of nonspecialty interest areas, (2) education for educators, (3) standardization of advanced education in dentistry, (4) revisiting by ADA of the issue of recognition of nonspecialty interest areas and consideration of alternatives, (5) not recognizing specialty interest groups at this time due to lack of need and resources and to risk of public confusion, and (6) the request for the Commission on Dental Accreditation (CODA) to develop an open process and protocol as it looks at recognizing new nonspecialty areas for accreditation.

Among the six recommendations, the meeting participants agreed that the following two are the most important.

Recommendations

1. Request that CODA develop an open process and protocol as it evaluates recognition of new nonspecialty areas for accreditation.

2. Request that CODA not recognize any additional general dentistry “special area” programs at this time because of lack of need and resources and because of public confusion.

Summary

The group had an energetic and insightful discussion. It discussed the conflict between CODA and ADA over recognition of nonspecialty groups. Most participants perceived that there would be more harm than value in recognizing nonspecialty interest groups.

Working Group B4: Curriculum

Questions

There is increasing recognition of nonspecialty interest areas in general dentistry. What are the effects on the dental educational system and scope of practice?

What responsibility does academic dentistry have for meeting the future dental workforce needs of a continuously changing U.S. patient population? Identify the two most important actions that can be undertaken to ensure that an adequate number and diversity of dentists are educated and trained in dental specialties and general dentistry.

The facilitator was Allen Wong, D.D.S., AEGD Assistant Program Director at the University of the Pacific Arthur A. Dugoni School of Dentistry.

Introduction

Dr. Wong opened by emphasizing the theme of converging, connecting, and working together. He told the story of “Stone Soup” to make the point that each participant in the room was bringing his or her own contribution of expertise and ideas to the final blend of recommendations that would emerge from the session.

Dr. Wong then posed the assigned question and helped establish its context by inviting the group to provide examples of how the U.S. patient population has been changing. They noted the following trends:

- The population is getting older and sicker.
- Racial and ethnic diversity has increased due to immigrant influx.
- A higher proportion of patients live in underserved areas (also known as “health provider shortage areas,” or HPSAs).
- There is an increased emphasis on physical appearance, beauty.
- There are higher expectations of prolonged function.
- The population is better informed because of greater access to more (although not necessarily better) information.

The group expressed uncertainty about which aspects of population diversity the meeting organizers meant them to focus on and eventually decided that they should focus on two main areas: (1) cultural/economic diversity and (2) geriatric and special medical needs patients (patients who are sick or disabled but not necessarily old).

They agreed that most dental school graduates today must be equipped to treat a much more diverse group of patients than a generation or two ago. The concurrent explosion of basic science and clinical information that must be taught during the four years of dental school means that it is also difficult to find enough time during that period to train students adequately in cultural competency or in dealing with geriatric or medically complex patients. Students can obtain additional expertise in these areas if they choose to do a general practice residency (GPR). However, there is such a high demand for dentists that most postgraduates can easily find jobs straight out of dental school, and they are frequently motivated to do so because of the heavy loan burdens they are carrying when they graduate.

To ensure that all dentists enter practice with sufficient training to care for a wide variety of patients, a fifth year of training should be required of all students after dental school. This year would be the equivalent of a GPR (and similar to the internship year that has been required of medical trainees for the last 40 years) and would be required even if the trainee subsequently planned to do a residency in some other specialty. An advantage of this system is that it would provide more opportunity for community-based as opposed to hospital-based training.

In addition to an increased need for trainees with broad cultural competency, there is also a need for practitioners (especially specialists) who are willing to serve in rural communities, inner cities, and other underserved areas. It was thought that both of these situations might improve automatically if the socioeconomic diversity of the dental trainee pool more closely matched that of the patient population.

Dental schools are already working hard to achieve diversity in their entering classes. However, their success is limited by the pools of students from which they can recruit, which contain few students from lower socioeconomic groups and underrepresented minorities. Therefore, efforts to reach out to and mentor potential dental school applicants should start earlier in the educational process, as early as middle school. These efforts could include visits to schools with underrepresented student groups to raise consciousness about dentistry as a possible future profession or programs offering hands-on experience in dental offices or clinics.

The group also agreed that all graduate programs should teach proficiency in dealing with geriatric and medically compromised patients, as well as patients from diverse cultural backgrounds. Such training could occur either in the context of a mandatory postgraduate year or in the context of current postgraduate training programs. In the latter case, standards of care for special patient groups should be formally harmonized across different specialties (which were felt currently to be silos in this regard). In addition, curriculum design should place more emphasis on community-based as opposed to hospital-based education, as the former provides more opportunity to interact with diverse patient groups.

Recommendations

1. PGY-1 should be mandatory for all graduates.
2. Postgraduate patient care experience in different demographic segments should include geriatric and special needs patients.

Summary

The socioeconomic characteristics of the current pool of postgraduate trainees do not match those of the emerging patient population. Postgraduate training programs must address this disparity to ensure that new practitioners are equipped to deal with the diversity of patients they will encounter, including geriatric and special medical needs patients, as well as patients from diverse cultural backgrounds. The working group also discussed the importance of earlier recruitment and mentoring of potential dental school applicants from diverse demographic groups.

Working Group C

Working groups C1 through C4 focused on resources needed to sustain advanced dental education. They addressed barriers to and incentives for recruiting and retaining qualified faculty and residents, compensation issues, and the type of infrastructure and administrative support needed for advanced dental education to thrive.

The reports that follow present in additional detail the question(s) each working group addressed, context for the discussions, and the recommendations put forward to the general session.

Working Group C1: Resources

Questions

The dental professions, specialty groups, and academic dentistry need to address a variety of issues related to the resources needed for maintaining and sustaining advanced education programs. Challenges relate to faculty recruitment and retention, recruitment of residents, patient pool, payment, and mission.

Identify the barriers to recruiting and retaining full-time board-certified faculty. What actions can be undertaken to alleviate the shortage? What groups should be involved in the solution?

The facilitator was Sheila H. Koh, R.N., D.D.S., Director of Government Funded Training Projects at the University of Texas Health Science Center at Houston and ADEA Vice President for Hospitals and Advanced Education Programs.

Introduction

This working group of 14 people was asked to consider the above questions. Dr. Koh asked participants to share their experiences with recruitment and retention of faculty. The discussion was animated, and everyone in the room had many chances to speak. A summary of the ensuing discussion and resulting recommendations follows.

The group expressed concern that sufficient national resources are not being allotted to dental educational institutions, given the expected expansion in the number of dental professionals needed to serve the aging baby boomer population. The group believed that dental organizations do not work together toward common issues that affect the face of the profession and that ADEA should form a consortium with the ADA and other professional organizations.

They were also concerned about educational institution resources and morals, feeling that workloads are often too heavy, mentorship is lacking at all career stages, pay is not comparable to that achievable in private practice, and administrative support is not adequate. In addition to the following two primary recommendations, they also recommended that the profession reevaluate full-time and part-time designations and consider how to combine academic workloads with private practice to address the current salary disparities.

The participants agreed that there are significant barriers to recruiting and retaining full-time board-certified faculty and made the following two recommendations to ADEA.

Recommendations

1. ADEA, with other professional organizations, should advocate public policy to expand and improve the profession (e.g., fund and expand schools' ability to attract academicians). It is recommended that ADEA develop a strategy for taking the lead in working with other dental organizations to develop a consensus and work on advocacy with the goal of addressing public policy and expanding and improving the profession.
2. Improve institutional environments so that recruitment and retention of board-certified faculty are increased. It is recommended that ADEA work to improve institutional environments in order to improve recruitment and retention of board-eligible/certified faculty. Improvements should be sought in workload flexibility, resources (e.g., research and administrative support), financing, and establishment of a systemwide mentorship program for students at all levels and for faculty.

Summary

Clearly, the participants saw a need for policy-level and institutional-level changes to improve the recruitment and retention of board-certified faculty. The participants ask that ADEA take a leading role both by forming a consortium of professional dental organizations to advocate for change and by working to improve institutional environments.

The working group also discussed the issue of board certification, although it did not make a recommendation in this regard. Much discussion centered on the current requirement that academic program directors be board-certified in their program's specialty, yet many specialists lack board certification. Therefore, the pool of eligible applicants for program director positions is very limited, and many in the group were worried about the future of educational programs because of the lack of qualified leadership. One suggestion was to advocate for changes in regulations to allow board-eligible program directors to be hired with a window of time in which to become certified. Another suggestion was to better support program directors administratively so they could hand off duties that did not require special expertise and reserve their time for tasks that require expertise unique to a board-certified clinician.

Working Group C2: Resources

Questions

The dental professions, specialty groups, and academic dentistry need to address a variety of issues related to the resources needed for maintaining and sustaining advanced education programs. Challenges relate to faculty recruitment and retention, recruitment of residents, patient pool, payment, and mission.

Identify effective incentives or strategies for recruiting and retaining residents and faculty. Identify the top two strategies (not including financial remuneration) that institutions and program directors can use to recruit and retain faculty and residents.

The facilitator was John R. Agar, D.D.S., M.A., Director of the Advanced Specialty Education Program in Prosthodontics at the University of Connecticut School of Dental Medicine and Member at Large, ADEA Council of Hospitals and Advanced Education Programs.

Introduction

Dr. Agar opened the session by explaining that besides the group's sending recommendations to ADEA, participants should discuss the issues with colleagues in the dental education community.

Dr. Agar put the working group assignment in context, saying that advanced dental education faces a crisis because of substantial difficulties in recruiting and retaining full-time and part-time junior faculty. The working group divided the problem into two areas: recruiting and retaining junior faculty and recruiting and retaining residents.

To address difficulties in recruiting and retaining junior faculty, the working group suggested the following:

- Make faculty workloads manageable by providing sufficient protected time for research and scholarly activities.
- Have sufficient numbers of faculty members.
- Improve the quality of life of those in academic positions by, for example, making work hours reasonable.
- Provide a benefits package that includes, for example, discounted continuing education and computer access.
- Improve faculty practice arrangements by providing choices to practice inside the dental school *or* outside in the community.
- Encourage department chairs to delegate responsibilities and titles to junior faculty to enhance junior faculty members' sense of value and involvement and to enhance their prestige and standing.
- Have senior faculty be role models, such as mentors, who foster a positive view of academic dentistry.
- Show residents that an academic life is an attractive one.
- Foster the sense that faculty offer value to students, the university or institution, the profession, and the public.
- Rethink the pathway to tenure that emphasizes research by considering the value of teaching versus research faculty. "You need all kinds of people in a department."

- Appreciate the importance of education and of educating residents about teaching.
- Encourage the view that part-time faculty contribute a valuable and satisfying payback to dentistry.
- Encourage dental society recognition of faculty.
- Consider enhancing education by developing technology/distance learning, sharing faculty resources, and reviewing other curriculum models of professional education, such as medicine and law.
- Enhance ADEA's promotion of professional development opportunities, such as opportunities for professional women raising families.
- Educate members and doctors about the extent of the crisis in dental faculty.
- Work with the Council of Deans and ADEA to implement these suggestions and to participate in brainstorming sessions such as this breakout session.
- Combine ADEA's Advanced Summit with the deans' conference.

To address difficulties in recruiting and retaining residents, the working group made these suggestions:

- Have “residency fairs” for dental students.
- Mentor students; involve them in research projects.
- Prepare media describing the value of advanced education to dental students.
- Organize speakers’ bureaus, which should include residents, to address dental students.
- Consider enhancing the resident-student relationship.
- Have faculty/program directors as role models—strong, energetic faculty.

The working group concluded by arriving at two recommendations.

Recommendations

1. For faculty recruitment, develop a sense of value of an academic career for students, colleagues, administration, and the general public. Strategies include enlisting the ADEA Council of Deans in the process of understanding faculty issues and supporting change.
2. For resident recruitment, promote the value of advanced dental education. This can be addressed, for example, by having faculty and residents act as role models for dental students. Other groups, such as the ADEA Council of Students, ASDA, and other dental societies, could be partners in this process.

Summary

Advanced dental education faces a crisis because of substantial difficulties in recruiting and retaining full-time and part-time junior faculty. The working group sees the problem as twofold. One issue is recruiting and retaining junior faculty. The other is recruiting and retaining residents. The group made many useful suggestions and then formed them into two global recommendations, both of which focus on promoting the value of advanced education and academic life.

Working Group C3: Resources

Questions

The dental professions, specialty groups, and academic dentistry need to address a variety of issues related to the resources needed for maintaining and sustaining advanced education programs. Challenges relate to faculty recruitment and retention, recruitment of residents, patient pool, payment, and mission.

Are compensation and incentives adequate for meeting recruitment and retention needs for specialty faculty? Identify incentives already being used successfully by advanced dental education programs. What actions can program directors and institutions take to address these issues?

The facilitator was C. Lynn Hurst, D.D.S., Associate Dean for Advanced Dental Education and Director of the Advanced Education in Orthodontics and Dentofacial Orthopedics at the University of Nevada, Las Vegas School of Dental Medicine.

Introduction

There is a recognized problem with recruitment and retention of specialty dentistry faculty. The working group addressed whether compensation issues play a role in this problem and, if so, what can be done to improve compensation and incentives.

Nineteen people participated in this working group session, representing professional associations, academic institutions, and residency program directors. The facilitator began the session by having participants introduce themselves. He encouraged participation from all and helped the group summarize the discussion's highlights and final recommendations.

The working group felt that compensation and incentives for full-time faculty must be improved. Suggestions for improving compensation and incentives include the following:

- Allow support from alumni and specialty associations to go directly to programs and departments.
- Allow faculty to control intramural and extramural practice with no limitations or caps.
- Minimize institutional taxes on clinic and research earnings by faculty.
- Create loan forgiveness programs.
- Provide faculty with state-of-the-art facilities and technology.
- Reduce ADA dues for full-time faculty.
- Do a better job of publicizing the total compensation packages available to faculty.

The group unanimously agreed that compensation and incentives are not sufficient for recruiting and retaining full-time specialty faculty. This has been a consistent finding of academic department and specialty organization surveys. Although there are problems with prestige and other issues, the most significant problem is the disparity between private practice and academic salaries, with variation among the specialties. It is believed that many practicing clinicians would like to be full-time educators but are not because of compensation issues.

Disparities continue to grow larger due to the current model of advancing faculty salaries. There needs to be a move to a clinical faculty model for dentistry faculty rather than the traditional

model of pay based solely on academic rank. Schools also need to remove caps on faculty incentive programs and provide faculty incentives for research and clinical practice initiatives. Difficulties in recruiting specialty department chairs may be minimized by allowing higher salary lines and bonuses for specialty department chairs, similar to the medical model.

The working group discussed several current incentive programs and potential solutions. Much of the discussion focused on faculty practice. Internal faculty practices need to develop better business models, reduce overhead, and minimize institutional taxes on income (e.g., dean's tax). Both internal and external faculty practices can be used, but faculty need to be allowed to practice in some capacity, have more control over their business practices and earnings, and have fewer restrictions on time allowed for practice.

It was noted that specialty associations and alumni associations are acting as first responders to this crisis of salary gaps. They are providing substantial funding for several incentive models (e.g., faculty scholarships/bonuses). New strategies, however, are needed to sustain funding for these programs. It is important that faculty receive these funding opportunities directly. Likewise, it was noted that alumni might be more likely to donate to schools if their donations went directly to departments or programs rather than general institution funds. Every school should also have its own foundation for raising direct funds.

There is a need for better school facilities and technologies. Many current facilities are inadequate for training or practice. Faculty are learning about technology from the community when they should be the ones knowing about and doing the state-of-the-art work. Providing state-of-the-art facilities can be considered a major incentive in recruiting faculty.

