Commission on Dental Accreditation

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

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link:
https://surveys.ada.org/jfe/form/SV_ehqpjQ5m2uAYkTP

Additions are Underlined;
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain

STANDARD 2 – EDUCATIONAL PROGRAM

2-1 The orofacial pain program **must** be designed to provide advanced knowledge and skills beyond the D.D.S. or D.M.D. training.

Curriculum Content

2-2 The program **must** either describe the goals and objectives for each area of resident training or list the competencies that describe the intended outcomes of resident education.

Intent: The program is expected to develop specific educational goals that describe what the resident will be able to do upon completion of the program. These educational goals should describe the resident's abilities rather than educational experiences the residents may participate in. These specific educational goals may be formatted as either goals and objectives or competencies for each area of resident training. These educational goals are to be circulated to program faculty and staff and made available to applicants of the program.

Examples of evidence to demonstrate compliance may include:
Written goals and objectives for resident training or competencies

2-3 Written goals and objectives **must** be developed for all instruction included in this curriculum.

Example of Evidence to demonstrate compliance may include:
Written goals and objectives
Content outlines

2-4 The program **must** have a written curriculum plan that includes structured clinical experiences and didactic sessions designed to achieve the program's written goals and objectives or competencies for resident training.

Intent: The program is expected to organize the didactic and clinical educational experiences into a formal curriculum plan. For each specific goal or objective or competency statement described in response to Standard 2-2, the program is expected to develop educational experiences designed to enable the resident to acquire the skills, knowledge, and values necessary in that area. The program is expected to organize these didactic and clinical educational experiences into a formal curriculum plan.

Examples of evidence to demonstrate compliance may include:
Written curriculum plan with educational experiences tied to specific written goals and objectives or competencies
Didactic and clinical schedules

Biomedical Sciences

2-5 Formal instruction **must** be provided in each of the following:

a. Gross and functional anatomy and physiology including the musculoskeletal and articular system of the orofacial, head, and cervical structures;

b. Growth, development, and aging of the masticatory system;

c. Head and neck pathology and pathophysiology with an emphasis on pain;

d. Applied rheumatology with emphasis on the temporomandibular joint (TMJ) and related structures;

e. Sleep physiology and dysfunction;

f. Oromotor disorders including dystonias, dyskinesias, and bruxism;

g. Epidemiology of orofacial pain disorders;

h. Pharmacology and pharmacotherapeutics; and

i. Principals of biostatistics, research design and methodology, scientific writing, and critique of literature.

2-6 The program **must** provide a strong foundation of basic and applied pain sciences to develop knowledge in functional neuroanatomy and neurophysiology of pain including:

a. The neurobiology of pain transmission and pain mechanisms in the central and peripheral nervous systems;

b. Mechanisms associated with pain referral to and from the orofacial region;

c. Pharmacotherapeutic principles related to sites of neuronal receptor specific action pain;

d. Pain classification systems;

e. Psychoneuroimmunology and its relation to chronic pain syndromes;

f. Primary and secondary headache mechanisms;

g. Pain of odontogenic origin and pain that mimics odontogenic pain; and

h. The contribution and interpretation of orofacial structural variation (occlusal and skeletal) to orofacial pain, headache, and dysfunction.

Behavioral Sciences

2-7 Formal instruction **must** be provided in behavioral science as it relates to orofacial pain disorders and pain behavior including:

a. cognitive-behavioral therapies including habit reversal for oral habits, stress management, sleep problems, muscle tension habits and other behavioral factors;

b. the recognition of pain behavior and secondary gain behavior;

c. psychologic disorders including depression, anxiety, somatization and others as they relate to orofacial pain, sleep disorders, and sleep medicine; and

d. conducting and applying the results of psychometric tests.

Clinical Sciences

2-8 A majority of the total program time **must** be devoted to providing orofacial pain patient services, including direct patient care and clinical rotations.