Faculty members do enjoy comprehensive benefit packages in addition to salary, which can be substantial (estimated at 25-30% above base salary). Depending on the institution, these packages may include healthcare, retirement, subsidized childcare, and free or reduced tuition. These benefit packages need to be better advertised to faculty and recruits.

The working group also believes that the challenges with compensation and workforce issues are not adequately understood by the groups that can bring about change. Schools (e.g., faculty, deans) need to educate higher education administration (e.g., Boards of Regents, trustees) on these challenges and advocate for change in the pay structure. The professional organizations (e.g., ADA, ADEA, specialty associations) need to make academic workforce issues a top priority.

There are a variety of ways to address compensation and workforce issues at both the state and federal levels. Suggestions include an evaluation of the current pay structure for faculty, a move toward the clinical model for salaries, a goal of 85% of market pay, and restoration of graduate medical education (GME) funding for specialty education. A major argument is that weak faculty recruitment and retention may eventually jeopardize accreditation status.

What follows are the working group's recommendations. The group had numerous recommendations that it combined into two main recommendations.

Recommendations

1. Address incentives and compensation. Improve compensation and incentives for full-time specialty faculty.

2. Advocacy is needed to improve compensation and workforce issues. To improve compensation and workforce issues, expect advocacy from deans, schools, universities, and specialty organizations and foundations. These groups need to educate and lobby groups such as institutional boards of regents, trustees, and state and federal legislators on these issues.

Summary

Described above are the working group's recommendations. The group concluded that compensation and incentives are not adequate for recruitment and retention needs for specialty faculty. They suggested several potential ways to improve compensation; however, change will occur only through strengthened advocacy by the schools and professional associations and a substantial investment at the state and federal levels.

Working Group C4: Resources

Questions

The dental professions, specialty groups, and academic dentistry need to address a variety of issues related to the resources needed for maintaining and sustaining advanced education programs. Challenges relate to faculty recruitment and retention, recruitment of residents, patient pool, payment, and mission.

Identify the infrastructure and administrative support needed for advanced dental education programs to survive and also to thrive. What groups should be involved with the process? What steps can program directors and dental schools take to enhance the success of advanced education programs?

The facilitator was Vincent J. Iacono, D.M.D., Chair of Periodontics and Implantology at the Stony Brook University School of Dental Medicine and American Academy of Periodontology delegate to the ADEA Council of Hospitals and Advanced Education Programs.

Introduction

Dr. Iacono presented the questions and asked the group to identify any topics that have to do with resources, for example, finances, staff, and clinical activities. The participants were also asked to identify parties that could provide economic support to dental schools, such as the federal government, private sector, corporate sector, or alumni.

The working group of nine agreed that dental schools vary in how they acquire and allocate financial income. Some income is government-based, some is from patient care provided by residents and faculty, and some comes from alumni contributions to a graduate education fund. Hospitals are different from standalone dental schools in that they can apply for graduate medical education (GME) money. However, since government funding is decreasing steadily, the feeling is that GME money should not be counted on for planning purposes. Costs are going up, so other sources of income besides GME are needed to maintain salaries, infrastructure, and support services.

In cases where income is earned for the program through clinical services provided by residents and faculty, schools sometimes use the graduate program as a “cash cow,” and the administration has the tendency to press for high production levels. In some cases, this helps departments receive some additional staff if the computer production analysis models identify practice efficiencies that would be improved by the addition of lesser cost administrative staff. In other cases, the residents take on more of a teaching role to free up faculty for the clinic. This last approach can backfire by driving away faculty who seek more of a teaching role. Some schools are limited by state law in how they can employ residents for teaching or clinic duties. There was some discussion of attendings supervising residents while treating patients. This practice is allowed by law, and as long as the number of students does not overwhelm the supervisor, the practice is considered safe and useful to the program.

Most working group participants felt that (1) graduate dental students should not have to pay tuition and (2) the business model should assume that the graduate school would be self-supporting. One problem that exists today is related to employing several tiers in the availability of financial support. For instance, in some schools, prosthodontics students do not pay tuition, while students in endodontics, orthodontics, and periodontics do pay. Moreover, graduate dental

students in pediatrics receive stipends. There are differences in this mix of student benefits and in sources of funding between public and private schools, between dental schools and hospitals, and in different geographic areas.

Since some hospitals provide financial resources to dental schools with which they are affiliated, one suggested solution to a fiscal problem would be for the dental school to combine its program with a hospital. This solution would not be available to all dental schools. Another solution mentioned was to enhance orthodontic/pediatric services, since pediatric dental care often receives more state funding.

Business models are being adopted by many, if not most, dental schools. The best way forward for ADEA in the face of this trend is to suggest workable models that incorporate academic and ethical goals to accompany the economic aims. In any model, one goal should be optimization of pre- and postdoctoral program interrelationships. The model should include volunteer faculty as a budget line item, since the resource is accounted for in the model and fiscal responsibility for the function is present should the institution lose the volunteer(s) and have to replace with salaried faculty.

In all cases, the group supported transparency in allocation of funds received from clinic services. Many schools do not share this information with program directors, which makes it difficult for directors to plan for optimal interdisciplinary interaction, since some specialties are not available to share curricula because they spend a majority of their time in the clinic. There were many varied examples of different types of financial allocation schemes: In some cases, the money flows first to the university, and then some is returned to departments in the dental school; in some cases, the department that earns the money controls the funds; others adopt a hybrid approach where the university and the departments share control. All believe that program directors should have a say in the allocation decision.

The working group also discussed career track alternatives for clinical faculty. Recruiting faculty for dental schools is a problem due to compensation and school environment issues. To assist dental schools in recruiting for both academic and clinical track faculty, two separate but equal systems are needed. For attraction and retention of academic faculty, tenure is key; for clinical educators, an alternative track is needed with access to promotions, incentives, and long-term contracts. Being on the clinical track would not negate other responsibilities such as teaching and research. It should receive the same respect from colleagues as the tenure track.

Several of the working group participants mentioned differences that they are aware of in various programs. One school, for example, chooses only 10% of faculty for the clinical track, and those who are not chosen and do not receive tenure do not get their contracts renewed. Another school has only tenure track positions. A third has both tracks, but a faculty member cannot switch tracks. In yet another school where there is academic tenure and a clinical educator track, if after three years the faculty member is not on a tenure track, he or she is automatically rolled over to the clinical track.

What follows are two recommendations the group made based on its discussion about the questions it was asked to consider.

Recommendations

1. Develop business models with financial autonomy and transparency in budgets.

2. Develop career track alternatives for clinical faculty.

The group also highlighted a need to identify an associate dean for advanced education programs. An associate dean would be an advocate for the overall graduate dental program and could deal with integration of resources versus each single program director's requesting resources for his or her own interests. Some participants embraced this idea, and some preferred to have direct access to the dean with no bureaucratic interference. The idea was more acceptable to everyone if the associate dean focused on just the graduate school and not research or other responsibilities. Another suggestion was to appoint associate program directors so a succession plan for continuity and longevity of programs would be ensured.

A recommendation was also made to ensure academic integrity through outcome assessment measures. Some schools offer incentives to residents to increase productivity. Rewards are based on production levels. With incentives, students can see their own productivity and discuss it with teachers and peers. However, this practice is subject to abuse, may be very competitive, and may result in laxity. It needs to be closely managed, which further increases the burden on members of the faculty.

Summary

There was significant discussion leading to the first recommendation concerning development of a business model for dental schools. The other recommendations support the financial model by providing ways to obtain funding while ensuring integrity of academic goals, retaining faculty, and attracting new students. It was clear from the discussions that participants feel that ADEA should approach dental school administrators with its concerns and needs and become more involved in decisions regarding allocation of funds.

Working Group D

The overriding topic for working groups D1 through D4 was dental care for underserved and special needs populations. Within this context, the participants discussed current efforts to enhance the diversity of the dental workforce, applying these efforts elsewhere, licensure as a barrier to access to care, and ways to increase interest among underserved groups in careers in dentistry.

The reports that follow present in additional detail the question(s) each working group addressed, context for the discussions, and the recommendations put forward to the general session.

Working Group D1: Dental Care for Underserved and Special Needs Populations

Questions

Graduates of advanced dental education programs can play a vital role in increasing access to dental care for underserved and special needs populations. Increased diversity in the practitioner workforce is one way to improve access. There is underrepresentation of minorities in the dental profession and in pre- and postdoctoral dental education programs. The dental profession and academic dentistry must address diversity issues.

Identify current activities to enhance the diversity of the dental workforce and the success of these efforts. How does diversity of the applicant pool play a role in increasing the diversity in the dental workforce? What are the two most important actions that should be taken to increase the diversity of the applicant pool?

The facilitator was Zakariah Messieha, D.D.S., Clinical Associate Professor of Anesthesiology at the University of Illinois at Chicago College of Dentistry.

Introduction

Research shows that dentists are likely to treat patients who are most similar to themselves. It is therefore important to maintain diversity within the dental workforce in order to provide dental care to the widely diverse U.S. population. Over the past years, while the number of dental school applicants has increased, the number of minorities within this applicant pool has remained constant. If the trend were to continue, the lack of diversity within the dental workforce would increase. The purpose of this session was to discuss the need for diversity and ways to increase diversity in the dental workforce.

The working group of 13 agreed that it is important to learn what would entice underrepresented minorities to apply to dental school. The group felt that it is important to learn more about the aspirations of today's younger generation. More specifically, they suggested that a survey be developed and distributed to the 98 colleges in the United States with the highest underrepresented minority populations. Once the results of the survey have been interpreted, a focus group can then be used for marketing purposes and for determining an effective approach to attracting qualified and diverse applicants to dentistry as a career.

The group also agreed that once the survey results demonstrate what would entice underrepresented minority students to apply to dental school, then actions can be taken to implement the ideas. If many organizations join together to share and reinforce ideas that work,

then there will be the potential for a large impact on the young underrepresented minority generations. One example of current attempts to aid in the recruitment of diverse student applicants comes from the Health Resources and Services Administration (HRSA). The organization provides grants for underrepresented minorities and for students who promise to practice in underserved areas and with high-risk groups such as people who have HIV/AIDS or are homeless. If organizations can provide incentives such as grants, minority and other dental students would be more likely to agree to practice in underserved areas for a set period, thus improving delivery of dental care.

The working group also discussed intervening as early as grade school to interest underrepresented minority students in dentistry and to ensure that underrepresented minority candidates are qualified to enter dental school. One reason for intervention as early as grade school is that, many times, children's beliefs and attitudes are already cemented by the time they reach middle school. The idea behind this suggestion is that early positive reinforcement in the younger generations will help to attract underrepresented minorities to higher education, specifically in dentistry. Another reason for early intervention is to give younger children equal educational opportunities that will allow them to be competitive applicants for dental school. One statistic mentioned is that only 40% of minorities in Detroit graduate from high school. Without first increasing the number of underrepresented minorities with the educational background necessary to apply to college, it will be impossible to increase the number of underrepresented minorities actually applying to dental school. The development of educational programs, such as mentoring programs, can be a valuable asset for drawing a more diverse applicant pool.

The working group felt that alumni could be role models at recruitment activities. Alumni could present information at school open houses and participate in career days. Alumni role models can also be considered a form of mentoring, which is mentioned above as a method of early intervention. This working group believes that existing faculty need to be more active in the recruitment of potential dental students and in promoting the dental profession.

Two overall recommendations from this working group are as follows.

Recommendations

1. Collect evidence, including focus group and marketing research, on what would work to entice underrepresented minorities to dental education.
2. Introduce a partnership between dentistry, government, and industry to implement the successful models on a broader scale.

Summary

These recommendations can provide the tools necessary to attract underrepresented minorities to a dental career. In order to accomplish this goal, it is first necessary to learn what will draw them to dentistry so that resources can then be focused on marketing dentistry to minorities, as well as helping to build educational programs that will provide the necessary foundations to become a dentist. By recruiting more underrepresented minority applicants, the dental profession can slowly integrate more minorities into the profession and the workforce. A more diverse workforce would improve dental care for all underserved groups.

Working Group D2: Dental Care for Underserved and Special Needs Populations

Questions

Graduates of advanced dental education programs can play a vital role in increasing access to dental care for underserved and special needs populations. Increased diversity in the practitioner workforce is one way to improve access. There is underrepresentation of minorities in the dental profession and in pre- and postdoctoral dental education programs. The dental profession and academic dentistry must address diversity issues.

Identify the efforts currently being employed to enhance cultural competency. What has successfully worked for advanced dental education programs, and how can these initiatives be applied elsewhere? What actions should be taken to improve cultural competency?

The facilitator was Todd Thierer, D.D.S., M.P.H., Chief Quality Officer for Dentistry, Director of Ambulatory Dental Services, and Director of the General Practice Residency Program at the University of Rochester Medical Center, Medical Director at the Eastman Dental Center, and Chair, ADEA Council of Hospitals and Advanced Education Programs.

Introduction

Dr. Thierer suggested that the 10 participants first try to define the term “cultural competency” and then offer examples from their own institutions of steps currently being used to address this issue.

Dr. Thierer tried to establish a context for the discussion by asking whether current mechanisms for training students in cultural competency are adequate. No one in the group offered a direct answer to this question, but remarks made during the course of the session suggested that they are not. In any event, the discussion proceeded on the assumption that cultural competency training could always be improved. The group agreed that the discussion should focus on post- rather than pre-graduate education and that the cultural competency of both residents and faculty should be considered.

With regard to the definition of cultural competency, one participant offered the following definition, which seemed to capture many of the salient points of the discussion: “Cultural competency is the sensitivity to cultural issues, beliefs, and needs that will allow you to provide effective, efficient healthcare to cultures across the board.” A key point that emerged from the discussion was that it is not only the cultural sensitivities and biases of patients that need to be taken into account, but also those of dental residents and faculty. Another important point is that cultural issues affect not only doctor-patient interactions, but treatment options, as well. An example is a Jehovah’s Witness who might refuse blood transfusions.

The working group felt that it is necessary to establish accreditation standards for cultural competency training. This should be applied across all postgraduate disciplines.

The dental profession must recognize the importance of cultural diversity in its education process. Currently no standards exist for training or evaluating postgraduates in cultural competency. Only two of the institutions represented by the participants in this working group offered formal classes in cultural competency; at other institutions, efforts were limited to sporadic handouts on specific issues (e.g., notices that a religious holiday such as Ramadan was approaching). More substantial efforts to teach cultural competency often seem to be

reactive rather than proactive, occurring at individual institutions in response to a patient complaint or a crisis arising from cultural differences or lack of sensitivity to them.

The group also recognized the need for a handbook, course, or information clearinghouse on cultural issues that might affect doctor-patient interactions. A common reference source could provide guidance to trainees on known cultural sensitivities and biases that might affect their interactions with patients (or with other members of the dental profession), as well as on potentially problematic dynamics between two specific cultures (those of two nations at war, for example). An analogy was made to the *Physicians' Desk Reference*, which is routinely consulted about possible drug reactions and interactions. There was some concern that such a reference manual might promote stereotypes, but the group felt this possibility could be minimized if the reference emphasized the full range of practices and attitudes within a given culture.

Such a reference source would not have to be invented from scratch, as similar material has already been developed by the State Department and probably also by the international business community, the hospitality industry, and U.S. companies (such as Disney) that routinely serve customers of diverse backgrounds. It might be possible to engage the Health Resources Service Administration in this effort.

In addition, the following points also received general acceptance by the group:

- Residents should be made aware of the possible effects of their *own* cultural biases and assumptions on their interactions with patients, faculty, and other residents of different cultures. They should receive training in recognizing their own cultural “baggage” and how to put it aside during professional interactions.
- Communication skills in general should be strongly emphasized in the training process. The question was raised of whether cultural competency really requires anything more than general courtesy and sensitivity: Wouldn't the best approach simply be to talk with every patient before treatment, regardless of the patient's background, and determine his or her individual needs and potential problem areas? Because awareness of specific cultural issues could inform this communication process, the group concluded that trainees should in fact receive specific training in cultural competency. Nonetheless, good communication skills are still essential to optimize interactions with a wide range of patients.

The following recommendations were formally agreed upon by the working group for sending forward to the plenary meeting.

Recommendations

1. Cultural competency should be added to all advanced dental education standards (not as a new standard but under an appropriate existing standard).
2. ADEA should take a leadership position in acting as a clearinghouse of resources regarding cultural competency and consider making available a reference handbook for residents and students.

Summary

The group felt that dental students should receive more training in cultural competency and that the best way to ensure that this training occurs is through formal requirements in the postgraduate period. In addition, the cultural competency of all dental practitioners could be enhanced by the development of a reference source detailing common culture-specific issues that might affect doctor-patient interactions and treatment plans.

Working Group D3: Dental Care for Underserved and Special Needs Populations

Questions

Graduates of advanced dental education programs can play a vital role in increasing access to dental care for underserved and special needs populations. Increased diversity in the practitioner workforce is one way to improve access. There is underrepresentation of minorities in the dental profession and in pre- and postdoctoral dental education programs. The dental profession and academic dentistry must address diversity issues.

Identify credentialing and licensure issues that impact access to care. Are there barriers that need to be addressed? How? What role should ADEA and specialty organizations play in remedying problems?

The facilitator was Stephen Wilson, M.A., D.M.D., Ph.D., Director of the Division of Dentistry at the Cincinnati Children's Hospital Medical Center and Chair-elect of the ADEA Council of Hospitals and Advanced Education Programs.

Introduction

Underserved populations, such as people in rural and low-income areas, rarely receive quality dental care. The working group addressed how licensure is one barrier that affects access to care. Deans of dental colleges, professors, private practitioners, and a Navy dentist were among the 10 people who contributed their perspectives to the conversation. The group discussed issues surrounding licensure, the role of ADEA, and recommendations for the future.

Dr. Wilson began the session by posing this question: Does licensure affect access to care?

Many issues were raised in response to the question. The most common issue was that there is not a nationwide license. This means that a dentist may not practice in a state unless he or she has passed the state board. Passing a state board is more than just a nuisance, particularly for specialists. Specialists often do not practice procedures required to pass the board. For example, a specialist who has not carved amalgam in years (or even decades) will have a difficult time performing this required task.

This presents a number of barriers to quality dental care reaching underserved populations. A dentist practicing in New England is unable to practice in places like New Orleans, where dental care is desperately needed, unless that dentist has passed the Louisiana board. A nationwide license would allow dentists to leave their home states to practice dentistry in underserved communities across the country.

Another issue raised with regard to the state-by-state licensure system was that the current system makes it extremely difficult to recruit faculty members at a national level. Potential faculty members are unlikely to move if they are unable to practice in the state where they have accepted a position. Minnesota has dealt with this situation by granting a Minnesota dental license to any dentist associated with a dental college. With this license, the dentist is able to practice at the college and in private practice for as long as the person remains associated with the college.

A third issue brought up during the session was that retired dentists often lose their licenses because they do not fulfill the continuing education credits to keep a dental license. This

becomes a major barrier to quality care reaching underserved populations, because retired dentists are often willing to donate their time in clinics that treat people who do not typically receive dental services. Again, Minnesota has come up with a way to solve this problem. Retired dentists in Minnesota are permitted to keep their licenses without fulfilling their continuing education requirements as long as they work in underserved areas.

The working group discussed the role of ADEA and made recommendations.

Recommendations

1. ADEA should actively pursue the requirement that all dental students complete an accredited advanced dental education program (AEGD/GPR or specialty program; at minimum PGY-1) prior to licensure.
2. ADEA should work with appropriate organizations to encourage uniformity (and reform) of national licensure that will, at a minimum, favorably encompass components and aspects of access to care.

The working group also suggested that ADEA address licensure issues that apply to allied and “auxiliary” professionals who are associated with the dental community, such as dental hygienists, nurses, and pediatricians.

Summary

The issue of licensure is an important component in the conversation about access to dental care. State-by-state licensure and the strict requirements that each state maintains for practicing dentists present barriers to many people getting the dental care they need. ADEA can play a significant role in improving access to quality dental care. By creating a national license, requiring a postgraduate year of service, and expanding the job responsibilities of select health professionals, ADEA could start to overcome the barriers to access to quality dental care.

Working Group D4: Dental Care for Underserved and Special Needs Populations

Questions

Graduates of advanced dental education programs can play a vital role in increasing access to dental care for underserved and special needs populations. Increased diversity in the practitioner workforce is one way to improve access. There is underrepresentation of minorities in the dental profession and in pre- and postdoctoral dental education programs. The dental profession and academic dentistry must address diversity issues.

Should accreditation standards include standards that address diversity issues? If so, how should these standards be crafted? Should program directors consider additional factors when recruiting residents from underrepresented minority groups? Identify barriers that prevent program directors from considering these additional factors. How can the use of these additional factors help increase the admissions of residents from underrepresented groups?

The facilitator was Allen Wong, D.D.S., AEGD Assistant Program Director at the University of the Pacific Arthur A. Dugoni School of Dentistry.

Introduction

Dr. Wong opened the meeting with a sincere welcome and introductions. Coming from all over the country, the 12 participants had different experiences of serving diverse populations and held different opinions on the current situation of diversity in dentistry. Although a couple of participants didn't think there was a need to address diversity issues in the dental profession and academic dentistry at this time, the majority agreed that diversity issues in dentistry should be addressed and certain actions should be taken to improve the situation and better serve the underserved areas.

All the participants agreed that accreditation standards should include standards that address diversity issues. Since predoctoral dental accreditation standards 2.2* and 2.14* have properly addressed diversity issues, the participants thought that diversity issues in postdoctoral programs could be addressed and crafted in a similar manner.

The group further analyzed the reasons that there are currently not enough residents representing certain minority groups in the dental practitioner workforce. They thought that the obstacles that prevent minorities from entering dental professional programs included lack of role models, lack of knowledge of how to choose dentistry as a profession, the psychological perception of discrimination in the dental profession, and finances.

The participants also pointed out that other factors, such as issues caused by differences in culture and religion, as well as applicants' skills, might also prevent some minority groups from entering the dental workforce. They agreed that diversity issues and the above factors should be considered when recruiting residents, but they also emphasized that they wanted qualified candidates.

To help increase the admissions of residents from underrepresented groups, the meeting attendees made the following two recommendations.

Recommendations

1. Support adoption of predoctoral standards 2.2* and 2.14* for diversity statements for postdoctoral programs.
2. Consider debt forgiveness and prorated compensation for dental professionals serving underserved areas or as educators.

Dr. Wong closed the meeting with three additional thoughts: Use a public relations and marketing program to encourage dentistry as a career. Consider foreign-trained dentists as a potential pool. Consider tele- and video dentistry and technology for community dentistry.

***Predoctoral Dental Accreditation Standards**

2.2. Admission policies and procedures must be designed to include recruitment and admission of a diverse student population.

2.14. Graduates must be competent in managing a diverse patient population and have the interpersonal and communication skills to function successfully in a multicultural work environment.

AFTERWORD

Setting Direction for the Council of Hospitals and Advanced Education Programs

Todd E. Thierer, D.D.S., M.P.H.

Dr. Todd E. Thierer is Chair of the ADEA Council of Hospitals and Advanced Education Programs and Director of Ambulatory Services and the General Practice Residency Program at the University of Rochester.



The Council of Hospitals and Advanced Education Programs is delighted to have had leaders in advanced dental education, including deans, associate deans for advanced education, program directors, and faculty from every specialty and general dentistry, as well as many of the nonrecognized dental specialties, corporate leaders, and leaders representing specialty groups, participate in this historic Summit.

The Council will meet at the ADEA Annual Session March 17-21, 2007, in New Orleans to discuss and review the Summit recommendations and the positive survey responses evaluating the Summit. Council members who were unable to attend the Summit will have an opportunity to review the recommendations and discuss the creation of a strategic plan for the Council. This plan is intended to guide the activities of the Council over the next several years.

Following the Annual Session, the Council Administrative Board will draft a strategic plan. The Council will collect feedback from members using the ADEA Communities of Interest. The Council will review the feedback and complete the strategic plan, which will then be forwarded to the ADEA Board of Directors for its input and approval.

The Council will review the strategic plan annually during subsequent ADEA Annual Session business meetings to ensure that progress is being made and that, as challenges arise, they are adequately being addressed.

This is an exciting time to be involved in advanced dental education. ADEA and the Council, in partnership with our Summit sponsors, armed with the information gleaned from this Summit and its subsequent dissemination, should be well positioned to move advanced dental education forward. This will allow us to positively impact the dental profession and the delivery of oral healthcare.

APPENDIX A

Interpreting the Priority Ratings and Audience Response System Data

To focus the discussion and dialogue during the general sessions, an audience response system (ARS) was utilized to electronically poll the group and prioritize the working group recommendations. Over the three days of the Summit, working groups examined and developed recommendations in four issue areas:

- A. The increasing overlap of educational standards and its impact on the dental education system and scope of practice.
- B. The increasing recognition of nonspecialty interest areas in general dentistry and its impact on the dental education system and scope of practice.
- C. The resources needed to maintain and sustain advanced education programs and how the dental professions, specialty groups, and academic dentistry will respond to this challenge.
- D. The role and responsibility of academic dentistry in improving access to care for the underserved and special needs populations.

During the general sessions, Summit participants were asked to identify their top three priority recommendations, in order of importance, within each of the four issue areas. Eight recommendations were presented within each of the four areas, for a total of 32 recommendations in all. Initially, recommendations were prioritized *within* each domain. At the end of the final general session, participants had the opportunity to prioritize the highest rated recommendations *across* the four domains.

The chart in Appendix B, Prioritization of the Working Group Recommendations, reports the priority rating for the recommendation within each of the four domains. The graphic illustrates the percentage of participants selecting a specific recommendation during each of the three rounds of voting.

There were three rounds of voting within each domain (first, second, and third most important priority). The priority rating is the sum of the three rounds of voting and is computed using the following weighted prioritization formula:

Round 1 (Most Important)	10 points x % of votes received
Round 2 (Second Most Important)	9 points x % of votes received
Round 3 (Third Most Important)	8 points x % of votes received

For example, “Promoting interdisciplinary interaction where appropriate throughout all advanced education programs in didactic and clinical curricula” received a priority rating of 5.6, which was computed as follows:

Round 1 (Most Important):	10 points x 24.8% of votes	=	2.5
Round 2 (Second Most Important):	9 points x 20.2% of votes	=	1.8
<u>Round 3 (Third Most Important):</u>	<u>8 points x 16.5% of votes</u>	<u>=</u>	<u>1.3</u>
	<i>Priority Rating</i>	=	5.6

While the priority rating itself is not statistically significant, the higher the rating, the greater the consensus among the group about the importance of a particular recommendation.

Additional analysis of the audience response system data includes the following:

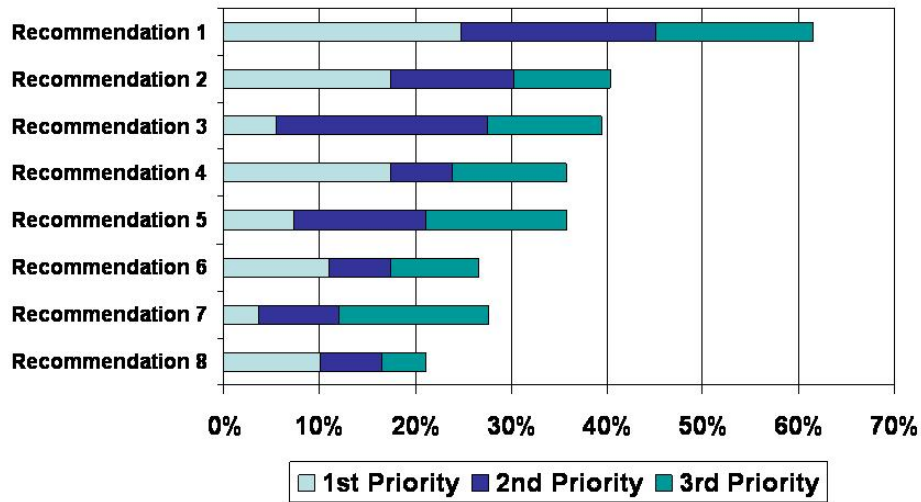
- Priority ratings by specialty area (Appendix C).
- Priority ratings by position within dental education (Appendix D).
- Individual reports for each of the specialty areas; which area intended to serve as a foundation for discussion within the specialty areas about action they could take in support of advanced dental education (Appendix E).
- A full listing of all recommendations from the Summit (Appendix F).
- A demographic profile of participants in the Second ADEA Advanced Dental Education Summit by specialty area, position within dental education, and length of time in dental education (Appendix G).

APPENDIX B
Prioritization of The Working Group Recommendations Overall

“A” Working Groups: Curriculum

There is an increasing overlap of education standards among the dental disciplines. How does this overlap affect our educational system and scope of practice?

Prioritization of Working Group A Recommendations
 (percentage of participants selecting each priority)

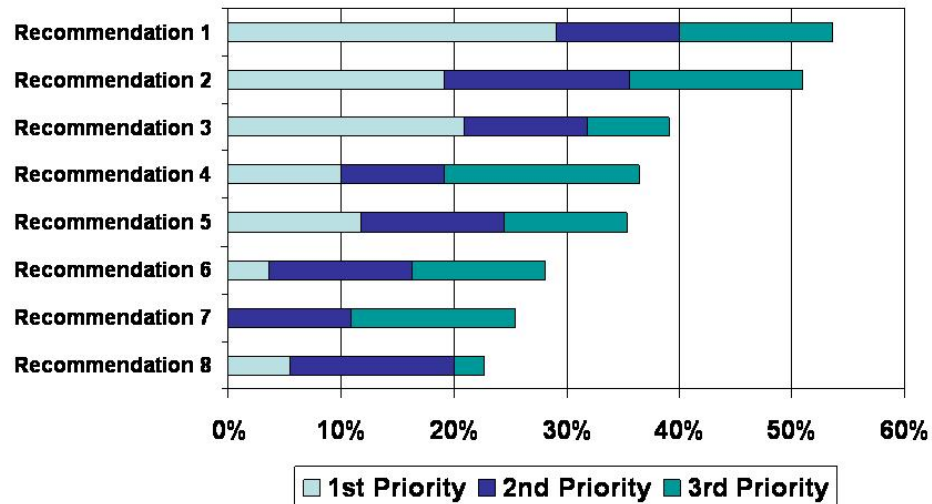


RECOMMENDATION	PRIORITY RATING
1. Promote interdisciplinary interaction where appropriate throughout all advanced education programs in didactic and clinical curricula.	5.61
2. ADEA should lead a collaborative effort to identify and review shared education standards among specialties and determine best educational practices.	3.71
3. ADEA should assemble a representative working group to evaluate standards that involve shared scopes of practice (including impact on projected resources).	3.49
4. It is necessary for advanced dental education programs to have input into the ADEA Commission on Change and Innovation (ADEA CCI) process from its inception.	3.28
5. Increase advocacy by academic dentistry and intensify lobbying efforts by ADEA, stakeholders (e.g., dental specialty groups, nursing home representatives, concerned citizens), and others at local, state, and federal levels and in corporate and private sectors.	3.15
6. Identify and develop financial incentives for educators providing service in community settings.	2.41
7. Develop new strategies for integration of biomedical sciences and professional studies with the applied clinical sciences.	2.36
8. ADEA should actively promote diagnostic codes, which facilitate a common language.	1.95

“B” Working Groups: Curriculum

There is increasing recognition of nonspecialty interest areas in general dentistry. What are the effects on the dental educational system and scope of practice?