2-9 The program **must** provide instruction and clinical training for the clinical assessment and diagnosis of complex orofacial pain disorders to ensure that upon completion of the program the resident is able to:

a. Conduct a comprehensive pain history interview;

b. Collect, organize, analyze, and interpret data from medical, dental, behavioral, and psychosocial histories and clinical evaluation to determine their relationship to the patient's orofacial pain and/or sleep disorder complaints;

c. Perform clinical examinations and tests and interpret the significance of the data;

Intent: *Clinical evaluation may include: musculoskeletal examination of the head, jaw, neck and shoulders; range of motion; general evaluation of the cervical spine; TM joint function; jaw imaging; oral, head and neck screening, including facial-skeletal and dental-occlusal structural variations; cranial nerve screening; posture evaluation; physical assessment including vital signs; and diagnostic blocks.*

d. Function effectively within interdisciplinary health care teams, including the recognition for the need of additional tests or consultation and referral; and

Intent: *Additional testing may include additional imaging; referral for psychological or psychiatric evaluation; laboratory studies; diagnostic autonomic nervous system blocks, and systemic anesthetic challenges.*

e. Establish a differential diagnosis and a prioritized problem list.

2-10 The program **must** provide training to ensure that upon completion of the program, the resident is able to manage patients with special needs.

Intent: *The program is expected to provide educational instruction, either didactically or clinically, during the program which enhances the resident's ability to manage patients with special needs.*

Examples of evidence to demonstrate compliance may include:
Written goals and objectives or competencies for resident training related to patients with special needs
Didactic schedules

2-11 ~~**2-10**~~ The program **must** provide instruction and clinical training in multidisciplinary pain management for the orofacial pain patient to ensure that upon completion of the program the resident is able to:

a. Develop an appropriate treatment plan addressing each diagnostic component on the problem list with consideration of cost/risk benefits;

b. Incorporate risk assessment of psychosocial and medical factors into the development of the individualized plan of care;

c. Obtain informed consent;

d. Establish a verbal or written agreement, as appropriate, with the patient emphasizing the patient's treatment responsibilities;

e. Have primary responsibility for the management of a broad spectrum of orofacial pain patients in a multidisciplinary orofacial pain clinic setting, or interdisciplinary associated services. Responsibilities should include:

1. intraoral appliance therapy;
2. physical medicine modalities;
3. sleep-related breathing disorder intraoral appliances;
4. non-surgical management of orofacial trauma;
5. behavioral therapies beneficial to orofacial pain; and
6. pharmacotherapeutic treatment of orofacial pain including systemic and topical medications and diagnostic/therapeutic injections.

Intent: *This should include judicious selection of medications directed at the presumed pain mechanisms involved, as well as adjustment, monitoring, and reevaluation.*

Common medications may include: muscle relaxants; sedative agents for chronic pain and sleep management; opioid use in management of chronic pain; the adjuvant analgesic use of tricyclics and other antidepressants used for chronic pain; anticonvulsants, membrane stabilizers, and sodium channel blockers for neuropathic pain; local and systemic anesthetics in management of neuropathic pain; anxiolytics; analgesics and anti-inflammatories; prophylactic and abortive medications for primary headache disorders; and therapeutic use of botulinum toxin injections.

Common issues may include: management of medication overuse headache; medication side effects that alter sleep architecture; prescription medication dependency withdrawal; referral and co-management of pain in patients addicted to prescription, non prescription and recreational drugs; familiarity with the role of preemptive anesthesia in neuropathic pain.

2-12 ~~2-11~~ Residents **must** participate in clinical experiences in other healthcare services (not to exceed 30% of the total training period).

Intent: *Experiences may include observation or participation in the following: oral and maxillofacial surgery to include procedures for intracapsular TMJ disorders; outpatient anesthesia pain service; in-patient pain rotation; rheumatology, neurology, oncology, otolaryngology, rehabilitation medicine; headache, radiology, oral medicine, and sleep disorder clinics.*

2-13 ~~2-12~~ Each assigned rotation or experience **must** have:

a. written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;
b. resident supervision by designated individuals who are familiar with the objectives of the rotation or experience; and
c. evaluations performed by the designated supervisor.