Prioritization of Working Group B Recommendations
(percentage of participants selecting each priority)

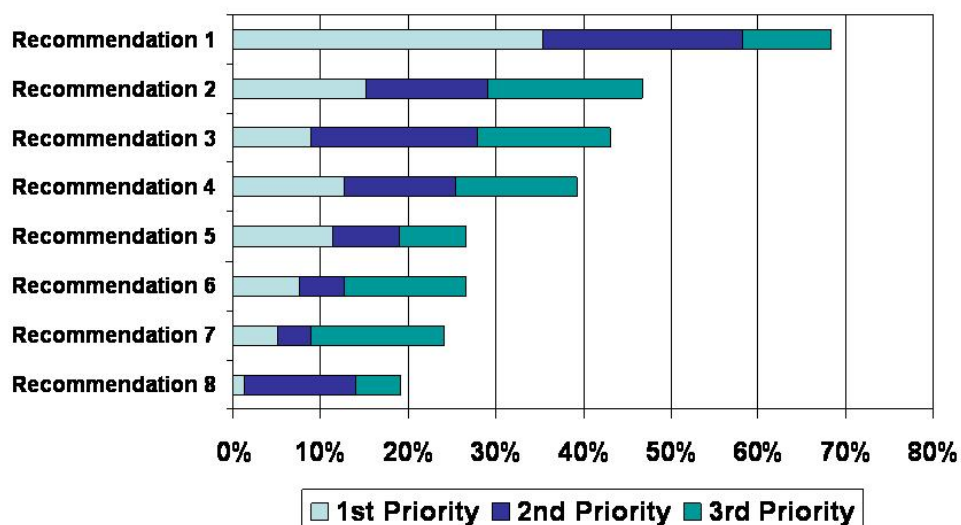


RECOMMENDATION	PRIORITY RATING
1. PGY-1 should be mandatory for all graduates.	4.98
2. CODA should begin a moratorium on accrediting nonrecognized specialty programs until an outcomes assessment is performed and shared with the communities of interest. Outcomes assessment would be broad-based and include the possible effects on the public and other existing CODA-accredited ADE training programs.	4.62
3. Request that CODA not recognize any additional general dentistry “special area” programs at this time because of lack of need and resources and because of public confusion.	3.65
4. Programs need to be held to a similar level of competency as that set by the existing specialties.	3.20
5. Develop, through ADEA leadership, a public and professional education program in order to increase awareness of the advantages of advanced dental education specialty training and the differences there are in the scope of training and education provided.	3.20
6. Postgraduate patient care experience in different demographic segments should include geriatric and special needs patients.	2.45
7. Request that CODA develop an open process and protocol as it evaluates recognition of new nonspecialty areas for accreditation.	2.15
8. With the exception of oral medicine and dental anesthesiology, it is undesirable to accredit more general dentistry special area programs.	2.07

“C” Working Groups: Resources

The dental professions, specialty groups, and academic dentistry need to address a variety of issues related to the resources needed for maintaining and sustaining advanced education programs. Challenges relate to faculty recruitment and retention, recruitment of residents, patient pool, payment, and mission.

**Prioritization of Working Group C Recommendations
(percentage of participants selecting each priority)**

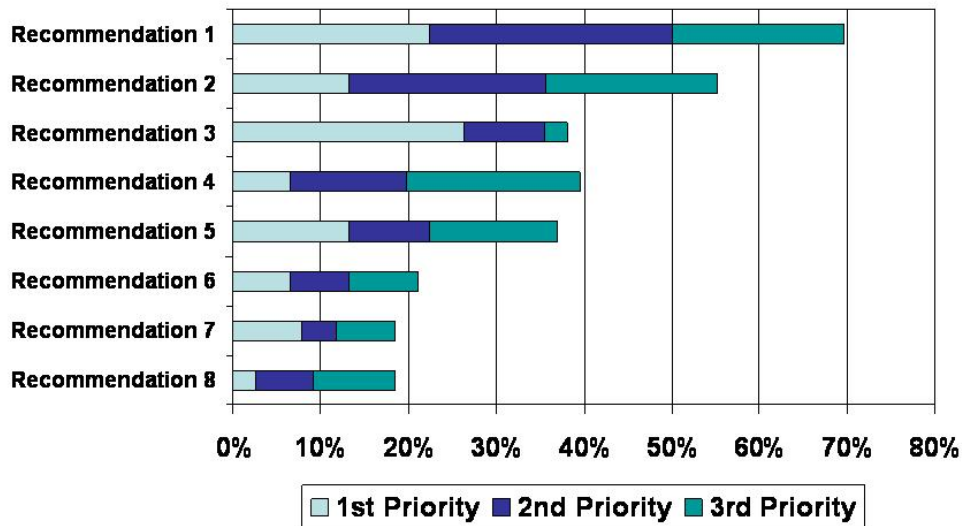


RECOMMENDATION	PRIORITY RATING
1. Address incentives and compensation.	6.41
2. Develop business models with financial autonomy and transparency in budgets.	4.19
3. For faculty recruitment, develop a sense of value of an academic career for students, colleagues, administration, and the general public.	3.81
4. Advocacy is needed to improve compensation and workforce issues.	3.52
5. ADEA, with other professional organizations, should advocate public policy to expand and improve the profession (e.g., fund and expand schools' ability to attract academicians).	2.43
6. Improve institutional environments so that recruitment and retention of board-certified faculty are increased.	2.33
7. Develop career track alternatives for clinical faculty.	2.06
8. For resident recruitment, promote the value of advanced dental education.	1.67

“D” Working Groups: Access and Diversity

Graduates of advanced dental education programs can play a vital role in increasing access to dental care for underserved and special needs populations. Increased diversity in the practitioner workforce is one way to improve access. There is underrepresentation of minorities in the dental profession and in pre- and postdoctoral dental education programs. The dental profession and academic dentistry must address diversity issues.

**Prioritization of Working Group D Recommendations
(percentage of participants selecting each priority)**



RECOMMENDATION	PRIORITY RATING
1. ADEA should work with appropriate organizations to encourage uniformity (and reform) of national licensure that will, at a minimum, favorably encompass components and aspects of access to care.	6.30
2. Consider debt forgiveness and prorated compensation for dental professionals serving underserved areas or as educators.	4.91
3. ADEA should actively pursue the requirement that all dental students complete an accredited advanced dental education program (AEGD/GPR or specialty program) prior to licensure.	3.67
4. Introduce a partnership between dentistry, government, and industry to implement the successful models on a broader scale.	3.42
5. Collect evidence, including focus group and marketing research, on what would work to entice underrepresented minorities to dental education.	3.30
6. Cultural competency should be added to all advanced dental education standards (not as a new standard but under an appropriate existing standard).	1.88
7. Support adoption of predoctoral standards 2.2 and 2.14 for diversity statements for postdoctoral programs.	1.67
8. ADEA should take a leadership position in acting as a clearinghouse of resources regarding cultural competency and consider making available a reference handbook for residents and students.	1.59

APPENDIX C

Prioritization of the Working Group Recommendations by Specialty Area

Recommendations from the “A” Working Groups

Curriculum: There is an increasing overlap of education standards among the dental disciplines. How does this overlap affect our educational system and scope of practice?

Recommendation: Promote interdisciplinary interaction where appropriate throughout all advanced education programs in didactic and clinical curricula.							Overall Rating: 5.61		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
5.50	9.50	5.60	6.00	5.39	7.71	5.60	4.67	5.61	5.75

Recommendation: ADEA leads a collaborative effort to identify and review shared education standards among specialties and determine best educational practices.							Overall Rating: 3.71		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
3.05	4.50	1.80	2.67	5.28	5.29	0.00	3.92	3.56	4.00

Recommendation: ADEA should assemble a representative working group to evaluate standards that involve shared scopes of practice (including impact on projected resources).							Overall Rating: 3.49		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
2.50	0.00	3.40	3.00	2.94	3.71	3.80	4.50	3.50	4.44

Recommendation: It is necessary for advanced dental education programs to have input into the ADEA Commission on Change and Innovation (ADEA CCI) process from its inception.							Overall Rating: 3.28		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
4.35	0.00	3.20	3.00	3.44	2.86	3.60	4.50	2.56	2.81

Recommendation: Increase advocacy by academic dentistry and intensify lobbying efforts by ADEA, stakeholders (e.g., dental specialty groups, nursing home representatives, concerned citizens), and others at local, state, and federal levels and in corporate and private sectors.							Overall Rating: 3.15		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
3.15	5.00	1.80	3.33	2.94	4.86	5.00	3.75	1.39	2.69

Recommendation: Identify and develop financial incentives for educators providing service in community settings.							Overall Rating: 2.41		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
4.50	0.00	1.80	2.67	2.00	0.00	5.80	1.33	0.00	3.56

Recommendation: Develop new strategies for integration of biomedical sciences and professional studies with the applied clinical sciences.							Overall Rating: 2.36		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
2.10	8.00	3.60	3.00	3.50	1.29	3.20	2.17	1.78	1.63

Recommendation: ADEA should actively promote diagnostic codes, which facilitate a common language.							Overall Rating: 1.95		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
1.00	0.00	3.80	3.33	1.00	1.29	0.00	0.00	7.17	0.50

Recommendations from the “B” Working Groups

Curriculum: There is increasing recognition of nonspecialty interest areas in general dentistry. What are the effects on the dental educational system and scope of practice?

Recommendation: PGY-1 should be mandatory for all graduates.							Overall Rating: 4.98		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
8.40	4.50	3.80	8.67	6.11	2.57	5.60	4.75	1.44	3.69

Recommendation: CODA should begin a moratorium on accrediting nonrecognized specialty programs until an outcomes assessment is performed and shared with the communities of interest. Outcomes assessment would be broad-based and include the possible effects on the public and other existing CODA-accredited ADE training programs.							Overall Rating: 4.62		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
3.05	0.00	1.80	9.00	5.67	3.71	3.80	6.25	7.00	3.94

Recommendation: Request that CODA not recognize any additional general dentistry “special area” programs at this time because of lack of need and resources and because of public confusion.							Overall Rating: 3.65		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
0.95	0.00	7.60	3.33	5.83	5.29	2.00	4.33	6.28	1.13

Recommendation: Programs need to be held to a similar level of competency as that set by the existing specialties.							Overall Rating: 3.20		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
3.45	8.00	1.60	0.00	3.50	2.43	3.80	3.75	0.94	4.50

Recommendation: Develop, through ADEA leadership, a public and professional education program to increase awareness of the advantages of advanced dental education specialty training and the differences there are in the scope of training and education provided.							Overall Rating: 3.20		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
2.55	9.50	1.80	0.00	2.11	3.86	7.00	3.58	3.11	4.63

Recommendation: Postgraduate patient care experience in different demographic segments should include geriatric and special needs patients.							Overall Rating: 2.45		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
4.85	5.00	1.80	3.00	0.44	1.43	3.20	1.33	0.44	4.31

Recommendation: Request that CODA develop an open process and protocol as it evaluates recognition of new nonspecialty areas for accreditation.							Overall Rating: 2.15		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
2.90	0.00	3.20	3.00	1.39	2.57	0.00	1.42	2.72	2.19

Recommendation: With the exception of oral medicine and dental anesthesiology, it is undesirable to accredit more general dentistry special area programs.							Overall Rating: 2.07		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
0.85	0.00	3.80	0.00	1.50	4.00	1.60	1.58	4.11	1.63

Recommendations from the “C” Working Groups

Resources: The dental professions, specialty groups, and academic dentistry need to address a variety of issues related to the resources needed for maintaining and sustaining advanced education programs. Challenges relate to faculty recruitment and retention, recruitment of residents, patient pool, payment, and mission.

Recommendation: Address incentives and compensation.							Overall Rating: 6.41		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
6.53	4.00	0.00	4.50	6.80	9.67	7.80	9.50	4.38	5.11
Recommendation: Develop business models with financial autonomy and transparency in budgets.							Overall Rating: 4.19		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
4.29	5.00	9.00	4.50	2.93	6.00	1.80	5.50	5.46	2.89
Recommendation: For faculty recruitment, develop a sense of value of an academic career for students, colleagues, administration, and the general public.							Overall Rating: 3.81		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
3.53	0.00	8.00	5.00	4.40	2.67	3.40	4.63	2.77	5.67
Recommendation: Advocacy is needed to improve compensation and workforce issues.							Overall Rating: 3.52		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
2.18	4.50	0.00	5.00	5.33	3.17	5.00	4.25	2.85	2.11
Recommendation: ADEA, with other professional organizations, should advocate public policy to expand and improve the profession (e.g., fund and expand schools' ability to attract academicians).							Overall Rating: 2.43		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
2.65	4.50	0.00	0.00	1.80	1.50	4.00	0.00	2.62	5.33
Recommendation: Improve institutional environments so that recruitment and retention of board-certified faculty are increased.							Overall Rating: 2.33		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
2.47	5.00	0.00	4.00	4.07	2.67	1.80	0.00	2.23	1.00
Recommendation: Develop career track alternatives for clinical faculty.							Overall Rating: 2.06		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
2.71	0.00	10.00	0.00	1.13	1.33	3.20	2.00	2.54	1.89
Recommendation: For resident recruitment, promote the value of advanced dental education.							Overall Rating: 1.67		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
2.18	4.00	0.00	4.00	0.53	0.00	0.00	0.00	3.38	3.00

Recommendations from the “D” Working Groups

Access and Diversity: Graduates of advanced dental education programs can play a vital role in increasing access to dental care for underserved and special needs populations. Increased diversity in the practitioner workforce is one way to improve access. There is underrepresentation of minorities in the dental profession and in pre- and postdoctoral dental education programs. The dental profession and academic dentistry must address diversity issues.

Recommendation: ADEA should work with appropriate organizations to encourage uniformity (and reform) of national licensure that will, at a minimum, favorably encompass components and aspects of access to care.							Overall Rating: 6.30		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
5.82	8.50	0.00	5.00	6.67	7.50	9.00	8.13	5.91	4.13
Recommendation: Consider debt forgiveness and prorated compensation for dental professionals serving underserved areas or as educators.							Overall Rating: 4.91		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
5.06	4.00	9.00	4.50	6.07	1.67	3.40	4.25	6.45	3.63
Recommendation: ADEA should actively pursue the requirement that all dental students complete an accredited advanced dental education program (AEGD/GPR or specialty program) prior to licensure.							Overall Rating: 3.67		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
8.00	10.00	10.00	0.00	2.53	3.33	2.00	2.25	0.00	3.38
Recommendation: Introduce a partnership between dentistry, government, and industry to implement the successful models on a broader scale.							Overall Rating: 3.42		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
1.47	4.50	0.00	4.00	3.40	2.83	7.20	5.63	3.09	3.13
Recommendation: Collect evidence, including focus group and marketing research, on what would work to entice underrepresented minorities to dental education.							Overall Rating: 3.30		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
1.06	0.00	8.00	8.50	3.53	2.67	3.80	4.75	4.09	3.63
Recommendation: Cultural competency should be added to all advanced dental education standards (not as a new standard but under an appropriate existing standard).							Overall Rating: 1.88		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
2.59	0.00	0.00	0.00	2.40	1.50	0.00	2.00	1.73	2.38
Recommendation: Support adoption of predoctoral standards 2.2 and 2.14 for diversity statements for postdoctoral programs.							Overall Rating: 1.67		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
1.06	0.00	0.00	0.00	1.87	4.33	0.00	0.00	2.45	3.50
Recommendation: ADEA should take a leadership position in acting as a clearinghouse of resources regarding cultural competency and consider making available a reference handbook for residents and students.							Overall Rating: 1.59		
AEGD / GPR	DPH	ENDO	OMP / OMR	OMS	ORTHO	PEDDENT	PERIO	PROS	OTHER
1.94	0.00	0.00	5.00	0.53	0.00	1.60	0.00	3.27	3.25

APPENDIX D

Prioritization of the Working Group Recommendations by Position in Dental Education

Recommendations from the “A” Working Groups

Curriculum: There is an increasing overlap of education standards among the dental disciplines. How does this overlap affect our educational system and scope of practice?