Intent: *This standard applies to all assigned rotations or experiences, whether they take place in the sponsoring institution or a major or minor activity site. Supplemental activities are exempt.*

Examples of evidence to demonstrate compliance may include:
Description and schedule of rotations
Written objectives of rotations
Resident evaluations

2-14 ~~2-13~~ Residents **must** gain experience in teaching orofacial pain.

Intent: *Residents should be provided opportunities to obtain teaching experiences in orofacial pain (i.e. small group and lecture formats, presenting to dental and medical peer groups, predoctoral student teaching experiences, and/or continuing education programs.*

2-15 ~~**2-14**~~ Residents **must** actively participate in the collection of history and clinical data, diagnostic assessment, treatment planning, treatment, and presentation of treatment outcome.

2-16 ~~**2-15**~~ The program **must** provide instruction in the principles of practice management.

Intent: *Suggested topics include: quality management; principles of peer review; business management and practice development; principles of professional ethics, jurisprudence and risk management; alternative health care delivery systems; informational technology; and managed care*; *medicolegal issues, workers compensation, second opinion reporting; criteria for assessing impairment and disability; legal guidelines governing licensure and dental practice, scope of practice with regards to orofacial pain disorders, and instruction in the regulatory requirements of chronic opioid maintenance.*

Examples of evidence to demonstrate compliance may include:
Course outlines

2-17 ~~**2-16**~~ Formal patient care conferences **must** be held at least ten (10) times per year.

Intent: *Conferences should include diagnosis, treatment planning, progress, and outcomes. These conferences should be attended by residents and faculty representative of the disciplines involved. These conferences are not to replace the daily faculty/resident interactions regarding patient care.*

Examples of evidence to demonstrate compliance may include:
Conference schedules

2-18 ~~**2-17**~~ Residents **must** be given assignments that require critical review of relevant scientific literature.

Intent: *Residents are expected to have the ability to critically review relevant literature as a foundation for lifelong learning and adapting to changes in oral health care. This should include the development of critical evaluation skills and the ability to apply evidence-based principles to clinical decision-making.*

Relevant scientific literature should include current pain science and applied pain literature in dental and medical science journals with special emphasis on pain mechanisms, orofacial pain, head and neck pain, and headache.

Examples of evidence to demonstrate compliance may include:
Evidence of experiences requiring literature review

Program Length

2-19 ~~**2-18**~~ The duration of the program **must** be at least two consecutive academic years with a minimum of 24 months, full-time or its equivalent.

Examples of evidence to demonstrate compliance may include:
Program schedules
Written curriculum plan

2-20 ~~**2-19**~~ Where a program for part-time residents exists, it **must** be started and completed within a single institution and designed so that the total curriculum can be completed in no more than twice the duration of the program length.

Intent: *Part-time residents may be enrolled, provided the educational experiences are the same as those acquired by full-time residents and the total time spent is the same.*

Examples of evidence to demonstrate compliance may include:
Description of the part-time program
Documentation of how the part-time residents will achieve similar experiences and skills as full-time residents
Program schedules

Evaluation

2-21 ~~**2-20**~~ The program's resident evaluation system **must** assure that, through the director and faculty, each program:

a) periodically, but at least two times annually, evaluates and documents the resident's progress toward achieving the program's written goals and objectives of resident training or competencies using appropriate written criteria and procedures;

b) provides residents with an assessment of their performance after each evaluation. Where deficiencies are noted, corrective actions **must** be taken; and

c) maintains a personal record of evaluation for each resident that is accessible to the resident and available for review during site visits.

Intent: *While the program may employ evaluation methods that measure a resident's skills or behavior at a given time, it is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific goals and objectives or competencies for resident training described in response to Standard 2-2.*

Examples of evidence to demonstrate compliance may include:

Written evaluation criteria and process
Resident evaluations with identifying information removed
Personal record of evaluation for each resident
Evidence that corrective actions have been taken