Recommendation: Promote interdisciplinary interaction where appropriate throughout all advanced education programs in didactic and clinical curricula.					Overall Rating: 5.61	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
6.33	7.86	6.34	4.56	6.80	3.33	4.42

Recommendation: ADEA should lead a collaborative effort to identify and review shared education standards among specialties and determine best educational practices.					Overall Rating: 3.71	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
3.33	2.71	3.52	2.81	4.25	0.00	7.00

Recommendation: ADEA should assemble a representative working group to evaluate standards that involve shared scopes of practice (including impact on projected resources).					Overall Rating: 3.49	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
3.33	2.57	3.75	3.33	1.42	5.67	4.58

Recommendation: It is necessary for advanced dental education programs to have input into the ADEA Commission on Change and Innovation (ADEA CCI) process from its inception.					Overall Rating: 3.28	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
0.00	2.43	3.59	3.78	3.00	3.00	2.92

Recommendation: Increase advocacy by academic dentistry and intensify lobbying efforts by ADEA, stakeholders (e.g., dental specialty groups, nursing home representatives, concerned citizens), and others at local, state, and federal levels and in corporate and private sectors.					Overall Rating: 3.15	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
2.67	1.14	3.02	3.59	3.67	3.00	3.67

Recommendation: Identify and develop financial incentives for educators providing service in community settings.					Overall Rating: 2.41	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
0.00	2.86	2.43	3.59	0.83	3.33	1.58

Recommendation: Develop new strategies for integration of biomedical sciences and professional studies with the applied clinical sciences.					Overall Rating: 2.36	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
5.67	5.00	2.09	2.52	2.25	0.00	1.50

Recommendation: ADEA should actively promote diagnostic codes, which facilitate a common language.					Overall Rating: 1.95	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
3.00	1.29	1.86	1.74	3.33	0.00	1.33

Recommendations from the “B” Working Groups

Curriculum: There is increasing recognition of nonspecialty interest areas in general dentistry. What are the effects on the dental educational system and scope of practice?

Recommendation: PGY-1 should be mandatory for all graduates.					Overall Rating: 4.98	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
9.33	5.00	5.16	5.41	5.33	3.33	2.33

Recommendation: CODA should begin a moratorium on accrediting nonrecognized specialty programs until an outcomes assessment is performed and shared with the communities of interest. Outcomes assessment would be broad-based and include the possible effects on the public and other existing CODA-accredited ADE training programs.					Overall Rating: 4.62	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
6.33	3.86	4.43	4.56	5.08	6.00	4.67

Recommendation: Request that CODA not recognize any additional general dentistry “special area” programs at this time because of lack of need and resources and because of public confusion.					Overall Rating: 3.65	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
0.00	4.00	4.14	3.37	4.58	0.00	3.17

Recommendation: Programs need to be held to a similar level of competency as that set by the existing specialties.					Overall Rating: 3.20	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
2.67	2.57	3.07	3.22	3.00	3.00	4.25

Recommendation: Develop, through ADEA leadership, a public and professional education program to increase awareness of the advantages of advanced dental education specialty training and the differences there are in the scope of training and education provided.					Overall Rating: 3.20	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
3.00	2.86	3.11	2.70	3.92	6.67	3.83

Recommendation: Postgraduate patient care experience in different demographic segments should include geriatric and special needs patients.					Overall Rating: 2.45	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
3.00	4.00	2.77	2.22	0.75	2.67	2.08

Recommendation: Request that CODA develop an open process and protocol as it evaluates recognition of new nonspecialty areas for accreditation.					Overall Rating: 2.15	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
0.00	2.43	1.50	2.81	1.33	0.00	5.08

Recommendation: With the exception of oral medicine and dental anesthesiology, it is undesirable to accredit more general dentistry special area programs.					Overall Rating: 2.07	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
0.00	0.00	2.25	2.07	3.00	2.67	1.58

Recommendations from the “C” Working Groups

Resources: The dental professions, specialty groups, and academic dentistry need to address a variety of issues related to the resources needed for maintaining and sustaining advanced education programs. Challenges relate to faculty recruitment and retention, recruitment of residents, patient pool, payment, and mission.

Recommendation: Address incentives and compensation.					Overall Rating: 6.41	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
6.33	6.71	6.79	5.94	8.55	0.00	4.50
Recommendation: Develop business models with financial autonomy and transparency in budgets.					Overall Rating: 4.19	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
3.33	4.86	4.38	5.69	3.91	0.00	2.17
Recommendation: For faculty recruitment, develop a sense of value of an academic career for students, colleagues, administration, and the general public.					Overall Rating: 3.81	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
0.00	1.14	4.21	3.38	3.09	0.00	6.75
Recommendation: Advocacy is needed to improve compensation and workforce issues.					Overall Rating: 3.52	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
3.00	5.00	3.31	4.06	2.45	0.00	3.17
Recommendation: ADEA, with other professional organizations, should advocate public policy to expand and improve the profession (e.g., fund and expand schools' ability to attract academicians).					Overall Rating: 2.43	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
0.00	5.29	2.17	1.19	1.64	0.00	4.58
Recommendation: Improve institutional environments so that recruitment and retention of board-certified faculty are increased.					Overall Rating: 2.33	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
2.60	2.71	2.38	2.00	2.64	0.00	2.25
Recommendation: Develop career track alternatives for clinical faculty.					Overall Rating: 2.06	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
5.33	0.00	1.83	2.63	3.18	0.00	1.42
Recommendation: For resident recruitment, promote the value of advanced dental education.					Overall Rating: 1.67	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
3.00	1.29	1.86	1.56	0.82	0.00	2.17

Recommendations from the “D” Working Groups

Access and Diversity: Graduates of advanced dental education programs can play a vital role in increasing access to dental care for underserved and special needs populations. Increased diversity in the practitioner workforce is one way to improve access. There is underrepresentation of minorities in the dental profession and in pre- and postdoctoral dental education programs. The dental profession and academic dentistry must address diversity issues.

Recommendation: ADEA should work with appropriate organizations to encourage uniformity (and reform) of national licensure that will, at a minimum, favorably encompass components and aspects of access to care.					Overall Rating: 6.30	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
9.00	5.83	6.66	8.33	5.50	0.00	3.67
Recommendation: Consider debt forgiveness and prorated compensation for dental professionals serving underserved areas or as educators.					Overall Rating: 4.91	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
5.33	6.17	4.90	5.27	4.20	0.00	4.00
Recommendation: ADEA should actively pursue the requirement that all dental students complete an accredited advanced dental education program (AEGD/GPR or specialty program) prior to licensure.					Overall Rating: 3.67	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
6.67	3.33	3.97	3.93	3.70	0.00	2.33
Recommendation: Introduce a partnership between dentistry, government, and industry to implement the successful models on a broader scale.					Overall Rating: 3.42	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
2.67	5.83	3.00	3.00	3.40	0.00	3.42
Recommendation: Collect evidence, including focus group and marketing research, on what would work to entice underrepresented minorities to dental education.					Overall Rating: 3.30	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
3.33	1.67	3.00	4.07	3.00	0.00	3.75
Recommendation: Cultural competency should be added to all advanced dental education standards (not as a new standard but under an appropriate existing standard).					Overall Rating: 1.88	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
0.00	1.33	2.45	0.67	2.70	0.00	2.25
Recommendation: Support adoption of predoctoral standards 2.2 and 2.14 for diversity statements for postdoctoral programs.					Overall Rating: 1.67	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
0.00	1.50	0.62	0.60	2.60	0.00	5.42
Recommendation: ADEA should take a leadership position in acting as a clearinghouse of resources regarding cultural competency and consider making available a reference handbook for residents and students.					Overall Rating: 1.59	
Dean	Associate Dean	Program Director	Dept. Chair / Chief / Head	Faculty	Corporate	Other
0.00	1.33	2.07	0.53	1.90	0.00	2.17

APPENDIX E

Individual Specialty Group Reports

Some of the recommendations listed in this report fall neatly within the mission of ADEA. Others are more properly the domain of advanced dental education programs or the specialty professions.

As such, the list of priority recommendations emerging from the Second ADEA Advanced Dental Education Summit will inform the work of the ADEA Council on Hospitals and Advanced Dental Education Programs as it develops its action plan to guide its work for the upcoming years. But to create the changes desired in advanced dental education, responsibility for implementation of the recommendations must extend beyond ADEA and the Council. All stakeholders—individual institutions and programs, specialty associations, faculty members, students, corporate partners, and others—will need to take action.

To support the efforts of the specialty groups to take action in support of advanced dental education and to help these groups understand the priorities of their members, we have provided individual prioritization reports for each of the specialty areas participating in the Summit. These reports can be found on the following pages.

PRIORITIZATION OF RECOMMENDATIONS: AEGD/GPR

“A” WORKING GROUP RECOMMENDATIONS	RATING
Promote interdisciplinary interaction where appropriate throughout all advanced education programs in didactic and clinical curricula.	5.50
Identify and develop financial incentives for educators providing service in community settings.	4.50
It is necessary for advanced dental education programs to have input into the ADEA Commission on Change and Innovation (ADEA CCI) process from its inception.	4.35
Increase advocacy by academic dentistry and intensify lobbying efforts by ADEA, stakeholders (e.g., dental specialty groups, nursing home representatives, concerned citizens), and others at local, state, and federal levels and in corporate and private sectors.	3.15
ADEA should lead a collaborative effort to identify and review shared education standards among specialties and determine best educational practices.	3.05
ADEA should assemble a representative working group to evaluate standards that involve shared scopes of practice (including impact on projected resources).	2.50
Develop new strategies for integration of biomedical sciences and professional studies with the applied clinical sciences.	2.10
ADEA should actively promote diagnostic codes, which facilitate a common language.	1.00
“B” WORKING GROUP RECOMMENDATIONS	RATING
PGY-1 should be mandatory for all graduates.	8.40
Postgraduate patient care experience in different demographic segments should include geriatric and special needs patients.	4.85
Programs need to be held to a similar level of competency as that set by the existing specialties.	3.45
CODA should begin a moratorium on accrediting nonrecognized specialty programs until an outcomes assessment is performed and shared with the communities of interest. Outcomes assessment would be broad-based and include the possible effects on the public and other existing CODA-accredited ADE training programs.	3.05
Request that CODA develop an open process and protocol as it evaluates recognition of new nonspecialty areas for accreditation.	2.90
Develop, through ADEA leadership, a public and professional education program to increase awareness of the advantages of advanced dental education specialty training and the differences there are in the scope of training and education provided.	2.55
Request that CODA not recognize any additional general dentistry “special area” programs at this time because of lack of need and resources and because of public confusion.	0.95
With the exception of oral medicine and dental anesthesiology, it is undesirable to accredit more general dentistry special area programs.	0.85
“C” WORKING GROUP RECOMMENDATIONS	RATING
Address incentives and compensation.	6.53
Develop business models with financial autonomy and transparency in budgets.	4.29
For faculty recruitment, develop a sense of value of an academic career for students, colleagues, administration, and the general public.	3.53
Develop career track alternatives for clinical faculty.	2.71
ADEA, with other professional organizations, should advocate public policy to expand and improve the profession (e.g., fund and expand schools' ability to attract academicians).	2.65
Improve institutional environments so that recruitment and retention of board-certified faculty are increased.	2.47
Advocacy is needed to improve compensation and workforce issues.	2.18
For resident recruitment, promote the value of advanced dental education.	2.18
“D” WORKING GROUP RECOMMENDATIONS	RATING
ADEA should actively pursue the requirement that all dental students complete an accredited advanced dental education program (AEGD/GPR or specialty program) prior to licensure.	8.00
ADEA should work with appropriate organizations to encourage uniformity (and reform) of national licensure that will, at a minimum, favorably encompass components and aspects of access to care.	5.82
Consider debt forgiveness and prorated compensation for dental professionals serving underserved areas or as educators.	5.06
Cultural competency should be added to all advanced dental education standards (not as a new standard but under an appropriate existing standard).	2.59
ADEA should take a leadership position in acting as a clearinghouse of resources regarding cultural competency and consider making available a reference handbook for residents and students.	1.94
Introduce a partnership between dentistry, government, and industry to implement the successful models on a broader scale.	1.47
Collect evidence, including focus group and marketing research, on what would work to entice underrepresented minorities to dental education.	1.06
Support adoption of predoctoral standards 2.2 and 2.14 for diversity statements for postdoctoral programs.	1.06

PRIORITIZATION OF RECOMMENDATIONS: DPH

“A” WORKING GROUP RECOMMENDATIONS	RATING
Promote interdisciplinary interaction where appropriate throughout all advanced education programs in didactic and clinical curricula.	9.50
Develop new strategies for integration of biomedical sciences and professional studies with the applied clinical sciences.	8.00
Increase advocacy by academic dentistry and intensify lobbying efforts by ADEA, stakeholders (e.g., dental specialty groups, nursing home representatives, concerned citizens), and others at local, state, and federal levels and in corporate and private sectors.	5.00
ADEA should lead a collaborative effort to identify and review shared education standards among specialties and determine best educational practices.	4.50
ADEA should assemble a representative working group to evaluate standards that involve shared scopes of practice (including impact on projected resources).	0.00
It is necessary for advanced dental education programs to have input into the ADEA Commission on Change and Innovation (ADEA CCI) process from its inception.	0.00
Identify and develop financial incentives for educators providing service in community settings.	0.00
ADEA should actively promote diagnostic codes, which facilitate a common language.	0.00
“B” WORKING GROUP RECOMMENDATIONS	RATING
Develop, through ADEA leadership, a public and professional education program to increase awareness of the advantages of advanced dental education specialty training and the differences there are in the scope of training and education provided.	9.50
Programs need to be held to a similar level of competency as that set by the existing specialties.	8.00
Postgraduate patient care experience in different demographic segments should include geriatric and special needs patients.	5.00
PGY-1 should be mandatory for all graduates.	4.50
CODA should begin a moratorium on accrediting nonrecognized specialty programs until an outcomes assessment is performed and shared with the communities of interest. Outcomes assessment would be broad-based and include the possible effects on the public and other existing CODA-accredited ADE training programs.	0.00
Request that CODA not recognize any additional general dentistry “special area” programs at this time because of lack of need and resources and because of public confusion.	0.00
Request that CODA develop an open process and protocol as it evaluates recognition of new nonspecialty areas for accreditation.	0.00
With the exception of oral medicine and dental anesthesiology, it is undesirable to accredit more general dentistry special area programs.	0.00
“C” WORKING GROUP RECOMMENDATIONS	RATING
Develop business models with financial autonomy and transparency in budgets.	5.00
Improve institutional environments so that recruitment and retention of board-certified faculty are increased.	5.00
Advocacy is needed to improve compensation and workforce issues.	4.50
ADEA, with other professional organizations, should advocate public policy to expand and improve the profession (e.g., fund and expand schools' ability to attract academicians).	4.50
Address incentives and compensation.	4.00
For resident recruitment, promote the value of advanced dental education.	4.00
For faculty recruitment, develop a sense of value of an academic career for students, colleagues, administration, and the general public.	0.00
Develop career track alternatives for clinical faculty.	0.00
“D” WORKING GROUP RECOMMENDATIONS	RATING
ADEA should actively pursue the requirement that all dental students complete an accredited advanced dental education program (AEGD/GPR or specialty program) prior to licensure.	10.00
ADEA should work with appropriate organizations to encourage uniformity (and reform) of national licensure that will, at a minimum, favorably encompass components and aspects of access to care.	8.50
Introduce a partnership between dentistry, government, and industry to implement the successful models on a broader scale.	4.50
Consider debt forgiveness and prorated compensation for dental professionals serving underserved areas or as educators.	4.00
Collect evidence, including focus group and marketing research, on what would work to entice underrepresented minorities to dental education.	0.00
Cultural competency should be added to all advanced dental education standards (not as a new standard but under an appropriate existing standard).	0.00
Support adoption of predoctoral standards 2.2 and 2.14 for diversity statements for postdoctoral programs.	0.00
ADEA should take a leadership position in acting as a clearinghouse of resources regarding cultural competency and consider making available a reference handbook for residents and students.	0.00

PRIORITIZATION OF RECOMMENDATIONS: ENDO

“A” WORKING GROUP RECOMMENDATIONS	RATING
Promote interdisciplinary interaction where appropriate throughout all advanced education programs in didactic and clinical curricula.	5.60
ADEA should actively promote diagnostic codes, which facilitate a common language.	3.80
Develop new strategies for integration of biomedical sciences and professional studies with the applied clinical sciences.	3.60
ADEA should assemble a representative working group to evaluate standards that involve shared scopes of practice (including impact on projected resources).	3.40
It is necessary for advanced dental education programs to have input into the ADEA Commission on Change and Innovation (ADEA CCI) process from its inception.	3.20
ADEA should lead a collaborative effort to identify and review shared education standards among specialties and determine best educational practices.	1.80
Increase advocacy by academic dentistry and intensify lobbying efforts by ADEA, stakeholders (e.g., dental specialty groups, nursing home representatives, concerned citizens), and others at local, state, and federal levels and in corporate and private sectors.	1.80
Identify and develop financial incentives for educators providing service in community settings.	1.80
“B” WORKING GROUP RECOMMENDATIONS	RATING
Request that CODA not recognize any additional general dentistry “special area” programs because of lack of need and resources and because of public confusion.	7.60
PGY-1 should be mandatory for all graduates.	3.80
With the exception of oral medicine and dental anesthesiology, it is undesirable to accredit more general dentistry special area programs.	3.80
Request that CODA develop an open process and protocol as it evaluates recognition of new nonspecialty areas for accreditation.	3.20
CODA should begin a moratorium on accrediting nonrecognized specialty programs until an outcomes assessment is performed and shared with the communities of interest. Outcomes assessment would be broad-based and include the possible effects on the public and other existing CODA-accredited ADE training programs.	1.80
Develop, through ADEA leadership, a public and professional education program to increase awareness of the advantages of advanced dental education specialty training and the differences there are in the scope of training and education provided.	1.80
Postgraduate patient care experience in different demographic segments should include geriatric and special needs patients.	1.80
Programs need to be held to a similar level of competency as that set by the existing specialties.	1.60
“C” WORKING GROUP RECOMMENDATIONS	RATING
Develop career track alternatives for clinical faculty.	10.00
Develop business models with financial autonomy and transparency in budgets.	9.00
For faculty recruitment, develop a sense of value of an academic career for students, colleagues, administration, and the general public.	8.00
Address incentives and compensation.	0.00
Advocacy is needed to improve compensation and workforce issues.	0.00
ADEA, with other professional organizations, should advocate public policy to expand and improve the profession (e.g., fund and expand schools’ ability to attract academicians).	0.00
Improve institutional environments so that recruitment and retention of board-certified faculty are increased.	0.00
For resident recruitment, promote the value of advanced dental education.	0.00
“D” WORKING GROUP RECOMMENDATIONS	RATING
ADEA should actively pursue the requirement that all dental students complete an accredited advanced dental education program (AEGD/GPR or specialty program) prior to licensure.	10.00
Consider debt forgiveness and prorated compensation for dental professionals serving underserved areas or as educators.	9.00
Collect evidence, including focus group and marketing research, on what would work to entice underrepresented minorities to dental education.	8.00
ADEA should work with appropriate organizations to encourage uniformity (and reform) of national licensure that will, at a minimum, favorably encompass components and aspects of access to care.	0.00
Introduce a partnership between dentistry, government, and industry to implement the successful models on a broader scale.	0.00
Cultural competency should be added to all advanced dental education standards (not as a new standard but under an appropriate existing standard).	0.00
Support adoption of predoctoral standards 2.2 and 2.14 for diversity statements for postdoctoral programs.	0.00
ADEA should take a leadership position in acting as a clearinghouse of resources regarding cultural competency and consider making available a reference handbook for residents and students.	0.00

PRIORITIZATION OF RECOMMENDATIONS: OMP/OMR

“A” WORKING GROUP RECOMMENDATIONS	RATING
Promote interdisciplinary interaction where appropriate throughout all advanced education programs in didactic and clinical curricula.	6.00
Increase advocacy by academic dentistry and intensify lobbying efforts by ADEA, stakeholders (e.g., dental specialty groups, nursing home representatives, concerned citizens), and others at local, state, and federal levels and in corporate and private sectors.	3.33
ADEA should actively promote diagnostic codes, which facilitate a common language.	3.33
ADEA should assemble a representative working group to evaluate standards that involve shared scopes of practice (including impact on projected resources).	3.00
It is necessary for advanced dental education programs to have input into the ADEA Commission on Change and Innovation (ADEA CCI) process from its inception.	3.00
Develop new strategies for integration of biomedical sciences and professional studies with the applied clinical sciences.	3.00
ADEA should lead a collaborative effort to identify and review shared education standards among specialties and determine best educational practices.	2.67
Identify and develop financial incentives for educators providing service in community settings.	2.67
“B” WORKING GROUP RECOMMENDATIONS	RATING
CODA should begin a moratorium on accrediting nonrecognized specialty programs until an outcomes assessment is performed and shared with the communities of interest. Outcomes assessment would be broad-based and include the possible effects on the public and other existing CODA-accredited ADE training programs.	9.00
PGY-1 should be mandatory for all graduates.	8.67
Request that CODA not recognize any additional general dentistry “special area” programs at this time because of lack of need and resources and because of public confusion.	3.33
Postgraduate patient care experience in different demographic segments should include geriatric and special needs patients.	3.00
Request that CODA develop an open process and protocol as it evaluates recognition of new nonspecialty areas for accreditation.	3.00
Programs need to be held to a similar level of competency as that set by the existing specialties.	0.00
Develop, through ADEA leadership, a public and professional education program in order to increase awareness of the advantages of advanced dental education specialty training and the differences there are in the scope of training and education provided.	0.00
With the exception of oral medicine and dental anesthesiology, it is undesirable to accredit more general dentistry special area programs.	0.00
“C” WORKING GROUP RECOMMENDATIONS	RATING
For faculty recruitment, develop a sense of value of an academic career for students, colleagues, administration, and the general public.	5.00
Advocacy is needed to improve compensation and workforce issues.	5.00
Address incentives and compensation.	4.50
Develop business models with financial autonomy and transparency in budgets.	4.50
Improve institutional environments so that recruitment and retention of board-certified faculty are increased.	4.00
For resident recruitment, promote the value of advanced dental education.	4.00
ADEA, with other professional organizations, should advocate public policy to expand and improve the profession (e.g., fund and expand schools' ability to attract academicians).	0.00
Develop career track alternatives for clinical faculty.	0.00
“D” WORKING GROUP RECOMMENDATIONS	RATING
Collect evidence, including focus group and marketing research, on what would work to entice underrepresented minorities to dental education.	8.50
ADEA should work with appropriate organizations to encourage uniformity (and reform) of national licensure that will, at a minimum, favorably encompass components and aspects of access to care.	5.00
ADEA should take a leadership position in acting as a clearinghouse of resources regarding cultural competency and consider making available a reference handbook for residents and students.	5.00
Consider debt forgiveness and prorated compensation for dental professionals serving underserved areas or as educators.	4.50
Introduce a partnership between dentistry, government, and industry to implement the successful models on a broader scale.	4.00
ADEA should actively pursue the requirement that all dental students complete an accredited advanced dental education program (AEGD/GPR or specialty program) prior to licensure.	0.00
Cultural competency should be added to all advanced dental education standards (not as a new standard but under an appropriate existing standard).	0.00
Support adoption of predoctoral standards 2.2 and 2.14 for diversity statements for postdoctoral programs.	0.00

PRIORITIZATION OF RECOMMENDATIONS: OMS

“A” WORKING GROUP RECOMMENDATIONS	RATING
Promote interdisciplinary interaction where appropriate throughout all advanced education programs in didactic and clinical curricula.	5.39
ADEA should lead a collaborative effort to identify and review shared education standards among specialties and determine best educational practices.	5.28
Develop new strategies for integration of biomedical sciences and professional studies with the applied clinical sciences.	3.50
It is necessary for advanced dental education programs to have input into the ADEA Commission on Change and Innovation (ADEA CCI) process from its inception.	3.44
ADEA should assemble a representative working group to evaluate standards that involve shared scopes of practice (including impact on projected resources).	2.94
Increase advocacy by academic dentistry and intensify lobbying efforts by ADEA, stakeholders (e.g., dental specialty groups, nursing home representatives, concerned citizens), and others at local, state, and federal levels and in corporate and private sectors.	2.94
Identify and develop financial incentives for educators providing service in community settings.	2.00
ADEA should actively promote diagnostic codes, which facilitate a common language.	1.00
“B” WORKING GROUP RECOMMENDATIONS	RATING
PGY-1 should be mandatory for all graduates.	6.11
Request that CODA not recognize any additional general dentistry “special area” programs at this time because of lack of need and resources and because of public confusion.	5.83
CODA should begin a moratorium on accrediting nonrecognized specialty programs until an outcomes assessment is performed and shared with the communities of interest. Outcomes assessment would be broad-based and include the possible effects on the public and other existing CODA-accredited ADE training programs.	5.67
Programs need to be held to a similar level of competency as that set by the existing specialties.	3.50
Develop, through ADEA leadership, a public and professional education program to increase awareness of the advantages of advanced dental education specialty training and the differences there are in the scope of training and education provided.	2.11
With the exception of oral medicine and dental anesthesiology, it is undesirable to accredit more general dentistry special area programs.	1.50
Request that CODA develop an open process and protocol as it evaluates recognition of new nonspecialty areas for accreditation.	1.39
Postgraduate patient care experience in different demographic segments should include geriatric and special needs patients.	0.44
“C” WORKING GROUP RECOMMENDATIONS	RATING
Address incentives and compensation.	6.80
Advocacy is needed to improve compensation and workforce issues.	5.33
For faculty recruitment, develop a sense of value of an academic career for students, colleagues, administration, and the general public.	4.40
Improve institutional environments so that recruitment and retention of board-certified faculty are increased.	4.07
Develop business models with financial autonomy and transparency in budgets.	2.93
ADEA, with other professional organizations, should advocate public policy to expand and improve the profession (e.g., fund and expand schools’ ability to attract academicians).	1.80
Develop career track alternatives for clinical faculty.	1.13
For resident recruitment, promote the value of advanced dental education.	0.53
“D” WORKING GROUP RECOMMENDATIONS	RATING
ADEA should work with appropriate organizations to encourage uniformity (and reform) of national licensure that will, at a minimum, favorably encompass components and aspects of access to care.	6.67
Consider debt forgiveness and prorated compensation for dental professionals serving underserved areas or as educators.	6.07
Collect evidence, including focus group and marketing research, on what would work to entice underrepresented minorities to dental education.	3.53
Introduce a partnership between dentistry, government, and industry to implement the successful models on a broader scale.	3.40
ADEA should actively pursue the requirement that all dental students complete an accredited advanced dental education program (AEGD/GPR or specialty program) prior to licensure.	2.53
Cultural competency should be added to all advanced dental education standards (not as a new standard but under an appropriate existing standard).	2.40
Support adoption of predoctoral standards 2.2 and 2.14 for diversity statements for postdoctoral programs.	1.87
ADEA should take a leadership position in acting as a clearinghouse of resources regarding cultural competency and consider making available a reference handbook for residents and students.	0.53

PRIORITIZATION OF RECOMMENDATIONS: ORTHO

“A” WORKING GROUP RECOMMENDATIONS	RATING
Promote interdisciplinary interaction where appropriate throughout all advanced education programs in didactic and clinical curricula.	7.71
ADEA should lead a collaborative effort to identify and review shared education standards among specialties and determine best educational practices.	5.29
Increase advocacy by academic dentistry and intensify lobbying efforts by ADEA, stakeholders (e.g., dental specialty groups, nursing home representatives, concerned citizens), and others at local, state, and federal levels and in corporate and private sectors.	4.86
ADEA should assemble a representative working group to evaluate standards that involve shared scopes of practice (including impact on projected resources).	3.71
It is necessary for advanced dental education programs to have input into the ADEA Commission on Change and Innovation (ADEA CCI) process from its inception.	2.86
Develop new strategies for integration of biomedical sciences and professional studies with the applied clinical sciences.	1.29
ADEA should actively promote diagnostic codes, which facilitate a common language.	1.29
Identify and develop financial incentives for educators providing service in community settings.	0.00
“B” WORKING GROUP RECOMMENDATIONS	RATING
Request that CODA not recognize any additional general dentistry “special area” programs at this time because of lack of need and resources and because of public confusion.	5.29
With the exception of oral medicine and dental anesthesiology, it is undesirable to accredit more general dentistry special area programs.	4.00
Develop, through ADEA leadership, a public and professional education program to increase awareness of the advantages of advanced dental education specialty training and the differences there are in the scope of training and education provided.	3.86
CODA should begin a moratorium on accrediting nonrecognized specialty programs until an outcomes assessment is performed and shared with the communities of interest. Outcomes assessment would be broad-based and include the possible effects on the public and other existing CODA-accredited ADE training programs.	3.71
PGY-1 should be mandatory for all graduates.	2.57
Request that CODA develop an open process and protocol as it evaluates recognition of new nonspecialty areas for accreditation.	2.57
Programs need to be held to a similar level of competency as that set by the existing specialties.	2.43
Postgraduate patient care experience in different demographic segments should include geriatric and special needs patients.	1.43
“C” WORKING GROUP RECOMMENDATIONS	RATING
Address incentives and compensation.	9.67
Develop business models with financial autonomy and transparency in budgets.	6.00
Advocacy is needed to improve compensation and workforce issues.	3.17
For faculty recruitment, develop a sense of value of an academic career for students, colleagues, administration, and the general public.	2.67
Improve institutional environments so that recruitment and retention of board-certified faculty are increased.	2.67
ADEA, with other professional organizations, should advocate public policy to expand/improve the profession (e.g., fund and expand schools' ability to attract academicians).	1.50
Develop career track alternatives for clinical faculty.	1.33
For resident recruitment, promote the value of advanced dental education.	0.00
“D” WORKING GROUP RECOMMENDATIONS	RATING
ADEA should work with appropriate organizations to encourage uniformity (and reform) of national licensure that will, at a minimum, favorably encompass components and aspects of access to care.	7.50
Support adoption of predoctoral standards 2.2 and 2.14 for diversity statements for postdoctoral programs.	4.33
ADEA should actively pursue the requirement that all dental students complete an accredited advanced dental education program (AEGD/GPR or specialty program) prior to licensure.	3.33
Introduce a partnership between dentistry, government, and industry to implement the successful models on a broader scale.	2.83
Collect evidence, including focus group and marketing research, on what would work to entice underrepresented minorities to dental education.	2.67
Consider debt forgiveness and prorated compensation for dental professionals serving underserved areas or as educators.	1.67
Cultural competency should be added to all advanced dental education standards (not as a new standard but under an appropriate existing standard).	1.50
ADEA should take a leadership position in acting as a clearinghouse of resources regarding cultural competency and consider making available a reference handbook for residents and students.	0.00

PRIORITIZATION OF RECOMMENDATIONS: PEDDENT

“A” WORKING GROUP RECOMMENDATIONS	RATING
Identify and develop financial incentives for educators providing service in community settings.	5.80
Promote interdisciplinary interaction where appropriate throughout all advanced education programs in didactic and clinical curricula.	5.60
Increase advocacy by academic dentistry and intensify lobbying efforts by ADEA, stakeholders (e.g., dental specialty groups, nursing home representatives, concerned citizens), and others at local, state, and federal levels and in corporate and private sectors.	5.00
ADEA should assemble a representative working group to evaluate standards that involve shared scopes of practice (including impact on projected resources).	3.80
It is necessary for advanced dental education programs to have input into the ADEA Commission on Change and Innovation (ADEA CCI) process from its inception.	3.60
Develop new strategies for integration of biomedical sciences and professional studies with the applied clinical sciences.	3.20
ADEA should lead a collaborative effort to identify and review shared education standards among specialties and determine best educational practices.	0.00
ADEA should actively promote diagnostic codes, which facilitate a common language.	0.00
“B” WORKING GROUP RECOMMENDATIONS	RATING
Develop, through ADEA leadership, a public and professional education program to increase awareness of the advantages of advanced dental education specialty training and the differences there are in the scope of training and education provided.	7.00
PGY-1 should be mandatory for all graduates.	5.60
CODA should begin a moratorium on accrediting nonrecognized specialty programs until an outcomes assessment is performed and shared with the communities of interest. Outcomes assessment would be broad-based and include the possible effects on the public and other existing CODA-accredited ADE training programs.	3.80
Programs need to be held to a similar level of competency as that set by the existing specialties.	3.80
Postgraduate patient care experience in different demographic segments should include geriatric and special needs patients.	3.20
Request that CODA not recognize any additional general dentistry “special area” programs at this time because of lack of need and resources and because of public confusion.	2.00
With the exception of oral medicine and dental anesthesiology, it is undesirable to accredit more general dentistry special area programs.	1.60
Request that CODA develop an open process and protocol as it evaluates recognition of new nonspecialty areas for accreditation.	0.00
“C” WORKING GROUP RECOMMENDATIONS	RATING
Address incentives and compensation.	7.80
Advocacy is needed to improve compensation and workforce issues.	5.00
ADEA, with other professional organizations, should advocate public policy to expand and improve the profession (e.g., fund and expand schools' ability to attract academicians).	4.00
For faculty recruitment, develop a sense of value of an academic career for students, colleagues, administration, and the general public.	3.40
Develop career track alternatives for clinical faculty.	3.20
Develop business models with financial autonomy and transparency in budgets.	1.80
Improve institutional environments so that recruitment and retention of board-certified faculty are increased.	1.80
For resident recruitment, promote the value of advanced dental education.	0.00
“D” WORKING GROUP RECOMMENDATIONS	RATING
ADEA should work with appropriate organizations to encourage uniformity (and reform) of national licensure that will, at a minimum, favorably encompass components and aspects of access to care.	9.00
Introduce a partnership between dentistry, government, and industry to implement the successful models on a broader scale.	7.20
Collect evidence, including focus group and marketing research, on what would work to entice underrepresented minorities to dental education.	3.80
Consider debt forgiveness and prorated compensation for dental professionals serving underserved areas or as educators.	3.40
ADEA should actively pursue the requirement that all dental students complete an accredited advanced dental education program (AEGD/GPR or specialty program) prior to licensure.	2.00
ADEA should take a leadership position in acting as a clearinghouse of resources regarding cultural competency and consider making available a reference handbook for residents and students.	1.60
Cultural competency should be added to all advanced dental education standards (not as a new standard but under an appropriate existing standard).	0.00
Support adoption of predoctoral standards 2.2 and 2.14 for diversity statements for postdoctoral programs.	0.00

PRIORITIZATION OF RECOMMENDATIONS: PERIO

“A” WORKING GROUP RECOMMENDATIONS	RATING
Promote interdisciplinary interaction where appropriate throughout all advanced education programs in didactic and clinical curricula.	4.67
ADEA should assemble a representative working group to evaluate standards that involve shared scopes of practice (including impact on projected resources).	4.50
It is necessary for advanced dental education programs to have input into the ADEA Commission on Change and Innovation (ADEA CCI) process from its inception.	4.50
ADEA should lead a collaborative effort to identify and review shared education standards among specialties and determine best educational practices.	3.92
Increase advocacy by academic dentistry and intensify lobbying efforts by ADEA, stakeholders (e.g., dental specialty groups, nursing home representatives, concerned citizens), and others at local, state, and federal levels and in corporate and private sectors.	3.75
Develop new strategies for integration of biomedical sciences and professional studies with the applied clinical sciences.	2.17
Identify and develop financial incentives for educators providing service in community settings.	1.33
ADEA should actively promote diagnostic codes, which facilitate a common language.	0.00
“B” WORKING GROUP RECOMMENDATIONS	RATING
CODA should begin a moratorium on accrediting nonrecognized specialty programs until an outcomes assessment is performed and shared with the communities of interest. Outcomes assessment would be broad-based and include the possible effects on the public and other existing CODA-accredited ADE training programs.	6.25
PGY-1 should be mandatory for all graduates.	4.75
Request that CODA not recognize any additional general dentistry “special area” programs at this time because of lack of need and resources and because of public confusion.	4.33
Programs need to be held to a similar level of competency as that set by the existing specialties.	3.75
Develop, through ADEA leadership, a public and professional education program in order to increase awareness of the advantages of advanced dental education specialty training and the differences there are in the scope of training and education provided.	3.58
With the exception of oral medicine and dental anesthesiology, it is undesirable to accredit more general dentistry special area programs.	1.58
Request that CODA develop an open process and protocol as it evaluates recognition of new nonspecialty areas for accreditation.	1.42
Postgraduate patient care experience in different demographic segments should include geriatric and special needs patients.	1.33
“C” WORKING GROUP RECOMMENDATIONS	RATING
Address incentives and compensation.	9.50
Develop business models with financial autonomy and transparency in budgets.	5.50
For faculty recruitment, develop a sense of value of an academic career for students, colleagues, administration, and the general public.	4.63
Advocacy is needed to improve compensation and workforce issues.	4.25
Develop career track alternatives for clinical faculty.	2.00
ADEA, with other professional organizations, should advocate public policy to expand and improve the profession (e.g., fund and expand schools’ ability to attract academicians).	0.00
Improve institutional environments so that recruitment and retention of board-certified faculty are increased.	0.00
For resident recruitment, promote the value of advanced dental education.	0.00
“D” WORKING GROUP RECOMMENDATIONS	RATING
ADEA should work with appropriate organizations to encourage uniformity (and reform) of national licensure that will, at a minimum, favorably encompass components and aspects of access to care.	8.13
Introduce a partnership between dentistry, government, and industry to implement the successful models on a broader scale.	5.63
Collect evidence, including focus group and marketing research, on what would work to entice underrepresented minorities to dental education.	4.75
Consider debt forgiveness and prorated compensation for dental professionals serving underserved areas or as educators.	4.25
ADEA should actively pursue the requirement that all dental students complete an accredited advanced dental education program (AEGD/GPR or specialty program) prior to licensure.	2.25
Cultural competency should be added to all advanced dental education standards (not as a new standard but under an appropriate existing standard).	2.00
Support adoption of predoctoral standards 2.2 and 2.14 for diversity statements for postdoctoral programs.	0.00
ADEA should take a leadership position in acting as a clearinghouse of resources regarding cultural competency and consider making available a reference handbook for residents and students.	0.00

PRIORITIZATION OF RECOMMENDATIONS: PROS

“A” WORKING GROUP RECOMMENDATIONS	RATING
ADEA should actively promote diagnostic codes, which facilitate a common language.	7.17
Promote interdisciplinary interaction where appropriate throughout all advanced education programs in didactic and clinical curricula.	5.61
ADEA should lead a collaborative effort to identify and review shared education standards among specialties and determine best educational practices.	3.56
ADEA should assemble a representative working group to evaluate standards that involve shared scopes of practice (including impact on projected resources).	3.50
It is necessary for advanced dental education programs to have input into the ADEA Commission on Change and Innovation (ADEA CCI) process from its inception.	2.56
Develop new strategies for integration of biomedical sciences and professional studies with the applied clinical sciences.	1.78
Increase advocacy by academic dentistry and intensify lobbying efforts by ADEA, stakeholders (e.g., dental specialty groups, nursing home representatives, concerned citizens), and others at local, state, and federal levels and in corporate and private sectors.	1.39
Identify and develop financial incentives for educators providing service in community settings.	0.00
“B” WORKING GROUP RECOMMENDATIONS	RATING
CODA should begin a moratorium on accrediting nonrecognized specialty programs until an outcomes assessment is performed and shared with the communities of interest. Outcomes assessment would be broad-based and include the possible effects on the public and other existing CODA-accredited ADE training programs.	7.00
Request that CODA not recognize any additional general dentistry “special area” programs at this time because of lack of need and resources and because of public confusion.	6.28
With the exception of oral medicine and dental anesthesiology, it is undesirable to accredit more general dentistry special area programs.	4.11
Develop, through ADEA leadership, a public and professional education program in order to increase awareness of the advantages of advanced dental education specialty training and the differences there are in the scope of training and education provided.	3.11
Request that CODA develop an open process and protocol as it evaluates recognition of new nonspecialty areas for accreditation.	2.72
PGY-1 should be mandatory for all graduates.	1.44
Programs need to be held to a similar level of competency as that set by the existing specialties.	0.94
Postgraduate patient care experience in different demographic segments should include geriatric and special needs patients.	0.44
“C” WORKING GROUP RECOMMENDATIONS	RATING
Develop business models with financial autonomy and transparency in budgets.	5.46
Address incentives and compensation.	4.38
For resident recruitment, promote the value of advanced dental education.	3.38
Advocacy is needed to improve compensation and workforce issues.	2.85
For faculty recruitment, develop a sense of value of an academic career for students, colleagues, administration, and the general public.	2.77
ADEA, with other professional organizations, should advocate public policy to expand and improve the profession (e.g., fund and expand schools’ ability to attract academicians).	2.62
Develop career track alternatives for clinical faculty.	2.54
Improve institutional environments so that recruitment and retention of board-certified faculty are increased.	2.23
“D” WORKING GROUP RECOMMENDATIONS	RATING
Consider debt forgiveness and prorated compensation for dental professionals serving underserved areas or as educators.	6.45
ADEA should work with appropriate organizations to encourage uniformity (and reform) of national licensure that will, at a minimum, favorably encompass components and aspects of access to care.	5.91
Collect evidence, including focus group and marketing research, on what would work to entice underrepresented minorities to dental education.	4.09
ADEA should take a leadership position in acting as a clearinghouse of resources regarding cultural competency and consider making available a reference handbook for residents and students.	3.27
Introduce a partnership between dentistry, government, and industry to implement the successful models on a broader scale.	3.09
Support adoption of predoctoral standards 2.2 and 2.14 for diversity statements for postdoctoral programs.	2.45
Cultural competency should be added to all advanced dental education standards (not as a new standard but under an appropriate existing standard).	1.73
ADEA should actively pursue the requirement that all dental students complete an accredited advanced dental education program (AEGD/GPR or specialty program) prior to licensure.	0.00

PRIORITIZATION OF RECOMMENDATIONS: OTHER SPECIALTY AREAS

“A” WORKING GROUP RECOMMENDATIONS	RATING
Promote interdisciplinary interaction where appropriate throughout all advanced education programs in didactic and clinical curricula.	5.75
ADEA should assemble a representative working group to evaluate standards that involve shared scopes of practice (including impact on projected resources).	4.44
ADEA should lead a collaborative effort to identify and review shared education standards among specialties and determine best educational practices.	4.00
Identify and develop financial incentives for educators providing service in community settings.	3.56
It is necessary for advanced dental education programs to have input into the ADEA Commission on Change and Innovation (ADEA CCI) process from its inception.	2.81
Increase advocacy by academic dentistry and intensify lobbying efforts by ADEA, stakeholders (e.g., dental specialty groups, nursing home representatives, concerned citizens), and others at local, state, and federal levels and in corporate and private sectors.	2.69
Develop new strategies for integration of biomedical sciences and professional studies with the applied clinical sciences.	1.63
ADEA should actively promote diagnostic codes, which facilitate a common language.	0.50
“B” WORKING GROUP RECOMMENDATIONS	RATING
Develop, through ADEA leadership, a public and professional education program to increase awareness of the advantages of advanced dental education specialty training and the differences there are in the scope of training and education provided.	4.63
Programs need to be held to a similar level of competency as that set by the existing specialties.	4.50
Postgraduate patient care experience in different demographic segments should include geriatric and special needs patients.	4.31
CODA should begin a moratorium on accrediting nonrecognized specialty programs until an outcomes assessment is performed and shared with the communities of interest. Outcomes assessment would be broad-based and include the possible effects on the public and other existing CODA-accredited ADE training programs.	3.94
PGY-1 should be mandatory for all graduates.	3.69
Request that CODA develop an open process and protocol as it evaluates recognition of new nonspecialty areas for accreditation.	2.19
With the exception of oral medicine and dental anesthesiology, it is undesirable to accredit more general dentistry special area programs.	1.63
Request that CODA not recognize any additional general dentistry “special area” programs at this time because of lack of need and resources and because of public confusion.	1.13
“C” WORKING GROUP RECOMMENDATIONS	RATING
For faculty recruitment, develop a sense of value of an academic career for students, colleagues, administration, and the general public.	5.67
ADEA, with other professional organizations, should advocate public policy to expand and improve the profession (e.g., fund and expand schools' ability to attract academicians).	5.33
Address incentives and compensation.	5.11
For resident recruitment, promote the value of advanced dental education.	3.00
Develop business models with financial autonomy and transparency in budgets.	2.89
Advocacy is needed to improve compensation and workforce issues.	2.11
Develop career track alternatives for clinical faculty.	1.89
Improve institutional environments so that recruitment and retention of board-certified faculty are increased.	1.00
“D” WORKING GROUP RECOMMENDATIONS	RATING
ADEA should work with appropriate organizations to encourage uniformity (and reform) of national licensure that will, at a minimum, favorably encompass components and aspects of access to care.	4.13
Consider debt forgiveness and prorated compensation for dental professionals serving underserved areas or as educators.	3.63
Collect evidence, including focus group and marketing research, on what would work to entice underrepresented minorities to dental education.	3.63
Support adoption of predoctoral standards 2.2 and 2.14 for diversity statements for postdoctoral programs.	3.50
ADEA should actively pursue the requirement that all dental students complete an accredited advanced dental education program (AEGD/GPR or specialty program) prior to licensure.	3.38
ADEA should take a leadership position in acting as a clearinghouse of resources regarding cultural competency and consider making available a reference handbook for residents and students.	3.25
Introduce a partnership between dentistry, government, and industry to implement the successful models on a broader scale.	3.13
Cultural competency should be added to all advanced dental education standards (not as a new standard but under an appropriate existing standard).	2.38

APPENDIX F

List of All Recommendations from the Second ADEA Advanced Dental Education Summit

Recommendations to address the overlap of educational standards among the dental disciplines and its effect on the education system and scope of practice.

- ADEA should lead a collaborative effort to identify and review shared education standards among specialties and determine best educational practices. By encouraging core courses and collaborative teaching, faculty workloads could be optimized, students could be better served, and the patients could benefit.
- ADEA should assemble a representative working group to evaluate standards that involve shared scopes of practice (including impact on projected resources). This recommendation is designed particularly to address the problem of unfunded mandates. The participants are concerned that new standards can stress programs' resources and faculty and need to be adequately considered.
- Promote interdisciplinary interaction where appropriate throughout all advanced education programs in didactic and clinical curricula. Interdisciplinary collaboration will improve communication, enhance educational quality, and reduce faculty workload.
- ADEA should actively promote diagnostic codes, which facilitate a common language. This will improve the ability to evaluate treatment outcomes, translating into better care for patients.
- It is necessary for advanced dental education programs to have input into the ADEA Commission on Change and Innovation (ADEA CCI) process from its inception. More input is necessary from postdoctoral educators concerning changes to predoctoral education, specifically in the progress of ADEA CCI.
- Develop new strategies for integration of biomedical sciences and professional studies with the applied clinical sciences. This recommendation reinforces the preceding recommendation. New strategies are needed for improving predoctoral education, specifically in improving the integration of biomedical and clinical sciences. New strategies (*e.g.*, evaluation of teaching strategies) are needed for improving retention of this information from the predoctoral level to the postdoctoral level.
- Identify and develop financial incentives for educators providing service in community settings. Financial incentives should be identified for dental residents and faculty to provide services in community settings (*e.g.*, rural areas, indigent populations, nursing homes).
- Increase advocacy by academic dentistry and intensify lobbying efforts by ADEA, stakeholders (*e.g.*, dental specialty groups, nursing home representatives, concerned citizens), and others at local, state, and federal levels and in corporate and private sectors. Petition local, state, and federal agencies, corporations, and private sector groups to increase funding and other support for community dental programs.

Recommendations to address the recognition of nonspecialty interest areas in general dentistry and its effects on the dental education system and scope of practice.

- Programs need to be held to a similar level of competency as that set by the existing specialties.
- With the exception of oral medicine and dental anesthesiology, it is undesirable to accredit more general dentistry special area programs. CODA accreditation for other nonspecialty interest training programs is discouraged. It is potentially confusing to the public, may decrease the quality of patient care, and may interfere with the ability of recognized dental specialty training programs to recruit students.
- CODA should begin a moratorium on accrediting nonrecognized specialty programs until an outcomes assessment is performed and shared with the communities of interest. Outcomes assessment would be broad-based and include the possible effects on the public and other existing CODA-accredited advanced dental education training programs.
- Develop, through ADEA leadership, a public and professional education program to increase awareness of the advantages of advanced dental education specialty training and the differences there are in the scope of training and education provided.
- Request that CODA develop an open process and protocol as it evaluates recognition of new nonspecialty areas for accreditation.
- Request that CODA not recognize any additional general dentistry “special area” programs at this time because of lack of need and resources and because of public confusion.
- PGY-1 should be mandatory for all graduates.
- Postgraduate patient care experience in different demographic segments should include geriatric and special needs patients.

Recommendations to address the challenges faced by the dental professions, specialty groups, and academic dentistry in generating the resources needed to maintain and sustain advanced dental education programs.

- ADEA, with other professional organizations, should advocate public policy to expand and improve the profession (e.g., fund and expand schools’ ability to attract academicians). It is recommended that ADEA develop a strategy for taking the lead in working with other dental organizations to develop a consensus and work on advocacy with the goal of addressing public policy and expanding and improving the profession.
- Improve institutional environments so that recruitment and retention of board-certified faculty are increased. It is recommended that ADEA work to improve institutional environments in order to improve recruitment and retention of board-eligible/certified faculty. Improvements should be sought in workload flexibility, resources (e.g., research and administrative support), financing, and establishment of a systemwide mentorship program for students at all levels and for faculty.

- For faculty recruitment, develop a sense of value of an academic career for students, colleagues, administration, and the general public. Strategies include enlisting the ADEA Council of Deans in the process of understanding faculty issues and supporting change.
- For resident recruitment, promote the value of advanced dental education. This can be addressed, for example, by having faculty and residents act as role models for dental students. Other groups, such as the ADEA Council of Students, ASDA, and other dental societies, could be partners in this process.
- Address incentives and compensation. Improve compensation and incentives for full-time specialty faculty.
- Advocacy is needed to improve compensation and workforce issues. To improve compensation and workforce issues, expect advocacy from deans, schools, universities, and specialty organizations and foundations. These groups need to educate and lobby groups such as institutional boards of regents, trustees, and state and federal legislators regarding these issues.
- Develop business models with financial autonomy and transparency in budgets.
- Develop career track alternatives for clinical faculty.

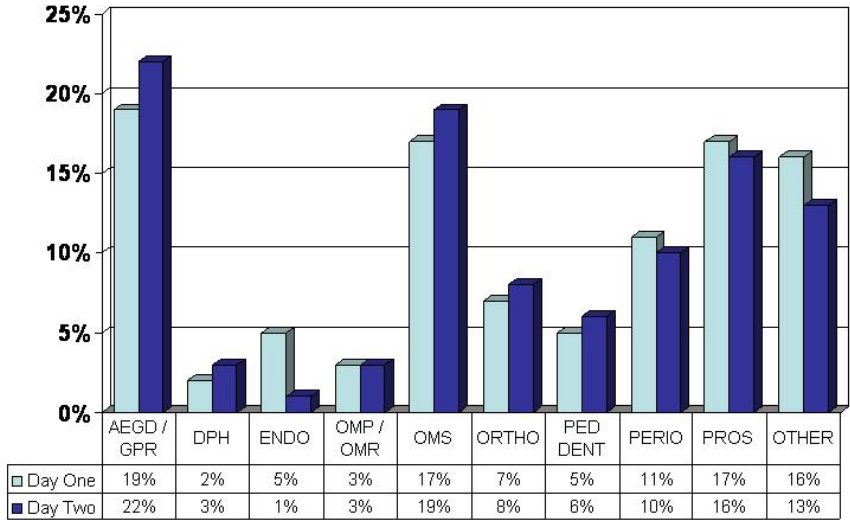
Recommendations to address the role of graduates of advanced dental education programs in increasing access to dental care for underserved and special needs populations and the underrepresentation of minorities in the dental profession and in pre- and postdoctoral dental education programs.

- Collect evidence, including focus group and marketing research, on what would work to entice underrepresented minority students to dental education.
- Introduce a partnership between dentistry, government, and industry to implement the successful models on a broader scale.
- Cultural competency should be added to all advanced dental education standards (not as a new standard but under an appropriate existing standard).
- ADEA should take a leadership position in acting as a clearinghouse of resources regarding cultural competency and consider making available a reference handbook for residents and students.
- ADEA should actively pursue the requirement that all dental students complete an accredited advanced dental education program (AEGD/GPR or specialty program; at minimum PGY-1) prior to licensure.
- ADEA should work with appropriate organizations to encourage uniformity (and reform) of national licensure that will, at a minimum, favorably encompass components and aspects of access to care.

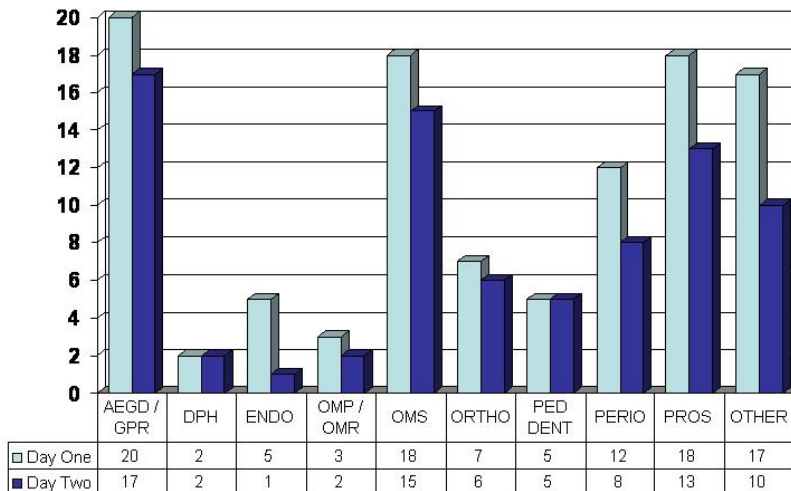
- Support adoption of predoctoral standards 2.2 and 2.14 for diversity statements for postdoctoral programs.
- Consider debt forgiveness and prorated compensation for dental professionals serving underserved areas or as educators.

APPENDIX G
Demographic Profile of Summit Participants

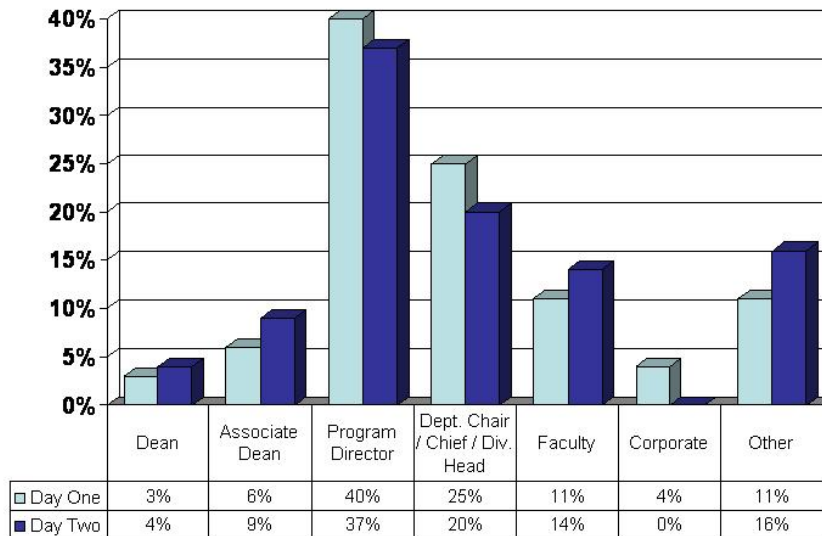
Participants by Specialty Area (percentage of total group)



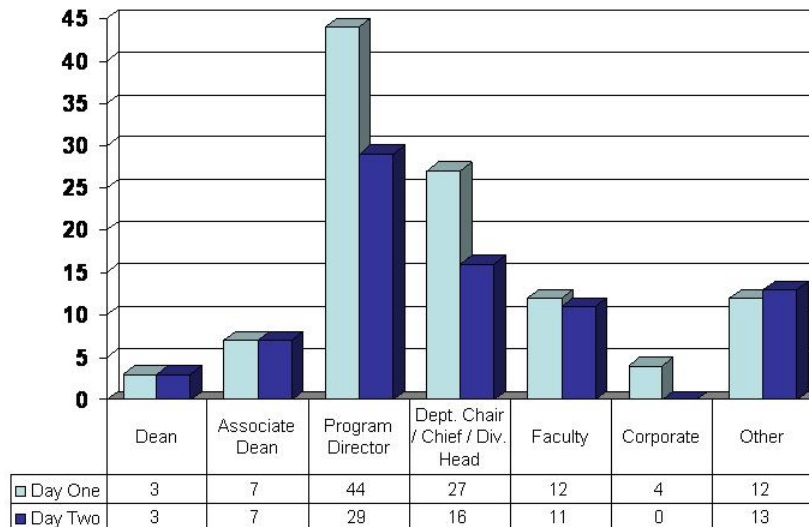
Participants by Specialty Area (actual count)



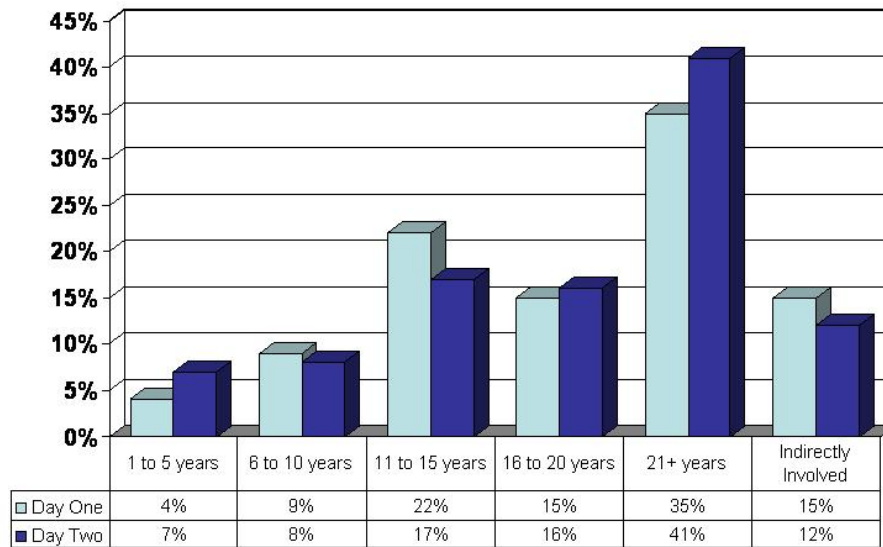
Participants by Role (percentage of total group)



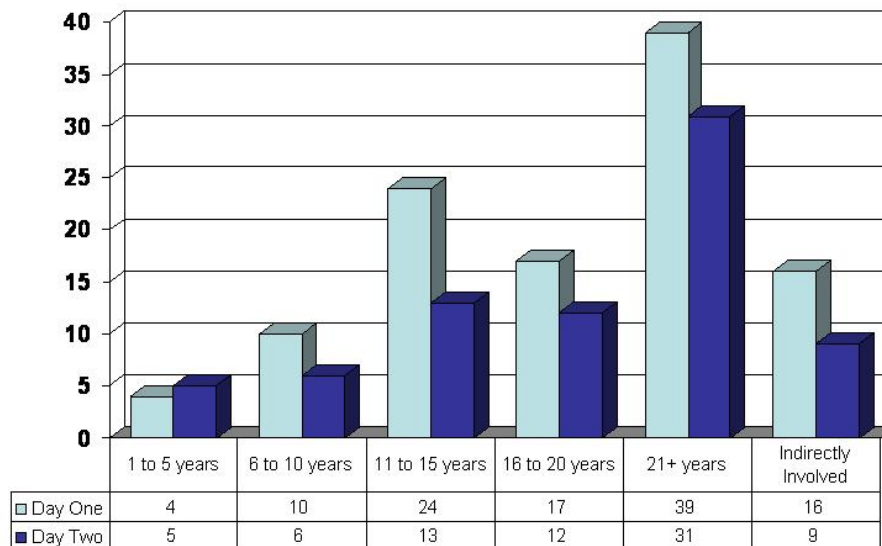
Participants by Role (actual count)



Participants by Time in Dental Education (percentage of total group)



Participants by Time in Dental Education (actual count)



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